PSA

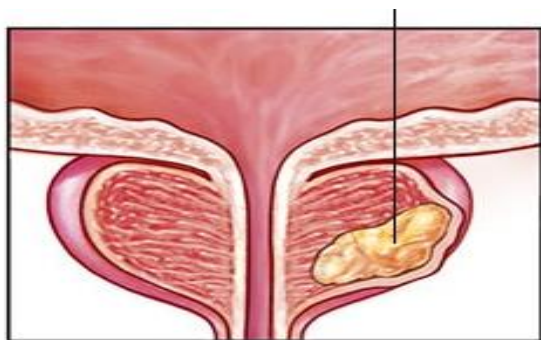
Patient Safety America Newsletter

May 2024 http://PatientSafetyAmerica.com John T. James, Ph.D.

Question: Among opioid users, how much more likely are fatal falls of 85+ adults than adults <44?
A) 10 B) 25 C) 100 D) 250 E) 1,000

Screening for Prostate Cancer

Screening for prostate cancer has evolved substantially from the days when an elevated PSA was used to go directly to a prostate biopsy. These biopsies had a low yield of finding any cancer and many of those found were low grade. There were significant risks of harm from the biopsies. Three MDs editorialized on how things have changed.[1] Soon came the idea of 'watchful waiting.' In 2012 the USPSTF downgraded the use of PSA screening to a 'D,' which means discourage use. Following more research, the use of PSA screening was updated in 2018 to a level 'C,' which means that the service may be offered only if other considerations support the service. Studies have suggested that MRIs could be used to discern whether a prostate biopsy is warranted; however, the writers of the editorial suggest that there is a wide variety in the quality of reading of MRIs for this purpose. The goal is to identify high-grade cancers without putting the patient through an unnecessary biopsy. If the MRI appears to show a potential cancer, then the question becomes whether to perform a targeted biopsy or a 12-section, systematic biopsy. This depends on how trustworthy the reading of the MRI is assumed to be. (image from Mayo Clinic)



Prostate with cancer

From the patient's viewpoint, he must step carefully if an elevated PSA measurement is found. As I recall in the early 2000s, one indicator for a biopsy was how rapidly the PSA was increasing. This fits in with the idea of watchful waiting. One's age and health status must also be factored into the choices. This is a great opportunity to engage in shared decision-making with your clinician.

Opioid Use and Risk of Serious Falls

A study of Australians who started taking an opioid sought to discover if the risk of falls was higher in older adults.[2] The investigators compiled the falls into two categories – serious, non-fatal falls and serious, fatal falls. The age categories were as follows: 18-44, 45-64, 65-84, and 85+. The rates of non-fatal falls, per person-years of opioid use were as follows: 59, 122, 439, 1717, respectively. The rates of fatal falls per person-year of opioid use were as follows: 0.12, 0.45, 3.3 and 30.9, respectively.

The investigators opined that clinicians should consider the risk of falls when considering a prescription for opioids, especially for those older than 84. The risk of falls was most common in the first month of initiating opioid use. The message here for caregivers and patients alike, is to use opioids only with careful attention to fall mitigation.

[1] https://jamanetwork.com/journals/jama/article-abstract/2817324

[2] https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/281500

Reduced Risk of Heart Failure with Physical Activity

Years ago, I had a marvelous colleague in toxicology who also supported the space program through the days of Mir, the Space Shuttle, and the International Space Station. Don was a huge man. Once when there was a chance to snag a ride somewhere or walk a half mile to our destination, he told me about his philosophy on walking. He said, 'God gives you a specific number of heartbeats and I do not want to waste them walking.'

This month a new study was published that showed that accelerometer-measured physical activity is inversely associated with the risk of heart failure in older women.[3] The investigators gathered a group of almost 6,000 women of average age 79 years and with a diverse racial background – black, Hispanic, and white. Over an average monitoring period of 7 ½ years, there were 407 cases of heart failure. The amount of physical activity in the women was divided into quartiles from lowest activity to most activity. The assigned risk of heart failure was '1.00' in the lowest activity group, and then that was compared to the risk in the other three groups. They applied three models to their data. Here I will report the average of the three models of risks. In order of increasing physical activity, the risk of heart failure was as follows: 0.71, 0.71, and 0.58. In other words, there was a declining risk even in the second quartile of physical activity and it was greatest in the group with the most physical activity recorded by the accelerometer. They also found that higher rates of sedentary time were inversely associated with the risk of heart failure.

The lesson here is obvious. If you want to reduce your risk of heart failure, then get moving. If you know an elderly person who has a sedentary lifestyle, encourage them to discover the joys of physical activity.

Food Insecurity and Toxic Stress in Children

A viewpoint published in *JAMA Pediatrics* and written by three experts calls on we Americans to do more to reduce the toxic effects of food insecurity in children.[4] By 'toxic effect' the authors mean a strong frequent or prolonged stressor without a supportive environment. The authors note that food insecurity disproportionately affects families with children and families of color. It is considered pervasive and persistent in our country.

What can be done to reduce this harm to children. First, pediatricians need to screen children for food insecurity using the Hunger Vital Sign. If the screening indicates food insecurity, then families can be referred to programs that provide food. There should be more attention to the concept that '[nutritious] food is medicine.' Finally, there should be more research to better characterize the origins of childhood food insecurity. Let me give you an example. I work at a food distribution site near Houston's inner city. Most of our clients drive through to get the groceries we distribute but we also have about a dozen walk ups each week to get food. There are typically preschool children in this line. These are presumably families that do not have a vehicle. We have just been told by the Houston Food Bank that we can only serve people driving through in a vehicle. I find that policy a little disturbing.

My suggestion to you is to go work at a food bank or food distribution site. Don't make excuses. One man that occasionally works with us is wheelchair bound and uses oxygen.

FDA's Accelerated Approval of Cancer Drugs

Cancer often elicits plenty of fear in the one getting that diagnosis. This may lead to desperate attempts to 'try anything' that could fight the cancer. If the cancer drug you are considering has received accelerated approval from the FDA, you may want to look further into its effectiveness. A small team of experts investigated the follow up studies after accelerated approval to discern how many cancer drugs proved effective.[5] They looked at drugs given this approval from 2013 to 2023 for 46 indications

[3] https://jamanetwork.com/journals/jamacardiology/article-abstract/2815

[4] https://jamanetwork.com/journals/jamapediatrics/article-abstract/2814613

[5] https://pubmed.ncbi.nlm.nih.gov/38583175/

with 5 years of follow up. Only 20 of the 46 indications for the drugs were found to produce a benefit, as measured by survival time or quality of life, after the follow up period. The authors' concluding statement was as follows: 'Patients should be clearly informed about the cancer drugs that use the accelerated approval pathway and do not end up showing benefits in patient-centered clinical outcomes.' I would add that if a cancer drug has received accelerated approval and has yet to be properly tested for its benefits and risks, then the patient should be told that reality before receiving the drug.

The Physicians Duty to Warn – and Yours

Getting old is not for sissies, as the saying goes. As one ages into their 70s, life becomes a process of giving up things that matter. For me the give-ups have included not climbing on a long ladder (mine was 'stolen'), not playing football, and not running due to back problems. Perhaps the most dreaded give-up is one's driver's license. A commentary in *JAMA Network Open* made the case that physicians have a duty to warn a patient, or her family, if their driving is likely to pose an unusual hazard.[6] Dementia kills about 100,000 Americans each year, so often the call to give up one's driver's license is present with that diagnosis. Some states have mandatory reporting of dementia; however, this seems to cause underdiagnosis, perhaps because neither the patient nor the clinician want to admit the diagnosis. It seems that loss of driving privileges is associated with a 25% increase in depression. Counselling the patient may be warranted.

One important factor that was overlooked in the commentary is the role of the family. They are likely to observe factors related to dangerous driving. As I recall in my family, these included the following: getting lost on familiar roads, adding scrapes to various parts of the vehicle, displacing parts of the garage upon entering it, missing red lights, slow reaction times, and trying to prove one's capability by driving too fast. My point is that the family has the ultimate responsibility in taking away someone's driver's license. I can attest that that is not easy.

Improving Discharge after Surgery

A team from the Veterans Health Administration engaged a variety of key players in the discharge process to discern how to improve this part of patient care.[7] Mistakes made during the discharge process can result in serious injury or even death. The study involved the team approach in which experts voiced their ideas about what should be included. Their findings were as follows: pain control, wound care, ostomies, tubes, drains, social situation, and team coordination. This was a small study done essentially at one hospital. The investigation found several challenges, which in decreasing order of discussion, were as follows: social and home situation, team communication, alignment with patient expectations, and complexity of care.

This is important information for those receiving a surgical patient into their care after surgery and discharge from the hospital. When one assumes that role, there is no such thing as asking too many questions and making certain that you understand the instructions. You should also know what to look out for in your patient that may suggest deterioration or complication. You should know who to call if something is going wrong.

Alcohol Use Disorder (AUD) Needs More Attention

Many of us know of someone who overuses alcohol and perhaps someone who has died from alcoholism. Three experts wrote a brief editorial about system and clinician failures when it comes to treating AUD with medications for AUD (MAUD).[8] Studies show that roughly 140,000 Americans die each year from alcohol misuse. Estimates are that 30 million Americans have AUD. There are three drugs known to offer effective treatment for AUD –

[6] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2818090

[7] https://pubmed.ncbi.nlm.nih.gov/38381415/

[8] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2816968

naltrexone, acamprosate, and disulfiram. One study showed that only 1 % of hospitalized Medicare patients with AUD used a medication for its treatment within a month of discharge. This is clearly a missed opportunity for improving patient care. However, when patients with AUD are discharged with a prescription for MAUD, only a small percentage fill the prescription.

The editorial goes on to explore the reasons clinicians fail to prescribe MAUDs. These include not having sufficient knowledge of MAUD even though the risks are minimal and sometimes overestimated, they do not understand how to integrate MAUD into the discharge plan, and the stigma of declaring that the extent of alcohol use in a given patient may be difficult to discuss. The editorialists ultimately opine that most patients with AUD do not receive evidence-based care. The Mayo Clinic has information on diagnosing AUD.[9]

Interesting Links

Jake Tapper reports on his daughter's frightening misdiagnosis:
https://www.youtube.com/watch?app=desktop&si=Tfsi8vgQKsPvuHtI&v=oh-Zt5CbQwM&feature=youtu.be

Stigmatizing patients and medical error:
https://www.medscape.com/viewarticle/1000689?ecd=wnl_edit_tpal_etid6447929&uac=121038BT&impID=6447929

Two-hour video of a Senate hearing on money and healthcare (view Berwick's testimony (1:05-1:10):
https://www.help.senate.gov/hearings/when-health-care-becomes-wealth-care-how-corporate-greed-puts-patient-care-and-health-workers-at-risk

Private equity risk scores by states (Texas is very high risk): https://privateequityrisk.org/

Hospital understaffing in Michigan attacked by widower:
https://kffhealthnews.org/news/article/nurse-ratios-understaffed-hospitals-michigan-legislation-detective-wife/

A surgeon cuts into our failing healthcare system:
https://www.generalsurgerynews.com/Opinion/Article/03-24/It-Cant-Happen-to-Us/73083

A new COVID variant (named FLiRT) to worry about:
https://time.com/6972143/covid-19-flirt-variants-kp-2/

Walmart to close its health centers due to low reimbursements and rising costs:
https://www.cnbc.com/2024/04/30/walmart-to-shutter-health-centers-virtual-care-service.html

Nursing Homes mandated to increasing nurse to patient ratios:
https://www.mcknights.com/news/breaking-cms-increases-hours-to-3-48-in-final-staffing-rule/

Answer to the Question: (D) about 260 based on findings reported in reference # 2.

Find past newsletters:
http://patientsafetyamerica.com/e-newsletter/

[9] https://www.mayoclinic.org/diseases-conditions/alcohol-use-disorder/symptoms-causes/syc-20369243