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Approaching the "Do Not Resuscitate" Issue with AIDS Patients

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WHEN TERMINALLY ILL patients are admitted to the hospital, the decision to resuscitate often rests with the patient or family. The time of hospital admission may not be an ideal setting to address the "do not resuscitate" (DNR) issue. Many states in the U.S. have pending or no legislation concerning the DNR question. When the issue is resolved legally, however, the problem of when and where it should be approached will still remain.

We have assessed the charts of all AIDS patients admitted to our hospital from March 1983 through July 19, 1988. Only two charts of 76 were unavailable for review. The 74 charts reviewed showed that 50% of patients died in the hospital, 39% were discharged, 3% signed out against medi-

cal advice, and 8% remain hospitalized. Of the 37 patients that died at the Lutheran Medical Center, only 30% had DNR orders; 70% were resuscitated.

It is interesting to note that there was no written documentation of any discussion, with the patient or family, about options other than the use of aggressive life-support systems in any of the cases that were resuscitated. In cases with DNR orders, the decision had been made by the patient or family during the hospitalization period. Only one patient came to the hospital with a living will. It is surprising that the DNR issue had never been raised before the crisis of an admission.

Intravenous drug abusers make up 63% of our AIDS patients. They often lack family support, legal counsel, and financial resources. Intravenous drug abusers usually do not have a primary physician, and often will have various physicians assigned to them on admission, thereby contributing to a fragmentation of information.

Drug abusers are frequently unaware of the resources that are offered to AIDS patients and rely on the hospital social service department for obtaining these resources. Therefore, it is incumbent upon social workers whose patients have AIDS to be aware of the biopsychosocial implications of HIV infection and of the government and community resources available. Many intravenous drug abusers with AIDS are unaware that they can request DNR orders.

We believe that our experience at the Lutheran Medical Center can assist other institutions with the dilemma encountered with terminally ill AIDS patients.¹ The AIDS patient and family must be asked about possible limitation of aggressive medical management. It would be best to discuss this with AIDS patients while they are still ambulatory. Patients' psychological status would have to be evaluated in order to approach the issue with sensitivity.²

Early discussion of DNR is beneficial for both the patients^{3,4} and the case management team. The patients are generally healthier, are stronger, and have clearer minds than when they are hospitalized, and therefore are better able to make informed decisions. Contrary to popular beliefs, discussion of DNR may help decrease, rather than increase, anxiety. When patients are skillfully helped to explore their options, they end up feeling more in control of their fate. This helps prepare the patients for the process of dying.⁵

It is essential to use the services of mental health professionals trained in working with terminally ill patients to evaluate mental status, suicidal risk, and social support systems. Professionals in medicine, nursing, social work, and mental health act as a case management team. The team management benefits from this multi-disciplinary approach by sharing responsibility, by allowing discussion of patient management, and by reduction of professional burnout.

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PRESCRIBING INFORMATION

Indications

Alupent has been found useful in the following conditions: Bronchial asthma, Chronic bronchitis, pulmonary emphysema. Alupent is also useful in sarcoidosis, silicosis, carcinoma of the lung and tuberculosis when bronchospasm contributes to the disability. When used regularly, Alupent offers effective management of chronic bronchospasm with reduction in frequency and severity of acute attacks.

Dosage

As with all drugs, the ideal dosage of Alupent varies from patient to patient. The following recommended dosages represent general guidelines which will be found suitable for the majority of patients.

Tablets 20 mg

Ages 4-12, 10 mg (1/2 tablet) t.i.d.
above 12, 20 mg (1 tablet) t.i.d. — q.i.d.

Syrup 10 mg/5 ml

Ages 4-12, 10 mg (one teaspoonful) t.i.d.
above 12, 20 mg (two teaspoonful) t.i.d. — q.i.d.

Metered Aerosol

One to two inhalations will usually provide control of an acute attack of bronchospasm for periods of 5 hours or longer. As a general rule, patients should not exceed a total of 12 inhalations per day.

Solution 5%

Hand nebulizer: 5 to 15 inhalations of 5% solution by hand nebulizer DeVilbiss No. 40 or 42 administered up to three times daily. Intermittent positive pressure breathing: 1/2-1 ml of 5% solution diluted if desired and administered over a period of about 20 minutes.

Side Effects

In the recommended dosage, adverse reactions to Alupent are infrequent. Mild tachycardia, nausea, vomiting, palpitations, minimal hypertension, nervousness, bad taste and tremor have been reported.

Precautions

In acute tests, Alupent has shown minimal effect on blood pressure and pulse. The drug should be used with care, however, in asthmatic or emphysematous patients who also have systemic hypertension, coronary artery disease, acute and recurring congestive heart failure, diabetes mellitus, glaucoma or hyperthyroidism. Extreme care must also be exercised in the concomitant use of Alupent with epinephrine or MAO inhibitors.

Warnings

Alupent should not be administered to pregnant women or to women of childbearing potential unless, in the opinion of the physician, the expected benefits outweigh the possible risk to the foetus. Occasional patients have been reported to have developed severe paradoxical airways resistance with repeated excessive use of sympathomimetic inhalation preparations. The cause of this refractory state is unknown. It is advisable that in such instances the use of the preparation be discontinued immediately and alternative therapy instituted, since in the reported cases the patients did not respond to other forms of therapy until the drug was withdrawn. Fatalities have been reported following excessive use of isoproterenol inhalation preparations and the exact cause is unknown. Cardiac arrest was noted in several instances.

Patients should be advised to seek medical aid in the event that they do not respond to their usual dose of a sympathomimetic amine aerosol. The failure to respond may be due to retention of viscid bronchial secretions, associated with an allergic or infective exacerbation of the patient's condition.

Increased airways resistance on the basis of bronchospasm alone is reversed promptly by bronchodilators, and if this does not occur, a more serious condition should be suspected. Admission to hospital for intensive support of the cardiovascular and respiratory systems may be necessary.

Contraindications

Known sensitivity to the drug or other sympathomimetic amines. The use of Alupent and other beta stimulators is generally considered to be contra-indicated in patients with cardiac arrhythmias associated with tachycardia. Beta blocking agents, e.g. propranolol, effectively antagonize the action of Alupent. Their concomitant use, except in the treatment of accidental over-dosage, is therefore contraindicated.

Availability

Alupent 20 mg tablets are available as round, white, single scored compressed tablets, printed on one side with the Boehringer Ingelheim symbol. Supplied in bottles of 100 and 500.

Alupent Syrup is clear, sugar-free and woodruff flavoured. 5 ml contains 10 mg of active ingredient. Supplied in bottles of 250 ml.

Alupent Metered Aerosol is supplied as a 15 ml metal vial (with free disposable mouthpiece) containing 300 individual doses. Each depression of the valve releases 0.75 mg of active ingredient as a micronized powder.

Alupent Solution 5% is supplied in bottles containing 10 ml.

For further information consult the Alupent Product Monograph or your Boehringer Ingelheim representative.

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We believe that the DNR decision can be approached with dignity and should not be made under duress in a crisis situation.⁶ Terminally ill AIDS patients are best approached in an ambulatory setting where they have an increased feeling of security and control over their decisions. ■

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