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Articles of interest in other scholarly journals

THE INCIDENCE AND PREVALENCE OF DELIRIUM ACROSS PALLIATIVE CARE SETTINGS: A SYSTEMATIC REVIEW

- Watt CL, Momoli F, Ansari MT, *et al*. The incidence and prevalence of delirium across palliative care settings: a systematic review. *Palliat Med* 2019;33(8):865–877. doi: 10.1177/0269216319854944.

This is a systematic review and meta-analysis looking at delirium in palliative care settings. There were 2596 records screened, and 42 studies were included. A total of 16 491 palliative care patients were included. The studies were conducted in 13 different countries. Studies (n=26) were in a single centre: 12 in a specialist palliative care unit based in a hospital, 7 in a cancer centre and 7 in a hospice. Three studies were conducted in the community. Of the remaining studies, seven had specialist palliative care team advice to teams caring for inpatient medical or oncology patients. The main diagnosis in the included studies was cancer (n=34), while other studies had mixed diagnoses (n=8). To diagnose delirium, 17 different delirium diagnostic tools were used. The Confusion Assessment Method was the most frequently used (n=17), followed by the Diagnostic and Statistical Manual of Mental Disorders-IV (n=10). The point prevalence estimate of delirium in the community was 4%–12%, in hospital palliative care consultative services was 9%–57% and in inpatient palliative care units was 6%–74%. Across all palliative care settings (n=8), the prevalence of delirium prior to death was 42%–88%. Only one study had an overall low risk of bias. In the meta-analyses, 14 studies were included that reported the point prevalence of delirium on admission to an inpatient palliative care unit; pooled point prevalence showed a point prevalence estimate of 35% (95% CI 0.29 to 0.40) on inpatient admission, with high heterogeneity between studies (I^2=85%). This paper concludes that delirium is highly prevalent across all palliative care settings, tends to be lowest on admission, increases during follow-up and is most prevalent prior to death. This study emphasises the potential need for screening of delirium and the importance of rapid recognition in palliative care.

OPIOID SAFETY AND CONCOMITANT BENZODIAZEPINE USE IN END-STAGE RENAL DISEASE PATIENTS

- Rupam Ruchi, Shahab Bozorgmehri, Tezcan Ozrazgat-Baslanti, *et al*. Opioid safety and concomitant benzodiazepine use in end-stage renal disease patients. *Pain Res Manag* 2019;2019:3865924. doi: 10.1155/2019/3865924.

This retrospective analysis of the US Renal Data System aimed to describe the use of opioids alone and in combination with benzodiazepines in patients with end-stage renal disease (ESRD) on haemodialysis (excluding those with malignancy) between 2006 and 2012, and to correlate it with their safety outcomes. The main measures collected were hospital admission with a diagnosis of prescription opioid overdose within 30, 60 and 90 days of prescription and death due to opioid overdose. Throughout the study period, out of the included cohort of 643,859 patients, 74.6% patients received at least one prescription of opioid; resulting in 52.2% patients being prescribed an opioid annually. The overall trend in opioid prescription has been increasing. Among patients on opioids, 3231 had 4014 hospital admissions with opioid overdose (the median length of hospital stay was 4 days; IQR: 2–8), with 5 deaths. Fentanyl and hydromorphone were associated with 2.5–3 times higher odds of hospitalisation due to overdose. Methadone was found to be associated with a very high risk of hospitalisation at 30, 60 and 90 days (OR 5.9, 5.3 and 4.7, respectively). Oxycodone demonstrated a high risk of hospitalisation (OR >3). Of the patients on an opioid, 30% also received a prescription for a benzodiazepine. Prescription of benzodiazepines significantly increased the odds of hospitalisation due to opioid overdose by 50% within 30, 60 and 90 days ($p<0.05$). Opioids were associated with four to five times more hospital admissions in the ESRD population compared with the general population. Concurrent benzodiazepine use is common and associated with a higher risk of hospitalisation due to opioid overdose. The authors suggest that prospective studies are needed to manage opioids and benzodiazepines in patients with ESRD.

REGULAR, SUSTAINED-RELEASE MORPHINE FOR CHRONIC BREATHLESSNESS: A MULTICENTRE, DOUBLE-BLIND, RANDOMISED, PLACEBO-CONTROLLED TRIAL

- Currow D, Louw S, McCloud P, Fazekas B, *et al*. Regular, sustained-release morphine for chronic breathlessness: a multicentre, double-blind, randomised, placebo-controlled trial. *Thorax* 2020;75:50–56. 10.1136/thoraxjnl-2019-213681

This is a phase III, parallel-arm, double-blind, multisite, randomised controlled trial in Australia where adults with chronic breathlessness received either 20 mg daily oral slow release (SR) morphine (intervention, n=145) or placebo (control, n=139) for 7 days. The primary outcome was change from baseline in intensity of breathlessness now (0–100 mm Visual Analogue Scale; two times per day diary) between groups. This study

was powered to detect a clinically meaningful difference, and analyses were on an intention-to-treat basis. The mean age of the recruited patients was 74.3 years (SD 9.33 years); 180 (63%) were men. There was no difference in the primary endpoint between groups (mean difference −0.15 mm (95% CI −4.59 to 4.29; p=0.95). The placebo group used more doses of oral morphine solution during the treatment period (mean 8.7 vs 5.8 doses; p=0.001). The morphine group had more constipation and nausea/vomiting. There were no cases of respiratory depression or death. The authors suggest that a large trial is required to describe the effectiveness and optimal dose and to look at the population with the worst breathlessness, and to further assess the safety of SR morphine in patients with severe chronic breathlessness.

ESTIMATING SURVIVAL IN ADVANCED CANCER: A COMPARISON OF ESTIMATES MADE BY ONCOLOGISTS AND PATIENTS

- Smith-Uffen, M.E.S., Johnson, S.B., Martin, A.J., *et al*. Estimating survival in advanced cancer: a comparison of estimates made by oncologists and patients. *Support Care Cancer* 2019. doi:10.1007/s00520-019-05158-5.

This substudy recruited 26 medical oncologists and 179 patients (208 patients were enrolled in the primary study between April 2014 and December 2016) and compared their estimates of expected survival time. Patients were asked to give their expected best-case, most-likely and worse-case survival time, or not answer/don't know. The observed survival time (OST) was calculated from the enrolment date to the date of death or last follow-up. The authors defined a point estimate of survival as precise if it was within 0.67–1.33 times the OST. The oncologists were asked to give the median survival for each of their patients. The results showed that the median estimate of survival from oncologists was 6 months (IQR 6–10 months); 27% of oncologists' estimates met the criterion for precision of OST, 44% estimated shorter than OST and 56% longer than OST. Of the patients, 60% reported 'I don't know' to estimates of survival. Only 47 patients provided a survival estimate. Forty patients provided estimates of most likely survival, and of these estimates 85% were longer than their OST. The authors point out the fact that despite the estimated expected survival time being less than 12 months, most patients did not know this. This study highlights the need for oncologists to have conversations about prognosis in patients with advanced cancer.

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