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HEPP REPORT

May 2003 Vol. 6, Issue 5

HIV & HEPATITIS
EDUCATION
PRISON
PROJECT

INFECTIOUS DISEASES IN CORRECTIONS

SPONSORED BY THE BROWN MEDICAL SCHOOL OFFICE OF CONTINUING MEDICAL EDUCATION.

ABOUT HEPP

HEPP Report, a forum for correctional problem solving, targets correctional physicians, nurses, administrators, outreach workers, and case managers. Published monthly and distributed by email and fax, HEPP Report provides up-to-the moment information HIV/AIDS, hepatitis, and other infectious diseases, as well as efficient ways to administer treatment in the correctional environment. Continuing Medical Education credits are provided by the Brown University Office of Continuing Medical Education. HEPP Report is distributed to all members of the Society of Correctional Physicians (SCP) within the SCP publication, CorrDocs (www.corrdocs.org).

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PROVIDING PALLIATIVE CARE FOR INCARCERATED PATIENTS

By Joseph Bick, M.D.*, Director, HIV Treatment Services, California Medical Facility, California Department of Corrections

During the past decade, this country has witnessed an increased emphasis on pain management and palliative care. Clinicians are being encouraged to more effectively alleviate pain in terminally ill patients, and there has been an intensified effort to encourage individuals to establish advance directives such as resuscitation status, living wills, and power of attorney. The routine assessment of pain has been advanced as the "fifth vital sign." These and other initiatives have raised awareness about end-of-life issues, and have contributed to an evolving standard of care for terminally ill patients.

Meanwhile, determinate sentencing, "three strikes" laws, and anti-drug initiatives have led to an overwhelming increase in the number of prisoners in this country. As of June 2002, 2.1 million people were incarcerated in this country's jails and prisons - the first time the U.S. prison and jail population exceeded two million.¹ At the same time, the prison population is aging, with an increase in the proportion of inmates over 50 years old. Prisoners have a higher prevalence of HIV infection, hepatitis C infection, tobacco addiction, alcoholism, substance abuse, chronic lung diseases, and musculoskeletal disorders than similarly aged men and women who are not incarcerated.² Many inmates received inadequate health care prior to incarceration, and therefore present with more sequelae and more advanced forms of their chronic illnesses.

In spite of this increase in the number of aging, chronically and terminally ill inmates, most people give little thought to how prisoners die. However, case law has established a constitutional duty under the 8th Amendment to provide care to the incarcerated that is not "indifferent to serious medical needs."³ Certainly, the alleviation of pain and suffering of the terminally ill falls under this requirement.

Recently, several groups have brought attention to palliative care in the correctional setting. Standards have been drafted to help guide those providing palliative and hospice care to prisoners.^{4,5,6} As of 2001, formal correctional end-of-life care programs were in place in 33 states and the Federal Bureau of Prisons, with more programs under development.⁴ The World Health

Organization has published two booklets detailing pain and symptom management.^{7,8} What follows is based upon these publications (see related resources on page 5) and the author's experiences caring for terminally ill inmates.

PAIN AND SYMPTOM MANAGEMENT

Terminally ill patients frequently experience pain and other unpleasant symptoms secondary to their underlying illness. Each patient should undergo a careful initial evaluation of his or her pain. A pain history should include pain location, severity, aggravating and alleviating factors, whether the pain is constant or intermittent, if the pain interferes with daily activities or sleep, and what treatments have and have not worked in the past.

Patients should undergo a careful initial physical exam, which should be repeated regularly during the course of the patient's illness. Radiographic studies can detect bone lesions that might be treated with palliative radiotherapy. In general, studies should be limited to those that are intended to lead to relief of pain or other unpleasant symptoms.

Anger, anxiety, and depression are common in those who are terminally ill. A careful psychological evaluation is therefore important when constructing a comprehensive treatment plan for the patient. The involvement of mental health professionals who are experienced with death and dying issues is invaluable.

NOCICEPTIVE AND NEUROPATHIC PAIN

Pain can be classified as either nociceptive or neuropathic, and each type responds differently to treatment. Nociceptive pain occurs when nerve endings are stimulated, such as when a tumor expands in an organ, or metastasizes to bone. Neuropathic pain occurs when a nerve is injured

Continued on page 2

WHAT'S INSIDE

Ask the Expert	pg 6
Meeting Update	pg 8
Inside News	pg 9
Self-Assessment Test	pg 10

PROVIDING PALLIATIVE CARE...

(continued from page 1)

or compressed, and can involve peripheral or central nerves.

Noiceptive pain is usually responsive to analgesics, whereas neuropathic pain may not be adequately relieved by analgesics alone. With neuropathic pain, additional benefit may be achieved with the use of tricyclic antidepressants or anticonvulsants. Amitriptyline or imipramine in starting doses of 25-50 mg orally each day can provide significant relief. Doses should be titrated as tolerated to 50-100 mg each day. These agents should be administered at bedtime as they can cause sedation, dry mouth, and postural hypotension. The anticonvulsants carbamazepine (Tegretol) and valproic acid (Depakene) can also be helpful in the treatment of neuropathic pain. Carbamazepine should be started at an initial dose of 100 mg twice daily and increased by 200 mg a day every few days as tolerated. Valproic acid is initially dosed at 500 mg at bedtime, and increased if necessary 200 mg every few days to a maximum dose of 1500 mg.

ADMINISTERING ANALGESICS

The World Health Organization emphasizes that analgesics should be given by mouth and on a fixed schedule. In situations where oral treatment is not feasible, rectal suppositories, transdermal patches, or subcutaneous injections can be used. (See Tables 1 and 2 for dosing schedules of common analgesics.)

Analgesics prescribed for severe pain in the setting of a terminal illness should be administered at fixed intervals to avoid cycles of poorly controlled pain and the associated anxiety and psychological distress of worrying about the next dose of medication. Analgesic doses should be increased as needed, with each subsequent dose administered before the prior dose has worn off. If the patient waits until the pain is significant before requesting an additional dose, consistent relief of pain will not be achieved. Long-acting analgesics should be used for the majority of a patient's daily dose, with additional rescue doses prescribed for "breakthrough" pain caused by activities such as movement or dressing changes. Typical rescue doses should be 50-100% of the dose being given every 4 hours.

With regular use, tolerance to narcotic analgesics commonly develops. This physiologic process necessitates the use of higher narcotic doses to provide the same degree of relief. Patients develop a physical dependence and will experience withdrawal symptoms if narcotics are rapidly tapered or discontinued. This is not the same as addiction or psychological dependence, where patients demonstrate cravings for narcotics and a preoccupation with getting them.

TABLE 1: NON-NARCOTIC ORAL ANALGESICS

Medication	Dose	Interval
Aspirin	500 mg	Every 4-6 hours
Acetaminophen (Tylenol)	650 mg	Every 4-6 hours, max 3 grams/day
Ibuprofen (Motrin)	400-600 mg	Every 4-6 hours
Indomethacin (Indocin)	25 mg	Every 6 hours
Tramadol* (Ultram)	50-100 mg	Every 4-6 hours

* Tramadol is a centrally acting synthetic analgesic with both narcotic and non-narcotic properties.

TABLE 2: NARCOTIC ANALGESICS**

Medication	Dose	Route	Dosing Interval
Codeine	Starting Dose 30 mg	By mouth	Every 4 hours
Morphine	10-15 mg	By mouth, rectum, or subcutaneous injection	Every 4 hours (long-acting tablets are dosed every 12 hours)
Oxycodone (Roxicodone, OxyContin)	5-15 mg	By mouth or rectum	Every 4-6 hours (long-acting tablets are dosed every 12 hours)
Levorphanol (Levo-Dromoran)	1-2 mg	By mouth	Every 6 hours
Methadone	5-10 mg	By mouth	Every 6-12 hours
Fentanyl (Duragesic)	50-75 mg	Transdermal patch	Replace patch every 72 hours

**Complete prescribing information is beyond the scope of this article. Clinicians should consult a more complete reference prior to prescribing for patients.

TABLE 3: MEDICATIONS FOR THE TREATMENT OF NAUSEA AND VOMITING

Drug class	Medication	Dose	Preferred route
Neuroleptics	Prochlorperazine (Compazine)	5-10 mg every 6-8 hours	By mouth
	Prochlorperazine (Compazine) suppository	25 mg every 12 hours	By rectum
	Promethazine hydrochloride (Phenergan)	25 mg every 4-6 hours as needed	By mouth or rectum
Antihistamines	Hydroxyzine (Atarax, Vistaril)	50-100 mg every 6-8 hours	By mouth
Prokinetics	Metoclopramide (Reglan)	10-20 mg every 6 hours	By mouth

Most pain can be relieved with appropriate doses of analgesics. When treating pain in terminally ill patients, the right dose is the dose that provides adequate pain relief. Depending on the patient, this could be 5 mg to 1000 mg of morphine (or its equivalent) every four hours. It may also be necessary to decrease the dosing interval of extended-release oral transdermal preparations.

Since most narcotics are metabolized by the liver, caution is necessary when treating patients with serious liver disease. Most narcotics are excreted by the kidneys, so individuals with renal failure can have metabolite accumulation. Dosing should be individualized based upon pain relief and side effects.

MITIGATING ANALGESIC SIDE EFFECTS

Common side effects of narcotic analgesics

include constipation, nausea, and emesis. Drowsiness and confusion often occur when narcotic analgesics are first taken. With time, these side effects tend to diminish. Patients who continue to be sedated or confused may require a dose reduction.

Laxatives should be prescribed for all patients receiving narcotics before problems with constipation develop. The routine use of a stool softener, such as docusate 200 mg, 2-3 times a day is useful. The additional regular use of an oral agent that stimulates peristalsis (such as senna) is often sufficient to maintain regular bowel function. The dose of senna is 2 tablets every 6-12 hours. Patients will also occasionally require a stimulant laxative suppository or an enema to relieve more severe constipation.

Continued on page 4

LETTER FROM THE EDITOR

Dear Colleagues:

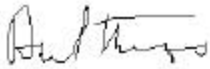
This month we have two substantive articles vital to all correctional providers. Dr. Joseph Bick gives a practical, erudite explication of providing palliative and end-of-life care in correctional facilities. Likewise, Dr. Stephen Tabet presents a case study of a patient with AIDS and widely metastatic lung cancer who has decided he does not want chemotherapy but is concerned about pain. Dr. J. Randall Curtis of the University of Washington provides the case study discussion, noting issues the physician should address first, what issues to address with the patient and how, and other important aspects of the case to consider.

This clinical approach is juxtaposed with a very real example of an inmate's personal experience: a letter recently received at the California Medical Facility from the wife of an inmate who died in the prison hospice, and who kindly allowed us to publish her letter in this issue.

All correctional providers have to deal with death and dying. This issue of HEPP Report once again provides front-line correctional clinicians the tools needed to approach the problem, as well as the thought processes needed to approach the problem well. These articles recognize the need to involve the entire correctional system in providing the residents with quality end-of-life care. Specific suggestions to involve correctional administration and staff on this issue are invaluable. Death and dying is something most people can empathize with, and this aspect of care can serve as a bridge for other areas of health care interaction with security staff.

After reading this month's issue, you should be familiar with the issues surrounding palliative and end-of-life care to for inmates, including managing pain effectively, communicating with patients, and overcoming challenges unique to the correctional system. As usual, every issue of HEPP Report has tremendous value and provides CME credit as well. This one is no exception. Enjoy it and I hope you learn as much as I did.

Sincerely,



David L. Thomas, M.D., J.D.
Chair, Division of Correctional Medicine and Department of Surgery
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FACULTY DISCLOSURE

In accordance with the Accreditation Council for Continuing Medical Education Standards for Commercial Support, the faculty for this activity have been asked to complete Conflict of Interest Disclosure forms. Disclosures are listed at the end of articles. All of the individual medications discussed in this newsletter are approved for treatment of HIV and hepatitis unless otherwise indicated. For the treatment of HIV and hepatitis infection, many physicians opt to use combination antiretroviral therapy which is not addressed by the FDA.

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This letter was received in April of 2003 at the California Medical Facility Hospice in Vacaville, California, and reprinted with the permission of the family.

Dear Chaplain:

I am writing to thank you for your diligence in helping my son and I visit John on April 4, 2003. Because of your assistance, my son Stephen* was able to meet his birth father for the first time. I'm not sure you realize what this meant to my son, although I am certain that you understand what it meant to John.*

When I told my son that I had heard that his birth father was terminally ill and in prison, Stephen struggled with the idea of meeting his father after 25 years. It took him a few hours to decide that he would like to meet him if he could. That's where you came in. Without your assistance, it could have taken many months to get in, and then it would have been too late. Due to your diligence, my son and I were able to meet with John and give him and Stephen a sense of closure. In addition, my son has learned many valuable lessons that he will carry with him throughout his life. He has learned to be more forgiving and less judgmental; and to look at every individual as a human being. He also learned that John didn't abandon Stephen, John abandoned himself. In the few hours that we were there, Stephen's years of hatred towards John dissolved into a kind of loving understanding of his birth father; not as a useless faceless criminal, but as a frail human being whose mistakes cost him dearly.

As of this writing, John passed away a little more than 24 hours ago there at CMF at the age of 48. I am hopeful that his visit with the son he had not seen in almost 25 years provided him some measure of comfort and helped him transition into the world beyond this one, even if he was not allowed the privilege of dying a free man.

Once again, I want to thank you for your efforts on our behalf and let you know that you make a difference not only in the lives of the inmates at CMF, but also to those whose lives are connected to those inmates. Please feel free to share this letter with other staff and to let them know that what they do is far more than just a job. Thank you again.

**All names have been changed.*

PROVIDING PALLIATIVE CARE... (continued from page 2)

Nausea and vomiting are common in patients being treated with narcotic analgesics. These symptoms can also be due to concomitant medications, constipation, renal failure, gastrointestinal disease, electrolyte abnormalities, and central nervous system disease. An effort should be made to determine the etiology of the patient's symptoms. Some useful medications for managing nausea and vomiting are listed in Table 3.

CHALLENGES IN CORRECTIONAL SETTINGS

Approximately 75% of prisoners have a history of drug and/or alcohol abuse.⁹ Given the opportunity, many prisoners continue to abuse drugs while incarcerated. Some prisoners who lack valid indications for narcotic analgesics amplify their symptoms in an attempt to obtain a prescription for these medications. Other patients who have a legitimate need for narcotics are victimized by inmates who coerce them to give up some or all of their medications. Correctional staff who witness these behaviors may actively discourage clinicians from prescribing these medications or create other roadblocks, and clinicians who have been deceived by prisoners may be less likely to believe their patients.

SOLUTIONS

Directly observed therapy (DOT) can be used to limit the diversion of controlled substances. Except in the case of slow release preparations, consideration should be given to crushing narcotics and mixing them with water before administration.

It is useful to have a formulary that presents a broad range of options for the treating clinician. Long-acting patches and pills are very helpful for treating pain in terminally ill patients. Some patients will be troubled by side effects from one type of narcotic analgesic, but will do well on another. The more options available to the clinician, the more likely that the patient's pain and other symptoms will be adequately addressed.

A multidisciplinary pain management team is very useful. Team members can include the attending physician, mental health clinicians, nurses, pharmacists, neurologists, pain management specialists, and a chaplain. Utilizing the collective knowledge and experience of different disciplines increases the likelihood that the patient will receive the best possible individualized approach to his or her symptoms.

PALLIATIVE CARE SETTINGS

Some systems routinely transfer all inmates to community hospitals when they are nearing death. In many cases, however, the continuation of aggressive care is futile and leads to unnecessary pain and suffering. In

an outside hospital, prisoners are more likely to be shackled because of security concerns. Family visitation may be more restricted in community facilities, which can result in the dying patient spending their last days or weeks isolated from family members and others close to them. For many terminally ill inmates who are not granted compassionate parole or release, allowing the patient to die in the correctional setting can be more compassionate than a hospital transfer.

Palliative and end-of-life care can be provided in a number of settings. Although it is not necessary to build a new unit to serve as a hospice, physical plant modifications may be required. If possible, do not house patients who have opted for palliative care together with those receiving aggressive curative measures. Clinicians often find it difficult to switch from a curative approach to a palliative model as they move from patient to patient. Patients who have elected comfort care often find it distressing to be housed with those who are being treated more aggressively, and may be troubled with doubt and regret about their decision.

STAFF COMMITMENT

Nothing will succeed in the correctional setting without the support and active participation of senior custody staff. Correctional administrators must believe that a program of palliative and end-of-life care can be securely provided, is fiscally prudent, and will not result in adverse media attention and/or litigation. Some correctional administrators are receptive to the idea of improving end-of-life care based upon their own personal experiences with illness and death. Unless legitimate security and fiscal issues are addressed, however, few will be willing to support this type of program.

COSTS

End-of-life care programs may require additional staffing. On the other hand, the costs associated with housing terminally ill patients in acute care hospitals during their last weeks or months can be extraordinary. In many cases, the costs associated with a quality end-of-life care program can be offset by avoiding unnecessary community hospitalizations.

HOSPICE ADMISSION CRITERIA

Not all health care providers are familiar with hospice and palliative care. Obtaining a truly informed consent to forego aggressive measures can be difficult within the correctional environment. Prior to hospice placement, patients should undergo a careful evaluation to ensure that they do in fact have a terminal illness likely to lead to death within the next six months. An effort should be made to ensure that all possible curative and or life extending measures have been considered and discussed with each patient. Patients

Continued on page 5

PROVIDING PALLIATIVE CARE... *(continued from page 4)*

should be educated about hospice and palliative care, and given an opportunity to visit the hospice unit. Assuming they choose to forego curative measures, only then should the patients be consented for transfer to the hospice unit.

ADVANCED DIRECTIVES

Choosing hospice care is a decision to pursue comfort and palliation over aggressive life-prolonging interventions. Patients should be given the opportunity to decide whether they want to be resuscitated in the event that their heart stops or they can no longer breathe without the assistance of a ventilator. For most of those who elect hospice care, a do not resuscitate (DNR) status is appropriate. However, requiring a patient to choose DNR status in order to have access to hospice services runs counter to community practice and can be coercive.

Living wills, which provide guidelines for what a patient would like done if he or she can no longer make medical decisions, can be useful. Some patients prefer to designate a health care power of attorney. Discussions should be held with patients as early as possible to ensure that their preferences are respected.

VOLUNTEERS

Both community and inmate volunteers can play an important role in a correctional end-of-life program. Community volunteers can be recruited from local churches, mosques, synagogues, hospice organizations, and religious-based service organizations. Many inmates are enthusiastic about participation in a pastoral care services (PCS) program, and can improve terminally ill patients' quality of life. Some inmates choose to participate as a way to seek personal redemption. Others, facing the possibility of their own death in jail or prison, volunteer with the hope that their participation will decrease the likelihood that they will someday die alone.

All potential volunteers must be carefully screened prior to involvement in a correctional PCS program. Volunteers from the community should be interviewed to determine their motivation for involvement and whether they appear to be suitable candidates. If deemed appropriate, community volunteers must then undergo a custodial background check to ensure that they have no criminal issues that would preclude their involvement. Likewise, the PCS coordinator should carefully interview inmates seeking to become volunteers. Potential inmate volunteers should be carefully evaluated by correctional staff to determine if they have a history of preying on vulnerable individuals. Additional factors to consider include in-custody drug offenses and other recent rules violations.

EDUCATION

An ongoing education program for caretakers of the terminally ill is

essential. Clinicians must be able to manage pain, nausea, emesis, shortness of breath and other symptoms that occur in individuals with terminal illnesses. All staff and volunteers should receive comprehensive training before beginning work with terminally ill patients. Training should cover basic concepts of death and dying, palliative and hospice care, pain and symptom management, and the psychosocial aspects of grief and loss.

The orientation curriculum should be clear about what volunteers are allowed to do for patients. Volunteers should not perform duties normally attended to by medical staff. For example, volunteers should not medicate patients, bathe them, perform dressing changes, or obtain vital signs. Volunteers should not have access to medical records, nor should confidential details of patients' care be discussed with them. Inmates are a particularly vulnerable class, especially when they are ill and approaching death. The placement of other prisoners in a position where they could take advantage of dying inmates must be avoided. For similar reasons, neither staff nor volunteers should be permitted to either accept gifts from or be included in the wills of dying prisoners.

VISITATION

Routine visitation policies rarely suffice when it comes to terminally ill inmates. A system to facilitate visitation on short notice (at any time of the day or night) should be put into place. Additionally, rules pertaining to minors and those with criminal histories may need to be modified if dying prisoners are to have access to family members in their last days. The clinical condition of patients can deteriorate suddenly. Unless there is a close custody-medical interface, it is not likely that such liberalized visitation policies for the terminally ill will succeed. If a patient is close to death, he or she should be placed on a vigil status. During vigil, a PCS worker should be allowed to remain at the patient's bedside 24 hours a day, and family should have even greater access to visitation.

FAMILY

For those who have been incarcerated for many years, "family" may include other prisoners. If possible, an effort should be made to facilitate visits from inmates housed at the same facility if the patient considers them family or close friends.

For inmates who have lost contact with family but wish to communicate with them, a mechanism should be in place to attempt to locate these individuals. One option is to use an outside volunteer agency to help locate family. Not all family members are willing to reestablish contact with those who are incarcerated, or vice versa. In such cases, the desire to maintain privacy should be respected. Even when family members are willing to visit, there are frequently many unresolved issues of anger and guilt. Family members may have been victims of

Continued on page 8

END-OF-LIFE RESOURCES**National Prison Hospice Association**

www.npha.org
npha@npha.org
 Call: 303-544-5923

The GRACE Project

Guiding Responsive Action for Corrections at End-of-Life
www.graceprojects.org
graceprojects@voa.org
 Call: 800-899-0089

World Health Organization

<http://www.whocancerpain.wisc.edu/>

American Academy of Hospice and Palliative Medicine

www.aahpm.org
 Call: 847-375-6312

Centers to Improve Care of the Dying

www.medicaring.org
 Call: 703-413-1100

Last Acts National Program Office

www.lastacts.org
 Call: 202-338-9790

National Hospice and Palliative Care Organization

www.nhpco.org
 Call: 703-243-5900

Standards for Health Services in Prisons

Published by the National Commission on Correctional Health Care (NCCHC). Price: \$59.95. Can be ordered online.
www.ncchc.org
 Call: 773-880-1460

ASK THE EXPERT

Case Study: End-of-life Care for Inmate with AIDS and Widely Metastatic Lung Cancer

Case presented by Stephen Tabet*, MD, MPH, Assistant Professor of Medicine, University of Washington, and Director, Northwest Correctional Medicine Education Program, NW AIDS Education and Training Center. Discussion and recommendations by J. Randall Curtis*, MD, MPH, Associate Professor of Medicine, Division of Pulmonary and Critical Care, University of Washington

A collaboration with the Northwest AIDS Education and Training Center, with Stephen Tabet, MD, and Kate Willner, trainer.

Case: A 52 year-old African-American male inmate with Class B2 AIDS (CD4 cell count 421, HIV RNA 5,790) was diagnosed with widely metastatic non-small cell carcinoma of the lung. He is currently taking multivitamins, citalopram (Celexa), and doxepin. He is being followed for depression by the psychiatrist at the prison. The patient was seen by a community oncologist who explained treatment options and the prognosis. The inmate decided that he does not want chemotherapy and wishes to be DNAR (Do Not Attempt Resuscitation). He is very concerned about pain and wants to be assured that he will not suffer. The patient still has five years left of a six-year prison term and is unlikely to get early release. The patient has been a devout Christian for the past year.

Discussion: Although this patient has HIV infection, his cancer is what limits his life expectancy. Patients with Stage IV lung cancer have a median survival rate of less than four months. The inter-quartile range on this estimate is relatively small, suggesting that this man is unlikely to survive more than six months.

What issues should the primary care provider deal with first?

The primary issues for this patient appear to be his possible depressive symptoms and concern about pain management. The first issue I will address is this patient's history of depression. It may be argued that depression can adversely influence a person's treatment decisions, and there is some evidence that depressed patients are more likely to choose to forego life-sustaining treatments.¹ However, just because someone is depressed does not mean that he or she is not competent to make treatment decisions. I would recommend that the primary care clinician and psychiatrist assess this patient's competency to make decisions. If they deem him competent, his wishes should be respected. Since his depression may respond to treatment, his preferences for palliative care should be reassessed from time to time. Data from the SUPPORT study suggest that when patients have a decrease in depressive symptoms, they are more likely to accept life-prolonging treatments.²

The second issue is the patient's concern about pain. Incarcerated patients often become concerned about inadequate pain treatment, especially since their complaints may be viewed with distrust by health care providers. A recent study showed that pain is an important concern among patients with HIV infection, particularly those with a history of drug addiction.³ Pain is a common symptom among patients with advanced AIDS⁴ and as many as two-thirds of these patients describe moderate-to-severe or constant pain.⁵

Do you think consulting another oncologist is in order?

Chemotherapy for widely metastatic lung cancer is not curative and the effect on duration of survival is minimal. However, recent advances in chemotherapy and current regimens that are much less toxic than they were several years ago make it a worthwhile option to consider. After initiating palliative care and reassuring the patient that his pain will be treated and that his treatment preferences will be respected, it would be reasonable for the clinician to readdress the option of palliative chemotherapy and ask the patient if he is interested in discussing this option with another oncologist.

When should end-of-life issues be discussed and how?

It is impossible to be prescriptive about the "right" time to discuss palliative and end-of-life care. Often, clinicians wait until they have decided that life-sustaining treatments are no longer indicated before they broach the subject of palliative and end-of-life care with patients or their families. Studies suggest that clinicians are waiting for patients to bring it up, while patients are waiting for clinicians to do so. In short, raise the subject early, and revisit it on a regular basis.

Because discussing palliative care with patients is an important part of providing high-quality care for patients with terminal illness, plan

ahead with the same care that you give to other medical procedures.

(1) Preparation: The clinician should review the patient's diagnoses, various treatment options, and likely prognosis with each type of treatment. It is important to know what has been communicated to the patient by other members of the health care team. It is also important to be familiar with the inmate's social support network, both in prison and in his community; (2) Location: This discussion should take place in a quiet and private room, safe from interruptions - admittedly difficult in a correctional facility; (3) Participants: If possible, ask the patient who should be present and what he or she would like to discuss; and (4) Plan for what is likely to happen after the discussion.

During these discussions, it is important to discuss prognosis and how the illness will affect the patient in an honest and meaningful way. At the same time, it is important to avoid completely discouraging hope among patients or their significant others who want to remain hopeful.^{6,7}

The discussion: First, review the treatment options and prognosis honestly and directly. Spend some time exploring feelings and listening to the patient's reactions about the discussion. It can be helpful for the clinician to repeat what the patient has said to show that the clinician is listening. It also allows a chance for the patient to correct any misunderstanding the clinician may have about what the patient said. It is important to tolerate silences. Sometimes, after what seems like a long silence, a patient will ask a particularly difficult question or express a difficult emotion.

It is important that the clinician make recommendations during the discussion. With increasing emphasis on patient autonomy and surrogate decision making, there may be a tendency for some clinicians to describe treatment options to a patient or significant other and then feel that they should not make a recommendation. On the contrary, it is important that clinicians offer their expertise to patients and their significant others, and part of this is offering sound recommendations.

Concluding the discussion, the clinician should summarize the major points and ask the patient if there are any questions. The clinician should then propose an appropriate follow-up plan. This often includes an appointment for a future meeting, and a way for the patient to get a message to the clinician if questions arise before the next meeting.

There are a number of issues unique to the correctional environment discussed in a recent publication from the HIV/AIDS Bureau of the Health Services and Resources Administration.⁸ For example, protecting an inmate's medical confidentiality can be difficult. Corrections officers may be involved in discussions with medical staff about patient care for security reasons. Also, the issue of advance directives is delicate in penal situations, where self-determination is, by definition, abridged. Care providers must be assured that a patient's decisions are voluntary regarding access to and withholding of life-sustaining treatment.

(Continued on page 7)

ASK THE EXPERT... (continued from page 6)**Is there anything that would make end-of-life discussions different given that the patient is African-American and a devout Christian?**

Culture and ethnicity are important factors to consider in patient-clinician communication, especially when discussing palliative care. In several studies of people with AIDS, black and Hispanic persons were less likely to communicate with their primary care clinicians about end-of-life care than Caucasian gay or bisexual men.⁹⁻¹¹ People of color with AIDS are more likely to report that they don't like to talk about end-of-life care and are more likely to worry that talking about death could bring death closer than are Caucasian patients with AIDS.¹² Similarly, injection drug users and women with high-risk sexual partners are more likely to worry that talking about death it brings it closer.¹² Caucasians are more likely to prefer a treatment approach that focuses on palliative care as opposed to extending life, and this association persists even after controlling for education, income and HIV risk behavior.¹³ While clinicians should be aware of the diversity of barriers that may exist for patients from different cultures and be willing to discuss these barriers openly with patients,^{12,14} it is important to realize that statistical associations by race and ethnicity are not predictive of a particular individual's treatment preferences.

Some surveys suggest that many patients want to discuss spiritual or religious issues with their primary care clinicians.¹⁵ Recent reviews have suggested approaches that physicians can take in discussing these matters with their patients.^{16,17} A clinician can ask the patient if there are aspects of his or her spirituality or religion that the patient feels the clinician should know about in providing medical care.

Is it possible to get a consult or assistance with end-of-life issues?

Palliative medicine specialists can help clinicians and patients decide on therapy goals and explain the available options for palliative treatments, including potential palliative benefits of therapies frequently not considered palliative, such as chemotherapy and antiretroviral therapy. Palliative medicine specialists help patients focus on what is most important to them, helping them find value and meaning as their lives come to a close.

HRSA recently published A Clinical Guide for Supportive and Palliative Care for People with HIV/AIDS,⁸ available on the web at <http://hab.hrsa.gov>.

For information specific to customs of various ethnic and cultural groups, see <http://www.pallcare.asn.au/mc/mccontents.html>.

*DISCLOSURES: Nothing to disclose

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RESOURCES & WEBSITES**"Hepatitis C: What Clinicians and Other Health Professionals Need to Know"**

www.cdc.gov/ncidod/diseases/hepatitis/c_training/edu/default.htm

A web-based training course for primary care physicians, nurses, and other health care workers. Developed by the CDC's Division of Viral Hepatitis and the Division of Media and Training Services. The course can be completed in about 2 hours; ACCME, CNE, and CEU continuing education credit is available.

New HIV Testing and Prevention Efforts

www.cdc.gov/mmwr/preview/mmwrhtml/mm5215a1.htm

New CDC-issued policies for HIV testing and prevention.

HIV Medication Chart

www.crine.org/info/pillchart.html

Drugs@FDA: A Catalog of FDA Approved Drug Products

www.accessdata.fda.gov/scripts/cder/drugcat/

A pilot project of the FDA that provides a single, searchable internet source for official, up-to-date information about FDA-approved brand name and generic drugs (including those for the treatment of HIV/AIDS and related conditions).

Interactive Database of Drug Interactions

hivinsite.ucsf.edu/InSite.jsp?page=ar-00-02

Drug Database

www.aidsinfo.nih.gov/drugs/fda_drug.asp

Searchable by drug name, class, or other search terms. Sponsored by AIDSinfo, a service of the U.S. Department of Health and Human Services.

PROVIDING PALLIATIVE CARE... (continued from page 5)

the dying patient, or the family member may have victimized the patient. Staff must anticipate and be prepared to mediate in these often-painful confrontations.

BEREAVEMENT SUPPORT

Working continuously with terminally ill patients can take an emotional toll on both staff and volunteers, so it is important to have an organized program to address their emotional needs. Memorial services - ideally open to both staff and inmates - should be held for those who have died.

CONCLUSION

The over two million individuals in this country's prisons and jails represent an aging population with multiple chronic medical problems. Many prisoners are destined to die while incarcerated. Correctional systems have a responsibility to attend to end of life issues, which include advance directives and management of pain and other symptoms of terminal conditions. Although many jails and prisons choose to transfer patients to community facilities for end of life care, patients can be cared for in the correctional setting in a secure, competent, compassionate manner. Close cooperation between custody and medical staff is necessary for the success of any correctional end of life care program. With the active participation of all those involved, terminally ill prisoners who will not be released can be provided a humane end of life experience within the correctional setting.

*DISCLOSURES: Nothing to disclose

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MEETING UPDATE: SOCIETY OF CORRECTIONAL PHYSICIANS (SCP)

Baltimore, Maryland, April 10, 2003

By Joseph Paris*, M.D., Medical Director, Georgia Department of Corrections

The Society of Correctional Physicians (SCP) held its semiannual meeting in Baltimore, Maryland, on April 10. The theme, Correctional Care of Infectious Diseases and Mental Health Issues, attracted experts willing to share recent developments with the audience of correctional physicians. In the field of infectious disorders, contributions were given by Drs. David Williamson of the C. T. Perkins Hospital Center, David L. Thomas of Johns Hopkins, Jay Hoofnagle of the National Institutes of Health, Glenn Treisman of Johns Hopkins, and others.

Dr. Thomas emphasized the importance of HBeAg testing of all patients with chronic hepatitis B virus (HBV). Patients with negative HBeAg tests and normal ALT levels are "healthy carriers," he said. Indications for interferon treatment include persistently elevated ALT levels (over twice the normal level), abnormal liver histology, and absence of end-stage liver disease. Sustained responders ("cures") will have no evidence of HBeAg, will show corresponding antibodies (Anti-HBe), and ALT normalization.

Dr. Hoofnagle described a new understanding of the natural history of chronic hepatitis C (HCV) infection. In the absence of HIV coinfection, HCV may take up to 50 years to evolve into fatal end-stage liver disease or hepatocellular carcinoma (HCC). HCV progression is marked by development of liver fibrosis, as measured by Stages 1-4 liver histology. Because therapies are constantly being improved, Hoofnagle stated that it might be prudent to wait for better therapies for patients with early stages of fibrosis. Otherwise, he said, a treatment failure may result and patients may not respond to retreatment with future therapies. Dr. Hoofnagle also showed his recent compilation of end-of-follow-up "cure" results for white and African American persons. Although the number of African American patients treated was small, a disturbing and unexplained lowered response rate was noted. The significance of this difference is not yet known.

Dr. Williamson described common psychiatric complications of HIV disease. He distinguished patients who can be safely treated by primary care physicians from those who may need psychiatric evaluation and follow-up. Lastly, Dr. Treisman reviewed mental health approaches to patients with HIV infection and other conditions. He emphasized the difficulty for psychiatrists to understand the motivations and social situation of the inmates that they treat. These barriers may result in a relative inability to achieve substantial patient rapport and therefore, less success in helping these patients.

Serologic testing for vaccinia is uninformative because it cannot be used to distinguish vaccinia immunity from vaccinia infection unless baseline antibody titers are available.

Diagnostic tests for vaccinia are available only for research purposes, but are undergoing multicenter validation studies that might enable FDA to approve the test reagents for diagnostic use.

Prophylaxis for Those at High Risk

Prophylactic treatment with VIG is not recommended for persons or close contacts with contraindications to smallpox vaccination who are inadvertently inoculated or exposed.

Reporting adverse events

Suspected cases of these illnesses or other severe adverse events after smallpox vaccination should be reported immediately to state health departments and to the Vaccine Adverse Event Reporting System. Reports can be made online at <https://secure.vaers.org/VaersDataEntryintro.htm>. To request clinical consultation and IND therapies for vaccinia-related adverse reactions for civilians, contact your state health department or the CDC's Clinician Information Line (877-554-4625). Those with suspected adverse events should be removed from work until evaluated and cleared to return.

Timing of Tuberculosis Screening and Smallpox Vaccination

Suppression of tuberculin skin test (TST) reactivity has been demonstrated after administration of smallpox vaccine. Health care workers scheduled to receive an annual TST should not receive the skin test for one month after smallpox vaccination to prevent possible false-negative reactions.

*DISCLOSURES: Nothing to disclose.

SAVE THE DATES

8th Northeast Correctional Health Care Conference

May 21, 2003
Sturbridge, Massachusetts
On-site registration: \$90
Call: 781-890-3435
Email: chcc@icg-ps.com

Legal Issues in Correctional Health Care

Sponsored by NCCHC and the American Bar Association Criminal Justice Section
June 27-28, 2003
Chicago, Illinois
Call: 773-880-1460
Visit: http://www.ncchc.org/edu_legal2003/legal_conf.pdf

American Correctional Association Summer Conference

August 9-13, 2003
Nashville, Tennessee
Call: 800-222-5646, ext. 1922
Visit: http://www.aca.org/conventions/conventions_2003_summer.htm

3rd Annual Intensive Review in Correctional Medicine

Sponsored by the Correctional Medicine Institute (CMI), the Society for Correctional Physicians (SCP), and Johns Hopkins University
September 4-6, 2003
Baltimore, Maryland
Baltimore Marriott Waterfront Hotel
Call: 314-607-1565
Email: admin@cm-institute.org
Visit: <http://www.cm-institute.org/>

43rd Interscience Conference on Antimicrobial Agents and Chemotherapy (ICAAC)

September 14-17, 2003
Chicago, Illinois
Call: 202-737-3600
Email: icaac@asmusa.org
Visit: www.icaac.org/ICAAC.asp

The United States Conference on AIDS

Sponsored by the National Minority AIDS Council
September 18-21, 2003
New Orleans, Louisiana
Call: 202-483-6622
Visit: www.nmac.org

National Conference on Correctional Health Care

October 4-8, 2003
Austin, Texas
Call: 773-880-1460
Visit: www.ncchc.org

INSIDE NEWS

Report: U.S. Prison Population Tops 2 Million

The number of inmates in U.S. prisons and jails rose to 2,019,234 last year, the first time the number has exceeded 2 million, according to a report released by the Justice Department. California, Texas, Florida and New York remain the four largest state prison systems, though the number of inmates in federal prisons for the first time surpassed that of any state, with nearly 162,000 federal inmates. The report also noted a 5.4% increase in the number of people confined to local and county jails, the largest growth in the jail population in five years. Other findings: about 12% of all black men in the U.S. between 20-39 years old were in prison or jail, compared to 4% of Hispanic males and 1.6% of white males. *New York Times and Associated Press, 4/7/03*

HIV

Study: Ending Segregation of HIV-Positive Inmates Could Save Money

Alabama's prison system could save between \$306,000 and \$392,000 per year if it didn't segregate HIV-positive inmates from the rest of the prison population, according to a report by the Alabama Prison Project and the ACLU National Prison Project. If the segregation ceased, 56 inmates would be eligible to join community-run corrections programs. Community corrections programs cost the state \$11 per day per inmate - \$15 less per day than it costs for an inmate to remain in prison. Alabama is the only state prison system that still segregates HIV-positive prisoners. *Associated Press, 4/30/03*

New Formulation of Viracept Approved by the FDA

The FDA approved a new formulation of Viracept (nelfinavir) that reduces the number of pills patients must take each day. Previously available in 50 mg oral powder and 250 mg tablets, Viracept is now available in a 625 mg pill, reducing the number of tablets taken each day from 10 per day to four per day. The 625mg tablets will be available in the 3rd quarter of 2003 and will be parity priced with the 250mg tablets. Viracept 250mg will be continued to be manufactured. *FDA Release, 4/30/03*

CDC Urges Expanded HIV Screening, Recommends Testing All Pregnant Women

The Centers for Disease Control and Prevention (CDC), in partnership with other federal agencies, is launching a new initiative to advance HIV prevention activities. While previous CDC efforts have focused mainly on preventing people from acquiring HIV/AIDS, new strategies will focus on prevention efforts for individuals already infected with HIV. This includes increased efforts to diagnose people who are not aware they are infected, and to educate each HIV-infected person on ways to prevent spreading the disease. As part of the new initiative, the CDC is recommending that HIV testing become a routine part of medical care, and in particular, offered to all pregnant women. It also aims to streamline the testing procedures so that prevention counseling is not a prerequisite for testing.

The agency will be conducting demonstration projects in high-prevalence settings (including correctional facilities) using the OraQuick HIV rapid test, which provides results in 20 minutes. The full report is available at www.cdc.gov/mmwr/preview/mmwrhtml/mm5215a1.htm. *CDC, 4/18/03*

FDA Approves Valacyclovir for HIV-infected Patients

GlaxoSmithKline announced that it has received supplemental approval from the U.S. Food and Drug Administration (FDA) to market its antiviral valacyclovir HCl (Valtrex) as the first FDA-approved antiviral therapy for the suppression of recurrent genital herpes in HIV-infected individuals. Valtrex was already approved for the treatment of herpes zoster and cold sores. *Reuters, 4/3/03*

Roche Gets FDA OK for Improved HIV Test

Roche announced that it has received FDA approval for an automated version of a test used to detect and measure viral levels in the blood of HIV-positive patients. The Cobas Amplicor HIV-1 Monitor Test (version 1.5) can measure viral load levels as low as 50 copies of HIV RNA per milliliter of blood plasma. The test can also detect a broader range of HIV-1 subtypes than previous tests, according to Roche. *Reuters, 4/11/03*

Study: Physician Experience a Major Contributor to AIDS Survival

Results from a study in Vancouver show that physician experience has an independent effect on the survival of patients with AIDS. Investigators from the British Columbia Centre for Excellence in HIV/AIDS evaluated the impact of "non-immune-based factors" in survival in 1400 HIV-infected patients starting HAART for the first time, following the cohort for 42 months. When HAART was initiated at CD4 levels about 200, patients treated by either experienced or inexperienced physicians had similar survival rates. However, in patients with CD4 counts <50, the hazard of death was greater for patients treated by inexperienced physicians. The study is presented in the March 28 issue of AIDS. *Reuters, 4/14/03*

TB

Am J Prev Med: Treatment for Latent TB in Correctional Facilities

A field study conducted by the CDC in nearly 50 correctional facilities evaluated high-risk populations at risk for co-infection with tuberculosis (TB) and HIV to find out if treating latent TB infection (LTBI) in inmates was feasible. In 49 correctional facilities in 12 states, 198,102 inmates had a tuberculin skin test (TST) read; 17% were positive. Of those who had a known HIV test result, 14.5% tested positive for HIV infection. Inmates with a positive TST were 4.2 times more likely than those with a negative TST to be infected with HIV. HIV-positive patients who began the 12-month TB treatment regimen were less likely than HIV-negative patients (40% vs 68%, respectively) to complete treatment. The results from the 8-year HIV-Related TB Prevention (HRTP) were published in the April 2003 American Journal of Preventative Medicine. *Am J Prev Med 2003;24(3)*

SELF-ASSESSMENT TEST FOR CONTINUING MEDICAL EDUCATION CREDIT

Brown Medical School designates this educational activity for 1 hour in category 1 credit toward the AMA Physician's Recognition Award. To be eligible for CME credit, answer the questions below by circling the letter next to the correct answer to each of the questions. A minimum of 70% of the questions must be answered correctly. This activity is eligible for CME credit through November 30, 2003. The estimated time for completion of this activity is one hour and there is no fee for participation.

1. For the first time, the number of people incarcerated in U.S. prisons and jails has reached:
 - (a) 1.5 million
 - (b) 1.7 million
 - (c) 2.1 million
 - (d) 2.5 million

2. Neuropathic pain occurs when nerve endings are stimulated, such as when a tumor expands in an organ or metastasizes to bone, and is usually responsive to analgesics alone.
 - (a) True
 - (b) False

3. Analgesics prescribed for severe pain for a terminally ill patient should be administered:
 - (a) Only at fixed intervals
 - (b) Only when the patient asks for them
 - (c) At fixed intervals, with "rescue" doses as needed
 - (d) None of the above

4. For terminally ill patients receiving palliative end-of-life care, the maximum allowable dose of morphine is:
 - (a) 100 milligrams per day
 - (b) 250 milligrams per day
 - (c) 500 milligrams per day
 - (d) The amount necessary to relieve the patient's pain

5. Patients receiving narcotics should also routinely be pre-scribed:
 - (a) Laxatives
 - (b) Antihistamines
 - (c) Anticonvulsants
 - (d) Antidepressants

6. In a correctional end-of-life care program, an appropriate activity for inmate volunteers is:
 - (a) Dispensing medications
 - (b) Taking vital signs
 - (c) Reading to patients
 - (d) Bathing patients

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