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Return of the Flu

After a two-year pandemic timeout, the flu is back. We are already beginning to see outbreaks in our homes and symptoms have been severe.

Fortunately, most homes have already completed their resident flu vaccine clinics. It takes two weeks or so to mount a full antibody response, so if you've avoided the flu to this point your residents should be well protected.

We don't know whether Influenza A or B will be more prevalent this year, or how well the vaccines will match. So far, labs have identified the H3N2, A subtype, as the most common. The two leading vaccines, Fluad® Adjuvanted Trivalent and Fluzone® High-Dose Quadrivalent each have A(H3N2) and A(H1N1) subtypes, plus one or two (Fluzone®) B lineage strains, so we're off to a good start.

It is very important that staff are vaccinated soon. We are all suffering from vaccine fatigue, but our "flu vacation" could lead to a nasty season this year. To help keep staff, and therefore residents, safe, we are offering our annual $75 flu-shot challenge prize to one staff member in each facility who bares their arm for the cause.

Metoclopramide for EOL

One of our MDs attended a palliative care conference recently and metoclopramide's (MCP) utility was highlighted. MCP is classified as an antiemetic (reduces vomiting) and prokinetic (moves contents out of the stomach and through the GI system quickly) drug. These are important features in multiple end-of-life (EOL) scenarios.

A literature review shows that oral or s.c. MCP, 10mg Q4H, is the first-line emesis treatment in the presence of many cancers, gastroparesis (slow emptying of stomach contents), liver failure, or nausea and vomiting of unknown cause. It should not be used in the presence of GI cancers where intestinal blockage is possible.

Other drugs, such as 5-HT3 antagonists (ondansetron and granisetron), antipsychotics (haloperidol and olanzapine), octreotide, and dexamethasone (brain malignancy) also have prominent roles in the treatment of EOL nausea and vomiting.

We will add MCP to our EOL drug list, found on our website portal. One challenge we have with MCP is that the injectable form of MCP is not always available. Fortunately, the oral form is well-supplied.

The Dentist and Prolia

An infrequent side effect of osteoporosis drugs is osteonecrosis of the jaw (ONJ). This condition is highlighted by pain, reduced bone mass, and delayed healing after dental extractions or implant failure.

Bisphosphonates (Fosamax® and Actonel®) can cause ONJ, complicating dental treatment. ONJ prevalence is increased in the elderly, particularly when the oral drugs have been used for more than three years. Since bisphosphonates remain bound to bone for more than 10 years it is difficult to mitigate their effect. It is recommended that extractions are done at least one week after an oral drug is taken and that the drug is not resumed until 4-6 weeks afterward.

Prolia® can also cause ONJ but manipulating the timing of dental extractions and implants can improve outcomes markedly. Prolia® does not bind to bone and has a half-life in the body of roughly one month. Extractions and implants should be performed a minimum of 45 days before the next dose of Prolia® to allow time for healing, and at least one month after a prior dose (some dentists wait a minimum of 4 months). Holding Prolia® is not an option as this increases fracture risk significantly.

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