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Poster Abstract

Case Report/Case Series

A Case of Cutaneous Myiasis

Presenting Author: *Cheryl Rifenburgh, RN, BA, Archcare*
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Introduction: Cutaneous myiasis is dermal infestation by fly larvae, also known as maggots. It is seen infrequently among patients in the United States and may be associated with prior travel or poor personal hygiene. We describe the case of a resident at a skilled nursing facility with cutaneous myiasis.

Case Description: A 50 year old morbidly obese female with underlying diabetes mellitus, a history of heart failure, quadriplegia, bowel and bladder incontinence, fibromyalgia, trigeminal neuralgia, gastric reflux and depression; who was a long term care skilled nursing facility resident continually refused all forms of medical and nursing care. She was known to exhibit hoarding behaviors, was being followed by psychiatry and was deemed to have decision making capacity.

After extensive negotiations, she agreed to be repositioned and while this was being done, she was observed to have maggots in the skin folds of her torso and back. No other dermatological findings were noted at the time. The patient was subsequently evaluated by all disciplines including medicine, nursing, psychiatry and social work. She was offered dermatological and surgical subspecialty consultations alongside treatment with permethrin and ivermectin but refused all suggested care.

Eventually, she was agreeable to skin care and bathing which led to full clinical resolution.

Discussion: Cutaneous myiasis is a parasitic skin infestation caused by maggots or larvae of flies. It is a relatively infrequent diagnosis in the United States and even less so among residents of skilled nursing facilities. In our case, we believe the underlying cause was severe depression which subsequently led to the patient's condition despite continual care offered by all disciplines at the facility. Myiasis can be treated by surgical excision of the maggots and dermal/wound care. Evidence for the use of pharmacological therapies for cutaneous myiasis is sparse.

Disclosures: All authors have stated there are no financial disclosures to be made that are pertinent to this abstract.

A Case of Hidradenocarcinoma

Presenting Author: *Wanda Taylor, DO, East Kentucky Veterans Center*
Author(s): *Jordan Adams, DO, Brittany Harlow, DO, Emily Carico, DO; and Erica Schuster, MD*

Introduction: This is a case regarding a rare type of skin cancer, hidradenocarcinoma, in an older adult man.

Case Description: An 89 yo Caucasian male resident of a long-term care facility with past medical history of hypertension, type 2 diabetes mellitus, and coronary artery disease developed a painless skin lesion on the right side of his face. The lesion grew rapidly into a large lesion. Initial biopsy resulted inconclusive and required further pathological analysis. Further study of the specimen revealed the presence of hidradenocarcinoma. The patient underwent surgical excision and subsequent skin grafting due to the size of the lesion. He had recurrence of the tumor, requiring multiple additional surgical procedures and radiation therapy. Despite aggressive treatment, the tumor continued to grow, invading into surrounding tissues including the orbit and oral cavity. The patient decided to discontinue treatments and opted for comfort care with Hospice. He subsequently passed away at the long-term care facility.

Discussion: Hidradenocarcinoma is a rare form of malignancy associated with abnormal growth of sweat glands. Typically occurring in people aged 30-60, it can occur anywhere on the body, but is usually seen on the head and neck area. It generally begins as a painless, solitary lesion that tends to have slow growth. Hidradenocarcinoma does have the ability to metastasize to local tissues or to distant body parts. At this time, the cause of hidradenocarcinoma remains unknown. Diagnosis is made via obtaining a skin biopsy and pathological evaluation, which can be challenging. Hidradenocarcinoma can resemble benign lesions on pathological exam. Treatment includes surgery to remove the tumor, as well as radiation and/or chemotherapy. Prognosis is best if found early, otherwise it is poor.

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A Network of Sharing: How Community Collaboration Allowed for Flexible and Timely Administration of Monoclonal Antibodies for COVID-19 in Skilled Nursing Facilities

Presenting Author: *Mark Shehata, MD, Universtiy of Rochester*
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Introduction: Monoclonal antibody treatment for COVID-19 transitioned to an allocation per state by dictate by hospitalization rate in state by HHS. A nursing home needs to request doses needed for the next week by Monday. However, the unpredictable nature and small numbers of an individual nursing home's outbreaks make accurate ordering difficult. In this series, we describe how a local collaboration among skilled nursing facilities in the Rochester, NY region allowed for rapid delivery of mAb doses to residents positive for or exposed to COVID-19.

Case Description: A team was developed within the UR Medicine Geriatrics Group and the Hurlbut Care Communities Corporation to oversee distribution and administration of mAb to regional nursing homes. The team includes a medical director, RN and RN nursing home administrator. Doses were delivered and held centrally at facility A. Participating facilities, 7 of which are within 1 corporate entity and an additional 3 of which operate independently, procured mAbs through the team. Data regarding case details, vaccination status, indication, doses given, and outcomes is tracked centrally by an RN at facility A. A protocol was shared with

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facilities, including instructions for subcutaneous administration and monitoring, indications, and standardized consent, progress notes, and flow sheet. Doses were administered by corporate nurses, facility nurses and medical providers depending on availability and need. In total, across 10 facilities, 219 doses were given. The number of treated residents in each facility varied from 1 to 34. The smallest participating facility is home to 34 residents, a total of whom 15 were treated: 7 positive cases and 8 exposures. To date there have been no deaths in treated patients in this group and 1 hospitalization for those receiving treatment as post-exposure prophylaxis. Additionally, the large majority of residents receiving post exposure prophylaxis remained asymptomatic and negative for COVID-19.

Discussion: This case series highlights how 219 symptomatic and exposed residents in nursing homes achieved favorable outcomes through community collaboration to improve access to monoclonal antibody treatment despite the more restrictive allocation plan. The interdisciplinary team-based approach and standardization of protocols allowed for real time distribution of mAb doses according to need to facilities that may have not otherwise been able to feasibly procure and administer doses independently. This supports the value of collaboration among skilled nursing facilities to improve the community outcomes.

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Anxiolytic Drugs for Anxiety: Adverse Effects May Be Worse Than the Mood Disorder. A Case of Buspirone Induced Facial Dyskinesia

Presenting Author: *Thiruvinvamalai Dharmarajan, Montefiore Medical Center*
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Introduction: Dopamine, a neurotransmitter for motor function, is implicated in dyskinetic illness. Movement disorders are significant adverse drug effects (ADEs) of several psychotropic drugs with anti-dopamine action. Buspirone, an azapirone, is a partial agonist to serotonin 5HT1A. The medication's therapeutic advantages relate to its interaction with these receptors. Buspirone also inhibits dopamine receptors, which could be linked to the medication's unusual side effects in individuals who are predisposed to them.

Case Description: 92 year old female on hospice in a long term care facility, with breast cancer, hypertension, and osteoporosis was on lorazepam 0.25 mg thrice daily for adjustment disorder with anxiety and depression, as suggested by the Hospice Care team. Her symptoms were controlled, but given falls risk, she was switched to buspirone 5 mg twice a day.

After 2 weeks on buspirone, she developed classic facial dystonia affecting the face, lips and tongue. Facial twitching was so severe that it led to tongue and lip bites, resulting in persistent bleeding. A medication review followed and buspirone was stopped. The patient was placed on lorazepam 1 mg IM as she could not presently tolerate oral medications. Despite receiving 3 doses of lorazepam, her symptoms persisted.

The next morning, the facial twitching became intermittent, involving lips, tongue, cheeks and eyes. Being an ADE, buspirone was discontinued and switched to 0.5 mg lorazepam every 6 hours.

On the 3rd day of evaluation, no facial twitching was noticed. The patient was followed for recurrence of symptoms, but none were reported. Lorazepam was continued with the intent to slowly taper off.

Discussion: Buspirone has gained popularity over benzodiazepines in recent years, due to its non-sedating anxiolytic effect and the ADEs associated with benzodiazepines in older adults, especially high risk of falls. Dizziness is a common side effect associated with buspirone. Other ADEs include nausea, headache, nervousness, blurred vision, confusion, diarrhea, insomnia, myalgia, numbness, loss of sensation, rash, muscle pain, spasms, cramps, stiffness of the arms or legs, uncontrolled body movements/dystonia, tremor, weakness, and nonspecific chest pain.

While in most cases, the drug is safely tolerated at therapeutic doses, ADEs are reported with low doses. Thus ADEs are dose independent. A high index of suspicion for ADEs is warranted in older adults, especially in those unable to voice their complaints. Further, the dyskinetic effect of this medication is augmented if used in conjunction with other drugs with similar mechanisms of action (SSRIs, anti-psychotics). Buspirone ADEs seldom occur so soon after initiation as in our case; typically they occur in 1 – 2 weeks.

Lesson Learnt

- Adverse effects of medications for mood disorders may be worse than the indication itself.
- Non-drug approaches may be a safer initial option for behavioral disorders
- Avoidance of ADEs is important for those on hospice.

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Chronic Palliative Inotropes in Subacute Rehab

Presenting Author: *Meghan Brennan, DO, University of Louisville*
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Introduction: The number of patients living with end-stage heart failure is steadily growing. Although originally intended to serve solely as a bridge to more definitive surgical therapies, there is an increasing number of patients receiving inotropic therapy (milrinone, dobutamine) for purely palliative purposes. Continuous infusion may increase quality of life and reduce symptom burden at the cost of increasing mortality.

Case Description: A 71 year old male was hospitalized with a congestive heart failure exacerbation with transthoracic echocardiogram showing an EF of 10-15%. Midodrine and Dobutamine were initiated. The option of Left Ventricular Assist Device placement was discussed with the patient and his family, and he decided to pursue palliative care on inotropy. His code status was changed from full code to DNR, and he was discharged to subacute rehab with an indwelling chest catheter. He was given a 6 month prognosis by the advanced heart failure team. His goal was to rehab on Dobutamine and discharge to home with hospice, as he did not qualify while on Dobutamine. His fluid overload worsened, and his diuretic was increased. He was started on Digoxin. He developed anasarca and was unable to participate in physical and occupational therapy. He declined Hospice but agreed to palliative care. He was started on Ativan, Morphine, and Scopolamine. He passed away 2 months after admission.

Discussion: The optimal ways to initiate, manage, and discuss the risks and benefits of palliative inotropes in the current era of heart failure care are unclear. Challenges regarding drug selection, administration, coordinating transitions between care settings, duration of therapy, and patient and/or provider acceptance arise in clinical practice. There is a lack of data and guidance on the effect of palliative inotropes on quality of life and mortality and little consensus on how this therapy can be optimally used in skilled nursing facilities. The benefit of inotropic palliative therapy and if and when it should be discontinued at the end of life needs further investigation.

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Hurdles Faced By Healthcare Providers in Titrating Phenytoin Dosage in Long-Term Care

Presenting Author: *Thulasi Priya Jayaprakash, MD, Montefiore Medical Center - Wakefield campus, Bronx*
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Introduction: Medications are associated with development of adverse drug events (ADEs), some more than others, due to alteration in pharmacokinetics and dynamics with age. Phenytoin efficacy and toxicity relate to drug levels, interaction with cytochrome P450, hepatic function and albumin levels; phenytoin is largely protein bound. Our case illustrates the difficulties in dosing phenytoin in a long-term care resident.

Case Description: 68 year old male with seizure disorder, alcoholic liver cirrhosis and other comorbidities was admitted to our unit 2 years ago. The neurologist recommended phenytoin and leviteracetam, with periodic check of drug levels. (Data on serum phenytoin levels and corresponding serum albumin will be depicted in a graph in the poster). Phenytoin dosage