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Review Article

MANAGEMENT OF TERMINAL PATIENTS

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Abstract:

Introduction: A great majority of patients are keen on discussing end-of-life care with their physician, and most trust that doctors ought to present the topic. End-of-life discussion should address a wide cluster of issues fundamental to the dying patient and family. Discussions that emphasis focus solely on resuscitation neglect to perceive critical physical and psychosocial importance. Most individuals, as they get closer to death, contend with same feelings of fear, needs, and desires. Dying patients encounter fear of pain, fear of indignity, fear of abandonment, and fear of the unknown. Open and direct discussions can ease a great number of these fears. By including family members in these discussions, relationships inside the family such as relatives can be strengthened and can diminish the isolation encountered by the dying patient.

Aim of work: In this review, we will discuss multiple aspects of end-of-life care, emphasizing on symptomatic care, and the best way to of a physician to approach the patient and family.

Methodology: We conducted this review using a comprehensive search of MEDLINE, PubMed, and EMBASE, January 1985, through February 2017. The following search terms were used: end of life care, palliative care, supportive care, terminal patients, symptomatic treatment

Conclusions: The job of palliative care toward the end of life is to soothe the suffering of patients and their families by the extensive evaluation and treatment of physical, psychosocial, and spiritual symptoms patients encounter. As death approaches, the side effect burden of a patient may decline and require more aggressive palliation. As comfort measures intensify, so does the support given to a dying patient's family. When death has happened, the job of palliative care centers primarily around the support of the patient's family and bereavement

Key words: end of life care, palliative care, supportive care, terminal patients

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INTRODUCTION:

Doctors are well prepared to maintain wellbeing and battle illness, however regularly receive minimal guidance on the best way to communicate with patients who are approaching their demise and their families. Therefore, in our death-averse community, it is not shocking that numerous doctors find it hard to engage in end-of-life discussion [1].

Demise has for some time been viewed as tantamount to medicinal failure, which suggests that doctors have nothing to give a dying patient and family. Physicians must perceive that an incredible opposite is true. Great communication can help relieve fears, limit pain and suffering, and empower patients and their families to encounter a "peaceful death". Poor communication can result in imperfect care, and patients and their families might be exposed to undue psychic or physical anguish [1].

A great majority of patients are keen on discussing end-of-life care with their physician, and most trust that doctors ought to present the topic. Physicians should in this way acknowledge obligation to start timely dialogue, the same number of patients will trust that their doctor will raise the topic [2].

End-of-life discussion should address a wide cluster of issues fundamental to the dying patient and family. Discussions that emphasis focus solely on resuscitation neglect to perceive critical physical and psychosocial importance. Most individuals, as they get closer to death, contend with same feelings of fear, needs, and desires. Dying patients encounter fear of pain, fear of indignity, fear of abandonment, and fear of the unknown. Open and direct discussions can ease a great number of these fears. By including family members in these discussions, relationships inside the family such as relatives can be strengthened and can diminish the isolation encountered by the dying patient [3].

As demise approaches, numerous patients have moderately modest needs and desires. At the point when therapeutic treatments are no longer efficient, most individuals and families want that aggressive interventions to be avoided. They need the last days, weeks, and months to pass without pain, to be spent harmoniously with family and dear friends, ideally at home in familiar environment. In uncommon cases, individuals and family members may have major disagreements, or futile medications might be requested. However, in vast majority of cases, individuals and family members are aligned, and end-of-life care can be achieved in a sensible and struggle free manner [4].

METHODOLOGY:**• Data Sources and Search terms**

We conducted this review using a comprehensive search of MEDLINE, PubMed, and EMBASE, January 1985, through February 2017. The following search terms were used: end of life care, palliative care, supportive care, terminal patients, symptomatic treatment.

• Data Extraction

Two reviewers have independently reviewed the studies, abstracted data, and disagreements were resolved by consensus. Studies were evaluated for quality and a review protocol was followed throughout.

The study was approved by the ethical board of King Abdulaziz University Hospital

Management of common physical symptoms

Patients nearing death may encounter outrageous symptoms that incorporate physical, spiritual, and psychosocial suffering. Preventing and dealing with these symptoms while optimizing the quality of life all through the dying process is the objective of palliative medicine. Factors essential to seriously sick patients incorporate adequately controlling pain and different symptoms, dodging prolongation of the dying process, accomplishing a feeling of self-control, discovering importance in life, and soothing the care burdens of family and friends and loved ones while reinforcing and completing those equivalent relationships. As death turns out to be closer, the side effect burden increases while the individual and family tolerance of physical and emotional pressure diminishes. At this time, primary palliative care interventions should come 1st, and the attention on restorative care should diminish [5]. The triggers for the shift to palliative care incorporate the following four symptoms:

Dyspnea

Shortness of breath, the subjective symptom of breathlessness, is a common and upsetting manifestation, especially in dying individuals. Narcotics and benzodiazepines are the most broadly advised drugs for treating dyspnea. As death approaches, a clinician may use constant infusion to manage symptoms and calm anguish whenever planned or as-required doses are not sufficient. The physician ought to constantly assess the patient and make changes that will control symptoms [6].

Pain

It is critical to screen pain and treat properly which incorporates the need to embrace regular observations with the point of observing the intensity

of the issue and recommending as per individuals' needs as opposed to diagnosis of dying [7].

Despite the fact that the individual is dying, keenly evaluating the probable reason for pain (or pains) and the experience of this pain for the individual is proper. This incorporates thinking about how this pain is best be tended to and the painful experience modified. For some, this will require strong pain killers, for example, opioids however additionally, other adjuvant drugs or non-pharmacological approaches as prescribed in the WHO three step pain relieving ladder. While thinking about how best to manage pain, a similar attention to detail is recommended as while giving analgesia at some other stage of life including [7]:

- The individual's previous history of pain;
- Previous utilization of standard or as required analgesia, incorporating over the counter medications;
- Most as of late accessible biochemical parameters particularly renal and hepatic function;
- A past history of hypersensitivities or intolerance to narcotics and other pain-relieving agents;
- The most suitable course of administration that guarantees the prescription can be safely and effectively controlled.

Up to 75% of advanced malignancy individuals will have adequately extreme pain that they will require narcotic analgesia. These figures make it almost certain that most patients will enter the terminal phase already administering opioids. In Australia, individuals are most commonly switched to a subcutaneous infusion of with morphine or hydromorphone the most widely recognized choices. Different narcotics including oxycodone, fentanyl and methadone are additionally accessible. If needed, it is imperative to look for the support of a specialist palliative care service to administer the most proper decision of drug [8].

An adjuvant pain relieving agent is a medicine that has a primary sign for an issue other than pain yet having some pain-adjusting properties in particular circumstances. For instance, ranitidine is most regularly recommended for the management of reflux symptoms and peptic ulcer disease. In any case, an ongoing randomized control trial supported that the combination of a placebo agent and subcutaneous ranitidine diminished the probability of individuals encountering abdominal cramping pain from inoperable gut obstructions contrasted to octreotide

and ranitidine [9].

At this phase of life, one of the difficulties while thinking about how to treat pain with adjuvant drugs when individuals are dying is the means by which such drugs can be safely regulated when individuals are unable to swallow. Prior in life, the utilization of oral or intravenous courses of administration might be advised. nevertheless, respecting individual's desires for the slightest burdensome way to care makes this less safe and practical as demise approaches [9].

Delirium

Suppliers ought to recognize the manifestations of the restlessness related with delirium toward the end of life. The most widely common recognizable reason for delirium in the healing center setting is medication: anticholinergics, sedative-hypnotics (eg, benzodiazepines), and opioids. Delirium and restlessness toward the end of life are normally portrayed by anguish (spiritual, emotional, or physical), anxiety, agitation, and cognitive impairment. The treatment of terminal delirium as a rule requires the utilization of a major sedative, for example, haloperidol [10].

Depression

Studies uncover that over 60% of individuals with malignancy report mental distress, while nearly half of patients with differing stages of cancer fulfill diagnostic criteria for mental disorders [11]. Depression, which happens in up to 45% of terminally sick patients with cancer, has additionally been positively connected with thoughts of suicide. Patients who are especially inclined to suicidal ideation are older men with a diagnosis of malignancy or HIV contamination/AIDS as well as a background marked by hopelessness, delirium, and exhaustion [12]. The presence and severity of clinical depression are both positively related with the severity of physical illness, and, in somewhere in the range of, a progressive inability to get up and a diminished hunger may likewise recommend major depression. Anxiety regularly exists together with depression, and it might be driven by fears of helplessness, lost control, abandonment, or pain. When screening for depression in individuals with advanced illness, one must think about that anxiety, and also organic mental disorders, may impersonate the features of mood disorders. Thus, the physical manifestation of terminal illness and its therapy (e.g., chemotherapy) can create the neurovegetative symptoms of depression (e.g., fatigue, expanded sleep, weight reduction). Often the distinctive factor between clinical depression, discouragement, and natural causes for neurovegetative symptoms is the

presence of anhedonia. Treating patients with terminal sicknesses who additionally experience the ill effects of clinical depression enhances their state of mind, as well as improves their adapting strategies and enhancing their compliance with therapy [13].

Chochinov and colleagues [14] discovered that appraisal and diagnosis of depression in the terminally ill can be effectively tended to with the single inquiry, "Are you depressed?" Also, the Hospital Anxiety and Depression Scale (a psychological instrument developed to test for depression in medically sick patients) can be utilized to evaluate for depression in the dying patient. nevertheless, a few studies have affirmed that the clinical interview remains the best instrument for the diagnosis of depression in the medically ill or the dying individual [15].

Independence and dignity

For a subset of terminally ill individuals, keeping up a feeling of control is a central task of the dying procedure. This requirement for control is prominent between patients who ask for physician assisted suicide (PAS) in Oregon (where the training has been legitimate since 1997). In an overview of 2649 Oregon doctors, Ganzini and colleagues [16] reviewed the epidemiology of PAS in Oregon and in addition the characteristics of patients and doctors surrounding the demand. The most widely recognized reasons behind patients to ask for PAS were a loss of independence, a longing to control the circumstances of death, readiness to pass away, and low quality of life. Different symptoms related with the demand for PAS were pain, dyspnea, and fatigue; additionally, needing to maintain control and not needing be a burden on others is critical for a lot of dying individuals. They further refined this idea by interviewing Oregon doctors about their patients who had experienced PAS. These patients universally portrayed as having had tough personalities; they were determined and inflexible, and they needed to control both the planning and the way of their deaths. For the majority of these patients, the demand was persistent, forceful, and often joined by refusal of palliative treatments. Despite the lawfulness of PAS or a caregiver's specific opinion of it, doctors and nurses ought to endeavor to give such people as much power over their care as possible (to support their adapting style and help them keep up their dignity) [16].

For dying individuals, a primary disease related concern is the conservation of dignity, extensively characterized in terms of being worthy of respect, honor, and esteem. For numerous patients, dignity is specifically related with the level of freedom and

autonomy held through the course of disease. For a case series of 50 individuals in an urban hospital diagnosed with advanced-stage cancers, Chochinov and colleagues [17] found that an assortment of components were vital for preserving dignity in the terminally ill. These elements included functional capacity, intellectual acuity, symptom management, and easing of mental distress. Moreover, anguish about medical uncertainty (i.e., not knowing, or being uninformed of, parts of one's wellbeing status or treatment) and anxiety explicitly connected with the procedure or expectation of death and dying exacerbated a patient's feeling of dignity. other study including 213 terminally sick patients from 2 palliative care units recommended that loss of dignity is nearly connected with particular types of pain, (for example, the loss of independence for inpatients confined to the hospital, weakening of physical appearance, and a feeling of being burdensome to other people) known among the terminally ill. when combined with uplifted depression and a feeling of sadness, the loss of dignity may decrease a patient's desire to keep living even with imminent death [18].

Death rattle

As responsiveness diminishes progressively toward death, it turns out to be progressively troublesome for individuals to control their oropharyngeal secretions. The death rattle of the active dying patient is the noise of air movement crossing over pooled discharges. Despite the fact that not a reason for suffering over the dying individual, the death rattle can be irritating for the loved ones and family to hear. Repositioning the patient's head and utilizing anticholinergics, for example, atropine or scopolamine are the backbones of treatment [10].

Recommendation for physician

There are numerous clinical difficulties inherent in the caretaking of the dying individual. however, there are numerous interventions that clinicians can perform to treat the emotional and physical symptoms of the patient toward demise. Despite the fact that an extensive discussion of these therapies is past the extent of this article, we will examine a clinical way to deal with the dying patient and in addition the major interventions that physicians ought to know about [19].

The initial phase in taking care of the dying individual is to maintain a strategic distance from clinical nihilism: that is, to abstain from feeling that there is nothing left to be given. Often patients and families welcome a specialist for listening to their

worries unquestionably more than an explicit physical intervention. Also, such a methodology will allow the specialist to give care that is better custom fitted to individual patient needs and concerns. Many patients are most scared of not realizing what the way toward dying is like, of pain, and of being disregarded toward the end of their lives. The engaged clinician can offer a lot of consolation just by advising patients what's in store from the dying process, by treating their pain, and by promising not to abandon them toward the end (and by following through with this promise) [20].

The second issue for doctors treating dying individuals is to review that, even toward the end of life, there are numerous conditions that can and must be treated to primarily enhance a patient's quality of life. In fact, between patients asking for PAS in Oregon, those for whom doctors made "substantive" interventions were bound to alter their opinions about needing a solution for a deadly medication [16].

In characterizing its clinical practice guidelines, the National Consensus Project for Quality Palliative Care (an agreement project of 5 national palliative care associations) outlined 8 domains that ought to be tended to. Primary care doctors who care for individuals with terminal illness ought to guarantee that they address every one of these areas (either specifically or through referrals). The first is the structure and procedure of care. Crafted by thinking about the dying patients is best performed by a multidisciplinary group to help distribute the multiple tasks of this work with the goal that staff can support each other amid troublesome times. The arrangement of care for the palliative care patient ought to be a result of an interdisciplinary appraisal that incorporates both the patient and his or her family. Moreover, this interdisciplinary structure perceives that the care of the dying individual is related with significant personal burdens for caregiver. Indeed, even the most experienced clinician ought to depend on colleagues for help in confronting the troublesome emotions of patients and their families, and also his or her own memories and feelings [21].

The second domain outlined by the National Consensus Project includes the physical parts of care. Pain, pulmonary symptoms, and gastrointestinal symptoms specifically ought to be managed aggressively, while utilizing the best-accessible evidence. Doctors ought to evaluate their patient's pain routinely, ideally with approved instruments (e.g., analogue scale), and treat it immediately. pulmonary symptoms can prompt significant anxiety and fear, while gastrointestinal symptoms (e.g.,

opiate- induced constipation) can prompt significant uneasiness. As a rule, physical symptoms are best treated assertively, and doctor's ought to be careful about signs of delirium or medication toxicity, especially in the elderly [22].

Mental and psychiatric parts of care are the third domain. Depression is encountered frequently in patients with terminal disease. It tends to be primary (caused by previous mental disease), drug-induced (e.g., from corticosteroids or chemotherapy), or natural (e.g., from metastases or paraneoplastic syndromes). In patients with terminal illness, physical symptoms can be mistaken for neurovegetative symptoms of depression; this makes depression hard to diagnose. thus, mental symptoms (e.g., anhedonia and hopelessness) might be better markers of depression in this populace. Regardless of cause, depression is treated a same fashion (with judicious use of pharmacologic [e.g., selective serotonin reuptake inhibitors and psychostimulants] and nonpharmacologic [e.g., psychotherapy] therapies). Doctors ought to think about referral to a therapist for further assessment as necessary [23].

Other psychiatric issues incorporate anxiety and psychological hindrance. Whenever recognized, a large number of these conditions can be turned around or at least considerably improved.

Different domains critical for the therapy of the patient with terminal illness incorporate watching out for the social, cultural, and spiritual aspects of care. Often interconnected, these 3 territories allude to progressively larger circles of association—from the interpersonal (i.e., family and friends), to the cultural (i.e., interfacing with a larger set of customs, traditions, and methods of communication), and to the existential (i.e., the manner by which individuals comprehend their lives and deaths in perspective of ultimate importance and value). Guaranteeing that the requirements of patients in these spheres are taken care of is an important task of those individuals who care for the terminally ill [21].

Doctors should feel great engaging patients around their worries in these areas. nonetheless, they should feel similarly great counseling or alluding patients to social workers, clerics, or psychologists. Just by focusing on one's own limitations can the doctor caring about a dying patient best serve the patient [21].

The last 2 domains outlined by the National Consensus Project are caring about the unavoidably dying patient and ethical/lawful concerns. These two domains are often interrelated, as significant moral

and lawful issues often surface around the last piece of the dying procedure. Primary care doctors ought to do their most extreme to recognize when the patient changes to the active dying phase and ought to discuss effectively with the patient and his or her family about their desires in regards to the dying procedure (e.g., the setting of death and the intensity of symptom management). If not discussed about beforehand, making a referral to a hospice is additionally an effective method to help care for the imminently dying patient and his or her family. Ultimately, working with the patient and family to clear up issues of decision making toward the end of life (e.g., What are the patient's desires, and who will be the patient's surrogate when he or she is no longer able to take decisions?) lets patients and their caregivers to work and convey better and encourages them maintain a strategic distance from or improve ethical issues about decision making that can emerge toward the end of life [24].

Barriers to quality care for terminally ill patients

Various components clarify why imminently dying individuals are not all around accepting the most suitable care for their necessities. The need to connect this care gap is progressively recognized by health services with the World Health Organization (WHO) repeating this is an essential human right. In spite of this, numerous hospital-based health care specialists do not feel satisfactorily talented or resourced to give such care. Rather, such specialists consider hospitals to be places where debilitated individuals get treatment furnished with interventional and curative aim with numerous health care professionals believing such care is always to the greatest advantage of the patient [25; 26].

The circumstance is made considerably complicated by certainty that very generally health care specialists are not recognizing that their patients are inevitably confronting the very end of their lives. This is a complicated issue that is probably going to emerge as a result of advances in public health and readier availability of increasingly effective therapy. Thus, diseases that may have recently brought about sudden death are presently bound to be experienced as repetitive scenes of life-threatening exacerbations from which the individual recovers. This makes acknowledgment of the last relapse considerably more difficult, especially when individuals have lived for prolonged periods with such life-limiting illnesses [27].

Numerous health professionals feel poorly prepared to take part in the necessary discussions around prognosis and end-of-life care. There is a perception

that by discussing demise and dying with patients and family's that such negative points will dispose of hope. But instead of wiping out hope, such discussions may move toward becoming opportunities to allow individuals to articulate what their objectives are and by doing so, change the concentration with respect to how health services may support this patient and family to accomplish such goals [26].

CONCLUSION:

The job of palliative care toward the end of life is to soothe the suffering of patients and their families by the extensive evaluation and treatment of physical, psychosocial, and spiritual symptoms patients encounter. As death approaches, the side effect burden of a patient may decline and require more aggressive palliation. As comfort measures intensify, so does the support given to a dying patient's family. When death has happened, the job of palliative care centers primarily around the support of the patient's family and bereavement.

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