Palliative Care& Hospice in Patients with Heart Failure

Indication

• Palliative care is a patient and family centered care that optimizes QOL by anticipating, preventing, and treating suffering. (Clinical Practice Guidelines for Quality Palliative Care. National Consensus Project; 2013)

• Palliative care is not the same as hospice care or end-of-life care which is for patient in the final phase of life (weeks to months).

• Palliative care is not about dying, it is about living!

Top 5 distribution of adults in need for palliative care, by disease groups
1. Cardiovascular disease (38.5%)
2. Cancer (34.0%)
3. COPD (10.3%)
4. HIV/AIDS (5.7%)
5. DM (4.6%)

(BMJ 2016;352:i1010)

Who & When to consider palliative care

• Palliative care is appropriate for patients at any age and at any stage of a serious illness such as malignancy, COPD, HF, ESRD, cirrhosis, etc.

• Would you be surprised if the patient died within the next year? (JAMA Intern Med 2014;5217)

• Palliative care can be provided together with curative treatment.

• In heart failure
  - Should be an ongoing key component of the plan of care in HF (ACC/AHA HF guideline 2013).
  - Specially focus on patient who is undergoing ICD placement, evaluation for stage D treatment such as heart transplant, LVAD, long terms inotropic support.

Benefits of palliative care

• Most evidences are from oncology population. Limited evidences in HF population.

• Evidences from many type of patients and palliative interventions have shown:
  - Equal or improve survival.
  - Better quality of life.
  - Reduced uses of life-sustaining treatments.
  - Improve both patient and care-giver experiences.
  - Cost saving.
  - No increased in anxiety, depression or hopelessness.

• In an RCT of palliative care in patients with metastatic non-small-cell lung cancer (n = 151):
  - Palliative care on top of standard care associates with less aggressive care, better QoL, less depression and 2.7 months survival benefits. (NEJM 2010;363:733)

• In HF population (J Palliat Med 2015:18:134)
  - Not different survival or 30-day hospitalization.
  - Improve QOL, symptoms (dyspnea, pain, tiredness), depression, anxiety, advance care plan.

Hospice care, end-of-life care

• When patients are entering the last weeks to months of life.

• When curative treatments are no longer available and the treatment burdens exceed the benefits.

• Not the same as euthanasia or physician assist suicide.

Challenges of palliative care implementation

• Stigma of death, hopelessness, dependency, giving up, just comfort care (Can Med Assn J, 2016).

• Provider discomfort (11%), perception of patient/ family unreadiness e.g. in denial (21, 12%), fear of destroying hope (9%), lack of time (8%), lack of confidence (>30%) (Dunlay SM, et al. Pall Med 2015)

• Challenge in heart failure:
  - Prognosis uncertainty.
  - Episodic improvement and worsening clinical course.
  - Multiple complex, advanced therapy.

Palliative intervention in HF

• HF is very symptoms burden conditions e.g. dyspnea, fatigue, pain, edema and depression.

• For pain and dyspnea refractory to hemodynamic intervention:
  - Opioids and benzodiazepines are used.
  - Non-pharmacologic intervention e.g. massage, acupuncture, heat therapy, fan, cardiac rehab, O2 supplement.

• For depression:
  - SSRI
  - Sertraline found no benefits in HF with depression- not a palliative care population. (SADHART-CHF. JACC 2010)

• Home inotrope: possible prolong survival and improved symptoms.
  - Allow discharging to home hospice.

• In end-of-life care, consider deactivation of the ICD shock.
  - The pacemaker, or CRT function should continue to be on.

• Discussion on an advanced care planning

Clinical points

• Never said “there is nothing else we can do” but offer only realistic options.

• Physician is responsible to initiate the conversation.

• Everyone who take care of patient with serious illness should have basic palliative care skills.
  - Palliative care consult/specialist may help with symptom management, advanced care plan.

• The earlier (in the clinical course) the conversation is started, the easier the conversation is.
  - Preferably in an outpatient setting
  - The first conversation about end-of-life care happened late at a mean of 33 days before death (J Clin Oncol 2012;30:4387).

• Increased prognostic awareness.
  - Starting thinking about prognosis in patient with mid to late HF stage C
  - Give direct, honest prognosis without giving specific timepoint or statistic.
  - Patient with HF are likely to overestimate their survival (JAMA 2008;299:2533).

• Assess symptoms, spiritual, psychosocial, goal.

• Talk about outcomes that are relevant to the patient.
  - Less about diagnosis or treatment more about “ชอบทำอะไร, ถ้าแข็งแรงขึ้นอีกครั้ง อยากทำอะไร“

• Promote discussion on advanced-care preferences.

• Effective communication skills and confidence are important in facilitate palliative care.

• Being available and flexible.

• During crisis e.g. hospitalization, patient and family usually lack of cognitive and emotional resources to manage resources and decisions.

Recommend reading

• Communication about serious illness care goals: a review and synthesis of best practices. JAMA Intern Med. 2014;174(12):1994.

• Palliative care in patients with heart failure. BMJ 2016;352:i1010.

• Ethics in the Treatment of Advanced Heart Failure: Palliative Care and End-of-Life Issues. Congest Heart Fail. 2011;17:235.