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Review article

Palliative care in cardiology

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ABSTRACT

Palliative care is an approach aimed at improving the quality of life of patients (and their families) faced with a life-threatening condition. Chronic heart failure (CHF) is a progressive disease with increasing incidence and prevalence. Despite (or perhaps, because of) all the advances in medicine, CHF remains one of the leading causes of death. Even with the availability of numerous prognostic tools, an estimate of the course and outcome of a CHF patient continues to pose a challenge. As a result, palliative care should be initiated early and provided in parallel with curative treatment. The cornerstone of palliative care is communication based, mainly, on listening to the patient, telling the patient their unfavorable diagnosis, and therapeutic dialog. Drug therapy is provided in an effort to alleviate the symptoms. Non-pharmacological options of improving the quality of life of the patient include nutritional care, rehabilitation and, possibly, treatment of sleep apnea. Deactivation of the implantable cardioverter/defibrillator should also be considered as an option. Last but not least, the attending physician should focus on the psychological and spiritual needs of the patient. Palliative care in cardiology poses a major challenge to all members of teams caring for the CHF patient not only over the last weeks of their lives, but during their entire course of treatment.

Contents

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Introduction

Cardiac and cancer patients alike face numerous physical, psychological, and social problems. Due to the advances in modern medicine, the incidence of CHF is on the increase and its mortality continues to be high and comparable with those of the most common malignancies [1]. Symptoms deteriorating the quality of life occur in CHF patients at the same rate as in cancer patients [2]. Despite all the advances in CHF management, the final stage of the disease is associated with very poor quality of life [3]. Generally, the term palliative care refers to an approach designed to improve the quality of life of patients (and families thereof) faced with a life-threatening condition [4]. All these facts taken together, there is logically an effort to implement palliative approaches also in cardiology. However, the concept of palliative care in cardiology has not been clearly defined. To date, no methodology of palliative care has been developed, there are no large randomized trials providing the evidence base for current cardiology, many cardiologists actually do not think in the context of palliative care, there is a lack of experience and, occasionally, also willingness to communicate about end-of-life issues, patients' feelings and preferences. Some reports have documented an astonishingly low level of agreement between the views of the patient and his physician (cardiologist) regarding priorities for care toward the end of life [5,6].

When exploring the issue of palliative care in cardiology, it is worthwhile to highlight some aspects distinguishing palliative care in cardiology from that in oncology. It is a well-known fact that the end stage of the heart failure patient may be largely different [7]. In addition to the underlying disease, other factors significantly affecting the quality of life of the cardiac patient include their often older age, polypharmacy, and comorbidities. Likewise, in some patients, the side effects of commonly used drugs may pose a problem bigger than the disease *per se*. Multiple episodes of heart failure progression experienced by the patient and perceived by their family members with a gradually waning response to therapy are often in stark contrast with their expectations and absence of an explanation why this is so. In oncology, the limitations of therapeutic options are almost generally anticipated, and different rates of disease progression to death are accepted. Given the impressive strides in reducing morbidity and mortality rates, the situation is just the opposite in cardiology, a specialty associated – among lay people – with triumph of medical science over disease and patient recovery, all this despite the fact that cardiovascular disease remains the number one killer in Europe (42% of males, 52% of females) [8].

Prognostic stratification and optimal timing of palliative care initiation

Establishing the prognosis of an individual heart failure patient, that is, estimating the time until their death at various stages of the disease is indeed a major challenge. In this context, the question naturally arises as to the timing of palliative care initiation. To date, up to 300 potential prognostic markers have been investigated. A rough estimate of prognosis can be based on the NYHA classification combined with some biochemical markers (B-type natriuretic peptide, natremia), and exercise capacity or cardiac output measurement. Several comprehensive tools and scoring systems have been developed and tested to estimate the prognosis of heart failure patients; these include the Seattle Heart Failure Score [9] available online at (http://depts.washington.edu/shfm/). Other scoring systems such as the CardioVascular Medicine Heart Failure (CVM-HF) index [10] or that employed in the EFFECT trial [11] have incorporated comorbidities into the prognostic scheme. Still, in most cases, the presence of progressive renal insufficiency, cachexia, and increased diuretic use serve as reliable markers of a dismal prognosis in elderly and polymorbid patients [12]. While an estimate of survival of an individual patient remains difficult despite the above options, the following situations may lead to the decision to initiate palliative care: repeated episodes of heart failure over the last 6 months despite optimal management, occurrence of malignant arrhythmias, frequent need for intravenous diuretics or their continuous administration, long-term poor quality of life, refractory NYHA IV class symptoms, and signs of cardiac cachexia [13]. Recently, there has been general consensus that palliative care should optimally be initiated in parallel with full curative therapy with a gradual increase in the proportion of palliative care and adequate decrease in curative therapy toward the end of life, that is, both approaches run in parallel. The previous strategy whereby curative therapy is replaced by palliative care several weeks before death is being discarded (Fig. 1). The current integrating strategy seems to be the most advantageous particularly because many heart failure patients do not show major deterioration of their quality of life in its final stages [14].

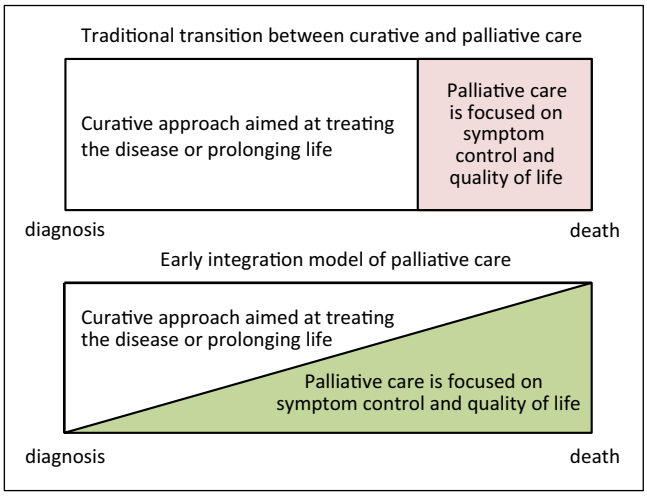

Fig. 1 – Mode of care integrating palliative and curative approaches.
Adapted from [45].

Communication

Communication is the cornerstone of palliative care. Unlike oncologists, cardiologists find themselves in a much more