

Multimorbidity and End of Life Care in Patients with Cardiovascular Disease



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KEYWORDS

• End of life • Withdrawal of cardiac devices • Decision-making

KEY POINTS

- Care of patients with cardiovascular disease (CVD) and multimorbidity is complicated.
- There are significant challenges in prognostication in end-stage CVD that further complicate the difficulties of care at the end of life.
- Nuances in end of life decision-making are inherent in multimorbidity, but they are compounded by particular issues raised by cardiac device therapy.
- Early palliative care involvement as part of a multidisciplinary approach (before end stage) can improve end of life care.
- The end of life care of patients with cardiovascular disease who have multiple other morbid conditions is complex and best served with early palliative care involvement as part of a multidisciplinary team.

INTRODUCTION

Best practices in end of life care for patients with cardiovascular disease (CVD) and multiple comorbidities have not been comprehensively studied.¹⁻³ The number of patients with CVD and multimorbidity continues to grow with the aging of the population, as discussed elsewhere in this issue (See [Bell SP, Saraf AA: Epidemiology of Multimorbidity in Older Adults with Cardiovascular Disease](#), in this issue). Patients with CVD suffer from a high burden of symptoms, even before diagnosis of severe cardiac disease, and especially at end of life.⁴ The prevalence of multimorbidity in patients with CVD may complicate efforts to diagnose and treat symptoms. Prevalence of cognitive impairment in patients with CVD is particularly underappreciated as a complicating factor in decision making and self-care.⁵⁻⁷

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Despite a high mortality among patients with end-stage heart failure (HF),^{8,9} difficulty in prognostication complicates advance care planning and may serve as a significant barrier to receiving palliative care and transitioning to hospice. As a result, patients with CVD tend to receive aggressive care¹⁰ and to use large amounts of health care resources¹¹ in the terminal stages. Hospice agencies traditionally have had limited experience with patients with end-stage CVD, and costly palliative end-stage cardiac therapies, such as inotropes, may complicate hospice admissions.¹²

CHALLENGES IN PROGNOSTICATION

Validated instruments are available to help determine prognosis in patients with severe CVD. Data, such as the 6-minute-walk test, maximal oxygen consumption, and laboratory parameters, such as creatinine and brain natriuretic protein, can help predict mortality in a variety of risk scoring systems (Table 1). Some of these tools may help determine if and when patients with CVD may benefit from hospice. The simple “surprise” question (“Would I be surprised if this patient was to die in the next 6 to

Prognostic Tool	Variables	End Point
Seattle Heart Failure Model ¹³	Age Sex New York Heart Association class Weight Ejection fraction Systolic blood pressure Cause of heart failure Medication use Diuretic dose Anemia % Lymphocytes	Death at 1 y, 2 y, 3 y
Heart failure survival score ¹⁴	Ischemic cardiomyopathy Resting heart rate Ejection fraction Mean resting blood pressure Intraventricular conduction delay Maximal oxygen consumption Serum sodium Pulmonary capillary wedge pressure	Death at 1 y
Heart failure risk scoring system ¹⁵	Age Respiratory rate Systolic blood pressure Blood urea nitrogen Serum sodium Comorbid conditions: dementia, cerebrovascular disease, chronic obstructive pulmonary disease, cirrhosis, cancer, anemia	Death at 30 d, 1 y
Acute decompensated heart failure national registry ¹⁶	Systolic blood pressure Blood urea nitrogen Creatinine	Death in hospital

Adapted from Adler ED, Goldfinger JZ, Kalman J, et al. Palliative care in the treatment of advanced heart failure. *Circulation* 2009;120:2600.

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