

Palliative Therapy in Heart Failure

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KEYWORDS

• Palliative care • Heart failure • Prognostication • Symptom management • Referral

KEY POINTS

- Palliative care is a multidisciplinary approach to patient care with the aim to improve quality of life alongside disease-directed management.
- Recent studies suggest that palliative care consultation improves quality of life and symptom burden for both patients and families.
- Challenges remain in providing quality end-of-life care in patients with heart failure, especially when patients have undergone left-ventricular assist device implantation.

INTRODUCTION

Heart failure in most cases is a chronic, ultimately terminal illness accompanied by increased symptom burden throughout the progression of the disease. Palliation, meaning to treat symptoms without curing, is a virtual necessity in the management of heart failure and is often provided by multiple clinicians including cardiologists as well as palliative medicine specialists. The American Academy of Hospice and Palliative Medicine defines palliative care as “[focusing] on improving a patient’s quality of life by managing pain and other distressing symptoms of a serious illness. Palliative care should be provided along with other medical treatments.”¹ Along with symptom management, a palliative care team provides support for various aspects of caring for someone with a serious illness. It is becoming apparent that palliative care can provide significant improvements in patients with heart failure, both throughout disease management and at end of life. Palliative care can also provide much needed support for patients undergoing invasive, life-altering treatment modalities often required in end-stage heart failure.

THE PALLIATIVE CARE ASSESSMENT AND DOMAINS

To adequately care for patients suffering from life-limiting illnesses, 8 domains have been identified as essential for quality care. These domains include “structure and process of care,” “physical aspects of care,” “psychological and psychiatric aspects of care,” “social aspects of care,” “spiritual, religious, and existential aspects of care,” “cultural aspects of care,” “care of the patient at end of life,” and “ethical and legal aspects of care.” A dedicated palliative care team is often multidisciplinary to better address these domains as they expand beyond medical issues. Examples of information or opportunities elicited through exploring these domains includes identifying unmanaged symptoms, recognizing grief, evaluating family support, exploring living situations, striving for respectful communication in the setting of different cultures, educating families about the dying process, and ensuring a bereavement plan is in place. Because these domains are broad, an interdisciplinary team is required and often includes physicians, nurses, social workers, chaplains, rehabilitative experts, and psychiatrists.²

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Social workers and chaplains can contribute significantly to the effectiveness of support and management of patient and family issues falling under the later domains. A comparable focus on domains including “medical,” “mind and emotion,” and “social environment” along with goals-of-care discussion has been recently suggested for geriatric patients suffering from heart failure. These domains are analogous to the palliative domains of “structure and process of care,” “physical aspects of care,” “psychological and psychiatric aspects of care,” and “social aspects of care.”³

REFERRAL/UTILIZATION

Although access to subspecialty palliative care has expanded over the past 2 decades, it remains a limited resource. There is approximately 1 palliative care specialist per 1200 patients with life-limiting illnesses. In the United States access varies depending on geographic location and size of hospital system, with the south lacking somewhat in palliative care support relative to the rest of the United States. Hospitals smaller than 50 beds are much less likely to have palliative care support, with only 29% having palliative care teams in 2015. Around 90% of larger hospitals with more than 300 beds have palliative care support, although this can vary depending on region.⁴ These statistics show that although palliative care support has grown, many practice settings still lack a palliative care team and the importance of exploring support options available in a patient’s current clinical setting.

Unfortunately palliative care training during cardiology fellowship is currently limited despite nearly all cardiologists recognizing its importance.⁵ Although palliative care continues to grow as a subspecialty, the immense need will require the delivery of primary palliative care by nonpalliative specialists as an essential part of providing excellent care to patients with heart failure, underscoring the need to develop more robust palliative care training for cardiology fellows. The primary palliative care assessment should include a physical and psychological symptom assessment, identification of social or spiritual concerns, exploring understanding of illness, prognosis and treatment options, identifying goals of care, and exploring safe care following discharge.⁶

Subspecialty palliative care may be sought in the setting of complex symptom management or difficulties in defining goals of care. Given the limited subspecialty palliative care resources and prognostic uncertainty associated with heart failure, timing of palliative care consultation is challenging. Prognostic models may be beneficial in

identifying heart failure patients with palliative care needs. Events associated with heart failure, such as a change in baseline New York Heart Association (NYHA) class to IV, implantable cardioverter defibrillator (ICD) discharge, a resuscitation event, or frequent hospital readmissions, may also trigger palliative care consultation.⁷ Recently, the PAL-HF trial compared patients with heart failure who received cardiologist-driven usual care with patients who received usual care along with palliative care intervention over a period of 6 months. The study population included currently hospitalized patients with a previous hospitalization in the last year and the Evaluation Study of Congestive Heart Failure and Pulmonary Artery Catheterization Effectiveness (ESCAPE) risk score of greater than or equal to 4. Patients on chronic inotropes, at least 3 heart failure hospitalizations in the past year, or patients with an ESCAPE risk greater than 4 regardless of recent hospitalization were also included.⁸ The palliative care intervention involved assessment and management of multiple quality-of-life domains by a palliative care-trained nurse practitioner, a board-certified hospice and palliative medicine physician, and a counselor. The usual care + palliative care arm of the study exhibited improved quality of life and spiritual well-being along with decreased anxiety and depression.⁹ This supports integration of palliative care throughout a patient’s heart failure trajectory rather than relying on the previously mentioned event triggers.¹⁰

Although most common in the inpatient setting, palliative care intervention is likely beneficial in the outpatient setting as well. Currently the most common patient population addressed in outpatient palliative care clinics is patients with cancer, although patients with heart failure do currently receive outpatient palliative care in some practices.¹¹ Exploration of outpatient palliative care over the past few years has suggested a possible benefit in symptom reduction, depression, and quality of life in patients with heart failure.¹² The ENABLE CHF-PC pilot has shown promise in the outpatient setting for patients with NYHA Class III and IV heart failure. This study provided outpatient palliative care consultation, weekly sessions with a nurse, and monthly sessions focusing on an educational guidebook. In this pilot, patients receiving intervention experienced improved quality of life, symptom burden, and mental health, as well as improved caregiver quality of life and mental health.¹³

Hospice care is a subset of palliative care for patients thought to have a prognosis of 6 months or less and who choose to focus only on comfort

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