

A Integração da Insuficiência Cardíaca Avançada e da Medicina Paliativa: Porquê Estamos à Espera?

Integrating Advanced Heart Failure and Palliative Medicine: What Are We Waiting For?

Paulo Reis-Pina^{1,2,3}(<https://orcid.org/0000-0002-4665-585X>)

Palavras-chave: Cuidados Paliativos, Insuficiência Cardíaca.

Keywords: Heart Failure; Palliative Care.

Dear Director

I have read carefully the article by Vieira Silva *et al* published recently in your journal.¹

Heart failure (HF) is one of the most common diseases in patients admitted to Internal Medicine wards. Deaths from diseases of the circulatory system are those contributing the most for the mortality rates in Portugal.

In this study, the hospital-based palliative care team (HPCT) was accompanying only 0.5% of the HF patients admitted to acute care settings. Moreover, the HPCT was only involved in the care of 2.4% of the terminally-ill patients who eventually died in the hospital. I think that is far insufficient.

Patients were admitted to several services/departments (Internal Medicine, Cardiology, Intermediate Care Unit, Haematology and Gynaecology). Were these specialists trained in palliative care (PC)? Where they able to assess their patients' palliative needs? The American College of Cardiology & the American Heart Association guidelines recommend clinicians to introduce PC as an option for patients who develop HF, while considering advanced therapies including ventricular assist device and transplant, if appropriate.² Considering that the criteria for heart transplant are very restrict, most patients with terminal HF should receive early referral to PC. Unfortunately, in this study, PC referral was delayed, so 56.6% of referrals were terminal patients.

The stage of HF was so advanced that, although 83.3% of the patients needed care organization after discharge, death occurred in the hospital. Mortality was 75% and 50% among those who waited for vacancies in PC and long-term care units, respectively. Given that there were 15 patients who died 3 days after the request for the HPCT support, probably among these there were people in agony. The study does not pronounce on these cases, but it is hoped that there has been time to relieve useless suffering.

In a recent questionnaire-based study, 46 Internal Medicine doctors (being 18 specialists and 28 residents) were asked to designate which criteria they used for referring HP patients to PC.³ Qualitative (clinical) criteria were chosen by 90% of the sample, whereas only 10% of the doctors opted for quantitative (measurable) criteria. Most frequent quantitative criteria were poor controlled symptoms (56.5%), patient's values and beliefs (50%), multiple admissions to acute hospital care (23.9%), semiology of HF (13%) and the physician's perception of his/her patients' suffering (13%). The most frequent quantitative criterion was the echocardiogram findings (6.5%).³

In the study by Vieira Silva *et al* both the presence of prior hospitalization related to HF in the last 12 months and the New York Heart Association (NYHA) functional class III or IV were considered important markers of advanced HF disease. In fact, the following criteria are considered compulsory for timely PC referral: 1- two or more hospital admissions for HF in the prior six months; 2- one or more emergency department visits within the prior six months; 3- NYHA class III or IV symptoms; 4- not eligible or interested in mechanical circulatory support or heart transplant.⁴ To these four criteria it should also be added one of the following: a) chronic comorbidity (renal failure, diabetes mellitus, cancer, HIV, cerebrovascular accident, interstitial pulmonary fibrosis, oxygen-dependent obstructive pulmonary disease); b) previous intensive care unit admission or cardiopulmonary resuscitation within past year.⁴

Specialists and residents in Internal Medicine departments believe that PC may help patients with HF in symptom control, by supporting their families and by monitoring and improving their quality of life.³

Mandatory PC training is urgently needed, as it is the

¹Unidade de Cuidados Paliativos, Casa de Saúde da Idanha, Sintra, Portugal

²Unidade de Cuidados Paliativos Poverello - Domus Fraternitas, Braga, Portugal

³Faculdade de Medicina da Universidade de Lisboa, Lisboa, Portugal

proportional allocation of resources and the implementation of protocols for symptomatic control in terminal patients. Consequently, the dignity of patients who die in hospital wards will be assured.⁵ ■

Conflitos de Interesse: Os autores declaram a inexistência de conflitos de interesse na realização do presente trabalho.

Conflicts of interest: The authors have no conflicts of interest to declare.

Fontes de Financiamento: Não existiram fontes externas de financiamento para a realização deste artigo.

Financing Support: This work has not received any contribution, grant or scholarship.

Correspondence/Correspondência:

Paulo Reis-Pina – preispina@hotmail.com

Unidade de Cuidados Paliativos, Casa de Saúde da Idanha, Sintra, Portugal

Rua Bento Menni, 8, 2605-077, Belas

Received/Recebido: 29/03/2019

Accepted/Aceite: 15/04/2019

REFERENCES

1. Vieira SS, Oliveira A, Barbedo I, Mirra J, Santos M, Alves J, et al. Cuidados paliativos na insuficiência cardíaca avançada: a experiência de uma Equipa Intra-Hospitalar de Suporte em Cuidados Paliativos. *Rev Soc Port Med Interna*. 2019;26:33-9. doi: 10.24950/rspmj/original/150/1/2019.
2. Yancy CW, Jessup M, Bozkurt B, Butler J, Casey DE Jr, Drazner MH, et al. 2013 ACCF/AHA guideline for the management of heart failure: a report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. *J Am Coll Cardiol*. 2013;62:e147–e239. doi: 10.1016/j.jacc.2013.05.019.
3. Braz A. Avaliação de critérios utilizados por internistas na referência de doentes com insuficiência cardíaca para cuidados paliativos. Tese de Mestrado, Cuidados Paliativos, Universidade de Lisboa, Faculdade de Medicina, 2017 [accessed 2019 March 23]. Available at: <http://hdl.handle.net/10451/33609>
4. Lewin WH, Cheung W, Horvath AN, Haberman S, Patel A, Sullivan D. Supportive cardiology: moving palliative care upstream for patients living with advanced heart failure. *J Palliat Med*. 2017;20:1112-9. doi: 10.1089/jpm.2016.0317.
5. Machado S, Reis-Pina P, Mota A, Marques R. Morrer num Serviço de Medicina Interna: as últimas horas de vida. *Rev Soc Port Med Interna*. 2018;25:286-92. doi: 10.24950/rspmj/original/90/4/2018.