Referral to Palliative Care in CHF Patients

Kevin Mikielski, DO, FACC
Objectives

• Define Advanced Heart Failure
• Define Palliative Care
• Define when to refer for Palliative Care
• Define modalities of Palliative Care
• Identify benefits of Palliative Care vs. traditional methods of care
• Differentiate Palliative Care from Hospice Care
Advanced Heart Failure

• Defined as:
  – Moderate/severe symptoms of dyspnea and/or fatigue (NYHA FC III-IV) or Class D
  – Recurrent episodes of fluid retention and/or reduced cardiac output
  – Objective evidence of severe cardiac dysfunction (need at least one of the following):
    • LVEF <30%
    • Severe impairment in LV diastolic filling
    • Elevated left and/or right filling pressures, or elevated BNP
  – Severely impaired functional capacity (6-minute walk distance <300m )
  – At least 1 hospitalization in past 6 months
  – Symptoms/findings present despite optimal medical therapy
ECHOCARDIOGRAPHY
KEY ISSUES

• Need to definitively exclude exacerbating factors for CHF including:
  – CAD, Valvular Dz, Arrhythmias, Metabolic diseases, Renal disease, Noncompliance with meds and fluid restriction

• Patient needs to be treated with optimal/guideline-directed medical therapies unless limitations are present:
  – Beta Blocker
  – ACEI/ARB
  – Aldosterone Antagonists
  – Nitrates/Hydralazine
DON’T FORGET

Cardiac Resynchronization
Transplantation
Ventricular Assist Device
When to Refer to Palliative Care

- Patients with Advanced Heart Failure
- Difficulty controlling symptoms of congestion
- Recurrent hospitalizations for volume overload
- Significant symptoms despite optimal medical therapy (Guideline – Directed Medical Therapy)
- EARLY, EARLY, EARLY!!!
Palliative Care Defined

• Care that aims to improve the *quality* of life for patients and their families facing any life-threatening illness

• Focuses are:
  – Relieving pain and other distressing symptoms
  – Affirming life and regards death as a normal process
  – Neither hastening nor postponing death
  – Patients living an active life until death
  – Providing social and psychological support services for patients and families
  – NEEDS TO BE MULTIDISCIPLINARY
  – IS NOT HOSPICE NOR A DEATH SENTENCE
Benefits of Referral to Palliative Care

• Symptom management
• Provides forum for open discussions between patient, family and healthcare providers
• Provides transition to hospice care and withdrawal of therapies (end-of-life care)
• ALL OF THE ABOVE ARE IMPROVED WHEN PATIENTS ARE REFERRED TO PALLIATIVE CARE VS TRADITIONAL CHF TREATMENT STRATEGY
Frequent Symptoms in Advanced CHF

- Pain – 78%
- Dyspnea – 61%
- Depression – 59%
- Insomnia – 45%
- Anorexia – 43%
- Constipation – 37%
- Nausea / Vomiting – 32%
- Anxiety – 30%
Pain

• Frequent symptom and often not dealt with adequately
• Avoid NSAIDs - cause fluid retention, GI and renal dysfx
• Opioids, and particularly Morphine, may help in relieving pain and improve dyspnea
Dyspnea

- Potentially disabling symptom of “air hunger”
- Methods to treat:
  - PO diuretics
  - IV diuretics
  - Ultrafiltration
  - Inotropes: Dobutamine and Milrinone
  - Morphine
OPEN DISCUSSION/COMMUNICATION

• Patients and families are often unaware of the severity and prognosis of the illness
• Bereaved family members of patients with nonsudden cardiac deaths reported minimal communication from physicians about what to expect
• Only 37% were aware of poor prognosis
• Only 8% of patients and 44% of family members were told by a physician that time was short
• 36% of these patients died alone
Benefits of open discussion/communication

• Lower levels of Medicare spending, lower likelihood of in-hospital death, and higher use of hospice

• Palliative care interventions delivered early have a positive impact on survival and quality of life
End-of-Life Care/Decisions

• Make a collaborative decision regarding expectations and patient desires
• Reduces confusion of “code status”
• Facilitates withdrawal of therapies/Hospice Care
  – ICD termination
  – Medication withdrawal other than comfort care measures
  – Agreement that patient will not be “taken back to hospital” and will be allowed to “pass at home”
CASE STUDY

• 44 yo Female
• Divorced and lives with mother
• 17 yo daughter
• Hx CAD S/P PCI/stent 2010, CHF with LVEF 15% via echo 2011, DM, HTN, ex-smoker, osteonecrosis of L hip with limited ambulation
• 14 hospitalizations for CHF in past 2 years
  – Largely treated by NP in outpatient CHF clinic at large facility
Initial Visit

- NYHA III-IV
- Marked volume overload on exam
- On GDMT: ACEI, Beta-blocker
- On Furosemide 80 mg BID
- Added Spironolactone
- LVEF 10-15%
- ICD in place
- Sent for RHC/LHC: PCI/stent to RCA
- Seen back in 4 weeks: No improvement in sx
Course

- Referred to CCF for BiV evaluation and MCD +/- transplant evaluation
- EP at CCF unable to place LV lead and patient refused epicardial lead
- Refused for transplant evaluation given advanced DM
- Refused for MCD given multiple comorbidities
- What to do now???
Course

• Discussed Palliative Care because CCF said “we have nothing more to offer”
• Referred to Home Health Agency for CHF monitoring
  – I receive weekly weights, BP and medication list
• Referred for PICC line placement for parenteral diuretics and possible inotropes
• Since early 2012, has been receiving Bumetanide 2 mg IV q8 hours and has not needed inotropes
• Has not been hospitalized for CHF exacerbation since late 2011
THANK YOU
REFERENCES


