



PALLIATIVE CARE OF HEART FAILURE

Heart failure is a common chronic condition (there are estimated to be $\frac{3}{4}$ million patients in the UK) which leads to disability and death. It is the final common pathway for many patients with hypertension or ischaemic heart disease and 40% will die within a year of diagnosis. Current treatments for heart failure (Factfile 11/99) slow but do not arrest progression of the disease. The limited evidence available suggests that quality of life is poor and often worse than with other chronic illnesses. The need for a palliative approach to the management of end-stage heart failure is recognised by the NHS.¹ However, recent studies have confirmed the high symptom burden, lack of communication and demonstrated psychological and social needs in end-stage heart failure that are not being met.^{2,3,4}

The palliative care approach should concentrate on quality of life and good symptom control, a whole-person approach to patients and their carers, and respect patient autonomy and choice. It is facilitated by open and sensitive communication with patients, their carers and professional colleagues.

Needs.

The common limiting symptoms of heart failure include breathlessness and fatigue. The first approach to managing these symptoms is to ensure that optimal medical therapy for heart failure, is prescribed and is taken by the patient (Factfile 11/99). Depression occurs in about one third of patients and since it frequently goes unrecognised should be sought and treated. However, tricyclic anti-depressants are best avoided. Breathlessness should be treated as outlined in Factfile (11/99), but where it persists despite other treatments, opioids may be beneficial. Other severe common symptoms are sleep disturbance and nausea and vomiting. Distressing pain is common throughout the last year of life and at around the time of death. It is usually amenable to techniques learnt from the palliation of cancer patients especially the use of the WHO pain ladder except that non-steroidal

anti-inflammatory agents should be avoided. In addition, patients often experience confusion and short term memory loss.

Barriers to good information, communication and understanding for patients and their families are widespread. The needs of patients with heart failure include a desire for information about their illness, its treatment and when to seek unplanned medical help. Some patients would welcome timely and frank discussion about their prognosis to help them to prepare for the end of life.⁴ In future there is likely to be an increase in specialist heart failure nurses who can co-ordinate and mobilise social and financial support, as well as playing an important role as GP facilitators. In addition, they can help patients to understand their treatment and improve compliance with it, thereby reducing the frequency of admission to hospital.

Role of specialist palliative care.

Specialist palliative care varies across the country in terms of referral criteria and services offered, but most services will accept any diagnosis on the basis of extraordinary palliative needs. The subtlety and rapidity of terminal decline can make the mobilisation of supportive and palliative resources difficult. Currently cardiovascular disease accounts for only 1.6% of referrals for specialist palliative care. However, most patients would be well served by a proactive and responsive care strategy modelled on the palliative approach.⁵

Conclusions.

The breadth of palliative needs in heart failure patients requires better recognition. It is the responsibility of all health care professionals to acknowledge this need, as well as their potential role in improving the patient's situation. Good care at the end of life should be a universal right and not just reserved for those with cancer. Any unmet needs could be met by purchasers bringing pressure to bear on the hospice providers by buying additional services.

Further Reading

1. NHS. National Service Framework for Coronary Heart Disease. Modern Standards and Service Models. Department of Health, 2000, London.
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3. McCarthy M, Lay M, Addington-Hall, Dying from heart disease. *JR Coll Physicians* 1996;30:326-8.
4. Rogers A, Addington-Hall JM, Abery A, McCoy A, Bulpitt C, Coats AJS, Gibbs JSR. Knowledge and communication difficulties for patients with chronic heart failure: qualitative study. *Brit. Med. J.* 2000; 321:605-607.
5. Gibbs LME, Addington-Hall J, Gibbs JSR. Dying from heart failure: lessons from palliative care. *Brit. Med J* 1998; 317:961-962.