HARTCENTRUM GENT

E17 ziekenhuis netwerk

MARIA MIDDELARES

Palliatieve zorg bij hartfalen: rationale, evidentie en prioriteiten voor de toekomst

Hans ‘T Kindt, cardioloog, palliatief arts

Hartfalen : multidisciplinaire aanpak

- Huisarts en team cardio (cardioloog, hartfalen verpleegkundige,interventie cardioloog, electrofysioloog, revalidatie arts, cardiochirurg, sociale dienst,…)
- Transmurale zorg

- Bij gevorderd hartfalen: verdere uitbreiding met palliatief support team, palliatieve thuiszorg

Palliatieve zorg en cardiologie

- Wat betekent de diagnose van hartfalen: algemeen, perspectief van patiënt ?
- Waarom palliatieve zorg bij hartfalen ?
- Symptoom controle: wat kan je doen ?
- Wat zijn de effecten van palliatieve zorg ?

- Wat is de verhouding tussen curatieve (DMR/) en palliatieve zorg ?
- Welk model van palliatieve zorg ?
- Welke competenties zijn vereist ?

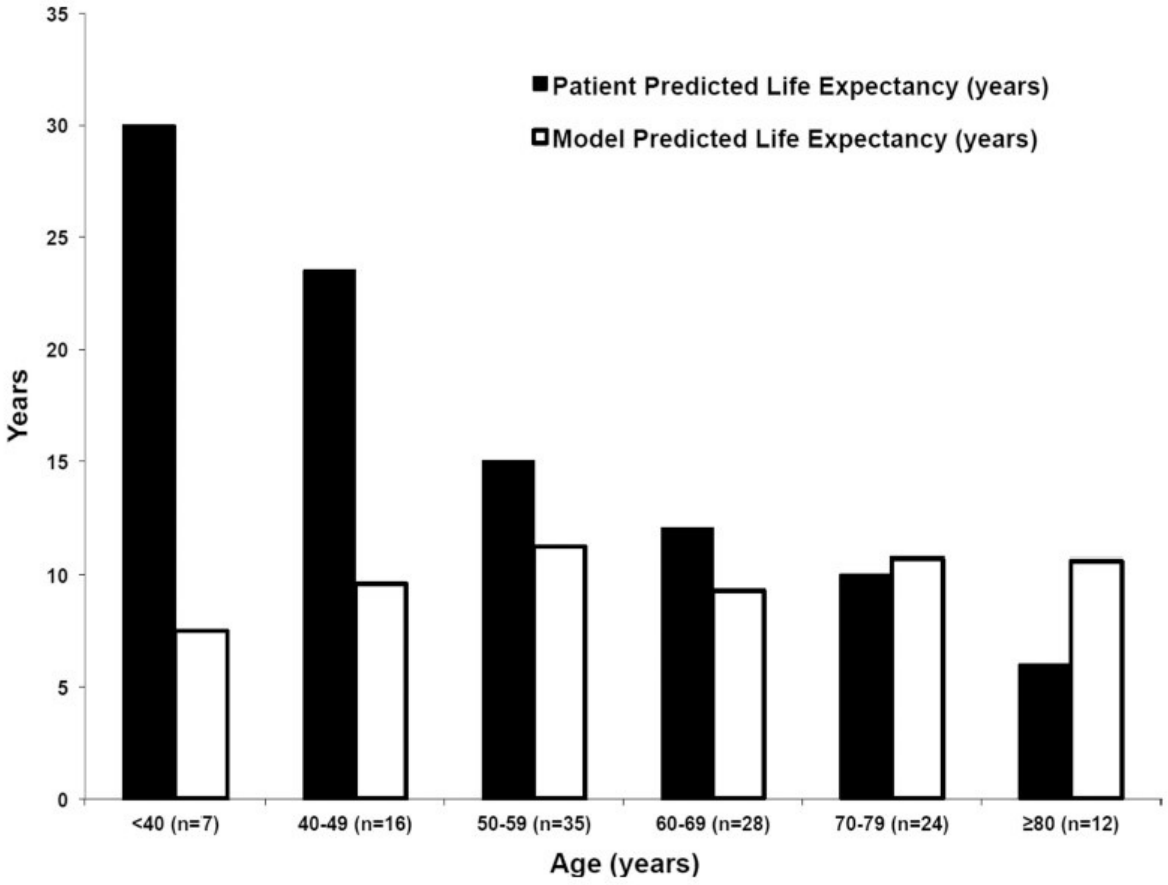
Wat betekent diagnose van hartfalen: algemeen ?

HFrEF	HFpEF
diuretica	diuretica
acei (arbs, arni's) betablockers aldosterone antagonisten SGLT2 inhibitors	
ICD CRT CRT-D	(ICD)

- Laatste 30 jaar 5-jaarsoverleving + 30 % (1)
- 40 % overlijden binnen jaar na eerste hospitalisatie (2)
- Hoge maatschappelijke kost, vooral door hospitalisatie
- Symptomatologie: dyspnoe, pijn, depressie, vermoeidheid, cachexie,…

1. Jones NR, Eur J Heart Fail 2019, 2. Liu L. Cardiol Clin 2014

Wat betekent de diagnose van hartfalen: voor de patiënt ?



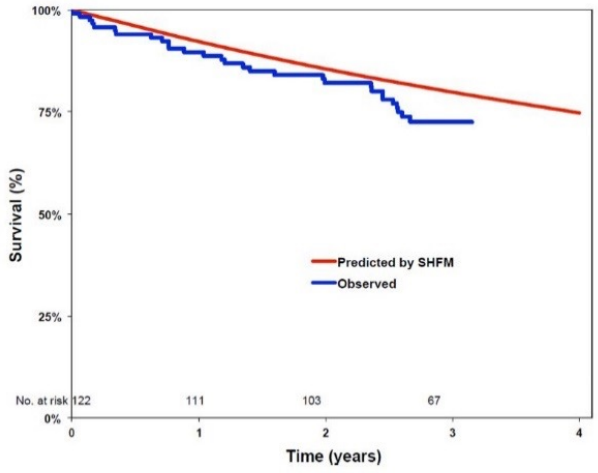


Figure 2.
Survival curves comparing the observed survival in our cohort to that predicted by the Seattle Heart Failure Model.

L. Allen, JAMA 2008

Wat betekent de diagnose van hartfalen: voor de patiënt ?

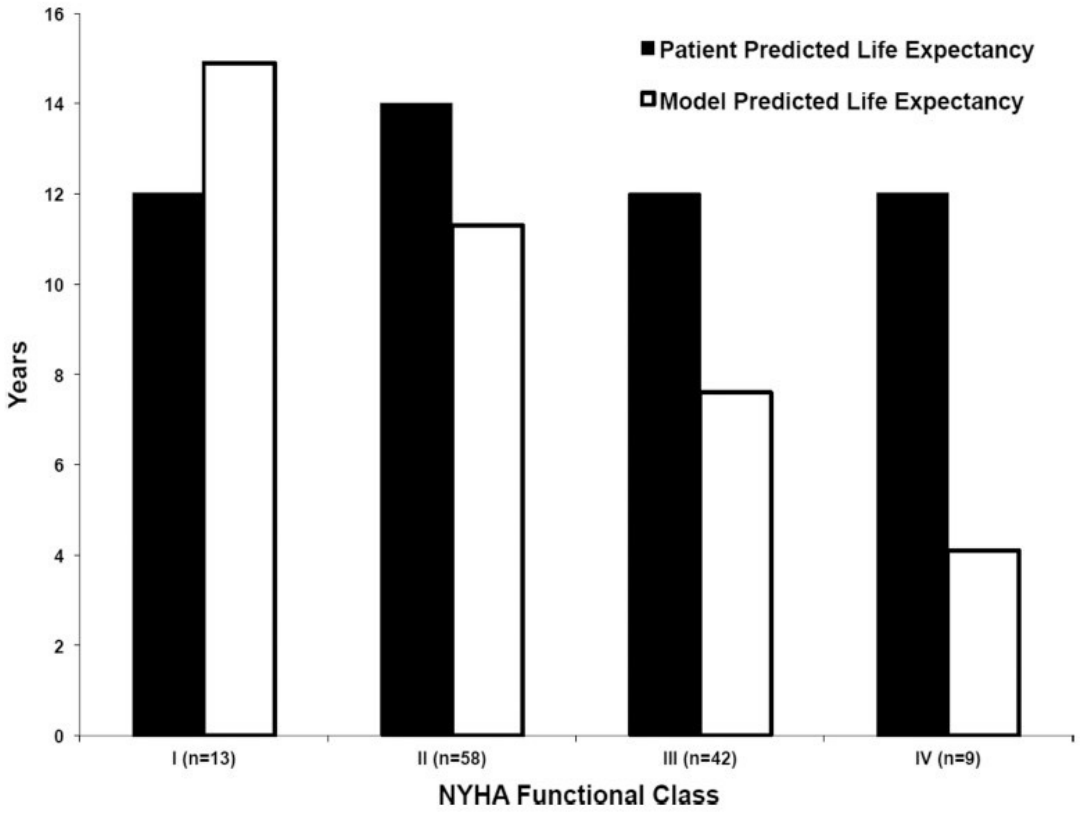


Figure 4.
Patient predicted life expectancy vs. model predicted life expectancy stratified by patient age (A) and by NYHA class (B).

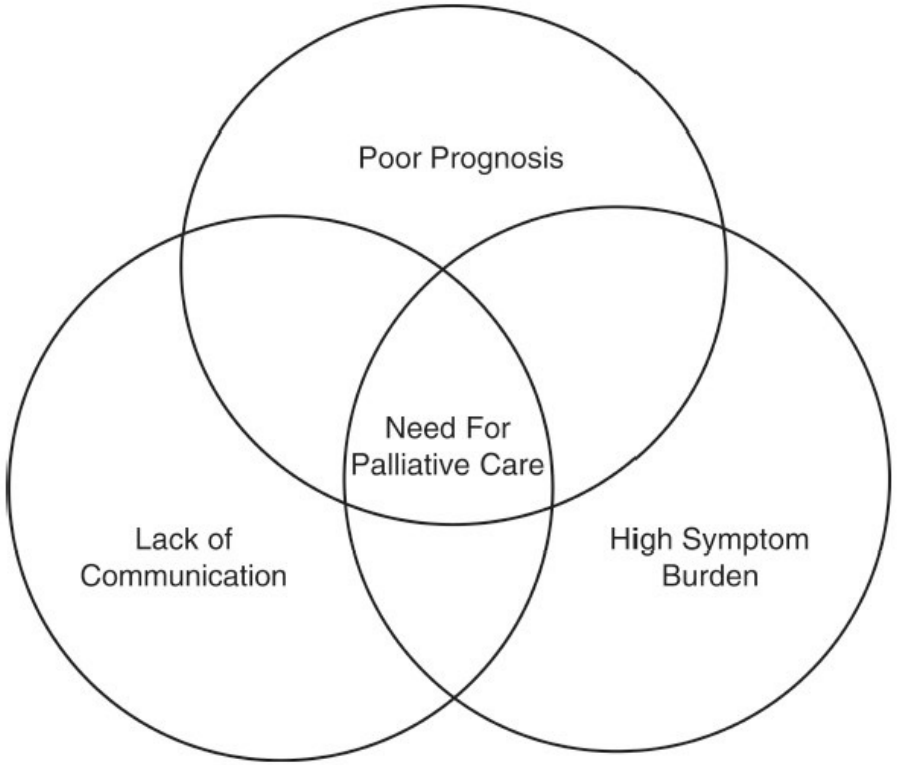
L. Allen, JAMA 2008

Palliatieve zorg : WHO definitie

- Benadering die ***de levenskwaliteit*** van patiënt en familie poogt te verbeteren door voorkomen en behandelen van symptomen
- ***Holistische*** aanpak: fysisch, psychosociaal, spirituele dimensie.
- Aandacht voor ondersteuning van ***mantelzorgers***
- ***Interdisciplinaire*** samenwerking

WHO Definition of Palliative Care 1 september 2019

Waarom palliatieve zorg bij hartfalen ?



L. Lemond, Prog Cardiovasc Dis 2011

Waarom palliatieve zorg bij hartfalen ?

- 2009 ESC : aandacht palliatieve zorg bij gevorderd hartfalen

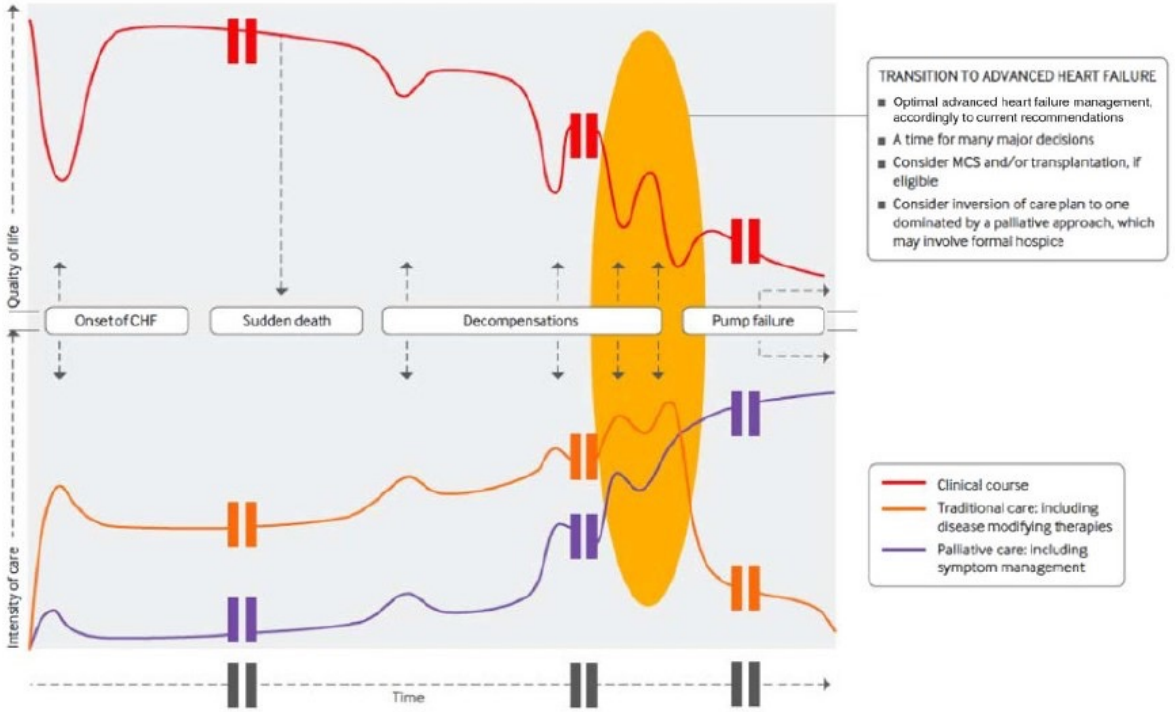
- Intrinsieke onzekerheid over verloop hartfalen traject
- Lage prioriteit bij zorggevers
- Nood aan staftraining, organisatie, tijd

- 7 % palliatieve begeleiding bij ernstig hartfalen (1), < 1 % op palliatieve eenheden

1. den Herder-Van der Eerden M., Pall. Med 2018

Symptoom controle: wat kan je doen ?

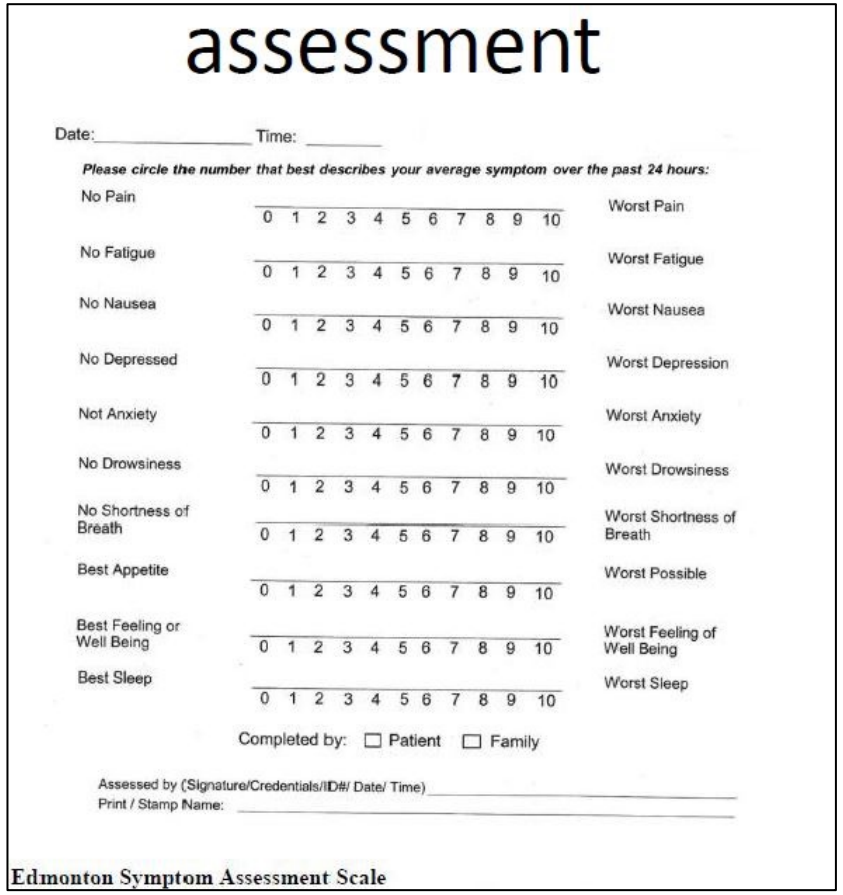
- Wisselende en onvoorspelbare symptomatologie, moeilijke prognosticatie



P. Sobanski, Cardiovascular Research 2020

Symptomen gevorderd hartfalen:

- Kortademigheid
- Vochtretentie
- Pijn
- Vermoeidheid
- Angst en depressie
- Dorst
- Nausea, braken, obstipatie,..



assessment

Date:_____ Time: _____

Please circle the number that best describes your average symptom over the past 24 hours:

No Pain	0 1 2 3 4 5 6 7 8 9 10	Worst Pain
No Fatigue	0 1 2 3 4 5 6 7 8 9 10	Worst Fatigue
No Nausea	0 1 2 3 4 5 6 7 8 9 10	Worst Nausea
No Depressed	0 1 2 3 4 5 6 7 8 9 10	Worst Depression
Not Anxiety	0 1 2 3 4 5 6 7 8 9 10	Worst Anxiety
No Drowsiness	0 1 2 3 4 5 6 7 8 9 10	Worst Drowsiness
No Shortness of Breath	0 1 2 3 4 5 6 7 8 9 10	Worst Shortness of Breath
Best Appetite	0 1 2 3 4 5 6 7 8 9 10	Worst Possible
Best Feeling or Well Being	0 1 2 3 4 5 6 7 8 9 10	Worst Feeling of Well Being
Best Sleep	0 1 2 3 4 5 6 7 8 9 10	Worst Sleep

Completed by: ☐ Patient ☐ Family

Assessed by (Signature/Credentials/ID#/ Date/ Time) _____

Print / Stamp Name: _____

Edmonton Symptom Assessment Scale

- Dyspnoe: > 90 %
  - overvulling, anemie, COPD
  - opiaten, eventueel benzodiazipines bij angst
  - weinig effect van O2 zo niet hypoxisch

- Pijn: > 90 %
  - te correleren met ernst van HF, leeftijd, vrouw
  - aanpak ifv. pathofysiologie (nociceptief, neuropathisch, ischemie, psychotherapie, accupunctuur,…)
  - ondergebruik van opiaten (cave morfine bij nierfalen)
  - contra-indicatie voor NSAID's

P. Sobanski, Cardiovascular Research 2020

- Depressie en angst: > 50 %, open communicatie, cardiale revalidatie, cognitieve gedragstherapie, SSRI en Mirtazipine veilig
- Vermoeidheid: mobilisatie, ijzer therapie, dosisaanpassing medicatie
- Dorst: ijsschilfers, kauwgom, muntsnoepjes
- Obstipatie: mobilisatie, laxativa

P. Sobanski, Cardiovascular Research 2020

Wat zijn de effecten van palliatieve zorg ?

- Hospitalisatie
- Overleving
- Levenskwaliteit
- Symptoomcontrole

Wat zijn de effecten van palliatieve zorg ?

Hospitalisatie

Study or Subgroup	Palliative Care Events	Palliative Care Total	Usual Care Events	Usual Care Total	Weight	Odds Ratio IV, Random, 95% CI
Brannstrom 2014	13	36	21	36	22.7%	0.40 [0.16, 1.04]
Denvir 2016	6	25	7	25	14.3%	0.81 [0.23, 2.88]
Rogers 2017	35	75	38	75	38.3%	0.85 [0.45, 1.62]
Wong 2015	14	43	25	41	24.7%	0.31 [0.13, 0.76]
Total (95% CI)		**179**		**177**	**100.0%**	**0.56 [0.33, 0.94]**
Total events	68		91			

Heterogeneity: Tau² = 0.08; Chi² = 4.12, df = 3 (P = 0.25); I² = 27%

Test for overall effect: Z = 2.21 (P = 0.03)

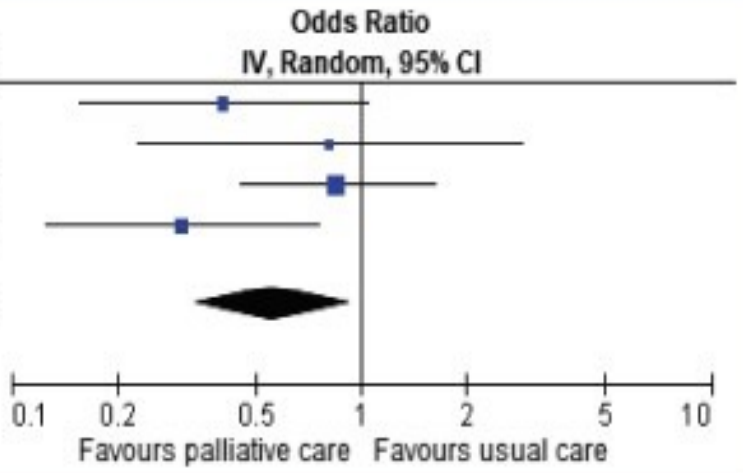


Figure 3 Risk of at least one hospitalization during follow-up with palliative care vs. usual care. CI, confidence interval.

Nick Sahlollbey, European Journal of Heart Failure 2020

Wat zijn de effecten van palliatieve zorg ?

Overleving

Study or Subgroup	Palliative Care Events	Palliative Care Total	Usual Care Events	Usual Care Total	Weight	Odds Ratio IV, Random, 95% CI
Aiken 2006	16	100	12	91	17.7%	1.25 [0.56, 2.82]
Brannstrom 2014	8	36	4	36	9.8%	2.29 [0.62, 8.41]
Denvir 2016	3	25	0	25	2.4%	7.93 [0.39, 162.07]
Hopp 2016	11	43	8	42	13.5%	1.46 [0.52, 4.10]
O'Donnell 2018	10	26	9	24	11.8%	1.04 [0.33, 3.27]
O'Riordan 2019	1	22	1	18	2.6%	0.81 [0.05, 13.92]
Rogers 2017	23	75	20	75	20.0%	1.22 [0.60, 2.47]
Sidebottom 2015	14	116	5	116	13.1%	3.05 [1.06, 8.76]
Wong 2015	3	43	11	41	9.2%	0.20 [0.05, 0.80]
Total (95% CI)		**486**		**468**	**100.0%**	**1.30 [0.80, 2.09]**
Total events	89		70			

Heterogeneity: Tau² = 0.17; Chi² = 12.03, df = 8 (P = 0.15); I² = 33%

Test for overall effect: Z = 1.06 (P = 0.29)

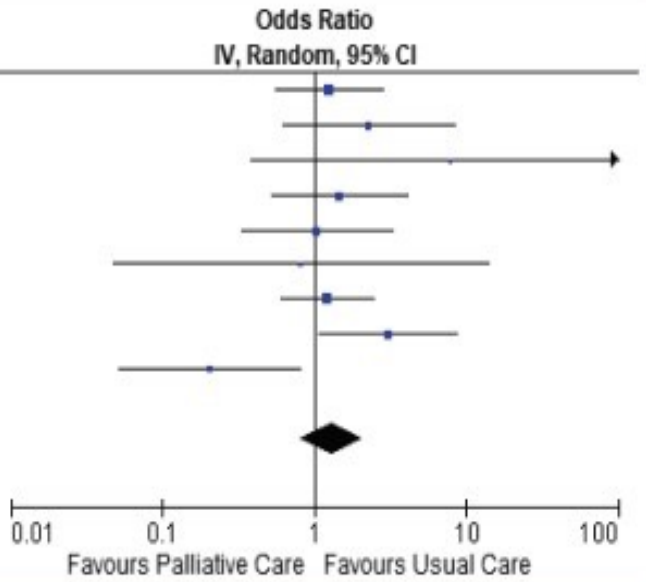


Figure 4 Risk of death with palliative care vs. usual care. CI, confidence interval.

Nick Sahlollbey, European Journal of Heart Failure 2020

Wat zijn de effecten van palliatieve zorg ?

Levenskwaliteit

Study or Subgroup	Palliative Care Mean	SD	Total	Usual Care Mean	SD	Total	Weight	Std. Mean Difference IV, Random, 95% CI
Brannstrom 2014	60.4	20.6	36	52.3	23.2	36	14.3%	0.37 [-0.10, 0.83]
Denvir 2016	0.54	0.29	21	0.56	0.24	23	9.4%	-0.07 [-0.67, 0.52]
O'Donnell 2018	50.2	21.5	26	52.8	27.3	24	10.5%	-0.10 [-0.66, 0.45]
O'Riordan 2019	65	26.2	16	59.6	26.8	14	6.6%	0.20 [-0.52, 0.92]
Rogers 2017	63.1	20.4	41	52.1	25	40	15.6%	0.48 [0.04, 0.92]
Sidebottom 2015	14.86	24.4	79	11.8	21.4	88	27.8%	0.13 [-0.17, 0.44]
Wong 2015	5.26	1.11	43	4.47	1.47	41	15.8%	0.60 [0.17, 1.04]
Total (95% CI)			**262**			**266**	**100.0%**	**0.25 [0.06, 0.45]**

Heterogeneity: Tau² = 0.01; Chi² = 7.06, df = 6 (P = 0.32); I² = 15%
Test for overall effect: Z = 2.61 (P = 0.009)

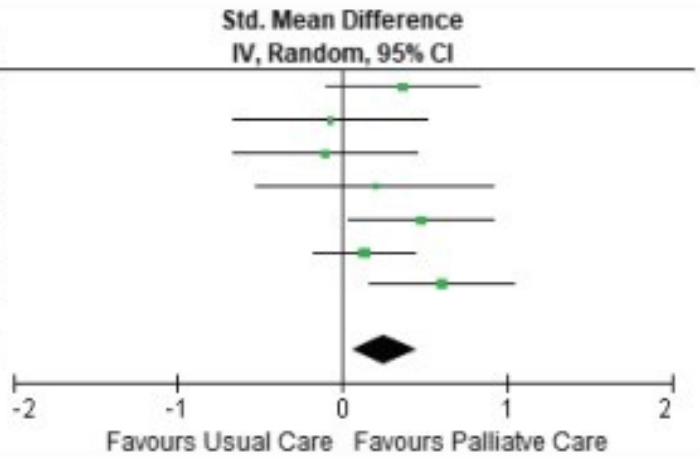


Figure 5 Quality of life with palliative care vs. usual care. Quality of life was measured by the EuroQol-5D (Brannstrom 2014; Denvir 2016), Kansas City Cardiomyopathy Questionnaire (O'Donnell 2018, Rogers 2017), Minnesota Living with Heart Failure Questionnaire (O'Riordan 2019, Sidebottom 2015), and the McGill Quality of Life Questionnaire for Hong Kong (MQOL-HK) (Wong 2015). If necessary, studies corrected for directionality to allow higher scores to represent better quality of life. CI, confidence interval; SD, standard deviation.

Nick Sahlollbey, European Journal of Heart Failure 2020

Wat zijn de effecten van palliatieve zorg ?

Symptoomcontrole

Study or Subgroup	Palliative Care Mean	SD	Total	Usual Care Mean	SD	Total	Weight	Std. Mean Difference IV, Random, 95% CI
Denvir 2016	24.5	12.5	25	23.5	14.7	25	18.9%	0.07 [-0.48, 0.63]
Sidebottom 2015	79	12.5	79	83.3	14.7	88	51.8%	-0.31 [-0.62, -0.01]
Wong 2015	23.97	14.42	43	32.39	20.49	41	29.3%	-0.47 [-0.91, -0.04]
Total (95% CI)			**147**			**154**	**100.0%**	**-0.29 [-0.54, -0.03]**

Heterogeneity: Tau² = 0.01; Chi² = 2.34, df = 2 (P = 0.31); I² = 15%
Test for overall effect: Z = 2.22 (P = 0.03)

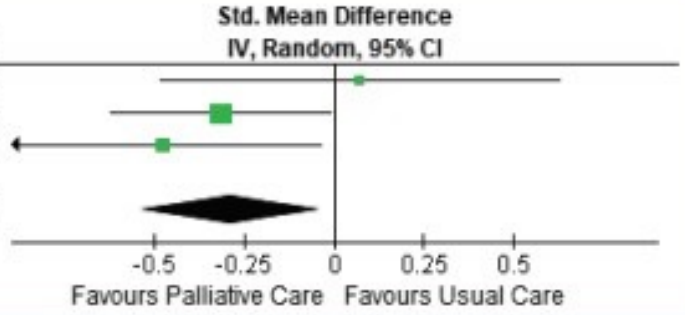
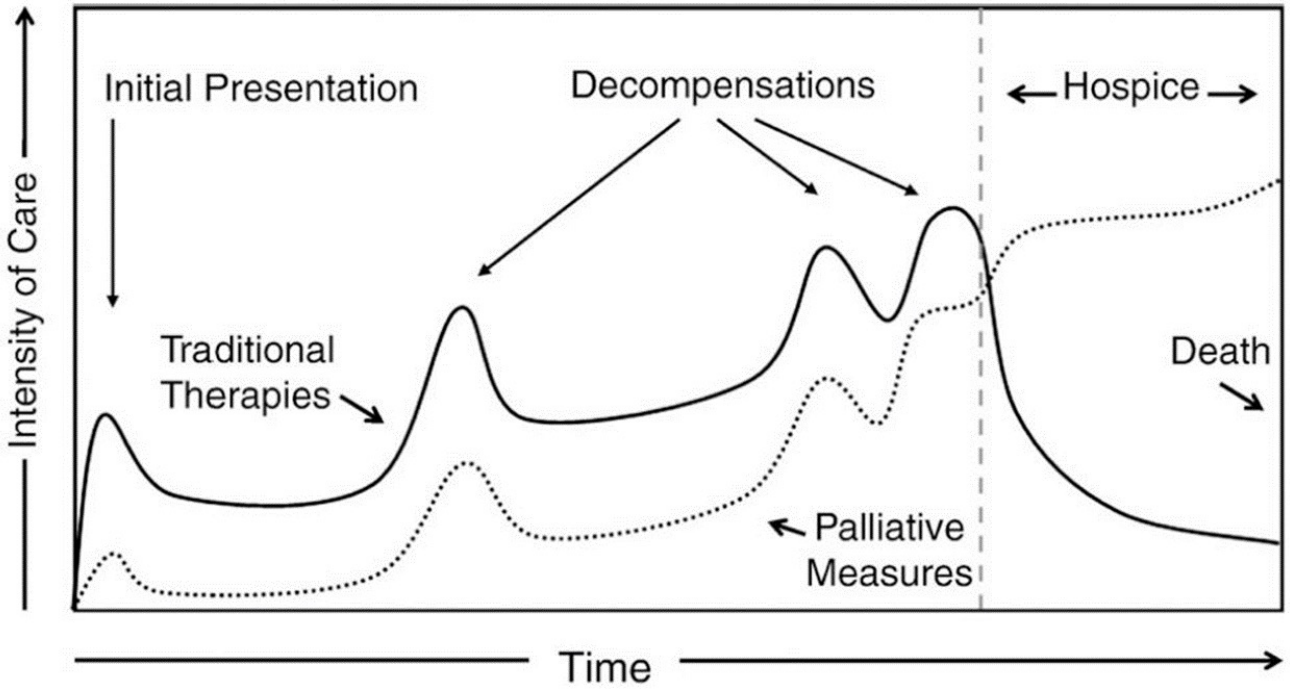


Figure 6 Total symptom burden with palliative care vs. usual care. Total symptom burden was measured by the Edmonton Symptom Assessment Scale in all studies. Sidebottom (2015) reported the mean change from baseline to 3 months, which was subtracted from each baseline score; standard deviations (SD) were not reported for 3-month scores and were imputed from Denvir (2016) as both studies used the same measurement scale and had the same time periods between baseline and final value measurement. CI, confidence interval.

Nick Sahlollbey, European Journal of Heart Failure 2020

Disease modifying therapie versus palliatieve zorg ?

- Heart failure management continuum:
  - geen opponenten, eerder complementair



L. Lemond, Prog Cardiovasc Dis. 2011

Trigger points voor transitie van curatieve naar palliatieve zorg

- Gebaseerd op symptomen en noden, minder op inschatting prognose

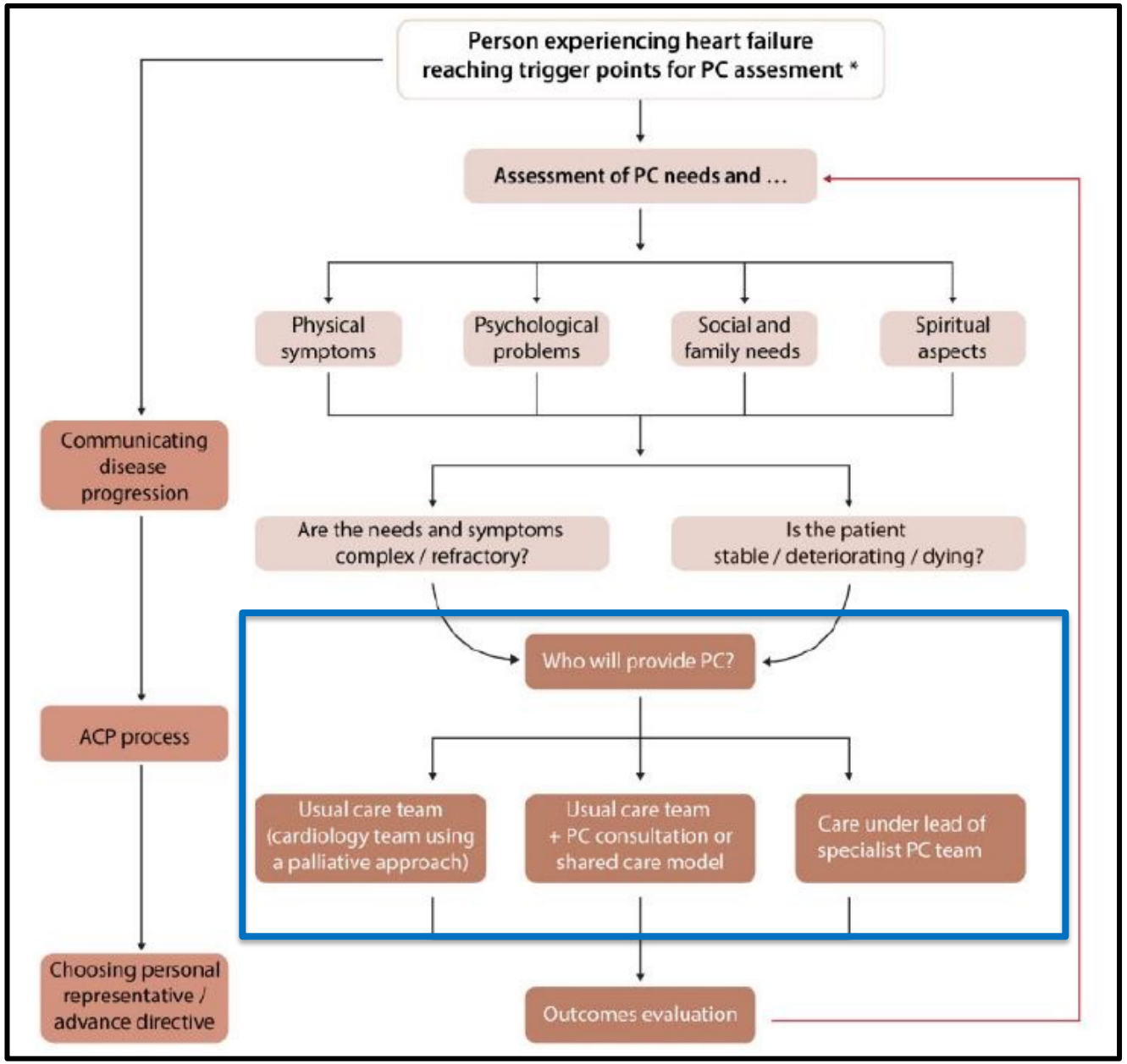
- Prognostische elementen: leeftijd, sterk gedaalde EF, cardiorenaal syndroom, medicatie intolerantie, hypotensie, NYHA klasse, cachexie, NT pro BNP, troponine

L. Lemond, Prog Cardiovasc Dis. 2011

Trigger points voor transitie van curatieve naar palliatieve zorg

- Triggers: wijzen op toenemende noden van patiënt
  - Significante wijziging in hartfalen traject: refractaire symptomen, ICD, HTX of LVAD gesprek, na succesvolle reanimatie, symptomen van gevorderd hartfalen met heropnames.
  - Bij periodische opvolging en wijzigingen in algemene gezondheid.
  - Psychosociale stressfactoren, existentiële of spirituele stress.

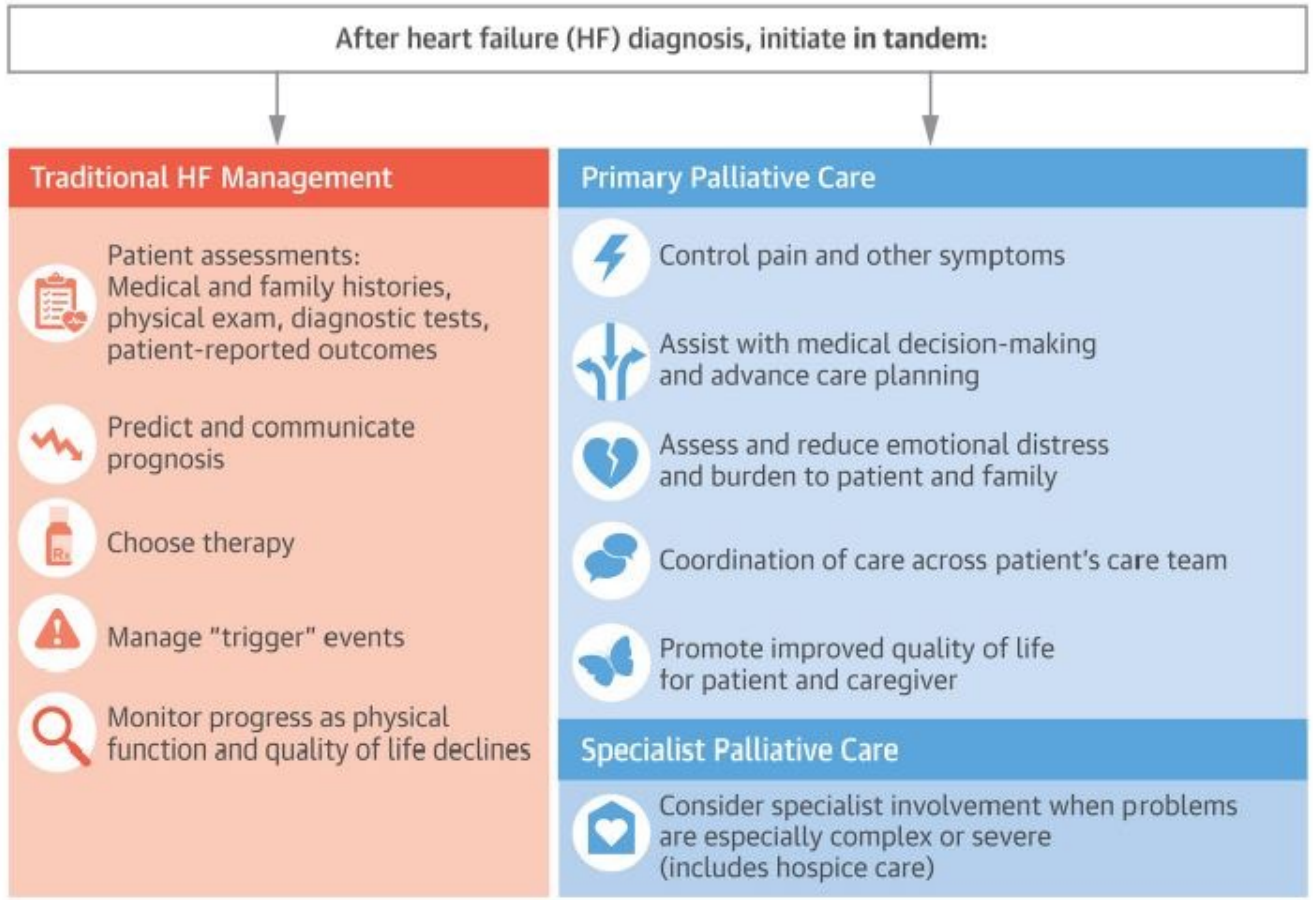
L. Lemond, Prog Cardiovasc Dis. 2011



NAT-PD HAF (need assessment tool): helpt actief noden in kaart brengen

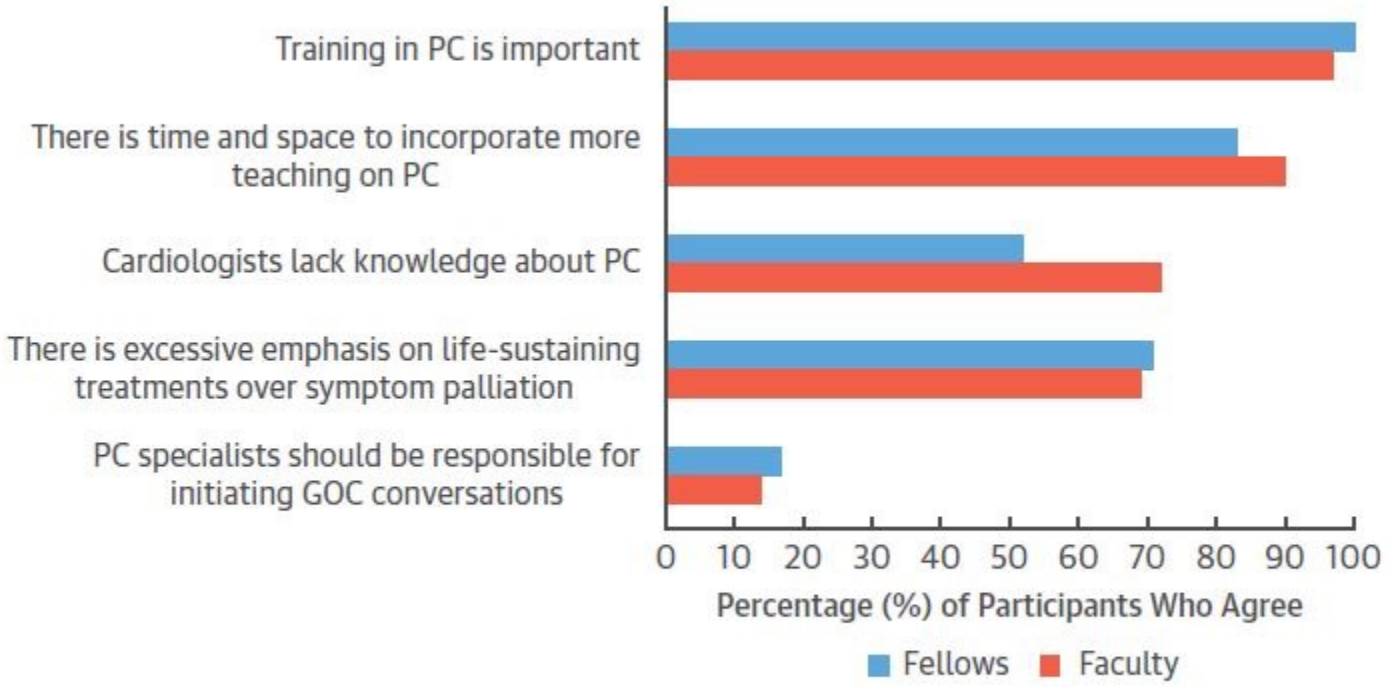
P. Sobanski, Cardiovascular Research 2020

Welk model van palliatieve zorg ?



D. Kavalieratos, JACC 2017

Welke competenties zijn vereist ?



Percentage of fellows and faculty who agree with each statement about PC education and delivery. GOC = goals of care; PC = palliative care.

D. Crousillat, JACC 2018

TABLE 1 Essential Primary PC Competencies for Cardiology Fellows

PC Domains	PC Competencies
Communication	1. Engage in shared decision making with patients and exhibit sensitivity to patient's values and preferences* (TF 1) 2. Effectively assess and communicate disease prognosis with patients and their families† (4,8-11)
Pain and symptom management	3. Recognize and manage common comorbidities in AHD, including depression, anxiety, and sleep-disordered breathing* (TF 12) 4. Demonstrate appropriate use of opioid analgesics for management of refractory dyspnea at or near the EOL† (8,11)
Psychosocial, spiritual, and cultural aspects of care	5. Utilize interdisciplinary care team to assess and manage psychosocial stressors of patients and their families* (TF 12) 6. Demonstrate awareness of psychosocial, spiritual, and cultural aspects of care and their effects on preferences at EOL† (4,8-11)
Terminal care and bereavement	7. Recognize and effectively communicate futility of life-sustaining treatments at EOL* (TF 13) 8. Effectively communicate with patients and their families regarding the option for deactivation of rhythm-control devices at the EOL* (TF 13) 9. Engage in shared decision making regarding discontinuation of inotropic or mechanical circulatory support at or near EOL† (9-11)
PC principles and practice	10. Recognize appropriate indications for PC and hospice* (TF 12) 11. Effectively incorporate PC into the management of all patients with symptomatic AHD, regardless of disease prognosis† (4,10)

*Adapted from Core Cardiovascular Training Statement 4 by Task Force (7). †Adapted from select national society practice guidelines (4,8-11).

AHD = advanced heart disease; EOL = end of life; PC = palliative care; TF = task force.

D. Crousillat, JACC 2018

Aandachtspunten !

- Deprescribing
- Inactivatie ICD:
  - ICD geen effect op symptomen, CRT-D wel
  - R. Stoevelaar, Netherland Heart Journal 2020
    - 42 % desactivatie
    - 9 % shock in laatste levensmaand

Recommendations for Terminal Care

References that support the recommendations are summarized in Online Data Supplement 59.

COR	LOE	Recommendations
I	C-EO	1. At the time of ICD implantation or replacement, and during advance care planning, patients should be informed that their ICD shock therapy can be deactivated at any time if it is consistent with their goals and preferences.
I	C-EO	2. In patients with refractory HF symptoms, refractory sustained VA, or nearing the end of life from other illness, clinicians should discuss ICD shock deactivation and consider the patients' goals and preferences.

Al-Kathib, Circulation 2018

Aandachtspunten !

- Repetitieve toediening van Levosimendan ?

- Vroegtijdige zorgplanning: anticiperen op toekomstige zorgnoden
  - Niet enkel TB code
  - Shared decision making: EOL preferences, heropname ?
  - Te overwegen bij transitiemomenten

Palliatieve zorg en cardiologie

- “Een goede dood”
- Sterven, afscheid nemen, terugkijken.
- Dying well: “forgive me, i forgive you, thank you, love you, goodbye”, Dr. Ira Byock

HARTCENTRUM GENT

E17 ziekenhuis netwerk

MARIA MIDDELARES

Palliatieve zorg bij hartfalen: rationale, evidentie en prioriteiten voor de toekomst

Hans ‘T Kindt, cardioloog, palliatief arts