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Hospice & Palliative Medicine International Journal

Mini Review

# Heart failure: a palliative care illness

## Abstract

Heart failure is a disease whose prevalence has been increasing. Improved health care, and the consequent increase in average life expectancy, has allowed people to live longer and diseases to reach more advanced stages. This disease has high mortality and morbidity rates.

When the subject of palliative care is approached, we inevitably associate it with cancer. But palliative care must be provided to selected patients with chronic diseases without possibility of cure. Symptomatic improvement, improved quality of life and patient satisfaction are some of the objectives of these units. In 2014, a study was conducted in England concluded that the percentage of cancer patients in palliative care is higher than patients with HF. The most important thing is to treat the patient, not the disease.

**Keywords:** heart failure, palliative care, quality of life

Volume 2 Issue 4 - 2018

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**Received:** May 10, 2018 | **Published:** August 22, 2018

## Introduction

Heart failure (HF) is a disease whose prevalence has been increasing. Improved health care, and the consequent increase in average life expectancy, has allowed people to live longer and diseases to reach more advanced stages. HF, as the name implies, is related to the impairment of function of the heart that may be due to structural and/or functional abnormalities.[1]

The classification of the New York Heart Association (NYHA) has 4 stages: class I patients without functional limitation, class II patients with mild symptoms in daily activities but no symptoms at rest, class III patients with significant limitation in physical activity in which minor activities that the routine causes symptoms and class IV patients with symptoms at rest.[2]

## Materials and methods

The bibliographic search was performed in Pubmed and Google Scholar databases, in May of 2018. The inclusion criteria were free text articles, less than 5years old and that addressed the topic of heart failure and palliative care. Based on the previously mentioned criteria, 5 articles were selected.

## Results and discussion

HF is a disease with high mortality and morbidity rates.[3] Mortality rates can reach 40% at 3years and 75% at 5years.[4] Morbidity is related to signs and symptoms that cause disability and consequent depression and sometimes isolation.

The treatment and follow-up of these patients becomes essential in the control of signs and symptoms and consequent improvement, not only physical but also psychological. This monitoring can be done in palliative care center (PCC), in selected patients.

When the subject of palliative care is approached, we inevitably associate it with cancer. This idea is reflected in the definition developed by the World Health Organization in 1990, which provided for the use of this type of care only for cancer patients. However, this definition was revised in 2002 and redefined palliative care as follows: “an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual”.[5] Therefore, palliative care aims not only to follow up cancer patients and their families, but also people with other chronic diseases without possibility of cure.

Symptomatic improvement, improved quality of life and patient satisfaction are some of the objectives of these units.[1]

Countries such as the United States and Canada increasingly emphasize the importance of palliative care for patients with heart failure.[1]

Patients with HF in more advanced stages, especially NYHA IV, are very symptomatic and benefit from follow-up in these units.[1]

The role of Primary Care is increasingly important in this connection between patients with HF and UCC, since most patients are followed up and treated by the family physician.

In 2014, a study was conducted in England comparing two groups of patients followed up in PCC: cancer patients and HF patients. From the research, it was concluded that 48% of the patients in PCC had diagnosis of cancer and only 7% with HF. It was concluded that 1/3 of the patients with HF entered the week of their death while the percentage of cancer patients accounted for only 8%. Therefore, in patients with HF, referral is likely to be delayed, and when admitted to the PCC, they have a more deteriorated condition than patients with cancer. The recognition of the need for follow-up of patients with HF in a PCC tends to be later than in cancer patients.[1]

There are authors who argue that late referral is related to factors associated with the patient, family, physicians and systems of health. There is a lack of information on the part of patients and families, not only in relation to the possibility of referral, but also in relation to the objectives of referral for palliative care.[3] It is of great importance to demystify this idea so that families participate actively in this referral process, identifying the deterioration of the patient’s health status.

## Conclusion

Health care should be increasingly centered on the patient rather than on the disease. Just as patients with cancer feel the need to discuss end-of-life measures, patients with HF may also have this need.[1] The view of the patient as a whole, that is, take into account the physical, mental, and spiritual aspects is of great relevance.[3] The most important thing is to treat the patient, not the disease.

## Acknowledgements

None.

## Conflict of interest

The author declares no conflict of interest.

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**Citation:** Santos SD, Guedes MA. Heart failure: a palliative care illness. *Hos Pal Med Int Jnl.* 2018;2(4):253–254. DOI: 10.15406/hpmij.2018.02.00102