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Patient-Centred Palliative Care for Patients With CVD

Implementing patient-centred palliative care therapies, including prescribing, adjusting, or discontinuing medications as needed, may help control symptoms and improve the quality of life for people with heart disease, according to a new scientific statement from the American Heart Association.

The statement reviews current evidence on the benefits and risks of cardiovascular and essential palliative medications. It guides healthcare professionals in incorporating palliative methods in holistic medication management at all stages of a patient’s health condition.

Palliative care aims to relieve symptoms and enhance the quality of life for people experiencing health-related issues due to serious illnesses. This approach may benefit patients with cardiovascular disease, including coronary heart disease, valvular heart disease, pulmonary arterial hypertension, and heart failure. These conditions significantly reduce quality of life, require ongoing treatment, are usually progressive, and are associated with high mortality rates. The progression of many conditions, from chronic to advanced and end-stage, may be unpredictable and marked by worsening symptoms that result in recurrent hospitalisation.

Palliative care complements standard cardiovascular care by reducing physical symptoms, managing emotional distress, and assisting patients in making decisions that align with their goals of care. A palliative approach can be integrated into the medication management of patients at any stage of heart disease, from chronic, stable heart disease to advanced and end-stage cardiovascular disease. Importantly, palliative care supports a more goal-oriented, patient-centred approach to treatment.

Previous studies have found that adding palliative care interventions to evidence-based care improved patients’ quality of life, functional status, depression, anxiety, and spiritual well-being and reduced the risk of hospital readmission for patients with advanced heart disease compared to clinical care alone. Despite these benefits, fewer than 20% of people with end-stage heart disease receive palliative care.

Despite significant progress in cardiovascular care, disparities in care and outcomes related to race, ethnicity, gender, and social determinants of health persist. People with heart failure who are referred to palliative care are predominantly white, have higher socioeconomic status, and are more likely to receive care at academic medical centers. Patients from underrepresented racial and ethnic groups are less likely to receive palliative care, contributing to poorer outcomes and increased risk of early mortality.

Cardiovascular medications that provide symptom relief, such as diuretics to manage fluid retention in heart failure, should be prioritised in patients with advanced heart disease. Adding palliative medicines to evidence-based cardiovascular therapies can complement managing symptoms and optimizing quality of life. Examples of common palliative medicines include antidepressants, opioids for pain relief and difficulty breathing, and anti-nausea medications.

Deprescribing and de-escalating medications are also essential components of palliative medication management for people with heart disease. Deprescribing involves tapering, withdrawing, or discontinuing a medication to improve outcomes. De-escalating medications focus on reducing the dose or switching to another medication based on the patient’s response to the medicine.

Other reasons to consider deprescribing medications include polypharmacy, defined as taking five medications or more daily. This increases the risk of adverse reactions or side effects, not taking medications as prescribed, hospital readmission, and mortality. Excessive out-of-pocket medication costs may also prompt the need to deprescribe certain medications.

Future research is needed to determine the best ways to provide timely and targeted access to palliative medication management, particularly for patients with advanced heart disease from under-represented racial and ethnic groups who are less likely to receive palliative care or may face barriers to care.

Source: American Heart Association
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