



GRG
Journal Club
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Le cure per l'anziano: modelli e outcome

Le cure palliative

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What is a good death?

“It is not death, but dying which is terrible” wrote Henry Fielding in his novel Amelia (1751). Palliative care is, ethically, a mandatory part of the care of the dying. A byproduct of the success of modern medicine is that the dying process is prolonged.

Lancet 1995; 346: 163-66

LE CURE PALLIATIVE

- **Cosa sono?**
- **Per chi?**
- **Quando?**

LE CURE PALLIATIVE

- **Cosa sono?**
- Per chi?
- Quando?

From margins to centre: a review of the history of palliative care in cancer

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Lancet Oncol 2007; 8: 430-38

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Palliative care and hospices have developed rapidly since the late 1960s. The pioneering work of Cicely Saunders was instrumental in drawing attention to the end-of-life care needs of patients with advanced malignant disease. Palliative care began to be defined as a subject of activity in the 1970s and came to be synonymous with the physical, social, psychological, and spiritual support of patients with life-limiting illness, delivered by a multidisciplinary team. Palliative care services have developed in many settings and have often been closely related to oncology. The worldwide need for this type of care remains much greater than the available provision, but there are encouraging signs of recognition by policymakers and influential bodies, and interest in palliative care has never been greater. This paper charts the modern history of such care around the world and concludes on some current issues and future challenges.

CLINICAL PRACTICE

Palliative Care

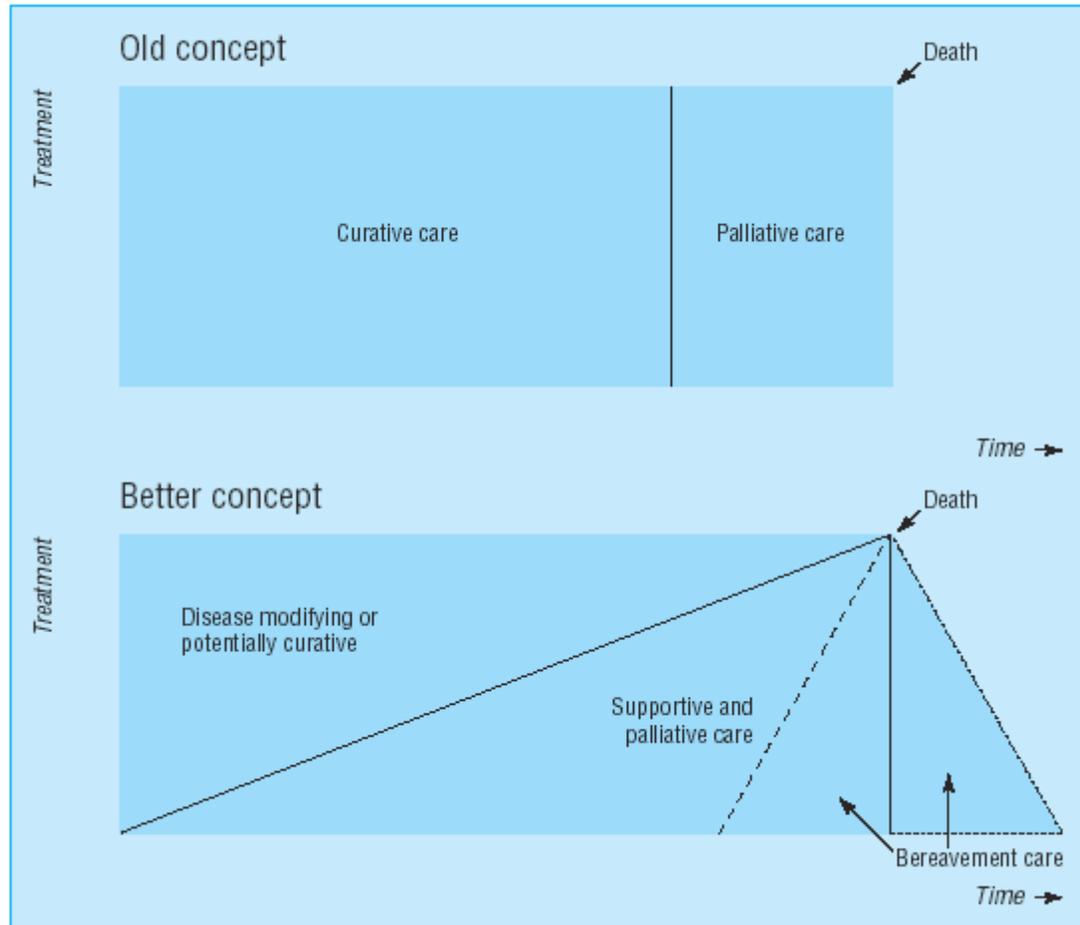
R. Sean Morrison, M.D., and Diane E. Meier, M.D.

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An 85-year-old man with New York Heart Association class IV heart failure, hypertension, and moderate Alzheimer's disease is admitted to the hospital after a hip fracture. His postoperative course is complicated by pneumonia, delirium, and pressure ulcers on his heels and sacrum. He is losing weight and is unable to participate in rehabilitation because of his confusion. This is his fourth hospitalization in the past year. His 84-year-old wife, who has been caring for him at home, feels overwhelmed by his medical and personal care needs. The patient's physician is increasingly frustrated by his frequent readmissions. What might she do to address his needs, alleviate his suffering, and facilitate his discharge from the hospital and subsequent care at home?



THE ROLE OF PALLIATIVE CARE

There are many reasons why patients who have advanced illnesses receive inadequate care, but most of those reasons are rooted in a medical philosophy that is focused almost exclusively on curing illness and prolonging life, rather than on improving the quality of life and relieving suffering. Traditionally, medical care has been articulated as having two mutually exclusive goals: either to cure disease and prolong life or to provide comfort care.¹ Given this dichotomy, the decision to focus on reducing suffering is made only after life-prolonging treatment has been ineffectual and death is imminent.⁶

In the United States, this forced choice is driven largely by the reimbursement system — that is, regular Medicare covers curative therapies and the Medicare hospice benefit covers comfort care. That division of services results both in the provision of burdensome and costly life-prolonging treatments when they are no longer beneficial and in preventable suffering during all stages of advanced illness.⁷ In contrast, patients would benefit most from care that included a combination of life-prolonging treatment (when possible and appropriate), palliation of symptoms, rehabilitation, and support for caregivers.

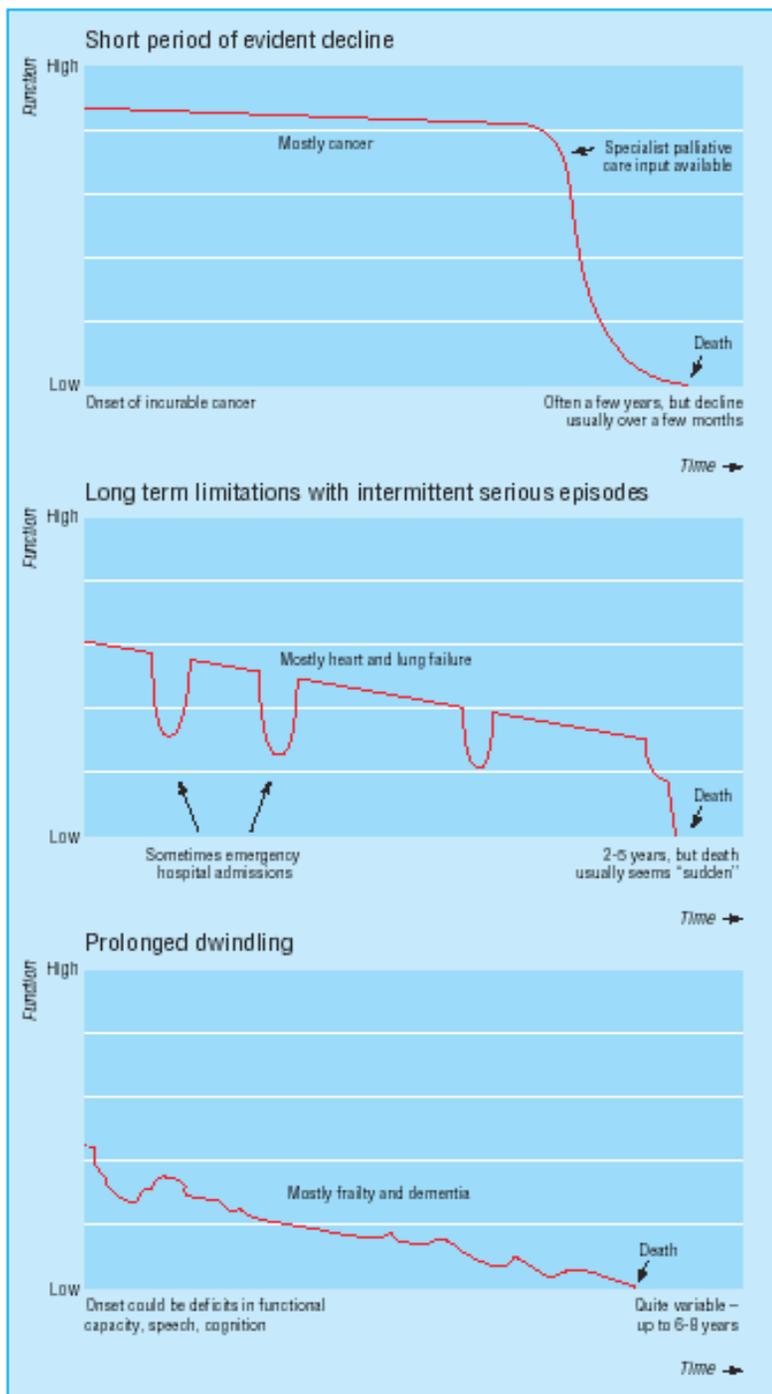
- **Approccio multidisciplinare a pazienti con breve aspettativa di vita.**
- **Supporto fisico, sociale, psicologico e spirituale.**
- **Combinazione di “Cure” e “Care”.**

LE CURE PALLIATIVE

- Cosa sono?
- **Per chi?**
- Quando?

Neoplasie e malattie croniche in fase avanzata

- **Malattie neoplastiche**
- **Malattie cardiache (scompenso cardiaco)**
- **Malattie polmonari (insufficienza respiratoria)**
- **HIV**
- **Malattie epatiche**
- **Malattie renali**
- **Coma e ictus**
- **Demenza**



BMJ 2005;330:1007-1011

LE CURE PALLIATIVE

- Cosa sono?
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- **Quando?**

Prognostic Disclosure to Patients with Cancer near the End of Life

Elizabeth B. Lamont, MD, MS, and Nicholas A. Christakis, MD, PhD, MPH

Background: Patients' understanding of their prognosis informs numerous medical and nonmedical decisions, but patients with cancer and their physicians often have disparate prognostic expectations.

Objective: To determine whether physician behavior might contribute to the disparity between patients' and physicians' prognostic expectations.

Design: Prospective cohort study.

Setting: Five hospices in Chicago, Illinois.

Patients: 326 patients with cancer.

Intervention: Physicians formulated survival estimates and also indicated the survival estimates that they would communicate to their patients if the patients insisted.

Measurements: Comparison of the formulated and communicated prognoses.

Results: For 300 of 311 evaluable patients (96.5%), physicians were able to formulate prognoses. Physicians reported that they would not communicate any survival estimate 22.7% (95% CI,

17.9% to 27.4%) of the time, would communicate the same survival estimate they formulated 37% (CI, 31.5% to 42.5%) of the time, and would communicate a survival estimate different from the one they formulated 40.3% (CI, 34.8% to 45.9%) of the time. Of the discrepant survival estimates, most (70.2%) were optimistically discrepant. Multivariate analysis revealed that older patients were more likely to receive frank survival estimates, that the most experienced physicians and the physicians who were least confident about their prognoses were more likely to favor no disclosure over frank disclosure, and that female physicians were less likely to favor frank disclosure over pessimistically discrepant disclosure.

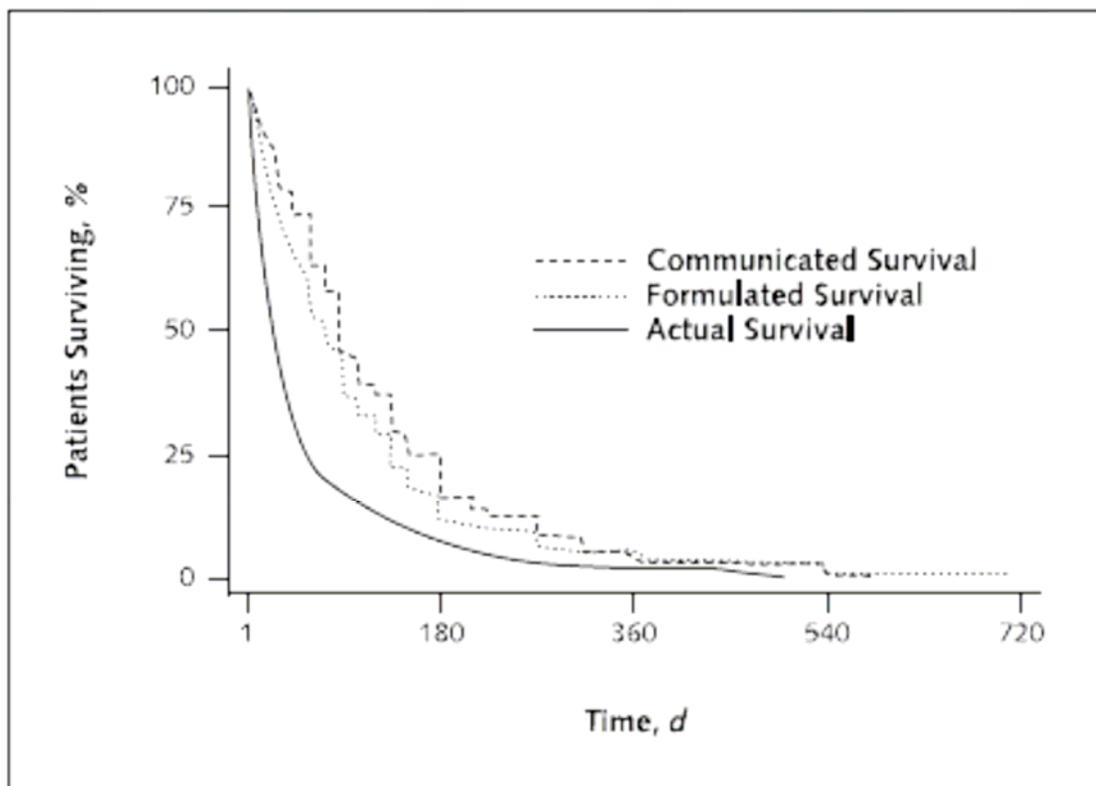
Conclusions: Physicians reported that even if patients with cancer requested survival estimates, they would provide a frank estimate only 37% of the time and would provide no estimate, a conscious overestimate, or a conscious underestimate most of the time (63%). This pattern may contribute to the observed disparities between physicians' and patients' estimates of survival.

Ann Intern Med. 2001;134:1096-1105.

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For author affiliations, current addresses, and contributions, see end of text.

See editorial comment on pp 1142-1143.



The differences between actual survival, formulated survival, and communicated survival in 300 terminally ill patients with cancer are shown. The median actual survival was 26 days, the median formulated survival was 75 days, and the median communicated survival was 90 days.

Association of Patient, Physician, and Patient-Physician Characteristics with Physician Preference for Prognostic Disclosure to Terminally Ill Patients with Cancer*

Characteristics	No Disclosure		Optimistic Disclosure		Pessimistic Disclosure	
	OR (95% CI)	RR	OR (95% CI)	RR	OR (95% CI)	RR
Patient						
Age (per decade)	0.66 (0.48–0.91)	0.74	0.85 (0.65–1.10)		0.60 (0.40–0.91)	0.66
Male sex	1.85 (0.90–3.80)		1.79 (0.92–3.47)		1.68 (0.55–5.17)	
Disease duration	1.00 (1.00–1.00)		1.00 (1.00–1.00)		1.00 (0.99–1.00)	
Performance status score	1.16 (0.78–1.71)		0.95 (0.68–1.31)		0.58 (0.36–0.92)	0.58
Physician						
Upper quartile of practice experience	2.90 (1.24–6.79)	2.34	1.18 (0.49–2.89)		0.94 (0.25–3.52)	
Female sex	2.96 (1.00–8.74)		2.67 (0.96–7.45)		16.96 (3.85–74.74)	9.00
<50% confidence in prediction	4.42 (1.54–12.65)	3.12	1.26 (0.38–4.16)		1.29 (0.22–7.53)	
Specialty						
Hematology–oncology	1.86 (0.64–5.45)		0.90 (0.36–2.21)		0.63 (0.15–2.72)	
Other internal medicine subspecialty	1.13 (0.38–3.40)		0.68 (0.25–1.86)		1.19 (0.31–4.60)	
Other specialties	1.99 (0.33–12.10)		1.21 (0.28–5.26)		0.63 (0.06–6.98)	
Family practice/general practice	1.04 (0.26–4.18)		2.08 (0.64–6.69)		1.60 (0.24–10.48)	
Cared for similar patients in past 12 months (10-patient increments)	0.98 (0.90–1.08)		0.99 (0.92–1.07)		1.11 (1.01–1.21)	1.11
Referred ≥2 patients to hospice in the past quarter	1.02 (0.42–2.47)		2.14 (1.05–4.34)	1.47	11.04 (3.12–39.14)	7.57
Physician–patient relationship						
Duration (10-week units)	1.01 (0.99–1.02)		1.01 (1.00–1.02)		1.01 (1.00–1.03)	
Number of contacts in past 3 months	0.99 (0.97–1.01)		0.98 (0.96–1.00)		0.97 (0.93–1.00)	
Days since last examination	0.99 (0.97–1.01)		0.99 (0.98–1.00)		0.94 (0.89–0.99)	



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CLINICS IN
GERIATRIC
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End-of-Life Care in the Treatment of Heart Failure in the Elderly

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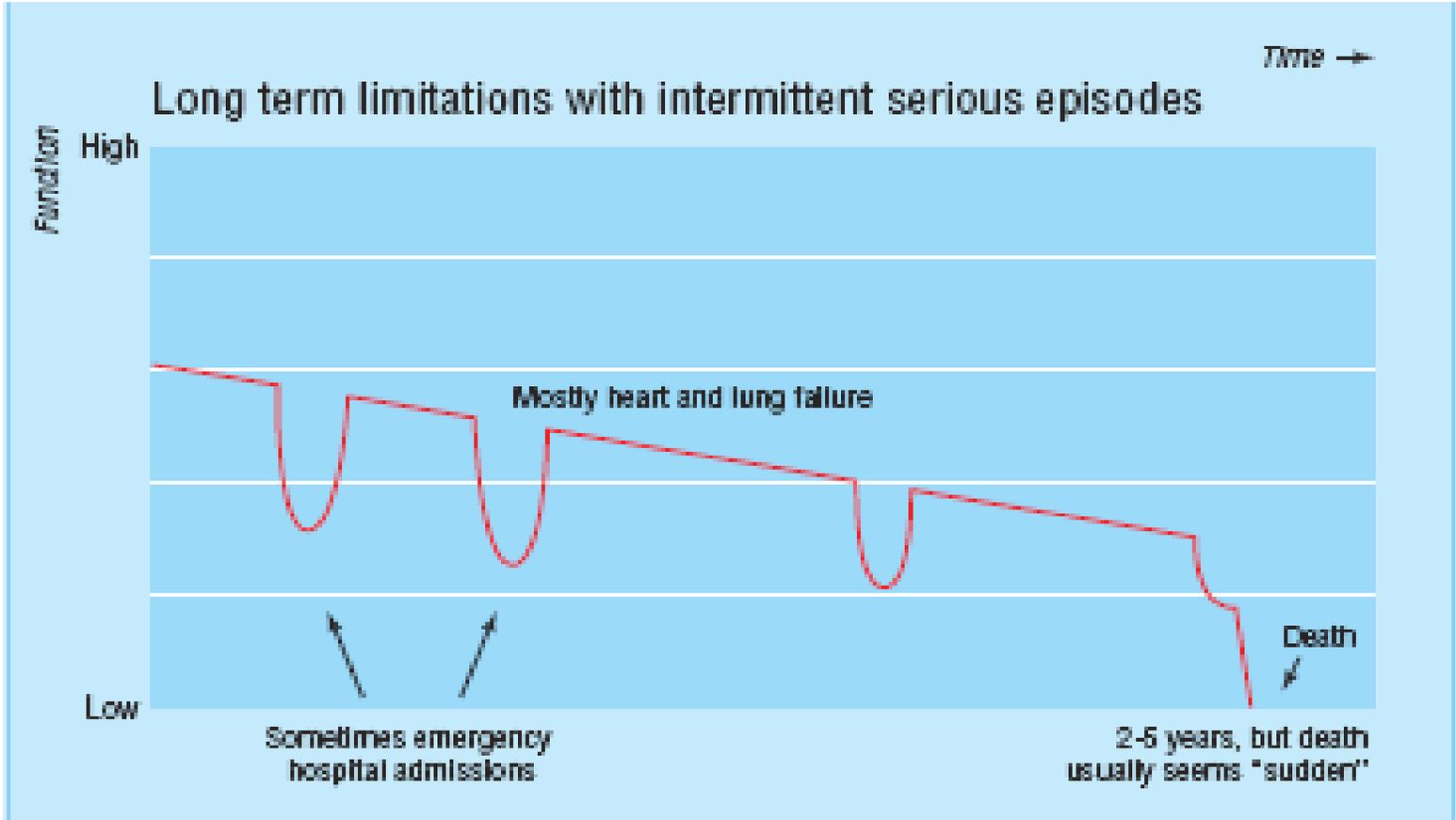
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The terminal stages of HF present challenges to both the patient and the clinician that are the equal of terminal cancer, but with facets that are unique to cardiovascular disease.

Among these unique characteristics are prognostic uncertainty, episodes of acute decompensation followed by relatively rapid improvement, and the relative frequency of device therapy.

- How can the physical and psychosocial burdens of advanced HF on patients and families best be decreased?**
- Which patients will benefit from which interventions and how can they be counseled best?**
- Which interventions improve quality of life and best achieve the outcomes desired by patients and family?**
- How can care be coordinated between sites of care and barriers to evidence-based practice reduced?**
- How can prognosis and treatment options be communicated better?**

These five questions effectively summarize some of the gaps that are currently present in the care of patients who have end-stage HF.



BMJ 2005;330:1007-1011

Characteristics of 149 elderly patients consecutively discharged with a diagnosis of HF (NYHA classes III-IV)

Variables	Mean±SD (%)
Age	81.4±7.1
Male gender	(35.6)
Ejection fraction %	60.6±18.8
Ischemic heart disease	(53.2)
Diabetes mellitus	(34.2)
Renal failure	(37.6)
COPD	(51.7)
Dysrhythmias	(46.3)
Hypertension	(69.1)
Hypotension	(4.8)
Cognitive impairment	(20.1)
Mood Depression	(26.8)
Disability in BADL	(40.1)
Diseases (n)	5.4±2.4
Charlson Index	7.9±2.6
Apache Score	11.0±6.8
Drugs (n)	5.3±1.8
Serum Albumin g/dl	3.9±0.6
Mortality at 6-month (in NYHA III-IV)	(33.6)

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Palliative Care Reviews
AAHPM

Feature Editors: Robert M. Arnold and Solomon Liao

Palliative Care for the Older Adult

JENNIFER KAPO, M.D.,¹ LAURA J. MORRISON, M.D.,² and SOLOMON LIAO, M.D.³

Functional Assessment Staging (FAST) Scale

Box. Medicare Hospice Benefit Guidelines for Determining Prognosis in Dementia³⁵

To be eligible for hospice, patients must meet both of the following criteria:

Functional Assessment Staging (FAST)³⁷: Patient must be at or beyond stage 7c and show all of the features of stages 6a-7c.

Medical conditions: Patients must have had at least 1 of the listed medical conditions over the prior year.

Functional Assessment Staging (FAST)

Stage 1: No objective or subjective difficulties

Stage 2: Subjective reports of forgetting

Stage 3: Decreased job functioning evident to coworkers. Difficulty traveling to new locations

Stage 4: Decreased ability performing complex tasks (eg, planning dinner for guests, handling finances)

Stage 5: Requires assistance to choose proper clothes for day, season, or occasion

Stage 6a: Cannot dress without assistance occasionally or more frequently

Stage 6b: Cannot bathe without assistance occasionally or more frequently

Stage 6c: Cannot toilet without assistance occasionally or more frequently

Stage 6d: Incontinent of urine occasionally or frequently

Stage 6e: Incontinent of bowel occasionally or frequently

Stage 7a: Speech limited to fewer than 6 intelligible words during an average day

Stage 7b: Speech limited to a single intelligible word during an average day

Stage 7c: Unable to ambulate independently

Stage 7d: Cannot sit up independently

Stage 7e: Cannot smile

Stage 7f: Cannot hold head up independently

Medical conditions

Aspiration pneumonia

Pyelonephritis or other upper urinary tract infection

Septicemia

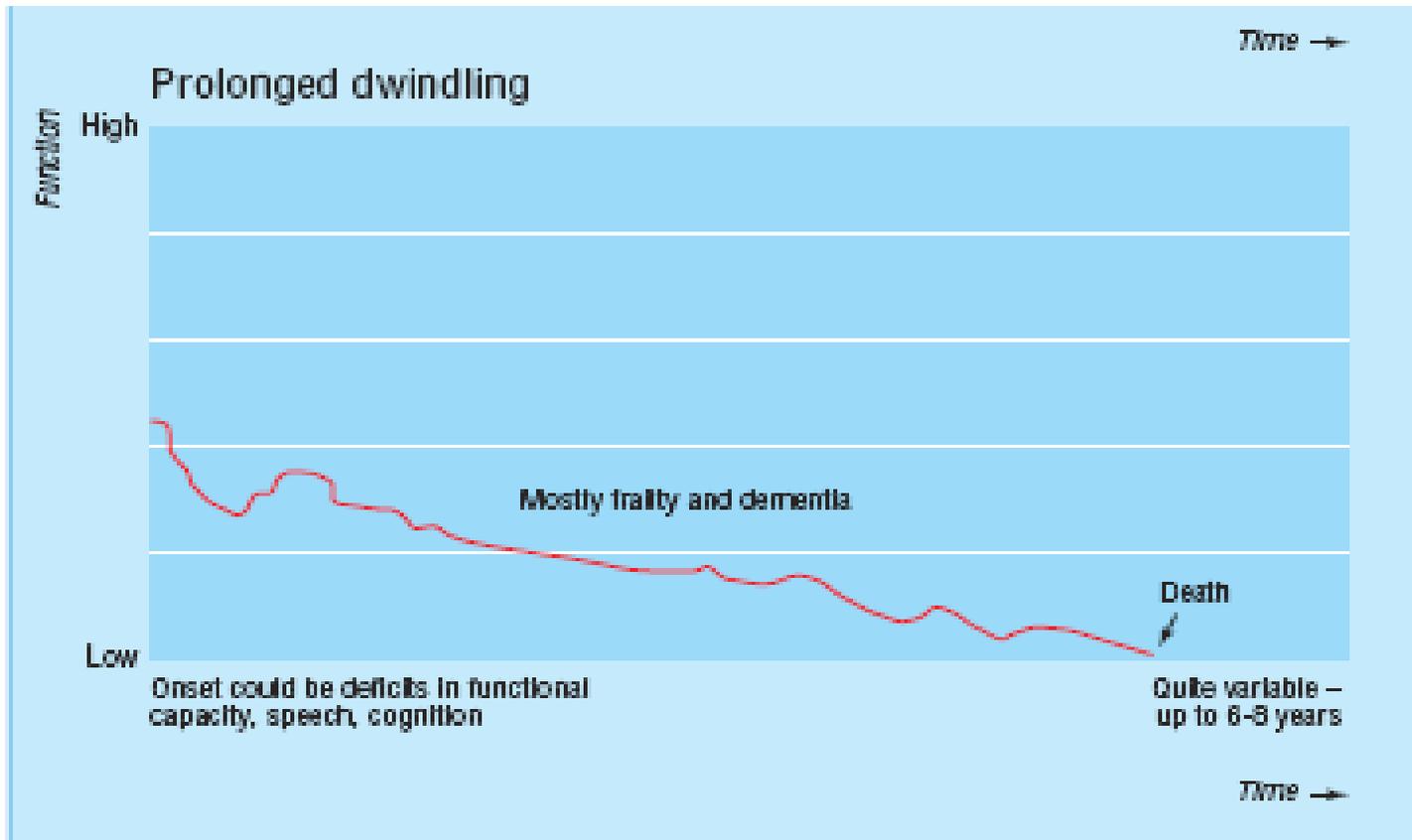
Decubitus ulcer, multiple, stage 3-4

Recurrent fever after treatment with antibiotics

Eating problems such that fluid or food intake is insufficient to sustain life (or, if tube fed, weight loss >10% over prior 6 months or serum albumin <2.5 g/dL)

Mortality Risk Index Score

<i>Points</i>	<i>Risk factor</i>
1.9	Complete dependence with ADLs
1.9	Male gender
1.7	Cancer
1.6	Congestive heart failure
1.6	O ₂ therapy needed within 14 day
1.5	Shortness of breath
1.5	<25% of food eaten at most meals
1.5	Unstable medical condition
1.5	Bowel incontinence
1.5	Bedridden
1.4	Age > 83 years
1.4	Not awake most of the day
Risk estimate of death within 6 months	
Score	Risk %
0	8.9
1-2	10.8
3-5	23.2
6-8	40.4
9-11	57.0
≥12	70.0

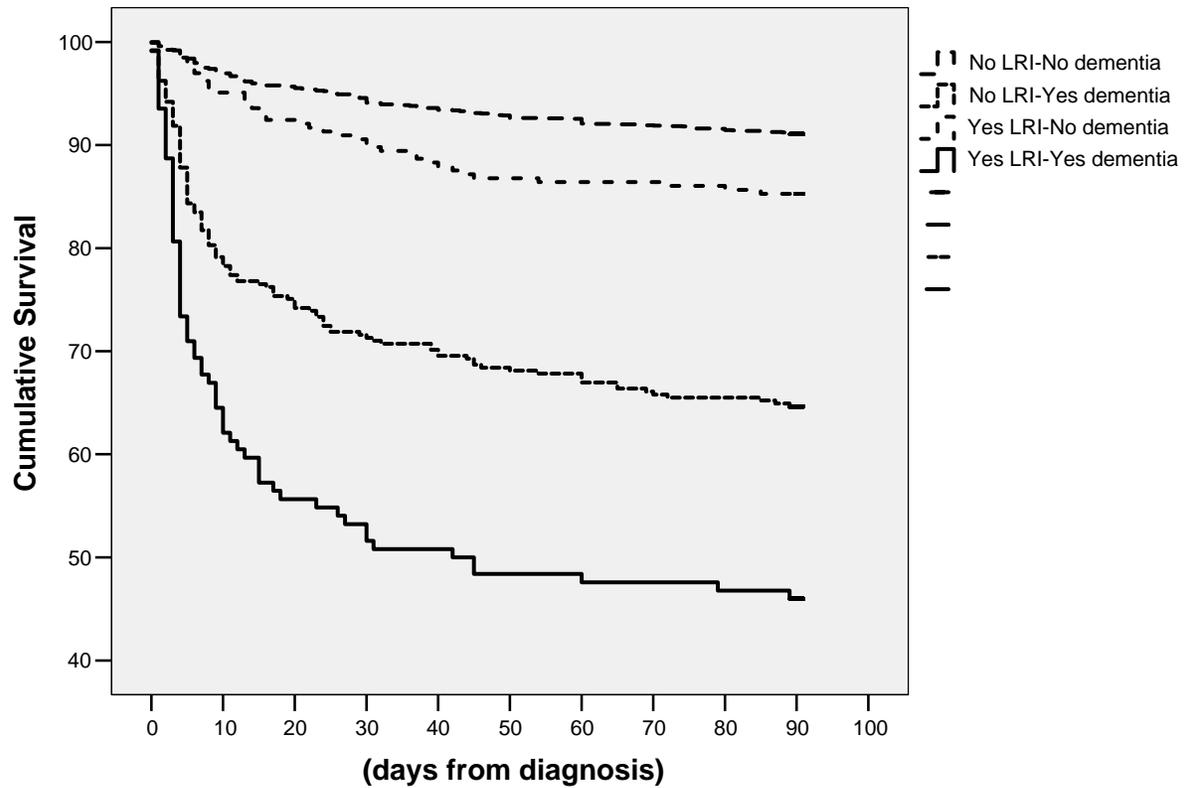


BMJ 2005;330:1007-1011

Characteristics and 3-months mortality rate of 3300 in patients affected by **Low Respiratory Tract Infections (LRI) and dementia.**

	Total (N=3300)	NoLRI-NoD (N=2566)	YLRI-NoD (N=265)	NoLRI-YD (N=345)	YLRI-YD (N=124)	<i>p</i>
	M±SD (%)	M ±SD (%)	M ±SD (%)	M ±SD (%)	M ±SD (%)	
Age (years)	79.2 ±8.0	78.4 ±7.7	80.0 ±8.2	83.2 ±7.7	83.4 ±8.4	0.001
Gender (males)(%)*	(38.3)	(24.5)	(24.5)	(24.5)	(19.3)	0.001
MMSE score	21.8 ±8.5	24.9 ±4.4	23.4 ±4.9	4.5 ±4.7	3.7 ±4.4	0.001
GDS score	4.6 ±3.5	4.6 ±3.5	4.2 ±3.1	---	---	0.155
Barthel Index (15 days bef)	78.7 ±27.9	86.5 ±19.8	76.2 ±26.6	45.7 ±34.5	30.2 ±28.7	0.001
Barthel Index (on adm)	60.1 ±38.1	71.8 ± 32.2	48.6 ±37.1	22.0 ±29.2	5.5 ±14.2	0.001
IADL (functions lost)	3.3 ±2.9	2.6 ±2.6	3.4 ±2.9	6.3 ±2.4	7.0 ±1.6	0.001
Diseases (n)	5.1 ±2.0	5.1 ±1.9	5.3 ±2.0	5.2 ±2.2	5.4 ±2.3	0.142
Charlson Index	5.3 ±1.8	5.0 ±1.7	5.5 ±1.9	5.8 ±2.1	6.5 ±2.2	0.001
Drugs (n)	5.7 ±2.9	5.4 ±2.6	6.2 ±3.3	5.8 ±3.1	6.9 ±3.0	0.194
APACHE II score	10.6 ±5.9	9.1 ±4.9	13.7 ±4.9	13.0 ±6.8	18.3 ±6.6	0.001
APACHE II-APS subscore	4.4 ±5.2	3.1 ± 3.9	6.1 ±5.1	6.5 ±6.4	10.9 ±6.9	0.001
Serum Albumin (g/dl)	3.7 ±0.7	3.8 ±0.6	3.4 ±0.6	3.3 ±0.7	3.1 ±0.6	0.001
Hemoglobin (g/dl)	12.5 ±2.3	12.6 ±2.3	12.2 ±2.2	12.0 ±2.5	11.9 ±2.5	0.000
Serum Cholesterol (mg/dl)	187.3 ±53.3	192.2 ±51.9	162.8 ±49.6	175.4 ±53.5	160.9 ±52.5	0.001
CPR (mg/dl)	4.4 ±7.4	2.9 ±5.7	9.1 ±10.4	7.3 ±9.6	11.1 ±9.1	0.001
Creatinine (mg/dl)	1.1 ±0.7	1.1 ±0.6	1.3 ±0.8	1.2 ±1.0	1.4 ±1.1	0.000
Length of stay (days)	6.5 ±3.7	6.5 ±3.6	7.8 ±4.1	5.8 ±4.0	5.4 ±3.9	0.001
3 mos mortality (%)*	(13.9)	(9.0)	(14.7)	(35.4)	(54.0)	0.001

Three months survival of elderly patients according to lower respiratory tract infection (LRI) and dementia



ASPETTI ETICI

The distinction between palliative care and euthanasia causes conflict and confusion. If a physician's actions meet the following criteria they constitute palliative care and not euthanasia: the patient is suffering, the doctor's therapeutic response is commensurate with the degree of that suffering and the continuing therapy; and the actions are not intended to lead directly and deliberately to death.

Lancet 1995; 346: 163-66

From the ethical point of view, doses of analgesics sufficient to relieve pain, which, as an unintended effect, might hasten death, are permissible if the conditions of the “rule of double effect” are observed.¹¹⁻¹³ Although this rule has been challenged, it remains important if used properly.¹⁴ Under this rule, an action having 2 effects, 1 good and 1 bad, is permissible if 5 conditions are fulfilled: (1) the act itself is good or at least morally neutral, eg, giving morphine to relieve pain; (2) only the good effect is intended (relieving pain) and not the bad effect (killing the patient); (3) the good effect is not achieved through the bad effect (pain relief does not depend on hastening death); (4) there is no alternative way to attain the good effect (pain relief); and (5) there is a proportionately grave reason for running the risk, eg, relief of intolerable pain. Clearly, to justify use of this rule, the patient would need to be informed of the risks and give valid consent.

If the doses of narcotics necessary to relieve pain are large enough to produce deep sedation, this too would be permissible, if suffering can be relieved in no other way. This is not, as 1 commentator argues,¹⁸ the same as “slow euthanasia” since the intent is not the death of the patient. Deep sedation is intended to re-

Above all, both the profession and society at large need to reacquaint themselves with the existential reality of death. Confronting this reality for what it is in ourselves, our loved ones, and our patients and their families will help to ensure that our patients are served to the best of our ability, both in their living and in their dying.

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