

## The Need for Palliative Care in Chronic Respiratory Patients With Non-Malignant Disease<sup>☆</sup>



### Necesidad de cuidados paliativos en pacientes respiratorios crónicos con patología no neoplásica

Dear Editor,

Treatment guidelines recommend offering palliative care to patients with severe chronic pulmonary disease,<sup>1,2</sup> but it has been reported that only 2% of patients with chronic obstructive pulmonary disease (COPD) who need palliative care actually receive it.<sup>3</sup> This failure means that most COPD or diffuse interstitial lung disease (DILD) patients die in hospital (67% and 70%, respectively).<sup>4</sup>

We reviewed the extent to which palliative care (treatments prescribed with the sole intention of improving symptoms, with no aim of improving the course of the disease) is offered to patients with COPD or DILD in an “end-of-life” situation. A COPD patient was considered as being in this situation if they had documented progressive disease (FEV1 decline despite appropriate treatment), BODE >7 or BODEX >5, had been hospitalized at least twice in the last 12 months, had reached a therapeutic ceiling, and presented respiratory failure and poor quality of life: grade 3 or 4 on the modified Medical Research Council (mMRC) dyspnea scale. These criteria are very similar to those of the GesEPOC guidelines.<sup>5</sup> In the case of DILD, criteria included documented FVC and/or DLCO decline, respiratory failure, baseline dyspnea grade 3 or 4, at least 2 hospitalizations in the previous 12 months, and therapeutic ceiling status. All admissions to the department of respiratory medicine of the Hospital Lucus Augusti during 2016 were reviewed, and 20 patients were identified (13 with COPD and 7 with DILD: 5 with idiopathic pulmonary fibrosis, and 2 with a fibrotic form of farmer’s lung) who met the criteria for palliative care (15 men and 5 women, mean age 77.9±9.2 years). In that year, their mean admission rate was 2.9±1.3 admissions (range: 2–6), which represented 7.39% of all admissions to the department, and they required 2.8±1.1 (range: 1–6) additional unscheduled visits. All COPD patients received home oxygen therapy (HOT) and dual bronchodilation. In total, 16/17 received triple therapy, 3/17 theophylline, 3/17 roflumilast, 6/17 home ventilation and 6/17 chronic antibiotic therapy. All patients with DILD received HOT, 5/7 chronic antibiotics, 1/7 home ventilation, and 1/7 antifibrotic treatment. None of the patient had signed a living will. Thirteen of the 20 (65%) patients received palliative treatment,

prolonged-release morphine in all cases, 84% received rescue morphine, and 53% received anxiolytics. Twelve (60%) patients died during 2016, all in hospital except for one case, and 10 received terminal sedation.

This study showed that, even with a restrictive definition of “end of life”, a high percentage of patients (35%) did not receive palliative treatment, and almost none died at home. An effort must be made to ensure that specialists are aware of this deficiency in the care of chronic respiratory patients, and to encourage them to implement integrated care models that include experts in palliative care and primary care doctors.

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1579-2129/

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<sup>☆</sup> Please cite this article as: Nieto Cano S, Golpe Gómez R, Pérez de Llano LA. Necesidad de cuidados paliativos en pacientes respiratorios crónicos con patología no neoplásica. Arch Bronconeumol. 2018;54:57.