



Editorial

Palliative Care: The Pulmonologist's Role From Beginning to End[☆]

Cuidados paliativos: el neumólogo de principio a fin

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In recent years, we have gone from offering palliative care (PC) to cancer patients only, to believing that between 70% and 80% of all terminal patients needed such treatment.¹ This conceptual change has led the World Health Organization to define the objectives of PC.² These should include end-of-life care, understood as care provided to patients who will probably die within 12 months, whether from a fatal illness or due to progression of chronic disease or a sudden acute exacerbation of their existing disease.

Two respiratory diseases stand out above others when discussing the need for PC: chronic obstructive pulmonary disease (COPD) and idiopathic pulmonary fibrosis (IPF). The first has a high prevalence worldwide and is a significant cause of morbidity and mortality. The incidence of IPF is increasing, and it is estimated that over the next few years age-adjusted mortality will be 4–10 deaths per 100,000 inhabitants.³ Although clinical practice guidelines^{4,5} recommend that patients with severe respiratory illness receive PC, it is offered only to a small percentage of patients,^{6,7} and the ideal respiratory patients for the administration of PC have yet to be defined. “End-of-life” in chronic respiratory diseases is difficult to define. Some authors believe that this stage begins if the disease progresses despite optimal treatment, with BODE⁷>7 or BODE⁵>5, at least 2 admissions in the previous year, respiratory failure, and mMRC dyspnea grade 3–4.⁸ However, a 1-year follow-up of a group of patients with similar or even more serious characteristics cared for in a respiratory day hospital showed that fewer than 20% treated in this unit died.⁹ The application of these criteria, then, could lead to the widespread use of this type of unit. Individuals who need PC can also be identified using tools such as the Prognostic Indicator Guidance of the Gold Standards Framework,¹⁰ developed in the United Kingdom to improve palliative care. This led to the development of the NECPAL CCOMS-ICO[®] (palliative needs) tool in Spain, which combines 4 criteria, assessing: (1) subjective perception, by asking the surprise question, “Would you be surprised if the patient dies within the next year?”; (2) demand and perceived need: the patient requests PC and the professional believes that it is needed; (3) disease severity and progression (sustained nutritional

or functional decline, clinical markers, existence of comorbidities, 2 or more urgent admissions, etc.); (4) specific clinical indicators of severity and progression for selected diseases. For chronic lung disease, these include: baseline dyspnea (mMRC grade 4), persistent symptoms despite optimal treatment, poor lung function (FEV1<30%, FVC<40%, DL_{CO}<40%), need for home oxygen therapy, associated symptomatic heart failure, and more than 3 exacerbations in the last year that required admission to hospital.¹¹ PC should be administered to any patient with a positive response to the surprise question, and at least one positive response to criteria 2 or 3, or the presence of 2 or more specific indicator criteria.

The aim of PC is to improve the quality of life of patients and alleviate their suffering using treatments that improve symptoms, but without the intention of prolonging the course of the disease.¹² This patient care should be provided by trained multidisciplinary teams¹³ formed of professionals qualified to provide PC, sufficiently specialized to be able to deal with complex underlying advanced disease, and coordinated to develop specific programs with the possibility of intervention at all levels of health care. Respiratory experts must play a significant role in this process. Respiratory diseases are very prevalent and some, such as COPD or lung cancer, are among the most frequent causes of death worldwide. These patients now survive longer, their pharmacological management is becoming more complex and specific,⁴ and in the most advanced stages of chronic diseases, dyspnea – the most disabling symptom and the one that most impacts on quality of life – is difficult to control with standard treatment. The pulmonologist is the most appropriate specialist for the management of opioids¹⁴ and benzodiazepines¹⁵ in these situations. It is becoming increasingly common for patients with chronic diseases, even those with cancer, to receive domiciliary non-invasive ventilation, both for COPD and neurological or neuromuscular disease. In these cases, care provided by a specialist with experience in this type of ventilation is essential, because inappropriate use can lessen its potential benefit, and even increase the risk of damage. Moreover, some ventilation-dependent patients will have tracheostomy tubes, which require specific management. Finally, cancer patients may require drainage by thoracentesis or chest tube to improve their quality of life in end-of-life situations.

It is essential that we, as pulmonologists, take our place in our hospitals as part of the PC multidisciplinary team. Our knowledge and experience are essential to provide these patients with the

[☆] Please cite this article as: Riveiro V, Ricoy J, Valdés L. Cuidados paliativos: el neumólogo de principio a fin. Arch Bronconeumol. 2019;55:355–356.

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best possible care, and are the final element in a comprehensive care strategy that does not end with diagnosis and treatment, but follows patients through the natural course of their disease (exacerbations, hospitalizations, etc.), up to the final decisions in the end-of-life situation. This entails leaving the hospital, visiting the patient at home, working together with primary care physicians, and involving nursing staff experienced in caring for these patients in day hospitals or in hospital-at-home arrangements.

In summary, the number of respiratory patients requiring PC is growing. Although the patients who should receive PC are not properly defined, all patients in the final stages of life should be offered this care with the aim of improving their quality of life. Pulmonologists should form part of the multidisciplinary teams that provide this care, in collaboration with other specialists, primary care physicians, and nursing staff. Our aim in coming years should be to include a greater number of pulmonologists in PC multidisciplinary teams.

Authorship

Vanessa Riveiro: author; conception and design, drafting of the submitted article, approval of the final version.

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