Reply to "Prevalence and Mortality of Patients with Palliative Needs in an Acute Respiratory Setting"

Respuesta a «Prevalencia y mortalidad de pacientes con necesidades paliativas en una planta de Neumología»

To the Editor:

We thank Dr Torrente Jimenez and her colleagues[1] for their interest in our study and for giving us an opportunity to discuss it in further depth.

Firstly, we fully agree with the authors when they mention the need to extend knowledge of palliative medicine to professionals who treat chronic respiratory diseases. We have been aware of its importance for more than a decade, but even so, few advances have been made in structured care and training. Our data suggest that a quarter of patients admitted to a pulmonology ward may be candidates for palliative care[2]. A recent survey of Spanish pulmonologists found that only 10% of them felt that they had sufficient training in palliative care and only half of their departments used a palliative care protocol[3].

Secondly, we would like to reiterate that our study series included all patients admitted to the pulmonology ward in a predetermined period, and of these only 31% had COPD, so specific COPD indices such as BODE were not included the study. In any case, none of the criteria suggested to date for initiating palliative care in COPD patients based on poor short-to-medium-term life expectancy is sufficiently reliable in specific patients[4].

Timely identification of patients with palliative needs is a complex issue that remains to be resolved. We agree with the authors of the letter that refractory symptoms are certainly an indication for symptomatic treatment, but if we look only at refractory symptoms, we will be engaging a little late in the communication that will progressively facilitate the initiation of a palliative approach and help in decision-making. Therefore, it is important to identify these patients earlier rather than later.

The NECPAL tool is a simple, validated tool for identifying individuals with palliative needs and limited life prognosis. It offers a multidimensional evaluation and its version 3.0[5] explicitly includes the Barthel index to evaluate functional decline, which we also measured in our study (Table 3). In our paper, Barthel used alone did not achieve statistical significance in the multivariate analysis of mortality. Despite our data, we agree with Torrente Jimenez et al.[1] that assessing dependence is useful for the pulmonologist, since we are treating an aging population, and dependence has demonstrated prognostic value in a hospital ward[1].

Finally, as the authors point out, palliative care has much to offer individuals with advanced respiratory disease who have a heavy symptom burden. It comprises more than end-of-life care and addresses the emotional, spiritual, and practical needs of patients and their caregivers, including a discussion of future care, without abandoning medical treatment. For this reason, in our opinion, the situation requires not only awareness of palliation on the part of the pulmonologist, but also a structured multidisciplinary approach, centered on the patient's home setting, with psychologists, social workers, home hospitalization, and specific palliative support teams when required by the complexity of the case.

References

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