



Editorial

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

Cuidados paliativos: el neumólogo de principio a fin

 Vanessa Riveiro,^{a,*} Jorge Ricoy,^a Luis Valdés^{a,b}
^a Servicio de Neumología, Complejo Hospitalario Universitario de Santiago, Santiago de Compostela, Santiago de Compostela, Spain

^b Grupo Interdisciplinar de Investigación en Neumología, Instituto de Investigaciones Sanitarias de Santiago (IDIS), Santiago de Compostela, Spain


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 BODE^{>7} or BODE^{>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.

^{*} Corresponding author.

 E-mail address: vanessa.riveiro.blanco@sergas.es (V. Riveiro).

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.

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

Luis Valdés: responsible author; conception and design, drafting of the submitted article, approval of the final version.

References

- Murtagh FEM, Bausewein C, Verne J, Groeneveld EI, Kaloki YE, Higginson IJ. How many people need palliative care? A study developing and comparing methods for population based estimates. *Palliative Med.* 2014;28:49–58.
- Sepulveda C, Marlin A, Yoshida T, Ulrich A. Palliative care: the World Health Organization's global perspective. *J Pain Symptom Manage.* 2002;24:91–6.
- Hutchinson JP, McKeever TM, Fogarty AW, Navaratnam V, Hubbard RB. Increasing global mortality from idiopathic pulmonary fibrosis in the twenty-first century. *Ann Am Thorac Soc.* 2014;11:1176–85.
- Global Initiative for Chronic Obstructive Lung Disease (GOLD). GOLD 2017 Global Strategy for the Diagnosis, Management and Prevention of COPD; 2018 [accessed 26 Sep 2018]. Available in: <http://goldcopd.org/gold-2017-global-strategy-diagnosis-management-prevention-copd/>
- Xaubet A, Ancochea J, Bollo E, Fernández-Fabrellas E, Franquet T, Molina-Molina M, et al. Normativa sobre el diagnóstico y tratamiento de la fibrosis pulmonar idiopática. *Arch Bronconeumol.* 2013;49:343–53.
- Meffert C, Hatami I, Xander C, Becker G. Palliative care needs in COPD patients with or without cancer: an epidemiological study. *Eur Respir J.* 2015;46:663–70.
- Lindell KO, Liang Z, Hoffman LA, Rosenzweig MQ, Saul MI, Pilewski JM, et al. Palliative care and location of death in decedents with IPF. *Chest.* 2015;147:423–9.
- Pérez de Llano LA. Cuidados paliativos para pacientes con insuficiencia respiratoria crónica. *Gac Sanit.* 2018;32:383–5.
- Lourido-Cebreiro T, Rodríguez-García C, Gude F, Valdés L. ¿Es útil un hospital de día de enfermedades respiratorias en pacientes graves? *Arch Bronconeumol.* 2017;53:399–402.
- Prognostic Indicators Guidance at the Gold Standards Framework [accessed 26 Sep 2018]. Available in: www.goldstandardsframework.org.uk
- Gómez-Batiste X, Martínez-Muñoz M, Blay C, Amblás J, Vila L, Costa X. Identificación de personas con enfermedades crónicas avanzadas y necesidad de atención paliativa en servicios sanitarios y sociales: elaboración del instrumento NECPAL CCOMS-ICO®. *Med Clin (Barc).* 2013;140:241–5.
- Bajwah S, Higginson IJ, Ross JR, Wells AU, Birring SS, Riley J, et al. The palliative care needs for fibrotic interstitial lung disease: a qualitative study of patients, informal caregivers and health professionals. *Palliat Med.* 2013;27:869–76.
- Plan Galego de Coidados Paliativos. Xunta de Galicia. Consellería de Sanidade. Servizo Galego de Saúde. Depósito legal C-671/2006. Santiago de Compostela, 2007;9-73.
- Jennings AL, Davies AN, Higgins JPT, Gibbs JSR, Broadlye KE. A systematic review of the use of opioids in the management of dyspnoea. *Thorax.* 2002;57:939–44.
- Allcroft P, Margitanovic V, Greene A, Agar MR, Clark K, Abernethy AP, et al. The role of benzodiazepines in breathlessness: a single site, open label pilot of sustained release morphine together with clonazepam. *J Palliat Med.* 2013;16:741–4.