Palliative Care of Heart Failure

The management of chronic heart failure (CHF) has improved considerably in recent years but there still remains a significant number of people who will die from this chronic disease. Many of those could benefit from palliative care.

The National Institute for Health and Care Excellence (NICE) has identified the need for palliative care.[1] Around 40% will die within a year of diagnosis and the quality of life may well be poorer than with other illnesses. There is a heavy burden of symptoms, a lack of communication and many psychological and social needs that are not being met. Much of what has been learned from cancer care is not being applied to the care of end-stage heart failure.

Place of care

The most appropriate place of care does not depend on the aetiology of the terminal condition. Most people would prefer dying at home if there is sufficient support. The hospice movement has made a great impact and deals with all forms of terminal care. Specially trained nurses can improve the management of patients with heart failure in hospital and there is also outreach to the community.[2] Nurse-led community management can provide support with:

- Regular follow-up and assessment, including blood chemistry, to detect early clinical deterioration.
- Continued adjustment and optimisation of therapy according to agreed protocols.
- Promotion and support of self-management, including daily monitoring of weight.
- Education: covering both pharmacological and non-pharmacological aspects of care, including exercise and nutrition advice.
- Acting as an intermediary between the patient and other professionals - eg, cardiologists and the primary healthcare team.
- Provision of support for patients and their carers.

Patient needs[3]

CHF produces a wide range of symptoms.

- Fatigue and breathlessness (see below) are the most common limiting and distressing complaints:
  - The position of the patient (supine/prone) should be considered.
  - Oxygen may well be helpful.
  - If dyspnoea remains a problem then morphine is often effective. It does not cause undue suppression of the respiratory drive but it does help to relieve distress and can have a pharmacological action to improve left ventricular failure.

- Depression may occur in about a third of patients and is often overlooked:
  - It should be sought and treated if found.
  - Tricyclic antidepressants are best avoided in heart failure.

- Pain is very common, especially in the terminal stages:
  - One common cause is stretching of the capsule of the liver.
  - It should be managed in the usual way for palliative care except that non-steroidal anti-inflammatory drugs should be avoided.
  - Morphine or diamorphine may be of value for both pain and dyspnoea.
Nausea and decreased appetite are common problems and may result in such low nutritional intake that health is impaired:

- Factors include decreased hunger sensations, diet restrictions, fatigue, shortness of breath, nausea, anxiety and sadness.
- In the elderly, early satiety, decreased taste and smell, and eating alone also contribute. [4]

**Management** [3, 5]

**Communication**

CHF patients are still being ignored despite all that has been learned from communicating with cancer patients.

- Talk to the patient. Spend some unhurried time. Find out what they know. Breaking bad news is not easy but it must be done.
- Patients want to learn about their prognosis at a time when they have optimum cerebral function. They want an honest discussion about treatment options and prognosis but do not want to be left bereft of hope. [6]
- Poor cerebral blood flow is likely to lead to confusion and memory problems. Therefore, it may be necessary to repeat information that has already been given.
- Poor imparting of information and disease-specific barriers to effective communication, such as short-term memory loss, confusion and fatigue, should be addressed.

**Drug management**

Make sure that maximum tolerated doses of drugs are used to control the heart failure. Dyspnoea can be extremely distressing and a much-feared way to die. See the separate *Dyspnoea in Palliative Care* article which covers many aspects of care, including coping with the patient who is panicking and distressed.

**Nutrition**

Maintaining adequate nutrition is important and difficult. Small, frequent, easily digested and appetising meals are required.

**Prognosis**

- Despite advances in therapy, the life expectancy for patients with CHF is worse than for any of the common cancers and is associated with a comparable number of expected life-years lost.
- In Scotland, as in many other countries, despite progressive heart failure therapeutic strategies, the prognosis has remained poor compared to many cancers. After first hospitalisation with heart failure 50% of men and women have died by 2.3 years and 1.7 years respectively. [5]
- In one American study, 54% of those who were expected to live for another six months died within three days.
- Various risk stratification methods, based on patient profiles and clinical features, are being developed to make the assessment of life expectancy more accurate. [7]

**Conclusion**

Talking to the patients, managing pain, nausea and distress, and the many facets of good terminal care are not receiving the attention they deserve.

The Department of Policy, Care and Rehabilitation at King's College Hospital, London has devised the following recommendations: [8]

- Sensitive provision of information and discussion of end-of-life issues with patients and families.
- Mutual education of cardiology and palliative care staff.
- Mutually agreed palliative care referral criteria and care pathways for patients with CHF.

**Further reading & references**

- *Acute and Chronic Heart Failure; European Society of Cardiology* (2012)
1. **Chronic heart failure: Management of chronic heart failure in adults in primary and secondary care; NICE Clinical Guideline (August 2010)**


3. **Heart failure - chronic; NICE CKS, May 2015 (UK access only)**


5. **Management of chronic heart failure; Scottish Intercollegiate Guidelines Network - SIGN (2016)**

6. **Caldwell PH, Arthur HM, Demers C; Preferences of patients with heart failure for prognosis communication. Can J Cardiol. 2007 Aug;23(10):791-6.**


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