

# Breaking the deadlock

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We know that people with advanced heart failure have unmet supportive and palliative care needs, and the burden of these concerns is comparable with people with cancer.<sup>1–2</sup> Palliative care services in the UK and elsewhere have grown up around oncology services. Randomised controlled trials (RCTs) have confirmed that early integration of palliative care, alongside cancer treatment, improves patient outcomes.<sup>3–7</sup> In contrast, experience of and the evidence base for integration of palliative care alongside heart failure treatment has been slow to develop. However, this is changing. A pilot RCT comparing the addition of a palliative care intervention to usual care for people with advanced heart failure has reported benefit in health-related quality of life, symptom control and health service utilisation (reduced hospital admission)<sup>8</sup> and several phase three RCTs are ongoing.

Implementation of integrated palliative care for people with heart failure in clinical practice is patchy in the UK and also in similar health care models such as those in Australia, unusual in continental Europe, and challenging in the US where the funding of health services does not facilitate access to life-prolonging treatment alongside hospice care. A recent paper examining a UK general practice database demonstrated that people who have died were much more likely to have been entered onto the primary care palliative care register if they had cancer than if they had heart failure (48% vs. 7%).<sup>9</sup> Of the few patients with heart failure who were entered onto the palliative care register, a third were registered within a week of death; a challenging timeframe within which to arrange the community support required to enable a patient to die at home. This dismal picture is mirrored in data from the US where a third of patients with heart failure referred for hospice care were referred within the last week of life.<sup>10</sup>

## Overcoming barriers

The misunderstanding that palliative care is only for those in the last few days or weeks of life, only to be implemented once all other options

are gone and irreversible deterioration is certain, forms a major barrier to access to palliative care. Attempts to identify a prognostic tool to identify when palliative care should be employed have failed, and the consensus is that a problem-based approach is more fit for purpose.<sup>11–12</sup> Such a model would enable the “concerns of today” facing the patient to be addressed in the context of the management options appropriate at their stage of disease; a discussion which may lead on to include appropriate options for the future and involve other professionals such as palliative care services if needed. Therefore it is imperative that the cardiology team is able to assess and manage symptom and quality of life issues, and have the expert communication skills required for complex and difficult conversations regarding device and other therapies, ceilings of medical care and cardiopulmonary resuscitation, as heart failure advances. With these competences, the majority of patients’ supportive and palliative care needs will be addressed by their cardiac or primary care team, and specialist palliative care services only needed for complex or persistent problems.

In this light, the article by Ismail and colleagues (page 26)<sup>13</sup> in this issue, is concerning. Despite changes to the UK cardiology specialist curriculum and a recognition that the care of people with advanced disease is important, these trainees report a lack of expertise. A systematic reluctance to recognise the dying, poor communication, and inadequate engagement with and from palliative care teams is described by some. Various solutions are suggested by the authors including joint teaching for cardiology and palliative care trainees and the introduction of a fellowship scheme. However, cardiology trainees also need their seniors to be good role models; training tools such as case-based discussion and mini-clinical examinations will be less effective if the clinical/educational supervisors are not confident and competent in basic palliative care skills themselves, or do not see the importance of this area. Lessons could be learned from the field of oncology where providing advanced communication skills for consultants as well as

trainees was considered a crucial part of improving services.<sup>14</sup>

There is an urgent need to overcome the deadlock preventing access to palliative care.

Clinicians caring for people with advanced heart failure need to be equipped with the skills they require to assess and address the palliative care concerns of this group of patients ●

### Conflict of interest

None declared.

### Editors' note

See also the article by Ismail *et al.* on page 26 of this issue.

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# Correspondence

## Accurate chest pain classification is important in assessing CAD by cardiac CT

From Drs Yasmin Ismail, Nathan Manghat and Mark Hamilton

Identification of patients with suspected coronary artery disease (CAD) relies on clinical history, examination and laboratory results. We assessed the impact of history-taking in 50 computed tomographic coronary angiography (CTCA) referrals for chest pain. A repeat history was taken by a senior cardiologist/radiologist. 25 of 50 patients referred for CTCA were classified as 'non-cardiac' chest pain. Inaccurate history taking appears to be a major cause of misclassification, which may be due to several factors. *The full version of this letter with references is available online...*

## Don't see their heart broken

From Dr Mervyn Huston

There has been much debate regarding the prophylactic prescribing of antibiotics in patients deemed at risk of developing infective endocarditis

(IE) as a result of certain dental procedures. Various guidelines have emerged for dental practitioners, who may decide to accept one particular code entirely, or a modified version based on discussion with local cardiology departments. Perhaps we should place a greater emphasis on oral screening during pre-operative assessment, to both reduce the future risk of IE and add to the discussion. *The full version of this letter with references is available online...*

## Preventing rheumatic heart disease in India

From Drs Arun Prasad, Sanjeev Kumar, and Birendra K Singh

The global burden of rheumatic heart disease and rheumatic fever currently falls disproportionately on children and young adults in low-income countries and is responsible for about 233,000 deaths annually. Primary prevention of acute rheumatic fever is achieved by treatment of acute throat infections caused by group A streptococcus. Secondary prevention is currently thought to be more cost effective than primary prevention and may be the only feasible option for low- to middle-income countries. *The full version of this letter with references is available online...*



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