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Permalink
https://escholarship.org/uc/item/7fx0p87f

Journal
JOURNAL OF CARDIAC FAILURE, 19(8)

ISSN
1071-9164

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Publication Date
2013-08-01

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Peer reviewed
Does the Type and Dose of Palliative Care Services Impact Symptom Control in Patients with Advanced Heart Failure?
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Introduction: Outpatient palliative care (PC) for patients with symptomatic heart failure (HF) is a relatively new practice and few data exist that describe the nature of these clinical encounters. Hypothesis: We hypothesized that the nature of outpatient PC services (i.e. type, duration, frequency) used by patients with advanced HF would impact symptom burden 3 months post-discharge. Methods: This study was conducted at a single, tertiary care medical center. Patients were recruited from the inpatient setting during an episode of acute HF exacerbation and referred for an initial PC consultation and subsequent follow-up support with the PC team. Data on PC services accessed were monitored over 3 months. Surveys were conducted immediately after and 3 months post-discharge to assess symptom burden. Results: Thirty six patients completed the initial PC consultation with a PC specialist (17%) or advanced practice nurse (83%); care focused on physical and psychosocial assessment (100%), advanced care planning (100%), symptom management (81%), illness understanding (69%), and patient and family coping (50%). Median total time for the initial PC consultation was 75 minutes (range 50-120). Twenty-nine (83.7%) agreed to receive additional PC support (Figure 1); median number of visits per patient was 2 (range 1-4). Marked improvements in all symptoms, except depression, were noted at 3 months (Table 1). Participants who sought PC services beyond the initial consultation reported significantly better symptom control than their counterparts (P < .050). Conclusion: Our findings suggest that the type and dose of PC significantly improved the symptoms evaluated. Randomized controlled trials are indicated to further evaluate the effectiveness of PC services in patients with advanced HF.
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Patients with and without Left Ventricular Dysfunction Suffering from Acute Ischemic Stroke Benefit Similarly from Thrombolytic Therapy

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Introduction: Heart failure is an important risk factor for thromboembolic events and it is associated with a greater incidence of ischemic stroke and worse outcomes. However, little is known regarding results of thrombolytic therapy in patients with left ventricle systolic dysfunction suffering from ischemic stroke. In this scenario, where cerebral perfusion may be impaired by lower cardiac output, thrombolysis may not be as effective as expected. Objective: To investigate rates of successful response of thrombolytic therapy and mid-term neurologic outcomes among patients with acute ischemic stroke and moderate to severe left ventricular dysfunction. Methods: Consecutive patients with ischemic stroke that underwent systemic thrombolysis with alteplase in the Emergency Unit of Hospital de Clínicas de Porto Alegre, in Brazil, were prospectively followed. Clinical evaluations were performed by trained neurologists at admission, discharge and 3 months post event. Ejection fraction (EF) evaluated by bi-dimensional Doppler echocardiography was part of patients’ assessment; left ventricular systolic dysfunction was defined as EF ≤35%. Adequate acute response to thrombolysis was defined as National Institute of Health Ischemic Stroke Scale (NIHSS) ≤1 point at discharge, while neurologic outcome at 3 months was assessed according to the modified Rankin scale (mRS) as: minimal or no neurologic deficit mRS ≤1 and functional independence as mRS ≤2. Results: Among 268 included patients (age 65±13 years; 55% male; NIHSS at admission 11±7; symptoms-to-thrombolysis time 182±62 min), the prevalence of systolic dysfunction was 13.5%. The severity of neurologic deficits at presentation was similar between patients with systolic dysfunction and normal EF (14.4±11.2 points vs 12.3±10.1 points; p=0.01), but systolic blood pressure was higher among the later (147 vs 161 mmHg; p=0.03); however, rates of functional independence were similar between groups (63% vs 65%, respectively; p=0.9). There was no difference in the incidence of symptomatic cerebral hemorrhage or death in 3 months. In multivariate analyses adjusted for age, NIHSS at admission, systolic blood pressure and atrial fibrillation, the presence of systolic dysfunction was not independently associated with mRS >1 (OR for EF ≤35% = 2.1 (CI 0.8-5.4; p=0.1)). Conclusions: Among patients with ischemic stroke treated with thrombolytic therapy, individuals with systolic dysfunction presented similar rates of functional independence at 3 months as compared to those with normal EF. Systolic dysfunction was not an independent predictor of mortality. On the other hand, systolic dysfunction did not impair the therapeutic effects on mortality. Systolic dysfunction is not an independent predictor of worse outcomes, but patients with systolic dysfunction presented similar rates of functional independence at 3 months as compared to those with normal EF. Systolic dysfunction was not an independent predictor of mortality. On the other hand, systolic dysfunction did not impair the therapeutic effects on mortality. Systolic dysfunction is not an independent predictor of worse outcomes, but patients with systolic dysfunction presented similar rates of functional independence at 3 months as compared to those with normal EF. Systolic dysfunction was not an independent predictor of worse outcomes, but patients with systolic dysfunction presented similar rates of functional independence at 3 months as compared to those with normal EF.