OXFORD SPECIALIST HANDBOOKS

HEART FAILURE

FROM ADVANCED DISEASE TO BEREAVEMENT

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Series Editor: Max Watson

END OF LIFE CARE

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OXFORD
UNIVERSITY PRESS

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Great Clarendon Street, Oxford OX2 6DP
United Kingdom

Oxford University Press is a department of the University of Oxford.
It furthers the University's objective of excellence in research, scholarship,
and education by publishing worldwide. Oxford is a registered trade mark of
Oxford University Press in the UK and in certain other countries

First Edition published in 2012

Impression: 1

British Library Cataloguing in Publication Data

Data available

Library of Congress Cataloging in Publication Data

Library of Congress Control Number: 2011944044

ISBN 978–0–19–929930–0

Printed in Great Britain
on acid-free paper by
Ashford Colour Press Ltd, Gosport, Hampshire

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Acknowledgement

The chapters on Diagnosing end-stage heart disease (Chapter 5), Management of pain (Chapter 9), and Spiritual and religious care (Chapter 14) include adapted text from *End of Life Care in Nephrology: From Advanced Disease to Bereavement* by Edwina Brown, E Joanna Chambers and Celia Eggeling, Oxford University Press, 2007. With permission of Oxford University Press.

Symbols and abbreviations

📖	cross-reference in this book
AAs	aldosterone antagonists
ACE	angiotensin-converting enzyme
ACP	advance care planning
ADL	activities of daily living
ADRT	advance decision to refuse treatment
A&E	Accident and Emergency [hospital department]
AF	atrial fibrillation
ARBs	angiotensin II receptor antagonists
AV	atrioventricular [node]
B3G	buprenorphine-3-glucuronide
bd	twice a day
BHF	British Heart Foundation
BiVAD	biventricular assist device
BMA	British Medical Association
BNP	brain natriuretic peptide
BP	blood pressure
CABG	coronary artery bypass graft
CNS	central nervous system
COPD	chronic obstructive pulmonary disease
CPR	cardiopulmonary resuscitation
CrCL	creatinine clearance
CRT	cardiac resynchronization therapy [device]
CRTD	cardiac resynchronization therapy [device] with defibrillator
CRTP	CRT [with] pacemaker
DCM	dilated cardiomyopathy
DIG	Digitalis Investigation Group
DNACPR	do not attempt cardiopulmonary resuscitation
DVT	deep vein thrombosis
ECG	electrocardiogram
ESAS	Edmonton Symptom Assessment Scale
FPA	financial power of attorney
GMC	General Medical Council [UK]
GP	general practitioner
GSF	Gold Standards Framework

H3G	hydromorphone-3-glucuronide
HF	heart failure
HFNS	heart failure nurse specialist
HFSS	Heart Failure Survival Score
H-ISDN	hydralazine and isosorbide dinitrate
HIV	human immunodeficiency virus
hr	hour(s)
HRUK	Heart Rhythm UK
ICD	implantable cardioverter defibrillator
IABP	intra-aortic balloon pump
IV	intravenous
KCCQ	Kansas City Cardiomyopathy Questionnaire
KPS	Karnofsky Performance Status/Score
LCP	Liverpool Care Pathway [for the Dying]
LMWH	low molecular weight heparin
LPA	lasting power of attorney
LV	left ventricle
LVAD	left ventricular assist device
LVEF	left ventricular ejection fraction
M3G	morphine-3-glucuronide
M6G	morphine-6-glucuronide
mcg	microgram
mg	milligram
MI	myocardial infarction
MR	mitral regurgitation
MV	mitral valve
NaSSA	noradrenergic and specific serotonergic antidepressant
NICE	National Institute for Health and Clinical Excellence
NMDA	*N-methyl-D-aspartate*
NNT	number needed to treat
nocte	at night
NorB	norbuprenorphine
NRS	numerical rating scale
NSAID	non-steroidal anti-inflammatory drug
NYHA	New York Heart Association
od	once a day
OOH	out of hours
PCI	percutaneous coronary intervention
POA	power of attorney
PPA	property power of attorney

PPS	post-phlebitic syndrome
prn	as needed
qds	four times a day
RAAS	renin–angiotensin–aldosterone system
SARI	serotonin antagonist and re-uptake inhibitor
SC	subcutaneous
SHFS	Seattle Heart Failure Score
SL	sublingual
SNRI	serotonin–norepinephrine re-uptake inhibitor
SSRI	selective serotonin re-uptake inhibitor
TD	transdermal
tds	three times a day
VAD	ventricular assist device
VF	ventricular fibrillation
VO2max	maximal oxygen consumption
VT	ventricular tachycardia
WHO	World Health Organization
WPA	health/welfare power of attorney

Contents

Detailed contents

Chapter 1

The challenge of patients with heart failure (HF): barriers to accessing supportive and palliative care

Introduction

HF is a major public health problem, which is escalating due to the aging population, improved survival rates from acute cardiac syndromes, and the impact of secondary prevention. Therapy for HF has increased survival and improved symptoms.

Potential therapeutic strategies for HF include:[1–3]

- Conventional drug therapy.
- Complex device therapy:
  - implantable cardioverter defibrillator (ICD)
  - cardiac resynchronization therapy (CRT).
- Ventricular assist devices.
- Cardiac transplantation.

However, symptom burden and mortality remain high, and for many quality of life is poor on a scale similar to or worse than for many common cancers. Despite this, patients with HF still lack routine access to palliative care services.[3–6] Patients in developed countries tend to be elderly (average age 76) with concomitant comorbidities and psychosocial problems associated with age and chronic disease.[3,7] Failure to address the supportive and palliative care needs of this patient group risks the following:

- Persistent symptom burden.
- Prolonged caregiver burden.
- Loss of opportunity to be involved in planning for end of life care.
- Risk of inappropriate and most often prolonged hospital admissions.
- Risk of inappropriate and unwanted hospital death.

These unmet needs are well known but barriers exist that until recently have deterred the provision of palliative care for people with HF. However, although challenging, providing this type of care and service has been deemed an international public health priority.[8,9]