Palliative care beneficial to manage symptoms, improve quality of life for people with cardiovascular disease

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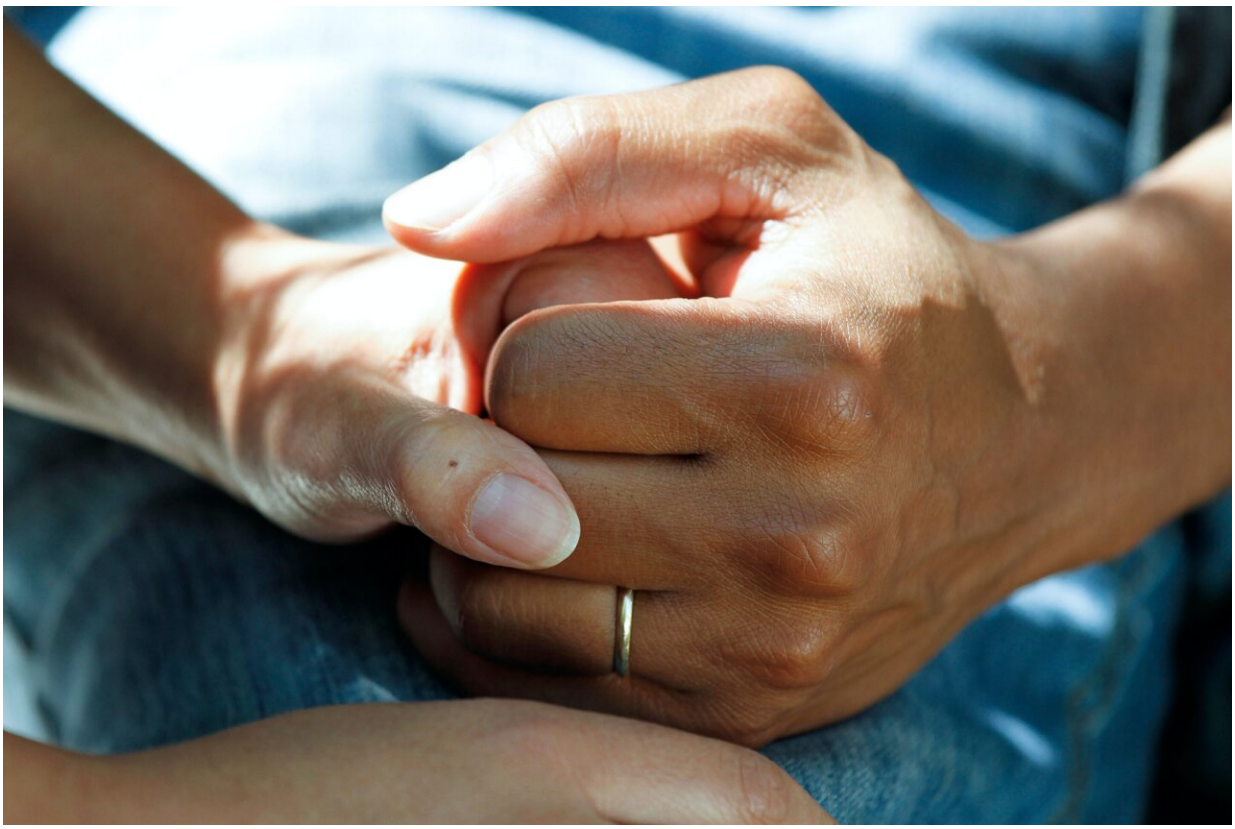

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Implementing patient-centered palliative care therapies, including prescribing, adjusting or discontinuing medications as needed, may help

control symptoms and improve quality of life for people with heart disease, according to "Palliative Pharmacotherapy for Cardiovascular Disease," a new scientific statement from the American Heart Association, published in *Circulation: Cardiovascular Quality and Outcomes*.

The new scientific statement reviews current evidence on the benefits and risks of cardiovascular and essential palliative medications. The statement provides guidance for health care professionals to incorporate palliative methods as part of holistic medication management at all stages of a patient's health conditions, emphasizing the importance of shared decision-making and goal-oriented care.

Palliative care is specialized medical care that aims to relieve symptoms and enhance quality of life for people experiencing health-related issues due to serious illnesses. This approach may benefit patients with cardiovascular disease, including coronary heart disease, valvular heart disease, pulmonary arterial hypertension and heart failure.

These conditions significantly reduce quality of life, require ongoing treatment, are usually progressive and are associated with high mortality rates. The progression of many conditions, from chronic to advanced and end-stage, may be unpredictable and marked by worsening symptoms that result in recurrent hospitalization.

Palliative care complements standard cardiovascular care by reducing physical symptoms, managing emotional distress and assisting patients in making decisions that coincide with their goals of care.

A palliative approach can be integrated into the medication management of patients at any stage of heart disease, from chronic, stable heart disease to advanced and end-stage cardiovascular disease. And, importantly, palliative care supports a more goal-oriented, patient-

centered approach to treatment.

Previous studies have found that adding palliative care interventions to evidence-based care improved patients' quality of life, functional status, depression, anxiety and spiritual well-being and reduced the risk of hospital readmission for patients with advanced heart disease compared to clinical care alone. Despite these benefits, fewer than 20% of people with end-stage heart disease receive palliative care.

In addition, despite significant progress in cardiovascular care, disparities in care and outcomes related to race, ethnicity, gender and social determinants of health persist. People with heart failure who are referred to palliative care are predominantly white, have higher socioeconomic status and are more likely to receive care at academic medical centers.

Patients from underrepresented racial and ethnic groups are less likely to receive palliative care, which contributes to poorer outcomes and increased risk of early mortality.

"It is critical for patients to be fully informed about their diagnosis and how medication management may change throughout the disease progression so they have ample time to set and share their goals," said Chair of the statement writing group Katherine E. Di Palo, Pharm.D., M.B.A., M.S., FAHA, senior director of Transitional Care Excellence at Montefiore Medical Center and assistant professor of medicine at Albert Einstein College of Medicine in New York City.

"These goals often include reducing symptoms such as shortness of breath, fatigue, and pain as well as improving sleep, mood and appetite."

To achieve these goals, cardiovascular medications that provide symptom relief, such as diuretics to manage fluid retention in heart

failure, should be prioritized in patients with advanced heart disease. Adding palliative medicines to evidence-based cardiovascular therapies can be complementary to manage symptoms and optimize quality of life. Examples of common palliative medicines include antidepressants, opioids for pain relief and difficulty breathing, and anti-nausea medications.

"Given the complexities of medication management in people with heart disease, a team-based approach is urged. Collaboration between multidisciplinary clinicians across primary care, cardiology and palliative care is needed to deliver effective, person-centered care," said Di Palo.

Because the health status of patients can change rapidly, it is crucial to have ongoing discussions to ensure that treatment plans align with the patient's preferences and priorities. Clinicians should routinely evaluate—and clearly communicate—to patients and their families about the potential risks, benefits and expected time to benefit of each medication.

Deprescribing and de-escalating medications are also essential components of palliative medication management for people with heart disease. Deprescribing involves tapering, withdrawing or discontinuing a medication to improve outcomes. De-escalating medications focuses on reducing the dose or switching to another medication based on the patient's response to the medicine.

"Deprescribing that targets medications with limited benefit or increased risk of adverse events can be done safely with patient permission," Di Palo said.

The statement provides several examples where deprescribing medications may be appropriate to consider, such as when the time to benefit from the medication may be longer than the patient's life-

expectancy. Anti-clotting medications (also known as anticoagulants) may be prescribed to reduce the risk of blood clots. However, some of these medicines may increase the risk of bleeding, especially in older patients over the age of 75 who are at increased risk of falls.

Discontinuing non-steroidal anti-inflammatories (NSAIDs) may also be considered in patients with end-stage heart disease due to increased risk of bleeding and fluid retention.

Although beta-blockers are commonly prescribed for high blood pressure and heart failure, they may contribute to fatigue and functional decline in end-stage heart disease. A slow-tapering schedule can help to reduce the risk of rebound high blood pressure or withdrawal when large doses are abruptly stopped.

Other reasons to consider deprescribing medications include polypharmacy, defined as taking five medications or more daily. This increases the risk of adverse reactions or side effects, not taking medications as prescribed, hospital readmission and mortality. Excessive out-of-pocket medication costs may also prompt the need to deprescribe certain medications.

Future research is needed to determine the best ways to provide timely and targeted access to palliative medication management, particularly for patients with advanced heart disease from under-represented racial and ethnic groups who are less likely to receive palliative care or may face barriers to care.

More information: Palliative Pharmacotherapy for Cardiovascular Disease: A Scientific Statement From the American Heart Association, *Circulation* (2024). www.ahajournals.org/doi/10.116 … HCQ.0000000000000131

Provided by American Heart Association