Liu et al\textsuperscript{1} report a large cohort study of palliative care (PC) consultations for 57,272 hospitalized adult patients with a diagnosis of heart failure (HF) (16,741 patients [12.4%]) or cancer (40,531 patients [30.0%]), using the Palliative Care Quality Network database. A comparison of patient baseline characteristics, time to PC consultation, changes in symptom scores, care plan documentation, mortality, and hospice referrals is made between patients with HF and cancer. Liu et al\textsuperscript{1} conclude that there is an opportunity for increased and earlier involvement of PC for patients with HF.

Palliative care is an interdisciplinary approach aimed at improving the quality of life of patients and caregivers by providing physical, emotional, psychosocial, and spiritual interventions. Although PC has been traditionally associated with patients with cancer, there is increasing recognition of its important role in caring for patients with other life-limiting chronic diseases such as HF.

Even though HF is, for the most part, a chronic incurable disease, it is also a progressive and ultimately lethal condition. It is associated with high morbidity and mortality, which increase with each hospitalization, similar to if not worse than many types of cancer. However, PC consultations remain widely underutilized in the management of patients with HF.\textsuperscript{2}

Patients with HF usually have high hospital readmission rates because of worsening symptoms secondary to either a decrease in cardiac output and/or fluid retention, both of which are associated with a high symptom burden and a progressively decreasing quality of life. Thus, HF represents a significant health care burden, with an estimated annual cost of $69.8 billion by 2030.\textsuperscript{3}

To understand the underlying reasons for delayed or lack of use of PC for patients with HF, the following factors need to be emphasized. Both patients and physicians often misunderstand PC and frequently regard it as being equivalent to hospice care. In fact, PC is focused on improving the quality of life regardless of the treatment plan, including pursuing aggressive treatments and curative therapies, such as heart transplantation. Therefore, the use of PC should be prognosis independent. Palliative care can assist with alleviation of symptom burden, including pain, and with quality-of-life issues and ongoing clarification of treatment goals aligned with the patients’ values. This was outlined in our studies\textsuperscript{4,5} of patients with advanced HF undergoing cardiac transplant; in our experience, the long-term prognosis of patients was excellent, and PC was instrumental in relieving symptoms and improving quality of life. Hospice care, on the other hand, is usually limited to end-of-life care for patients with a life expectancy of 6 months or less who are not eligible for or forgoing curative treatments.

A recent systemic review and meta-analysis\textsuperscript{6} of PC for patients with HF suggests that PC interventions are associated with improved patient-centered health outcomes, including quality of life and symptom control. Palliative care has also been shown to decrease the cost of care and hospitalizations. Current guidelines\textsuperscript{7} recommend early involvement of PC in patients with advanced HF.

Liu et al\textsuperscript{1} found that patients with HF were less frequently referred for pain management (6.8% vs 34.6%; \(P < .001\)) compared with patients with cancer, which was not surprising because pain is usually not seen as a classic symptom of HF. However, our cross-sectional studies\textsuperscript{4,5} showed that generalized or localized pain is prevalent in most patients with HF. This is highly distressing for patients and their caregivers.\textsuperscript{8,9} Contrary to common perception, we demonstrated that among 100 patients admitted to the hospital with acute decompensated HF, 60 patients (60%) reported pain.\textsuperscript{4,5} Patients with ejection fraction less than or equal to 40% (61 patients) reported significantly higher pain scores than patients with ejection fraction greater than 40% (36 patients) (mean [SD])
pain score, 4.1 [3.6] vs 2.7 [3.4]; P < .05). Another study showed that among 62 patients with stable chronic HF, 32 patients (52%) reported pain of varying severity in locations, such as the chest, back, abdomen, or the extremities with a mean (SD) pain score of 2.5 (3.1). Patients with an ejection fraction less than or equal to 40% (45 patients [73%]) reported higher pain scores than did patients with an ejection fraction greater than 40% (17 patients [27%]) (mean [SD] pain score, 3.1 [3.3] vs 1.2 [1.9]; P < .001). Early PC integration not only resulted in improved management of pain but also an overall decrease in opioid use. This can often result in a reduction of hospital length of stay and, thus, costs.

Given the high prevalence of HF and the substantial morbidity and mortality associated with it, we recommend the following principles. First, interdisciplinary collaboration is critical to providing optimal care for patients throughout the full spectrum of HF. Palliative care should be integrated as routine care for patients with HF. Cardiologists and primary care physicians should collaborate with PC teams to ensure patient-centered outcomes through shared decision-making. In addition, they should take advantage of the growth of home-based PC to provide better continuity of care.

Second, PC and prognosis should be delinked. This is especially critical in this patient population because the disease course is much more unpredictable compared with diseases such as cancer. Even though patients with HF often improve temporarily with aggressive diuresis and optimization of medical management, there is a high recurrence rate of worsening symptoms with a high hospital readmission rate in advanced stages. The PC team should get involved early during the disease course for symptom management and also for a smooth and timely transition to hospice for those patients who are not candidates for cardiac transplant. Each hospital admission is a potential opportunity to discuss the PC needs of patients and caregivers. Better outcomes are seen not only with early involvement of PC during the disease course but also during hospitalizations as well.

Third, promote PC education for both patients and physicians. It is important to widely address the importance of PC with an emphasis on the difference between PC and hospice care. Multiple guidelines advocate the involvement of PC for patients with chronic HF; however, there is little consensus on when and how PC will be most beneficial for patients with HF. Further research and early clinical implementation of PC in HF can serve as a role model for timely PC intervention in other chronic nonmalignant illnesses.

ARTICLE INFORMATION

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REFERENCES


