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Palliative Care in Heart Failure

The PAL-HF Randomized, Controlled Clinical Trial

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CME/MOC Objective for This Article: After reading this article, the reader should be able to: 1) discuss the rationale for the use of palliative care approaches in the management of patients with heart failure; and 2) identify the outcome benefits of palliative care interventions in heart failure.

CME/MOC Editor Disclosure: *JACC* CME/MOC Editor Ragavendra R. Baliga, MD, FACC, has reported that he has no financial relationships or interests to disclose.

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ABSTRACT

BACKGROUND Advanced heart failure (HF) is characterized by high morbidity and mortality. Conventional therapy may not sufficiently reduce patient suffering and maximize quality of life.

OBJECTIVES The authors investigated whether an interdisciplinary palliative care intervention in addition to evidence-based HF care improves certain outcomes.

METHODS The authors randomized 150 patients with advanced HF between August 15, 2012, and June 25, 2015, to usual care (UC) (n = 75) or UC plus a palliative care intervention (UC + PAL) (n = 75) at a single center. Primary endpoints were 2 quality-of-life measurements, the Kansas City Cardiomyopathy Questionnaire (KCCQ) overall summary and the Functional Assessment of Chronic Illness Therapy–Palliative Care scale (FACIT-Pal), assessed at 6 months. Secondary endpoints included assessments of depression and anxiety (measured via the Hospital Anxiety and Depression Scale [HADS]), spiritual well-being (measured via the FACIT-Spiritual Well-Being scale [FACIT-Sp]), hospitalizations, and mortality.

RESULTS Patients randomized to UC + PAL versus UC alone had clinically significant incremental improvement in KCCQ and FACIT-Pal scores from randomization to 6 months (KCCQ difference = 9.49 points, 95% confidence interval [CI]: 0.94 to 18.05, p = 0.030; FACIT-Pal difference = 11.77 points, 95% CI: 0.84 to 22.71, p = 0.035). Depression improved in UC + PAL patients (HADS-depression difference = −1.94 points; p = 0.020) versus UC-alone patients, with similar findings for anxiety (HADS-anxiety difference = −1.83 points; p = 0.048). Spiritual well-being was improved in UC + PAL versus UC-alone patients (FACIT-Sp difference = 3.98 points; p = 0.027). Randomization to UC + PAL did not affect rehospitalization or mortality.

CONCLUSIONS An interdisciplinary palliative care intervention in advanced HF patients showed consistently greater benefits in quality of life, anxiety, depression, and spiritual well-being compared with UC alone. (Palliative Care in Heart Failure [PAL-HF]; NCT01589601) (J Am Coll Cardiol 2017;70:331–41) © 2017 by the American College of Cardiology Foundation.

Important progress has been made over the last 25 years in the identification and use of prognosis-modifying therapies for patients with heart failure (HF) (1). Unfortunately, over time these therapies often fail to prevent disease progression. Acute decompensated HF remains the most common cause of hospitalization in the Medicare population, highlighting the public health importance of the problem

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