

## Palliative care in COPD patients: A challenge in modern medicine

Palliative care (PC) in patients with chronic obstructive pulmonary disease (COPD) remains a challenge in modern medicine. The classic World Health Organization (WHO) definition of PC<sup>[1]</sup> fits in the case of cancer patients but is far from the reality of patients with COPD.

The absence of curative treatment is characteristic of COPD. It entails the presence of symptoms such as dyspnea, usually progressive and limiting in the advanced stages of the disease; the need to include opioid drugs such as morphine in the treatment of severe and symptomatic patients, with the prejudice it entails for the patient and his/her family; the existence of multiple physically burdensome symptoms, not only of dyspnea or fatigue but also high levels of depression and anxiety; and the impact of periodic exacerbations that produce a significant and permanent impairment of the health status.<sup>[2]</sup>

Unlike other diseases such as cancer, COPD patients can live in these conditions for prolonged periods of time when it is unpredictable to estimate the clinical course of the disease.<sup>[3]</sup> In addition, noninvasive ventilation has been a remarkable advancement in the management of the advanced disease and severe exacerbations since it is an authentic active treatment that prolongs the lives of these patients.<sup>[4]</sup> This can sometimes become a really aggressive therapy for some patients where instead of reaching the end of life in a state of calm and serenity, the patient is attached to machines and tubes that appear to be a new way to die, usually called “connected to bipap.”<sup>[5]</sup>

It is well-known that the emotional and psychosocial suffering of patients and their families often remains unnoticed and is not adequately relieved. Furthermore, the patient has a poor quality of life in his/her last years. Despite the high morbidity and mortality associated with severe COPD, many patients do not receive adequate PC.<sup>[6]</sup> Compared to patients with lung cancer, COPD patients receive fewer opiates and benzodiazepine and more frequently die in intensive care units, on mechanical ventilation, and with dyspnea.<sup>[7]</sup>

Why is PC not widespread in COPD? PC is usually considered for patients who are in the terminal phase of their illness. But as we have said before, it is not easy to define which COPD patient is in the end-stage phase of the disease. In the literature, it has been discussed in the subjective criteria that one should not be surprised if the patient dies in the next year as an indicator of the terminal phase.<sup>[8]</sup> But irrespective of the answer to the abovementioned question, the patient may have high symptom distress, live for more than 1 year in this situation, and be a candidate for PC for a long time. In the study by Bausewein *et al.*,<sup>[9]</sup> the “surprise” question was not effective in identifying PC needs in COPD patients. The decision to initiate PC for symptom control should not be based on life expectancy but on the needs and symptomatology of the patient and his/her family. We usually tend to forget that PC (within definition) is appropriate at any age or stage of the illness, not just the “end of life.” Perhaps this uncertainty and subjectivity are responsible for the “curative mentality” of health care professionals for advanced COPD patients (e.g. noninvasive ventilation as a life-prolonging treatment option) instead of the “palliative mentality.”

Should we consider administering PC to a COPD patient when we start treatment with morphine? Should we mark the time to consider a patient under PC with the presence of exacerbations requiring noninvasive ventilation? Should we establish functional parameters that indicate to us that it is time to incorporate elements of PC focus to provide relief from distressing symptoms, to integrate the physiological and spiritual aspects of patient care, to offer a support system to help patients live as actively as possible until death, and to offer a support system to help the family cope during the patient’s illness and in their own bereavement? In this sense, could we consider the PC starting point in patients with major functional impairment [e.g. forced expiratory volume in 1 s (FEV1) <30%] or hypercapnic respiratory failure, in cachectic patients [body mass index (BMI) <21] and in patients with dyspnea III-IV in the Modified Medical Research Council (MMRC) scale or body mass index, obstruction, dyspnea, exercise capacity (BODE) index 7-10, in patients with a low physical activity level or frequent exacerbations?<sup>[10]</sup>

COPD is an important comorbid condition frequently associated with other chronic conditions such as chronic heart failure or cancer. This data deserve a reflexion due to the fact that we could consider PC in these patients attending not to the symptoms produced by COPD but to

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those due to the comorbid conditions. So, does PC really play a role in COPD patients or should we consider PC only in COPD patients with another associated comorbidity? Does PC have any sense in COPD?

In our opinion, the answer is “yes.” We think the available data do not highlight the importance of PC for COPD patients. We need studies to focus on the actual PC needs of COPD patients and to identify clinical and functional parameters that determine clearly the starting point for PC in these patients. COPD guidelines should incorporate measures to control symptoms from the beginning of the disease beyond the “dual bronchodilation” philosophy. Finally, these studies have to focus on COPD patients and not on COPD associated with other confounding factors, such as cancer, that require PC in themselves, in order to know the real importance of PC in COPD.

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