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Palliative Care Needs in Liver Cirrhosis Patients

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Abstract

The concept of Palliative Care (PC) is more and more known in medicine and the need for this type of approach is growing in a world with great longevity and exponentially increasing chronic diseases.

End-stage liver disease (ESLD) is the culmination of progression of chronic liver disease to cirrhosis, decompensation, and chronic liver failure, featuring portal hypertension or hepatocellular failure-related complications. In this context, palliative care offers best possible quality of life and is not limited to end-of-life care. It also encompasses achievable goals such as symptom control and avoidance of aggressive disease-modifying treatments or interventions that beneficially alter the natural course of the disease to offer curative intend.

Keywords: Palliative care in cirrhosis; End stage liver disease; Symptom control

Introduction

Specialist palliative care is more then end of life care. Palliative Care (PC) is an approach that improves the quality of life of patients (adults or children) and their families who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether they are physical, psychosocial or spiritual. [1] Palliative care must be available and accessible to all, wherever and whenever they need it. In healthcare, most researchers and clinicians agree that quality of life (QOL) is related to symptoms, functioning, psychological and social wellbeing, and probably to a lesser extent to meaning and fulfilment. This multidimensional health-oriented concept has been named health-related quality of life (HRQOL). However, during end-of-life care spirituality and existential issues become more prominent, as well as family members' perception of quality of care [2]. Early integration of palliative care has been shown to provide improved outcomes in patients with advanced cancer. So, why not apply this principle also in management of liver cirrhosis or other chronic disease.

Liver cirrhosis- patients' needs and accessibility

Improving patients' quality of live is the cornerstone of PC medicine and the main need expressed by these patients. It is known that improvement of hepatic encephalopathy management, ascites control and malnutrition treatment have the greatest impact on patients' day by day live and prognosis. Patients usually tend to avoid hospital admissions, so educating and empowering patients and their carers to optimise symptom management themselves may help support this. In chronic diseases the successful palliation techniques involve effective symptoms but also relief of unnecessary burdens such as polypharmacy/iatrogeny. Palliative care offers a wide range of benefits, from controlling muscle cramps, performind timely paracentesis for recidivating ascites, prophilaxy/treatment of hepatic encephalopaty, controlling pain with safe dosages without side effects, avoiding malnutrition to controlling care by involving also the family psysician (GP), discutions about the financial needs, about place of death or considering the caregiver burden.

Some indication for palliative care in patients with cirrhosis could be :

- uncontrolled physical symptoms
- patient/family/caregiver emotional or spiritual distress or conflicts about goals of care
- accelerating/frequent need for medical care or repeated hospitalisation

- curative treatment not available or not possible for the case

Recent indication found in literature identify several triggers for palliation in advanced liver disease: MELD score over 29 or increase in MELD more than 5 points in the last 30 days, ACLF (Acute chronic liver failure) grade 2-3 after 1 week of treatment, sarcopenia or recurrent sepsis. [3] Since resources are limited, in palliation we consider the surprise question (SQ) to be one of standards by which the patients will benefit most from PC services. The surprise question - "Would I be surprised if this patient died in the next 12 months?" - has been used to identify patients at high risk of death who might benefit from palliative care services. Several studies suggest that the surprise question performs poorly to modestly as a predictive tool for death, with worse performance in noncancer illness. The SQ was developed more than a decade ago and has been suggested as a simple test to identify patients who might benefit from hospice and palliative care. It was thought that the SQ would correct some physician's tendency to overestimate prognosis by asking the physician to consider whether death in the coming year is possible rather than probable. The surprise question has been widely promoted and adopted into frameworks for assessing hospice and palliative care needs [4].

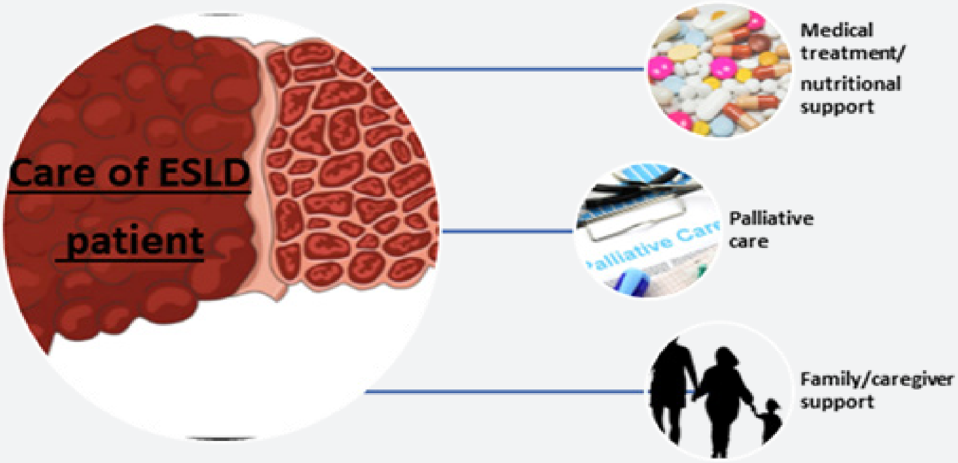

Figure 1: Holistic approach to End of Stage Liver Disease (ESLD) patients.

The study called COMPASS: A Pilot Trial of an Early Palliative Care Intervention for Patients with End-Stage Liver Disease was a randomized controlled trial of patients with end-stage liver disease admitted to the hepatology service at a tertiary referral centre whose attending hepatologist indicated they would not be surprised if the patient died in the following year on a standardized questionnaire. The control group patients received usual care , while the intervention group patients received inpatient specialist palliative care consultation and outpatient follow-up by a palliative care nurse by phone. The primary outcome was time until first readmission. Secondary outcomes included days alive outside the hospital, referral to hospice care, death, readmissions, patient quality of life, depression, anxiety, and quality of end-of-life care over 6 months. The was stopped early because of difficulties in finding patients, since of 293 eligible patients, only 63 patients were enrolled, 31 in the intervention group and 32 in the control group. Even with this bias, the intervention group patients had a lower hazard of readmission (hazard ratio: 0.36, 95% confidence interval: 0.16-0.83, P = 0.017) and greater odds of having more days alive outside the hospital than control group patients (odds ratio: 3.97, 95% confidence interval: 1.14-13.84, P = 0.030), with no other statistically significant differences observed. This study proves pre-emptive palliative care intervention resulted in increased time to first readmission and more days lived outside the hospital in the six months following study entry [5]

In an a retrospective, single-centre study published in 20121 from a metropolitan tertiary referral hospital from Australia the research aimed to determine palliative care referral rates and patterns for patients admitted with decompensated cirrhosis and to identify the factors associated with referral. Only a fifth of eligible patients (25/116) were referred to palliative care. Despite benefits from timely referral, less than one quarter of palliative care eligible patients was referred, and the study concludes that referral was reserved for those facing imminent death-surviving just under 3 weeks post referral, although the mortality in non referred patients remained high (148-day median). Low rates and late referral are a missed opportunity to improve the end-of-life care for patients with end-stage liver disease [6]

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In most of the studies published for this topic , liver disease is strongly associated with significant social, psychological and financial hardships for patients or carers and strategies that involve the wider multidisciplinary team at an early stage in the disease trajectory help ensure proactive management of such issues. PC introduced at an early stage in the trajectory of advanced chronic disease has been shown to improve quality of life (QOL) and symptom management, often in conjunction with ongoing active and potentially curative therapy.

Core palliative care is best delivered by the hepatology team in parallel with active disease management. This include ensuring that discussions about disease trajectory and advance planning occur onside active management of disease complications. Liver disease is strongly associated with significant social, psychological and financial hardships for patients and their families so we must create strategies that involve a multidisciplinary team- physician (family doctor, internist, hepatologist), medical nurse, social worker, priest.

Symptom care in palliation of end stage liver disease (only medication available in Romania): after Philips CA, & Kedarisetty CK (2023)

- Muscle cramps – taurine, zinc sulphate, L-carnitine, quinidine sulphate, BCAA
- Pain- Acetaminophen (under 2g/day), NSAIDS, gabapentin, pregabalin, lidocaine, tramadol, morphine
- Itching: UDCA (Ursodeoxycholic acid) 10-15mg/kg, naltrexone, sertraline
- Fatigue- testosterone replacement, gabapentine, sertraline, venlafaxine (unless Child C, hyponatremia)
- Sleep disorders- lactulose (for encefalopathy), zolpidem, melatonin, avoid duloxetine
- Malnutrition- bed time snack, early dietitian referral
- Refractory ascites: Long-term abdominal drains, day case paracentesis, alfapump®

Hospital treatments specialised for cirrhotic patients:

- Oxygen therapy
- TIPS
- Repeated paracentesis with weekly intravenous albumin protocol
- Fecal microbiota transplant

Conclusion

Palliative care practice offers several scales and models of symptom control and evaluation techniques that can be adopted in caring also non-oncological patients. Promoting PC among all healthcare workers is vital, and dispelling the myth that PC is synonymous with final period of live is important. PC should be viewed as a mean of optimising quality of life for patients and carers in parallel with an active management of chronic liver diseases. Gastroenterology/Internal medicine trainees and ward nurses need to gain awareness and practical training in the principles of PC to help achieve this goal. Proper evaluation, symptom control and advance care plan discussions could ease the burden of the disease and increase quality of care in these patients.

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