End-of-life care for patients with advanced lung cancer and chronic obstructive pulmonary disease

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LETTER TO THE EDITOR

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To the editor We have read with great interest the article by Brożek et al[1] published in *Polish Archives of Internal Medicine* (*Pol Arch Intern Med*) presenting the results of a survey among Polish pulmonologists on the end-of-life care for patients with advanced lung cancer and chronic obstructive pulmonary disease (COPD). We are also very interested in this procedure for patients with active hemoptysis.[2-4] We do agree with the results but we would like to ask the authors 3 questions. The first one concerns the questionnaire. The authors described that they used the Likert scale (1 – never; 2 – seldom; 3 – occasionally; 4 – often; and 5 – always).[1] As for the fifth option, what did the authors mean by "always"? Did it mean every day for hospitalized patients and every visit for outpatients? The second question regards consultation with the patient. Please elaborate on when the authors considered the best timing to talk about the end of life with patients. For example, is it the time of discharge for hospitalized patients? Is it the time of stable disease for outpatients? The third question concerns the administration of opioids. The main complaint in patients with COPD is breathlessness. We wonder whether additional use of opioids might cause falls and fractures in patients with COPD with reduced muscle strength and/or respiratory depression. We also evaluated psychotropic drugs for terminally ill patients with respiratory disease,[4] and are also searching for the best treatment. Based on the results of this study, we would appreciate an answer from the authors.

ARTICLE INFORMATION

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Authors' reply We thank Okauchi et al[1] for their interest in our study, and also we believe that it would be thoughtful to ask Japanese professionals about their attitude to the end-of-life (EOL) practice among patients with chronic pulmonary diseases. Until now, the findings from the countries of different cultures and different types of healthcare systems indicate that the frequency of EOL discussion is generally low and many important topics are not discussed until the very end or not at all.[2] Similarly, the burden related to symptoms (including chronic breathlessness, which is particularly prevalent in COPD patients) is at least comparable to that in patients with advanced cancer.

In response to the first question asked by Okauchi et al,[1] in our study, "always" means that the procedure was performed (or attempted) in every patient as a routine (either at the ward or out-patient clinic). Considering the second question, the opinion of responders on the best timing to talk with patients about the EOL issues was not raised as a separate topic. We only sought this response about people with advanced disease.

A recent systematic literature review supported the observation that, for clinicians, the deterioration of the overall health status of the patient (for example, on, or prior to, an intensive care unit

admission, the introduction of noninvasive ventilation, or when maximum therapy was achieved) triggered palliative care discussions.[2] However, for many patients it might mean that such conversations are initiated (if it is done at all) too late. Effective advance care planning, defined as a person-centered approach for planning health and personal care that reflects the person's values, beliefs, and preferences, should be based on ongoing communication between the patients, people important to them, and multidisciplinary healthcare team. Thus, for those with COPD, similarly to others with life-limiting diseases, such discussions should be initiated early enough to give them at least time necessary to discover what is important for them, and to support them in understanding and sharing with others their personal values and life goals.

In the third question, Okauchi et al[1] wondered whether the use of opioids might cause falls and fractures or respiratory depression in patients with COPD. Any centrally acting medication can raise the risk of harms including falls, especially in the frail elderly. For chronic breathlessness, Australia's recent decision to license for the first time a medication for the symptomatic reduction of chronic breathlessness is an indication of the burden that this symptom imposes on patients and their caregivers across our communities.[3] Importantly, the therapy that has been licensed is regular, low-dose, sustained-release morphine (up to maximum daily dose of only 30 mg per 24 hours).[3] This formulation was chosen because the plasma peaks are lower (and the troughs are higher) than immediate-release oral morphine solution, which is a way to lessen the likelihood of adverse events including falls.[4] In randomizing more than 400 people in double blind studies of regular, low-dose, sustained-release morphine for breathlessness, the only person who fell (and broke her femur) was on the placebo arm. Long term follow-up of people on low-dose morphine for chronic breathlessness also found no cases of falls resulting in hospitalization.[5] There is an imperative that we use the available evidence to reduce the burden of chronic breathlessness safely and predictably.[6]

To conclude, our study pointed at the necessity to improve the care for people with advanced COPD by addressing symptom burden and palliative care needs along with the need for early initiated communication on EOL issues.

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