Kroonilise kopsuhaiguse lõppfaas – kodus või intensiivravis?

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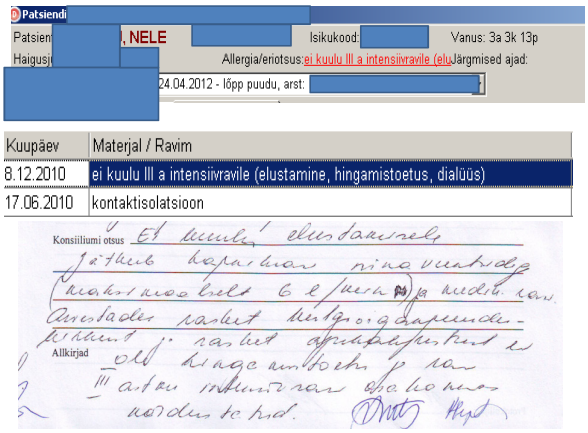
SA Tallinna Lastehaigla
Olustvere, 27.04.2012


Patsiendi
Patsien , NELE Isikukood: Vanus: 3a 3k 13p
Haigusj Allergia/eriotsus:ei kuulu III a intensiivravile (elu Järgmised ajad:
24.04.2012 - lõpp puudu, arst:

Kuupäev	Materjal / Ravim
8.12.2010	ei kuulu III a intensiivravile (elustamine, hingamistoetus, dialüüs)
17.06.2010	kontaktisolatsioon

Konsiiliumi otsus
Allkirjad

Otsuste tegemisel tuleb alati lähtuda patsiendi huvidest

- Kas kõik võimalikud ravimeetodid rakendatud?
- Missugused kommunikatiivsed võimed on lapsel tulevikus?
- Kas ta suudab tulevikus iseseisvalt elada?
- Kas laps vajab pidevat meditsiinilist abi?
- Kas ta kannatab vaimselt või füüsiliselt?
- Missugune on ta arvatav eluiga?
- Ravi hind vs prognoositav tulemus

TLH ravi piiramise või lõpetamise otsused

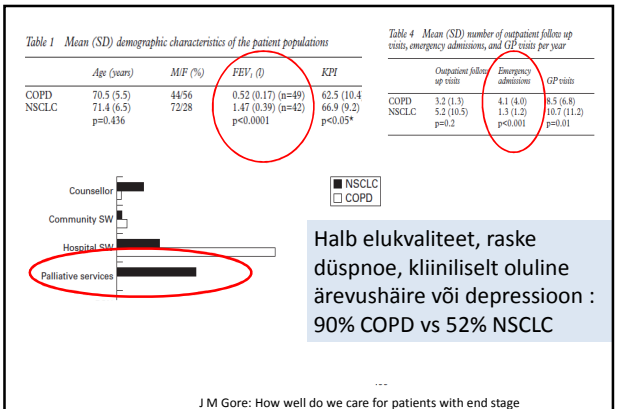


Table 1 Mean (SD) demographic characteristics of the patient populations

	Age (years)	M/F (%)	FEV$_1$ (l)	KPI
COPD	70.5 (5.5)	44/56	0.52 (0.17) (n=49)	62.5 (10.4
NSCLC	71.4 (6.5)	72/28	1.47 (0.39) (n=42)	66.9 (9.2)
	p=0.436		p<0.0001	p<0.05*

Table 4 Mean (SD) number of outpatient follow up visits, emergency admissions, and GP visits per year

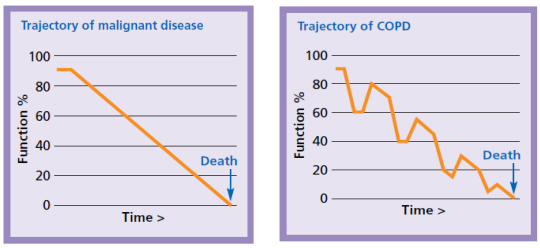
	Outpatient follow up visits	Emergency admissions	GP visits
COPD	3.2 (1.3)	4.1 (4.0)	8.5 (6.8)
NSCLC	5.2 (10.5)	1.3 (1.2)	10.7 (11.2)
	p=0.2	p<0.001	p=0.01

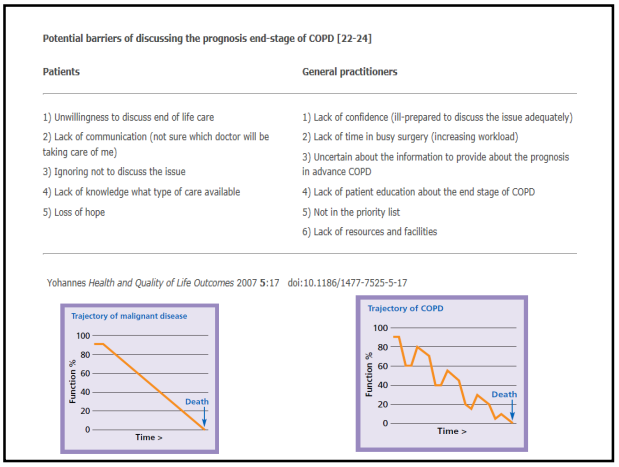
Counsellor
Community SW
Hospital SW
Palliative services
NSCLC
COPD

Halb elukvaliteet, raske düspnoe, kliiniliselt oluline ärevushäire või depressioon : 90% COPD vs 52% NSCLC

J M Gore: How well do we care for patients with end stage chronic obstructive pulmonary disease (COPD)?; *Thorax* 2000;55:1000–100

Miks on palliatiivne ravi ja nõustamine KOK haigetel halvem?




Potential barriers of discussing the prognosis end-stage of COPD [22-24]

Patients	General practitioners
1) Unwillingness to discuss end of life care	1) Lack of confidence (ill-prepared to discuss the issue adequately)
2) Lack of communication (not sure which doctor will be taking care of me)	2) Lack of time in busy surgery (increasing workload)
3) Ignoring not to discuss the issue	3) Uncertain about the information to provide about the prognosis in advance COPD
4) Lack of knowledge what type of care available	4) Lack of patient education about the end stage of COPD
5) Loss of hope	5) Not in the priority list
	6) Lack of resources and facilities

Yohannes *Health and Quality of Life Outcomes* 2007 **5**:17 doi:10.1186/1477-7525-5-17

Kes otsustab?

Table 4: How respondents perceived their role in deciding about mechanical ventilation and the frequency with which they modify information provided to COPD patients

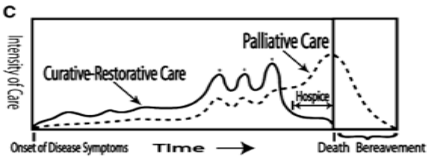
Variable	No. (and %) of respondents
Perceived role in decision-making process	
Patient decides	8 (2.9)
Patient decides after physician gives opinion	83 (29.7)
Patient and physician collaborate to make decision	154 (55.2)
Physician decides after patient gives opinion	22 (7.9)

Mc Neely, et al.
Can Med Assoc J 1997;156(2):

5000 pt.
64% pt soovis CPR; 36 % ei soovinud.
Arstid hindasid õigesti 86% CPR grupis,
kuid ainult 46% NO-CPR grupis
Wenger, et al; J Am Geriatr Soc 2000

Omaksed ülehindavad sageli haige soovi agressiivseks raviks.

Kuidas?



Time- or event – limited trial of therapy ⇒ withdrawal of therapy

An Official American Thoracic Society Clinical Policy Statement: Palliative Care for Patients with Respiratory Diseases and Critical Illnesses; 2007

Miks? KOK ja IRO

- Haigla suremus 2,5 – 30% N Roche, Eur Respir J 2008
- 1 - aasta suremus 22 – 43%
- 2 - aasta suremus 36 – 49% J J Soler-Cataluna, Thorax 2005

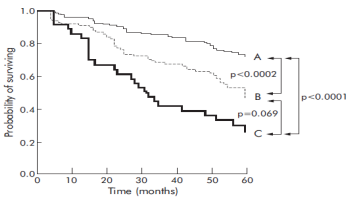
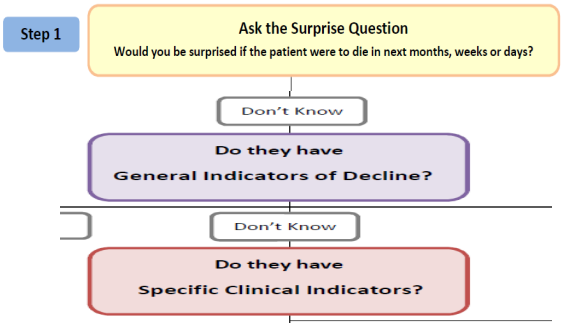


Figure 1 Kaplan-Meier survival curves by frequency of exacerbations in patients with COPD: group A, patients with no acute exacerbations of COPD; group B, patients with 1–2 acute exacerbations of COPD requiring hospital management; group C, patients with ≥3 acute exacerbations of COPD.

J J Soler-Cataluna, Thorax 2005

Kellele?



Prognostic Indicator Guidance (PIG) 4th Edition Sept 2011 © The Gold Standards Framework Centre In End of Life Care CIC, Thomas.K et al

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b) Organ Failure – erratic decline

Chronic Obstructive Pulmonary Disease (COPD)

At least two of the indicators below:

- Disease assessed to be severe (e.g. FEV1 <30% predicted)
- Recurrent hospital admissions (at least 3 in last 12 months due to COPD)
- Fulfils long term oxygen therapy criteria
- MRC grade 4/5 – shortness of breath after 100 metres on the level o confined to house
- Signs and symptoms of right heart failure
- Combination of other factors – i.e. anorexia, previous ITU/NIV resistan organisms
- More than 6 weeks of systemic steroids for COPD in preceding 6 months.

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TABLE 5. MEDICARE CRITERIA FOR HOSPICE ELIGIBILITY OF PATIENTS WITH ADVANCED LUNG DISEASE

Patients will be considered to be in the terminal stage of pulmonary disease (life expectancy of 6 mo or less) if they meet the following criteria. The criteria refer to patients with various forms of advanced pulmonary disease who eventually follow a final common pathway for end-stage pulmonary disease. (Criteria 1 and 2 should be present. Criteria 3, 4, and 5 will lend supporting documentation):

1. Severe chronic lung disease as documented by both a and b:
   (a) Disabling dyspnea at rest, poorly or unresponsive to bronchodilators, resulting in decreased functional capacity (e.g., bed-to-chair existence), fatigue, and cough. (Documentation of FEV_1, after bronchodilator, less than 30% of predicted is objective evidence for disabling dyspnea, but is not necessary to obtain.)
   (b) Progression of end-stage pulmonary disease, as evidenced by increasing visits to the emergency department or hospitalizations for pulmonary infections and/or respiratory failure or increasing physician home visits before initial certification. (Documentation of serial decrease of FEV_1 > 40 ml/yr is objective evidence for disease progression, but is not necessary to obtain.)
2. Hypoxemia at rest on ambient air, as evidenced by Po_2 less than or equal to 55 mm Hg; or oxygen saturation less than or equal to 88% on supplemental oxygen determined either by arterial blood gases or oxygen saturation monitors; OR hypercapnia, as evidenced by Pco_2 ≥ 50 mm Hg. These values may be obtained from recent (within 3 mo) hospital records.
3. Right heart failure secondary to pulmonary disease (cor pulmonale) (e.g., not secondary to left heart disease or valvulopathy).
4. Unintentional progressive weight loss of greater than 10% of body weight over the preceding 6 months.
5. Resting tachycardia > 100/minute.

Modified from Reference 57.

An Official American Thoracic Society Clinical Policy Statement: Palliative Care for Patients with Respiratory Diseases and Critical Illnesses; 2007

Planning for My Future Care

Preparing for the future, my way

This booklet is a patient held document for you to outline your wishes and preference your future care

Statement of my wishes and preferences for my future care

Name .....Date of Birth .....Tel.....

Address .....

.....

.....

I have:	Yes	No	I keep them at	Copies are available from	
Another document outlining my preferences (e.g. Living Will)					
Advance Decision to Refuse Treatment (ADRT)					
Do not attempt cardio-pulmonary resuscitation order (DNACPR)					

Please attach a copy of your Living Will, ADRT, and other relevant documents to this form

Aitäh, dr. Tiina Tamm

ALLOWING NATURAL DEATH

'Allow Natural Death' vs. 'Do Not Resuscitate'

A kinder, gentler approach would benefit everyone.

Treatment which does not provide net benefit—that is, is futile—may be ethically and morally withheld or withdrawn, and there is no legal or moral difference between withholding and withdrawing treatment. UK, British Medical Association

762. Tervishoiuteenuse osutamine

Tervishoiuteenus peab vastama vähemalt arstiteaduse üldisele tasemele teenuse osutamise ajal ja seda tuleb osutada tervishoiuteenuse osutajalt tavaliselt oodatava hoolega.

Võlaõigusseadus
Vastu võetud 26.09.2001
RT I 2001, 81, 487
jõustumine 01.07.2002

Aitäh, Ants Nõmper