

Desafíos de la integración paliativa en candidatos a Trasplante Hepático

Dr. Francisco Idalsoaga Ferrer
Departamento de Gastroenterología UC
Instituto de Trasplante UC-CHRISTUS

Sociedad Médica Cuidados Paliativos Chile

Sociedad Médica Cuidados Paliativos Chile

- Los pacientes con cirrosis tienen una **alta morbi – mortalidad.**
- Descompensaciones deterioran la **calidad de vida.**
- Existen prejuicios sobre la cirrosis y su manejo de los sintomas.



¿Porqué es importante?

Marchesini. Gastroenterology 2001;120:170–178.
Moscucci F. Liver Int 2011;31:1505–1510.
Boyd K. Hepatology 2012;55:1650–1651.

Sociedad Médica Cuidados Paliativos Chile

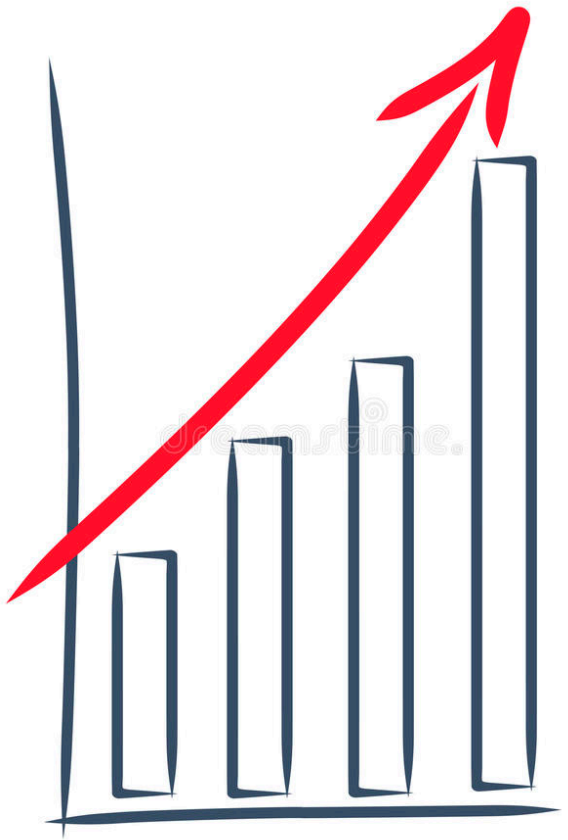
TABLE 1. Mortality of Patients With Cirrhosis Based on Child-Pugh, MELD Score, and ACLF Grade

	28-day	90-day	365-day
Child-Pugh			
A	n/a	n/a	5%
B	n/a	n/a	20%
C	n/a	n/a	55%
MELD Score			
10-19	n/a	6%	n/a
20-29	n/a	20%	n/a
30-39	n/a	53%	n/a
ACLF Grade			
ACLF 1	22%	41%	n/a
ACLF 2	32%	52%	n/a
ACLF 3	77%	79%	n/a

LIVER TRANSPLANTATION, vol. 24, no. 7, 2018

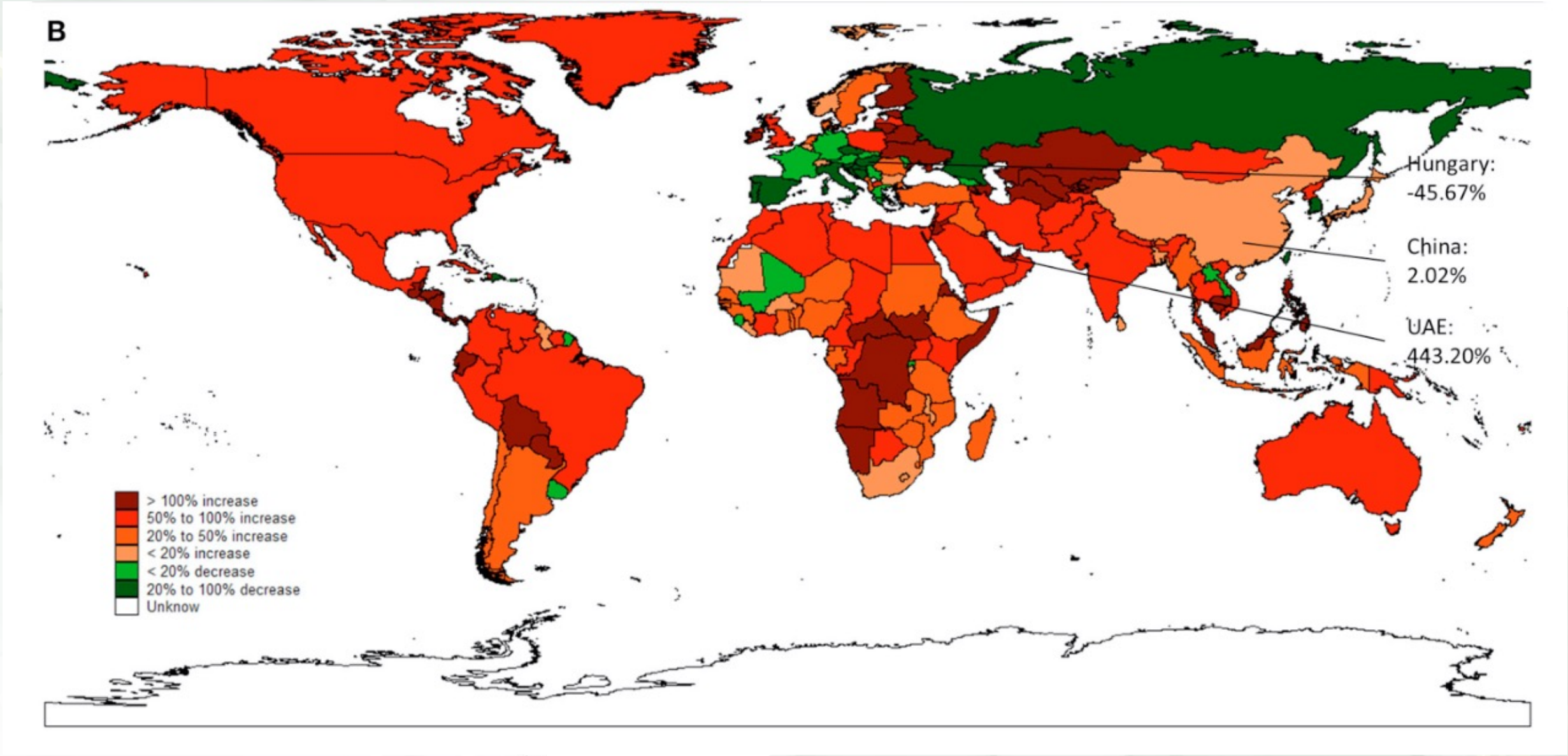
Sociedad Médica Cuidados Paliativos Chile

- La enfermedad hepática en etapa terminal (ESLD) es la **12ª causa principal de muerte** (66,000 vidas cada año en USA).
- Entre 2006 y 2016, la prevalencia de ESLD **aumentó en un 7,9 %** entre los hombres de 25 a 34 años de edad y en **un 11,4 % entre las mujeres**
- La mortalidad por ESLD aumentó en un 65% de 1999 a 2016.
- Impacto del MASLD en LATAM ha tenidouen aumento sostenido.



¿Qué impacto tiene?

Hepatology, Vol. 71, No. 6, 2020



Ye et al. Front. Public Health 2022

Table 3. Comparison of common symptom prevalence (range min to max) in end-stage liver disease and other advanced conditions.[a]

Symptom	ESLD	Cancer[a]	COPD[a]	CHF[a]	ESRD[a]	Dementia[a]	MND[a]	MS[a]
Pain	30–79	30–97	21–77	14–78	11–83	14–63	52–76	68
Breathlessness	20–88	16–77	56–98	18–88	11–82	12–52	81–88	26
Insomnia	26–77	3–67	15–77	36–48	1–83	14	24–33	
Fatigue	52–86	23–100	32–96	42–82	13–100	22		80
Anorexia	49	76–95	64–67		38–64			
Nausea or vomiting	58	2–78	4	2–48	8–52	8		26
Depression	4·5–64	4–80	17–77	6–59	2–61	46	23	15
Anxiety	14–45	3–74	23–53	2–49	7–52	8–72	19	24

¿Qué impacto tiene para los pacientes?

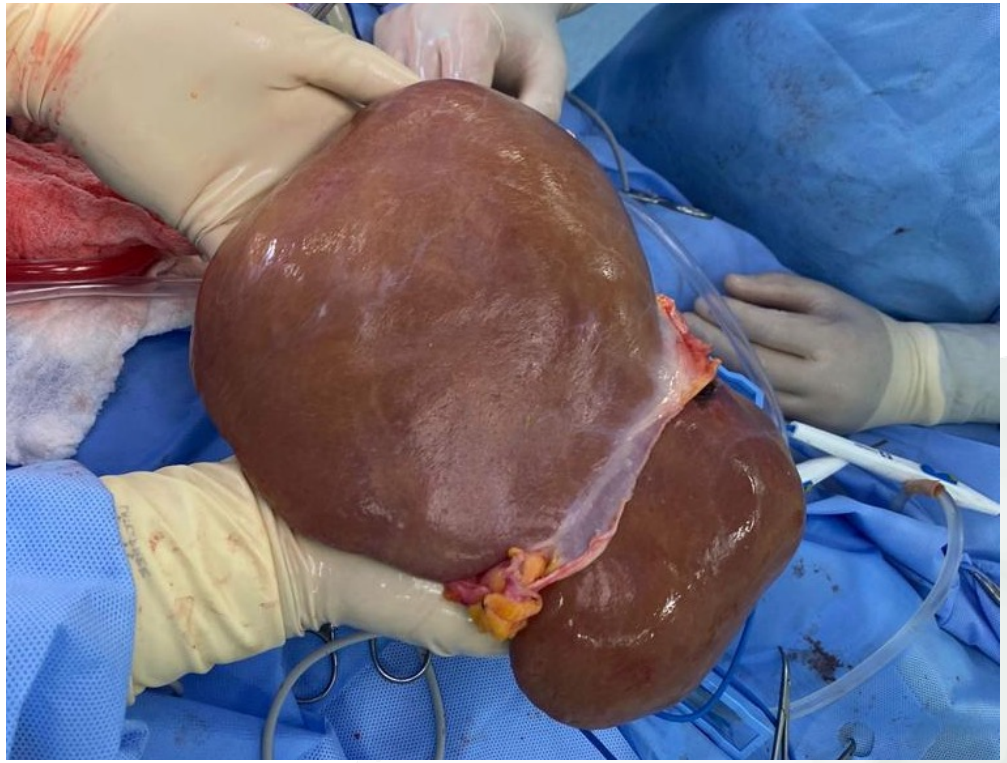
Peng et al. Palliative Medicine 2019.



El **50% de los pacientes** evaluados para THO se consideran no elegibles

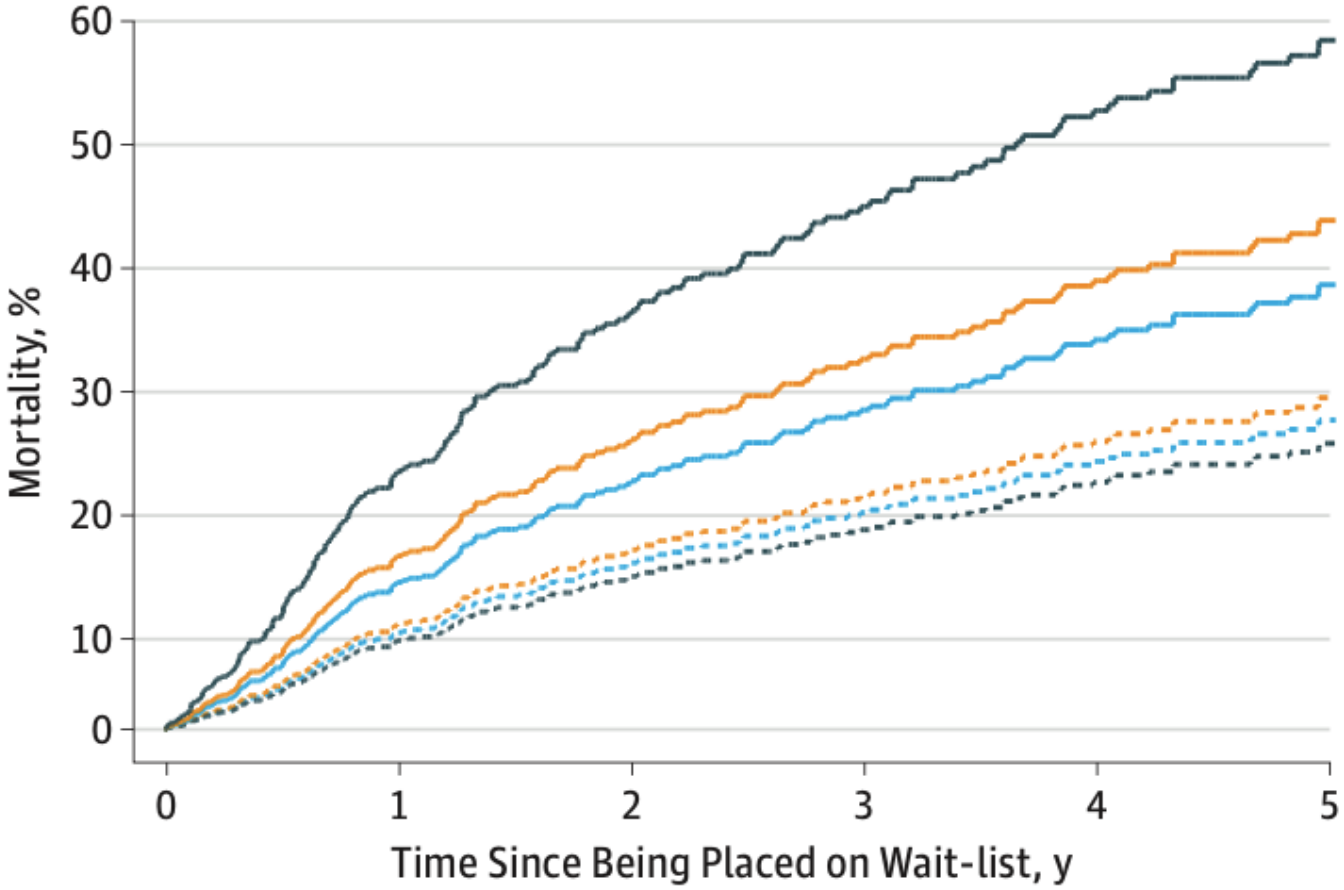
El **20% de los candidatos** a LT en los EE. UU. mueren o son excluidos de la lista cada año porque están “demasiado enfermos para el trasplante”.

La Mortalidad en lista de espera es **30% en Canadá, 40% en Chile.**



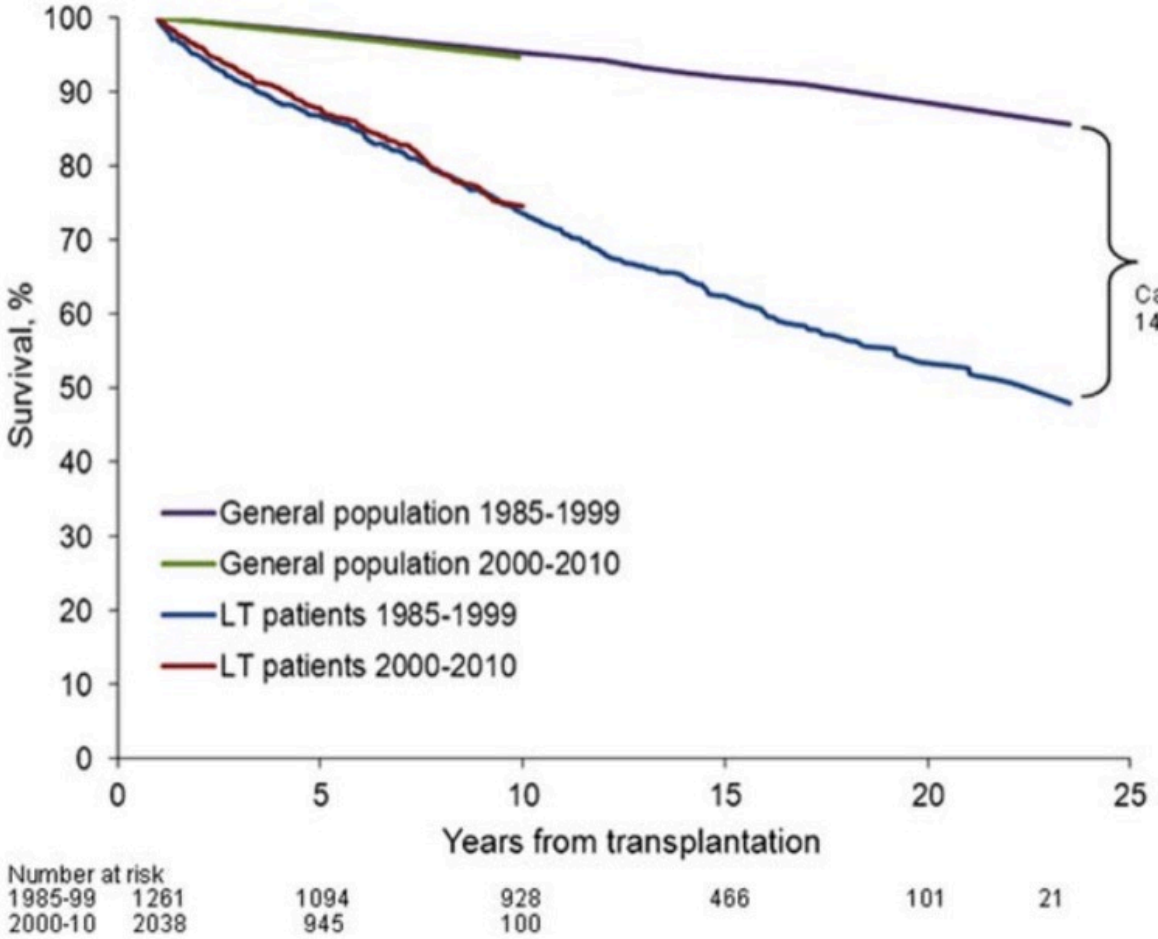
Trasplante Hepático

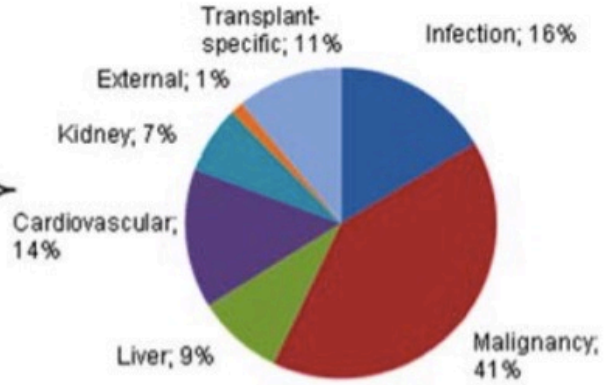
LIVER TRANSPLANTATION, vol. 24, no. 7, 2018



Mortalidad en lista de espera

Haugen et al. JAMA Surgery 2019.





Sobrevida Post Trasplante

Aberg et al. Hepatology 2015





Fotos autorizadas por paciente



Cuidados Paliativos en Cirrosis

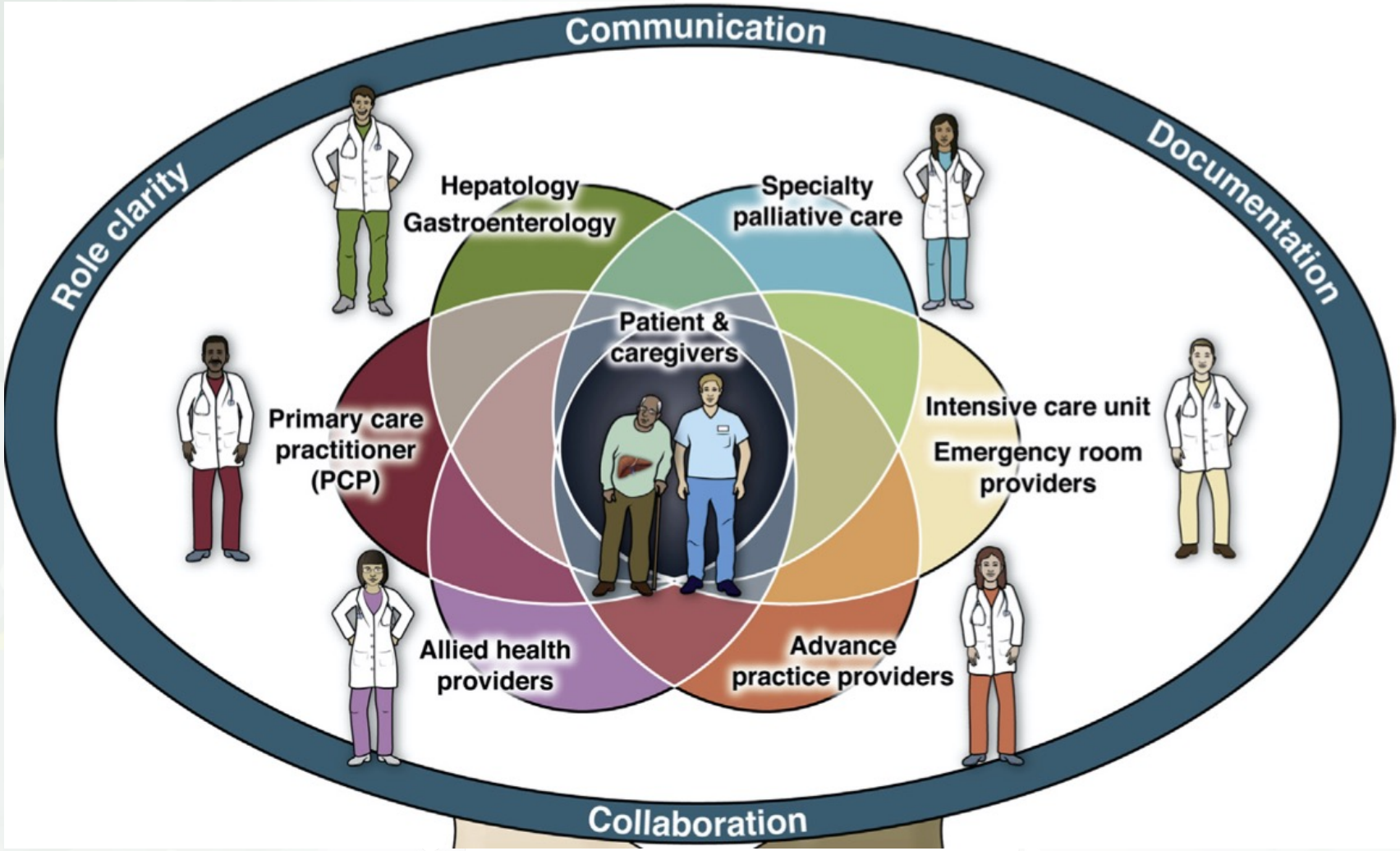
- Cuando los pacientes son excluidos de la lista de trasplante es necesario un **cambio en el enfoque terapéutico**.

- **No es simple** (MELD es evolutivo, Donante Vivo)

- **Los cuidados paliativos (CP)** son clave en el manejo de los pacientes y sus familias.



Lamba S. J Pain Symptom Manage 2012;44:508–519.
Casarett D. J Pain Symptom Manage 2010; 40:801–809.



Cuidados Paliativos en Cirrosis

LIVER TRANSPLANTATION, vol. 24, no. 7, 2018

Cuidados Paliativos en Cirrosis

- Cuando los pacientes son excluidos de la lista de trasplante es necesario un **cambio en el enfoque terapéutico**.

- **No es simple** (MELD es evolutivo, Donante Vivo)

- Los **cuidados paliativos (CP)** pueden dar soporte y acompañamiento a los pacientes y a sus familias.



LIVER TRANSPLANTATION, vol. 24, no. 7, 2018

Received: 14 January 2022 | Accepted: 14 January 2022

DOI: 10.1002/hep.32378

PRACTICE GUIDANCE

AASLD Practice Guidance: Palliative care and symptom-based management in decompensated cirrhosis

Shari S. Rogal[1,2] | **Lissi Hansen**[3] | **Arpan Patel**[4,5] | **Nneka N. Ufere**[6] | **Manisha Verma**[7] | **Christopher D. Woodrell**[8,9] | **Fasiha Kanwal**[10,11]

[1]Departments of Medicine and Surgery, University of Pittsburgh, Pittsburgh, Pennsylvania, USA

[2]Center for Health Equity Research and Promotion, VA Pittsburgh Healthcare Center, Pittsburgh, Pennsylvania, I

[3]School of Nursing, Oregon Health and Science University, Portland, Oregon, USA

[4]Division of Digestive Diseases, David Geffen School of Medicine at University of California, Los Angeles, Califo

[5]Division of General Internal Medicine and Health Services Research, David Geffen School of Medicine at Unive USA

Clinical Gastroenterology and Hepatology 2021;19:646–656

CLINICAL PRACTICE UPDATE

AGA Clinical Practice Update on Palliative Care Management in Cirrhosis: Expert Review

Puneeta Tandon,* Anne Walling,[‡,§] Heather Patton,[‖] and Tamar Taddei[¶]

*Liver Unit, Division of Gastroenterology, University of Alberta, Edmonton, Alberta, Canada; [‡]VA Greater Los Angeles Healthcare System, Los Angeles, California; [§]Division of General Internal Medicine and Health Services Research, University of California, Los Angeles, Los Angeles, California; [‖]Gastroenterology Section, VA San Diego Healthcare System, San Diego, California; and [¶]VA Connecticut Healthcare System, West Haven, and Department of Medicine, Section of Digestive Diseases, Yale School of Medicine, New Haven, Connecticut

Check for updates

Cuidados Paliativos en Cirrosis

Table 2. Subsequent Interventions in 102 Palliative Cirrhotic Patients After Declined for Transplant

	n (%)[a]	Mean (SD)[b]
ICU admission	49 (48)	
Number of subsequent ICU admissions[c]		1 (0.5)
Hospital admission	80 (78)	
Number of subsequent admissions[c]		2 (1)
Therapeutic paracentesis	51 (50)	
Paracentesis per patient		5 (8)
Gastroscopy	46 (45)	
Number of subsequent gastroscopies per patient		2 (1)
RRT	17 (17)	

[a]Number of patients reported as a percentage.
[b]In those requiring interventions, number of events (eg, ICU admissions, paracentesis) reported as means (SD) after normality testing.
[c]All events were subsequent to delisting/decline for LT (ie, if the patient was in ICU, only subsequent ICU admissions were included).



Cuidados Paliativos en Cirrosis

Poonja Z et al. Clin Gastroenterol Hepatol. 2014

Table 3. Outcomes in 102 Palliative Cirrhotic Patients Declined for LT

	N	n (%)
Palliative care/goals of care		
Referral to SW	94	40 (43)
Referral to home care	94	21 (22)
Referral to palliative care	102	11 (11)
DNR status	102	29 (28)
Place of death	102	
ICU		27 (26)
UAH		28 (27)
Hospice		4 (3.9)
Home		26 (25)
Unknown		9 (8.8)
Alive (at end of study period)		9 (8.8)

SW, social worker; UAH, University of Alberta Hospital.

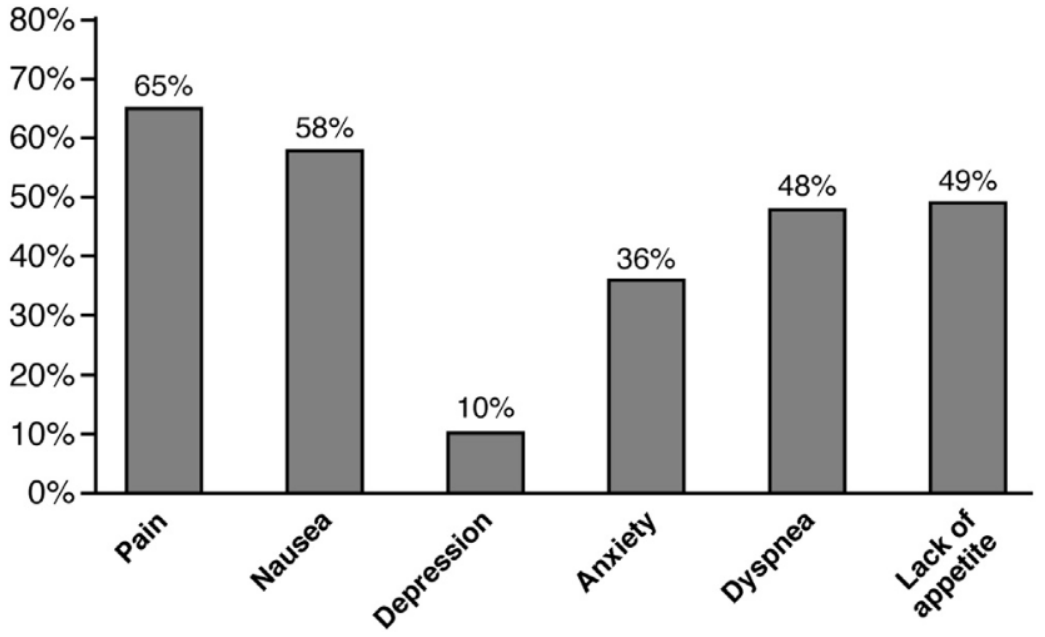


Figure 2. Symptomatology in palliative cirrhotic patients according to ESAS (revised).[15] Fraction of patients listed in the Results section.

Cuidados Paliativos en Cirrosis

Poonja Z et al. Clin Gastroenterol Hepatol. 2014

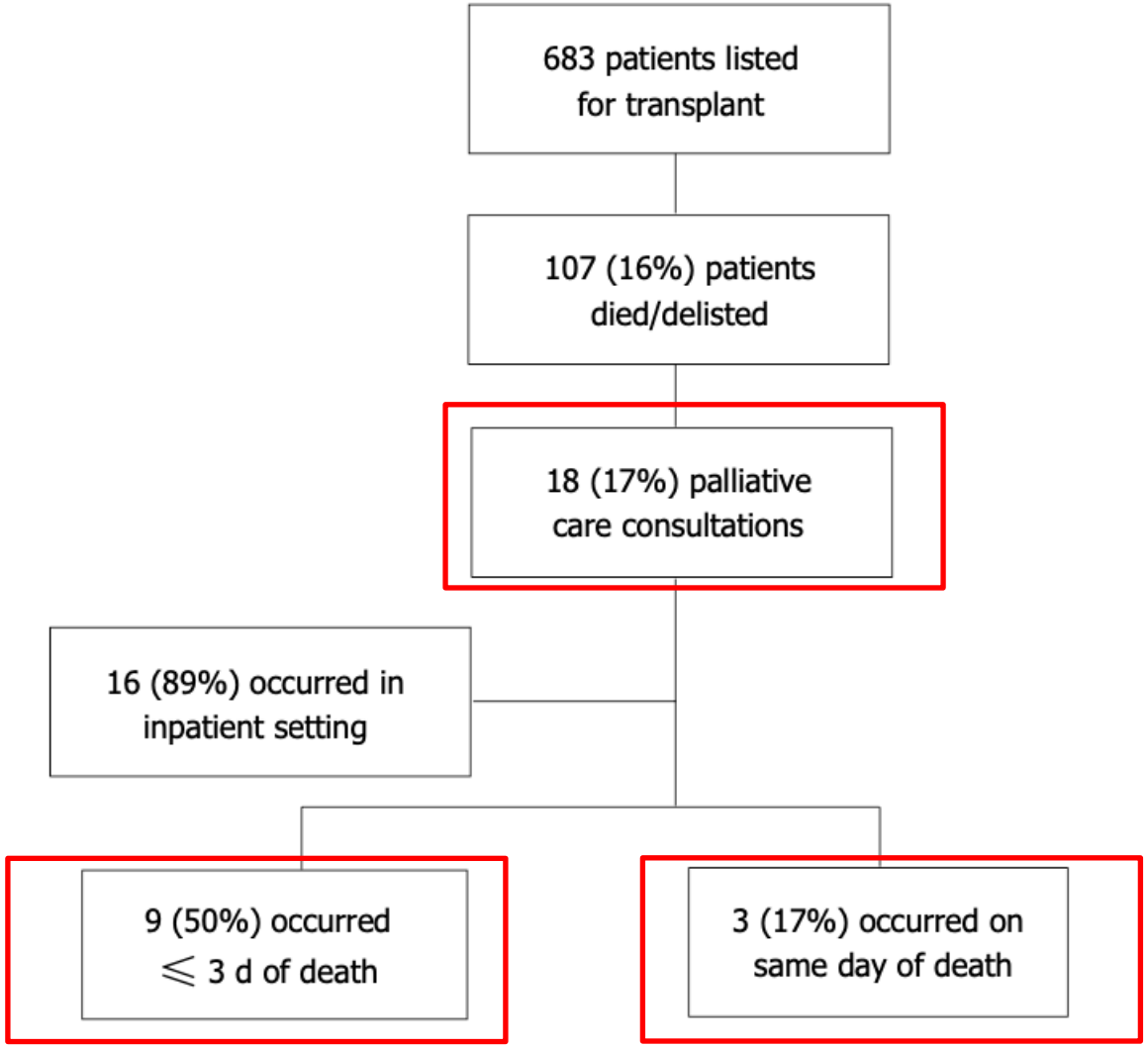


Figure 1 Palliative care consultations in patients who died or were delisted over a 24-mo period.

Table 2 Factors associated with palliative care consultation, univariable and multivariable logistic regression analysis

Factor	Univariable analysis		Multivariable analysis	
	OR (95%CI)	*P* value	OR (95%CI)	*P* value
Age, per year	0.92 (0.87-0.98)	< 0.01	0.92 (0.87-0.98)	0.02
Male sex	0.76 (0.27-2.16)	0.61	-	-
White race	3.74 (1.14-12.26)	0.03	4.90 (1.30-18.30)	0.02
MELD at listing	1.06 (1.01-1.12)	0.02	1.00 (0.97-1.10)	0.39
MELD at delisting	1.05 (1.00-1.10)	0.01	1.00 (0.97-1.10)	0.34
Etiology of liver disease				
Alcohol related	Reference	Reference		
Hepatitis C	0.95 (0.17-5.28)	0.95	-	-
Alcohol + hepatitis C	1.56 (0.25-9.65)	0.63		
Other	0.77 (0.12-4.88)	0.78		
Child-pugh score at delisting				
A	Reference	Reference		
B	0.60 (0.03-10.30)	0.73	-	-
C	4.90 (0.60-40.10)	0.14		
HCC	0.89 (0.32-2.46)	0.83	-	-
College or lower level of education (*vs* graduate level)	1.23 (0.14-10.9)	0.85	-	-
Private insurance (*vs* government)	0.70 (0.25-1.97)	0.50	-	-
English language	0.93 (0.24-3.65)	0.92	-	-

MELD: Model for end-stage liver disease; HCC: Hepatocellular cancer.

Kathpalia P et al . World J Transplant 2016 September 24

Table 3. Outcomes in 102 Palliative Cirrhotic Patients Declined for LT

	N	n (%)
Palliative care/goals of care		
Referral to SW	94	40 (43)
Referral to home care	94	21 (22)
Referral to palliative care	102	11 (11)
DNR status	102	29 (28)
Place of death	102	
ICU		27 (26)
UAH		28 (27)
Hospice		4 (3.9)
Home		26 (25)
Unknown		9 (8.8)
Alive (at end of study period)		9 (8.8)

SW, social worker; UAH, University of Alberta Hospital.

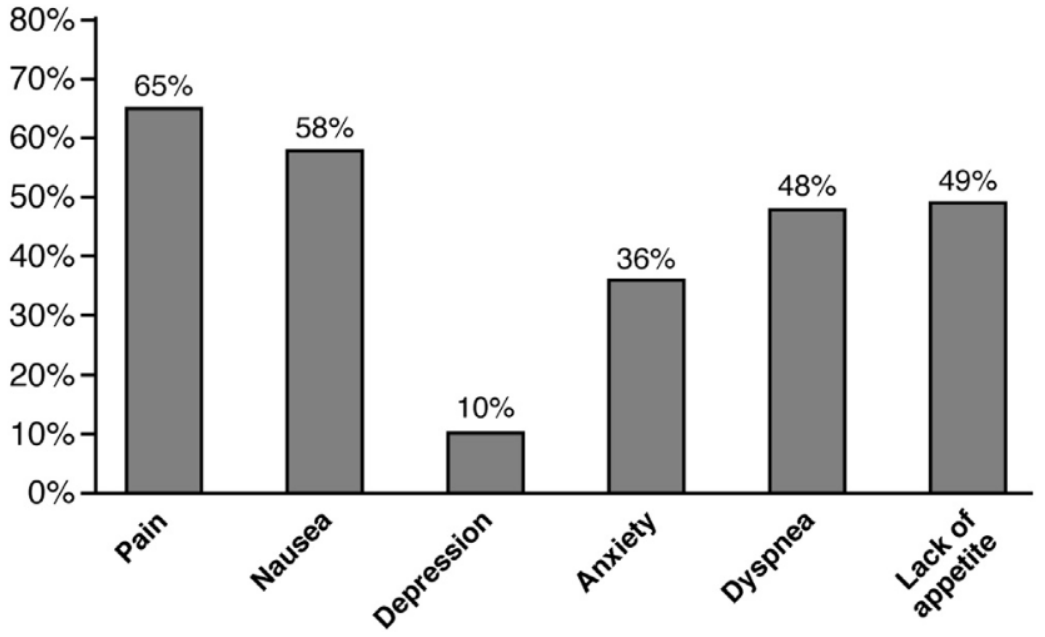
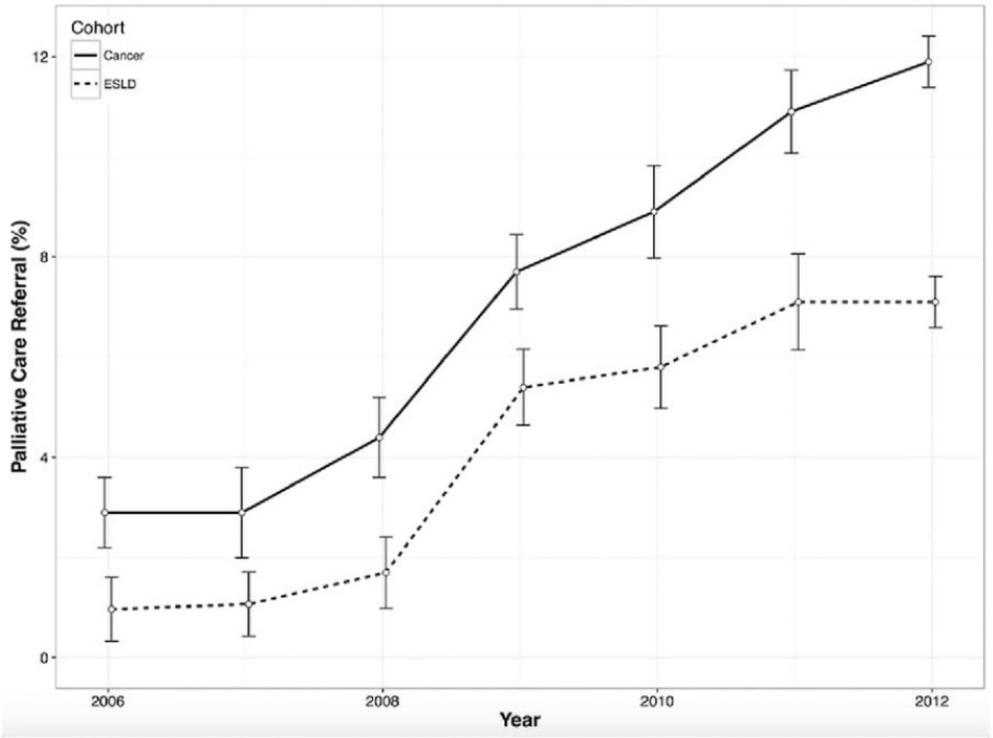


Figure 2. Symptomatology in palliative cirrhotic patients according to ESAS (revised).[15] Fraction of patients listed in the Results section.

Cuidados Paliativos en Cirrosis

Poonja Z et al. Clin Gastroenterol Hepatol. 2014



La tasa de derivación a CP en ESLD **aumentó del 0,97% en 2006 al 7,1% en 2012** (p<0,01).

Rush et al. Hepatology, vol. 66, no. 5, 2017

TABLE 2. Results of Multivariate Logistic Regression Analysis for the Prediction of PC Referral in Patients With ESLD

Variable	OR	95% CI	*P*
Older age, per 5-year increase	1.05	1.03-1.08	<0.01
Female gender	1.01	0.90-1.12	0.93
White race	—*	—	—
Black race	1.08	0.91-1.30	0.37
Hispanic race	0.77	0.66-0.89	<0.01
Other race	1.00	0.82-1.23	0.96
Insurance coverage	0.74	0.65-0.84	<0.01
Zip code income quartile 1	—	—	—
Zip code income quartile 2	1.18	1.04-1.35	0.01
Zip code income quartile 3	1.09	0.95-1.26	0.21
Zip code income quartile 4	1.08	0.93-1.26	0.34
Northeast hospital	—	—	—
Midwest hospital	1.31	1.09-1.58	<0.01
South hospital	1.24	1.05-1.47	0.01
West hospital	1.81	1.53-2.14	<0.01
Small hospital	—	—	—
Medium hospital	1.36	1.09-1.70	<0.01
Large hospital	1.49	1.22-1.82	<0.01
Teaching hospital	1.25	1.12-1.39	<0.01
DNR status	16.24	14.20-18.56	<0.01
HCC	2.00	1.71-2.33	<0.01
Metastatic cancer	2.39	1.80-3.18	<0.01

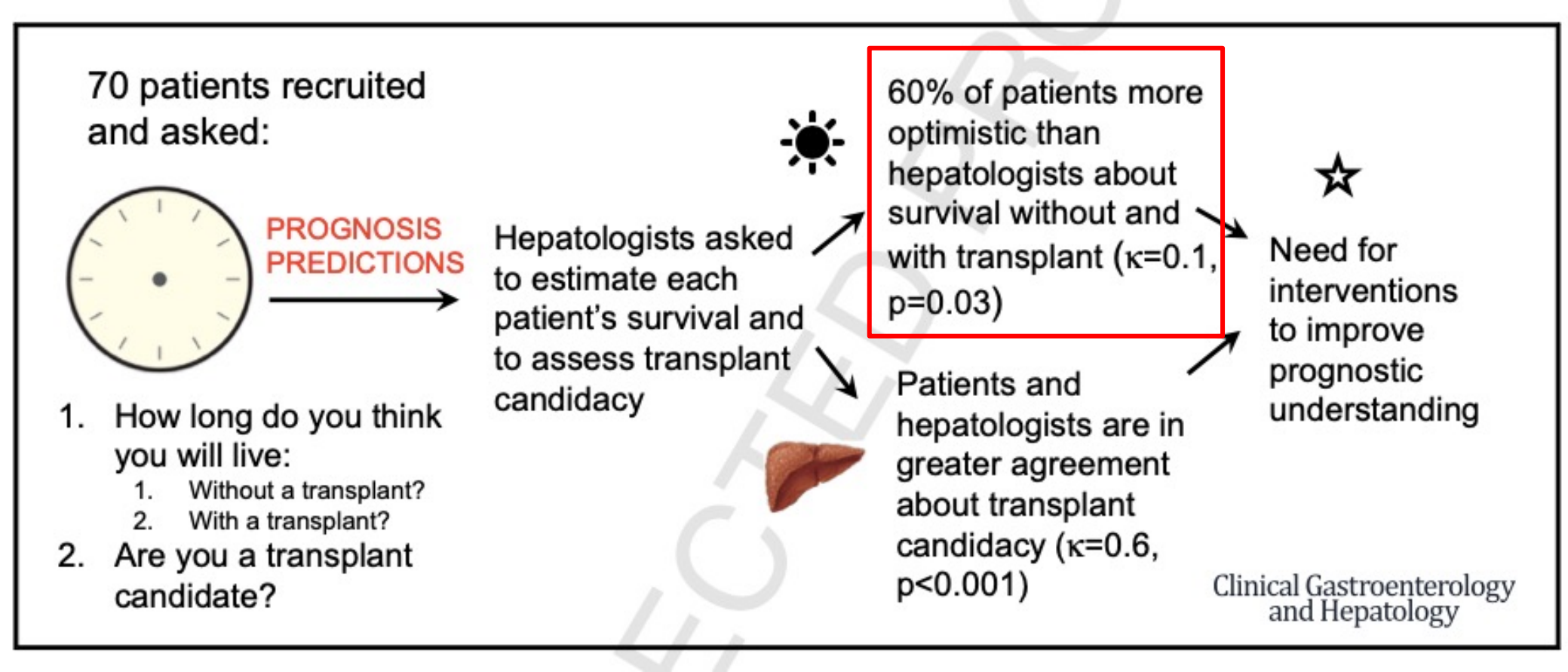


- La **trayectoria fluctuante** de la Cirrosis se asocia con una infraderivación de los pacientes.

- Difícil alcanzar un equilibrio adecuado entre **las intervenciones activas y paliativas**

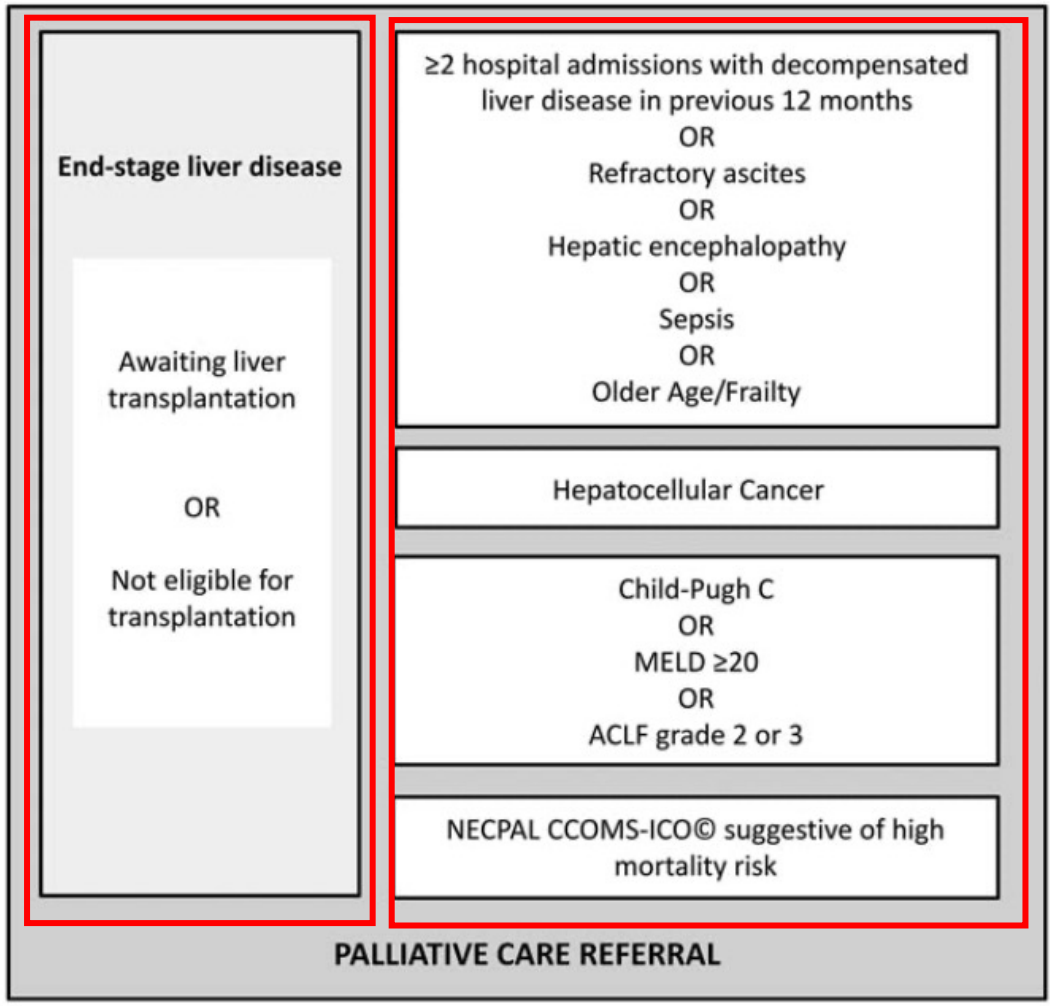


Infra derivación a CP



Infra derivación a CP

Clinical Gastroenterology and Hepatology 2022.



Patients will be considered to be in the terminal stage of LD (life expectancy of ≤6 months) if they meet the following criteria (criteria 1 and 2 should be present; factors from criterion 3 will lend supporting documentation):

1. The patient should show both a and b:
   a. Prothrombin time prolonged >5 s over control or international normalized ratio >1.5;
   b. Serum albumin <2.5 g/dl.
2. End-stage liver disease is present and the patient shows at least one of the following:
   a. Ascites, refractory to treatment or patient noncompliant;
   b. SBP;
   c. Hepatorenal syndrome (elevated creatinine and blood urea nitrogen with oliguria);
   d. HE, refractory to treatment or patient noncompliant;
   e. Recurrent variceal bleeding, despite intensive therapy.
3. Documentation of the following factors will support eligibility for hospice care:
   a. Progressive malnutrition;
   b. Muscle wasting with reduced strength and endurance;
   c. Continued active alcoholism (>80 g of ethanol per day);
   d. HCC;
   e. HBsAg positive;
   f. Hepatitis C refractory to interferon treatment.Patients awaiting LT who otherwise fit these criteria may be certified for the Medicare hospice benefit; but if a donor organ is procured, the patient should be discharged from hospice.

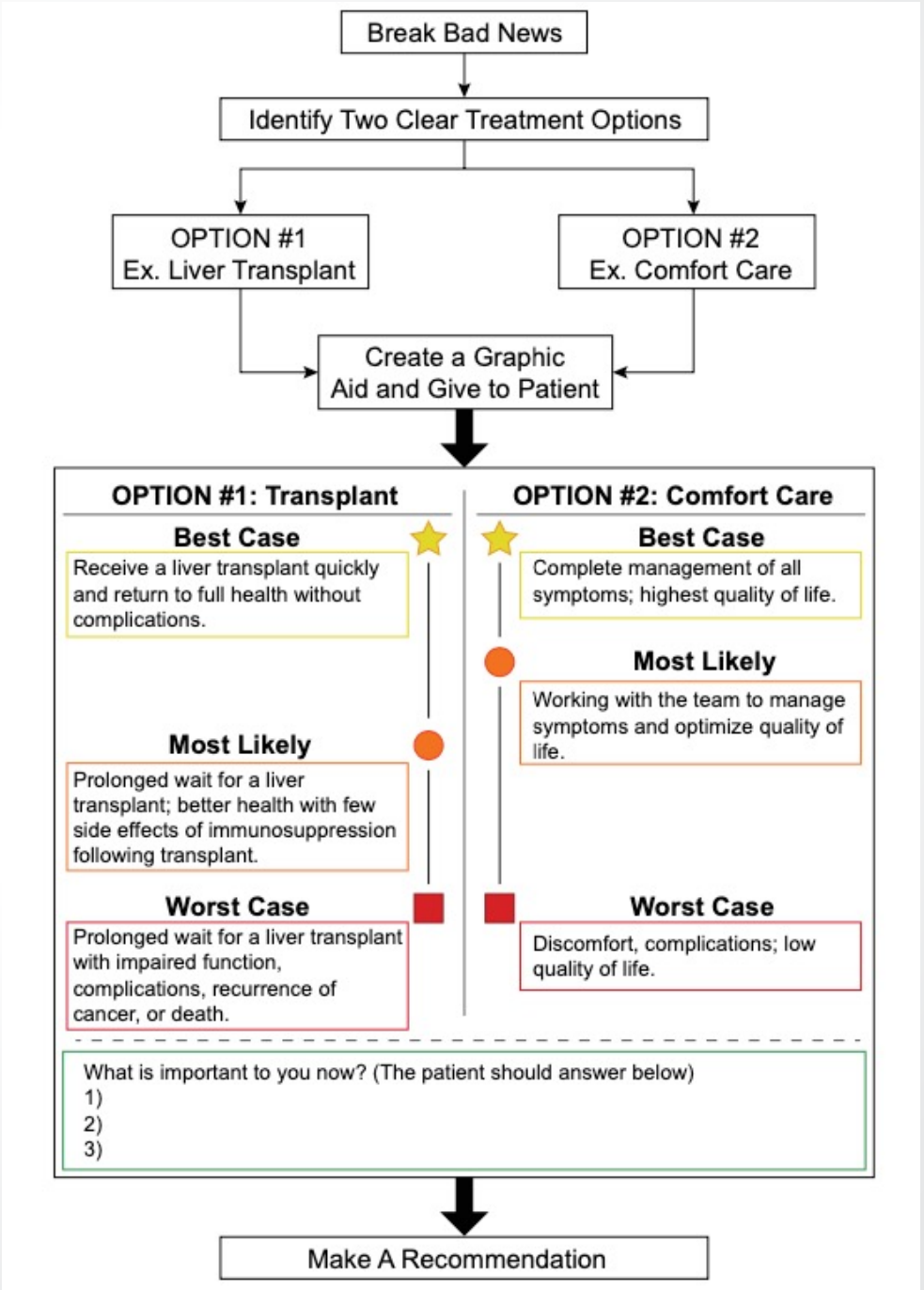
Reference: Hospice determining terminal status. CMS. https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34538. Last accessed January 7, 2022

¿Cuando derivar a CP?

Clinical Gastroenterology and Hepatology 2022.



¿Cuando derivar a CP?



Clinical Gastroenterology and Hepatology 2022.

Take-Home message

- Los pacientes con Cirrosis tiene una **mortalidad muy alta a corto plazo** y tienen **muchos síntomas** por lo que el manejo Multidisciplinario es clave.
- **Planteamiento de todos los posibles escenario** y la claridad del pronóstico es un desafío.
- **Preguntar y evaluar** los síntomas de todos los pacientes con Cirrosis avanzada.
- **Todos tenemos un rol** en el manejo paliativo de los pacientes, no abandonar.
- Es clave el manejo **multidisciplinario** y la **derivación adecuada** a los equipos de CP.



GRACIAS



Sociedad
Médica
Cuidados
Paliativos
Chile