O3_A2_A_Scientific Evidence

DISCUSSION ABOUT END OF LIFE CARE
(PLACE OF CARE, AGGRESSIVE TREATMENT, DNR)

Q1	**Does aggressive treatment improve quality of life in end of life patients?**
Patients	Patients elderly and/or frail and/or end of life indications in a palliative facility Frail, aged, end of life adults
Intervention	Aggresive treatment
Comparator	Follow-up by a Palliative Unit Care
Outcome	Core outcome measures: Quality of life, EOL preference decisions
Methodology	Cohort studies Retrospective observational study
Extra	Planned subgroup analysis: ederly patients, terminally ill patients supportted by religious communities.

Studies:
A retrospective observational study was included (N= 231) [1], a cross-sectional survey study (N= 2467) [2].

Indications:

1. Early discontinuation of treatment decreases overall survival and does not improve the quality of life. However follow-up by a Paliative Care Unit decrease the aggressiveness of cancer treatment in elderly patients which improves the quality of care of the patients (duration of hospitalization and ICU admission during the last month of life) (1):
   - PCC led to a change in the pattern of treatment administered in the last month of life with less cytotoxic therapy (OR = 0.27 CI 95 % 0.09–0.9, $p = 0.02$) and higher rates of oral agents being prescribed (OR = 3.8; 95 % CI 1.3–11.3, $p = 0.014$).
   - Patients with PCC had a trend for a lower number of treatment lines being administered (1.9 vs 1.6; $p = 0.133$) and lower rate of imaging in the last 30 days (38.3 vs 28.6 %; $p = 0.144$).
   - PCC did not decrease the duration of hospitalization or rates of ICU admissions in the elderly population ($p > 0.05$).

2. EOL care discussions were associated with fewer aggressive treatments.(2)
   - Patients who reported discussing EOL-care preferences with their physicians were significantly less likely to prefer receiving CPR when life is in danger (AOR = 0.50, 95% CI = 0.36–0.69) and aggressive life-sustaining treatments at EOL, including ICU care (AOR (95% CI) = 0.70 (0.53–0.93)), cardiac massage (0.61 (0.41–0.91)), intubation (0.62 (0.44–0.86)), and mechanical ventilation support (0.58 (0.39–0.87)). (2)

Erasmus+
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- Patients with higher perceived spiritual support from religious communities were more likely to receive aggressive EOL interventions and more likely to die in intensive care units (ICUs). Those receiving additional spiritual support from the medical team had higher rates of hospice use, fewer aggressive interventions and fewer admissions to ICU.(3)

3. Family of patients who received no hospice or ≤3 days of services before death were less likely to report excellent quality end-of-life care than those who received more. Family of patients admitted to an ICU ≤30 days of death were less likely to report excellent of care compared with those who were not, as were family of patients who died in the hospital (4).

References:
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2. Tzuh Tang S, Tsang-Wu L, Li Ni Liu, Chang-Fang Chiu, Ruey-Kuen Hsieh, Chun-Ming T. Physician–patient end-of-life care discussions: Correlates and associations with end-of-life care preferences of cáncer patients—a cross-sectional survey study.
3. Balboni TA, Balboni M, Enzinger AC, et al. Provision of spiritual support to patients with advanced cancer by religious communities and associations with medical care at the end of life. JAMA Intern Med 2013; 173:1109–17.
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