

PACIENT S POKROČILÝM ZÁKLADNÍM ONEMOCNĚNÍM
V INTENZIVNÍ PÉČI

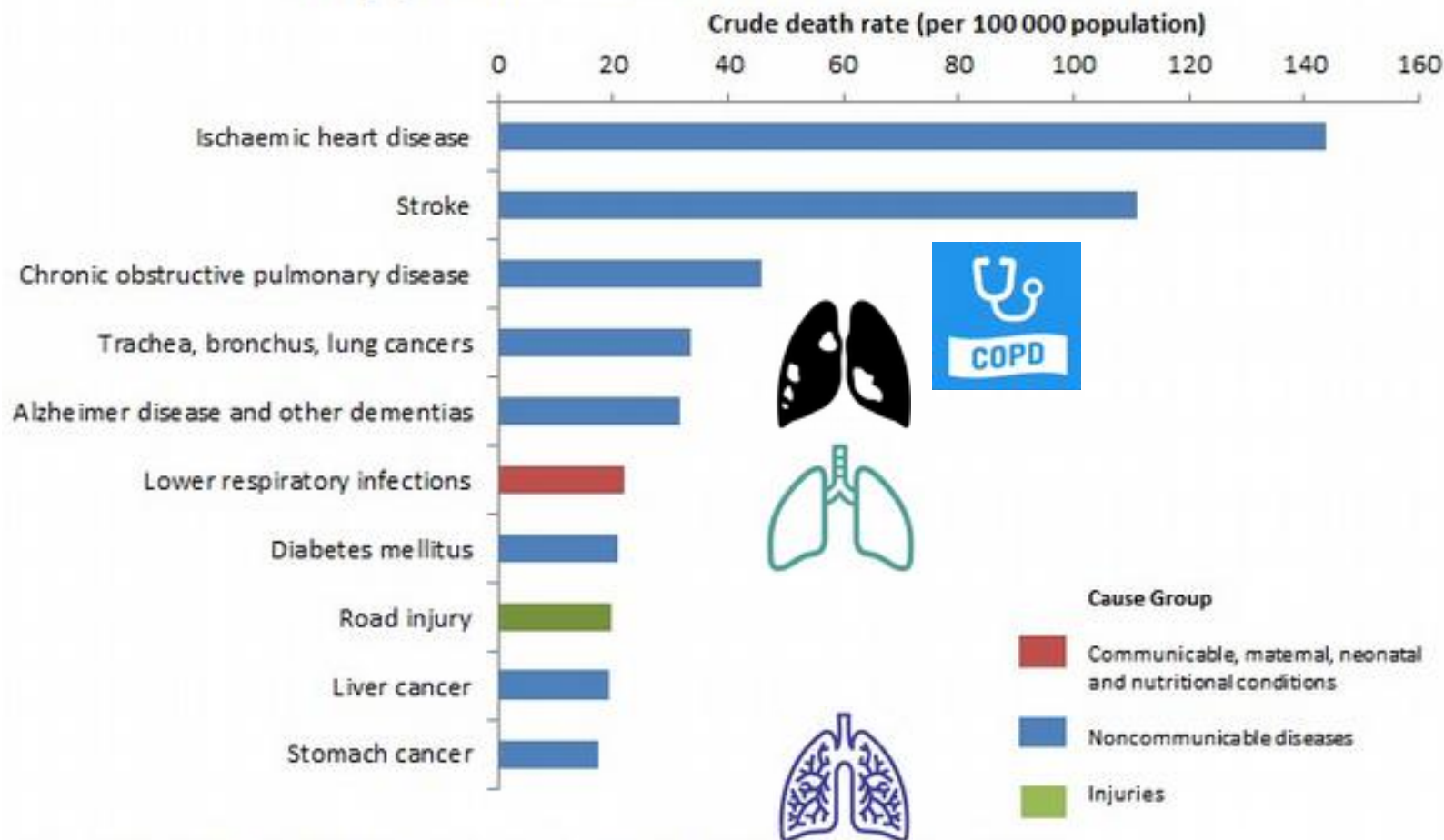
aneb

JAK DALEKO MÁME JÍT?????

PNEUM**L****GIE**

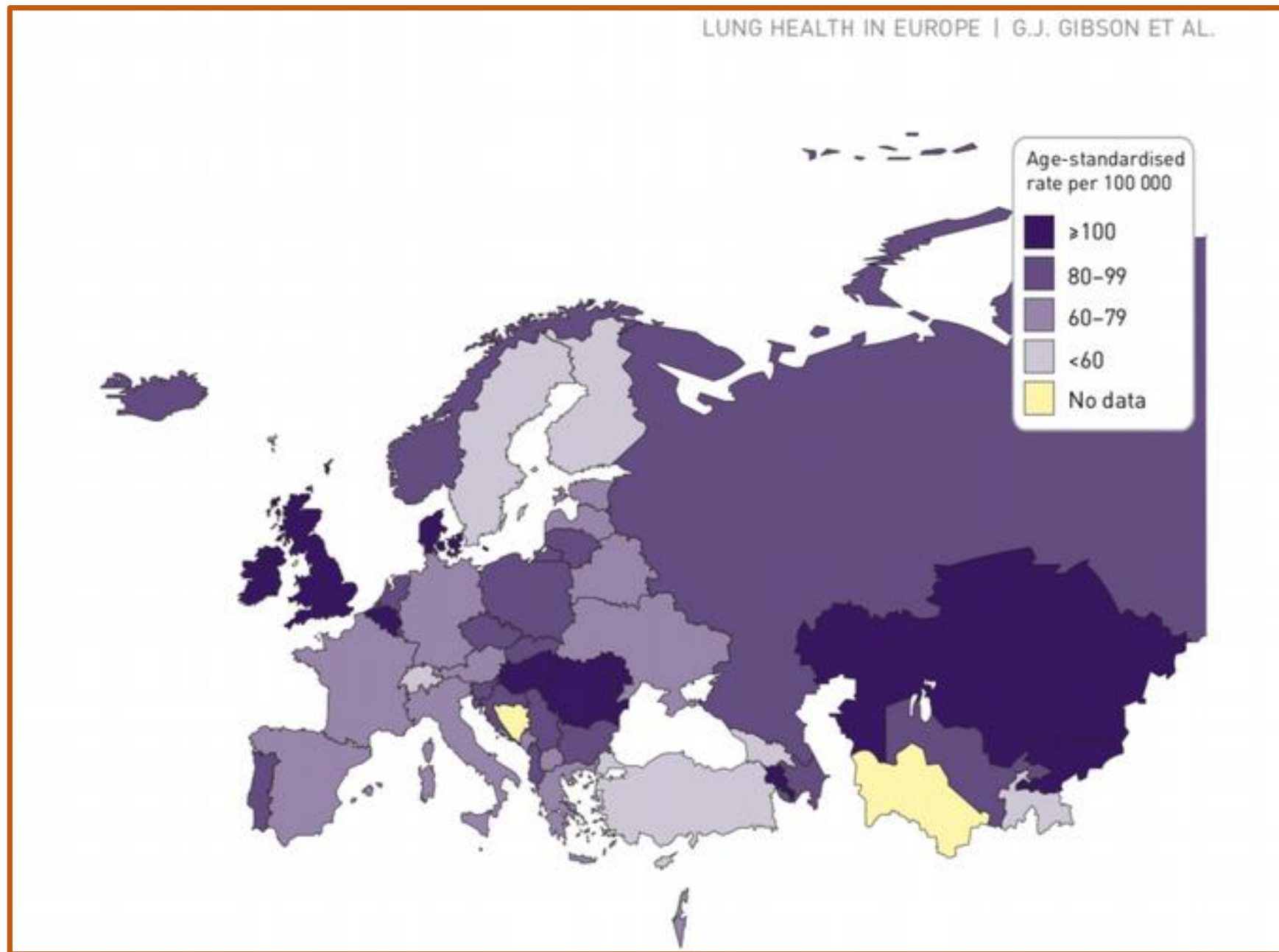
Na co reálně umíráme v bohaté části světa?

Top 10 causes of deaths in upper-middle-income countries in 2016



Respirační
mortalita

ČR versus
Evropa



Vývoj respirační mortality 2008-2015-2030

Aneb co nás čeká v další dekádě

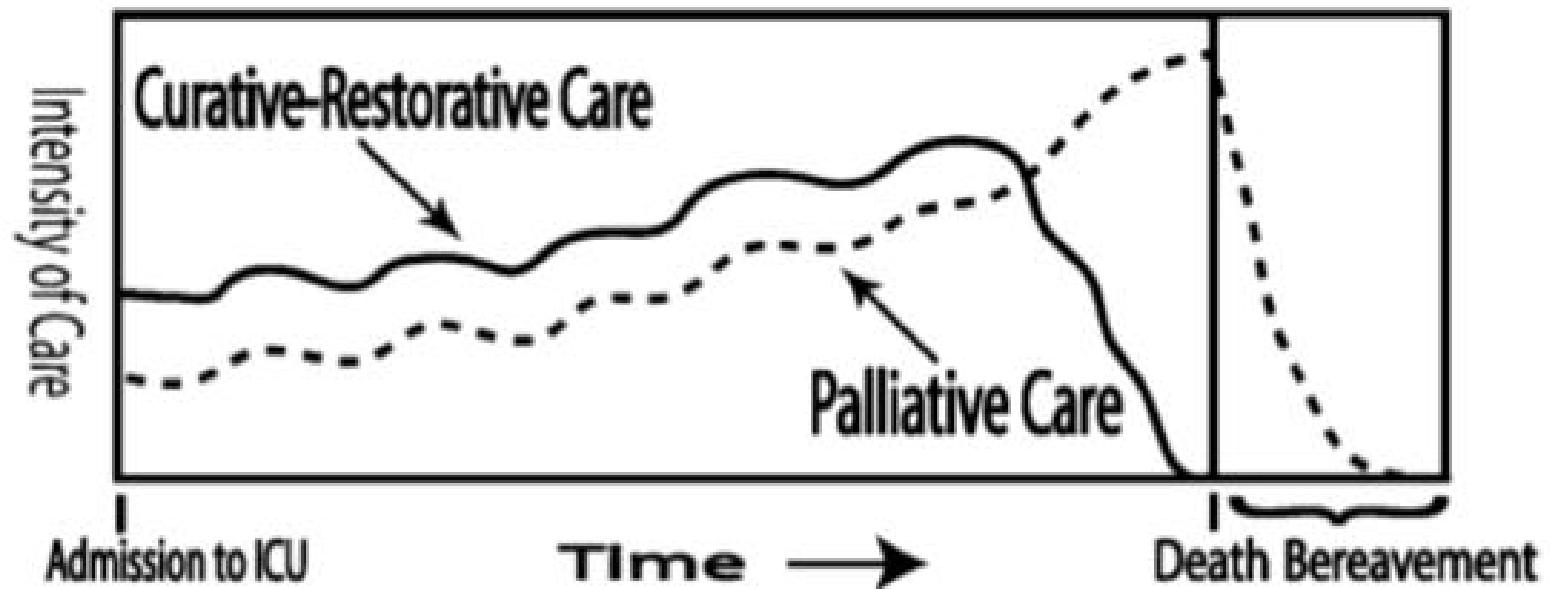
TABLE 2 Projected proportion of deaths due to leading respiratory causes

Percentage of deaths in WHO European region	2008	2015	2030
Lower respiratory infections	2.3	2.2	1.9
COPD	2.5	2.7	3.2
Trachea/bronchus/lung cancer	3.9	3.9	4.1
Tuberculosis	0.8	0.7	0.4





Kdy zahájit paliativní péči? Dříve než by nás napadlo

AMERICAN JOURNAL OF RESPIRATORY AND CRITICAL CARE MEDICINE VOL 177 2008



Potenciál paliativní péče respiračních chorob

Table 3 Comparison of disease-focused and palliative treatments in respiratory diseases





Condition	Disease-focused treatment	Palliative treatment
Lung cancer 	Surgery/radiation/chemotherapy	Treatment of side-effects from medical treatments, such as management of fatigue, nausea, decreased appetite and dyspnoea
Chronic obstructive pulmonary disease (COPD) 	Bronchodilators (oral/inhaled)/oxygen/pulmonary rehabilitation	Counselling and medications to reduce anxiety and dyspnoea; moving air (fan) to reduce dyspnoea perception
Cystic fibrosis (CF)	Antibiotics/enzymes/percussive therapy/lung transplant	Teaching mastery skills to manage dyspnoea, opioids to control intractable coughing
Pulmonary arterial hypertension (PAH)	Antibiotics for infection/targeted medications/oxygen	Discussions of disease trajectory/treatment options/advanced care planning



PATIENT EDUCATION | *INFORMATION SERIES*

Palliative Care for People with Respiratory Disease or Critical Illness



Condition	Medical Treatment	Palliative Care
Lung cancer 	Chemotherapy or radiation therapy	Medication to treat side effects of your medical treatments. Side effects managed by palliative care might include fatigue, nausea, poor appetite, pain, or difficulty breathing.
Chronic lung disease, such as Chronic Obstructive Pulmonary Disease (COPD) or Idiopathic Pulmonary Fibrosis (IPF) 	Oxygen and bronchodilators (inhalers) 	Medicines and counseling to help with anxiety and difficulty breathing. A fan blowing cool air to reduce shortness of breath.
Severe pneumonia 	Antibiotics and care in an intensive care unit (ICU)	Medications to reduce pain, help with sleep, or reduce feelings of anxiety.





Kritéria terminální fáze plicních chorob (očekávaná délka života < 6M)

2. Hypoxemia at rest on ambient air, as evidenced by P_{O_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 $P_{CO_2} \geq 50$ 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.

Odhad terminální fáze tumorů versus CHOPN

u CHOPN poměrně velký problém



Vol. 46 No. 4 October 2013

Journal of Pain and Symptom Management 491

Original Article

Factors to Inform Clinicians About the End of Life in Severe Chronic Obstructive Pulmonary Disease

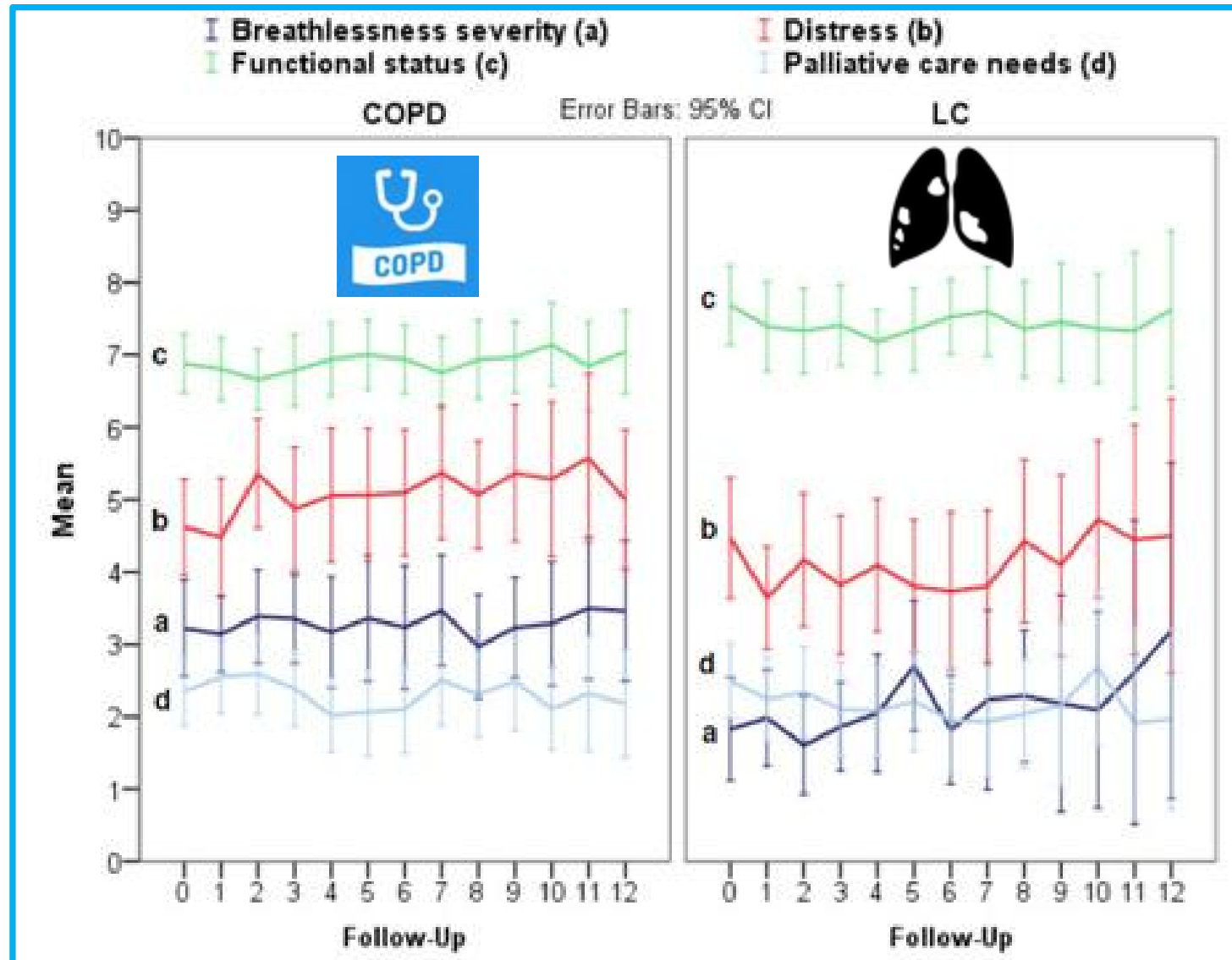
Roberto Benzo, MD, MS, Wendy Siemion, MD, Paul Novotny, MS, Alice Sternberg, ScM, Robert M. Kaplan, PhD, Andrew Ries, MD, MPH, Robert Wise, MD, Fernando Martinez, MD, James U're, MD, and Frank Scharba, MD, for the National Emphysema Treatment Trial (NETT) Research Group
 Department of Medicine (R.B., W.S., J.U.) and Cancer Center (P.N.), Mayo Clinic, Rochester, Minnesota; Department of Epidemiology (A.S.) and Department of Medicine (R.W.), Johns Hopkins University, Baltimore, Maryland; Office of Behavioral and Social Sciences Research (R.M.K.), National Institutes of Health, Bethesda, Maryland; Department of Medicine (A.R.), University of California San Diego, San Diego, California; Department of Medicine (F.M.), University of Michigan, Ann Arbor, Michigan; and Department of Medicine (F.S.), University of Pittsburgh, Pittsburgh, Pennsylvania, PA

Repeated Measures Multivariate Logistic Modela

Variables	Odds Ratio	95% Confidence Interval	P-value
Maximal inspiratory pressure (cm H ₂ O)	2.29	1.45–3.62	0.0004
Feeling upset or downhearted	1.97	1.16–3.33	0.0117
Gait speed decline by 0.137 at 6 mo or six-minute walk decline by 50 m	1.70	1.09–2.66	0.0202
PaO ₂ (mm Hg) at rest on room air decline by 5.14	1.69	1.07–2.67	0.0240



Obtíže při CHOPN > Obtíže při BCA



Advancing Palliative Care, Respiratory, and Symptom Research

Home Articles & Issues Collections CME For Authors Journal Info Resource Center

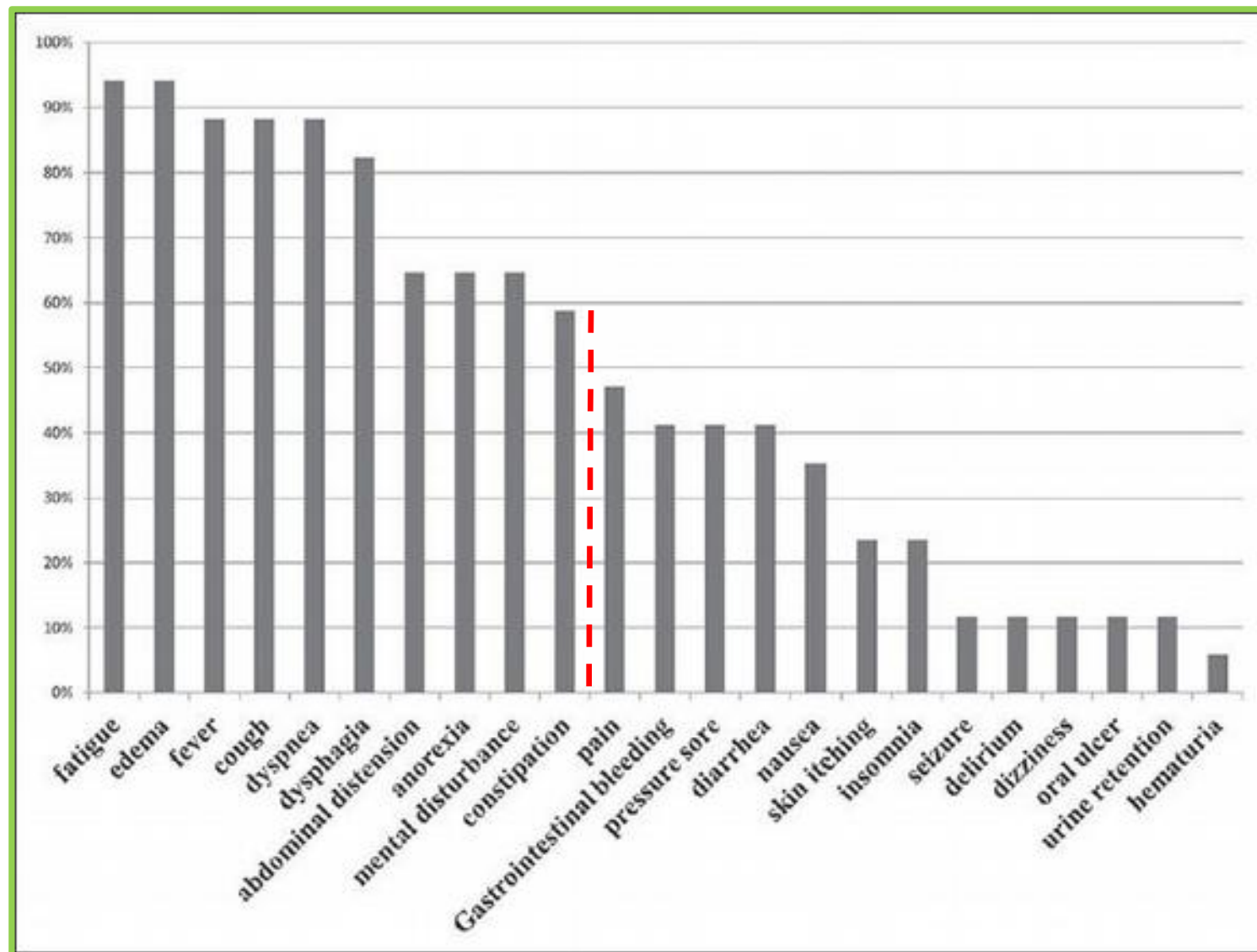
All Content Search Advanced Search

< Previous Article **October 2014** Volume 48, Issue 4, Pages 569-581.e1 Next Article >

Breathlessness, Functional Status, Distress, and Palliative Care Needs Over Time in Patients With Advanced Chronic Obstructive Pulmonary Disease or Lung Cancer: A Cohort Study

Yera Weingaertner, Dipl. Ges. Oek^{1,2}, Christine Scheve, Dipl. Pflegew³, Verena Gerdes, Dipl. Päd⁴, Michael Schwarz-Eywill, MD⁵, Regina Frenzel, MD⁶, Claudia Bauserwein, PhD, MD, MSc^{7,8}, Inge J. Higginson, BM, BS, BMedSci, PhD, FFPHM, FRCPP⁹, Raymond Voltz, MD¹⁰, Lena Herich, Dr. Rev. PoP¹¹, Stefan T. Simon, MD, MSc¹²⁻¹⁴ on behalf of the ILLPALLIATIV Project

Co signalizuje riziko blízkého konce u CHOPN?



J Res Med Sci. 2013 Jul; 18(7): 594–600.

PMCID: PMC3897028

PMID: [24516493](#)

Comparing end-of-life care in hospitalized patients with chronic obstructive pulmonary disease with and without palliative care in Taiwan

Wen-Chi Chou,^{1,2} Yu-Te Lai,¹ and Yu-Shin Hung²



Chronické respirační nemoci existují spolu

Annals of Internal Medicine
LATEST ISSUES CHANNELS CME/MOC IN THE CLINIC JOURNAL CLUB WEB EXCLUSIVES AUTHOR INFO

PREV ARTICLE THIS ISSUE NEXT ARTICLE
ORIGINAL RESEARCH | 1 OCTOBER 1996

Higher Risk of Lung Cancer in Chronic Obstructive Pulmonary Disease: A Prospective, Matched, Controlled Study

DAVID M. SKILLERUD, M.D.; KENNETH P. OFFORD, M.S.; R. DREW MILLER, M.D.
[Article, Author, and Disclosure Information](#)

FULL TEXT

Abstract

To assess the risk of lung cancer in patients with chronic obstructive pulmonary disease, we matched, on the basis of age, sex, occupation, and smoking history, 113 persons ("cases") who had a forced expiratory volume in 1 second (FEV₁) of 70% or less of predicted normal with 113 control persons who had an FEV₁ of 85% or more. All persons were observed from 1973-74 through 1984 for a diagnosis of lung cancer, death from lung cancer, and death from any cause. At entry, subjects had an age range of 45 to 59 years; men numbered 186 and women 40. Histologically proven lung cancer developed in 9 cases and in 2 controls, all men. The rate of development of lung cancer was significantly different in the two groups ($p = 0.024$): the 10-year cumulative percentage was 8.8% for cases and 2.0% for controls. Overall 10-year survival was estimated to be 74.0% for cases and 91.1% for controls ($p < 0.001$).

The Impact of Coexisting COPD on Survival of Patients With Early-Stage Non-small Cell Lung Cancer Undergoing Surgical Resection

Rihong Zhai, MD, PhD; Xiaojin Yu, PhD; Andrea Shafer, MPH; John C. Wain, MD, FCCP; and David C. Christiani, MD, FCCP

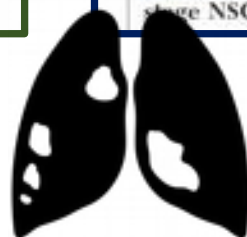
Background: COPD is a recognized risk factor for lung cancer, but studies of coexisting COPD in relation to lung cancer outcomes are limited. We assessed the impact of COPD on overall survival (OS) and progression-free survival (PFS) in patients with early-stage non-small cell lung cancer (NSCLC).

Methods: Patients (N = 902) with early-stage (stage IA-IIIB) NSCLC treated with surgical resection were retrospectively analyzed. The association of self-reported, physician-diagnosed COPD with survivals of NSCLC was assessed using the log-rank and Cox regression models, adjusting for age, sex, BMI, smoking, stages, and performance status.

Results: Among this cohort of patients with NSCLC, 330 cases had physician-diagnosed COPD, and 572 did not have COPD. The 5-year OS in patients with COPD (54.4%) was significantly lower ($P = .0002$) than that in patients without COPD (69.0%). The 5-year PFS rates for patients with COPD and without COPD were 50.1% and 60.6%, respectively ($P = .007$). Compared with patients without COPD, patients with COPD had increased risk of worse OS (adjusted hazard ratio [HR_{adj}] = 1.41, $P = .002$) and PFS (HR_{adj} = 1.67, $P = .003$). **The associations between COPD and worse survival outcomes were stronger in men and in squamous cell carcinoma (SCC).**

Conclusions: Coexisting COPD is associated with worse survival outcomes in patients with early-stage NSCLC, particularly for men and for SCC.

CHEST 2014; 145(2):346-353



Místo úmrtí na CHOPN versus BCA?



Table 1. Deaths from COPD and lung cancer in 14 countries during the year 2008 ($N = 5,568,827$)

Country	Abbreviations	Total number of deaths	COPD deaths (N)	COPD deaths (% of all deaths)	Lung cancer deaths (N)	Lung cancer deaths (% of all deaths)
Mexico	MX	528,093	21,804	4.6	6563	1.2
Korea	KR	247,757	7349	3.0	14,883	6.0
Total		5,568,827	245,345	4.4	320,591	5.8

npj | Primary Care Respiratory Medicine

www.nature.com/npjpcrm

ARTICLE OPEN

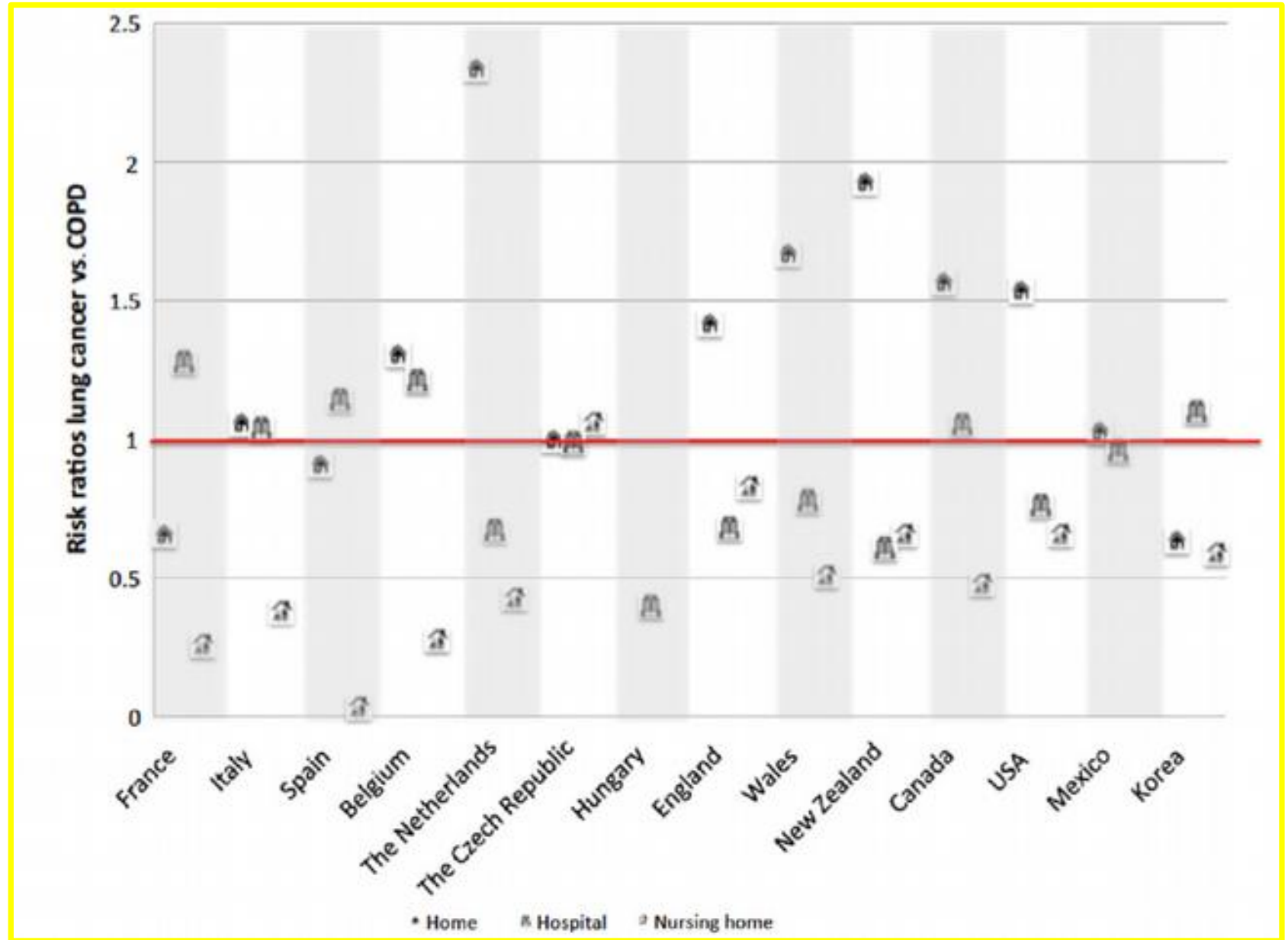
Differences in place of death between lung cancer and COPD patients: a 14-country study using death certificate data

Joachim Cohen¹, Kim Beernaert¹, Lieve Van den Block^{1,2}, Lucas Morin^{3,4}, Katherine Hunt⁵, Guido Miccinesi⁶, Marylou Cardenas-Turanzas⁷, Bregje Onwuteaka-Philipsen⁸, Rod MacLeod⁹, Miguel Ruiz-Ramos¹⁰, Donna M Wilson¹¹, Martin Loucka¹², Agnes Csikos¹³, Yong-Joo Rhee¹⁴, Joan Teno¹⁵, Winne Ko¹, Luc Deliens^{1,16} and Dirk Houttekier¹



Doma s paliací
= BCA

Nemocnice bez
paliace = CHOPN



Paliativní péče na JIP




Palliative Care for Patients Dying in the Intensive Care Unit with Chronic Lung Disease Compared with Metastatic Cancer

Crystal E. Brown, Ruth A. Engelberg, Elizabeth L. Nielsen, and J. Randall Curtis

Division of Pulmonary and Critical Care, Department of Medicine, Harborview Medical Center, University of Washington, Seattle, Washington

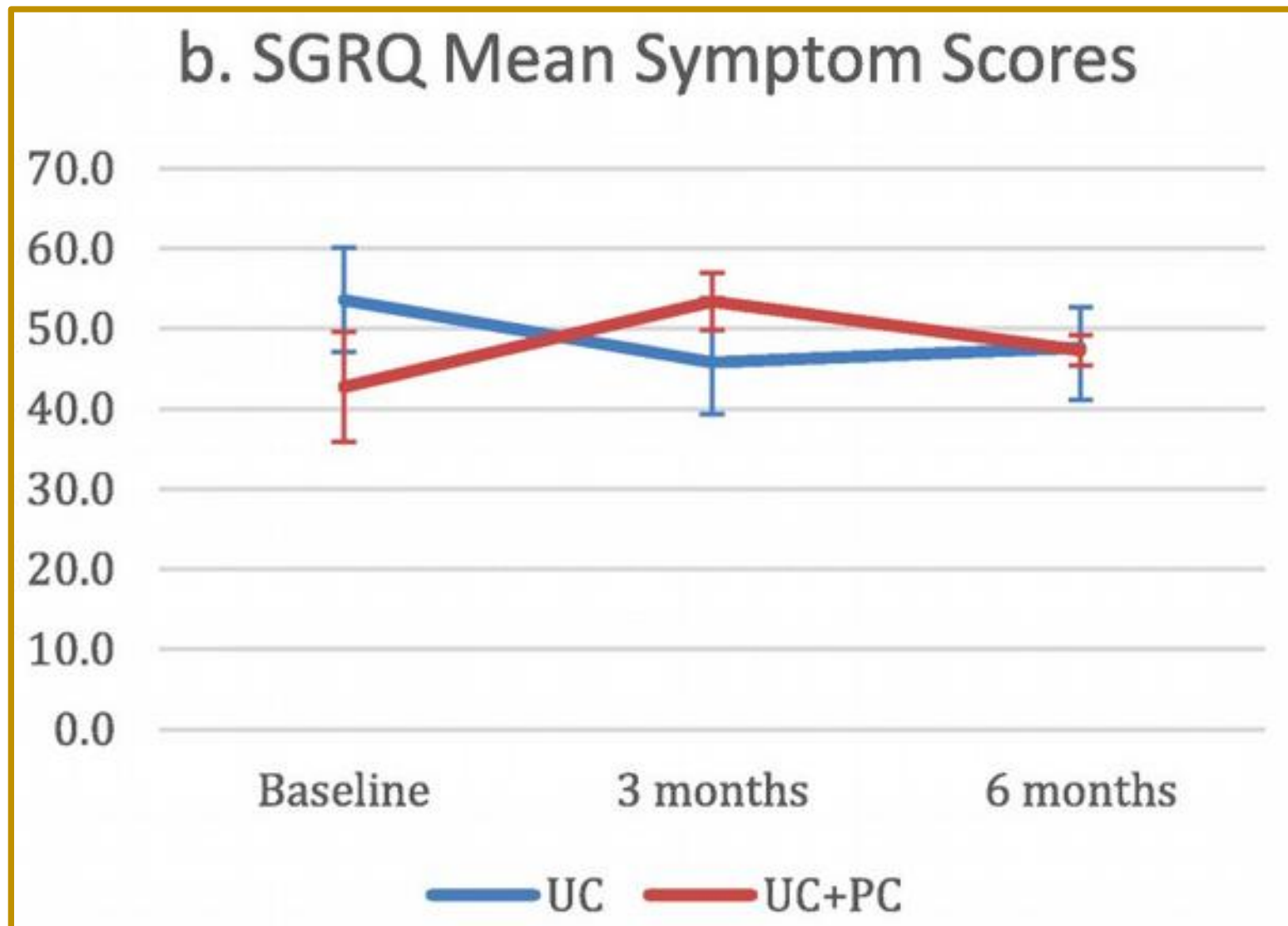
(PICO ID: 0000-0002-1223-7422 (C.E.B.))

Table 2. Palliative care processes and lengths of stay for patients dying in the intensive care unit

	ILD 	COPD 	Metastatic Cancer 
Processes of care, n (%n)			
No CPR 1 h before death	94.9 (75)	89.0 (527)	93.0 (147)
Pain assessed in day before death	75.9 (60)	81.6 (483)	91.1 (144)
DNR at time of death	78.5 (62)	81.8 (482)	87.3 (137)
Prognosis discussed	21.5 (17)	31.4 (186)	44.3 (70)
Palliative care consultation	12.7 (10)	8.8 (52)	10.8 (17)
Spiritual care involvement	50.6 (40)	44.2 (261)	44.3 (70)
Life support withheld/withdrawn	75.9 (60)	75.0 (442)	76.3 (119)
Presence of advance directive	63.3 (31)	62.2 (253)	58.9 (63)
Length of stay, median (IQR)			
Hospital LOS, d	7.0 (4.0–12.0)	6.0 (3.0–12.0)	6.0 (3.0–12.0)
ICU LOS, d	4.2 (1.6–8.6)	2.9 (1.1–7.4)	2.3 (0.9–5.3)



Jak (ne)funguje paliativní péče u IPF ?



Respiratory Research

[Home](#) [About](#) [Articles](#) [Submission Guidelines](#)

Research | [Open Access](#) | Published: 03 January 2020

The impact of palliative care on quality of life, anxiety, and depression in idiopathic pulmonary fibrosis: a randomized controlled pilot study

Katherine Janssen , Drew Rossiello, Qi Wang & Hyun Joo Kim

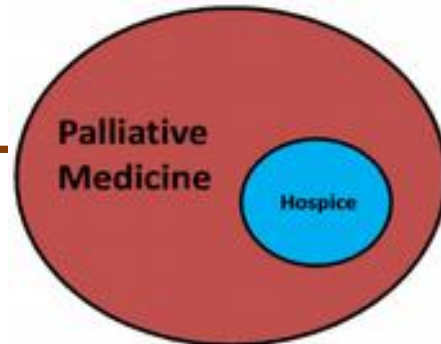
Respiratory Research 21, Article number: 2 (2020) | [Cite this article](#)

379 Accesses | 4 Altmetric | [Metrics](#)



S čím obecně přicházejí lidé v paliativním režimu?

Our study of 404 patients, reported 79 (19.5%, 95%CI: [16.0–23.7]%) being admitted with LSC limitations in the IMCU. This group of LSC limited patients presented with higher chronic and acute severity scores. The most common admission diagnosis of LSC limited patients was acute respiratory failure (51%). Non-invasive ventilation (NIV) was frequently used within this population (39%). Hospital mortality for LSC limited patients was high (53%) and associated with age (OR = 1.07, 95%CI: [1.01–1.13]), SOFA score (OR 1.29, 95%CI: [1.01–1.64]), and hypoxemic respiratory failure (OR 7.2, 95%CI: [1.27–40.9]). Withdrawal of LSC occurred in 19.5% of cases, often accompanied with terminal sedation with or without NIV removal (43.8%).



PLOS ONE

RESEARCH ARTICLE

Patients with limitation or withdrawal of life supporting care admitted in a medico-surgical intermediate care unit: Prevalence, description and outcome over a six-month period



Kdo určen k paliaci a nikoliv k maximální JIP péči ?

EUROPEAN CLINICAL RESPIRATORY JOURNAL
2018, VOL. 5, 1530029
<https://doi.org/10.1080/20018525.2018.1530029>



REVIEW ARTICLE

OPEN ACCESS Check for updates

Danish respiratory society position paper: palliative care in patients with chronic progressive non-malignant lung diseases

Kristoffer Marsaa^a, Svend Gundestrup^b, Jens-Ulrik Jensen^c, Peter Lange^c, Anders Løkke ^d,
Nassim Bazeghi Roberts^b, Saher Burhan Shaker^c, Anita Rath Sørensen^d, Ingrid Louise Titlestad^e,
Laura Hohwü Thomsen^f, Ulla Møller Weinreich ^g, Elisabeth Bendstrup ^{*d} and Torgny Wilcke^{*c}



Terminologie



Chronic lung failure is defined as a permanently reduced lung function and daily symptoms limiting daily activities despite optimal standard therapy. Palliative care can be started at this point.

Terminal lung failure is present when a patient with chronic lung failure meets the criteria of being terminally ill and when life expectancy is limited to weeks or a few months.

Imminently dying is when death is expected shortly i.e. within hours or a few days



CHOPN terminální plicní selhání



The patient is considered to be in the terminal phase of the disease when dependent on help from others because of dyspnea or general weakness over a period of several months, and when at least two of the following criteria are fulfilled:

- At least two hospitalizations because of a COPD exacerbation and/or one hospitalization requiring treatment with non-invasive ventilation (NIV) or a ventilator within the past 6 months.
- Need of long-term oxygen therapy (LTOT)
- Permanent NIV treatment at home
- Body mass index (BMI) <18 despite optimal nutrition, including nutritional supplementation
- Progressive or newly diagnosed severe comorbidity



ILD (zejm. IPF) terminální plicní selhání



The patient is considered to be in the terminal phase of the disease when dependent on help from others because of dyspnea or general weakness over a period of several months, and when fulfilling at least two of the following criteria:

- Two or more respiratory hospitalizations (e.g., due to infection or exacerbation) within the last year
- Peripheral oxygen saturation $<88\%$ at rest
- Reduced physical activity level (6-minute walk distance <212 m)
- Pulmonary hypertension
- Forced vital capacity (FVC) $<50\%$ of predicted or % FVC decline $>10\%$ of predicted or % predicted diffusion capacity for carbon monoxide (DLCO) decline $>15\%$ of predicted during the last 6 months
- Progressive or newly diagnosed severe comorbidity



Umírající respirační pacient



The patient is imminently dying when the disease has progressed to a stage where only symptomatic treatment is warranted. All other treatment possibilities are futile, and death is expected within hours or few days.



Závěr

- BCA častým důvodem paliativní péče vč. limitace přístupu k JIP
- Chronické nemaligní respirační choroby (CHOPN, IPF) redukuje QoL, zkracují život a způsobují symptomy obdobně jako BCA
- Chronické nemaligní respirační choroby mají omezený přístup k paliativní péči a méně predikovatelný časový průběh
- Přitom paliace je u těchto nemocí stejná jako u BCA
- Pečlivé posouzení dokumentace oš.l. NEZBYTNÉ (souvislosti)



Hledání biomarkerů signalizujících riziko smrti kvůli respiračnímu onemocnění

J Sex Med. 2015 Jul;12(7):1568-76. doi: 10.1111/jsm.12918. Epub 2015 Jun 23.

Erectile Dysfunction is Associated with Subsequent Cardiovascular and Respiratory Mortality in Cohort of 1,436 Chinese Elderly Men.

Chung RY¹, Chan D¹, Woo J², Kwok T², Leung JC¹, Lai FT¹, Wong SY¹.

⊕ Author Information

Abstract

INTRODUCTION: Erectile dysfunction (ED) is commonly shown to be associated with subsequent cardiovascular mortality, but not respiratory mortality, despite respiratory disease being highly prevalent among ED patients.

AIM: We aim to examine associations of ED with all-cause and cause-specific (i.e., cardiovascular and respiratory) mortality in a prospective cohort of 1,436 Chinese men, followed up from 2001 for a median of 11.5 years.

METHODS: ED measurement was based on a single question of four categories at the 4-year follow up.

MAIN OUTCOME MEASURES: Outcome measures include all-cause and cause-specific mortality (i.e., cardiovascular and respiratory mortality, classified according to the International Classification of Disease-version 10 [ICD-10]). Multivariable regression models estimated associations between ED and all-cause and cause-specific mortality, adjusting for the presence of chronic conditions, and socio-demographics and lifestyle factors. For each category of disease-specific mortality, subjects with the corresponding diseases and death cases from other causes were excluded. Cancer mortality was included for comparison.

RESULTS: Participants who were completely impotent had significantly increased risk of all-cause (HR = 1.63, 95% CI = 1.20-2.23), cardiovascular (HR = 3.94, 95% CI = 1.77-8.76) and respiratory mortality (HR = 3.16, 95% CI = 1.46-6.81) compared with non-impotent participants, adjusting for chronic conditions, and socio-demographics and lifestyle factors.

CONCLUSION: ED is significantly associated with subsequent all-cause mortality, possibly via its association with cardiovascular and respiratory mortality. Primary care practitioners should pay attention to ED patients' cardiovascular and respiratory risk profiles, which may benefit their prognosis.

© 2015 International Society for Sexual Medicine.

