

Letters to the Editor

Oxygen therapy and palliative care in patients with heart failure**Oxigenoterapia y cuidados paliativos en pacientes con insuficiencia cardíaca****To the Editor,**

We read with interest the consensus document and recommendations on palliative care in heart failure (HF) of the Heart Failure and Geriatric Cardiology Working Groups of the Spanish Society of Cardiology by García Pinilla et al.¹ The authors clearly state the importance of oxygen therapy in patients with hypoxemia and even for those without oxygen desaturation, and that simple measures such as fresh air (breezes or fans) directed toward the patient are also effective. The main aim in such patients is symptom control, and the provision of care that has been agreed upon with the involvement of the patient and their family, to ensure comfort and quality of life in the final stages of the disease.²

Often, however, conventional oxygen therapy does not provide effective control of dyspnea, especially during exacerbations, and the same may be said for home oxygen therapy, especially when HF is present along with sleep respiratory disorders. Over the past 30 years, new noninvasive methods have been developed for controlling dyspnea in patients with chronic cardiorespiratory disease: noninvasive mechanical ventilation (NIV), continuous positive airway pressure (CPAP) and high flow nasal cannula (HFNC) therapy are used in patients with acute respiratory failure (ARF) or exacerbation of chronic disease and for symptom control in all stages of palliative care, including end of life. In 2017, the European Respiratory Society and the American Thoracic Society recommended the use of NIV to reduce dyspnea in patients with advanced chronic disease of cancerous or other etiology.³ Some experts consider HFNC therapy the treatment of choice in hypoxemic ARF of any cause: in a recent publication by Shah et al.,⁴ the authors analyzed the use of HFNC in palliative care and concluded that it could be used in certain patients with ARF, including those with exacerbation of advanced HF, with better tolerability than NIV and a similar efficacy. Likewise, Tinelli et al.⁵ analyzed their experience in the use of HFNC in a case series in an elderly population (mean age, 84 years) in a clinical context of severe ARF, 61% having acute exacerbation of HF. They concluded that this technique is particularly indicated in this population due to its efficacy in controlling dyspnea and correcting hypoxia.⁵

We therefore conclude that both NIV with CPAP and HFNC therapy should be considered as noninvasive options for the control of dyspnea in patients with HF in any stage of palliative care, whether during exacerbations or as home therapy, and always in the interest of the patient's wellbeing, respecting their and their family's wishes.⁶

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