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Home Subcutaneous Infusion of Furosemide in Advanced Decompensated Heart Failure. Response



Infusión subcutánea domiciliar de furosemida en la insuficiencia cardíaca avanzada descompensada. Respuesta

To the Editor,

We are pleased to see, from the letter sent by Dr. Sancho-Zamora, that the *Revista Española de Cardiología* is expanding the interest in our specialty. We wish to clarify certain aspects.

The letter mentions the term “initial” used in the title.¹ This refers to our own experience with subcutaneous furosemide in chronic heart failure (CHF), a subject on which there is little literature and the published studies are small, even in palliative care.

In CHF, there is a slow, unpredictable deterioration that is interrupted by exacerbations. It is difficult to distinguish between the terminally ill patient requiring palliative care and the patient who can be stabilized, and CHF differs from diseases like cancer, in which the trajectory is linear and predictable. Less than 10% of patients with CHF receive palliative care,² and models of early palliative care are not being developed for patients with CHF in our population.³ It is generally the cardiologist who guides the patient to the end of his or her life after a number of nonfatal decompensations that deteriorate the quality of life. Our aim is to avoid this deterioration; however, Dr. Sancho-Zamora’s criticism is that the avoidance of hospital admissions resulted in economic benefits. This benefit should be confirmed by cost-benefit studies, which are far from what we wanted to achieve with our report. An improvement in quality of life is among the principles of palliative medicine, and by no means does this principle differ from ours.

Likewise, quality of life studies would be necessary to prove that the convenience of home care is “lost” because of weekly visits to the clinic. The use of surrogate parameters (functional class or absence of the need for hospital admission) is an impediment because a patient can become stabilized and improve without there being an improvement in his or her functional class. Of course, we did not allow patients who showed no improvement to be denied hospital admission.

With respect to the succinct methodological explanation due to matters of format, we would explain that our study population included patients with decompensated CHF without respiratory failure, hemodynamic instability, initial clinical picture, or definitive treatments that could change the prognosis.

Other subcutaneous treatments administered in the ambulatory setting, like prostanoids,⁴ are considered safe even if the puncture is not checked every day. In this respect, it is important to instruct patients on self-care and ensure that they can easily contact the unit. This, together with the very extensive experience in the use and safety of furosemide, led us to propose the off-label indication to resolve advanced clinical situations.

Multidisciplinary teams improve the treatment of CHF⁵ and, in our opinion, the systematic implementation of palliative care would be beneficial. Support for these initiatives on the part of scientific societies is essential to fostering interest in these issues, which at present are of minority interest in our specialty.

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Available online 5 February 2014

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