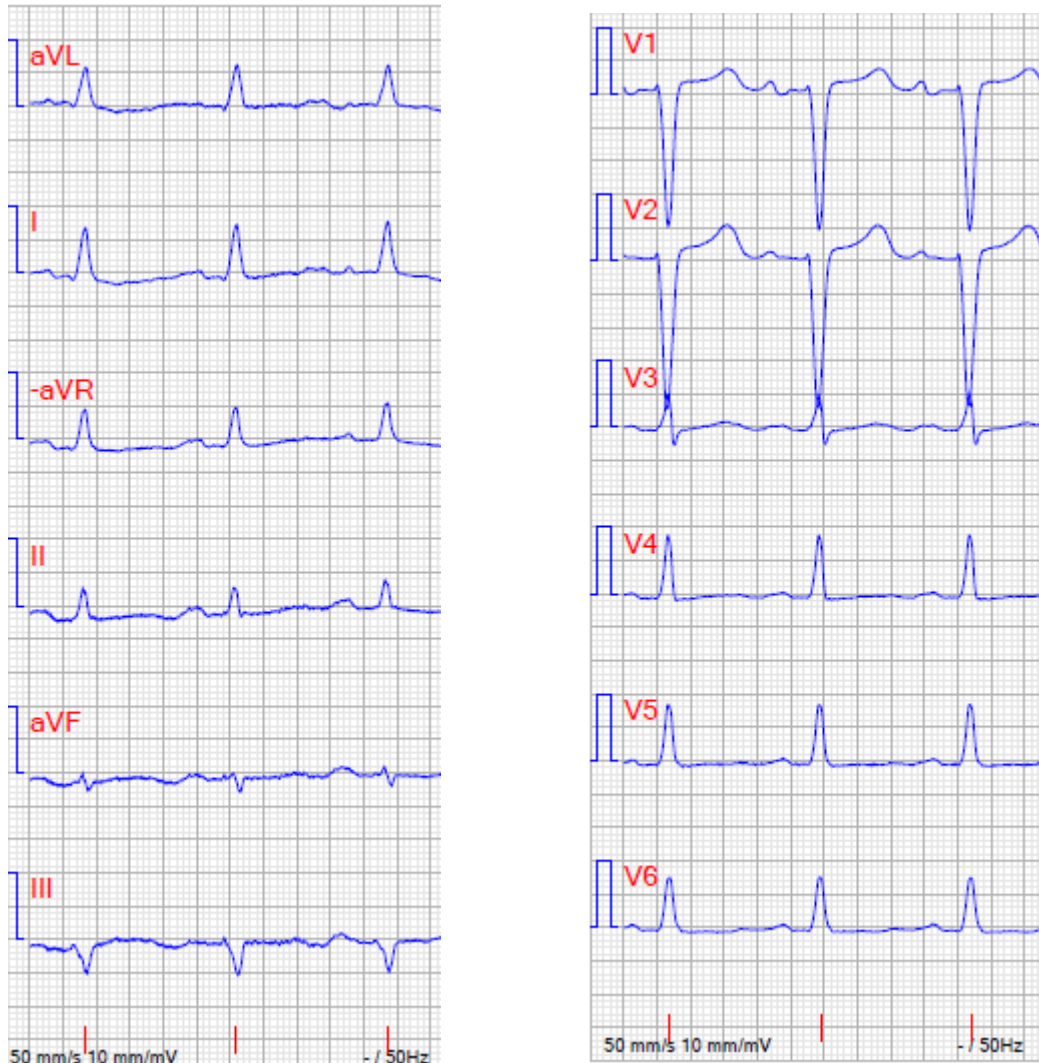


Case, heart failure, NSCPM August 2021

43 year old male, arriving the ER at a small hospital in northern Sweden. Severe dyspnoea, chest pains. BP 135/78, sat 76%, HR 130/min, RR 40/min, extremely exhausted.



Luckily a cardiologist is on call, echo: dilated almost still-standing left ventricle, EF 10-15 % at the most. Got morphine, furosemide, CPAP, O₂, ICU.

Next day a little better, still critical situation, 6 litres of fluid removed. Started on ACE-inhibitor. Tired a couple of months-1/2 a year prior to the acute situation, shortness of breath. Single, smoker, most often welder, no steady employer. Old parents contacted. On second day consultation with university hospital, 350 km away, wait and see, continue care as started.

After a 1-2 weeks increasing anxiety, increasing diffuse pain, tolerating beta-blocker and ace-inhibitor. We did not contact our palliative consultant team. **IF we had – what would you have done – do you think you can contribute in situations like this? Do you think it is appropriate to contact you? WHO-criteria full-filled? IAHPc-criteria?**

3 weeks post ER admitted to University Hospital for further investigation. NO clear cause of HF is found. Not ill enough for transplantation. Improves further. Walking around and strong enough to get angry. Frustrated. Problematic social situation evident. Expelled, more or less, from the ward.

Outpatient clinic try to have close contact with the patient, but often he doesn't show up, sometimes doesn't answer the phone either. Money-issues?

8 months later seeks ER, deteriorated, possibly because ended medication (ace-inhibitor, beta blocker, spironolactone, digoxin).

6 months later acute to another hospital, diuretics and back to work directly.

Another 7 months later acute to yet another hospital, furo, EF 20%, admitted back to me and shows up (!), apologetic. Proud, work is meaning in life, intelligent, still not accepting being the “normal nice” patient that the system would like him to be, I suspect both ADHD and PTSD. Indication for ICD – but I am really hesitant – Why? **What could a specialized palliative care unite contribute with?**

Exactly 4 years after first admittance for heart failure start of a 6 months long period of 5 ER visits, on the ward a couple of days, less and less tolerance for prior effective drugs, hypotension, still dyspnoea, collect fluid. Ascites. Slightly increased creatinine and hyperkalaemia. NYHA at least III often IV. **What is the answer to the Surprise-question? In which stage of the chronic Heart Failure trajectory is the patient?**

We have The Talk about what way to go – a little inconsequent, I thought then, he denies ICD-implantation, do not want to be controlled/monitored by anyone, but accepts further investigation for future transplantation. I sent him to University Hospital for tests, and he was further referred to Transplantation Unit in Gothenburg 1300 km away. **Do you think that you could have contributed in this situation? In what ways?**

4 months later, accepted for transplantation, forced to accept an ICD. Another 6 months later transplanted.

What happened then? Is this a patient that you would have accepted for support from your clinic? In what stage – from the start? Later? Do you think that you, if you were consulted, would have increased the patient's quality of life? Increased survival time? Decreased or increased the cost of care? Decreased or increased the quality of the patient's and the cardiologist's decisions? Do you meet patients like this? Do you have cardiologists in your team then? If an ICD needs to be switched off – who does it in your organisation? Do you think that you have to change something in your organisation, to better serve patients with heart failure (and other diagnosis from internal medicine, in a wide perspective?)