Too High Tech for Hospice? A Joint Collaboration to Facilitate Hospice Care for a Patient with Percutaneously Placed Ventricular Assist Device (TH321-A)

Anjali Grandhige, MD, Emory University Midtown Hospital, Decatur, GA

Objectives

- Appreciate the complex management of patients with congestive heart failure, in particular those at the end of life who have indwelling cardiac assist devices.
- Understand the interdisciplinary and multi-specialty collaboration required to facilitate a complex end stage congestive heart failure patient.
- Discuss the best approach to deceleration of an assist device with priority focus on patient and family comfort.

Background: 42 yo male with idiopathic cardiomyopathy, with ejection fraction 15%, presented to cardiac care unit (CCU) with cardiogenic shock and renal failure. Cardiology placed a percutaneous ventricular assist device (Impella) to support cardiac output but he showed no improvement. The decision to pursue hospice care was complicated by his dependency on the indwelling ventricular assist device.

Case Description: Patient was receiving maximal support in our CCU with inotropes, pressors, and percutaneously placed ventricular assist device (Impella) as a bridge for cardiac support until his own cardiac output improved. Attempts to wean Impella support resulted in exacerbation of patient's symptoms of severe dyspnea and anxiety and he therefore remained dependent on his Impella device. Palliative care met with the patient and family to discuss goals and options for end of life care. At our institution, the option of inpatient hospice was possible because of an imbedded six bed hospice unit in the hospital. However, the technical expertise required to care for a patient with an indwelling ventricular assist device (VAD) and decelerate this support complicated our ability to safely accommodate him in the inpatient unit (IPU).

Conclusion: Because of the medical and technical complexities of caring for this patient with an indwelling VAD, the CCU team offered to accompany him to the IPU. After bedside prayer with his family, his Impella settings were gradually decreased with corresponding titration in medications for comfort. Patient remained awake and conversive during deceleration. He died peacefully, surrounded by his family, four hours after the device was discontinued. His case highlights that as more technological advances are made in heart failure therapies, hospice and palliative care must also adapt to meet the needs of these complex patients and consider unique collaborative opportunities with cardiology to optimize the end of life experience for our patients.