

Evidencia Científica

¿Es posible en Cuidados Paliativos?

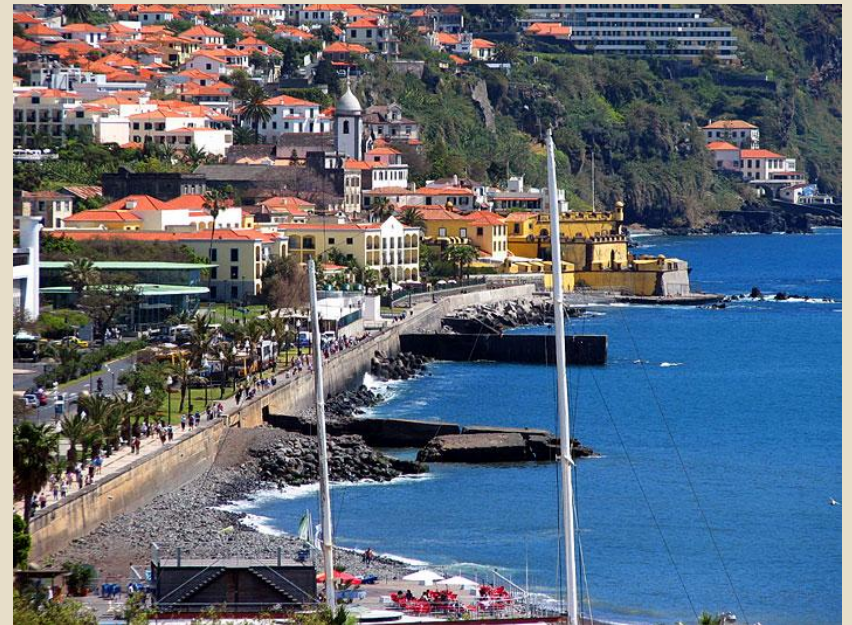


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¿Medicina Basada en la Evidencia o Medicina Basada en Pruebas?



La palabra “evidence” significa en inglés prueba, testimonio, indicio o señal. Sin embargo, se ha equiparado al término castellano “evidencia” que significa certeza clara, manifiesta y tan perceptible, que nadie puede racionalmente dudar de ella.

Por tanto, *rebajemos nuestras expectativas*. La absoluta evidencia suele estar muy alejada de la práctica clínica.

Medicina Basada en la Evidencia (MBE)



La medicina basada en la evidencia se define como la utilización consciente, explícita y juiciosa de la mejor evidencia científica disponible para tomar decisiones sobre el cuidado de pacientes individuales.

- Sackett et al. BMJ 1996; 312:71-2



Orígenes de la MBE



- La MBE surge como un **nuevo enfoque para la práctica de la medicina**. En el primer trabajo aparecido sobre MBE se proponía un cambio en el modelo o paradigma del aprendizaje y el ejercicio de la medicina y se formulaba el ideario del movimiento.
 - Evidence-Based Medicine Working Group. Evidence-based medicine. *JAMA* 1992;268:2420-5.
- Las metodologías empleadas para determinar la mejor evidencia fueron establecidas inicialmente por el equipo de McMaster conducido por los médicos David Sackett y Gordon Guyatt.

¿Objetivos claros o tramas encubiertas?



- El objetivo primordial de la MBE es el de que la **actividad médica cotidiana se fundamente sobre bases científicas** provenientes de estudios de la mejor calidad metodológica, en los que se refleje de forma fidedigna el estado actual de conocimientos. Algunas de las herramientas básicas sobre las que se asienta la metodología de la MBE son la **lectura crítica** de la literatura médica y la **revisión sistemática** de la evidencia existente.
- Las principales críticas se basan en que se trata de un método para reducir la libertad clínica y abaratar los costes o que resulta fácilmente manipulable por agentes externos.

Paradigma de la MBE como método para tomar decisiones clínicas



- Búsqueda y hallazgo de la literatura biomédica original y relevante. Lectura crítica de la misma y establecimiento de su nivel de evidencia para interpretarla correctamente. El razonamiento fisiopatológico tradicional se considera insuficiente para tomar decisiones clínicas.
- La experiencia clínica y el conocimiento sistemático del contexto de esa práctica.
- Las preferencias del paciente.

Etapas del Proceso de la MBE



- **Formulación de una pregunta** clínica clara y precisa a partir de un problema clínico dado.
- **Búsqueda de la literatura** de artículos originales relevantes y apropiados para el problema.
- **Evaluación crítica** de la validez y utilidad de los artículos encontrados (Nivel de evidencia).
- **Aplicación** de los resultados a la práctica clínica al paciente tomando en cuenta su contexto y sus preferencias

Nivel de Evidencia



El **nivel o grado de evidencia clínica** es un sistema jerarquizado, basado en las pruebas o estudios de investigación, que ayuda a los profesionales de la salud a valorar la fortaleza o solidez de la evidencia asociada a los resultados obtenidos de una estrategia terapéutica.

Niveles de Evidencia y Grados de Recomendación



- La estrategia de separar los niveles de evidencia y los grados de recomendación tuvo su origen en la **Canadian Task Force on Preventive Health Care** (CTFPHC, 2005). Las recomendaciones debían basarse en el peso de la evidencia presentado de forma jerárquica.
- Posteriormente diferentes instituciones y sociedades científicas también han contemplado estas diferencias en la apreciación de la calidad de las evidencias y han ido desarrollando diversos sistemas de clasificación para evaluar y estructurar la evidencia y establecer los grados de recomendación. Actualmente existen más de 100 sistemas de clasificación para valorar la calidad de la evidencia.

Sistemas de Clasificación de la Calidad de la Evidencia



- **Canadian Task Force on Preventive Health Care** (CTFPHC, 2003; CTFPHC, 2005; Harris RP, 2001).
- **US Preventive Services Task Force** (USPSTF). (actualmente integrada en la Agency for Healthcare Research and Quality-AHRQ) (Harris RP, 2001; USPSTF, 2003).
- **US Agency for Health Care Policy and Research** (actualmente denominada AHRQ) (AHRQ, 2005).
- **Centro de Medicina Basado en la Evidencia de Oxford** (OCEBM, 2005).
- **Scottish Intercollegiate Guidelines Network** (SIGN, 2008).
- **National Institute for Clinical Excellence** (NICE, 2008).



Niveles de Evidencia de SIGN (*Scottish Intercollegiate Guidelines Network*)

	Niveles de evidencia
1++	Metaanálisis de alta calidad, revisiones sistemáticas de ensayos clínicos o ensayos clínicos de alta calidad con muy poco riesgo de sesgo.
1+	Metaanálisis bien realizados, revisiones sistemáticas de ensayos clínicos o ensayos clínicos bien realizados con poco riesgo de sesgos.
1-	Metaanálisis, revisiones sistemáticas de ensayos clínicos o ensayos clínicos con alto riesgo de sesgos.
2++	Revisiones sistemáticas de alta calidad de estudios de cohortes o de casos y controles. Estudios de cohortes o de casos y controles con riesgo muy bajo de sesgo y con alta probabilidad de establecer una relación causal.
2+	Estudios de cohortes o de casos y controles bien realizados con bajo riesgo de sesgo y con una moderada probabilidad de establecer una relación causal.
2-	Estudios de cohortes o de casos y controles con alto riesgo de sesgo y riesgo significativo de que la relación no sea causal.
3	Estudios no analíticos, como informes de casos y series de casos.
4	Opinión de expertos.



Grados de Recomendación de SIGN (*Scottish Intercollegiate Guidelines Network*)

	Grados de recomendación
A	Al menos un metaanálisis, revisión sistemática o ensayo clínico clasificado como 1++ y directamente aplicable a la población diana de la guía; o un volumen de evidencia compuesta por estudios clasificados como 1+ y con gran consistencia entre ellos.
B	Un volumen de evidencia compuesta por estudios clasificados como 2++, directamente aplicable a la población diana de la guía y que demuestran gran consistencia entre ellos; o evidencia extrapolada desde estudios clasificados como 1++ ó 1+
C	Un volumen de evidencia compuesta por estudios clasificados como 2+ directamente aplicables a la población diana de la guía que demuestran gran consistencia entre ellos; o evidencia extrapolada desde estudios clasificados como 2++
D	Evidencia de nivel 3 ó 4; o evidencia extrapolada desde estudios clasificados como 2+

Metaanálisis



- Estudio basado en la **integración estructurada y sistemática de la información obtenida en diferentes estudios clínicos**, sobre un problema de salud determinado. Consiste en identificar y revisar los estudios controlados sobre un determinado problema, con el fin de dar una estimación cuantitativa sintética de todos los estudios disponibles.
- Al incluir un número mayor de observaciones, un metaanálisis tiene un poder estadístico superior al de los ensayos clínicos que incluye.
- Los dos principales **problemas metodológicos** de los metaanálisis de ensayos clínicos son:
 - ✦ La heterogenicidad entre los ensayos incluidos
 - ✦ El posible sesgo de publicación



Metaanálisis en Cuidados Paliativos

REVIEW

Efficacy and Safety of Opioid Agonists in the Treatment of Neuropathic Pain of Nonmalignant Origin Systematic Review and Meta-analysis of Randomized Controlled Trials

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IN THE UNITED STATES, AN ESTIMATED 2 million persons have neuropathic pain.¹ This may result from a large variety of insults to the peripheral or central somatosensory nervous system, including trauma, inflammation, ischemia, and metabolic and neoplastic disorders. Common examples of peripheral neuropathic pain include diabetic neuropathy, postherpetic neuralgia (PHN), and trigeminal neuralgia. Central neuropathic pain includes central poststroke pain, pain in multiple sclerosis, and post-spinal cord injury pain. The main clinical characteristics of neuropathic pain are continuous or intermittent spontaneous pain, typically described as burning, aching, or shooting in quality, and abnormal sensitivity of the painful site to normally innocuous stimuli such as light touch by garments, running water, or even wind (allodynia).² Neuropathic pain, like many other forms of chronic pain, often has negative effects on quality of life. Pharmacotherapy of neuropathic pain has generally involved the use of antidepressants or anticonvulsants, but even with the current generation of these drugs, effective analgesia is achieved in less than half of this group.

Context In the United States, an estimated 2 million persons have neuropathic pain that is often resistant to therapy. The use of opioids for neuropathic pain remains controversial, in part because studies have been small, have yielded equivocal results, and have not established the long-term risk-benefit ratio of this treatment.

Objective To assess the efficacy and safety of opioid agonists for the treatment of neuropathic pain based on published randomized controlled trials (RCTs).

Data Sources We searched MEDLINE (1966 to December 2004) and the Cochrane Central Register of Controlled Trials (fourth quarter, 2004) for articles in any language, along with reference lists of reviews and retrieved articles, using a combination of 9 search terms for RCTs with 32 terms for opioids and 15 terms for neuropathic pain.

Study Selection Trials were included in which opioid agonists were given to treat central or peripheral neuropathic pain of any etiology, pain was assessed using validated instruments, and adverse events were reported. Studies in which drugs other than opioid agonists were combined with opioids or opioids were administered epidurally or intrathecally were excluded.

Data Extraction Data were extracted by 2 independent investigators and included demographic variables, diagnoses, interventions, efficacy, and adverse effects.

Data Synthesis Twenty-two articles met inclusion criteria and were classified as short-term (less than 24 hours; n = 14) or intermediate-term (median = 28 days; range = 8–56 days; n = 8) trials. The short-term trials had contradictory results. In contrast, all 8 intermediate-term trials demonstrated opioid efficacy for spontaneous neuropathic pain. A fixed-effects model meta-analysis of 6 intermediate-term studies showed mean post-treatment visual analog scale scores of pain intensity after opioids to be 14 units lower on a scale from 0 to 100 than after placebo (95% confidence interval [CI], –18 to –10; $P < .001$). According to number needed to harm (NNH), the most common adverse event was nausea (NNH, 3.6; 95% CI, 2.9–4.8), followed by constipation (NNH, 4.6; 95% CI, 3.4–7.1), drowsiness (NNH, 5.3; 95% CI, 3.7–8.3), vomiting (NNH, 6.2; 95% CI, 4.6–11.1), and dizziness (NNH, 6.7; 95% CI, 4.8–10.0).

Conclusions Short-term studies provide only equivocal evidence regarding the efficacy of opioids in reducing the intensity of neuropathic pain. Intermediate-term studies demonstrate significant efficacy of opioids over placebo for neuropathic pain, which is likely to be clinically important. Reported adverse events of opioids are common but not life-threatening. Further RCTs are needed to establish their long-term efficacy, safety (including addiction potential), and effects on quality of life.


JAMA. 2005;293:3043–3052

www.jama.com

Revisión Sistemática



- Estudio que pretende recopilar toda la investigación sobre un tema determinado, evaluarla críticamente y obtener unas conclusiones que resuman el efecto de una intervención sanitaria.
- Metodología:
 - ✦ Formulación del problema
 - ✦ Localización y selección de los estudios
 - ✦ Evaluación de la calidad de los estudios
 - ✦ Proceso de extracción de datos
 - ✦ Análisis y presentación de resultados
 - ✦ Interpretación de los resultados



Revisión Sistemática en Cuidados Paliativos

Annals of Internal Medicine

CLINICAL GUIDELINES

Evidence for Improving Palliative Care at the End of Life: A Systematic Review

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Background: Many persons and their families are burdened by serious chronic illness in late life. How to best support quality of life is an important consideration for care.

Purpose: To assess evidence about interventions to improve palliative and end-of-life care.

Data Sources: English-language citations (January 1990 to November 2005) from MEDLINE, the Database of Abstracts of Reviews of Effects, the National Consensus Project for Quality Palliative Care bibliography, and November 2005 to January 2007 updates from expert reviews and literature surveillance.

Study Selection: Systematic reviews that addressed "end of life," including terminal illness (for example, advanced cancer) and chronic, eventually fatal illness with ambiguous prognosis (for example, advanced dementia), and intervention studies (randomized and nonrandomized designs) that addressed pain, dyspnea, depression, advance care planning, continuity, and caregiving.

Data Extraction: Single reviewers screened 24 423 titles to find 6381 relevant abstracts and reviewed 1274 articles in detail to identify 33 high-quality systematic reviews and 89 relevant intervention studies. They synthesized the evidence by using the Grading of Recommendations, Assessment, Development, and Evaluation (GRADE) classification.

Data Synthesis: Strong evidence supports treating cancer pain with opioids, nonsteroidals, radionuclides, and radiotherapy; dyspnea

from chronic lung disease with short-term opioids; and cancer-associated depression with psychotherapy, tricyclics, and selective serotonin reuptake inhibitors. Strong evidence supports multi-component interventions to improve continuity in heart failure. Moderate evidence supports advance care planning led by skilled facilitators who engage key decision makers and interventions to alleviate caregiver burden. Weak evidence addresses cancer-related dyspnea management, and no evidence addresses noncancer pain, symptomatic dyspnea management in advanced heart failure, or short-acting antidepressants in terminal illness. No direct evidence addresses improving continuity for patients with dementia. Evidence was weak for improving caregiver burdens in cancer and was absent for heart failure.

Limitations: Variable literature indexing for advanced chronic illness and end of life limited the comprehensiveness of searches, and heterogeneity was too great to do meta-analysis.

Conclusion: Strong to moderate evidence supports interventions to improve important aspects of end-of-life care. Future research should quantify these effects and address the generalizability of insights across the conditions and settings of the last part of life. Many critical issues lack high-quality evidence.

Ann Intern Med. 2008;148:147-159.
For author affiliations, see end of text.

www.annals.org



Revisión Sistemática en Cuidados Paliativos

Palliative Medicine 2008; 22: 938–948

Daily symptom burden in end-stage chronic organ failure: a systematic review

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Chronic diseases are nowadays the major cause of morbidity and mortality worldwide. Patients with end-stage chronic organ failure may suffer daily from distressful physical and psychological symptoms. The objective of the present study is to systematically review studies that examined daily symptom prevalence in patients with end-stage chronic organ failure, with attention to those that included patients with either congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD) or chronic renal failure (CRF). Thirty-nine articles (8 CHF, 7 COPD, 2 CHF and COPD, 22 CRF) have been included. The included studies used various study designs. There was a wide range of daily symptom prevalence that may be due to the heterogeneity in methodology used. Nevertheless, findings suggest significant symptom burden in these patients. This review highlights the need for further prospective and longitudinal research on symptom prevalence in patients with end-stage CHF, COPD and CRF to facilitate the development of patient-centred palliative care programs. *Palliative Medicine* (2008); 22: 938–948

Key words: chronic obstructive pulmonary disease; congestive heart failure; chronic kidney failure; palliative care; symptom burden

Estudios Experimentales: Ensayos Clínicos



- **Ensayo clínico controlado aleatorio:**
 - **Doble ciego:** Es el patrón oro en el diseño de estudios clínicos. Para lograr el doble ciego, la asignación del factor objeto de estudio no debe revelarse al médico ni al paciente, antes ni después de la aleatorización. Este diseño proporciona protección contra el sesgo en la asignación por parte del investigador y del sesgo en la evaluación de resultados tanto por el investigador como por el paciente.
 - **No ciego:** El investigador y a veces el paciente conocen a qué grupo pertenecen (control o experimental).
- **Ensayo clínico controlado no aleatorio:** Esta categoría incluye ensayos en los que la asignación de tratamientos se realiza sin aleatorización sino por otra regla como: fecha de nacimiento, número de historia clínica del paciente, día de la visita al consultorio, disponibilidad de cama, u otra estrategia que permitiera que el investigador conociera la asignación antes de obtener el consentimiento del paciente. Está demostrado que puede producirse un sesgo en la asignación de tratamientos en tales circunstancias.



Ensayos Clínicos en Cuidados Paliativos

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Methylnaltrexone for Opioid-Induced Constipation in Advanced Illness

Jay Thomas, M.D., Ph.D., Sloan Karver, M.D., Gail Austin Cooney, M.D., Bruce H. Chamberlain, M.D., Charles Kevin Watt, D.O., Neal E. Slatkin, M.D., Nancy Stambler, M.S., Alton B. Kremer, M.D., Ph.D., and Robert J. Israel, M.D.

ABSTRACT

BACKGROUND

Constipation is a distressing side effect of opioid treatment. As a quaternary amine, methylnaltrexone, a μ -opioid-receptor antagonist, has restricted ability to cross the blood-brain barrier. We investigated the safety and efficacy of subcutaneous methylnaltrexone for treating opioid-induced constipation in patients with advanced illness.

METHODS

A total of 133 patients who had received opioids for 2 or more weeks and who had received stable doses of opioids and laxatives for 3 or more days without relief of opioid-induced constipation were randomly assigned to receive subcutaneous methylnaltrexone (at a dose of 0.15 mg per kilogram of body weight) or placebo every other day for 2 weeks. Coprimary outcomes were laxation (defecation) within 4 hours after the first dose of the study drug and laxation within 4 hours after two or more of the first four doses. Patients who completed this phase were eligible to enter a 3-month, open-label extension trial.

RESULTS

In the methylnaltrexone group, 48% of patients had laxation within 4 hours after the first study dose, as compared with 15% in the placebo group, and 52% had laxation without the use of a rescue laxative within 4 hours after two or more of the first four doses, as compared with 8% in the placebo group ($P < 0.001$ for both comparisons). The response rate remained consistent throughout the extension trial. The median time to laxation was significantly shorter in the methylnaltrexone group than in the placebo group. Evidence of withdrawal mediated by central nervous system opioid receptors or changes in pain scores was not observed. Abdominal pain and flatulence were the most common adverse events.

CONCLUSIONS

Subcutaneous methylnaltrexone rapidly induced laxation in patients with advanced illness and opioid-induced constipation. Treatment did not appear to affect central analgesia or precipitate opioid withdrawal. (ClinicalTrials.gov number, NCT00402038.)

W Nortriptyline and gabapentin, alone and in combination for neuropathic pain: a double-blind, randomised controlled crossover trial

Ian Gilron, Joan M Bailey, Dongsheng Tu, Ronald R Holden, Alan C Jackson, Robyn L Houlden

Summary

Background Drugs for neuropathic pain have incomplete efficacy and dose-limiting side-effects when given as monotherapy. We assessed the efficacy and tolerability of combined nortriptyline and gabapentin compared with each drug given alone.

Methods In this double-blind, double-dummy, crossover trial, patients with diabetic polyneuropathy or postherpetic neuralgia, and who had a daily pain score of at least 4 (scale 0–10), were enrolled and treated at one study site in Canada between Nov 5, 2004, and Dec 13, 2007. 56 patients were randomised in a 1:1:1 ratio with a balanced Latin square design to receive one of three sequences of daily oral gabapentin, nortriptyline, and their combination. In sequence, a different drug was given to each randomised group in three treatment periods. During each 6-week treatment period, drug doses were titrated towards maximum tolerated dose. The primary outcome was mean daily pain at maximum tolerated dose. Analysis was by intention to treat. This trial is registered, number ISRCTN73178636.

Findings 45 patients completed all three treatment periods; 47 patients completed at least two treatment periods and were analysed for the primary outcome. Mean daily pain (0–10; numerical rating scale) was 5·4 (95% CI 5·0 to 5·8) at baseline, and at maximum tolerated dose, pain was 3·2 (2·5 to 3·8) for gabapentin, 2·9 (2·4 to 3·4) for nortriptyline, and 2·3 (1·8 to 2·8) for combination treatment. Pain with combination treatment was significantly lower than with gabapentin (−0·9, 95% CI −1·4 to −0·3, $p=0\cdot001$) or nortriptyline alone (−0·6, 95% CI −1·1 to −0·1, $p=0\cdot02$). At maximum tolerated dose, the most common adverse event was dry mouth, which was significantly less frequent in patients on gabapentin than on nortriptyline ($p<0\cdot0001$) or combination treatment ($p<0\cdot0001$). No serious adverse events were recorded for any patients during the trial.

Interpretation Combined gabapentin and nortriptyline seems to be more efficacious than either drug given alone for neuropathic pain, therefore we recommend use of this combination in patients who show a partial response to either drug given alone and seek additional pain relief. Future trials should compare other combinations to their respective monotherapies for treatment of such pain.

Funding Canadian Institutes of Health Research.

Introduction

First described by the International Association for the

than 60% and provide relief in only 40–60% of patients because of incomplete efficacy and dose-limiting side-

Lancet 2009; 374: 1252–61

Published Online

September 30, 2009

DOI:10.1016/S0140-

6736(09)61081-3

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Estudio de Cohorte



- Estudio epidemiológico, observacional, analítico, longitudinal prospectivo o retrospectivo, en el que se hace una **comparación de la frecuencia de enfermedad (o de un determinado desenlace) entre dos poblaciones**, una de las cuales está expuesta a un determinado factor de exposición o factor de riesgo al que no está expuesta la otra. Los individuos que componen los grupos de estudio se seleccionan en función de la presencia de una determinada característica o exposición. Estos individuos no tienen la enfermedad de interés y son seguidos durante un cierto periodo de tiempo para observar la frecuencia con que la enfermedad aparece en cada uno de los grupos.
- El objetivo de estos estudios es **medir causalidad** entre factores de riesgo y la enfermedad a estudiar.



Estudios de Cohorte en Cuidados Paliativos

Associations Between End-of-Life Discussions, Patient Mental Health, Medical Care Near Death, and Caregiver Bereavement Adjustment

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END-OF-LIFE DISCUSSIONS OFFER patients the opportunity to define their goals and expectations for the medical care that they want to receive near death. But these discussions also mean confronting the limitations of medical treatments and the reality that life is finite, both of which may cause psychological distress.¹ Studies suggest that physicians and patients are ambivalent about talking about death and often avoid these conversations.²⁻¹³ To date, however, research has not examined whether these discussions are associated with patients' psychological distress or medical care near death. With-

Context Talking about death can be difficult. Without evidence that end-of-life discussions improve patient outcomes, physicians must balance their desire to honor patient autonomy against a concern of inflicting psychological harm.

Objective To determine whether end-of-life discussions with physicians are associated with fewer aggressive interventions.

Design, Setting, and Participants A US multisite, prospective, longitudinal cohort study of patients with advanced cancer and their informal caregivers (n=332 dyads), September 2002-February 2008. Patients were followed up from enrollment to death, a median of 4.4 months later. Bereaved caregivers' psychiatric illness and quality of life was assessed a median of 6.5 months later.

Main Outcome Measures Aggressive medical care (eg, ventilation, resuscitation) and hospice in the final week of life. Secondary outcomes included patients' mental health and caregivers' bereavement adjustment.

Results One hundred twenty-three of 332 (37.0%) patients reported having end-of-life discussions before baseline. Such discussions were not associated with higher rates of major depressive disorder (8.3% vs 5.8%; adjusted odds ratio [OR], 1.33; 95% confidence interval [CI], 0.54-3.32), or more worry (mean McGill score, 6.5 vs 7.0; $P=.19$). After propensity-score weighted adjustment, end-of-life discussions were associated with lower rates of ventilation (1.6% vs 11.0%; adjusted OR, 0.26; 95% CI, 0.08-0.83), resuscitation (0.8% vs 6.7%; adjusted OR, 0.16; 95% CI, 0.03-0.80), ICU admission (4.1% vs 12.4%; adjusted OR, 0.35; 95% CI, 0.14-0.90), and earlier hospice enrollment (65.6% vs 44.5%; adjusted OR, 1.65; 95% CI, 1.04-2.63). In adjusted analyses, more aggressive medical care was associated with worse patient quality of life (6.4 vs 4.6; $F=3.61$, $P=.01$) and higher risk of major depressive disorder in bereaved caregivers (adjusted OR, 3.37; 95% CI, 1.12-10.13), whereas longer hospice stays were associated with better patient quality of life (mean score, 5.6 vs 6.9; $F=3.70$, $P=.01$). Better patient quality of life was associated with better caregiver quality of life at follow-up ($\beta=.20$; $P=.001$).

Conclusions End-of-life discussions are associated with less aggressive medical care near death and earlier hospice referrals. Aggressive care is associated with worse patient quality of life and worse bereavement adjustment.

JAMA. 2008;300(14):1665-1673

www.jama.com



Estudios de Cohorte en Cuidados Paliativos

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812

OCTOBER 15, 2009

VOL. 361 NO. 16

The Clinical Course of Advanced Dementia

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ABSTRACT

BACKGROUND

Dementia is a leading cause of death in the United States but is underrecognized as a terminal illness. The clinical course of nursing home residents with advanced dementia has not been well described.

METHODS

We followed 323 nursing home residents with advanced dementia and their health care proxies for 18 months in 22 nursing homes. Data were collected to characterize the residents' survival, clinical complications, symptoms, and treatments and to determine the proxies' understanding of the residents' prognosis and the clinical complications expected in patients with advanced dementia.

RESULTS

Over a period of 18 months, 54.8% of the residents died. The probability of pneumonia was 41.1%; a febrile episode, 52.6%; and an eating problem, 85.8%. After adjustment for age, sex, and disease duration, the 6-month mortality rate for residents who had pneumonia was 46.7%; a febrile episode, 44.5%; and an eating problem, 38.6%. Distressing symptoms, including dyspnea (46.0%) and pain (39.1%), were common. In the last 3 months of life, 40.7% of residents underwent at least one burdensome intervention (hospitalization, emergency room visit, parenteral therapy, or tube feeding). Residents whose proxies had an understanding of the poor prognosis and clinical complications expected in advanced dementia were much less likely to have burdensome interventions in the last 3 months of life than were residents whose proxies did not have this understanding (adjusted odds ratio, 0.12; 95% confidence interval, 0.04 to 0.37).

CONCLUSIONS

Pneumonia, febrile episodes, and eating problems are frequent complications in patients with advanced dementia, and these complications are associated with high 6-month mortality rates. Distressing symptoms and burdensome interventions are also common among such patients. Patients with health care proxies who have an understanding of the prognosis and clinical course are likely to receive less aggressive care near the end of life.

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N Engl J Med 2009;361:1529-38
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Estudios de Casos y Controles



- Estudios epidemiológicos, observacionales, analíticos, los que los **sujetos son seleccionados en función de que tengan (casos) o no tengan (control)** una determinada enfermedad, o en general un determinado efecto. Una vez seleccionados los individuos en cada grupo, se investiga si estuvieron expuestos o no a una característica de interés y se compara la proporción de expuestos en el grupo de casos frente a la del grupo de controles.
- Algunas características de estos estudios facilitan la introducción de sesgos. La adecuada selección de casos y controles es esencial.



Estudios Casos Controles en Cuidados Paliativos

Defining Cancer Patients As Being in the Terminal Phase: Who Receives a Formal Diagnosis, and What Are the Effects?

B. Aabom, J. Kragstrup, H. Vondeling, L.S. Bakkevig, and H. Stovring

A B S T R A C T

Purpose

Physicians either do not define cancer patients as being terminal, or their prognostic estimates tend to be optimistic. This might affect patients' appropriate and timely referral to specialist palliative care services or can lead to unintended acute hospitalization.

Patients and Methods

We used the Danish Cancer Register and four administrative registers to perform a retrospective cohort study in 3,445 patients who died as a result of cancer. We used the Danish "terminal declaration" issued by a physician as a proxy for a formal terminal diagnosis (prognosis of death within 6 months). The terminal declaration gives right to economic benefits and increased care for the dying. We investigated patient-related factors of receiving an explicit terminal diagnosis by logistic regression and then analyzed the effects of such a diagnosis on admission rate per week and place of death.

Results

Thirty-four percent of patients received a formal terminal diagnosis. Age of ≥ 70 years (odds ratio [OR], 0.44; 95% CI, 0.34 to 0.56; $P < .001$), women (OR, 0.81; 95% CI, 0.69 to 0.96; $P = .02$), hematologic cancer (OR, 0.20; 95% CI, 0.09 to 0.41; $P < .001$), and a less than 1-month survival time (OR, 0.10; 95% CI, 0.07 to 0.15; $P < .001$) were associated with a lesser likelihood of receiving a formal terminal diagnosis. Explicit terminal diagnosis was associated with lower admission rate and an adjusted OR of hospital death of 0.25 (95% CI, 0.21 to 0.29).

Conclusion

Women and the elderly were less likely to receive a formal terminal diagnosis. The formal terminal diagnosis reduced hospital admissions and increased the possibilities of dying at home.

J Clin Oncol 23:7411-7416. © 2005 by American Society of Clinical Oncology

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Submitted March 1, 2005; accepted June 3, 2005.

Supported by the Health Insurance Foundation (Grants No. 20010116 and 20010225), the Danish Research Foundation for General Practice (Grant No. 585-103250), and the Danish College of General Practitioners' Foundation for Research in General Practice 2001.

Authors' disclosures of potential conflicts of interest are found at the end of this article.

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0732-183X/05/2320-7411/\$20.00

DOI: 10.1200/JCO.2005.16.493



Niveles de Evidencia de OXFORD

Niveles de evidencia	Tipo de evidencia
Ia	Revisión sistemática con homogeneidad de estudios de nivel 1
Ib	Estudios de nivel 1
II	Estudios de nivel 2 Revisión sistemática de estudios de nivel 2
III	Estudios de nivel 3 Revisión sistemática de estudios de nivel 3
IV	Consenso, opiniones de expertos sin valoración crítica explícita
Estudios de Nivel 1	Cumplen: -Comparación enmascarada con una prueba de referencia ("patrón oro") válida -Espectro adecuado de pacientes
Estudios de Nivel 2	-Presentan sólo uno de estos sesgos: -Población no representativa (la muestra no refleja la población donde se aplicará la prueba) -Comparación con el patrón de referencia ("patrón oro") inadecuado (la prueba a evaluar forma parte del patrón oro o el resultado de la prueba evaluar influye en la realización del patrón oro -Comparación no enmascarada -Estudios casos control
Estudios de Nivel 3	Presentan dos o más de los criterios descritos en los estudios de nivel 2



Grados de Recomendación de OXFORD

Recomendación	Evidencia
A	1a ó 1b
B	2
C	3
D	4

Metodología para la Búsqueda de la Evidencia



1. Identificar la evidencia
2. Revisión y gradación de la evidencia
3. Selección de estudios relevantes
4. Evaluación de la calidad de los estudios
5. Síntesis de los resultados
6. Gradación de la evidencia
7. Elaboración de recomendaciones

Guías de Práctica Clínica



- Conjunto de instrucciones, directrices y recomendaciones, desarrolladas con el propósito de ayudar a los médicos a tomar decisiones, sobre la modalidad de atención más apropiada para unas circunstancias.
- Las guías resumen la evidencia científica y las cuestiones clave de un determinado tema, para facilitar a los clínicos la toma de decisiones y el juicio clínico.

Guía de Práctica Clínica sobre Cuidados Paliativos

GUÍAS DE PRÁCTICA CLÍNICA EN EL SNS
MINISTERIO DE SANIDAD Y CONSUMO



¿Por qué es difícil aplicar la evidencia clínica a los cuidados paliativos?



- La evidencia clínica otorga mucha importancia al **ensayo clínico aleatorizado (ECA)** o a la **revisión sistemática de ECA**. En muchas preguntas sobre cuidados paliativos la realización de ECA presenta dificultades metodológicas y éticas. Existen muchas áreas con ausencia de ECA, incluso para el tratamiento de síntomas habituales. Es especialmente llamativa la ausencia de evidencia sobre los cuidados paliativos en el paciente no oncológico.
- Aspectos como la calidad de vida, la comunicación, el confort o el bienestar del enfermo y de sus cuidadores son variables de resultado difíciles de valorar a través de un ECA convencional y, sin embargo, son probablemente las más importantes para los pacientes y cuidadores. La evidencia que se obtiene mediante la **investigación cualitativa** es muy relevante en este campo pero la metodología sobre su integración con los resultados de los estudios cuantitativos para formular recomendaciones está actualmente en discusión y desarrollo.
 - Aoun SM, Kristjanson LJ. Evidence in palliative care research: How should it be gathered? Med J Aust 2005 Sep 5;183(5):264-6.

Death and the Research Imperative

Callahan S. NEJM 2000



“La muerte no es el enemigo a batir... Hemos de aceptar la muerte en nuestra práctica clínica como algo inevitable...pero podemos cambiar el modo en que cuidamos de la gente al final de sus vidas y con ello reducir el sufrimiento que conlleva la fase final de la enfermedad...Una parte esencial para conseguir esto es **fomentar la investigación sobre la fase final de las distintas enfermedades y sobre los cuidados necesarios en cada paciente**. Este debe ser uno de los principales objetivos de la medicina en nuestros días”.



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80º CONGRESO

**Paalexco/5-8 mayo
A Coruña/2010**