

Palliative Care in Patients with Advanced Heart Failure: An Integrative Review

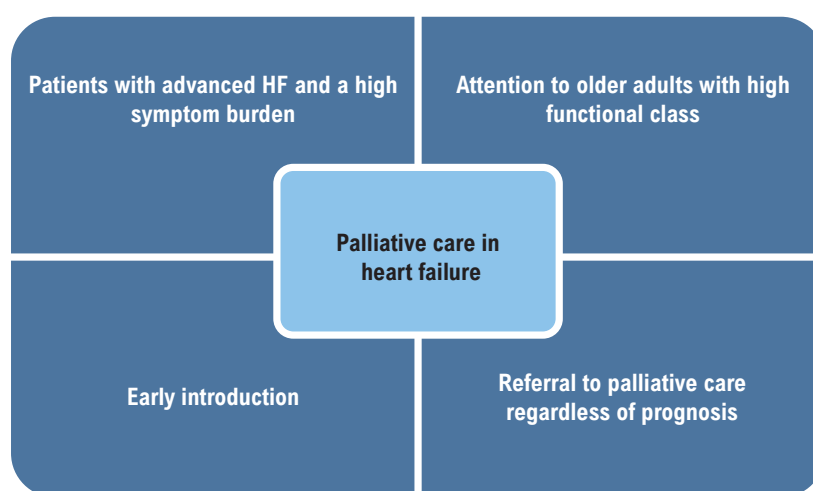
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Central Illustration: Palliative Care in Patients with Advanced Heart Failure: An Integrative Review



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Abstract

The term advanced heart failure (HF) defines a profile of patients with severe symptoms, recurrent decompensations, and cardiac dysfunction despite optimized therapy. The clinical course of advanced HF is difficult to predict, and identifying the appropriate moment for integrating palliative care (PC) remains a challenge.

To conduct an integrative review on the incorporation of palliative care in patients with advanced HF, highlighting the main differences in quality-of-life outcomes based on the most recent clinical studies.

The topic was defined and the guiding question formulated according to the PICO model. A systematic search was

performed for studies in Portuguese, Spanish, and English in the PubMed, LILACS, and SciELO databases, published in the last five years. The descriptors used were “heart failure,” “palliative care,” and “elderly patient.”

A total of 54 articles were identified; after applying the inclusion and exclusion criteria, 9 studies were selected. Patients with advanced HF present a high symptom burden (pain, dyspnea, fatigue, anxiety, and depression). Early introduction of PC, ideally at critical points in the disease trajectory, enables symptom relief, reduced hospitalizations, and improved communication between families and healthcare teams.

Early integration of palliative care should be understood as an essential strategy in the management of advanced heart failure. We emphasize the substantial gap that persists in the early introduction of palliative care in advanced HF, which requires coordinated, multidisciplinary action. It is essential that healthcare teams and public policies recognize PC as a fundamental and humanized component of advanced HF treatment, ensuring maximum comfort, dignity, and well-being for patients.

Keywords

Heart Failure; Palliative Care; Quality of Life

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Introduction

The term advanced heart failure (HF) defines a profile of patients with severe symptoms, recurrent decompensations, and cardiac dysfunction despite optimized therapy.¹ Patients who

remain severely symptomatic or in persistent New York Heart Association (NYHA) class IV may be candidates for advanced therapies such as heart transplantation (HT), mechanical circulatory support devices (MCSDs), or palliative care.^{1,2}

The characteristics of candidates for advanced HF therapies, such as HT and MCSDs, have changed substantially over the years, making the selection process more challenging and rigorous.²

Regarding HT, which is the treatment of choice for advanced HF, several strategies have been proposed to increase the number of effective donors. In fact, the United States has recently revised its organ allocation policy. Considering that post-transplant survival is worse in patients on preoperative ECMO compared with those supported by MCSDs, the new system assigns higher priority to patients with short-term mechanical circulatory support, whereas those with long-term MCSDs or on inotropes are placed in lower priority categories. In Brazil, similar changes have also been adopted in some states.

Another recent proposal is to replace body weight with predicted heart mass as the ideal tool for assessing size mismatch between donor and recipient.¹

Finally, PC has proven to be an indispensable strategy in the management of advanced HF, assuming an even more prominent role in patients who are not candidates for HT or MCSD. Intermittent use of ultrafiltration, peritoneal dialysis, or inotropes represents possible strategies in inpatient settings, day-hospital programs, or even at home, with the primary goal of symptom relief.

In the advanced stages of the disease, when there is refractoriness to optimized pharmacological therapy and recurrent decompensations, HF becomes a condition with a poor prognosis, characterized by high hospitalization rates, functional decline, and a substantial symptom burden. In this context, advanced heart failure shares features comparable to other terminal chronic illnesses, such as certain types of cancer, in terms of suffering, life limitation, and caregiver impact.^{3,4}

Given the clinical complexity and the incurable nature of end-stage HF, palliative care emerges as an essential approach to promote quality of life, symptom relief, and psychosocial support for both patients and their families. Early integration of palliative principles into the management of advanced HF enables more person-centered care, respecting individual values, preferences, and goals – particularly in situations requiring decision-making regarding the limitation of invasive interventions or the artificial prolongation of life.^{3,4}

According to the World Health Organization, palliative care consists of an active, comprehensive, and continuous approach aimed at the physical, psychological, social, and spiritual well-being of individuals with serious or life-threatening illnesses, promoting dignity and autonomy for patients and their families. It is indicated regardless of diagnosis, prognosis, age, or stage of disease, whenever clinical or psychosocial needs are not fully met.^{3,4}

PC plays a fundamental role in the prevention of dysthanasia, understood as the artificial prolongation of life or

therapeutic obstinacy – that is, the practice of using medical interventions to maintain the life of a terminally ill patient even when there are no reasonable prospects of recovery, thereby prolonging existence at the cost of continuous suffering. The goal of this approach is to avoid unnecessary interventions that do not provide real benefit to the patient.

The palliative philosophy is centered on comfort, dignity, and respect for the patient's wishes, offering physical, emotional, and spiritual support. In this way, it seeks to ensure that care is proportional, humane, and aligned with the individual's values and life goals.⁴⁻⁷

Objective

To conduct an integrative review on the incorporation of palliative care in patients with advanced HF, demonstrating the main differences in quality-of-life outcomes based on the most recent clinical studies.

Methods

This study is an integrative review aimed at synthesizing the available evidence regarding the implementation of PC in patients with advanced HF, with a focus on improving quality of life. First, the study topic was defined and the guiding question was formulated using the PICO framework. Subsequently, inclusion and exclusion criteria were established, a database search was performed, and studies were pre-selected and selected based on the screening of titles, abstracts, and keywords to assess their relevance to the guiding question. When the information provided in the abstract was insufficient, the full text was reviewed (Figure 1).

A systematic search was conducted across multiple databases. Inclusion criteria comprised randomized clinical trials, meta-analyses, and systematic reviews published in Portuguese, Spanish, or English in the PubMed, LILACS, and SciELO databases within the last five years. The descriptors used were: “heart failure”, “palliative care”, and “elderly patient”. Exclusion criteria included experimental studies, editorials, reviewer communications, and duplicate publications across databases.

All records identified were exported to the Rayyan reference manager, which was used for organizing and screening the studies. Subsequently, four reviewers conducted the title screening, and any disagreements were resolved by consensus among the researchers. Data collection took place between June 2025 and September 2025.

Afterward, the selected studies were organized into a table using a synthesis matrix for the critical analysis of the included studies (Table 1). Based on the interpretation and synthesis of the results, the findings were compared with the theoretical framework in a descriptive manner, allowing for the assessment of the applicability of the integrative review and the development of the discussion, to meet the objective of this study.

Finally, a document was prepared containing the synthesis of the evidence identified and the final construction of the integrative review.

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Population	Patients with advanced heart failure
Intervention	Integration of palliative care
Control	Standard curative therapeutic treatment
Outcome	Improvement in the quality of end-of-life care

Figure 1 – PICO strategy applied to define the guiding research question.

Results

A total of 54 articles were identified in the PubMed, SciELO, and LILACS databases. After screening according to the inclusion and exclusion criteria, nine studies were selected: four from PubMed, three from SciELO, and two from LILACS. The included publications ranged from current guidelines on palliative care in HF to systematic reviews addressing this topic (Figure 2).

Table 1 presents the main articles included in this integrative review, highlighting the relevant topics addressed in each study.

Discussion

PC in patients with advanced HF is associated with a significant improvement in quality of life and greater control of symptoms at the end of life. In line with recent studies, it is evident that the integration of PC should not be understood as an exclusively end-of-life measure, but rather as an integral component of the overall management of HF, especially in stages III and IV of the NYHA classification (Central Figure).

One of the main points identified is the high symptom burden in these patients, frequently characterized by dyspnea, fatigue, pain, anxiety, and depression. The study by Ochoa et al.,¹³ for example, shows that the prevalence of PC needs is twice as high in patients with NYHA III/IV HF and nearly twice as high in individuals over 70 years of age.¹

International consensus statements and systematic reviews, such as that by Marcondes-Braga et al.,⁴ demonstrate that the combination of optimized therapy and PC reduces the frequency and intensity of these symptoms, in addition to promoting greater satisfaction among both patients and their families. This reinforces the importance of comprehensive disease management, including symptom control and psychosocial support from the moment advanced HF is diagnosed.

The study by Santos et al.⁵ supports this perspective by highlighting that PC provides clear benefits for physical and psychological well-being, even without altering mortality—an essential aspect in opposing dyshthanasia. By prioritizing relief of suffering and improvement in quality of life, PC directly

counters the futile prolongation of life.⁵ However, the data also show that referrals to PC still occur late, often limited to the final days of life, which significantly restricts the potential benefits of this approach.

In a recent Delphi study, important criteria were established by expert consensus for referring patients with HF to PC. These criteria included a combination of patient characteristics (severe left ventricular dysfunction, cardiorenal syndrome, cardiac cachexia), treatment-related factors (inability to tolerate goal-directed medical therapy, need for mechanical circulatory support, frequent readmissions, consideration of advanced therapies), symptoms (severe physical or emotional symptoms, significant functional limitation), and social/psychological characteristics (difficulty making decisions, limited social support, mental health challenges, and the need for advance care planning). Although still limited, the available evidence also supports the use of PC interventions even during hospitalization for acute HF.^{15,16}

The difficulty in determining the appropriate moment to initiate PC is an important issue highlighted in the studies. Although prognostic tools and clinical criteria help guide this decision, the unpredictability of HF progression remains a major barrier. This uncertainty, combined with the predominance of the traditional biomedical model and the cultural resistance to associating PC with therapeutic abandonment, contributes to the persistence of dyshthanasia practices, with the use of invasive measures that add little in terms of survival or comfort. As noted by Santos et al.,³ there is a prevailing perception – shared by medical teams, patients, and their families – that PC is an approach reserved exclusively for the “end of life.” This misconception creates cultural and clinical resistance that leads to delayed referral.³

The qualitative studies analyzed also emphasize that the implementation of PC requires structural and educational changes. There is a limited availability of specialized services, a lack of standardized protocols, and constraints related to healthcare system funding, especially in Latin American countries. Moreover, the lack of professional knowledge about palliative principles and the absence of multiprofessional training hinder the early integration of this approach. However, the study by Santos et al.³ points to a potential solution: the development of clinical protocols to systematize

Table 1 – Main characteristics of the studies included in the integrative review

Article title	Year of publication Database	Type of study	Authors	Relevant topics
Palliative care in heart failure	2022 Pubmed	Systematic review	Isabel O. Cruz Céu Rocha Hugo M. Oliveira ⁸	The decision to refer patients with HF to PC should, in fact, be independent of prognosis and should not be considered a last-line treatment. The focus must be on improving symptoms and enhancing patients' quality of life. The high one-month mortality rate suggests that patients were referred to the palliative care team at very advanced stages of frailty and heart failure
OThe right time for palliative care in heart failure: a review of critical moments for palliative care intervention	2020 Pubmed	Systematic review	Samuel D. Slavin Haider J. Warraich ⁹	Referrals from cardiologists to palliative care have decreased in recent years and, when they do occur, they are often made very late – frequently within the last three days of life. This is despite evidence from randomized trials showing that such interventions provide multiple benefits, including improvement in NYHA functional class, reduction of symptoms and hospitalizations, and enhancement of quality of life
Consensus document and recommendations on palliative care in heart failure of the Heart Failure and Geriatric Cardiology Working Groups of the Spanish Society of Cardiology	2020 Pubmed	Positioning of Medical Societies	José Manuel García Pinilla Pablo Díez-Villanueva Ramón Bover Freire ¹⁰	Recent clinical trials and meta-analyses have shown that interdisciplinary PC interventions in patients with advanced heart failure are more beneficial than conventional treatment in terms of quality of life, anxiety, depression, and spiritual well-being. However, the vast majority of patients report that they have not discussed end-of-life issues. Thus, palliative sedation is considered a therapeutic tool for the management of refractory symptoms that have not responded to treatment and that cause discomfort or suffering at the end of life.
Continuous care is essential from the onset	PubMed 2019	Scope review	Francesc Formiga Oscar Farinas Balaguer ¹¹	The clinical course of patients with heart failure is difficult to predict, and therefore correctly identifying those in the terminal phase of the disease is often complex. Several tools exist, including risk calculators and prognostic factors. Despite these advances, such tools remain imperfect when used to support the decision-making process.

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Emerging Topics in Heart Failure: Contemporaneous Management of Advanced Heart Failure	SciELO LILACS 2020	Integrative review	Fabiana G. Marcondes-Braga Jefferson L. Vieira João D. S. Neto Gustavo Calado Sílvia M. Ayub-Ferreira Fernando Bacal Nadine Clausell ⁴	Patients with persistent severe HF (NYHA class IV) or significant comorbidities should be evaluated for heart transplantation, mechanical circulatory support, or PC. PC remains essential for patients who are not eligible for heart transplantation or left ventricular assist device, aiming to provide symptom relief and improve quality of life.
Qualitative Study of the Limits and Possibilities of Integrating Palliative Care in Heart Failure	LILACS 2023	Observational study	Karoliny A. Santos Liana A. C. Trotte Audrei Telles Tereza C. Guimarães Eunice Sá Marcelle M. da Silva ³	The factors identified as barriers to the integration of palliative care in heart failure include the severity of signs and symptoms, poor quality of life, lack of knowledge about the disease and its progression, late initiation of treatment, and the risk of discontinuity due to socioeconomic factors. In addition to issues related to the biomedical model, limited investment in palliative care within the healthcare network, as well as difficulties in clinical judgment and decision-making regarding whom to palliate, how, and when, also contribute to these challenges
Palliative care and its impact on the quality of life in heart failure patients	LILACS 2022	Observational study	Adriana M. E. Gonzalez Emilio J. E. Chávez ¹²	The European Association for Palliative Care recommends to include palliative care in the management of heart failure to prevent hospital readmissions and improve symptom control, with the goal of enhancing quality of life. Studies involving patients with advanced heart failure (NYHA III–IV) show that PC, when combined with usual care, improves quality of life and reduces symptoms such as depression, anxiety, and dyspnea. Overall, PC provides clear benefits for the physical and psychological well-being of these patients, even though it does not change mortality.
Prevalence and characteristics of patients with heart failure needing palliative care	LILACS 2021	Estudo observacional	Luisa F. A. Ochoa Valentina González-Jaramillo Clara Saldarriaga Mariantonia Lemos Alicia Krikorian John J. Vargas Xavier Gómez-Batiste Steffen Eychmüller ¹³	The prevalence of palliative care needs was twice as high in NYHA III/IV patients compared with NYHA I/II patients, and nearly twice as high in patients over 70 years of age compared with those under 70. Compared with –NECPAL patients, +NECPAL patients showed worse quality of life, more severe shortness of breath, fatigue, drowsiness, and pain, as well as a greater number of psychosocial problems.
Signs and Symptoms of Heart Failure Patients in Palliative Care: A Scoping Review	SciELO LILACS 2022	Revisão de escopo	Paola P. Jardim Ana Carla D. Cavalcanti Alyne S. Borges Paula Vanessa P. Flores Camila A. Rosa ¹⁴	Regarding the signs and symptoms presented by patients with heart failure receiving palliative care, there was a high prevalence of pain, dyspnea, fatigue, nausea, depression, sleep disturbances, anxiety, and edema, in addition to a wide range of other less frequent symptoms

HF: heart failure; PC: palliative care; NYHA: New York Heart Association

Identification	Articles identified in the database n = 54		
	Pubmed n = 11	Scielo n = 12	LILACS n = 31
Screening	Duplicate articles excluded n = 6		Records excluded due to topic inadequacy n = 10
	Articles excluded after title and abstract screening n = 29		
Eligibility	Total number of articles excluded n = 45		
Inclusion	Pubmed n = 4	Scielo n = 2	LILACS n = 3

Figure 2 – Articles included in the review.

eligibility criteria for PC. This is a highly relevant point, as standardizing the assessment process may help overcome clinical uncertainty, facilitate referrals to PC services, and ensure that patients receive appropriate care at the right time.

Valvular heart disease is highly prevalent in the elderly population. Despite this high prevalence of valvular heart disease (VHD), referral to PC remains low. Although the management of VHD has been transformed by percutaneous therapies, the condition continues to be associated with high morbidity and mortality. For example, high-risk patients undergoing transcatheter aortic valve replacement still have a 47% mortality rate at two years, even in the context of advanced age, multiple comorbidities, and frailty, and 17% of survivors continue to experience NYHA class III symptoms.^{17,18}

Another relevant point concerns patients with implantable cardioverter-defibrillators. Individuals who receive shocks from their devices may experience significant psychological distress, including post-traumatic stress disorder. The sudden and unexpected nature of these shocks can intensify fear and anxiety, profoundly affecting quality of life and overall well-being. PC can assist in aligning patient values and goals with complex decision-making related to invasive procedures and device management, including implantation, replacement, removal, or deactivation.^{19,20}

Data suggest that deactivation of the implantable cardioverter-defibrillator occurs in only 30% to 40% of patients

with terminal illness, while 10% to 20% receive a shock from the device in the last month of life. The use of PC is also low: only 9% to 14% of patients with these devices receive a palliative care consultation before death.^{19,20}

Although the literature does not show a significant impact of PC on reducing mortality, there is consensus regarding its positive effects on quality-of-life indicators, symptom control, reduction of hospital readmissions, and improved communication in decision-making. These findings reinforce that the goals of PC go beyond longevity, focusing instead on dignity, relief of suffering, and respect for individual preferences.

As highlighted by Formiga et al.,¹¹ continuous care is essential from the moment HF is diagnosed. The implementation of a multidisciplinary approach – involving physicians, nurses, psychologists, social workers, and other professionals – is fundamental for successful integration, as the care of patients with advanced HF extends beyond the strictly biological dimension.

Another relevant point concerns patients who survive a cardiorespiratory arrest (CRA). Mortality rates among those admitted after CRA range from 50% to 80%; another 8% to 10% survive but present some degree of moderate residual disability. The sudden and often catastrophic nature of CRA, combined with the uncertainty surrounding neurological prognosis, creates an ideal context for the

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integration of palliative care (PC) to support caregivers and legal decision-makers in the decision-making process.²¹

Therefore, the findings of this review reinforce the need to reorient care in advanced HF toward a more humanized, interdisciplinary, and patient-centered model, in which PC is incorporated early and continuously. This process requires both the strengthening of public policies and the engagement of healthcare teams and society, in order to overcome cultural and structural barriers that still delay its effective implementation.

Limitations

The main limitation of this study is the heterogeneity of the articles included in the review. It is important to note that this remains a relatively scarce topic in the literature, which leads to difficulties and potential selection bias. We sought to minimize this bias by removing duplicate articles, carefully reviewing studies across databases, and resolving disagreements by consensus. Even so, many of the available studies are reports of national experiences, which limits the generalizability of the findings. Nevertheless, they represent an important starting point for encouraging broader and more specific research in this population.

Conclusion

Patients with advanced HF benefit from the integration of PC into routine clinical management, showing positive outcomes particularly in reducing the risk of dyspnea. We highlight the substantial gap that still persists in the early introduction of PC in advanced HF, which requires coordinated and

collaborative action among different healthcare professionals. Thus, it is essential that healthcare teams and public policies recognize PC as a fundamental and humanized component of the treatment of advanced HF, ensuring maximum comfort, dignity, and well-being for patients.

Author Contributions

Conception and design of the research and Critical revision of the manuscript for intellectual content: Bispo IGA; Acquisition of data and Analysis and interpretation of the data: Silva CV, Pereira GTG, Lopez VPM; Writing of the manuscript: Pereira GTG, Lopez VPM.

Potential Conflict of Interest

No potential conflict of interest relevant to this article was reported.

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Ethics Approval and Consent to Participate

This article does not contain any studies with human participants or animals performed by any of the authors.

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