



End-of-life therapy: palliative care instead of palliative scare

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In this issue of *memo*, a series of short reviews update important issues concerning end-of-life care of patients suffering from incurable diseases. Palliative care aims to provide symptom control, relieve anxiety and depression and also decrease stress levels of patients and their relatives.

Jahn-Kuch [1] gives an overview on how to avoid late cancer-directed therapy in terminally ill cancer patients. This remains challenging, as survival rates have improved in recent decades while treatment of cancer patients near death is becoming increasingly aggressive [2]. However, there is evidence that late cancer-directed therapy leads to an unfavorable patient outcome [3]. In regard to cancer patients in a palliative care setting, close interdisciplinary cooperation and a broad knowledge of therapeutic options and targeted therapies seems to be mandatory for palliative care physicians.

Following the recommendation of the American Society for Clinical Oncology (ASCO), advanced cancer patients should have contact with an interdisciplinary palliative care team within eight weeks of diagnosis concurrent to anticancer treatment [4]. Besides symptom management, palliative care skills include conversations about the future as well as end-of-life discussions. It is a well-known fact that patients want to know about their life expectancy, while a consultation about this sensitive topic only takes place in a few cases [5].

To synopsise symptom management as well as soft skills, Kreye [6] provides insight into the top ten things that must be known about end-of-life therapy. The topics include the early integration of palliative care,

the management of delirium, death rattle and dyspnea, palliative sedation, psilocybin as a potential drug to reduce the fear of death and denial as a coping mechanism. Also, deprescribing drugs is mentioned as an important skill in palliative care.

Roider-Schur [7] focuses on palliative sedation for delirium management. With a prevalence that ranges from 20 to 40% and up to 90% in the end-of-life phase, delirium is a frequent neurocognitive impairment in patients suffering from cancer. Palliative sedation is known not to shorten life and should be regarded as a measure for symptom management in case of refractory symptoms. It is not a treatment to hasten death nor a kind of slow euthanasia [8, 9].

My contribution [10] focuses on the management of breathlessness in chronic and advanced lung diseases. I tried to provide some principles that may be helpful in the daily routine. Those principles might sound simple, but from a palliative point of view they are very much worth considering.

Listen to your patients, they will tell you what they need (Cicely Saunders).

Conflict of interest E.K. Masel declares that she has no competing interests.

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