care power of attorney and considering general values, goals, and preferences), which may or may not include the provider's recommendations for these personal choices.

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In Reply — Serious Illness Conversation

To the Editor: We would like to thank Drs Lycan and Taylor for their thoughtful comments and interest in our recent article describing our Three-Stage protocol.1 Drs. Lycan and Taylor accurately point out the implicit challenges we face in providing prognosis (Stage 1) and recommending treatment options (Stage 3).2 Acknowledging their concerns, we actually find that this protocol is useful because it can be applied to all types of serious illness conversations throughout the illness trajectory.

First, we want to emphasize that “prognosis” is not limited to sharing a concrete time frame. We agree that it is frequently difficult to share the prognosis, and in many cases it may not be appropriate — or possible — to state the life expectancy (eg, early-stage cancer). “It is too early for me to tell you what will happen” could be a prognostic statement in this situation. When cancer advances and becomes incurable, however, we may need to adjust our prognostic statement: “At some point, the cancer will progress and you will become sick,” or “We are hoping we can slow down the progression of cancer, but we are also worried we cannot.” The goal of Stage 1 is to make patients aware that their disease will cause some form of future limitation, whether it is of time, function, and/or unpredictability of the disease. These statements will help patients prepare for possible future negative events. Importantly, we also use invitation statements and elicit the patient’s information-sharing preferences earlier in Stage 1 to avoid disclosing the prognosis in a way that is not compatible with the patient’s wishes.

Secondly, when we emphasize the importance of making recommendations in Stage 3, this does not necessarily mean de-escalation of care intensity or code status. Even with serious illnesses such as incurable cancer, when the patient’s goal is “to prolong life with decent quality of life” and we think this is achievable, we should recommend anti-cancer treatments if available. We agree that it is better to reinforce patients’ sense of control, which is why, in Stage 2 (eliciting goals of care), we should listen to them carefully and fully explore their goals and values. The recommendation we provide must suit the goals of the patient in the context of this particular point in their disease; in fact, for patients with early-stage disease, our recommendation may be to pursue intensive care unit—level care as the next best step in achieving our goal. Additionally, while we make a recommendation, we do not force it. When patients do not like the recommendation, we explore the reasons and correct their misunderstandings, if any. For this reason, we described Stage 3 as “negotiating” treatment options.

Lastly, the take-home point of this three-stage protocol is that we always need to clear Stage 2. Even when you skip sharing the prognosis in Stage 1 altogether because patients are afraid to hear the prognosis, you have to ask Stage 2 questions (“What do you enjoy?” “What makes your life meaningful?””). In a study of heart failure patients who required left ventricular assist devices, the patients who could articulate their unique “unacceptable condition” received less intensive care at the end of life.3 When possible, we should explore patients’ goals, values, and fears surrounding possible negative situations in the future.

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To the Editor: Sudden cardiac death (SCD) affects approximately 1 in every 7 adults in the United States.\(^1\) A similarly high burden is reported globally, with estimates of 4 to 5 million cases of SCD per year.\(^2\) Hypertension increases the risk of SCD, suggesting that blood pressure (BP) is an important risk factor for SCD.\(^3\) With advancing age, there are increases in systolic BP and slight decreases in diastolic BP, resulting in a widening of pulse pressure (PP) concomitant with negligible changes in mean arterial pressure (MAP). Increases in PP are attributable to large artery stiffening and have been shown to be more predictive of adverse cardiovascular outcomes than other BP components, particularly in middle-aged and older adults.\(^4,5\) It remains unclear whether PP predicts the risk of SCD in the general population. The purpose of this study was to investigate whether PP is associated with the risk of SCD, independently of MAP, in middle-aged men.

Participants were part of the Kuopio Ischaemic Heart Disease Risk Factor Study, which is a prospective population-based study designed to investigate risk factors for cardiovascular disease (CVD) and related outcomes in a randomly selected sample of men from eastern Finland. At baseline, examinations were conducted on 2682 men (82.9% of the potential eligible) who resided in Kuopio, Finland, or its surrounding rural communities between March 1, 1984, and December 31, 1989. Complete data were available on 2356 participants (aged 42-60 years) at baseline in this analysis.

Resting systolic and diastolic BPs were measured using a sphygmomanometer and are expressed as mean values from 6 different measurements (3 while supine, 1 while standing, and 2 while sitting). Brachial PP was defined as the difference between systolic and diastolic BPs. The participants were divided into PP quartiles as follows: quartile 1, less than 37 mm Hg; quartile 2, 37 to 43 mm Hg; quartile 3, greater than 43 to 51 mm Hg; and quartile 4, greater than 51 mm Hg.

An SCD was defined as a fatal event that occurred within 1 hour after the onset of symptoms or within 24 hours when autopsy data did not reveal a noncardiac cause of SCD or after a fatal cardiac arrest following successful resuscitation from ventricular tachycardia or ventricular fibrillation. Diagnostic classification of events was based on symptoms, electrocardiographic findings, cardiac enzyme elevations, autopsy findings (80% of the SCDs), and history of coronary heart disease combined with relevant clinical and electrocardiographic findings.\(^6\) Data on SCDs were derived from interviews with family members,