About the "surprise question"

We congratulate Downar and colleagues[1] for their systematic review of the sensitivity and specificity of the "surprise question," a tool widely publicized to identify patients in the last year of life.

We recently completed a systematic search and analysis. We searched for "surprise question" in five electronic databases (MEDLINE, Embase, PsycINFO, Cochrane Library and CINAHL) and identified two additional full papers (Lilley and colleagues, and Gómez-Batiste and colleagues)[2,3] with values of 82.2% and 93.7% for sensitivity, and 48.7% and 26.4% for specificity, respectively. Downar and colleagues[1] included six published abstracts; we believe that these should be considered with caution, because results can change following peer (including statistical) review.

Critically though, we believe that there are errors in two of the original studies. In Downar and colleagues' review,[1] one has been corrected (Moroni and colleagues 2014)[4] and the other is not corrected at the present date (Feyi and colleagues 2015).[5] Having identified these, we had written to the authors for corrected data, which they provided. The former study had transposed sensitivity and specificity; for the latter, the corrected values are slightly higher: 72.7% (sensitivity) and 83.5% (specificity) rather than 66.7% and 77.9%.

Despite these differences, we support the conclusion of Downar and colleagues[1] that the surprise question performs poorly to modestly, often with a high proportion of false positives. Before including such questions in clinical practice, tools to assess prognosis should be subject to appraisal as screening instruments. They are also likely to become unreliable over time as new treatments emerge, changing the disease trajectory. Those studying their results or conducting systematic reviews need to carefully ensure that sensitivity and specificity are correctly analyzed and reported. However, closeness to death is not the best indicator of need for palliative care. Patients can have severe problems or symptoms in earlier stages of illness,[6,7] when much can be done to improve quality of life.[8] Therefore, patient need, not prognosis, should be the driver for referral to palliative care.

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