Everyone who is among the living has hope ...

Ecclesiastes 9:4

Luiza Kent-Smith - Faculty of Nutrition, Univ. of Porto - LKS@fcna.up.pt
The Question?

Is Nutrition Support needed / justified in Palliative Care ???

Presentation Outline

- Palliative Care
  - Definition (WHO 2002)
  - Principles
- Nutrition in Palliative care
  - What changes?
  - EAPC guidelines
  - Nutrition support options
**Definition**

**Palliative Care:**

- Is the total care of patients whose conditions do not respond to curative treatment.

- Goal - to promote the best possible QOL for patients and their families

(Who 2002)

---

**WHO states that Palliative Care:**

- Affirms life and regards dying as a normal process;

- Neither hastens nor postpones death;

- Provides relief from pain and other distressing symptoms.
Palliative Care

- Physical care
- Symptom management
- Psychosocial & spiritual care
- Multidisciplinary team
- Patient & family care decisions

(© WHO 2002)

What Changes in Palliative Care?

The aims of nutritional support change with disease progression.

Patients must receive food/nutrition but the emphasis is on QOL and symptom relief rather than active nutritional therapy.
Palliative Nutrition Support

<table>
<thead>
<tr>
<th>Dilemas</th>
<th>Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td>Individuality</td>
</tr>
<tr>
<td>Ethical</td>
<td>Consent</td>
</tr>
<tr>
<td>Moral</td>
<td>Benefits/Discomfort</td>
</tr>
</tbody>
</table>

Multidisciplinary approach

Constant follow-up (Power, 1999)

Nutrition Support in Palliative Care?

Health Care Team Perspective:

- Clinical, ethical & moral dilemmas
- Doubts & uncertainties
- Different opinions
- Lack of a systematic approach
- Need for trained professionals
Nutrition Support in Palliative Care?

**Patient’s Perspective:**

- Disease progression
- Symptoms
- Progressive nutritional deterioration
  - Weight loss
  - Changes in body image
- Altered food intake
- The meaning of “Food”

**The meaning of “Food”**

Food can serve many needs:

- **Physical**
- **Comfort/nurture**
- **Tradition/culture**
- Socialization
- Psychological

Food is life
In advanced disease

Food means:

+ Hope
+ Comfort
+ Pleasure

- Guilt
- Fear
- Pain

(Gallagher, 1989)

Overall Objective:

Nutrition Support

Palliative Care

- Maintain/improve QOL
- Control symptoms
Guidelines Palliative Nutrition Support

- Clinical assessment
- Oncological staging
- Symptoms

- Nutritional assessment
- Psychological attitude
- Food intake
- G.I. Function

- Survival:
  - Short
  - Medium
  - Long

Special needs

Decision

(EAPC, 1996)

Nutritional Assessment

- Advanced metastatic cancer (n=352)
- No single measurement is adequate!
  - CRP – increased in 74%
  - Severe fat deficiency by TSF in 51%
  - High muscle mass loss by AMA in 30%
  - BMI – normal or increased
  - Wt loss in 87% (≥ 10% Wt loss in 71%)
  - Anorexia in 81%
  - Early satiety in 69%

- Bioimpedance (body composition & BCM)

(Sarhill et al, 2003)
Validated Assessment Tools

- Edmonton Symptom Assessment Scale
- Symptom Distress Scale
- Palliative Performance Scale
- QLQ – C30 (EORTC)
- Support Team Assessment
- Symptom Distress Scale

Nutrition Support Options

Oral Feeding
Oral Supplements
Enteral Nutrition
Parenteral Nutrition
Hydration

Confort Foods
As Long as Food = Pleasure

Comfort Foods...

Oral Feeding

Practical Approach

- Individual preferences
- “à la carte” meals
- Appealing presentation
- Personalized portions
- Adapted consistency
- Diet counselling
- Flexible timetables
- Agreeable environment
- Family involvement
- Staff participation

Re-think and adapt hospital feeding routines

(Gallagher, 1989)
(ADA 1997)
Barriers to Eating

- Difficulty chewing / swallowing
  → Adapt consistency
- Nausea / vomiting
  → ↑ CHO & cool clear liquids
- Anorexia / early satiety
- Overwhelmed by portion size
- Xerostomia
- Taste and smell changes
  → Chewing gum, sour candy, ice chips, stews, sauces
  → Luke warm bland foods

Oral Supplementation

- Allows for:
  - Increased energy intake
  - Increased protein intake

(Frequent bolus
Reduced volume
Easy ingestion)

(Power, 1999)
**Enteral Nutrition**

- **Recommended:**
  - severe dysphasia
  - severe anorexia
  - decreased food intake

- **Clinical indications:**
  - head & neck / esophagus tumours
  - inoperable *fistulae*
  - esophageal obstructions

(Boyd, 1994)

---

**Enteral Nutrition**

- **Adjust:**
  - delivery method
  - volume
  - duration of delivery

- **Changes with:**
  - disease progression
  - new symptoms
  - interruption (?)

(Boyd, 1994)
Parenteral Nutrition

- Selected patients
- Inoperable intestinal obstruction
- Prolonged survival
- Risks vs. Benefits

Limited Use:
- Increased complications
- Difficulties in Home Care implementation
- Cost
- Ethical Dilemas

(Torelli, 1999)
(Faisinger, 1997)
**Advanced Gynaecological Cancer** *(n=33)*

**PCU hospitalization**

- **Motive**
  - Symptom control – 92.3 %
  - Terminal care – 7.7 %

- **Duration (7 – 98 dias)**
  - mean = 31; median = 19
  - 46.1% discharged
  - 53.8% deceased

(Porto Cancer Centre)

---

**Nutritional Support** *(n=33)*

<table>
<thead>
<tr>
<th>NS - 78%, 40 interventions =1.5/patient</th>
</tr>
</thead>
</table>

- Comfort foods (CF) – 50%
- CF + Oral supplements (OS) – 12.5%
- Low Residue Diets + OS – 10%
- Clear liquids – 7.5%
- Parenteral nutrition + CF – 7.5%
- Hydration - ?

(Porto Cancer Centre)
**Hydration - (against)**

- Comatose patients don’t experience thirst
- Hydration may prolong death
- Decreased diuresis – less mobilization
- Dehydration - ↓ consciousness ↓ suffering
  - ↓ GI secretions - ↓ vomiting
  - ↓ Lung secretions - ↓ coughing
  - ↓ Oedema - ↓ ascites

MacDonald & Faisinger 1996

---

**Hydration - (in favour)**

- ↑ patient comfort
- No evidence that prolongs death
- Dehydration – delirium & renal failure
- Good in opioid toxicity delirium
- Good in hypercalcemia

MacDonald & Faisinger 1996
Hydration 1st approach

Decrease thirst by:

- Keeping mouth wet
- Keeping lips lubricated
- Good oral care
- Small sips of liquids
- Sucking iced water or fruit

Hydration Methods

- Enteral route
- Parenteral route
  - peripheral
  - central
- Subcutaneous route (hypodermoclysis)

(Fainsinger & Bruera 1994)
Subcutaneous Hydration

- Easier access
- Easier & safer home use
- Subcutaneous sites last up to 7 days
- Easily turned off and disconnected
- Facilitates mobility

Fainsinger et al. (1994)

Ordering Hypodermoclysis

For Rehydration
- Fluid type: Normal saline
- Rate: 70-100 mL/h (c.i.)

To ↑ or = fluid intake
- Fluid type: 2/3 glucose (5%)
- 1/3 saline
- Rate: 40-80 mL/h c.i.
- Overnight clysis – 1L
- Bolus: 500 mL 2xd / 1 h

Fainsinger et al. (1994)
**Monitoring Hydration**

- Urine output
- Blood pressure
- Mental status
- Subcutaneous sites (reactions/infection)
- Ensure no over-hydration:
  - 1L 3 or 4 x week
  - 1L / d

Fainsinger et al. (1994)

---

**Research Perspectives**

Evaluate the Impact

- Nutritional Status
- Nutritional Support

Survival & QOL
**Conclusion...**

- Palliative Nutritional Support, responds to the needs and wishes of patients and family

We need to adapt and adjust

- Knowledge
- Rotines and professional outlook

To The Palliative Care Philosophy

(Rápin, 1993)

---

**The Answer?**

Nutrition Support is an integral part of Palliative Care