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Education and Clinical Practice Programme

Session: Nutrition and Palliative Care

Nutritional Management

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Nutritional Management in Palliative Care

Everyone who is among the living has hope …

Ecclesiastes 9:4

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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

Dilemas	Solutions
■ Clinical	■ Individuality
■ Ethical	■ Consent
■ Moral	■ Benefits/Discomfort

Multidisciplinary approach

Constant follow-up

(Power, 1999)

Nutrition Support in Palliative Care ?

Health Care Team Perspective:

- ✓ Clinical, ethical & moral dilemas
- ✓ 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

In advanced disease

Food means:

+	−
Hope	Guilt
Confort	Fear
Pleasure	Pain

(Gallagher, 1989)

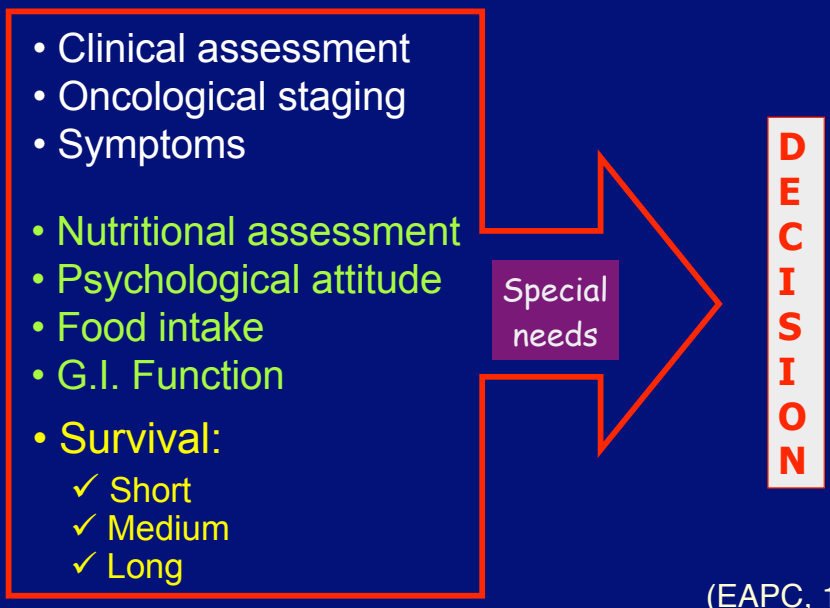
Overall Objective:

Nutrition Support

Palliative Care

- Maintain/improve QOL
- Control symptoms

Guidelines Palliative Nutrition Support



(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)

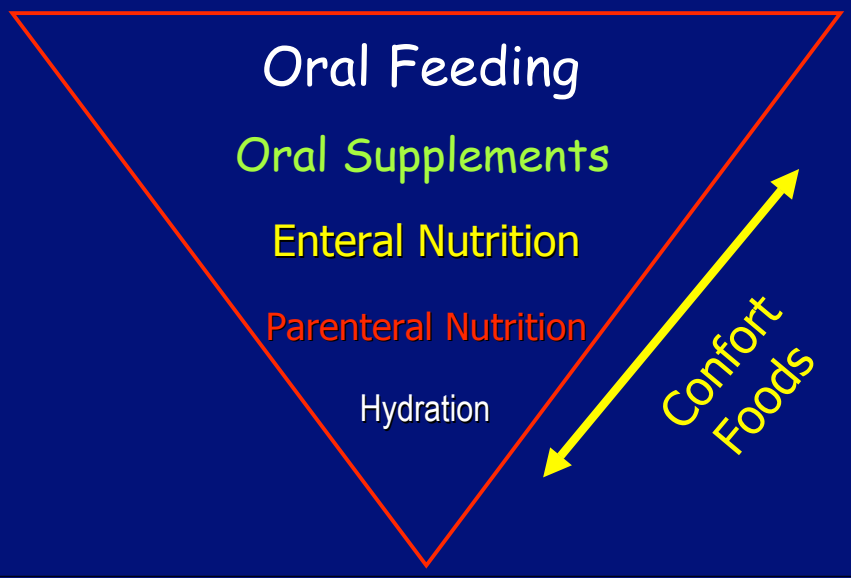
(Sarhill et al, 2003)

Validated Assessment Tools

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

WWW.albertapalliative.net

Nutrition Support Options



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

} Food preferences, small frequent meals, ↑ Kcal foods & supplements

- Xerostomia → Chewing gum, sour candy, ice chips, stews, sauces
- Taste and smell changes → 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

(Torelli, 1999)
(Faisinger, 1997)

Parenteral Nutrition

- 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)

NS - 78%, 40 interventions =1.5/patient

- 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