

Journal Watch

TO FEED OR NOT TO FEED: IS THAT THE RIGHT QUESTION?

Presented by: Sabahat Khurram, 10th Nov 2009, at the Grey Nuns Tertiary Palliative Care Unit.

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J Clin Oncol Moynihan et al. 23 (25): 6256, 2005

CASE: 54 year old male with Esophageal Ca, Liver Metastasis. Had Esophagectomy done. Received Palliative RT. Had a feeding tube which fell out. Later Surgery suggested that they were unable to reinsert tube. Family insistant that he is being starved to death?????

ABSTRACT: Article which is based on a case in a patient with Non small lung Ca who had significant anorexia and cachexia. Family had questions about Feeding tube.

Salient features are as follows:

-Nutrition at the end of life is an issue that is fraught with multiple sources of confusion contradiction, myth, and emotion. Anorexia and cachexia in the context of a terminal illness form a poorly understood syndrome mediated by multiple factors.

-One of the most important aspects of end-of-life palliative care is defining the patient's goals and balancing these goals with the medical realities of the situation and the patient's and family's desires. Thus, it is essential for the physician to weigh the risks of any proposed treatment against the potential gain.

-Legal perspective: most states consider artificial nutrition and hydration as no different from any other medical treatment. and as such these are generally regarded as extraordinary care

-A patient's cultural or religious beliefs may play a crucial role in the decision-making process because some faith systems place any extension of survival ahead of quality of life where much of Western medicine now places the most emphasis. The physician must ensure that the patient and the family are basing nutrition-related decisions on a realistic grasp of what artificial nutrition can and cannot accomplish and not on myths and emotions.

Relevant data regarding the expected risks and benefits of artificial nutrition:

ANOREXIA: a patient who is anorexic from the effects of a terminal disease may not be bothered by this symptom. In fact, many such patients tend to report a complete lack of hunger. McCann et al¹¹ monitored 32 terminally ill patients for hunger and thirst during the final 6 months of their disease course. They found that 63% of patients (20 of 32 patients) never experienced hunger, and 34% (11 of 32 patients) had hunger only transiently at the beginning of the observation period. In the patients who did experience hunger most were relieved with small amounts of oral intake. Similarly, 63% of the patients in this study denied thirst, and those who did experience thirst had their symptoms relieved with oral fluids, mouth care, ice chips, and lubrication of their lips.

WEIGHT LOSS: Both Nixon¹⁴ and Lundholm et al¹⁵ examined the use of artificial nutrition in terminal cancer patients. In both studies, there was no significant gain of lean body mass, although fat stores (as measured by triceps skinfold thickness) did increase marginally. Neither study suggested any improvement in the quality of life for patients receiving artificial nutrition. Loeser et al¹⁶ noted that, in patients with a variety of terminal diseases, enteral feedings did cause their weight to stabilize, but none of the patients showed any significant weight gain. Need more randomized controlled trials to show if they would have continued to loose weight at the same rate prior to the tube feeds.

FATIGUE AND PERFORMANCE STATUS: The study by Lundholm showed no improvement in fatigue and performance status at the end of life.

SURVIVAL: The Lundholm et al's study examined the effects of enteral and parenteral nutrition on terminally ill cancer patients. In an intent-to-treat analysis, there was no evidence of a survival advantage. Overall, physicians should feel comfortable informing the patient and family that there is no evidence to suggest that, in patients with cancer anorexia and cachexia, increased caloric intake will improve patient survival or quality of life. Therefore, family members should be encouraged to provide the patient with whatever nutrition he or she desires and is able to tolerate, but they should refrain from trying to force feed the patient.

EXCEPTIONS: A few patients might benefit.

THE ROLE OF TIME LIMITED THERAPEUTIC TRIAL OF ARTIFICIAL NUTRITION.

STRENGTHS:

- 1-Lists data with emphasis on individual points which are major concerns for the families of palliative patients.
- 2-Lists facts which can help physicians deal with issues regarding artificial nutrition.
- 3-Mentions studies that have been done in regard to artificial feeding.
- 4-Also addresses the Legal and cultural issues.
- 5-Authors indicated no potential conflicts of interest.

LIMITATIONS:

- 1-As end of life is a very sensitive issue, it is difficult to bring it up and address.
- 2-More trials and studies are required.
- 3-Addresses the role of Time limited Therapeutic trial of artificial nutrition which might be a very distressing measure for the family as well as patient.

RELEVANCE TO PALLIATIVE CARE:

This is a very common situation encountered in palliative care patients and physicians working with such patients should be ready with all the facts and data to help patients and their families to come to an informed decision that is in the best interest of the patient.