Palliative Care Review

Nutritional Issues in Palliative Care

Nutrition should be a priority early in palliative care. Food has a primary role in everyone's life, including people with advanced illness. Chronic illnesses and their treatment exert a major impact upon physical and psychological reserves, and at the end of life, problems with appetite and the ability to eat and drink compound such impact.

Adequate nutrition is essential, not only to meet physiological requirements, but also because it has additional psychological, spiritual, social, and cultural benefits for patients and caregivers. Strategically addressing these aspects of nutrition is of high importance in the palliative care setting.

Prevalence

Malnutrition affects 5% to 85% of the elderly population and 50% of hospitalized patients. Weight loss in all diseases is associated with a poor outcome. Anorexia and cachexia are common in patients with life-limiting diseases such as cancer, AIDS, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), end-stage renal disease (ESRD), and dementia. It is particularly common in some advanced cancers, such as pancreatic and gastric.

Causes of Malnutrition

Malnutrition has many causes, and it is often difficult to know whether one or multiple factors are involved. It may be related to depression, loss of smell, xerostomia or mucositis, chronic gastrointestinal disease, or persistent symptoms such as pain. Cachexia presumably requires a pathophysiological process that involves altered energy metabolism, such as systemic inflammation with production of pro-inflammatory cytokines (e.g., interleukin 1 alpha, interleukin 6, and tumor necrosis factor alpha) secondary to disease, or increased basal metabolic rate or disease-induced hypermetabolic state.

Assessment

An assessment of nutritional status and its impact should be included in the holistic assessment of all patients and reviewed appropriately. Assessment requires a careful history of diagnosis, pathway of disease progression, patient comfort, peer and social

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support, socioeconomic status, cultural and religious views, and ethical and legal issues.

If the potential for a reversible cause exists, it may also require appropriate diagnostic assessment. Serial measurements of weight and dietary intake should be noted. Assessment tools may be helpful, such as the Patient-Generated Subjective Global Assessment (PG-SGA), Mini-Nutritional Assessment (MNA), Malnutrition Universal Screening Tool (MUST), and Simplified Nutritional Appetite Questionnaire (SNAQ). Laboratory measures, such as albumin and/or prealbumin levels, and transferrin levels, may be informative.

Benefits of Nutritional Support

Nutritional support therapy has been shown to benefit patients by improving quality of life and reducing emotional and physical distress in appropriate patients. It is important to consider the anticipated life expectancy for patients with advanced illnesses when examining parenteral nutrition potential benefit vs. burden.

Burdens of Nutritional Support

Nutritional support alone does not reverse or cure a disease or injury. It is an adjunctive therapy that allows a patient to meet nutrient needs during curative or palliative therapy. Nutritional support via a feeding tube or intravenous catheter is only indicated for patients who are unable to meet nutrient needs orally and have an overall good prognosis. Guidelines are available that provide timelines for how long clinicians should allow inadequate intake before initiating nutrition support. There are considerable amounts of data indicating that it is not beneficial to provide nutritional support for patients with an irreversible or terminal illness. For patients with irreversible or terminal illness, it appears that nutritional support may not benefit the patient but may increase suffering and hasten death.

Nutritional Recommendation

The American Dietetic Association's position paper on providing food and hydration to the terminally ill states, "The patient's expressed desire is the primary guide for determining the extent of nutrition and hydration." The difficulty lies in determining the patient's desires. Conversations about nutritional issues should be initiated early in the diagnostic and treatment stages rather than waiting until the dying process has begun. Ideally, there should be documentation through advance directives outlining the patient's beliefs, thoughts, and desires concerning care during the final stages of life.

Conclusions

Nutritional support in terminally ill patients should be carefully considered based on a patient's wishes, prognosis, and therapy goals. Communication among the patient, family, and healthcare providers is essential. Open and honest communication can facilitate decisions that are in the patient's best interest. Ongoing evaluation of benefit vs. burden should occur throughout therapy.

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Myths and Facts About Nutritional Support

MYTH: Artificial nutritional support is indicated for all palliative patients who experience anorexia or cachexia.
FACT: A Cochrane review concluded that there are insufficient good quality trials to make any recommendations for practice with regard to the use of medically assisted nutrition in palliative care patients.

MYTH: Aggressive efforts to increase oral nutrition are always indicated.
FACT: In the setting of advanced illness, oral nutrition may be best guided by emphasizing "what one likes" rather than "what is right or of value" nutritionally. As the illness progresses, intake inevitably decreases. Ice chips, small sips of beverages, and good mouth care become the norm.

MYTH: Fluids, tube feeding, and total parenteral nutrition (TPN) save lives and can help all patients recover from illness.
FACT: While these methods of nutrition save lives and play a major role in recovery from surgery and protect patients against the transient and toxic effects of cancer treatment, these benefits are not demonstrated in terminally ill patients.

MYTH: Dehydrated patients feel thirst.
FACT: Studies have proved that dehydrated patients do not feel thirst. As long as the patient's mouth is kept moist, he or she will not feel thirsty or uncomfortable.

MYTH: Once artificial nutrition/hydration is started it cannot be stopped.
FACT: This statement is false. Stopping these treatments is both legally and ethically acceptable.

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