

NUTRITION: IN PALLIATIVE CARE

Nutrition and feeding in palliative care can be a complex and often emotive issue. This article discusses some nutritional problems that can impact on patients' general wellbeing and wound status at the end of life and aims to offer some practical advice to help in these situations.

Jill Thorpe is a Nutrition Support Dietitian at St Helier Hospital, Carshalton, Surrey

What is palliative care?

Many patients with chronic wounds are in the end stages of life and will require palliative care. Palliative care is the active holistic care of patients with advanced progressive illness where the aim of treatment is no longer curative. It provides management of pain and other symptoms, and also the provision of psychological, social and spiritual support (National Institute for Health and Clinical Excellence [NICE], 2004). All of these facets can have an impact on the care of a patient's wound.

The goal of palliative care is to achieve the best balance between quality of life and length of life for each individual patient (World Health Organization [WHO], 2006). Patients may be in the palliative stage of their disease for many months or even years.

It is important that the care approach improves the quality of life for patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering.

This can be achieved with early assessment and with the treatment of pain and other problems, whether physical, psychosocial or spiritual. Care should be based on the individual needs and personal choice of the patient, and, therefore, will be different for each person.

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The principles of palliative care (WHO, 2006) aim to:

- ▶ Provide relief from pain and other distressing symptoms
- ▶ Integrate the psychological and spiritual aspects of patient care
- ▶ Offer a support system to help patients live as actively as possible until death and to help the family cope during

the patient's illness and in his/her own bereavement

- ▶ Neither hasten nor postpone death
- ▶ Use a team approach to address the needs of patients and their families.

Why is nutrition important?

Nutrition, especially in the palliative stage of illness, is more than just a means to refuel the body with nutrients. It also has important psychological, social, spiritual and cultural roles to play. Eating can help maintain a sense of normality within a patient's life. Meals and eating can be an emotional time as they often signify celebrations, milestones, happy times and memories.

Food intake is also associated with health and wellbeing, and for those struggling to eat it may evoke feelings of fear

Table 1.

Useful guidance for carers

- ▶ Feed the patient when hungry
- ▶ Serve small portions of food as this may be less off-putting
- ▶ Set an attractive table, tray or plate
- ▶ Favour a positive attitude towards social eating
- ▶ Encourage gently without excessive persistence
- ▶ Help patient get fresh air before eating
- ▶ A small alcoholic drink before a meal, e.g. sherry, can stimulate the appetite
- ▶ Remove bedpans, vomit bowls and other waste receptacles from the eating area.

and despair. This can have a major effect on an individual's self-esteem and confidence, potentially leading to social isolation and depression.

Many patients with chronic wounds and terminal illnesses are ultimately unable to eat enough to avoid weight loss and maintain activity levels. This can cause frustration within a patient's family, especially if the individual becomes weaker, smaller and frailer and refuses to eat. The family may push the patient to eat, which causes conflict and can put the patient off their food even more, creating tension and conflict.

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Mealtimes may be the only time during their illness when the patient feels in control. Families often feel that providing food is the one thing they can do to help. If the patient refuses, however, this can leave the family feeling neglected and uninvolved in the patient's care.

Research has shown that nutritional issues, such as a loss of appetite, can be more problematic to the carers than the patient (Poole and Froggatt, 2002). The giving and receiving of nourishment are a means of showing love and affection, and consequently food refusal can cause offence and create barriers within the family.

The principal objectives of providing good nutritional support

Table 2.

Practical advice for common symptoms

Poor appetite	<ul style="list-style-type: none"> Encourage patients to eat small frequent meals and snacks Eat favourite foods Eat with others Consider appetite stimulants Consume fluids after, rather than with or before a meal
Fatigue	<ul style="list-style-type: none"> Encourage patients to accept help in making the most of when they have more energy Use ready-prepared products
Taste changes	<ul style="list-style-type: none"> Avoid providing foods for the patient that they do not often eat If the patient dislikes salty foods, then provide more sweet foods and <i>vice versa</i> If the patient complains of bland food, try stronger flavours Combine different textures and temperatures of food within a meal or snack
Nausea	<ul style="list-style-type: none"> Help patients avoid strong smells Help them access fresh air Provide cold or room temperature food as these often smell less than hot food Provide 'little and often' rather than always preparing large meals Avoid providing greasy foods and try food and drinks that contain ginger
Sore mouth or throat	<ul style="list-style-type: none"> Provide soft food with additional sauce or gravy Avoid very hot, salty, acidic, spicy or rough food Provide ice cubes for patients to suck Remember, cold foods may be more soothing
Dry mouth	<ul style="list-style-type: none"> Consider using artificial saliva and mouthwashes Provide cool fluids and soft food Encourage the patient to suck sweets and ice cubes Provide moist foods and avoid very dry foods
Diarrhoea	<ul style="list-style-type: none"> Encourage plenty of fluids Provide small amounts regularly Avoid any foods that appear to exacerbate symptoms Try anti-diarrhoeal medications
Constipation	<ul style="list-style-type: none"> Encourage plenty of fluids Encourage gentle exercise Try laxative medications Consider increasing fibre intake
Early satiety	<ul style="list-style-type: none"> Consider medications to speed up stomach emptying Try small frequent snacks throughout the day rather than big meals Choose high energy foods Avoid drinks before meals Sit up straight during meals Avoid lying down after meals

to a person at the end of life are to maximise food enjoyment and minimise food-related discomfort (*Table 1*).

It is also important to prevent or treat avoidable and unnecessary malnutrition, since this can affect both physical and psychological wellbeing. Whilst attending to this, however, it is equally important that nutritional support measures are not so invasive or unacceptable that they impair the patient's quality of life.

The aims of nutritional support change with disease progression. Although patients must have the opportunity to receive nutrition, the emphasis is on quality of life and symptom relief rather than active nutritional therapy (*Table 2*).

Nutritional challenges in palliative care

There are a number of nutritional challenges that present in palliative care, including decreased oral intake, decreased absorption and altered metabolism, which can lead to muscle wasting (cachexia).

Decreased oral intake can be due to anorexia (or loss of appetite), altered tastes and smells, nausea or dysphagia. The causes of anorexia can be multifactorial and the use of appetite stimulants has been shown to increase food intake, body weight and quality of life in this patient group. However, they have not been found to affect the prognosis or prolong life (Dy, 2006).

Decreased absorption can be another challenge and this

may be caused by nausea, vomiting, diarrhoea or surgical or anatomical changes.

Patients will often have altered energy metabolism due to cachexia, which involves a cytokine-induced wasting of protein and energy stores caused by the disease (Thomas, 2002). Cachexia cannot be overcome by increased feeding, regardless of the amount of food given.

As the final phase of the illness develops, physiological functions such as gastric emptying, digestion, absorption and peristalsis may decline. As a result, both appetite and the ability to tolerate food will reduce.

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Alternative diets in palliative care

Many patients with a palliative diagnosis may be tempted to try unconventional remedies including alternative or complementary diets in the hope of cure or remission. The problem with many alternative and complementary diets is that they are more likely to worsen nutritional status than improve it.

These diets are often low in fat, sugar and salt, and include a lot of raw foods and as a result have a low energy density. It may, therefore, be difficult for

patients to eat enough to meet their needs.

Restrictions in food choice may result in dietary imbalances. These dietary regimens may be unpalatable and expensive, but patients often put up with them with high hopes of success.

Although there is no evidence that these regimens offer any benefit over conventional therapies, and in some instances make matters worse, some patients do claim to feel better. The reason for this is unclear, but may be associated with doing something positive to take control of their disease and treatment.

It is important that patients are able to make informed choices about following such regimens and are supported in the decisions they make (Thomas and Bishop, 2007).

Artificial nutritional support in palliative care

If a patient is not managing to eat and drink enough to meet their nutritional requirements, and this cannot be addressed using the tips in *Tables 1 and 2*, then artificial nutritional support can be considered. This can include nasogastric tube feeding, percutaneous endoscopic gastrostomy (PEG) feeding (a tube through the abdominal wall) or parenteral nutrition (intravenous feeding).

This should be considered in the same way as any other form of life-sustaining medical therapy that supports bodily function, such as antibiotics, oxygen therapy or dialysis.

These can be invasive treatments and the benefits and risks need to be assessed before providing any form of artificial nutritional support.

Not offering these options is ethically acceptable if the benefits of the treatment do not outweigh the risks for a particular individual (McClave and Ritchie, 2006). There is no ethical or legal difference between withholding a feeding tube *versus* placing the feeding tube and then later removing it (Ganzini, 2006).

Decisions made about feeding need to be discussed with the patient and his or her family, as well as the wider multidisciplinary team as it is often not straightforward.

There are two potential benefits of giving artificial nutritional support, which are to prolong life and enhance quality of life for the patients and their loved ones.

Little evidence has been found for benefits from enteral or parenteral nutrition in terminally ill cancer patients (Ganzini, 2006) and as a result, it may be more appropriate that the aim of their nutritional care be focussed around keeping them comfortable and not using invasive methods.

Hunger is not often reported as a problem in this patient group and can be treated with surprisingly small amounts of food or drink. If a patient is given artificial nutritional support, their changing symptoms need to be monitored and adjustments made to the feeding regimen as the disease progresses (McClave and Ritchie, 2006).

There are a number of ways the feed can be adjusted to suit the patients changing needs, such as reducing the volume or duration. These things need to be tailored to each individual patient by their dietitian.

The issue of when to stop providing artificial nutrition is addressed in the most recent version of the Liverpool Care Pathway (LCP). The LCP is a pathway for the dying patient supporting care in the last hours or days of life.

The latest version of this pathway states that the LCP does not preclude the use of clinically assisted nutrition or hydration, but all clinical decisions must be made in the patient's best interests.

The term 'best interest' includes medical, physical, emotional, social and spiritual as well as all other factors relevant to the patient's welfare (Marie Curie Palliative Care Institute [MCPCIL], 2009).

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Conclusion

Clinicians need to challenge their thinking on issues surrounding the palliative care of patients, including nutritional care. It is also necessary to adapt and adjust knowledge, routines and professional outlook to accommodate the palliative care philosophy. **WE**

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