ARTIFICIAL ENTERAL FEEDING IN PATIENTS WITH INCURABLE HEAD & NECK TUMOURS

PROGNOSIS INFORMING DECISION MAKING

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OVERVIEW

- What is palliative care?
- Prognostication - PPS & cachexia
- Artificial nutrition & enteral anatomy
- To start or not to start
- Withdrawal or withholding - ethical principles
- 2 case studies

DEFINITION OF PALLIATIVE CARE

- "Palliative care is an **approach** that **improves** the **quality of life** of patients and their families facing the problems associated with **life-threatening illness**, through the **prevention and relief of suffering** by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual."

World Health Organisation, 2010

FURTHERMORE…..

- **intends neither to hasten or postpone death;**
- **uses a team approach to address the needs of the patients & their families,** including bereavement counselling, if indicated;
- **will enhance quality of life & may also positively influence the course of the illness**

World Health Organisation, 2010

PALLIATIVE PERFORMANCE SCALE (PPS)

Palliative Performance Scale (PPSv2)
Version 2 - Victoria Hospice Society, Australia

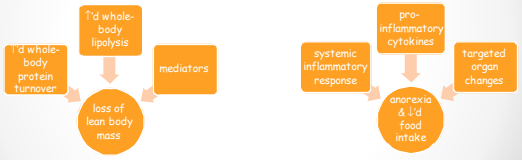
PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity with effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable normal job/work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
40%	Mainly in Bed	Unable to do any activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/-Confusion
30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/-Confusion
20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/-Confusion
10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/-Confusion
0%	Death	–	–	–	–

Victoria Hospice Society, 2001

CACHEXIA OF ADVANCED DISEASE

- A metabolic disorder & can occur in:
  - o advanced cancer
  - o end-stage COPD
  - o end-stage chronic renal failure
  - o end-stage CHF
  - o neurological conditions

PATHOPHYSIOLOGY OF CACHEXIA OF ADVANCED DISEASE



CACHEXIA OF ADVANCED DISEASE & PROGNOSTICATION

- Signs & symptoms:
  - weight loss
  - muscle wasting
  - anorexia
  - early satiety
  - ↓'d physical function
  - fatigue
  - anaemia
  - oedema
  - ↓'d serum albumin (34-38g/L)

IRREVERSIBLE

CACHEXIA OF ADVANCED DIESASE & PROGNOSITICATION

- **METABOLIC DISORDER – DOES NOT RESPOND TO NUTRITIONAL SUPPORT**

POOR PROGNOSIS

Danis, 2013

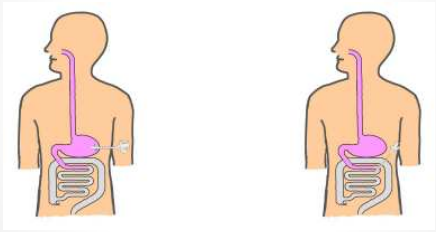
ARTIFICIAL NUTRITION

- ARTIFICIAL
- Non-oral
- Enteral
  - NG, PEG, PEJ, gastrojejunostomy
- Parenteral
  - Peripheral intravenous access, central venous access

ARTIFICIAL ENTERAL NUTRITION

- MEDICAL INTERVENTION
- A basic provision of comfort?

PEG & PEJ ANATOMY



Duszak et al, 2014

TO START OR NOT TO START ARTIFICIAL ENTERAL NUTRITION

- COMMUNICATION
- INFORMED CONSENT
- Patient/family & clinician goals of care
  - advance care plan?; emphasise artificiality (artificial nutrition rather than eating or feeding); provide information (disease process/stage of illness/prognosis); psychosocial impact; avoid "care" versus "no care"
- Hunger & starvation
  - fear of starving to death;
- Ethical, cultural & psychological issues
  - anticipate and explore assumptions about eating & food

WITHDRAWAL/WITHHOLDING OF ARTIFICIAL ENTERAL NUTRITION

- ETHICAL ISSUES:
- Autonomy: competent adults decide for themselves whether to stop eating & drinking and whether to withdraw or withhold artificial nutrition
- Beneficence & non-maleficence: clinicians decision to withhold or stop artificial nutrition should be informed by evidence (benefits & risks) and should also consider the wishes of patients & families

WITHDRAWAL/WITHHOLDING OF ARTIFICIAL ENTERAL NUTRITION

- Medical intervention = medical decision?

CASE STUDIES

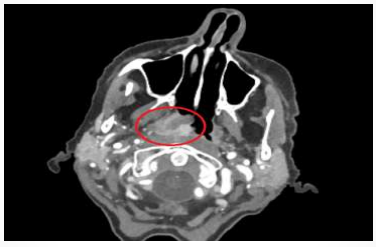
- Dot
- Brandon

DOT

- 77 year old female, lives locally & alone in unit, independent. Hx: smoker 50 pack year, bottle wine/day
- May 2015: seen in ENT clinic – large pharyngeal tumour, did not tolerate scope – no biopsy, referred for urgent CT scan for assessment/staging

DOT

- 11 days later: ED presentation with ↓'d oral intake & pain on eating & drinking; frail & cachetic
- PPS: 50%, albumin 29g/L (nil further blood tests taken during admission)
- Seen by SLT & dietician – soft, moist diet with mildly thickened fluids
- CT scan: oropharyngeal tumour 8.0 x 4.8 x 3.4cm, no metastatic lymph nodes, no metastatic disease within upper fields of lungs

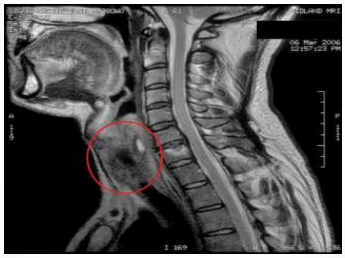


DOT

- Head & Neck MDM: non-curative, for symptomatic care
- Hospital acquired sacral pressure area
- Referral to palliative care consult service – pain management & discharge planning; PPS: 40%; discussion re: artificial enteral nutrition – Dot says NO
- 5 days later: discharged to ARC
- 23 days later: Dot died from disease related causes

BRANDON

- 37 year old male, lives 157kms (2 hr drive) away with wife, farmer. Hx: depression
- March 2006: adenoid cystic carcinoma of larynx with tracheal infiltration



BRANDON

- April 2006: total laryngectomy & tracheal resection with tracheostomy & Provox valve – positive inferior margins
- June 2006: 33#s RXT – growth arrest rather than tumour eradication

BRANDON

- May 2012: recurrence – multiple metastatic deposits in both lungs
- 2012- June 2014: regular medical oncology follow-ups – declined chemotherapy; routine ENT follow-ups – dysphagia, stomal granulation tissue
- July 2014: dilation & insertion of oesphageal stent – coughed up later that day
- August 2014: CT scan – disease progression of multiple pulmonary metastases, no evidence of disease in abdomen/pelvis or bones

BRANDON

- August 2014: 45 years old, still residing as prior & still farming, new partner & step-daughter, referral to palliative care consult service – pain management; PPS: 80%; albumin 43g/L
- PEG insertion secondary to dysphagia & pharyngeal stenosis; to be used for artificial nutrition & medication administration
- Discharged home, continues to run the farm – has been hospitalised twice with PEG insertion site infections – treated & resolved

SUMMARY

- Decisions regarding artificial nutrition are **difficult** for clinicians, patients & families
- Decision making should **incorporate** patient & family values as well as **informed consent** regarding potential benefits, burdens & alternatives

SUMMARY

- Artificial nutrition has **no effect** on prolonging life or improving functional status in the setting of many advanced illnesses
- **Prognosis & quality of life poor – artificial nutrition not beneficial**
- **Prognosis of months to years & good quality of life & patient likely to die of malnutrition rather than their disease – artificial nutrition reasonable if consistent with goals of care**

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