Dietetics in Palliative Care

St Joseph's Hospice

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Aim for this session

- The role of food and nutrition in palliative care
- Nutritional screening and assessment
- Nutritional treatment in palliative care
- Describe the Dietetic service at St Joseph's Hospice

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Our local area

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St Joseph's Hospice

- 42 beds (34 in patient and 6-8 respite beds)
- In-patient admission - for symptom management and terminal care
- Out-patients and day services including Day Hospice, support groups, self management programmes, gym group
- Community services

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Range of services

- Nursing and Medical including Community Palliative Care Team
- Therapies – Physio, OT, Dietetics, SLT
- Complementary Therapies
- Social work
- Psychology and Bereavement support
- Day Hospice
- Living well information support service.

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WHO definition of Palliative Care

“ 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”

(WHO 2002)

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Dietetics in Palliative Care

- Nutrition should be considered as early as possible to enable maximum patient benefit
- Dietitians play a fundamental role in enabling patients to benefit from palliative care
- Role in rehabilitative palliative care – integrates rehabilitation, enablement, self-management and self-care into the holistic model of palliative care.

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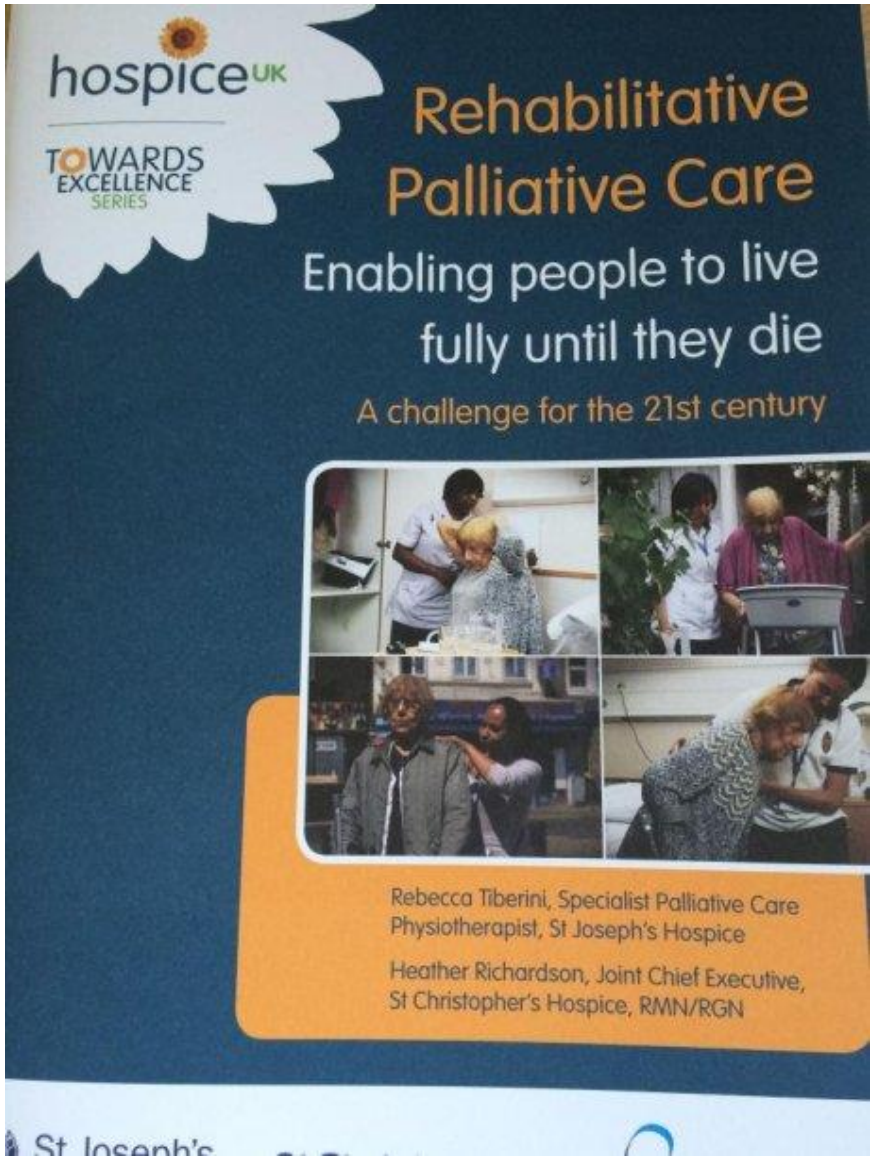
Rehabilitative Palliative Care



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Definition of “nutrition”

From the Latin nutrire meaning “feed, nourish”

“ the process of eating or taking nourishment”

Oxford English Dictionary:

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Malnutrition

“ a state of nutrition in which a deficiency or excess (or imbalance) of energy, protein and other nutrients causes measurable adverse effects on tissue/body form (body shape, size, composition), body function and clinical outcome”

(Elia 2000)

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Malnutrition

Refers to:

Under-nutrition – insufficient nutrients

Over-nutrition – more nutrients than needed

Consequences of malnutrition

- Impaired immune function
- Delayed wound healing and risk of pressure ulcers
- Muscle wasting weakness – affecting respiratory muscles; cardiac function; and mobility
- Altered gastrointestinal structure and function
- Apathy and depression

(Stratton and Elia 2014)

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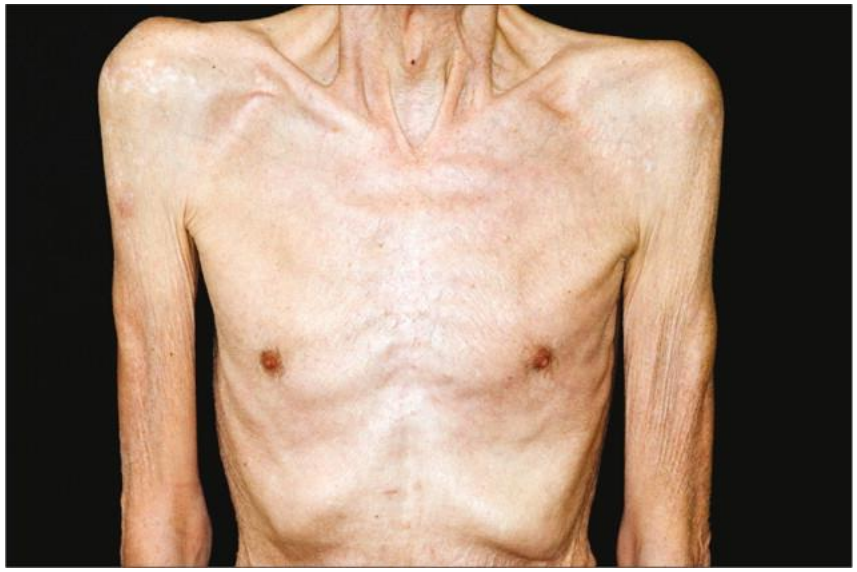
Cachexia

The word cachexia has Greek roots, “kakos” meaning bad and “hexus” meaning habit, appearance, condition.

Cachexia has been known for centuries (von Haehling 2010) and was described by Hippocrates “…the shoulders, clavicles, chest and thighs melt away” (Katz and Katz 1962).



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Cachexia

- Approximately 80% of people with advanced cancer have cachexia and of these, around 50% experience anorexia which is characterised by poor appetite and reduced food intake. (Addington-Hall and McCarthy 1995).
- Cachexia has a prevalence of 20-40% in COPD depending on the definition used (von Haehling 2010)

Cachexia

"a multifactorial syndrome characterised by an ongoing loss of skeletal muscle mass (with or without loss of fat mass) that cannot be fully reversed by conventional nutrition support, and progressive functional impairment. The pathophysiology is characterised by a negative protein and energy balance driven by a variable combination of reduced food intake and abnormal metabolism."

(Fearon et al 2011).

Stages of Cachexia

Pre-cachexia represented by:

- weight loss ≤ 5% (3kg in a 60kg individual)
- anorexia, defined as loss of appetite and diminished intake and metabolic change.

Stages of Cachexia

Cachexia: represented by

- weight loss ≥ 5%
- or BMI ≤ 20 kg/m2
- or sarcopenia (loss of muscle mass) and weight loss > 2%
- reduced food intake
- systemic inflammation indicated by raised C-reactive protein.

Stages of Cachexia

Refractory cachexia –

where cancer disease is both procatabolic and non-responsive to anticancer treatment; low performance score; and ≤ 3 month survival expected.

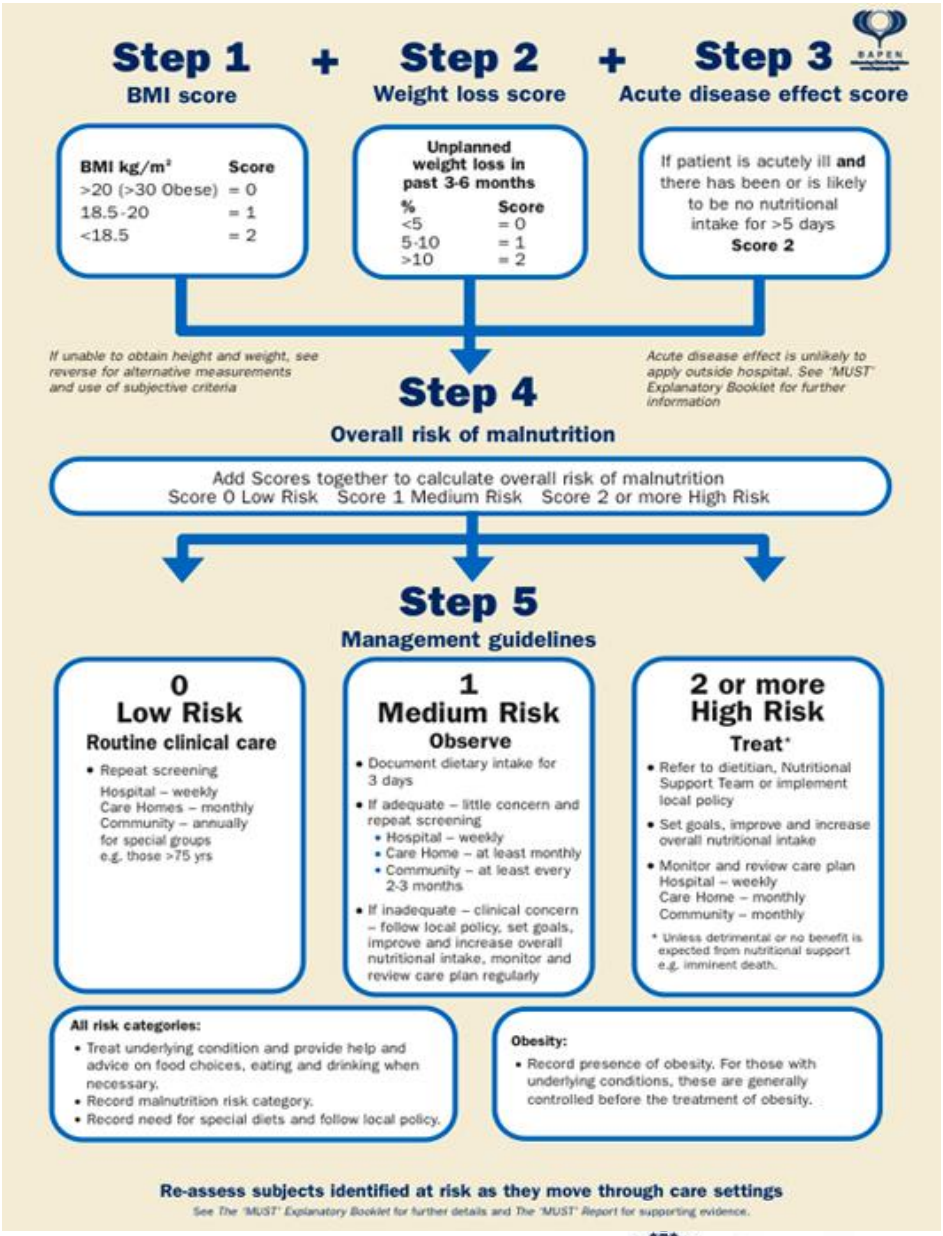
Refractory cachexia cannot be reversed.

Nutrition screening

All patients should have a holistic nutritional assessment including:

- Weight/height/BMI
- Assess *weight change* in past 3-6 months
- Change in appetite
- Need for texture modification
- Use of nutritional supplements
- Artificial nutrition and hydration
- Co-morbidities
- Psychosocial impact of poor appetite.

Malnutrition Universal Screening Tool



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Nutritional treatment

- Oral nutritional support – food first
- Use of Oral Nutritional Supplements
- Enteral and Parenteral feeding
- Supportive management of co-morbidities including renal disease, diabetes
- Support for families and carers

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Nutritional Treatment - Food First

- ✓ Maximise nutritional content
  - Food fortification
- ✓ Small and often meal plan
- ✓ Texture modification

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Nutritional treatment

Oral Nutritional Supplements (ONS) may be used however:

- poor compliance related to taste fatigue
- gastrointestinal symptoms such as early satiety due to energy load (Vermeeren et al 2005) , abdominal distension, nausea and diarrhoea

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Nutritional treatment

Enteral feeding

- Nasogastric tube feeding
- Gastrostomy feeding
- Jejunostomy feeding

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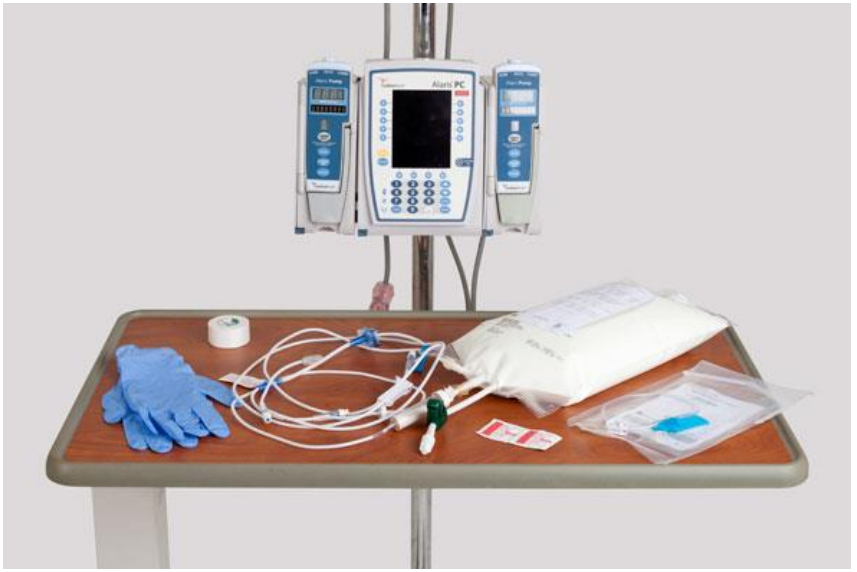
Nutritional treatment

Parenteral Nutrition



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Nutritional treatment

Supportive management of co-morbidities including renal disease and diabetes

Work with patient and MDT to identify the priorities of nutritional treatment

- Diabetes avoiding *symptoms* due to hyperglycaemia
- Renal disease – consider level of potassium restriction

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Psychosocial Impact of poor appetite

- Weight loss has not only a physical impact but includes psychosocial consequences that may compromise quality of life. (Higginson and Winget 1996)
- The emotional meaning attributed to food changes through the different stages of life and for individuals in the palliative stage of their illness, food can take on both positive and negative meaning.
- Positive themes include hope, comfort and the reminder of happier times; negative feelings include guilt about not eating, dread of mealtimes and refusing food to hasten death. (Eldridge 2011)

Nutrition is not just about the nutritional value of food

- Nurture
- Love
- Socialising
- Sharing
- Normality

Powerful emotions around eating and drinking

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What do patients and their carers say?

- I feel so frustrated…. I spend all morning cooking a delicious lunch. He eats two spoonsful and pushes it away
- What will happen if she doesn't eat?
- All they say is you must eat, you must eat……they never leave me alone.

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What support can HCPs give?

- If a patient is being weighed – respond to any weight change. Avoid the “weight loss taboo” (Hopkinson, Wright and Corner, 2006)
- Give patients/family the opportunity to talk about the weight / poor appetite
- Acknowledge weight loss may be due to cachexia
- Provide advice and refer to Dietitian

Dietetic service at St Joseph's Hospice

- 3 days a week
- In patients
- Out patients
- Symptom management groups – Icon (breathlessness) and Re-Energise (fatigue)
- Support groups - neurological support group; share, support and socialise; heart failure group.

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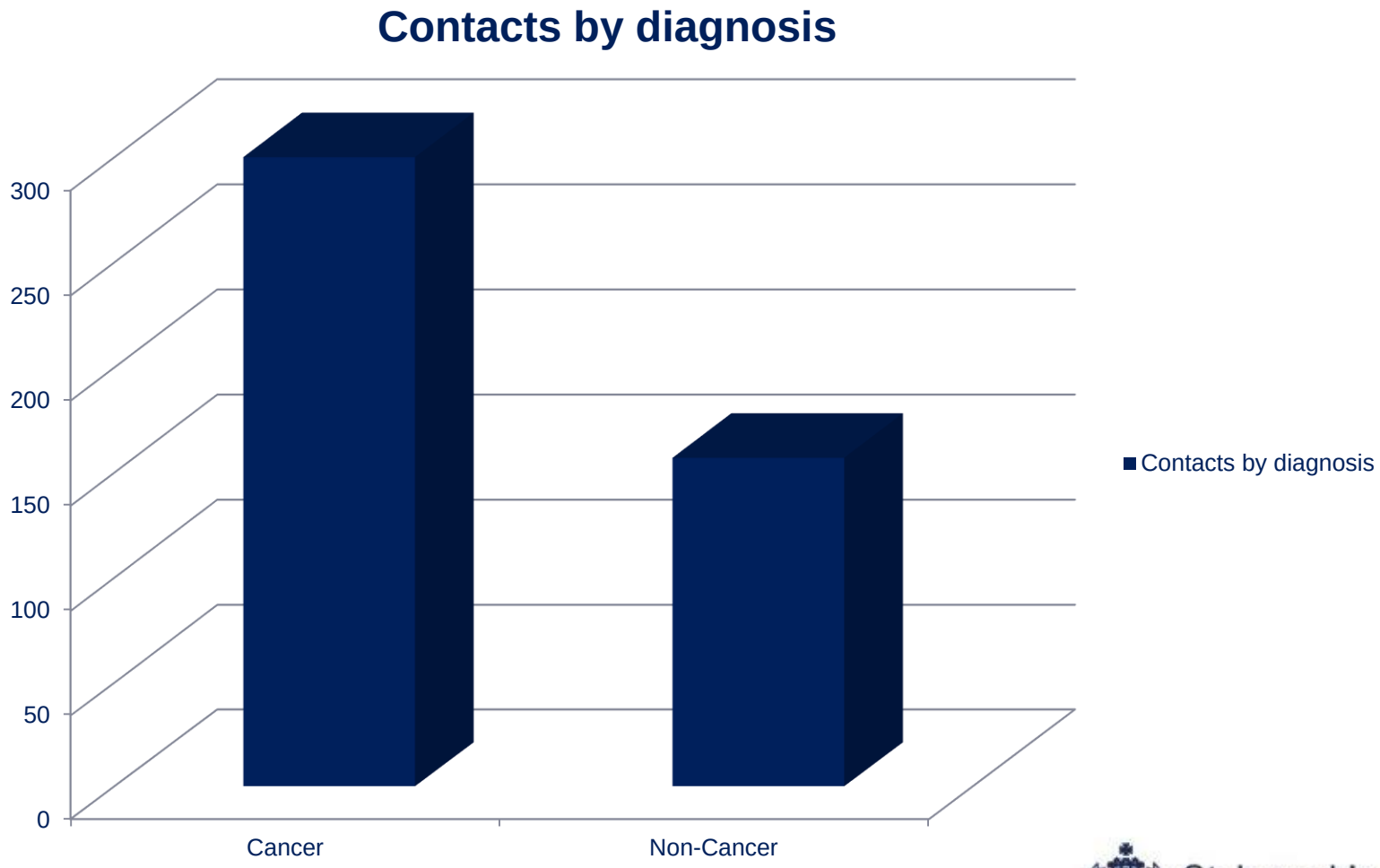
Malignant vs Non-malignant disease (2014/15)



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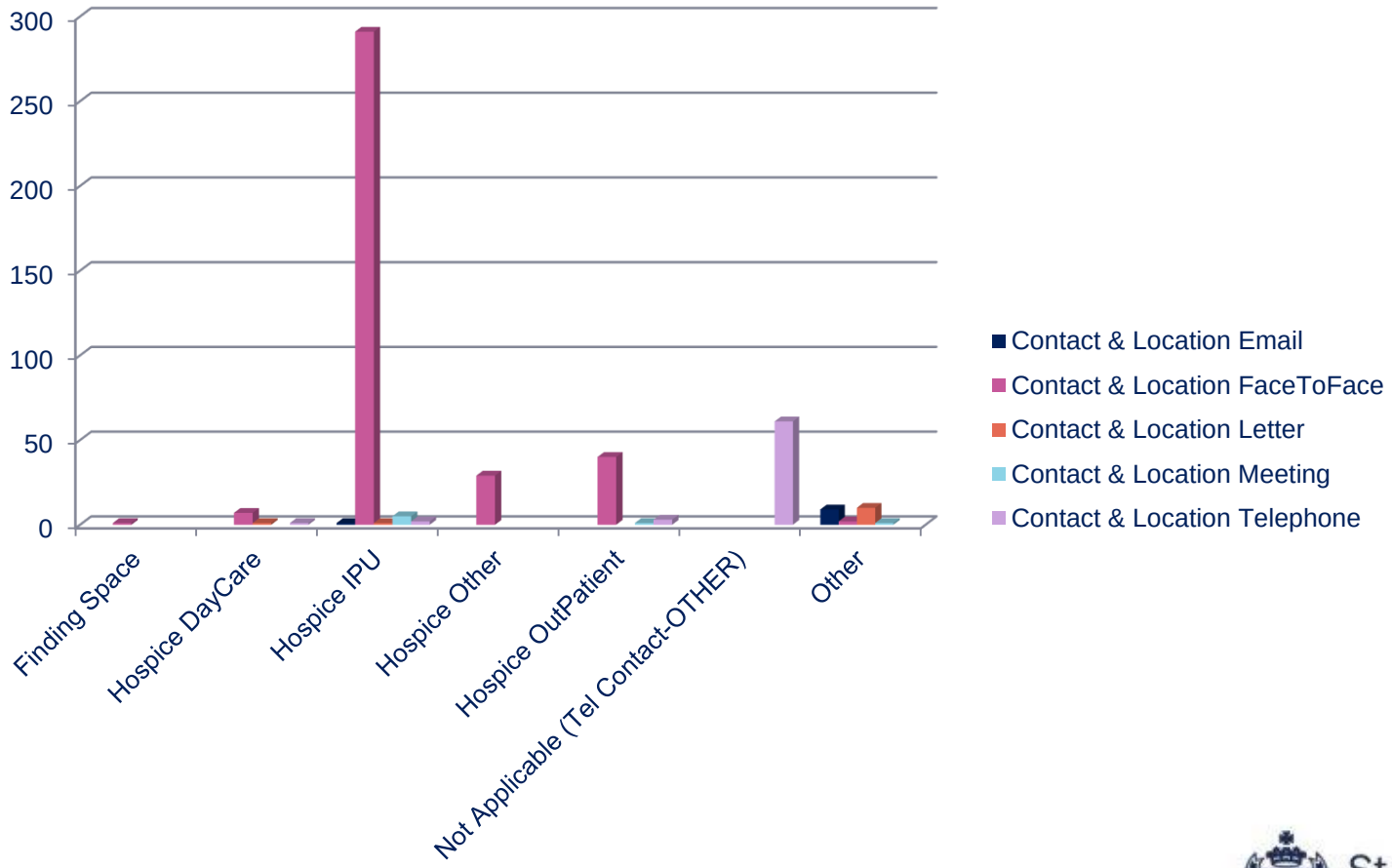
Contacts by location



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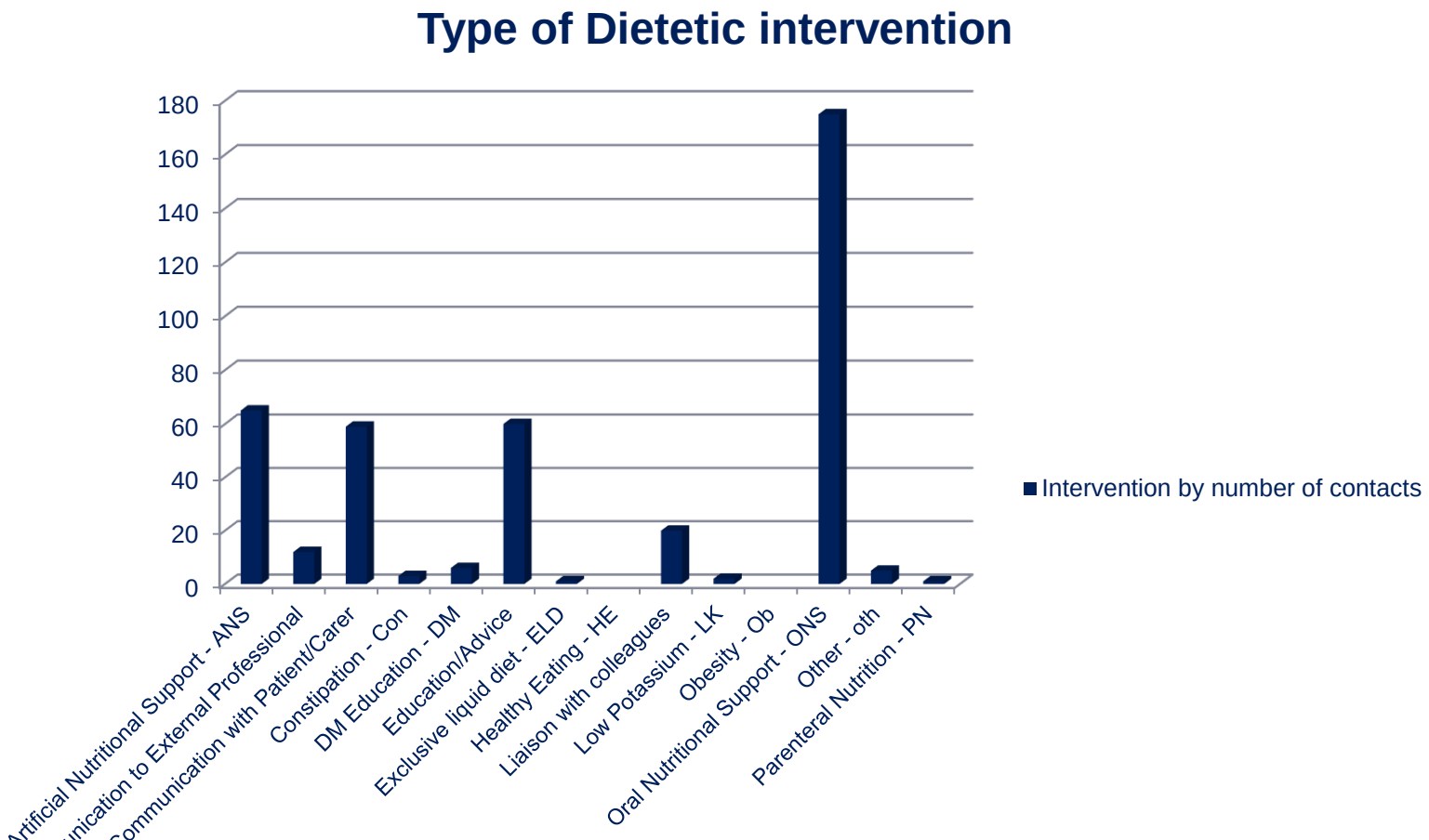
Type of dietetic intervention (2014/15)



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Dietetic service at St Joseph's Hospice

- Chair of the Hospice Nutrition Group
- Key link with Catering provision
- Training and education for staff
- Nutrition Policy, procedures and guidelines
- Chair of Hospice Dietitians and Speech and Language Therapy Network group.

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Food as treatment

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Thank you
and
questions?

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