Food and Nutrition in Palliative Care Session 1

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Outline of this session

- To consider the role of nutrition in palliative care
- For patients: Why is it important to maintain nutrition?
- Consequences of malnutrition
- Impact of co-morbidities
- Case study
Definition of “nutrition”

From the Latin nutrire meaning “feed, nourish”

“the process of eating or taking nourishment”

Oxford English Dictionary
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)
The role of HCPs in nutrition in the palliative care setting

…identify and address nutritional factors that impair a patient’s physical and psychological wellbeing with the primary objective of maintaining or improving QOL for the individual. (Eldridge and Power 2014)

Who’s role is this?
What is the role of nutrition in palliative care?

- Provision of nutrients (Energy, protein, vitamins and minerals)
- Prevent or treat avoidable malnutrition via a method that is acceptable to the patient
- Eating and drinking can help maintain a sense of normality
- Not eating can evoke feelings of despair (to be explored in webinar 3)
## Factors affecting food intake

<table>
<thead>
<tr>
<th>Physical factors</th>
<th>Psychological factors</th>
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<tbody>
<tr>
<td>Constipation</td>
<td>Anxiety</td>
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<tr>
<td>Malabsorption</td>
<td>Depression</td>
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<td>Mucositis</td>
<td>Inability to sleep</td>
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<td>Nausea and vomiting</td>
<td>Spiritual distress</td>
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<td>Obstruction (along G-I tract) or dysphagia (swallowing difficulty)</td>
<td>Family worries</td>
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<td>Oral problems such as oral thrush, dry mouth</td>
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<td>Pain</td>
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Hemming and Maher 2005; MacDonald et al 2003
What affects nutritional intake?

Physical symptoms of disease:
- fatigue
- dysphagia

Gastrointestinal symptoms
- nausea
- vomiting
- constipation

Side effects of treatment eg dry mouth, sore mouth, n & v

Side effects of medication eg opioids causing constipation

Increased nutritional requirements eg due to pyrexia

Malabsorption (diarrhoea) resulting in loss of nutrients

Terminal phase of illness: decline in gastric emptying, digestion, absorption and peristalsis
What is important to patients?

- Quality of life
- Ongoing treatment eg palliative chemo
- Maintain physical strength to undertake their final wishes and ambitions
- Physical strength to benefit from rehabilitative palliative care
- Social and emotional meaning of eating and drinking
Nutrition in Rehabilitative 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
  (Tiberini and Richardson, 2015)
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)
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)
Mrs B is a 53 year old woman with metastatic bowel cancer.

She had an ileostomy formed 4 months ago and is now having fortnightly chemo therapy.

She is losing weight and says that her appetite is very small.

In pairs /small groups, think about what general advice you would give to Mrs B.
The nutritional impact of co-morbidities

Supportive management of co-morbidities including renal disease and diabetes

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

eg: in Diabetes avoiding symptoms due to hyperglycaemia
Case study

- Mr R is a 63 year old man with metastatic lung cancer.
- He has had type 2 diabetes for approx. 10 years and was on gliclazide and metformin.
- He has recently been started on steroids and his blood glucose levels are fluctuating between 6 – 20 mmols/l. He has been converted to insulin.
- His appetite is poor consisting mainly of soup, jelly, ice cream, custard.
- He is very concerned that he is eating high sugar foods and has asked for your advice.
References


Tiberini R and Richardson H (2015). Rehabilitative Palliative Care. Hospice UK

WHO 2002,
http://www.who.int/cancer/palliative/definition/en/ last accessed 12.10.16
Thank you and questions?