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Doc Talk

When to tube feed dementia patients

Enteral nutrition may be controversial, but there are cases where this treatment is still the best option

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Stepping into the ward after a weekend break, I caught sight of an emaciated elderly woman at the corner bed. A nurse was attempting to feed her, but the woman's lips were shut tight. In one instance, she nudged the spoon away, spilling the contents.

I inched closer and attempted to catch the patient's gaze. She looked back but remained silent even as I tried to connect by speaking in her native dialect. I was struck by her sullen eyes, so I reached for her hand, hoping she would respond, but she did not.

I offered her a spoonful of water turned gooey with thickening powder, but she closed her eyes and turned her head away.

Looking at her records, the diagnosis of Madam T read "advanced dementia with pneumonia, dysphagia and poor feeding".

In the days that followed, she continued to eat and drink minimally, save for a few sips of coffee and occasional spoons of pureed food, and refused most of her medications.

We kept her on an intravenous drip but, as she was languishing by the day, we had to decide whether to provide nutrition and hydration via tube feeding.

Patients with advanced dementia inevitably present with eating difficulties at a point in the illness, often due to food refusal, problems with chewing and an impaired swallowing reflex.

Consequently, malnutrition, dehydration and recurrent pneumonia become realities to contend with.

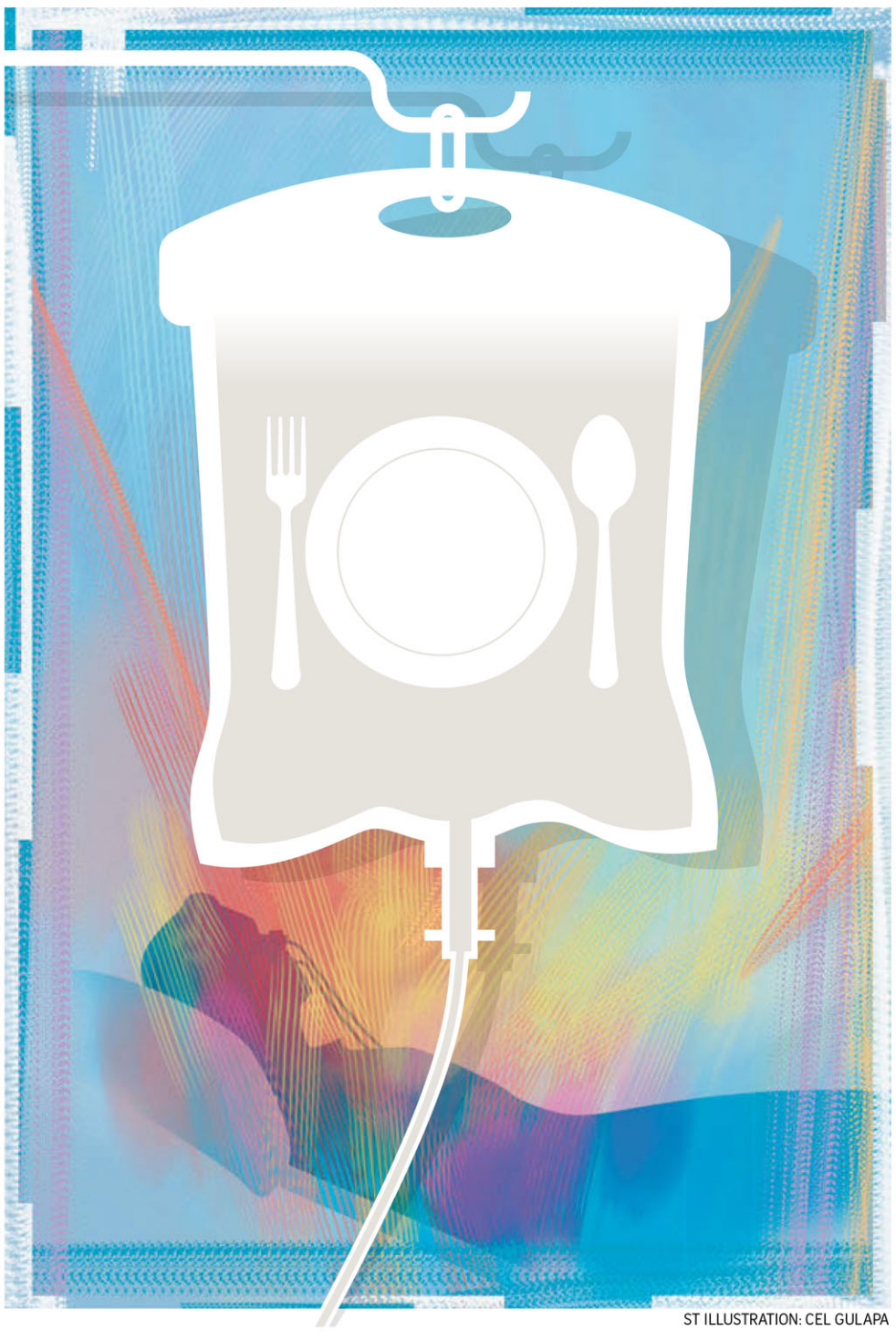
It is then that tube feeding, also known as enteral nutrition or EN, becomes a treatment option.

However, clinical guidelines on the care of patients with advanced dementia do not routinely recommend EN, as the studies on which the guidelines are based fail to show any benefit in survival or reducing the risk of pneumonia.

The guidelines have also come under scrutiny, as the recommendations were made on the basis of observational studies with methodological limitations, instead of randomised controlled clinical trials – the holy grail of clinical research. Nonetheless, tube feeding is sometimes still initiated for patients by doctors, in consultation with caregivers.

A recent report by the Lien Centre of Palliative Care, called Rethinking Advance Care Planning, found that while most caregivers' end-of-life care goal was "no life extension", 60 per cent still opted for tube feeding.

So, how should decisions on tube feeding be made?



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First of all, it is worth noting that patients with advanced dementia are highly diverse, with varying severities and abilities.

The severe stage of the Functional Assessment Stage for Dementia can be further divided into six levels of impairment.

Patients with advanced dementia may retain different functions, such as eating, walking, maintaining gaze and speech.

Applying the recommendations categorically to all patients with advanced dementia may not be appropriate. It is also salient to examine the circumstances under which eating problems arise.

Madam T was eating well prior to being hospitalised. However, pneumonia rendered her breathing more laborious, which aggravated her dysphagia, or difficulty with swallowing. The problem was compounded by blended food and thickened fluids that were unpalatable, as well as the unfamiliar environment.

In her case, she could benefit from tube feeding to tide her over a stormy phase in the hope that she would regain some semblance of normal feeding.

Tube feeding was carried out for Madam T, after discussion with her close relatives, who said she had retained a hearty appetite for her favourite foods despite her advanced dementia.

Tube feeding would also facilitate her intake of medications, especially those for underlying chronic conditions and anti-depressants to alleviate her distress in a challenging environment.

Madam T improved as her pneumonia abated and tube feeding replenished her physical reserves. She started with morsels, but within a month, she was eating and drinking enough for the tube to be removed.

Deliberations on tube feeding often occur in the context of uncertain outcomes. In Madam T's case, we assessed the benefits to potentially outweigh the risks. We offered the option to the family while leaving them to decide what was in her best interests, as she had not indicated a preference.

This is not to say it always results in positive outcomes. Another patient with advanced dementia for whom we had introduced tube feeding, who also had poor feeding and pneumonia, was less fortunate. He succumbed to another bout of pneumonia two weeks later.

It is prudent to be nuanced in adopting the recommendations of guidelines. Deciding whether or not to tube feed a patient should be individualised and contextualised in keeping with scientific evidence, the patient's and family's preferences, and the tenets of ethical medical practice.

Initiating tube feeding for patients with advanced dementia may be a decision that more doctors and families may have to make in time, given the increasing prevalence of dementia here.

What is needed is diligence and discernment when considering the care options at hand, as well as courage and temperance in pursuing what is most appropriate for the patient and family.

At the Bloomberg New Economy Forum last November, Prime Minister Lee Hsien Loong said: "Covid-19 is a powerful reminder that while man proposes, God disposes."

Even though good outcomes are never guaranteed, the best interests of the patient remain at the heart of our efforts.

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