

1 **Feeding Tube Placement in Elderly Patients with Advanced Dementia**

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3 On behalf of the AGS Clinical Practice Committee, the following authors abstracted this
4 guideline:

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19 **Background:**

20 Food and eating play important social, religious, biological and symbolic roles in society.

21 Given these diverse roles it is not surprising that great concern arises when a person loses

22 the ability or desire to eat. Eating problems typically occur in the advance stages of

23 dementia along with profound loss of memory, verbal skills, and the ability to walk. This

24 makes patients with advanced dementia dependent on others for all aspects of their care.

25 Whether to initiate tube-feeding (TF) or focus on comfort, is one of the most challenging

26 dilemmas facing families, health care providers, institutions and societies caring for these

27 patients.

28

29 Decisions about artificial feeding (AF) in patients with dementia can be difficult for

30 families and health care providers. Though Terri Schiavo was a young woman in a

31 persistent vegetative state, the case highlights the emotional impact that decisions about

32 AF can have on families and society.

33

34 When considering the use of AF in elderly patients with advance dementia, the

35 preponderance of evidence does not support its use. There is considerable variation in the

36 use of AF in long term care in the United States, which may reflect institutional

37 characteristics rather than patient values or efficacy.

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39 The present position statement is on feeding tube placement in older persons with

40 dementia was last updated in 1993 and collates data from recent studies.

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42 Robert McCann, MD and James Judge, MD drafted the statement. The final form of the
43 position statement reflects the consensus deliberations of the Clinical Practice Committee
44 with input from the Ethics Committee and final approval by the Board of the American
45 Geriatrics Society.

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47 **Position 1**

48 The use of tube feedings, in patients with advanced dementia, is unlikely to provide
49 medical benefit or improved comfort.

50 **Rationale**

51 Several studies have demonstrated very high mortality in patients who require artificial
52 feedings. (1-3) Tube feedings have not been shown to prevent aspiration, heal pressure
53 sores, reverse measures of malnutrition or decrease mortality in patients with severe
54 dementia. (4-6) Tube feedings subject patients to side effects that include aspiration,
55 infection, increased oral secretions, tube malfunction and discomfort. (4-6) Patients who
56 attempt to remove their tubes are at increased risk for being restrained and may require
57 return visits to hospitals. (5,6) Tube feedings have not been shown to increase patient
58 comfort in patients with cancer and it is very unlikely that patients with dementia suffer
59 from not eating either. (7) Patients with cognitive impairment being tube fed frequently
60 pull at the tube, suggesting that the tube is an irritant or source of discomfort. Such
61 patients are at risk for being restrained, which can increase agitation and harm to the
62 patient.

63

64 Like other therapies, the risks and benefits of TF should be discussed with patients'
65 families or surrogate decision makers before the treatment is begun. There may be
66 circumstances when short-term initiation of TF would be appropriate and consistent with
67 patients' previously expressed wishes and values. In these cases, clear goals of therapy
68 should be decided upon before the TF are initiated and should be reviewed frequently. In
69 general, the benefits versus the burdens of TF do not support its use in these patients with
70 advanced dementia. Based on a growing body of empirical data and expert opinion, many
71 feel the option of TF in advanced dementia should not be offered.

72

73 **Position 2**

74 Efforts to enhance oral feeding by altering the environment and creating patient-centered
75 approaches to feeding should be part of usual care for patients with advanced dementia.

76 **Rationale**

77 Oral feeding may be one of few remaining pleasures and a time for socialization for a
78 person with advanced dementia. Mealtime must be regarded as an event of importance,
79 instead of a task that needs to be completed as soon as possible. Environments with less
80 noise and clutter are more conducive to eating than chaotic ones. Nurse training and staff
81 education can result in techniques to improve feeding in patients with dementia (10).
82 Diets should be liberalized based on patient preference and adequate fluids should be
83 given with feedings to enhance the taste of foods. Feeding tubes should never be viewed
84 as a cheaper, more efficient way of feeding patients. When patients with advanced
85 dementia develop a loss of appetite, weight loss, difficulty swallowing or aspiration, a
86 discussion of feeding issues should occur without delay. This should involve a

87 multidisciplinary assessment of reversible causes of not eating and discussions with
88 family about the plan of care in relation to the stage of dementia.

89

90 **Position 3**

91 TF is a medical therapy that can be declined or accepted by a patient’s surrogate decision
92 makers in accordance with advance directives or what is thought the patient would want.

93 **Rationale**

94 In 1990, the Supreme Court ruled on the Nancy Cruzan Case. (11) Artificial feeding was
95 deemed to be “medical therapy” and like any other medical therapy, could be started and
96 stopped based on a person’s wishes and values. When patients lose their capacity to
97 consent to treatments, their previously expressed directives, wishes or values should be
98 used to guide surrogate decision makers. The court ruled that individual states could
99 define the level of evidence required to substantiate that a patient would not want
100 artificial feeding. Thus, Missouri was permitted to set this standard of evidence at the
101 level of “clear and convincing”. Many states have adopted a standard of “reasonable
102 evidence” while some like Missouri, and New York use the “clear and convincing”
103 standard. With few exceptions, the courts have upheld the rights of patients or their health
104 care agents to refuse TF.

105

106 **Position 4**

107 It is the responsibility of physicians and team members caring for patients in long-term
108 care settings to understand the previously expressed wishes of the patient regarding
109 artificial feeding and incorporate these wishes into the care plan.

110

111 **Rationale**

112 In most cases of advanced dementia, there is opportunity, often over a period of months,
113 to observe that a patient has a progressive decline in appetite and/or swallowing function.
114 Progressive loss of appetite and swallowing ability commonly accompany advanced
115 dementia and unlike an abrupt change in eating, are unlikely to be reversible. Discussion
116 of strategic planning and advanced directives regarding feeding support should begin
117 early in the course of illness, and should not be delayed until a crisis develops. Waiting
118 until the patient refuses all foods, or a crisis occurs, to discuss feeding issues is an
119 unacceptable practice, as it does not allow family members time to review the literature
120 and prepare to make a potentially difficult decision. As noted in position statement
121 number three, surrogate decision makers should use previously expressed directives,
122 wishes and substituted judgment to decide what the patient with advanced dementia who
123 is not eating, would want under the present circumstances.

124

125 **Position 5**

126 Institutions such as hospitals, nursing homes and other care settings should promote
127 choice and honor patient preferences regarding TF and should not impose obligations or
128 exert pressure on patients or physicians to institute TF.

129 **Rationale**

130 Patient values, goals, prognosis and efficacy of treatment should be the determinant of
131 any medical therapy including TF. Institutions such as nursing homes should develop
132 policies to ensure that patients with remediable causes of weight loss are evaluated and

133 treated appropriately and that TF are not regarded as the only treatment choice. Clinical
134 conditions such as constipation, depression, medication side effects and xerostomia are
135 among several conditions that should be considered in patients who are not eating and
136 losing weight. There is considerable variation in nursing homes in the use of TF in
137 patients with advanced dementia. National databases demonstrate that the frequency of
138 TF in patients with advanced dementia varies from a low of 8% in Maine, to a high of
139 67% in Washington DC. (12) Institutional characteristics may explain some of this
140 variation. Characteristics that are associated with increased use of TF in nursing homes
141 include; larger nursing homes, lack of dementia care units, no on-site midlevel providers
142 and for profit status (12). Patient characteristics and choice should shape our institutions
143 and drive clinical care. Institutions should not attempt to influence physicians or patients
144 into providing or accepting care that is not effective or in concert with patient values and
145 goals. If institutions, based on religious or moral grounds, have policies obligating the use
146 of TF, families and patients should be informed of them in advance. When a patient loses
147 the ability to eat in such an institution, and does not desire TF, the institution should
148 transfer that patient to an establishment that will honor the patient's wishes.

149

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