Artificial nutrition – when to consider NG feeding / PEG

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• Cases & dilemmas
• Indications
• Ethics
• Dysphagia
• Evidence & lack of it
• Best interests & at risk feeding
• PEG – preparation and complications
• Useful resources
What do you do?

- Mr G is a 71 year old man who was very fit (half marathon runner) until a TACI 10 days ago
- Now still semi-conscious and little functional outcome
- NG in place since admission to stroke ward
- Family not sure he would want to be alive like this, but want your advice
What do you do?

• Mr P is a 80 year old patient who had a prolonged cardiac arrest following a recent emergency CABG. He has not regained consciousness & is ventilated on Critical care.

• He had wanted to be made “Not for Resuscitation” prior to his CABG

• The cardiac surgeon is keen for him to have a PEG to facilitate discharge

• His daughter doesn’t think he would want this, his son wants everything done and is a lawyer
What do you do?

- Mr W is a 86 year old man admitted with falls and general deterioration
- Frail but no significant co-morbidities
- Family say general decline since his wife died 9 months ago
- BMI 17 MUST score 3
- Despite nurses best efforts his oral intake is poor
- Clearly depressed but won’t take his tablets
What do you do?

- Your F1 asks you to see Mr T, a 78 year old man, who is complaining of severe abdominal pains the day after his PEG
Problems preparing this talk

- Not many high quality trials
- Much is consensus
- Can be ethically very challenging
Four Principles of Medical Ethics

• Beneficence – providing benefit
• Non-maleficence – deliberate avoidance of harm
• Autonomy – principal of self-determination
• Justice – equitable provision of resources to all
Applying 4 Principles of Med Ethics

• Beneficence – Is feeding of benefit to patient?
• Non-maleficence – Will feeding cause harm?
• Autonomy – What does the patient think?
• Justice – Is the decision equitable?
Indications for Artificial feeding in the Elderly

- Dysphagia
- Neurological issues – CVA, MND
- Unsafe swallow
- Unconscious patient
- Malignancy – head & neck, upper GI, chemotherapy
- GI disease e.g. liver disease, Crohn’s
- Malnutrition unlikely to meet requirements with ONS including “can eat, won’t eat”
Dysphagia

- Not direct effect of ageing but increasingly common in elderly
- Elderly more vulnerable to FX of dysphagia
- Complex feeding decisions ↑ly common
- Needs MDT approach incl SALT & dietetics
- Best practice guidance for stroke & advanced dementia
- Less clear for other indications
- Patients wishes are of primary importance
RCP Oral Feeding Difficulties & Dilemmas

“Patients with oral feeding deserve special care but may not receive it. Their care should be tailored to their needs, not those of others”

- Recommend
  - MDT Nutrition support team – collaborative
  - 1st question – what are we trying to achieve?
  - Oral intake (modified if needed) should be aim
  - Extra support incl. red trays, enough support at mealtimes
  - ‘NBM’ should be last resort, not default option
RCP Oral Feeding Difficulties & Dilemmas

• At end of life with unsafe swallow a ‘risk management’ approach may offer best QOL
• In doubt, a NG tube with clear treatment objectives may be appropriate, & withdraw if not met.
• If longterm ANH, should be possible at home or NH
• Decision never be based on ease for carers or as criteria for admission to an institution e.g. nursing home, intermediate care
PEG vs NG for Adults with swallowing difficulties

- Cochrane review 2015 Gomes C
- 11 studies included
- Follow up 0-6 (<17) months
- Intervention failure less common for PEG
- No difference in mortality, adverse outcomes incl aspiration pneumonia, wt gain, mid arm circumference
- “PEG may be more effective and safe compared with NG tube”
Interventions for acute & subacute stroke

• Cochrane review Geeganage C 12
• PEG vs NG no difference for case fatality or composite outcome of death/dependency
• PEG ->fewer treatment failures, gastrointestinal bleeding & higher feed delivery
Evidence and consensus suggests we should not place PEG tubes in advanced dementia.

BSG: "PEG insertion does not improve survival in end stage dementia and should be avoided except in circumstances where it can be justified as a palliative intervention, genuinely in the patient’s best interests." 2010

ESPEN: "The guidelines recommend against the initiation of tube feeding patients with severe dementia." 2015

RCP: "in general then, careful hand feeding is preferred and gastrostomy should not be offered in advanced dementia." 2010
Decision Making in Tube Feeding in Cognitively Impaired Elderly

• 46 “substitute decision makers” interviewed of 57 patients > 65 yrs in “chronic care facilities”
  – 74% acute neurological event, 11% dementia
  – 85% spent > 50% day in bed

• Time spent discussing decision -<15 min 37%, not at all 28% - “understood benefits > risks”

• Reasons given– prolong life -80%, fulfil moral obligation-78%, prevent aspiration -72%, make it easier for staff to feed - 46%

• 46% would want tube feeding themselves

• 37% felt tube feeding improved quality of life

• Better explanation, alternatives, implications sought

Mitchell S CAMJ 99
Best Interests

- Find out patient’s own views if known
- Make decisions on an individual basis, not based on what decision maker might want to be done to them
- Include key stakeholders including family
- Use of statutory checklist
- Good documentation is vital
- If considered appropriate consult your legal department
Prolonged disorders of consciousness RCP 2013

• To achieve a more consistent approach to patients with MDOC
• Recognition of Persistent vegetative state (PVS) and Minimally conscious state (MCS)
• Provides tools for assessment and monitoring
• Impresses importance of Best interests meeting before placing PEG etc, as will need Court of Protection to stop CANH
Selection of Enteral Tube

- Nasogastic
- Nasojejunval
- PEG
- PEG-J
- RIG/RIJ
- Surgically inserted G/J
NG tubes

- Can be started with minimal input from others
- Need to be secured properly!
- Needs involvement of nurses and education why it is important
- Nasal bridles can be very helpful
- Mittens – need to be taken off regularly, but if done properly good results
- All need involvement of patient/family
Nasojejunal

- Generally well tolerated
- Reduced risk of aspiration
- More invasive
- Problems with insertion usually endoscopy, so may have delays
- Blocks easily – flush regularly and caution with medication
- May be option in nursing homes
PEG

• Longer term Feeding
• Cosmetic and practical advantages
• Contraindications & cautions
  Ascites or Portal Hypertension
  Sepsis – MRSA & MSSA – try to eradicate first but if not possible consider x 2 give specific antibiotics
  Clotting problems /Anticoagulation including DOAC & clopidogrel) – INR <1.5
  Recent major Abdominal Surgery (RIG safer)
  Advanced dementia
PEG Complications

- Immediate mortality low – 1-2%
- Aspiration pneumonia – 11-66%
  - early & late
- Tube related
  - Local site problems – leakage & infection
  - Haemorrhage
  - Peritonitis – rare
  - Tube occlusion
Preparing my patient for PEG

- Is the patient fit enough for procedure?
- Is it appropriate? Be realistic
- Provide PEG info booklet to patient & family
- Are they competent to consent?
- If yes – MRSA/MSSA swab (<1 week), INR, stop anticoagulation (BSG)
- If no - also needs consent form 4 – your consultant will need to sign & family members
- Are patient & family aware of risks & benefits?
Feeding At risk

• If competent patients are not prepared to give up food & fluids despite coughing or choking episodes & aspiration
• If risks of tube feeding outweigh benefits, then decision may be made to initiate ‘risk feeding’
• If enjoyment of food felt outweigh risks
• Need to accept risk and try to minimise risks with technique e.g. positioning, textures
• Need to document decision making and discussions
Post PEG abdominal pains – what do you do?

• Your F1 asks you to see Mr T, a 78 year old man, who is complaining of severe abdominal pains the day after his PEG

• The nurses want to know what to do about his feed
ABCDE approach
Alert, but in pain
P 115, BP 100/55, T 38.3
Abdominal tenderness with guarding

WCC 14.5 CRP 72
Erect CXR
CT ordered
Surgeons contacted
CT – what is the abnormality?

- CT of patient with PEG flange not pulled up tight
• NBM & iv fluids
• Nil by PEG
• Refer to surgeons
• Pull flange close to abdominal wall
• iv antibiotics
• Discuss with patient +/- family re poor prognosis but can do well
Conclusions vs Dilemmas

- MDT approach
- Is it in patients best interests?
- No “right” answers
- Treat every patient as an individual
- Don’t place PEG to facilitate discharge?
- Are there any nursing homes in your area that take patients with NGs?
- Involve Nutrition team if you are not sure
Resources


• Oral feeding, difficulties and dilemmas RCP 2010

• ESPEN guidance on ethical aspects of artificial feeding and hydration 2016

• Prolonged disorders of consciousness National clinical guidance RCP 2013