Home enteral nutrition

M. Ermelinda Camilo

Abstract

The quality of home enteral nutrition must rely on a network between hospital nutritional teams and primary care. Major issues are the selection of patients and access route. Percutaneous endoscopic gastrostomy, properly managed, may be the best option for the medium and long term cases.

Key words: quality, home enteral nutrition, percutaneous endoscopic gastrostomy.

In our culture, nutrition is an important symbol of love, social solidarity and connection to life. Nevertheless, it is essential to place in perspective that which is merely symbolic, and that which is actually sensible and effective. Without sophisms, the enteral tube feeding should meet the healthcare objectives that it encompasses, when changing from one curative or palliative approach, aimed at improving quality of life, without prolonged use that is unnecessary or undesired (by patients, family members or society).

Enteral feeding at home is an alternative method that potentially, is more cost effective than hospitalization. For enteral feeding at home, it is necessary to define the organization and control of quality, which should be guided by multidisciplinary nutrition groups (doctors, dieticians, nurses, pharmacists) in secondary or tertiary hospitals, in close collaboration with the family health team (doctor, nurse, dietician, social worker), and should be implemented according to the strict principles, pragmatically adjusted to suit the local and regional conditions.

The fundamental steps are: planning, organization, establishment of standards and records, and effective communication (among health workers with patients and/or family members). We should take advantage of the experiences of others, in a critical way, in order to carefully implement this sensitive healthcare technique. It is a sensitive method because it needs to integrate ethics, finance, and life, or quality of life.

The issue of patient selection is therefore a priority. Most of the patients have neurological diseases with swallowing disorders, but gastroenterological, pediatric, geriatric, and oncological diseases, as well as AIDS, account for a significant number. The percentage of incidence in each area depends largely on whether there are underlying policies, but as a rule, advanced age is a dominant component because it is associated with most of the neurological and oncological diseases. In that context, it is natural that mortality will be high, although there is evidence that with the exception of terminally ill patients, effective enteral nutrition gives enhanced nutritional status and a better quality of life and functional capacity. It is a fact that only 15% to 25% of the patients using enteral feeding return to full oral feeding after six months; for some patients, it occurs later. Therefore, with rigorous selection of patients, enteral feeding can be a valuable medium- to long-term supporting or adjuvant therapy. In this context, besides the underlying medical condition, the access route used for the administration of nutrients is also particularly relevant. The *why* should be taken into account, in order to define the *where* and the *how*. We can use small-diameter nasogastric or nasoenteric tubes (8 French) for short-term treatments; gastrostomy or jejunostomy, ideally percutaneous endoscopic, laparoscopic or through surgery (only when previous methods fail or are impossible) should be reserved for medium- and long-term treatments. The *correct* decision must be based on the individual, and earlier insertion (one to three weeks) of a percutaneous gastrostomy tube may be desirable. In fact, the access route affects whether a chemical diet or normal foods are administered, as well as the complications

Gastroenterology Senior Hospital Assistant and in charge of the Nutrition Group of Santa Maria Hospital, Medicine II Service of Santa Maria Hospital, Lisbon

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of the enteral feeding. At present, provided a proper protocol exists, enteral feeding with the insertion of a percutaneous endoscopic gastrostomy (PEG) tube is the most cost effective option for most patients, and for the healthcare services. Therefore, earlier use of this method should be promoted among doctors, for cases where the patient is unable to eat independently but access to a sufficiently functioning gastrointestinal tract is possible.

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