Feeding in Very Advanced Disease

In the concluding paragraphs of their CME article, the authors point out that "PEG tube feeding is not a terminal or even symbolic measure in patients with a poor prognosis or incurable illness in its terminal stages." We want to emphasize this important point.

The emotionally charged measure of introducing or continuing artificial feeding is requested every day, in innumerable therapeutic situations, by patients as well as their relatives. Especially the plea from relatives, not to let the patient starve to death, requires a closer look.

It is indisputable that in secondary cachexia (e.g. tumor-related mechanical or neurological impairment of the act of swallowing) artificial enteral feeding via PEG can make perfect sense. The sensation of hunger does, however, not occur in primary tumor cachexia, and artificial feeding does not make a positive contribution to the patient's remaining lifespan or quality of life. Often, this measure only reinforces stressful symptoms owing to the fluid imbalances caused (ascites, pleural effusion, cerebral edema, etc). The same is true for advanced non-oncological diseases (1). Doctors are therefore not under obligation to instigate artificial feeding in this context (2).

With this letter, we want to lend additional emphasis to the final important paragraph of the CME article by Löser et al. We are hoping in this way to reduce uncertainties in decision making in favor of or against artificial feeding in the course of advanced disease and thus reduce automatic therapeutic responses. DOI: 10.3238/arztebl.2008.0310a

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In Reply:

The overwhelmingly positive responses to our CME article underline the importance of the topic of malnutrition in elderly people. The many readers' letters outline especially the need for open and critical discussion about the value of artificial feeding (PEG tube feeding) in this context. As Gaertner et al. reiterate, the PEG tube is not a terminal or even symbolic measure in patients in the terminal stages of an incurable disease but requires a medical indication – whose aim must be an achievable improvement to the patient's quality of life – as well as an ethical justification. Especially in view of the often emotional discussions, the question about the possibility/potential and limitations of supportive artificial feeding via PEG tube should be brought into the debate early on if the course of the disease is foreseeable, and should be discussed with the patient's relatives while focusing on the situation of that particular patient. Infor-

mation provided by the doctor on an individual basis and detailed communication are crucial in this context – both of which take into consideration the patient's wishes, whether the objectives are realizable, individual emotions at play, and possibilities/options, as well as the limitations of what doctors can do.

We also thank Müller-Ladner for his comment – he reminds us that a multitude of chronic disease processes may very early on result in a stealthy but continuous weight loss, which doctors will have to recognize early and treat with the established measures mentioned in our article. Chronic inflammatory rheumatic disorders and the complex multitude of autoimmune disorders are relevant diagnoses in this context. Two medical aspects are important: on the one hand, nutritional status will have to be monitored and involuntary weight loss will have to be checked regularly in all patients with chronic diseases; on the other hand, in patients with unclear weight loss, the whole range of chronic disorders – including rheumatological-immunological disorders – should be considered as a possible cause.

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Conflict of interest statement

The authors of all articles declare that they have no conflict of interest as defined by the guidelines of the International Committee of Medical Editors.