Medication for the Terminal Patient Who Can’t Swallow

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Disclosure

I have no financial relationships to disclose

Route and medication list not all inclusive

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Why This Topic

• All Internists care for patients with dysphagia and/or terminal patients
• Addressing medications in all care settings for patient with dysphagia often not done well
  • ESPECIALLY THE HOSPITAL!! – “NPO”
• More patients may be able go home to die
• Call nationally for appropriate opioid dosing
Dysphagia

- Definition – difficulty in swallowing that may include oropharyngeal or esophageal problems
- Eating is one of the most basic human needs/pleasure – difficulty in swallowing can cause social/emotional isolation
- May or may not be inherent in aging, but common in the elderly
- Incidence
  - 15% in community-dwelling elderly
  - 50-75% in nursing home population
Dysphagia

Risk Factors in the elderly

- **Medications and dysphagia**
  - **Xerostomia**
    - Anticholinergic drugs (tricyclic, antipsychotics, antihistamines, antispasmodics, antiemetic, anti hypertensives)
  - **Esophageal/Laryngeal peristalsis**
    - Antihypertensives, antianginal
  - **Delayed neuromuscular responses**
    - Delirium causing, extrapyramidal side effects
  - **Esophageal injury/inflammation**
    - CCB, Nitrates relax lower esophageal sphincture
    - Large pills
Dysphagia

Assessment

• Primary care screening for the elderly
  • Example tool – Dysphagia screening form- University of Wisconsin and Madison GRECC
  • One question test – “Do you have difficulty swallowing food?”
  • Correlate symptoms of weight loss, cough and SOB

• Bedside clinician evaluation
  • 3 oz water swallow test, auscultate over trachea before and after water swallowed; eval for cough, choking change in breath sounds
Dysphagia

Assessment and Diagnosis

• Physical Exam
  • Subtle voice changes (hoarseness, wet, hypernasal, dysarthria)
  • Absent or poor dentition
  • Tongue strength/oral control
  • Palate exam – symmetry, mass
  • Head and neck
  • Gag reflex poor indicator of dysphagia
Disorders Associated with Dysphagia

Neuromuscular – affect the central control over muscles and nerves involved in swallowing (i.e. Parkinsons, CVA, ALS, Myasthenia gravis, MS)

Rheumatologic – (i.e. Polymyositis, Dermatomyositis, Inclusion body myositis)

Head and neck oncologic – Oropharyngeal cancer

Pharyngeal structural – Zenkers

Gastrointestinal – tumors, GERD, Schatzki ring (primarily esophageal but cause symptoms radiating to pharynx)

Diminished cough
Dysphagia

Treatment

Goal – optimize safety of swallow, maintain adequate nutrition and hydration, improve oral hygiene

• Swallow therapy
  • Postural adjustments
  • Food and liquid rate and amounts (time to eat, small amounts, concentrate, alternate food and liquid, stronger side of mouth, sauces)

• Adaptive Equipment
• Diet modification
Dysphagia

Treatment

• Dietary modifications (watch for dehydration)
• Aggressive oral care
• Modify eating environment
• Oral Hygiene
  • Also reduce risk of aspiration
• Consider palliative care

Interdisciplinary

• Speech pathologist, dietician, OT, PT, nurse, oral hygienist, dentist, PCP, Caregivers, SW, family
Dysphagia

Consequences

• Social isolation (embarrassment)
• Physical discomfort
• Dehydration
• Malnutrition
• Overt aspiration
• Silent Aspiration – a bolus comprising saliva, food, liquid, meds or any foreign material enters the airway below the vocal cords without triggering overt symptoms
• Pneumonia, death
Dysphagia in Long-Term Care

- Common 50-75%
  - Aspiration leading cause of death in nursing home patients
  - Can stress nursing assistants with difficult feeding patients
    - Place food in non-impaired side of mouth
    - Limit use of straws
    - Adaptive feeding equipment
    - Restrictive diets
Dysphagia

The non-fixable dysphagia

• Goal is enhanced quality of life

• Tube Feeding
  • Not essential in all patients who aspirate
  • No data to suggest TF in pts with advanced dementia prevented aspiration pneumonia, prolonged survival or improved function (aspiration pneumonia is the most common cause of death in PEG tube patients)
  • Short term TF indicated if improvement in swallow likely to improve
  • Pt autonomy, self-respect, dignity and QOL
Dysphagia

Goal is enhanced quality of life

• Tube Feeding
  • OK not to put in PEG
  • Do not need to put in PEG for meds
  • Does patient want to go home?
  • can family manage patient at home with PEG?
  • Is PEG being put in for reversible dysphagia/disease process- if no, need goals of care discussion
  • Consider prognosis, palliative care consult
    —More and more available in hospitals and outpatient (including nursing homes)
Decreasing appetite / food intake

**Thirst**

- 66% has thirst either initially or until death – all relieved with voluntary liquids or mouth care
- Only one patient had calculated intake of food or fluids >75% of requirements
- 9 patients had symptoms from eating encouraged by family
Arguments for Artificial Hydration

Delirium is common in dying patient
Hydration may improve the delirium

- Lawlor PG Support Care Cancer 2002
- Bruera E et al. Support Care Center 1996
Alternate Routes of Administration

Allow adjustment to patient’s changing needs

Transdermal
Transmucosal
Rectal opioids
Parenteral: Intravenous or Subcutaneous
Spinal infusions: Intrathecal or Epidural

Medication Philosophy in General for the Dysphagia Patient

Limit to essential medications

Choose less invasive route of administration

- buccal mucosal or oral first
- topical
- subcutaneous, intravenous rarely
- rectal
- intramuscular almost never
Medications for the non-terminal patient with Dysphagia

When NPO

- NPO except medications?
- Write order “may hold po meds if unable to swallow”
- Review medications and stop non-essential ones, change essential ones to IV, topical, sublingual, subcutaneous or rectal
- Example – catapres, nitropaste for HTN; rectal aspirin in stroke patient;
- Good time to evaluate if patient really needs med
Medication evaluation in the patient where dysphagia improving

Pureed diet, thickened liquids

- Still very guarded prognosis
- Address goals of care
- Review medications and stop non-essential ones
- Example – cholesterol meds, vitamins
- Good time to evaluate if patient really needs med
Nasogastric Tube

Closely evaluate why put in

• ? For meds – are medications necessary, ?alternate route available

• ? For feedings
  — Evaluate when patient will be able to eat and if patient will meet caloric needs
  — Likely proceed directly to PEG if meets goals of care

• Poor prognostic sign and high risk of complications
Subcutaneous route

- Button
- Butterfly needle
- Abdomen, thigh, upper arm

Hypodermoclysis

- subcutaneous infusion fluids
- Max 1-2 ml/min
- Often used in nursing home
Subcutaneous Medications

Pain
- Dilaudid, Morphine, Fentanyl
- For Morphine 1:1 IV/SQ
- Subcutaneous infusion

Anti-inflammatory
- Decadron

Agitation/Restlessness
- Ativan, Haldol, Phenobarbital

Shortness of Breath
- Morphine
Subcutaneous Medications

Nausea
  • Compazine
  • Haldol

Terminal congestion
  • Scopolamine

Subcutaneous Infusion
  Morphine, Dilaudid
Topical medications

Anti-hypertensive
  • Catapres

Pain
  • Fentanyl
  • Lidoderm
  • Over the counter topical creams
  • Compounded NSAIDS

Restlessness
  • Ativan Gel

Compounding Pharmacies
Additional medication routes to consider

Rectal
  • Many medications can be given rectally
  • Long acting Rx will become immediate release

Intrathecal

Nerve Blocks

Epidural
Treatment in last days of life

Loss of gag reflex

Xerostomia – mouth care/swabbing

Buildup of saliva, secretions
  • scopolamine to dry secretions
  • Levsin sublingual
  • Atropine drops given sublingual
  • postural drainage
  • positioning
  • Suctioning
Take Home Points

• Pause when writing an NPO order
• Pause when writing pureed diet or thickened liquid
• Pause in patient with anorexia
• Don’t forget topical, rectal, sublingual and subcutaneous route
• Consult hospice when needed for info
• Consult pharmacy
• Consult interventional pain specialist