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Nutritional Support in Terminal Cancer Patients

To the Editor:

I read with interest the paper by Winter,[1] and I agree with the author's conclusion if, for "terminally ill" he means "imminently dying/moribund" patients, because artificial nutrition has no role in these situations. Unfortunately, the definition of "terminally ill" has never been scientifically coded, and the author considers within the same term "oncologically" terminal patients who survived longer than 1 year,[2] and "biologically" terminal patients who were expected to die within 3 months.[3] This is ambiguous because some oncologically terminal patients could sometimes succumb prior from starvation/malnutrition rather than from tumor progression and hence, they could potentially benefit from artificial nutrition. As summarized in a recent paper,[4] (hypo)aphagic incurable cancer patients survive few weeks without nutritional support but could survive months if receiving parenteral nutrition.[5]

A further source of misunderstanding is the reference to meta-analyses and randomized controlled trials of the past millennium: Clamon et al[2] enrolled nonmalnourished patients, administering IV for 1 month 40-56 Kcal/Kg/d, in addition to the oral intake. Such a glucose-based regimen would be defined nowadays as extremely toxic by any expert. Current parenteral nutrition regimens are much better balanced and, if properly administered for a limited period of time, many of the complications reported in the table of Winter's paper[1] simply do not exist. Many "terminal" cancer patients still harbor a central venous catheter originally placed for chemotherapy, are familiar with its care, or more recently, they may receive a peripherally introduced catheter with minimal risk.

Finally, I accept the objective criteria of futility reported by Schneiderman et al;[6] however, it is well known that quality-of-life priorities recognized by the carers often do not parallel those of the patients. Hence, I would prefer a more patient-centered approach that also considers the eventual will of the patient to be discharged home while continuing to receive nutritional support.

In conclusion, I think it is difficult to keep a rigid position about what to do or not to do in a gray area like this; however, any choice should rely on the real-world experience, that is, the practice and the potential of artificial nutrition is not that of 30 years ago, and incurable cancer is becoming a chronic disease where sometimes malnutrition/starvation, more than tumor progression, affects the outcome.

Federico Bozzetti, MD
Faculty of Medicine, University of Milan, Milan, Italy

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Requests for reprints should be addressed to Federico Bozzetti, MD, Residenza Querce Milanodue, 20090 Segrate, Italy.
E-mail address: federicobozzetti@gmail.com