

British Intestinal Failure Alliance (BIFA) statement July 2017

Home parenteral nutrition (HPN) for patients with advanced malignancy

Introduction

Terms such as 'palliative' or "incurable" cancer or advanced malignancy are used interchangeably in medical literature and in clinical practice and have varying definitions. For this position statement we use the term 'advanced malignancy' for patients with malignancy, where cure is no longer possible, or has been declined by the patient or is not viable due to co-morbidities.

Intestinal failure (IF) in patients with advanced malignancy is most often caused by bowel obstruction, which may be partial, intermittent or complete. It can also be due to an enterocutaneous fistula, short bowel resulting from surgery, dysmotility or severe mucosal disease (often following chemotherapy or irradiation). Artificial nutrition support may be provided to patients within the community with advanced malignancy. In most cases this is given through a naso- or transabdominal enteral feeding tube. Historically, only a few patients in the United Kingdom (UK), have been fed by parenteral nutrition (PN) in the last year of their life, largely due to concerns regarding the logistics of establishing PN in the community and its perceived risks. However, with improvements in homecare support and safer delivery of PN (with aseptic care of the intravenous catheter) it is evident that there are patients with advanced malignancy and intestinal failure, who have failed enteral nutrition and can benefit from PN. The benefit can be both in terms of quality of life (including improved wellbeing and better energy levels) and increased life expectancy. The extra time gained as a result of receiving PN may allow a patient to achieve some personal goals. These include spending time with their family (especially if young), putting their affairs in order, achieving a personal ambition or attending an event. There are "burdens" associated with PN and these include disrupted sleep, much equipment and ancillaries in the home, regular nursing visits (if not independently doing the procedures) and the risks of complications especially catheter-related sepsis. There is also debate about whether nutritional support (especially glucose) may increase tumour growth.

Increasingly patients are being referred for consideration of HPN as medical staff, patients, relatives and careers are becoming aware of it as a treatment option. The British Artificial Nutrition Survey (BANS) 2014/15 report of adult home parenteral nutrition (HPN) in the UK, shows that the percentage of new HPN registrations with 'malignancy' as the underlying diagnosis has risen from 12% in 2005 to 27% in 2015 and accounts for approximately one in 4 new HPN registrations. While the curative status of malignancy is not reported to BANS, the vast majority of these patients have advanced malignancy (1).

Patients who are considered for PN in the palliative setting can be classified into three palliative (P) groups:

'P1' IF – those with an expected short survival (less than 12 weeks) but with a good performance status (2) and low inflammatory markers. These patients include young individuals with tumours that are usually rapidly growing – for example bowel

obstruction due to metastatic or locally advanced bowel, bladder, ovarian, cervical or diffuse gastric cancer. The priority for these patients is rapid discharge home with objective measureable goals.

'P2' IF – those who require HPN whilst receiving ongoing oncological treatment – such as chemotherapy for ovarian cancer or debulking surgery. The P2 state will regress to P1 if treatment is ineffective or to P3 if the tumour is very slow growing. These patients are often metabolically unstable (e.g. due to fluid balance, renal or hepatic impairment) and may require more intensive monitoring and modification of their PN scripts. They may require management from multiple specialities and require an individualised care plan.

'P3' IF – patients who require PN, usually due to slow growing tumours such as some ovarian cancer, neuro-endocrine tumours, some sarcomas or pseudomyxoma peritonei and who may survive a long time, often several years, with nutritional support. In terms of general medical management and follow up they are managed in the same way as other patients receiving HPN. There is likely to come a time when the disease has progressed and discussions about the withdrawal of treatment need to take place.

This document was produced following the BIFA annual meeting on 10 November 2015 entitled "Palliative HPN – benefits and burdens". Palliative HPN is less commonly needed in children and young people less than 18 years of age, but the same standards and recommendations do apply.

When to consider HPN in patients with advanced abdominal malignancy

1. Patients with IF from bowel obstruction (partial, intermittent or complete), enterocutaneous fistula(s), a short bowel, dysmotility or severe mucosal disease (often following chemotherapy or irradiation).

Which patients with advanced malignancy will have the best survival and quality of life (QOL) on PN?

2. Those patients with higher performance status for most of the time (e.g. Karnofsky performance scale index (2) above 50, ideally 70 or Eastern Cooperative Oncology Group (ECOG)/World Health Organisation WHO performance status (3) above 2, ideally 3 (table 1)) and low inflammatory markers in the blood (CRP <10 mg/L and albumin >30 g/L) are more likely to survive longer (4-6), but the sensitivity and specificity of objective inflammatory markers are low and cannot be relied upon in individual cases.
3. Existing guidelines (e.g. ESPEN (7)) select patients with an expected prognosis of 2-3 months or greater as those who are most likely to benefit from HPN, but a number of studies have shown that, despite variable selection criteria and guidelines, mortality at 3 months is approximately 50%.
4. It remains extremely difficult to predict the length of survival and there may be palliative benefits in providing PN to patients with a shorter prognosis with a good performance status.

The decision to start PN in patients with advanced malignancy

5. Patients who meet the above criteria (1-3), and their relatives, should be informed about PN as a potential treatment, including preliminary discussions of the potential benefits, practical implications and risks of HPN treatment.
6. All patients who may be considered for HPN should have an early multidisciplinary team (MDT) review by the nutrition team, oncologists and palliative care teams. The desired aim(s) of starting PN and the plans for withdrawal at the end of life should be discussed.
7. If the patient is based at a centre without HPN set-up provisions, early liaison with a commissioned regional or national HPN centre is necessary for the prescription to be written (with a Blueteq number needed in England). This includes palliative care involvement, before or during the patient selection process.

Other considerations at time of starting PN

8. When IF is due to bowel obstruction, there should be a surgical assessment to consider an operative resolution. This is most likely to be successful where there is a single discrete cause for the obstruction. Unfortunately obstruction is most commonly due to peritoneal disease causing multi-level obstruction, with a high chance of recurrence after surgery.
9. Patients who require HPN support for bowel obstruction should also be considered for a venting gastrostomy placement (20F or larger) in order to palliate vomiting and, if wanted, to allow eating and drinking of a limited diet.
10. It should be noted that abdominal interventions risk the tumour growing along any medically or surgically created tract, with a consequent chance of poor healing of the exit site/stoma and possible leakage.
11. When planning HPN the timing and routes of administering medications needs to be taken into account, especially if they are given intravenously.

Discharge process

12. In the early advance care planning stage the patient and family should be made aware that while arranging discharge, clear agreed guidance needs to be in place around when withdrawal of home PN will be considered. There should be a clear plan around monitoring, frequency of blood tests and the need for physical observations. There should have details of whom to contact in an emergency including if equipment fails.
13. If the patient is based in a hospital without the facilities to start HPN, priority should be given, by the commissioned regional or national HPN centre, to transfer the patient to expedite home discharge, or for the commissioned regional or national HPN centre to facilitate the remote discharge of the patient from the original referring hospital.
14. If networks already exist for 'remote discharge' from a local hospital, with links to a regional or national HPN centre, this should be utilised to expedite discharge. The co-ordination of remote discharge can be facilitated by phone, video or teleconferencing with the regional or national HPN centre (who will be writing the HPN prescription).
15. Patients and family will be encouraged to learn connections and disconnections, but discharge should not be delayed for training. It is envisaged that most advanced malignancy HPN patients will be supported with home nursing care (except in Northern Ireland and Scotland where no homecare nursing provision is available and district nurse training may be required).
16. There should be a discharge plan with, when appropriate, a record of a discussion around advanced care planning and about resuscitation such as Recommended Summary Plan for Emergency Care and Treatment (ReSPECT), Preferred Priorities of Care or Deciding Right and a statement of where the patient wishes to die. This should be shared with appropriate out of hours care providers in the locality.

17. Clear lines of responsibility must be stated in advance for all aspects of the patient's care after leaving the hospital. This may include the GP, hospice, palliative care, or nutrition support team.
18. Patient must have a point of contact after discharge. The clinic follow ups, if necessary, should be arranged before discharge. They may include the local hospital/oncology centre.
19. Community support for stoma, fistulas, gastrostomy site care and medications should ideally be provided.
20. Patients needing palliative care should have their individual needs/circumstances considered quickly by an integrated IF or HPN centre and be fast tracked home or to a hospice (that accepts patients having HPN) within 14 days of the decision for HPN, providing they are reasonably medically and psychologically stable. (As in BIFA HPN position statement 2016).

What type of PN is given?

21. All reasonable efforts should be made to reduce the burden and costs of HPN therapy by using the lowest frequency, volume and complexity of the HPN solution and keeping the ancillaries (i.e. pump) relatively user friendly. In addition the number of blood tests and time away from home for review should be kept to a minimum.
22. Fluid/electrolyte/nutrition prescriptions may not be ideal for P1 and P2 IF patients at discharge but a quick discharge is most important. Consider standard bags, part infusion of bags and less meticulous stabilisation to aid faster discharge into the community. The feed composition, if required, can be adjusted when the patient is at home.
23. Lipid is well tolerated in malignancy (8-12) and there is no need to limit it to prevent PN associated liver disease in P1 and P2 IF patients as this is unlikely to occur if the prognosis is less than 18 months. A lipid source containing fish oil (W3) may be beneficial.

Follow up/monitoring

24. A good action plan should be in place that includes clear individualised objective and measurable outcomes and goals.
25. Follow up should be arranged on a case-by-case basis, but it is envisaged that for patients discharged home an out-patient appointment is made within 2-4 weeks. For those patients discharged to a hospice, liaison with the palliative care team is likely to be sufficient to meet patients ongoing follow up needs
26. In the case of longer surviving patients (>3 months) follow up should be made on clinical requirements and depending upon the patient's condition standard HPN monitoring tests are recommended.
27. All the relevant teams involved (patient and family/carers, oncology, palliative care, regional and local nutrition teams and community nursing, palliative care and primary

care) should share contact details, in order to best communicate with each other about any issues arising.

28. Follow up planning requires clear communication between the oncology, palliative care and HPN providing teams regarding roles and responsibilities. For example responsibility for management of the catheter, IV medications, blood monitoring and how episodes of suspected catheter-related sepsis would be managed. Close follow up and communication between teams may be required to assess response and patient classification.

Stopping HPN

29. Advance care planning with the patients/family and palliative care team should be made in order to determine the patient's wishes with regard to the preferred place of care and dying; and the situations when PN would be stopped. Lasting power of attorney and a will should be made and in place (NB: Northern Ireland currently has no provision for appointing legal proxies with power to make healthcare decisions).
30. The criteria for stopping PN may include the patient and/or carers wishing to stop, the complications and burdens of the PN outweighing the benefits of the HPN such that the PN is considered a futile therapy. While PN may be stopped fluids and medication necessary for best symptomatic palliative care may be continued..
31. Home care companies must have good communication with the MDT/NST and must be informed when a patient is stopping HPN. They will need to collect all PN related equipment at an agreed time.
32. If not used the parenteral feeding catheter may be removed or flushed, using an aseptic technique, at least weekly with saline.
33. Clear pathways and lines of communication should be in place, should the patient need to be admitted to another hospital (approximately 40% of such patients will require this).

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Table 1 – Conversion of Karnofsky to ECOG/WHO performance status (3) (Eastern Cooperative Oncology Group/World Health Organisation)

Karnofsky Status	Karnofsky Grade	ECOG/WHO Grade	ECOG/WHO Status
Normal, no complaints	100	0	Fully active, able to carry on all pre-disease performance without restriction
Able to carry on normal activities. Minor signs or symptoms of disease	90	1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work
Normal activity with effort	80	1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work
Care for self. Unable to carry on normal activity or to do active work	70	2	Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours
Requires occasional assistance, but able to care for most of his needs	60	2	Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours
Requires considerable assistance and frequent medical care	50	3	Capable of only limited self-care, confined to bed or chair more than 50% of waking hours
Disabled. Requires special care and assistance	40	3	Capable of only limited self-care, confined to bed or chair more than 50% of waking hours
Severely disabled. Hospitalisation indicated though death not imminent	30	4	Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair
Very sick. Hospitalisation necessary. Active supportive treatment necessary	20	4	Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair
Moribund	10	4	Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair
Dead	0	5	Dead

By the BIFA Committee 2017

Jeremy Nightingale (Chair)
Alison Young (Secretary)
Barney Hawthorne
Phil Stevens
Alastair McKinlay
Gerard Rafferty
Sue Protheroe
Simon Gabe
Michael Glynn
Simon Lal
Trevor Smith
Jeremy Woodward - produced the first draft of the document
Mattias Soop
Kirstine Farrer
Alison Culkin
Jackie Eastwood
Carolyn Wheatley

And additional major contributions in writing the document were from:

Mani Naghibi – produced second draft and co-wrote final version
Penny Neald
Dr Susan Salt - Medical Director and Consultant in Palliative Medicine.
Clinical Lead for Lancashire and South Cumbria for Palliative and End of Life
Care.