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Proposal of Speech-Language Pathology activities in Palliative Care in hospitalized oncology patients

Proposta de atuação da Fonoaudiologia nos Cuidados Paliativos em pacientes oncológicos hospitalizados

Propuesta de acción fonoaudiologica para Cuidados Paliativos en pacientes oncológicos hospitalizados

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Abstract

The aim of this paper is to present a Speech-Language Pathology – SLP proposal to guarantee the security aspects of swallowing and facilitate the communication of palliative care patients with cancer admitted at a hospital. Every day, patients characterized as palliative care in the hospital receive a SLP visit and undergo professional assessment specially if it is observed predictors of aspiration risk or complaints of discomfort while feeding. After the clinical assessment, if oropharyngeal dysphagia is inferred, patients are accompanied by the SLP. The treatment aim's rehabilitation and/or minimization of the aspiration risk, according to the clinical status and desires of the patient and the family. The patient evaluation is always considered and the SLP seeks to avoid any discomforts related to feeding and/or communication disorders. Thus, it was concluded that the SLP can contribute actively within the multidisciplinary team of palliative care patients with cancer admitted at a hospital, assessing, preventing, rehabilitating and maintaining, when possible, the swallowing safe and pleasurable by managing the risk of aspiration and improving the patient quality of life related to the oral feeding and communication.

Keywords: *Palliative Care; Deglutition Disorders; Speech, Language and Hearing Sciences; Patient Care Team*

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Resumo

O objetivo deste trabalho é apresentar uma proposta de atuação fonoaudiológica para os aspectos de segurança da deglutição e facilitação comunicativa em pacientes oncológicos internados em ambiente hospitalar e em cuidados paliativos. Diariamente, os pacientes caracterizados como em Cuidados Paliativos hospitalizados recebem a visita fonoaudiológica e passam por avaliação profissional, sobretudo se observados sinais preditores de risco para broncoaspiração ou queixas que lhes ofereçam desconforto no processo de alimentação. Após a avaliação fonoaudiológica completa, se inferida a Disfagia orofaríngea, os pacientes são acompanhados pelo Fonoaudiólogo com condutas que visem à reabilitação e/ou a minimização dos riscos de broncoaspiração, de acordo com o quadro clínico, das necessidades e desejos tanto do paciente quanto da família, da evolução em que se encontra e a possibilidade de antever e prevenir desconfortos relacionados à alimentação e/ou comunicação desse paciente. Assim, conclui-se que o Fonoaudiólogo pode contribuir ativamente dentro da equipe multiprofissional de cuidados paliativos ao paciente oncológico internado em ambiente hospitalar, avaliando, prevenindo, reabilitando e mantendo uma deglutição de forma segura e prazerosa ao indivíduo, quando possível, gerenciando os riscos de broncoaspiração e melhorando sua qualidade de vida relacionada à alimentação via oral e comunicativa.

Palavras-chave: *Cuidados Paliativos; Transtornos de Deglutição; Fonoaudiologia; Equipe de assistência ao paciente*

Resumen

El objetivo de este trabajo es presentar una propuesta de atuación fonoaudiológica para los aspectos de seguridad de la deglución y la facilitación de la comunicación en pacientes oncológicos internados en ambiente hospitalar y que reciben cuidados paliativos. Diariamente, los pacientes que reciben cuidados paliativos, hospitalizados, reciben visita fonoaudiológica y pasan por evaluación profesional especialmente si se observan señales de riesgo para la aspiración bronquial, o quejas que ofrescan molestias en el proceso de alimentación. Después de la evaluación fonoaudiológica completa, si se infiere la existencia de disfagia orofaríngea, los pacientes son acompañados por fonoaudiólogo con conductas orientadas a la rehabilitación y / o minimización del riesgo de aspiración, de acuerdo con el cuadro clínico, con las necesidades y deseos del paciente y de la familia, con la evolución del cuadro y con la capacidad de antever y prevenir malestares relacionados con la alimentación y / o comunicación de ese paciente. De eso se concluye que el fonoaudiólogo puede contribuir de manera activa dentro del equipo multidisciplinar de cuidados paliativos al pacientes oncológico internado em ambiente hospitalar, evaluando, previniendo, rehabilitando y manteniendo una deglución segura y placentera para el individuo, siempre que sea posible, administrando los riesgos de aspiración bronquial y mejorando su calidad de vida relacionada con la alimentación oral y la comunicación.

Palabras clave: *Cuidados Paliativos; Trastornos de Deglución; Fonoaudiología; Grupo de Atención al Paciente*

Introduction

According to the World Health Organization (WHO), palliative care is defined as the improvement of the patient and the family quality of life. It helps both the patient and the family to address the problems related to the illness, while preventing and alleviating the suffering by identifying it as soon as possible through the performance of a complete and direct evaluation, as well as treating any physical, emotional and spiritual problems[1].

Since the begging of the treatment of patients with life-threatening diseases, such as cancer, besides the great importance of treating the pathology, with chemotherapy and radiotherapy, it is extremely important to work with the patient and the family the concept of death. The professional must show that death is a natural process that must not be accelerated or delayed. Also, the professional must give encouragement and support so that the patient lives as actively as possible with less pain and other distressing symptoms, always considering the emotional and spiritual factors of the patient and their relatives[1]. This definition does not estimate the palliative care patient's life time or time of death, on the other hand, it focus on the integrated care of this person, not specifying any model of how to proceed but with a philosophy of treatment[2].

Frequently, terminal illness appears related with palliative care matters however they are not synonymous. It is not always easy for the professional team, the patient and the family to accept that all possibilities of cure have been exhausted[3] and that the individual is in a terminal situation, however, the multi-professional palliative care team acts intensively in these cases, giving a better quality of life to the patient and unconditional support for the family members. In these cases, the disease and the cure are not the focus; the focus becomes the patient quality of life[4].

The multi-professional team personal and professional satisfaction in working with palliative care cases must be extremely valued, once their perception of the humanization of care, the presence of the process of death and the feeling of impotence impacts directly on the quality of the care provided to the patients and the families in these situations [5-8].

The speech-language pathologist (SLP), as an active and important member in the multi--professional palliative care team, provides to the palliative care patient more possibilities of interaction with the family members through communication. The SLP also maintains the social contact by guaranteeing, in the best possible and safer way, the pleasure of oral feeding[6], through dysphagia rehabilitation or by monitoring functions of breathing, voice and speech, along with safe swallow strategies[7,8]. Among these functions, swallowing is not the most important for the palliative care patient - although, a swallowing disorder can endanger the patient physical health, and may accelerate the death process due to pneumonia or respiratory insufficiency, going against the philosophy of the palliative care – therefore, even not being the most important function, dysphagia must be given a special attention by the SLP in palliative care patients[9-11].

Therefore, the objective of this article is to present a SLP proposal to guarantee the security aspects of swallowing and facilitate the communication of palliative patients with cancer admitted at a hospital.

SLP proposal for the care of palliative patients

Figure 1 exemplifies a flowchart developed in a Health Institution in São Bernardo do Campo, São Paulo, Brazil.

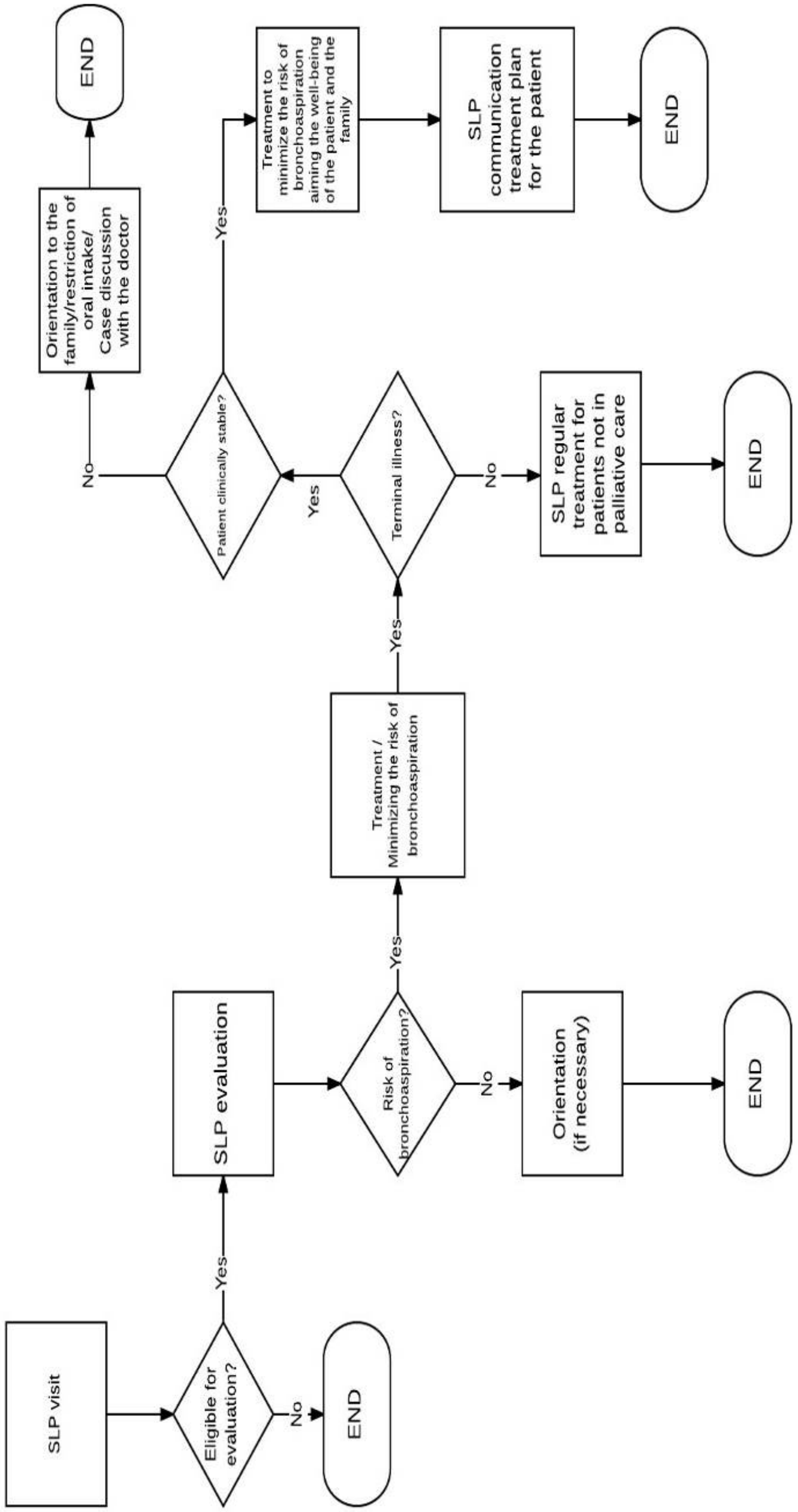

Figure 1. SLP proposal for the care of palliative patients

It is observed from the flowchart that the patients in palliative care hospitalized in the last 24 hours are daily seen by the SLP. Also, there is a professional evaluation, especially if observed any risk signs of bronchoaspiration or any complaints regarding discomfort while eating (odynophagia, choking, sialorrhea or dry mouth). After the complete SLP evaluation, this consists of the swallowing clinical evaluation that includes: indirect evaluation of the sensorimotor oral system, and a direct evaluation. For this second evaluation – the direct evaluation - different consistencies of food are presented to the patients such as: pudding thick foods (spoon tip, shallow spoon and full spoon); liquids (3, 5 and 10 ml) and solid food. After the evaluation, if oropharyngeal dysphagia is inferred, there are some follow-up SLP visits with conducts that aim rehabilitation and/or minimization of any risk of bronchoaspiration. The follow-up SLP visits may vary from one to three times a day, according to the clinical status, the needs and desires of both the patient and the family, the clinical evolution and the possibility of foreseeing and preventing discomforts related to oral nourishment and/or to the patient communication.

In cases where there is a total effort of the medical team to try to reverse or to compensate the pathology, palliative care patients are considered by the SLP as able for the dysphagia rehabilitation. Thus, according to the clinical findings, the SLP therapy is conducted based on the therapeutic procedures as conventionally described in the literature, with exercise[11] and maneuvers, suggestion of an alternative feeding method, food consistency, supply quantity, pace of supply, posture, state of alertness, responsiveness and respiratory pattern, suggestion of decannulation or conversion to tracheostomy (if indicated). Also, there must be a permanent orientation to the family and/or the caregivers and also SLP therapy after hospital discharge.

On the other hand, if the patient has a terminal medical prognosis but is still clinically stable, the SLP therapy has a multi-professional approach, in order to ensure the well-being of both the patient and his family, without ignoring the risk of bronchoaspiration, but focused on providing a better quality of life - according to the flowchart of Figure 1 - and not on rehabilitation.

Let's consider the real benefit of the therapeutic actions taking into account the patient clinical status: will myofunctional exercises sequences be beneficial to the case? If yes, then they are perfectly applicable, but if not, we must put the patient in a situation of greater comfort. It is also the time for the professional to question his doubts and conducts which should only be answered on frequent meetings – that occur sometimes everyday - involving the medical team, the multi-professional team and the patient's family, considering above all, the wishes of the patient and his life history.

Culturally, there are important social aspects of feeding that are commonly associated with good quality of life or health improvement; take as an example the families that traditionally enjoy their mealtime, what would be the benefit of suggesting an alternative feeding method at this point in life? Will there be an organic benefit for the patient clinical status? Or will it bring discomfort and dissatisfaction both for the patient and his family? Frequently, this is one of the dilemmas that the palliative care team must deal with: how to feed the patient in terminal condition? In the hospital where this research was done, the SLP team, together with the nutritionist team, carefully analyzes the possibility of maintaining the oral nourishment. Of course they consider the best consistency to avoid bronchoaspiration and suggest a smaller volume per swallow in order to avoid respiratory discomforts, which is the amount of comfort. Furthermore, the patient's food preferences are considered and the family may bring homemade foods; it is the SLP responsibility to guide the family in the preparation of this food according to the consistency that is best for the patient at that time. There are cases in which even a smaller volume per swallow becomes contraindicated, however, if there is still a desire for oral nourishment, the SLP must provide a gustatory stimuli aiming satisfaction and seeing the patient as many times as it is necessary - between one to three times a day - according to the case.

On the other hand, what can we do if the patient does not demand for food? From the SLP point of view, if it is notice that the oral feeding becomes an obligation and it is no longer a pleasure, its restriction is suggested and further discussions, with the medical team and the family, are done to define the future steps of the treatment.

At this stage of life enabling an effective communication between the patient and those around him becomes as important as any other type of care. When verbal communication is no longer possible, non-verbal communication may be used, such as writing, drawings, gestures, and alternative communication boards. In cases with tracheostomy, it is possible to use speech valves - if the patient has favorable criteria to its adaptation - or even suggestion to replace the cannula and use digital occlusion for phonation. Sometimes, in patients with no indication of maintaining a deflated cuff due to the amount of secretion, the palliative care team agrees to dry mouth procedures and sees the patient more often, together with the SLP and the physiotherapist, in order to provide verbal communication moments throughout the day with a deflated cuff and under professional supervision. The Chart 1 shows the SLP pathways for rehabilitation and risk minimization of bronchoaspitation and communication in patients in palliative care.

Chart 1. SLP pathways for rehabilitation and risk minimization of bronchoaspitation and communication in patients in palliative care

Treatment / Minimizing the risk of bronchoaspiration	Treatment to minimize the risk of bronchoaspiration aiming the well-being of the patient and the family	SLP communication treatment plan for the patient and the family well-being
Suggest an alternative feeding method	Suggest an alternative feeding method	Adaptation of oral communication or use of non-verbal communication methods (writing, drawings, gestures)
Provide a gustatory stimuli	Provide a gustatory stimuli	Suggestion of decannulation or conversion to tracheostomy aiming the communication
Adequacy in the amount of comfort	Adequacy in the volume per swallow (amount of comfort)	
Adequacy of food consistency, posture and pace of supply	Oral nourishment according to the patient and the family solicitation (homemade food, according to the patient desire)	
Oral, laryngeal, and pharyngeal exercises and various swallow strategies	Adequacy of food consistency, posture and pace of supply (homemade food)	
Constantly checking the state of alertness, the breathing pattern and the patient responsiveness	Restriction of oral intake if it is the desire of the patient and his family	
Suggestion of decannulation or conversion to tracheostomy	Constantly checking the state of alertness, the breathing pattern and the patient responsiveness	
Permanent orientation to the family and the caregivers	Suggestion of decannulation or conversion to tracheostomy	
SLP therapy after hospital discharge	Permanent orientation to the family and the caregivers	

Final considerations

The SLP can actively contribute with the multi-professional palliative care team with oncology patients in hospitals by evaluating, preventing, rehabilitating and maintaining, whenever possible, a safe and enjoyable oral feeding for the individual. Therefore, the SLP can manage the risks of bronchoaspiration and improve the patient quality of life related to oral feeding and communication at a moment full of difficulties with no more cure possibilities for the oncological disease.

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