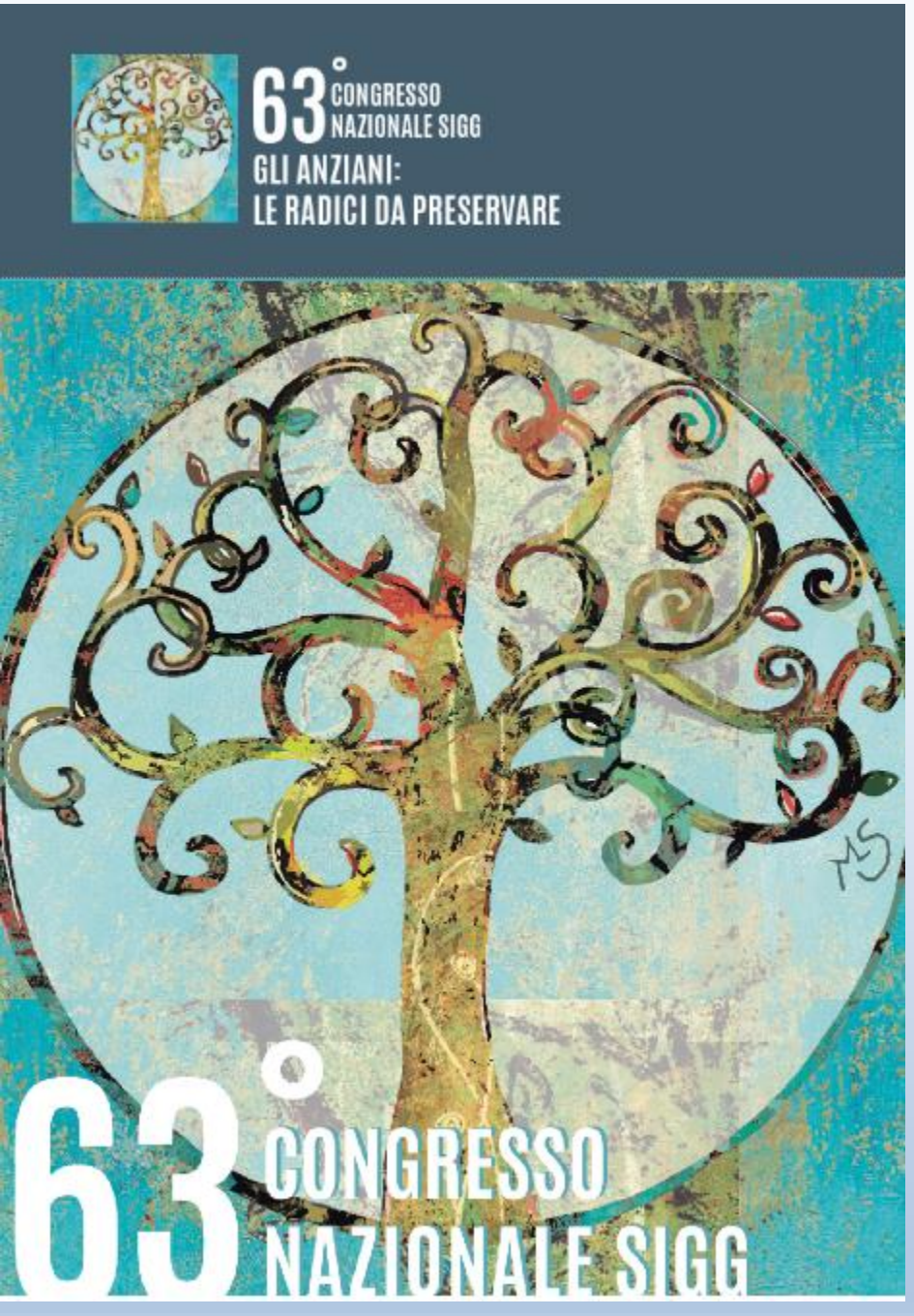


La Nutrizione Artificiale nella demenza severa

Salvatore Ricci

Azienda Policlinico Umberto I

Modificazioni fisiologiche nell'anziano con impatto sullo stato nutrizionale

- Composizione corporea e fabbisogno energetico
- Alterazioni della regolazione dell'assunzione del cibo
- Invecchiamento dell'apparato digerente
- Alterazioni metaboliche
- Organi di senso
- Modificazioni gastrointestinali

Demente

+

disturbi comportamento alimentare

Causes of malnutrition in older persons with dementia

Table 7
Potential causes of malnutrition in older persons with dementia and reasonable interventions.

Potential causes	Interventions
Mastication problems	• Oral care • Dental treatment • Texture modification
Swallowing problems	• Swallowing evaluation • Swallowing training • Texture modification
Xerostomia	• Check medication for adverse side effects – remove or change medication if possible • Ensure adequate fluid intake • Use mouth rinse and gel
Restricted mobility, immobility	• Physiotherapy • Group exercise • Resistance training • Help with shopping and cooking • Meals on wheels
Psychiatric disorders (e.g. depressive mood, depression, anxiety)	• Adequate medical treatment • Eating with others/shared meals • Pleasant meal ambience/eating environment • Group activities, occupational therapy
Acute disease, (chronic) pain	• Adequate medical treatment
Adverse effects of medications (e.g. xerostomia, nausea, apathy)	• Check medications • Reduce/replace medications
Social problems (e.g. lacking support, family conflict)	• Help with shopping, cooking and eating • Meals on wheels, shared meals • Resolve conflicts

Please cite this article in press as: Volkert D, et al., ESPEN guidelines on nutrition in dementia, Clinical Nutrition (2015), http://dx.doi.org/10.1016/j.clnu.2015.09.004

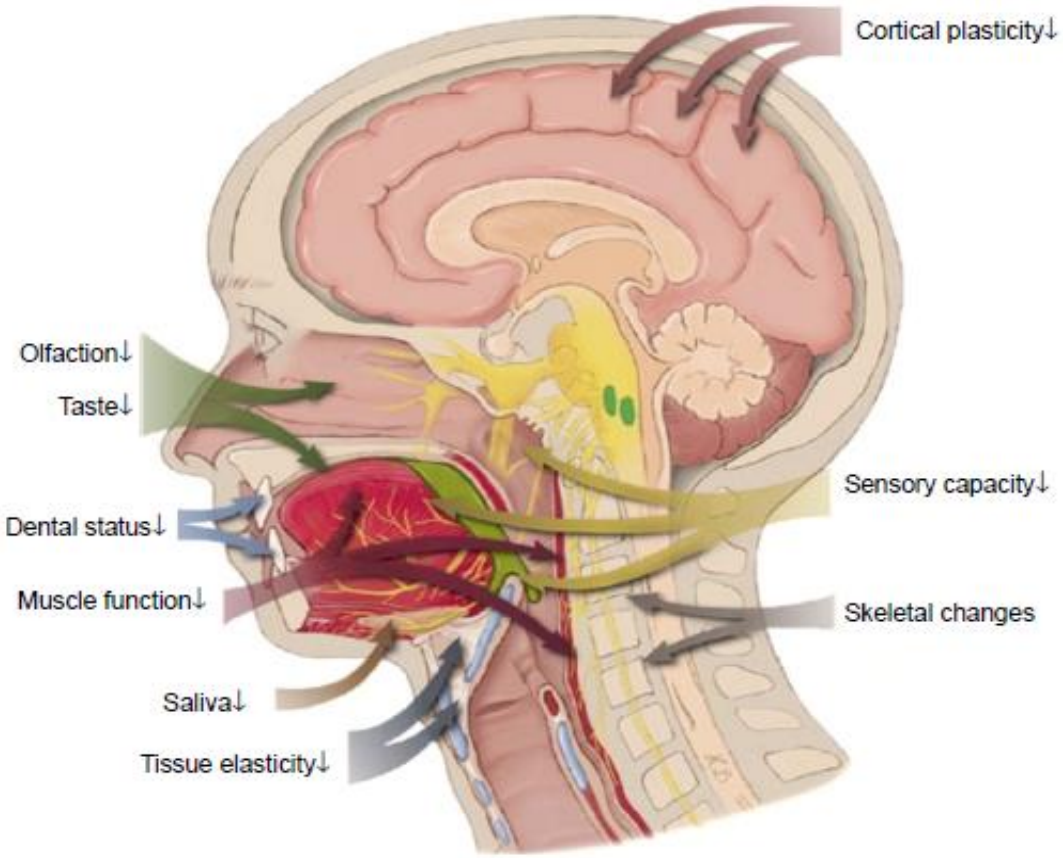
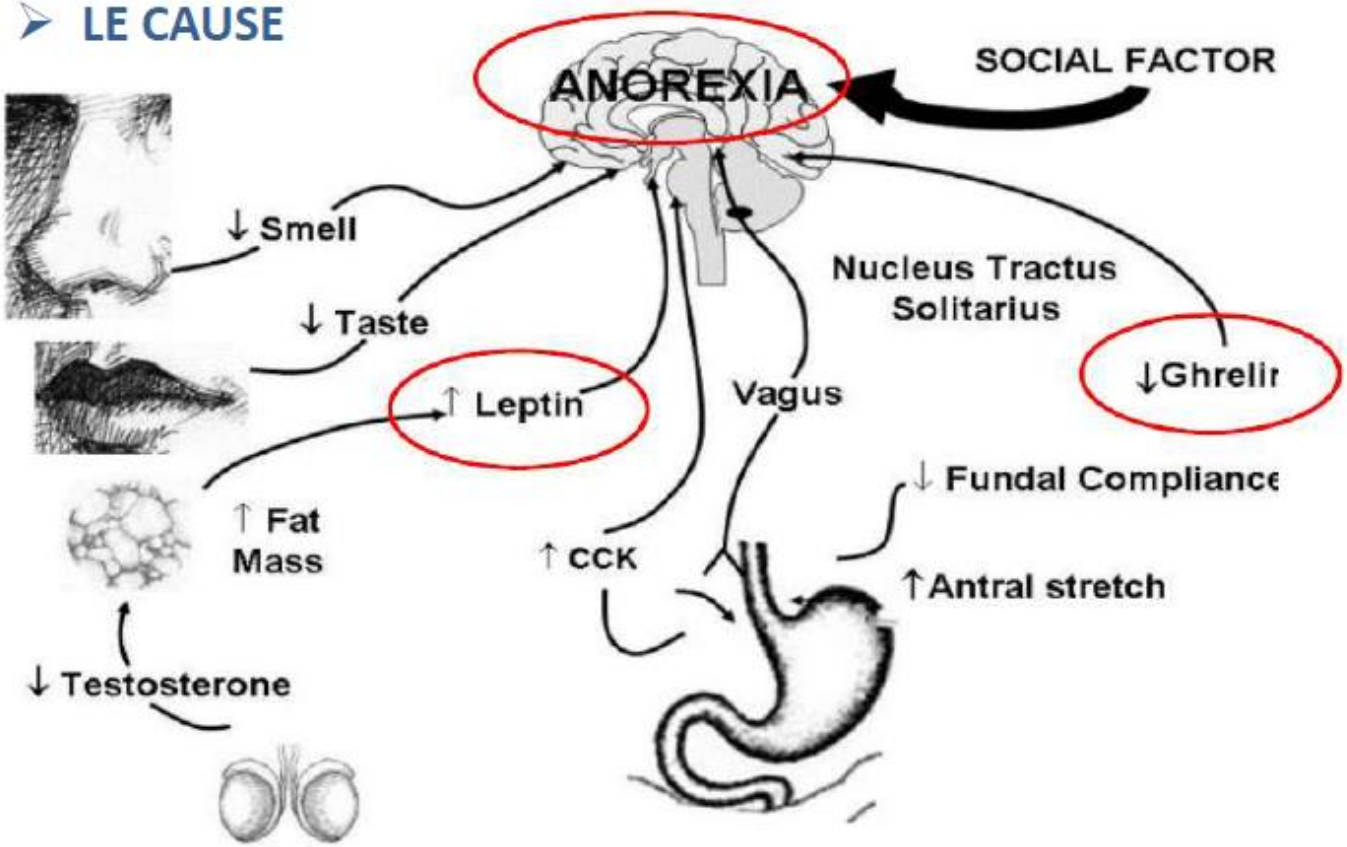


Figure 1 Factors associated with dysphagia in older persons.
Note: ↓ Indicates decreased function. Modified from Muhle P, Wirth R, Glahn J, Dziewas R. [Age-related changes in swallowing. Physiology and pathophysiology]. *Nervenarzt*. 2015;86(4):440–451.[29]

1 ALTERAZIONI ODONTOIATRICHE (EDENTULIA)
2 RIDUZIONE MASSA MUSCOLARE ORO BUCCALE
3 RIDOTTA CAPACITA' SENSORIALE
4 RIDOTTA CAPACITA' CORTICALE

I PROBLEMI NUTRIZIONALI NELLA DEMENZA

➢ LE CAUSE



DEMENZA

Problemi nutrizionali	Stadio di malattia
Alterazioni olfattive e gustative	Preclinico ed iniziale
Deficit di attenzione	Lieve-moderato
Deficit di funzioni esecutive (preparazione del cibo, fare la spesa)	Lieve-moderato
Alterata capacità decisionale (riduzione delle scelte alimentari, ridotto intake)	Lieve-moderato
Disprassia	Lieve-moderato
Agnosia	Lieve-moderato
Problemi comportamentali (wandering, agitazione, disturbi del comportamento alimentare)	Lieve-moderato
Disfagia orofaringea	**Moderato-severo**
Rifiuto del cibo	Severo

Volkert D. Clin Nutr 2015

ANNALS OF THE NEW YORK ACADEMY OF SCIENCES
Issue: *Nutrition in Prevention and Management of Dementia*

Improving food intake in persons living with dementia

Heather H. Keller

Schlegel–University of Waterloo Research Institute for Aging and Department of Kinesiology, University of Waterloo, Waterloo, Ontario, Canada

Ann. N.Y. Acad. Sci. 1367 (2016) 3–11 © 2016 New York Academy of Sciences.

- Garantire un ambiente confortevole, familiare nel momento del pasto
- Se il paziente presenta una <u>deglutizione sicura ed efficace</u>:
  - offrire «finger food»
  - liberalizzare la dieta
  - proporre cibi conosciuti, morbidi/cremosi, gustosi ed attraenti nel rispetto delle preferenze personali
  - posizionare il cibo sulla lingua prima di invitare a deglutire
  - utilizzare ausili
  - «reorienting» al pasto
  - **utilizzare integratori orali**

Screening tools

-MNA-SF

Mini Nutritional Assessment MNA®

ITEMS QUALITA' E TEMPI DI SOMMINISTRAZIONE DEL CIBO
MISURE ANTROPOMETRICHE DI RIFERIMENTO

Valutazione dello stato nutrizionale

24-30 da 24 a 30 punti	☐	stato nutrizionale normale
17-23.5 da 17 a 23,5 punti	☐	rischio di malnutrizione
meno 17 punti	☐	cattivo stato nutrizionale

Please cite this article in press as: Volkert D, et al., ESPEN guidelines on nutrition in dementia, Clinical Nutrition (2015), http://dx.doi.org/10.1016/j.clnu.2015.09.004

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e-SPEN guideline

ESPEN guidelines on nutrition in dementia

Dorothee Volkert [a, *], Michael Chourdakis [b], Gerd Faxen-Irving [c], Thomas Frühwald [d], Francesco Landi [e], Merja H. Suominen [f], Maurits Vandewoude [g], Rainer Wirth [a, h], Stéphane M. Schneider [i]

assessment

- The Aversive Feeding Behavior Inventory (AFBI) [88], also known as "Blandford Scale" can be of help in evaluating the causality of eating problems particularly in patients in advanced stages of dementia. This tool still needs validation, nevertheless it can be of help in dealing with such problems in the care of patients with dementia.
- The Edinburgh Feeding Evaluation in Dementia Questionnaire (EdFED-Q) [34] is a validated tool that aids in recognizing problems with eating and drinking in patients with dementia. It helps in planning an appropriate multidimensional intervention.
- The Eating Behavior Scale (EBS) [89] measures the ability to eat independently and consequently may enable judgment for the need of care during meals.

ARTICLE IN PRESS

Clinical Nutrition xxx (2015) 1–22

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SUMMARY

Background: Older people suffering from dementia are at increased risk of malnutrition due to various nutritional problems, and the question arises which interventions are effective in maintaining adequate nutritional intake and nutritional status in the course of the disease. It is of further interest whether supplementation of energy and/or specific nutrients is able to prevent further cognitive decline or even correct cognitive impairment, and in which situations artificial nutritional support is justified.
Objective: It is the purpose of these guidelines to cover these issues with evidence-based recommendations.
Methods: The guidelines were developed by an international multidisciplinary working group in accordance with officially accepted standards. The GRADE system was used for assigning strength of evidence. Recommendations were discussed, submitted to Delphi rounds and accepted in an online survey among ESPEN members.
Results: 26 recommendations for nutritional care of older persons with dementia are given. In every person with dementia, screening for malnutrition and close monitoring of body weight are recommended. In all stages of the disease, oral nutrition may be supported by provision of adequate, attractive food in a pleasant environment, by adequate nursing support and elimination of potential causes of malnutrition. Supplementation of single nutrients is not recommended unless there is a sign of deficiency. Oral nutritional supplements are recommended to improve nutritional status but not to correct cognitive impairment or prevent cognitive decline. Artificial nutrition is suggested in patients with mild or moderate dementia for a limited period of time to overcome a crisis situation with markedly insufficient oral intake, if low nutritional intake is predominantly caused by a potentially reversible condition, but not in patients with severe dementia or in the terminal phase of life.
Conclusion: Nutritional care and support should be an integral part of dementia management. In all stages of the disease, the decision for or against nutritional interventions should be made on an individual basis after carefully balancing expected benefit and potential burden, taking the (assumed) patient will and general prognosis into account.
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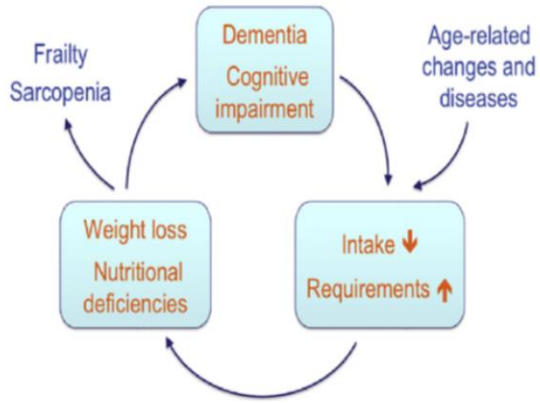

Fig. 1. Vicious circle of malnutrition and dementia.

…nutritional problems are part of the disease, putting persons with dementia at high risk of developing malnutrition.

Malnutrition is clearly associated with poor outcome and contributes to disease progression.

It also increases caregiver burden, which in turn may aggravate nutritional problems.

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e-SPEN guideline

ESPEN guidelines on nutrition in dementia

11. We recommend the use of ONS to improve nutritional status.

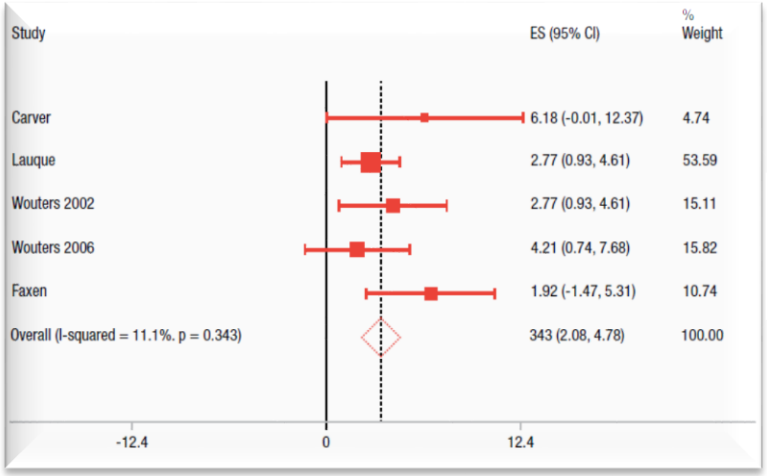
(Grade of evidence: high)

Legally, ONS are "food for special medical purposes" (FSMP), which should be used under medical supervision

DEMENZA

INTEGRATORI ORALI

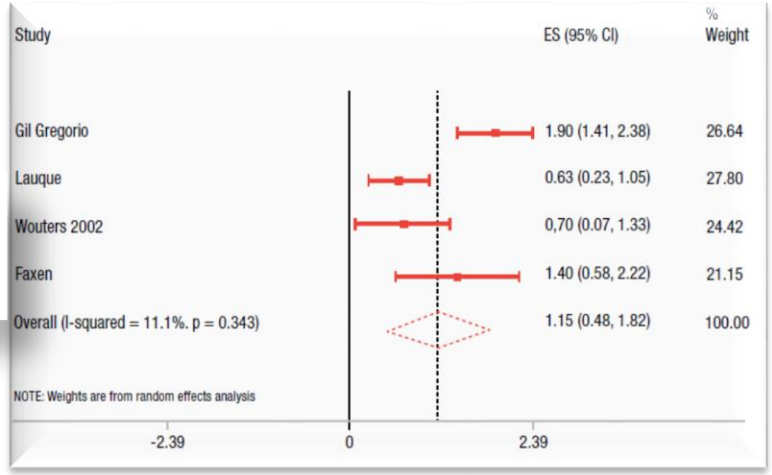
- Si raccomanda l'utilizzo di integratori orali per migliorare lo stato nutrizionale *(Grado di evidenza: alto)*



Peso: + 3.43%

Alzheimer's Disease International

2014



BMI: + 1.15 kg/m²

DEMENZA

NUTRIZIONE ARTIFICIALE E IDRATAZIONE

- Si suggerisce la NE per un limitato periodo di tempo in pazienti con **demenza lieve** e **moderat**a, per affrontare una situazione critica potenzialmente reversibile (es. anoressia in corso di infezione, disfagia per ictus, delirio) responsabile della riduzione delle ingesta* (*Grado di evidenza: molto basso; LG ESPEN 2015*)

* - < 50% dei fabbisogni per almeno 10 gg

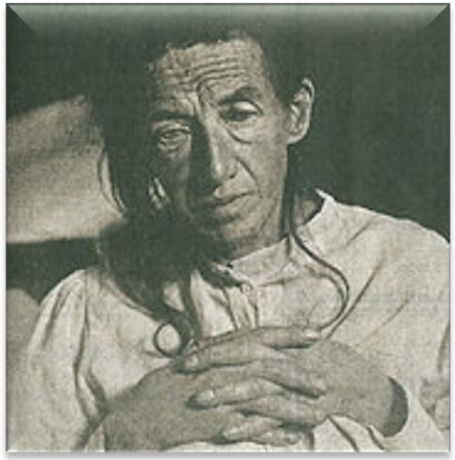
- SNG (PEG se durata presunta > 4 settimane o SNG non tollerato o accettato)

DEMENZA

NUTRIZIONE ARTIFICIALE E IDRATAZIONE

La NE nei pazienti con **demenza severa** è controindicata

(*Grado di evidenza: alto; LG ESPEN 2015)*



Auguste Deter (1901): la prima paziente descritta da Alzheimer come affetta da demenza senile.

La NE è gravata da un aumentato rischio di complicanze (es. polmonite ab ingestis,) e non è in grado di garantire un prolungamento della sopravvivenza e/o migliorare la funzione fisica e la qualità di vita

DEMENZA

In ogni caso la decisione pro o contro la nutrizione artificiale e l'idratazione deve essere sempre presa su **basi individuali** considerando:

- Volontà espresse o presunte
- Severità della malattia
- Prognosi ed aspettativa di vita
- Qualità di vita
- Possibili complicanze

con il coinvolgimento della famiglia, amministratore di sostegno/tutore legale e di tutti i componenti del team multidisciplinare

Clinical Nutrition (2006) 25, 196–202

ELSEVIER

Clinical Nutrition

http://intl.elsevierhealth.com/journals/clnu

INTRODUCTION PART TO THE ESPEN GUIDELINES ON ENTERAL NUTRITION

Ethical and Legal Aspects of Enteral Nutrition

U. Körner[a,*], A. Bondolfi[b], E. Bühler[c], J. MacFie[d], M.M. Meguid[e], B. Messing[f], F. Oehmichen[g], L. Valentini[h], S.P. Allison[i]

- Nelle fasi terminali della malattia *(demenza)* l'attenzione al **conforto** e alla **dignità della persona** dovrebbe avere la precedenza sulle scelte nutrizionali.

- Non dobbiamo dimenticare che la perdita di appetito e della sete sono eventi terminali di questa condizione clinica così come avviene nelle ultime fasi di molteplici malattie.

«Proteggere il diritto alla vita, senza inutilmente prolungare la sofferenza»