MULTINATIONAL ASSOCIATION OF SUPPORTIVE CARE IN CANCER (MASCC) EXPERT OPINION / GUIDANCE ON THE USE OF CLINICALLY-ASSISTED HYDRATION IN PATIENTS WITH ADVANCED CANCER

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Introduction

The provision of clinically-assisted hydration (CAH) in patients with advanced cancer is controversial, and there is a paucity of specific guidance, and so a diversity in clinical practice. Hence, the Palliative Care Study Group of the Multinational Association of Supportive Care in Cancer (MASCC) formed a sub-group to develop evidence-based guidance on the use CAH in patients with advanced cancer.

Method

This guidance was developed in accordance with the MASCC Guidelines Policy. A search strategy for Medline was developed, and the Cochrane Database of Systematic Reviews, and the Cochrane Central Register of Controlled Trials were explored for relevant reviews / trials respectively.

Results

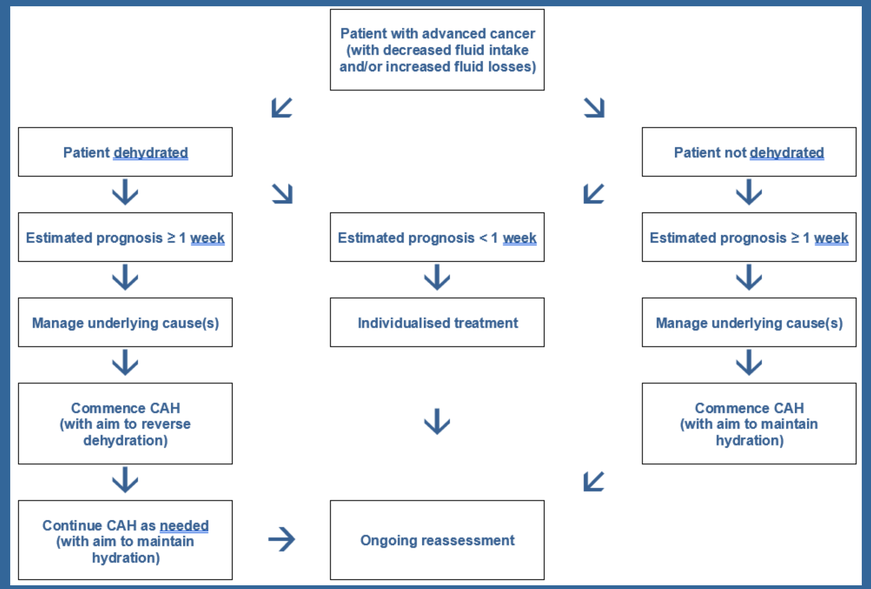
Due to the paucity of evidence, the sub-group were not able to develop a defined guideline, but were able to generate a number of "expert opinion statements":

- All patients with advanced cancer should be regularly assessed regarding hydration / de-hydration.
- Patients should be practically supported to maintain oral intake.
- Reversible causes of decreased fluid intake, or increased fluid loss, should be treated.
- Decisions relating to clinically-assisted hydration should be made by an appropriately constituted multidisciplinary healthcare team together with the patient and their family.
- Clinically-assisted hydration should be considered in patients at risk of dying from dehydration before dying from their cancer.

Results

- Protocols / processes should exist to deal with conflicts over the initiation (or withdrawal) of clinically-assisted hydration.
- Patients receiving clinically-assisted hydration should have a hydration care plan which defines the agreed objectives of treatment, and the agreed conditions for withdrawal of treatment.
- Patients should be given fluids via the most appropriate route (for that patient).
- Patients that are dehydrated should be given sufficient fluids to reverse the dehydration.
- Patients that are not dehydrated should be given sufficient fluids to maintain hydration / prevent dehydration.
- Clinically-assisted hydration should be available in all settings, including the home setting.
- All patients receiving clinically-assisted hydration should be regularly reassessed.

Decision algorithm for CAH in patients with advanced cancer



Ethical Considerations

- The physician / multidisciplinary team has the ultimate responsibility for making the decision on CAH
- CAH should be considered if the potential benefits outweigh the potential burdens (and vice versa)
- CAH should be considered if it is unclear whether the potential benefits outweigh the potential burdens (i.e. give a trial of CAH)
- The patient does not have the right to demand CAH
- The patient does have the right to refuse CAH (if the patient has capacity / competence)
- A valid advance directive to refuse treatment must be followed (if the patient does not have capacity / competence)
- The family do not have the right to demand CAH

Clinical Considerations

- Patient's views
- (Family's views)
- Estimated prognosis
- Current hydration status
- Oral intake
- Fluid losses
- "Hydration impact symptoms / problems"
- Co-morbid conditions (e.g. cardiac disease, renal impairment)
- Suitability of routes of administration
- Availability of indwelling catheters / enteral feeding tubes
- Current/future place of care

Conclusion

This guidance provides a framework for the use of CAH in advanced cancer, although every patient requires individualised management.