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End-of-life dementia care: A palliative perspective

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For advanced dementia patients the palliative care approach emphasizes relief of pain and suffering in the near term

Psychiatrists need to be aware of aspects of psychiatric and pain management that are unique to end-of-life care for patients with advanced dementia. The palliative care philosophy presents an opportunity to honestly acknowledge the terminal nature of advanced dementia, limit intrusive and unnecessary care, and thoughtfully address pain and suffering.

Studies suggest that nursing home patients with severe dementia have an average life expectancy of 2 years.[1] These patients often have substantial medical comorbidity, frequently with multiple illnesses, each of which has an accepted management that may involve several medications and interventions. Treatment guidelines for individual conditions don't necessarily take into account multiple interacting illnesses in advanced dementia. Applying recommended treatments for multiple conditions simultaneously may entail prescribing many medications and interventions. Often these techniques are designed to prevent or modify disease over long term, which a patient with advanced dementia is not likely to achieve.[2]

Such polypharmacy and intensive intervention are not likely to extend life or improve its quality. In fact, the opposite may occur. Dementia patients react poorly to polypharmacy and may require restraint or sedation to accommodate invasive interventions. Feeding tubes are particularly challenging. Studies have revealed that feeding tubes do not extend life in advanced dementia patients.[3]

Goals for palliative care. The palliative care approach emphasizes relieving suffering in the near term. Applying this philosophy to advanced dementia depends on acknowledging that the patient will not recover from this condition, has a limited life expectancy, and is not likely to benefit from—and in fact may be harmed by—an aggressive approach to comorbid conditions. Instead, these conditions are best managed by controlling pain and suffering in the near term. Hospitalization and invasive interventions are minimized.

Psychiatric management fits well within this approach. Near the end of life, dementia patients often suffer agitation, psychosis, depression, and delirium that may require the expert, judicious use of psychopharmacology. Patients often experience pain, but might not be able to communicate this, except through behavioral changes. Physicians may be overly concerned with possible adverse effects of pain medications, but when appropriately prescribed, these drugs may help relieve suffering. Psychiatrists also have a role in assisting staff and families during an emotionally difficult time.[4]

References

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Dr. Casey reports no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.