

FAST FACTS AND CONCEPTS #133 NON-ORAL HYDRATION IN PALLIATIVE CARE

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Background At the center of the debate with regard to hydration in terminally ill patients is the desire to maintain comfort and avoid unnecessary/distressing procedures. There is no controversy that terminally ill patients should be encouraged to maintain adequate oral hydration for as long as possible. However there is debate and controversy around the use of parenteral hydration. This *Fast Fact* discusses medical decision-making about non-oral hydration in palliative care settings; *Fast Fact* #134 discusses techniques of hydration.

Arguments Against Hydration

- Comatose patients do not experience symptom distress.
- Parenteral fluids may prolong dying.
- With less urine there is less need to void and use catheters.
- With less gastrointestinal fluid there can be less nausea and vomiting.
- With less respiratory tract secretions there can be less cough and pulmonary edema.
- Dehydration can help reduce distressing edema or ascites.
- Dehydration may be a “natural” anesthetic to ease the dying process.
- Parenteral hydration can be uncomfortable (e.g. needles/catheters) and limit patient mobility.

Arguments For Hydration

- Dehydration can lead to pre-renal azotemia, which in turn can lead to accumulation of drug metabolites (notably opioids), leading to delirium, myoclonus and seizures. Hydration can reverse these symptoms in some patients leading to improved comfort.
- There is no evidence that fluids prolong the dying process.
- Providing hydration can maintain the appearance of “doing something,” even though there may be no medical value, and thus ease family anxiety around the time of death.

Ethical/Legal Issues In the United States, the following ethical/legal standards exist:

- Competent patients or their surrogates can accept or refuse hydration based on relevant information.
- Non-oral hydration is considered a *medical intervention*, not *ordinary care*. As such, there is no legal or ethical imperative to provide it unless the benefits outweigh the burdens.

Recommendation There is published medical literature to support both the use of, and the withholding of, non-oral hydration in patients near death; thus, there is no consensus on the single best approach to care. A Cochrane review of 6 relevant studies showed that sedation and myoclonus were improved with hydration in adult palliative care patients; however, discomfort from fluid retention was significantly higher in the hydration group and survival seemed to be the same between the groups. Key issues to be considered when determining the role of non-oral hydration include the following:

- Expressed wishes of the patient or surrogate decision-maker regarding use of hydration.
- Patient-defined goals; the presence of a specific goal may direct the clinician to use hydration as a means to improve delirium and potentially delay death.
- Symptom burden: symptoms related to total body water excess may improve by withholding hydration, while delirium may lessen with hydration.
- Burden to the patient and caregivers of maintaining the non-oral route of hydration.
- Family distress concerning withholding hydration/nutrition.
- When in doubt, a time limited hydration trial is an appropriate recommendation.

Clinician Self-Reflection Finally, it is important to recognize that health care providers often have biases for or against non-oral hydration near the end-of- life. Self-reflection upon these biases is crucial to help patients and families make decisions that are based on the best interests and goals of the patient/family unit.

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