Letters to the Editor

Tube feeding in patients with dementia

SIR—The report by Rimon et al. on outcomes of patients with dementia fed artificially through a PEG tube gives valuable information for clinicians and relatives [1]. In about 40% of the patients in the study the indication for the PEG feeding was feeding difficulty. While dysphagia as a result of stroke is a straightforward indication for PEG placement, feeding difficulty due to dementia is often a difficult decision and one that is perhaps largely skewed towards carer’s rather than patient’s preference. There are a number of factors that result in feeding difficulty in patients with dementia such as co-existing depression, co-existing acute illness or other sinister pathology such as cancer, constipation, loss of teeth or poorly fitting dentures, limited physical activity, delay in swallowing resulting in prolonged feeding times, problems with food—inappropriate choice, texture, temperature etc. A thorough assessment by clinician, psychiatrist, speech and language therapist and dietician is therefore vital as the majority of these factors are reversible.

Also in many patients with dementia the only period of any social interaction between them and their carers over some length of time is during their feeding sessions. Feeding artificially through a PEG tube will ease the carers’ burden but will remove the only significant social stimulus from the patient. It would be interesting to know if the authors considered these factors in their study. The fact that only a significant minority of patients had a reversal of their PEG feeding in the study indicates that nutritional parameters and carers’ burden were perhaps given a higher clinical priority and this may be appropriate in some cases.

S. H. GUPTHA
Medicine for the Elderly, Edith Cavell Hospital, Peterborough PE3 9GZ, UK
Email: sunku.guptha@pbh-tr.nhs.uk

doi:10.1093/ageing/afi194

Reply

SIR—Dr Guptha is correct that feeding difficulty due to dementia is not a straightforward indication for PEG insertion. The timing and the necessity of PEG insertion in those patients is not evidence based. The reversible factors for feeding difficulty mentioned in Dr Guptha’s letter are well known, should always be considered and a therapeutic trial should be started when appropriate. We usually look for reversible factors before inserting a PEG and have had few cases of success during many years of experience. However, there are no studies about the frequency and the reversibility of these conditions. In our experience only rarely can one find a true reversible cause of feeding difficulty in severely demented patients referred for PEG insertion. Therefore, although these causes must not be forgotten, their importance is of minor significance.

We also agree with Dr Guptha that with enough patience many demented patients could be fed orally and would benefit from social interaction as well as from enjoyment of the taste of food. However, as appears in our manuscript, all patients in the study had less than 400 kcal intake per day as assessed by a dietician. Most patients had a prolonged trial of oral feeding and as this is a nutritional emergency we do not recommend another trial of oral feeding. It must be remembered that in real life, the staffing ratio is limited, and the burden on the carer is almost unbearable.

Moreover, in some countries, religions, or families it is inadmissible to let a patient die from dehydration or undernutrition, so that sometimes PEG insertion, even though not ideal, may be the only reasonable solution (even if it is not proved that it will increase life expectancy or improve the quality of life).

E. RIMON, S. LEVY
Geriatric Department, Harzfeld Medical Center, PO Box 48, Gedera 70750, Israel
Email: Efrain_r@clalit.org.il
doi:10.1093/ageing/afi195

Unmeasured aspects of the geriatric day hospital!

SIR—I read ‘The geriatric day hospital’ by Black [1] with interest and would like to thank him for taking us through a journey of its history, its unique and evolving role, evidence-based criticism of its existence and uncertainty about its future in the light of politically driven present day NHS initiatives.

I felt it was a shame that when I last mentioned day hospitals (in the right context I believe!) in a small discussion forum consisting of doctors, nurses and therapists, everybody looked at me and someone even made a remark ‘What day hospital!’ However, I also noticed a few nodding among the crowd, while some junior staff seemed confused, wondering what was it all about.
There are many aspects of the geriatric day hospital which were not measured and sadly may never be measured. It is user friendly to patients, doctors, nurses and therapists. It may not be equipped with a CT/MRI scan on site but there are neither fast lifts nor revolving doors. To me, it makes the working life of a geriatrician exciting and brings in unique variation from the problems that we usually deal with in acute hospital environment and other specialities. To be honest, it was one of the attractions of geriatric medicine when deciding over other specialities in my career choice. A session or two in a day hospital in a weekly timetable is something I can live with for the rest of my career. Now I feel so much better making myself heard, but will they listen?

Phyo K. Myint  
Clinical Gerontology Unit, Level 2, F&G Block,  
Addenbrooke’s Hospital, Box-251, Hills Road,  
Cambridge CB2 2QQ, UK  
Tel: (+44) 1223 217292  
Fax: (+44) 1223 336928  
Email: pkyawmyint@aol.com


doi:10.1093/ageing/afi217

Re: Vitamin D for older people: how much, for whom and—above all—why?

SIR—In his editorial, Anderson [1] essentially focuses on oral supplementation for the treatment of vitamin D deficiency in the elderly, and little attention is given to sunlight exposure which is the major source of the body’s vitamin D stores. It is known that skin in the elderly has a decreased capacity to synthesise vitamin D [2], and so a recommendation of regular outdoor activity and exercise is even more necessary in the elderly in order to prevent deficiency. Therefore, the elderly should be encouraged to have adequate, but safe, levels of sunlight exposure, which may be as little as 5–15 min of casual exposure between the hours of 10:00 and 15:00 [3]. Although one could argue that there is no evidence from randomised clinical trials that this method of increasing serum 25-hydroxyvitamin D reduces falls or fractures, it should be acknowledged that such a trial would be unethical (to restrict sunlight exposure in the control group) and extremely difficult to conduct. The inference must be made that sunlight exposure will have the same positive outcomes as oral supplementation has shown in placebo-controlled trials.

Henry Zeimer  
Aged Care Services, Heidelberg Repatriation Hospital,  
Melbourne, Australia  
Fax: (+61) 3 9496 2613  
Email: henry.zeimer@austin.org.au


doi:10.1093/ageing/afi214