

Benefits/Burdens of Tube Feeding/PEG Placement for Adults



	Dysphagic Stroke (Patients with previous good quality of life, high functional status ¹ and minimal co-morbidities)	Dysphagic Stroke (Patients with decreased level of consciousness, multiple co-morbidities, poor functional status ¹ prior to CVA)	Neurodegenerative Disease [e.g., Amyotrophic Lateral Sclerosis (ALS)]	Persistent Vegetative State (PVS)	Frailty (Patients with multiple co-morbidities, poor functional status, failure to thrive and pressure ulcers ² .	Advanced Dementia (Patients needing help with daily care, having trouble communicating, and/or incontinent)	Advanced Cancer (Age is the significant predictor of need in advanced head and neck cancer) ⁴	Advanced Organ Failure (Patients with CHF, renal or liver failure, COPD, anorexia-cachexia syndrome)
Prolongs Life	Likely	Likely in the short term	Likely	Likely	Not Likely	Not Likely	Not Likely	Not Likely
		Not likely in the long term						
Improves Quality of Life and/or Functional Status	up to 25% regain swallowing capabilities	Not Likely	Uncertain	Not Likely	Not Likely	Not Likely	Not Likely	Not Likely
Enables Potentially Curative Therapy/Reverses the Disease Process	Not Likely	Not Likely	Not Likely	Not Likely	Not Likely	Not Likely	Not Likely	Not Likely

This grid reflects only certain conditions. Some examples of other conditions where direct enteral feeding would be indicated include radical neck dissections, esophageal stenosis and motility diseases, post intra-thoracic esophageal surgery and safer nutrition when the alternative would be parenteral hyperalimentation.

Benefits of PEG placement rather than feeding orally:

- For dysphagic stroke patients in previous good health, patients with ALS, and patients in a persistent vegetative state, may prolong life
- For dysphagic stroke patients in previous poor health, may prolong life in the short-term (days to weeks)
- Enables family members/caregivers to maintain hope for future improvement
- Enables family members/caregivers to avoid guilt/conflict associated with choosing other treatment options
- Allows family/caregivers additional time to adjust to possibility of impending death

Burdens of PEG placement rather than feeding orally:

- 75% of stroke patients previously in good health not likely to have improved quality of life and/or functional status
- PVS patients not likely to have improved quality of life and/or functional status
- Possible patient agitation resulting in use of restraints
- Risk of aspiration pneumonia is the same or greater than that of patient being handfed
- Stroke patients previously in poor health, frail patients, and patients w/advanced dementia, cancer or organ failure have been reported to experience side effects: PEG site irritation or leaking (21%), diarrhea (22%), nausea (13%) and vomiting (20%)
- Nursing home residents do not find PEGs associated with prevention or improved healing of pressure ulcers and PEGs may cause increased risk of pressure ulcers.

Benefits of feeding orally rather than inserting a PEG:

- Patient able to enjoy the taste of food
- Patient has greater opportunity for social interaction
- Patient’s wishes and circumstances can be taken into consideration as pertains to pace, timing and volume of feeding

Burdens of feeding orally rather than inserting a PEG:

- Requires longer period of time to feed a patient
- Patient/family worry about “not doing everything in their power” to address the feeding problem and/or “starving patient”
- Patient/family feel that in not choosing option that could possibly prolong life, they are hastening death

This information is based predominately on a consensus of current expert opinion. It is not exhaustive. There are always patients who prove exceptions to the rule.

1. Functional Status refers to Activities of Daily Living. For more information on the CFS visit http://geriatricresearch.medicine.dal.ca/clinical_frailty_scale.htm A poor functional status means full or partial dependency in bathing, dressing, toileting, feeding, ambulation, or transfers.
 2. Matched residents with and without a PEG insertion showed comparable sociodemographic characteristics, rates of feeding tube risk factors, and mortality. Adjusted for risk factors, hospitalized NH residents receiving a PEG tube were 2.27 times more likely to develop a new pressure ulcer (95% CI, 1.95-2.65). Conversely, those with a pressure ulcer were less likely to have the ulcer heal when they had a PEG tube inserted (OR 0.70 [95% CI, 0.55-0.89]). Teno JM, Gozalo P, Mitchell SL, Kuo S, Fulton AT, Mor V. Feeding Tubes and the Prevention or Healing of Pressure Ulcers. Archives of internal medicine. 2012;172(9):697-701. doi:10.1001/archinternmed.2012.1200.
 3. Callahan CM, Haag KM, Weinberger M, et al. Outcomes of Percutaneous Endoscopic Gastrostomy among Older Adults in a Community Setting. J Am Geriatr Soc. 2000 Sep; 48(9):1048-5
 4. Sachdev, S., Refaat, T., Bacchus, I.D. et al. Age most significant predictor of requiring enteral feeding in head-and-neck cancer patients. Radiat Oncol 10, 93 (2015).
 5. Teno JM, Gozalo P, Mitchell SL, Kuo S, Fulton AT, Mor V. Feeding tubes and the prevention or healing of pressure ulcers. Arch Intern Med. 2012 May 14;172(9):697-701. doi: 10.1001/archinternmed.2012.1200. PMID: 22782196; PMCID: PMC3555136.

Guidelines are intended to be flexible. They serve as reference points or recommendations, not rigid criteria. Guidelines should be followed in most cases, but there is an understanding that, depending on the patient, the setting, the circumstances, or other factors, care can and should be tailored to fit individual needs. For patients associated with OPWDD a separate process must be followed, see OPWDD checklists.