SEVERE DEMENTIA & PALLIATIVE CARE: "WHO CARES?"

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The description of severe dementia as a terminal disease with similar life expectancy as end-stage cancer (~500 days) openly questions the way medical practitioners manage advanced dementia patients. A better understanding of its clinical trajectory raises important dilemmas in contemporary ethics, especially in cases where treatment is considered medically futile. Medical care, however, should follow the ethical principles of beneficence and non-maleficence and not be withdrawn on the grounds of futility. Should critically ill patients be transferred from long-term care facilities to acute care settings? Survival data are similar for both settings, emotional distress however is different. Recent data question the benefit of invasive treatments and support palliative care: a) antibiotics do not offer benefit over analgesics, antipyretics, or oxygen, while vaccination is associated with reduced pneumonia risk, b) feeding tubes or probes have severe side effects and are associated with higher risk of death (40% and 90% within month 1 and 12 respectively) - hand feeding instead can be provided, c) involuntary immobilization develops further complications and is considered "defensive medicine" for legal purposes, d) cardiopulmonary resuscitation is traumatic experience and 3 times less effective in dementia , e) withdrawal of mechanical ventilation decision is similar to hemodialysis or chemotherapy termination, while benzodiazepines and diadermal opioid could comfort from dyspnea.
Hospices have developed strategies to comfort early symptoms, and offer adequate management to patients, substituting i°death paneli± approach with good clinical practice for "dying the good-death". When hospices are not available, palliative hospital-based hospice services should be established.