Comfort Diet in Oncologic Palliative Care: Reflections on Food-related Meanings of Comfort

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Dieta de Conforto em Cuidados Paliativos Oncológicos: Reflexões sobre os Sentidos de Conforto da Comida
Dieta Reconfortante en Cuidados Paliativos Oncológicos: Reflexiones sobre los Sentidos de la Comida Reconfortante

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INTRODUCTION

The importance of food is undeniable in people's lives, beyond physiological issues, but also in the construction of social and psychological aspects foreach individual[1], assuming greater meanings than just the supply of nutrients[2].

It is eaten for nutritional needs, but also to meet emotional demands. Food provides affections and can trigger reactions beyond the five senses, connecting emotions and memories. This symbolic character of food is related to the potential that a meal has to bring up memories loaded with feelings, which may be linked to remarkable moments or sensations built throughout an individual's life, in situations of social interaction[3]. However, these sensations gain other connotations depending on the circumstances and stage of life of the subject.

With the aging of the population, due to the global epidemiological transition, there is a significant increase in the prevalenceof chronic diseases[4], including cancer, which affects a large part of society. In this context, the importance of palliative care stands out, defined as an approach that aims to improve the quality of life of patients and families facing life-threatening diseases, through prevention and relief of suffering, early identification, correct evaluation, treatment of pain and other problems of a physical, psychosocial and spiritual nature. This approach can be adopted at any stage of the disease, is recognized as a human right to health, and offers a support system to help patients live as actively as possible until the day of their death[5,6].

Patients in palliative care often suffer changes in their eating experiences due to symptoms resulting from changes in metabolism, side effects of therapeutic treatments, drugs, depression or the progression of the disease[7]. In the final moments of life, food can be refused or desired, assuming different meanings[8], which makes a comprehensive nutritional assessment essential to determine the most appropriate professional intervention to provide relief of suffering and comfort to the subject who still has viability for oral feeding.

The term "comfort diet" is widely used in this clinical practice, however, there is still no consensus on this topic. What is defined as comfort? How can food comfort you? Does it only include offering foods in pasty/liquid consistency or any desired food? What are the indications? There are still many gaps to be filled in this discussion.

Based on the authors' experience in the context of oncological palliative care and dialoguing with the already existing production on the subject, this article points out issues that permeate food and updates some principles for professional performance, with the objective of evoking reflections on what encompasses the comfort diet in the area of oncological palliative care.

DEVELOPMENT

WHAT KIND OF COMFORT?

The origin of the word "comfort" is linked to the concept of consolation, giving strength or strengthening, from the Latin confórtãre and adapted from the French term *confortable,* which, in the eighteenth century, gave rise to the English *comfort* and the term "conforto" in the Portuguese language[9,10].

According to Kolcaba[11,12], comfort can be defined as a multidimensional phenomenon, being an experience strengthened by the satisfaction of needs for relief, tranquility and transcendence, met in four contexts: physical, psycho-spiritual, sociocultural and environmental. In types of comfort, relief is seen as a condition in which a person sees a specific need met or

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discomfort relieved; tranquility as a state of well-being or contentment; and transcendence as a condition in which a person overcomes his or her problems and suffering. In relation to contexts, the author defines the physical as bodily sensations; the psycho-spiritual as self-awareness, self-esteem and meaning of life/spirituality; the environmental as light, noise, temperature and equipment; and, finally, the sociocultural as interpersonal, family and social relationships[11,12].

The various dimensions that complete the definition of comfort refer to the idea of help/support and also to the subjective state perceived by those who find relief, encouragement, problem solving or difficulties, anxiety reduction, or physical and mental satisfaction. Thus, comfort measures can be used as a way to prevent, relieve or reverse some discomfort[13]. All these factors point to an individual experience involving several domains that can be the focus of care in palliative care.

Regarding the particularities that the diet may be able to comfort, the prevention and relief of symptoms through dietary adaptations are integrated into the physical context, since changes in diet can attenuate important gastrointestinal symptoms present in cancer, in order to prevent them from causing major negative impacts on quality of life[14].

Despite the recognition of an advanced disease in progression, food is often associated with the maintenance of life due to the symbology it has for patients and caregivers. Thus, the hope of improvement may be related to food[15]. Diet can provide psychological comfort, as a food is capable of bringing good memories through affective memory or functioning as a motivation in the fight against the disease, in an attempt to "control" it by being able to eat, albeit in small volumes[16].

FOOD AS COMFORT?

The concept of *Comfort Food* has the meaning of "comfortable food" or "food that comforts" and was created in 1977 in the United States, being defined as a food that is rewarding because it has the potential to refer to the memories of home, family or friends, giving reason to a moment, a life and a symbolic affective memory for food, which causes emotional comfort[17-19].

In the sociocultural context, some authors describe comfort food as that which represents a culture and/or region, especially when making a connection with loved ones or good memories and when providing positive emotions and a sense of belonging[20,21]. The subject's food identity is related to feelings associated with tradition and ancestry, in which food is transmuted into social and personal legacies, and as a means to transmit lessons and wisdom[22]. For sociology, comfort food is linked to the vast majority of holiday moments, and, in symbolic terms, food is associated with a way of expressing care, affection and love[20].

Through taste memory, it is possible to be transported to other places, to relive feelings of moments that were saved, that is, existence itself. This means that there are pieces of personal history that can be accessed by eating a simple portion of a meal[19]. In this scenario, it can be considered that food would assume the role of maximizing the life potential of the patient and their families, within the limits established by the presence of an incurable disease at an advanced stage.

WHAT FOOD COMFORTS YOU?

Comfort food can have any consistency, considering all aspects that constitute the dimensions of comfort. In some cases, tailoring the diet for milder consistencies may alleviate symptoms, facilitate feeding, and optimize energy expenditure[23]. However, patients without contraindications can benefit from the comfort provided by solid meals, for example, preparations with great cultural significance, and there is no rule about the aspect of the meal. As a fundamental principle, individualization of conduct should be the guide for prescribing the comfort diet.

WHEN TO REFER?

The decision-making process in the indication of the comfort diet should take into account factors such as the prognosis, the desires expressed by the patient in relation to food (when possible), the evaluation of the risks and benefits of the conduct, the primary cause that originated the feeding difficulty and, essentially, the quality of life of the patient and their families should be prioritized[24]. When death is imminent, the relief of suffering should be the primary objective of health care, and this may include the suspension of food and hydration[25].

Palecek et al.[26] suggested the term *Comfort Feeding Only* in 2010, establishing what measures should be taken to ensure the comfort of patients with advanced dementia through an individualized feeding care plan. Considering that the patient with dementia often presents similar characteristics to the patient with advanced cancer, such as hyporexia, dysphagia and dependence on food, this approach consists of offering food and liquids when tolerated and, when oral feeding is no longer possible, providing the presence and attention of a caregiver for the remainder of the meal time, to provide human contact, dialogue and therapeutic touch. This means that comfort has a double meaning in this definition: the first refers to the point of interruption of feeding, emphasizing that the patient should be fed as long as it is not distressing for

them, respecting their limits; the second deals with the objectives of meals, which should be essentially guided to comfort, in a less invasive and potentially more satisfactory way to maintain oral feeding, when possible.

The comfort feeding in this case provides for continuous attempts to feed the patient manually. Food adaptations include alteration of the texture, temperature, volume and density of the food, attention to preferred foods, change of positioning at the time of the meal and environmental modifications, such as the use of dental prostheses and straws. Family members should also be reinforced that reduced oral intake is expected in the advanced stage of the disease and is part of the natural process of death[26]. It should be clarified that patients in end-of-life care are not usually hungry, and small amounts of desired food may provide adequate comfort[27].

CONCLUSION

The relief of discomfort does not always refer to a state of full comfort, this can only be partially achieved for a period, indicating the need for constant reassessment of interventions. Many actions are subjective and depend on the individual's perspective. Therefore, for a more adequate nutritional conduct, it is essential to consider the subject's history and their affective relationship with food, to check if there is any discomfort or need, and which dimensions of comfort were affected, understanding all the subjectivity that a term can involve.

CONTRIBUTIONS

All authors contributed substantially in the design and/or planning of the study; in the analysis and/or interpretation of the data; in the writing and/or critical review; and approved the final version to be published.

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There is no conflict of interest to declare.

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