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The Newsletter of the **British Association for Parenteral & Enteral Nutrition**

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Home Parenteral Nutrition in the UK, 2001: Towards Equity of Access & High Standards of Care.

The last year has seen some important steps towards a more rational approach to the delivery of Home Parenteral Nutrition (HPN) throughout the UK culminating in a BAPEN workshop in Harrogate in November. There were 51 attendees from almost all HPN centres, PINNT, Industry and the Department of Health. This article summarises the proceedings of the workshop and the present position of HPN in the UK.

Through British Artificial Nutrition Survey (BANS) data, presented by Professor Marinos Elia, it has become apparent that the demand for HPN is increasing every year but the distribution of HPN patients within Health Districts of residence varies from 0-36/million. This implies great inequity of access to HPN, which is most prevalent around major centres. It is also apparent that very few cancer patients will be offered HPN in the UK compared to mainland Europe. In 2000, a minimum of 500 HPN patients were identified by BANS.

In a joint presentation by Dr Simon Gabe and Dr Jon Shaffer, we heard that the two nationally funded Intestinal Failure Units (IFU) at St Marks in London and Hope Hospital Salford, care for 220 patients leaving 280 or more in as many as 40 other centres. In none of these centres is the HPN service specifically funded. Furthermore, the two IFU's are now saturated and need to offload their stable HPN patients to centres closer to their homes. The majority of re-admissions to the IFUs are due to HPN related problems. This is preventing admission of those with severe intestinal failure so that waiting list mortality is now 14% at Hope Hospital compared to only 4% once admitted.

Carolyn Wheatley, Chair of PINNT presented the results of their patient survey and was supported by another patient, Philip Jenkins and his carer (wife!). The survey confirms the affection which patients have for their main centre but that they wish they could receive follow-up closer to home. Two thirds said they had attended a local centre but 30% were dissatisfied with their treatment there. On the other hand, some were travelling hundreds of miles at great expense to visit their main centre for follow-up or emergencies. Almost all wanted better local services, particularly for emergencies. There are already 20 or so other centres in England and Wales providing a regular HPN service. Recognition of their vital role has been absent at government level but in Scotland there is good news.

Several years ago, it was recognised that similar problems of inequity of access, variable standards and lack of audit or research needed to be addressed. Dr Alastair McInlay described how the Scottish Managed Clinical HPN Network was born in 2000. With support from their Clinical Standards Board, 75 patients are now managed across Scotland using agreed protocols and standards coordinated by Janet Baxter under the leadership of Professor Chris Pennington, our Chairman. One year later, the BAPEN network is clearly functioning well and should provide the rest of the UK with a model to emulate.

The problem in England and Wales is that there are many units with very sporadic experience of HPN and some still do not use commercial homecare companies. Anecdote suggests suboptimal standards in these small centres. Even larger centres are not properly resourced. This applies in particular to Nurse Nutrition Specialists without which neither inpatient Parenteral Nutrition (PN) nor HPN can hope to achieve acceptable standards.

The challenge is therefore how to harness the enthusiasm of non-IFU centres so that patients can be assured of equivalent standards wherever they attend for HPN care. It was agreed that a centre wishing to provide an HPN service should be able to demonstrate satisfactory standards and infrastructure.

Those centres unable to do so would not be acceptable to commissioners of care. Carol Withenshaw of Calea and David Brassington of Clinovia both emphasised that industry has a vital role to play in this excellent example of "public-private partnership."

Many contacts have been established in the Department of Health (DoH)but only a few representatives were able to attend the workshop.

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HPN in the UK, 2001

Continued from page 1

However, there has been considerable progress. Firstly, HPN has been accepted as a specialised low volume – high cost service and now has an agreed "definition". This followed discussions with the London Commissioning Group which was charged with defining such specialised services for the NHS as a whole.

This is of vital importance as we approach April 2002 when NHS funding in England will be devolved to Primary Care Trusts (PCTs). The HPN definition will act as a spur to commissioners and a lever for those centres wishing to provide an HPN service. The manner in which HPN will be commissioned from 2002 is not yet clear. BAPEN must press for increased resources, particularly for more Nutrition Nurses if more local units are to thrive or evolve. It is therefore good news to announce that the DoH has now recognised the validity of BAPEN's policy of supporting HPN centres remote from the National Specialist Commissioning Advisory Group (NSCAG) funded IFUs. It also seems likely that the number of national IFU centres will be increased. There will clearly be important opportunities for developing HPN services more equitably in the near future.

We should now be looking forward to establishing dynamic links between major centres and more local HPN centres throughout the UK. Work has already started on national protocols led by Angie Davidson at St Marks Hospital.

The author would like to thank all those who attended the workshop for their support.

Dr Barry Jones, Consultant Gastroenterologist and BAPEN HPN coordinator

Education & Training Committee - An Update

The Education and Training Committee of BAPEN has joined a group assembled by the Royal College of Physicians of London Education Department to devise educational material for twenty-five medical sub-specialties. Other members of the group represent a wide range of specialist societies from cardiology to venereology, alphabetically. The target audience is specialist registrars and career grade medical staff. It follows on from the "Medical Masterclass" modular distance learning system for candidates studying for the MRCP (UK) examination.
It is intended that the material will be clinical case-based and interactive, with multimedia (web, CD-rom and paper) access. A gradation of difficulty of multiple choice questions will enable a broad range of users to learn progressively. The site will also provide a source of references for further development of knowledge.

The RCP is keen to involve specialist societies in the process because of their expertise in producing such information. Some journals eg Heart already contain case-based learning sections. and these have proved very popular with their readership. The content will be influenced by the specialist registrar curricula prepared by the Specialist Advisory Committees, but it is also recognised that many disciplines have a multi-professional input (particularly clinical nutrition).

The providers of teaching modules deserve recognition and citation for such work which is very demanding of time and effort. It is also expensive to develop attractive web-based projects but a broad range of support should help the more impecunious societies to achieve the desired ends. Collaboration between different sub-specialties is also needed to produce the desirable degree of cross-referencing between subjects. A rolling programme of development and review will be needed to maintain relevance and topicality.

It is hoped that there will be an international market for such high quality products and a business case is being devised for the project.

Ian Fellows

The Treatment of Intestinal Failure in Adults

A successful BAPEN meeting at St Marks Hospital, London

This BAPEN Regional meetingheld in October 2001 was certainly a popular meeting. It was the second meeting this year and attracted over 100 delegates from a variety of disciplines. The day gave a very good overview of the current treatment options and also a taste of what is on the horizon in the management of intestinal failure (IF).

The day was split into an introductory overview of the patients, enteral therapy, parenteral therapy and, finally, the way forward. The opening by Dr Simon Gabe gave a comprehensive review of the pathophysiology of intestinal failure, the anatomical functions of the gut and an update on the recently published BANS data relevant to intestinal failure.

A clinical case was then presented by Angie Davidson, who highlighted the treatment strategies used in the initial stages of IF. Next, pain control was tackled by Sonya Chelvanayagam, who described the steps taken to withdraw pethidine at St Mark's Hospital and also the current analgesic policy.

In the enteral nutrition session, the dietitians Morag Pearson and Diane Snoxell addressed both diet and supplementary feeding with practical advice on how this can be achieved. Mr Alastair Windsor completed the morning session with an enlightening presentation on the surgical management of short bowel syndrome, also outlining surgical strategies for preventing short bowel. He also discussed the management of fistulae, reconstructive surgery, adjunctive surgery and intestinal transplantation.

The afternoon session shifted the focus towards parenteral nutrition. The first session by Angie Davidson and Dr Simon Gabe, gave an insight into the techniques used to insert and maintain tunnelled central lines and included fascinating video footage.

Claire Chadwick then went on to discuss the issues surrounding the provision of parenteral fluids and nutrition (PN) to these patients and highlighted the importance of mixture stability for home HPN patients. Next, the practicalities of preparing a patient for HPN was addressed by Mia Small and included a useful insight into the psycho-social aspects of this condition and its treatment. A second clinical case was then presented by Dr Charlie Murray, bringing all the aspects discussed into perspective.

After tea, Dr Alastair Forbes presented the future for IF, including both intestinal transplantation and the use of growth factors. Finally, an invited talk by Mrs Hazel Rollins completed the day as she presented the work that led to her CBE award.

Overall, the day was well organised and provided a fascinating programme, with a good multidisciplinary representation and a balanced mix of physiology and practical aspects of care.

Dr Simon Gabe,
Senior Lecturer, Department of Medicine,
St Mark's Hospital, London
Rebecca White,
Department of Pharmacy,
Middlesex Hospital, London

Clips from Council

Here is a selection of points from those discussed at the BAPEN Council meeting on 13 November 2001.

Affiliate Organisations

Representatives of the Affiliates met the Officers in October. It was agreed that, going forward, the Affiliates would nominate a key contact on a rotating basis and that they would receive a six monthly written report on BAPEN activities and a summary of the mid-year 'Think Tank' meeting.

2002 Focus

Plans are progressing well. Professor Marinos Elia reported that the hospital version of the Screening Tool is now being piloted and the Working Group on Drugs and Nutrition have met and aim to produce feedback in time for ESPEN 2002.

ESPEN

Prof. O Ljundqvist, who was a guest for part of the meeting, gave an overview of the origins of ESPEN, emphasising that the society continues to attract international delegates and is still growing. There are two committees: Science, which is a news forum for the latest developments, and Education and Clinical Practice (ECPC) which is working on the need to focus on 'closing the circle'.

ESPEN's aspiration is to provide a meeting place to discuss issues on an international basis and the Executive Committee recognises the need to interface with european agencies. In addition, a pan-european internal curriculum is being discussed by the ECPC.

Achievements to date include:

- Acting as a forum for special interest groups, e.g. on tracer methodology.
- Developing new ways of promoting activities, such as the genomics and peri-operative groups.
- Forming a 'faculty' of expertise, initially drawn from people who have contributed to ESPEN activities, with the ultimate aim of acting as a resource for governments.

BAPEN Annual Meeting 2002

This will be a half day meeting immediately following the ESPEN 2002 Congress in Glasgow. ESPEN will help by providing some registration facilities. It will be organised jointly by BAPEN and Clinical Nutrition and Metabolism Group (CNMG): part one will consist of a symposium on Intestinal Failure and part two will comprise of both the 'State of the Art' and Cuthbertson Award Lectures.

Programme Committee

The structure for the 2003 meeting needs to be reviewed but must be cost-neutral. It could present an opportunity to develop themes along similar lines to ESPEN but it was agreed that any process of change should be evolutionary rather than revolutionary.

Research and Science Committee

The first meeting of this new group has been held. Finance is an obvious key issue and a consortium will be formed with representatives from the Founder Organisations, Medical Research Council and MIG, among others. It may be possible to obtain some pump priming funds from the profits generated by ESPEN 2002. Priorities need to be identified but could include the development of a BAPEN research projects database.

PEN Group

The Clinical Handbook will contain four additional sections: Refeeding Syndrome; Diabetes; Microbiological Control and Thermal Injury. Order forms can be obtained from Vera Todorovic, Tel: 01909 502773.

The PEN Group have a constitutional requirement to meet in 2002. The clinical meeting will probably be held in December 2002 in London and the key theme will be Nutritional Screening.

Dates to Remember

Opening of the abstract submissions
31 Jan 2002

Deadline for abstract submission
5 Apr 2002

Publication of the 2nd Announcement
Feb 2002

Early registration deadline
30 May 2002

For more information on the congress please see our website:-
www.espen.org

2002 BAPEN Meeting 4th Sept, SECC Glasgow

BAPEN is the local host for the ESPEN meeting 31st Aug - 4th Sept at the Scottish Exhibition & Conference Centre Glasgow.

The BAPEN meeting will be held in the afternoon of the 4th. We hope you will support BAPEN by attending ESPEN and staying on for the BAPEN meeting.

Registration for the BAPEN meeting will be included in the ESPEN registration form available early 2002 from: ESPEN, MCI Congress, Rue de Lyon 75, CH -1211 Geneva 13, Switzerland, Tel: +41 22 33 99 580, Email: espen@mci-group.com, web: www.espen.org

More details will be published here in the Newsletter and on our website: www.bapen.org.uk

The Crown Review & Subsequent Legislation:
Legal & Practical Implications for the Extension of Prescribing Rights

The Review of Prescribing, Supply and Administration of Medicines, chaired by Dr June Crown, was set up in March 1997 with the principal aims of:

i) Developing a framework to determine in what circumstances healthcare professionals could undertake new roles with regard to the prescribing, supply and administration of medicines.

ii) Consider the implications for legislation and professional training. However, it was clear that any recommended changes to existing roles must at least maintain, preferably enhance, patient safety; be cost effective; and bring demonstrable benefits to patient care.

The final report of this review was published in March 1999. One of the key recommendations of the report was that professions allied to medicine should be given prescribing powers, and that legislation was necessary to remove the barriers to this.

Until recently the Medicines Act 1968 had acted as a legal barrier to non-doctor prescribing of POMs (prescription only medicines), in that The Act specified that these medicines may only be supplied by a pharmacist against the prescription of an 'appropriate practitioner' who has been specified in an order made under section 58 of the Medicines Act. This, until 1992, had only included doctors.

The amendments made to the Medicines Act following the Medicinal Products Act 1992, allowed for limited prescribing rights for specific sections of the nursing profession. Therefore, non-doctor prescribing already exists within the current legal framework.

However, this is from limited lists; dentists and district nurses for example can prescribe from their respective formularies, and pharmacists can 'counter prescribe' from the range of P (pharmacy) and GSL (general sales list) medicines. In addition, it was specifically noted in The Review that many hospital pharmacists 'prescribe' parenteral nutrition on a daily basis but still secure technical observance of the law by a doctor's signature being added to the prescription.

Group Protocols

The Review encouraged the development of Group Protocols or Patient Group Directions, (PGDs) to facilitate quicker access to specific treatments. These protocols relate to the supply and administration of medicines only, practitioners using these protocols are not recognised 'prescribers' therefore the protocol must be compliant with the Medicines Act.

Breaches of the Medicines Act 1968 render the person in breach liable to criminal prosecution. This is quite different from the issue of civil liability which may ensue should any wrongful supply result in injury or death to a patient.

Sections 55(1)(b) and 58(2)(b) of the Medicines Act specify that medication must be supplied "in accordance with the directions of a doctor". Protocols must be explicit, leave the minimum of discretion to the health professionals involved and have been authorised by a doctor in order to meet this requirement.

Prescribing

To prescribe is to authorise in writing the supply of a named medicine (usually but not necessarily a prescription only medicine) for a named patient.

The Review recommended that two types of prescriber should be recognised, independent and dependent (now referred to as supplementary) prescribers.

An independent prescriber is responsible for the assessment of patients with undiagnosed conditions and for decisions about the clinical management required, including prescribing. The dependent prescriber is responsible for the continuing care of a patient who has been previously clinically assessed by an independent prescriber.

This continuing care may include prescribing, which will usually be informed by clinical guidelines and will be consistent with individual treatment plans; or continuing established treatments by issuing repeat prescriptions, with the authority to adjust the dose or dosage form according to the patients needs.

It is clear that prescribing can only be done within the sphere of a pharmacological knowledge base. This is particularly relevant to specialist practitioners who have only trained in one therapeutic area. This is a major issue when patients are on a number of medicines as any new medicine added must be assessed for the potential for interaction and therefore a wider knowledge base is essential.

At a practical level it is difficult to predict which model is likely to be more appropriate in any particular clinical circumstance. Administration or supply within a group protocol may be a suitable model where patients' clinical needs are broadly similar and individual prescriptions would be unwieldy or impracticable (e.g. mass vaccination campaigns) or where there is a need for urgent treatment (as in the relief of acute asthma by ambulance paramedics).

Dependent or independent prescribing is likely to be preferable where more detailed clinical assessment is required and the range of treatment options required to meet the clinical needs of the patients is wider (e.g. palliative care).

The review team has specified that they do not expect administration or supply under group protocol to be widely adopted in circumstances which do not fully meet the criteria set out in the first report, simply because this appears to be an easier option than applying for authority to prescribe.

Relating this to nutrition support, it is evident from this statement that if the prescribing of Parenteral Nutrition (PN) is to be undertaken by other practitioners it is likely to be as dependent prescribers within clear guidelines. The practicalities of determining competence need to be established, but it is clear that organisations such as BAPEN must have a stake in developing competence standards for relevant areas.

Since the publication of the Crown Report the Health and Social Care Act 2001 has removed more of the legal obstacles and provided a statutory framework in which non-doctor prescribing can take place. However, the focus between now and 2003 is on the establishment of the independent nurse prescriber, predominantly in areas such as minor injuries, minor ailments, health promotion and palliative care.

Currently 20,000 nurses are eligible to prescribe from the original Nurse Prescribers' Formulary. The nurses formulary has been reviewed and the list

of medicines extended. The supervised training scheme for new nurse prescribers is being developed and has been implemented in some areas. The first of the new nurse prescribers will qualify in spring 2002. Existing nurse prescribers will also have to complete this training to prescribe from the extended formulary.

The timescale for implementation is short, but, before we rush to embrace the opportunities for prescribing, we should perhaps reflect a little. The responsibility for prescribing is not taken lightly, medical doctors train for 6 years to earn the right to be independent prescribers.

The report was very clear that non-medical prescribing of POMs required postgraduate training. In fact, Crown wanted an assurance of competence before any medicines were prescribed.

Accountability and acceptance of responsibility is a consequence of prescribing. Responsibility is common across all healthcare professionals. We have a responsibility to our patients, the public, our colleagues, our employers, our profession and ourselves.

Responsibility has both legal and moral perspectives. Legally, it is reflected in the law of negligence. Morally it is reflected in the trust that exists between a patient and a healthcare provider. Accountability differs from responsibility in that it focuses on justifying and explaining our actions.

The ability to demonstrate assessment and diagnostic skills is likely to take considerable time to develop but is a necessity to become an independent prescriber.
Practice must be demonstrably safe and effective.

With respect to the management of nutrition support it is important that wider acquisition of prescribing rights should not remove the need for multidisciplinary input. BAPEN has always encouraged a multiprofessional approach with the patient in the central role. This should be encouraged, not compromised, as the NHS evolves.

Rebecca White, BPNG

To prescribe or not to prescribe? That is the question!

The Review of Prescribing (the Crown Report) published in 1999 contained a significant number of recommendations. If all were implemented there would be a major impact on the quality of health care in the United Kingdom.

Dietitians historically have required an authorisation signature for prescribable products in order to go some way to providing a quality of care. As a profession they do not have any argument with being empowered to 'prescribe' a product which would enhance the service.

While this may be the vision, moving forward to give total autonomy to the practitioner for total care has appeared almost a dream. However, 'new' Labour do like to make (or try to make) dreams come true.

In May 2001, just before Parliament was dissolved for the General Election, the Health & Social Care Act 2001 completed its journey through the Lords and history was made. Part 5 of the Act, Section 68, Extension of prescribing rights, point 3, states:

"(1A) The descriptions of persons which may be specified in an order by virtue of subsection (1)(e) are the following … (a) persons who are registered by any board established under the Professions Supplementary to Medicine Act 1960 …) This enables the Secretary of State to give the power to Allied Health Professions to prescribe.

Thus the beginning of a dream for many dietitians is being realised.   With the Crown Report, (and despite the fact that dietitians had been excluded from the work on Patient Group Directions (previously Protocols)), there is now the ability for discussion to commence to address the position of dietitians being empowered to prescribe.

The British Dietetic Association has already begun to address some of the issues. A position paper was produced which gave the present 'position' of the dietetic practitioner (www.bda.uk.com – professional affairs), and a Working Group has been established to guide the profession through the many issues which will need addressing.   This will need to be accomplished in consultation with other Allied Health Professions. Nurses are well down the route of prescribing and that road has not been easy. £14 million has been provided from central funds to support the initiative and they can only prescribe from a limited Formulary. The progress has been a mixed experience with many frustrations. The Allied Health Professions will need to build on this learning experience.

Dietitians need the authority for extended prescribing to ensure patient safety and making access to the service for them 'a better experience'.

A recent presentation by Dr Crown posed the following questions which need to be addressed:

- Are we looking to be independent prescribers able to make a diagnosis? Or supplementary prescribers responsible for the management of pre-diagnosed conditions?

- What pharmacological skills are needed?
- How do you keep up to date?
- What kind of training is necessary?
- How will new prescribers be identified and regulated?
- What do patients and the general public need to know?
- What do you need to know concerning the patient, treatment, etc?
- Who will pay?
- How will we know if it works? – evaluation by whom, for whom?

For many the immediate need to provide a complete service for the patient has been addressed through local protocols and procedures, thus enabling a dietitian to make an informed decision and move care forward and improve the patient's experience.

To be an autonomous healthcare professional who is able to prescribe (if we wish to have this responsibility) is not going to be a swift or easy exercise. I do believe, however, that to deliver health care within a 2020 service, those who wish should be enabled to prescribe as an option within the service they deliver.

Please contribute to this debate by keeping aware of developments through the BDA website and Dietetics Today. Remember also to access the BAPEN Resource Pack, available from the BAPEN office

Jane Eaton SRD FBDA
Professional Affairs Officer

2002 Intercollegiate Course on Human Nutrition

The unique five day course will be held on three occasions this year at the venues listed below. The course will cover:-
Monday - Introduction to Human Nutrition: Overview and Evidence
Tuesday - Normal Nutrition through the Life Cycle
Wednesday - Undernutrition
Thursday - Nutrition and Public Health: Chronic Disease, Biological, Sociological and Psychological Factors
Friday - Metabolic Response

Aviemore Course: 4-8th February
Hilton Coylumbridge Hotel, Aviemore, Scotland
Course Organiser: Carolyn Fraser, Dept. of Human Nutrition, Yorkhill Hospitals, Glasgow G3 8SJ, Tel: 0141 201 9275
Email: cf24f@clinimed.gla.ac.uk

Southampton Course, 8-12th April
Chilworth Manor
Course Organiser: Janice Taylor, Institute of Human Nutrition, University of Southampton, SO16 6YD, Tel: 02380 796317
Email: jmt1@soton.ac.uk

Nottingham Course, 16-20th September
University of Nottingham Medical School
Course Organiser: Sarah Marshall, School of Biomedical Sciences, University of Nottingham Medical School, Nottingham , NG7 2UH, Tel: 0115 970 9478
Email: sarah.marshall@nottingham.ac.uk

MSc / Postgraduate Diplomas

Clinical Nutrition
Clinical Nutrition and Immunology
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Roehampton, University of Surrey has devised flexible and modular programmes for a wide range of healthcare professionals and graduates. Their emphasis is on the underlying mechanisms and their clinical significance, and on modern developments in diagnosis and treatment. In addition, a taught Postgraduate Certificate in Clinical Nutrition is also available.

Programme details are available at:
www.roehampton.ac.uk/acprog/m/
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West Hill, London, SW15 3SN

Tel: 0208 392 3232
Fax: 0208 392 3470
Email: enquiries@roehampton.ac.uk or
prospectus@roehampton.ac.uk
web: www.roehampton.ac.uk

The 20th Leeds Course in Clinical Nutrition

3-6 Sept 2002

Tuesday, 3 September 2002
NUTRITIONAL BENEFITS IN CLINICAL MEDICINE
Chairman: Dr RV Heatley, Leeds

Wednesday, 4 September 2002
THE GUT AND NUTRITION
Chairman: Dr KJ Moriarty, Bolton

CHILDHOOD NUTRITION
Chairman: Dr J Puntis, Leeds

Thursday, 5 September 2002
LIPIDS AND OBESITY
Chairman: Dr J Bodansky, Leeds

NUTRITIONAL TREATMENT
Chairman: Dr RV Heatley, Leeds

Friday, 6 September 2002
WORKSHOP: MANAGING CLINICAL NUTRITION

For prices please refer to S. Armitage at the address below.

Miss Samantha Armitage
Professional Lifelong Learning Unit
School of Continuing Education
University of Leeds
Continuing Education Building
Springfield Mount
Leeds LS2 9NG
tel: 0113 233 3236/Fax: 0113 233 3240/email
s.armitage@leeds.ac.uk

The Annual Practical Nutritional Support Course for Clinicians

To be held at Chilworth Manor, Southampton from 22nd to 26th January 2002

Specifically designed for medical staff involved in areas such as gasatroenterology, major surgery and intensive care, where patient groups are likely to require nutritional support.

Aimed to develop and update practical management skills required by Clinicians with responsibility for nutritional support.

For more details please contact Janice Taylor,
Course Administrator, Institute of Human Nutrition, Southampton General Hospital, Level C, West Wing, MP 113, Tremona Road, Southampton, SO16 6YD.

Tel: 02380 796317, Fax: 02380 794945
Email: john@soton.ac.uk

Journal Watch - from a Dietitian's Perspective

Burd R.S. et al (2001) The limitations of using gastric residual volumes to monitor enteral feedings: a mathematical model. Nutrition in Clinical Practice, vol.6; No 6: 349 - 354

This article uses a mathematical model to assess the reliability of residual volumes to assess tolerance to enteral feeds in the critically ill. A residual volume of >200mls is considered to be indicative of delayed gastric emptying. The model predicted residual volumes based on feeding rates, estimated volume of endogenous secretions and estimated half-emptying time of the stomach. Residual volumes were calculated for different rates of continuous and bolus feeding, and were found to be lower than expected for slower rates of feed and greater than expected for faster rates of feed. (Gastric residuals of 137mls to 649mls at rates of feed ranging from 65mls/h to 175mls/h).

The authors went on to propose an alternative method for monitoring enteral feeding based on gastric half-emptying time. An acceptable half-emptying time is selected and the ratio of residual volumes at defined intervals monitored. When the ratio exceeds a threshold value, the infusion can be reduced. When a plateau volume is achieved, additional monitoring is used to confirm that residual volume does not increase indicating delayed gastric emptying.

It must be stressed that this study was purely to develop a mathematical model and no patient studies were carried out. This model also makes a number of assumptions:
1. Gastric emptying rates and volumes of endogenous secretions were assumed a constant throughout the study. However, if this model was used in the clinical setting and rates of gastric emptying and addition of exogenous secretions were not standard, predicted gastric residuals would be higher or lower than expected.
2. It assumes that the volume aspirated accurately reflects the gastric volume.
Although this is a purely mathematical model, it is based on current knowledge of gastric emptying and so may reflect actual gastric emptying patterns during enteral feeding more closely than the current practice of using a residual volume of >200mls. Prior to its implementation we need clinical validation and further research into real time gastric volume during enteral feeding.

Van den Berghe G, et al (2001). Intensive insulin therapy in critically ill patients.
New England Journal of Medicine 26; 19: 1359 – 1367

Hyperglycaemia is common in the critically ill, and may confer a predisposition to complications such as severe infections, multiple organ failure and death. The authors performed a randomised-controlled study on 1548 intensive care patients over a period of 12 months to test this hypothesis. The treatment group received intensive insulin therapy to maintain blood glucose within 4.4 to 6.1mmol/l, whilst the control group received conventional treatment (maintenance of blood glucose within 10.0 – 11.1mmol/l).

The results of the study are impressive. Mortality fell from 8.0 to 4.6% (p<0.04) which represented a 32% risk reduction, the greatest reduction in mortality being from deaths due to multiple organ failure with a proven focus of infection. Also, in the treatment group, there was a 46% reduction in bloodstream infections, 41% reduction in acute renal failure requiring renal replacement therapy, and a reduction in the number of patients staying more than five days on intensive care. Although more incidents of hypoglycaemia (blood glucose of < 2.2mmol/l) occurred in the treatment group, these did not cause haemodynamic deterioration or convulsions.

There were limitations with the trial, in that it was not carried out blind and results can only be applied to the intensive Care population. However, glycaemic control is a preventative treatment that can be widely implemented in intensive care patients and intervention may represent a significant improvement in survival rates.

Clare Soulsby, Research Dietitian,
The Royal London Hospital

Media Co-ordinator

Ms Rhonda Smith has been appointed BAPEN Media Co-ordinator on the flexible basis of one day per week for 12 months, commencing 1 January 2002.

For some time, Rhonda has supported the Digestive Disorders Foundation in a similar capacity, handling press releases, events, publications, sponsorship and their annual meeting. She has succeeded in significantly raising the profile and awareness of the DDF and I am sure she will provide tremendous help in promoting the aims, activities and achievements of BAPEN.

Rhonda will spend her time in January on an induction programme and will be having a discussion with a number of Council members and others. She will be explaining the broad approach to media co-ordination which will be used and will also be seeking input on the potential subjects for media comment and the key individuals who might speak on behalf of BAPEN.

Rhonda will join the Communications and Liaison Committee and will provide a report on her activities in future newsletters.

I am sure you will join me in welcoming her to BAPEN in what is an interesting development for our organisation.

Niall Bowen, Chairman, Communications and Liaison Committee

2nd International Conference

A two day conference on all aspects of Intravenous Therapy.
Aimed at:- Community: GP's and Nurses, Hospital: All healthcare professionals, Students:- Medical and Nursing.

6th & 7th March 2002
At The John Radcliffe Hospital, Oxford.

For more information contact Helen Harris, Helen Hamilton or Darah Drewett, Tel: 01865 221653,
Fax: 01865 222047,
Email: helen@johnradcliffe.fsnet.co.uk.

MAG Update

Policy forum

On the 5 December the MAG held its policy forum, Starvation in the Midst of Plenty, at Westminster Central Hall in London. The policy forum brought MPs, healthcare professionals and the media together to discuss what action could be taken by government and healthcare professionals to tackle malnutrition in the UK.

Speakers included Liberal Democrat Health Spokesperson Dr Evan Harris MP, Labour MP and GP Dr Howard Stoate, Conservative Frontbench Health Spokesperson Tim Loughton MP, BDA Chair Luci Daniels, BAPEN Chair Chris Pennington, MAG Chair Marinos Elia, the Royal College of Nursing Community Health Advisor Lynn Young, Chief Executive of the Registered Nursing Homes Association Frank Ursell and Nutrition Nurse Specialist and MAG member Hazel Rollins.

Professor Elia released new data showing that one in seven of those aged 65 and over were, according to classification by a MAG screening tool criteria, at medium and high risk of malnutrition. In response to the problem the three MP speakers called for a cross-party approach to reduce the level of malnutrition in the UK.

The policy forum was highly successful and delegates were drawn from all sectors including the NHS, media and voluntary sector. "We would like to thank all those that attended".

Intouch Survey on the MAG Tool

A total of 77 replies were received from our Intouch survey on the MAG Tool from dietitians, consultants and nurses. The survey showed that of the respondents:

o 95% had heard of the tool and 90% had seen it
o 10% had used the MAG tool or a MAG based tool
o 21% intended to use the MAG tool in the future

There was a variable response on the presentation, an issue that is being addressed. Conversion of the scoring system from an alphabetic to a numeric system has simplified the presentation and has made it more user friendly.

The MAG would like to thank all those who returned their questionnaires. All comments, both positive and negative, have proved invaluable in our current work adapting the MAG community tool for use in hospital, nursing and care homes settings.

Malnutrition Universal Screening Tool (MUST)

We have thought of a name for the new adapted MAG tool – the Malnutrition Universal Screening Tool. We believe that this name is a MUST!

The MUST will shortly be piloted in hospitals and nursing home care environments at five sites – London, Dundee, Rotherham, Bassetlaw and Southampton.

After this the MUST will be sent out for peer review for comment. We would delighted to hear from any BAPEN member who would like to be part of the peer review process.

For more information and to register for the MUST review process please write to the MAG at the MAG Secretariat, Porters' Place, 11-33 St John Street, London, EC1M 4GB. Tel 0207 309 1127.

Professor Marinos Elia
Chairman

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U.K. Dates

6-7 Mar 2002	2nd International Conference IV Therapy	John Radcliffe Hospital, Oxford. Contact Helen Harris, Helen Hamilton or Sarah Drewett Tel: 01865 221653, Fax: 01865 222047, email: helen@johnradcliffe.fsnet.co.uk
24-26 June 2002	8th World Congress on Clinical Nutrition	Contact Dr Heema Shukla, Tel 0207 9115 752 Fax 0207 9115 026 email: shuklah@wmin.ac.uk

International Dates

23-27 Feb 2002	26th ASPEN Conference	San Diego, California Contact: Christine Rossiter 856-423-7222, ext. 235 www.nutritioncare.org, click on "Nutrition Week"
18-19 Apr 2002	2nd Sanitarium International Nutrition Symposium	Melbourne, Victoria, Australia Contact: Rachel Parsons, Tel +61 2 4348 7777, Fax +61 2 4348 7786 email rachel.parsons@sanitarium.com.au
20-24 April 2002	The American Society for Clinical Nutrition 42nd Annual Meeting on Experimental Biology	Contact The American Society for Clinical Nutrition. 9650 Rockville Pike, Bethesda, MD 20814-3998 Tel +1 301 530 7110 Fax +1 301 571 1863 emailsecretar@ascn.faseb.org
22-25 April 2002	1st International Congress on Transthyretin in Health Disease	Strasbourg, For further information contact: Yves Ingenbleek MD, PhD Faculté de Pharmacie, 74, route du Rhin F-67401 Illkirch, email: ingen@pharma.u-strasbg.fr
20-31 May 2002	ESPEN Advanced Course in Clinical Nutrition	Maastricht, Netherlands and Bonn, Germany. For further information contact Monique Devies, Secretary to Prof. Dr. Soeters and Dr. N.E.P. Deutz Tel: +31 43 387 74 89, Fax: +31 43 387 54 73, Email: secretary.deutz@ah.unimaas.nl
31 Aug - 4 Sept 2002	24th ESPEN Congress	Glasgow Scotland, For more information contact: ESPEN 2002 c/o MCI Congress 75, rue de Lyon, CH-1211 Geneva 13, Switzerland, Tel: +41 22 33 99 580 Fax: +41 22 33 99 621, Email: espen@mci-group.com
4-7 June 2003	36th Annual Meeting of ESPGHAN	Prague, ccongress Secretariat, Guarant Ltd/ ESPGHAN 2003, Opletalova 22 110 00 Praha 1, Czech Republic.