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

The British Association for Parenteral and Enteral Nutrition;

Is a multi-professional association and registered charity established in 1992. Its membership is drawn from doctors, dieticians, nutritionists, nurses, patients, pharmacists, and from the health policy, industry, public health and research sectors.

Principal Functions

Enhance understanding and management of malnutrition

Establish a clinical governance framework to underpin the nutritional management of all patients

Enhance knowledge and skills in clinical nutrition through education and training

Communicate the benefits of clinical and cost-effective optimal nutritional care to all healthcare professionals, policy makers and the public

Fund a multi-professional research programme to enhance understanding of malnutrition and its treatment.

Contents

Honorary Professorship for Rosemary Richardson

Those of us who know Rosemary will not be at all surprised by the fact that her talents in the field of dietetics and clinical nutrition have been recognised by the award of an Honorary Professorship from Queen Margaret University College, Edinburgh. The Institution and Rosemary have recently departed - to the considerable benefit of South Glasgow NHS Trust! However the former association continues and remains a long and fruitful one.

It goes back to Rosemary's diplomate days in the seventies when as a student her classical training began. Following her introduction to clinical practice in Northern Ireland in 1978 she practiced for several years in the Middle East. Returning to Glasgow in 1984 she began her research career in earnest, undertaking an MSc while working as a research dietitian.

Continuing to develop her clinical & research skills in a move to the University of Edinburgh, Rosemary then took up a post as lecturer in dietetics at her alma mater in 1990. This initiated her considerable contribution to higher education in dietetics, including the introduction of problem-based learning to the dietetics curriculum as well as driving the continuing education of dietitians through activities such as Chair of PENG.

Having successfully completed her PhD in 2000, she continues to lead the profession into the age of clinical effectiveness. She appreciated the importance of interdisciplinary working before many of her peers and acknowledges the role of education and continuing education of all allied health professionals and how this in turn works to improve patient care. She was instrumental in founding Partnerships in Active Continuous Education (PACE) which provides an education solution to help healthcare professionals, patients, carers and others to understand the role of nutrition in health and disease. Her appointment to BAPEN as a member of Council, as well as her numerous consultancies is testament to the respect she commands within the clinical nutrition community both at national and international level.

Congratulations Professor Richardson.

BAPEN

Officers Contact Details

Dr Alastair Forbes — Tel: 020 8 235 4016
BAPEN Chairman — Fax: 020 8 235 4039
email: alastair.forbes@ic.ac.uk

Mr Niall Bowen — Tel: 01225 711 571
Hon Treasurer — Fax: 01225 711 798
email: nbowen@nutricia.co.uk

Mrs Pat Howard — Tel: 0117 928 2049
Hon Secretary — Fax: 0117 928 3005
email: pat.howard@ubht.swest.nhs.uk

Ms Vera Todorovic — Tel: 01909 502773
(PEN Group) — Fax: 01909 502809
Chairman: Communications and Liaison Committee
email: vera.todorovic@bhcs-tr.trent.nhs.uk

Mr Geoff Simmonett — Tel: 0116 286 7442
(PINNT) — Fax: as telephone
Chairman: LITRE
email: geoff@simmonett10.freeserve.co.uk

Prof Agostino Pierro — Tel: 020 7 905 2175
Fax: 020 7 404 6181
Chairman: Research and Science Committee
email: a.pierro@ich.ucl.ac.uk

Dr Ian Fellows — Tel: 01603 288 356
Fax: 01603 288 368
Chairman: Education and Training Committee
email: ian.fellows@nnuh.nhs.uk

Dr Barry Jones — Tel: 01384 244 074
Chairman: BANS — Fax: 01384 244 262
email: b.j.m.j@btinternet.com

BAPEN OFFICE

Secure Hold Business Centre, Studley Road, Redditch, Worcs. B98 7LG

Tel: 01527 457850 — Fax: 01527 458718

To contribute to *InTouch*, please contact the editors:

Vera Todorovic — Tel: 01909 502773
email: vera.todorovic@bhcs-tr.trent.nhs.uk

Niall Bowen — Tel: 01225 711571
email: nbowen@nutricia.co.uk

Chairman's Update

We are now entering the last few weeks before the Telford conference, and I hope that by now you have fixed your registration and accommodation, and begun to make your travel arrangements.

Lynne Colagiovanni and her team on the Programme Committee have done a splendid job despite the vagaries of the abstract submission process. I know that this has been very frustrating for many of you and I am personally very sorry that we are missing out on interesting material that was never sent. As is often the case with these things, there was no one error but rather a sequence of 'system failures.' On top of that some of you who did work out the date in time had difficulties with the electronic submission process.

Unfortunately there was a gremlin with those whose details tried to cross-populate with data already held by the Nutrition Society. It only affected a few but was a complete obstacle when it occurred. We will try to ensure that none of these problems are allowed to recur. I can now confirm that the abstract submission date for 2005 will be 24th June, and the meeting will again be in Telford on the 16th and 17th November 2005. Please put these dates in your diaries right away!

Progress is being maintained on a number of other fronts, including our ambitions to improve postgraduate training in nutrition for doctors. Our liaisons with the Nutrition Committee of the Royal College of Physicians of London, and the Training Committee of the British Society of Gastroenterology, are also proving especially productive. I remain keen to ensure that parallel endeavours in the other disciplines are carried forward with equal vigour, and will do all I can to help this happen.

I mentioned in my last piece the evolution of a strategy document for BAPEN. This is nearing completion and will be on the BAPEN website in a draft form for comments by the time you receive this issue of *InTouch*. Please look and respond - either in writing or when I see you in Telford!

Dr Alastair Forbes
Chariman BAPEN

A Focus On Professor Ann de Looy

Interview with Professor Anne de Looy, University of Plymouth

"At the age of eleven I knew I was destined to become a dietitian," explains Anne de Looy. Rather a strong conviction for someone so young, but an opportune comment from a doctor at her local hospital sealed her fate. "He asked me what I wanted to do when I grew up" said Anne, "and I replied something to do with food and medicine. In that case he told me, I had to become a dietitian!"

Today Anne is Professor of Dietetics at the University of Plymouth and is a well known and respected figure in the field of nutrition and dietetics.

Anne began her career in 1967 studying for her degree in nutrition at the Queen Elizabeth College, London where she worked with some of the leading authorities in nutrition. "I feel extremely fortunate to have studied under the auspices of some highly inspirational people", said Anne, "These included Professor John Yudkin - the founder of modern nutrition at the Queen Elizabeth College in London, and Professor John Garrow at the Medical Research Centre in Harrow whilst completing my PhD thesis on measurement of energy expenditure."

Once qualified, Anne's first job was as a paediatric dietitian at the Children's Hospital in Birmingham where she worked with Professor Charlotte Anderson, a specialist in the nutritional care of children with cystic fibrosis. This was followed by a 15 year stint lecturing at Leeds Polytechnic. Then in 1991, Anne reached the pinnacle of her career when she was awarded a Professorship at Queen Margaret University College, Edinburgh, and became the first Professor of Dietetics in the UK.

In January this year, Anne was appointed Professor of Dietetics at the University of Plymouth where one of her first tasks was to develop a new degree course in dietetics for the start of the academic year 2004/05. "I feel very privileged to have been asked to champion this project which will be the first three year dietetic course in the UK," said Anne. "What is so exciting about this new degree programme is that it is part of a Peninsula collaboration involving nine professional groups which will provide a much needed multi-disciplinary approach to teaching and shared learning. We are also collaborating with the new Peninsula Medical School to develop postgraduate awards."

As well as her role as an academic, Anne is heavily involved in professional associations. These include The Nutrition Society and the European Federation of Dietetic Associations (EFAD). She is well known at BAPEN where she is a strong advocate of its pro-active multi-disciplinary approach. She is particularly supportive of the recently produced 'MUST' which she sees as a welcome addition in the management of nutrition. "The 'MUST' is set to revolutionise the way we can identify and assess those at risk of malnutrition." says Anne, "and it can be applied by all sectors and disciplines. I will certainly be promoting its use in my multi-disciplinary teaching sessions."

Sally Robinson
GCI Healthcare

The Better Hospital Food Project

Better Hospital Food moves house

Earlier this Summer, the Department of Health in England had a major re-organisation. The principle behind the changes is to reduce activity driven from central Government and devolve more decision making to local level.

The number of 'arms length' agencies has been halved and casualties include NHS Estates, the current home of the Better Hospital Food project in England. The plan is for the project to move to the National Patient Safety Agency (NPSA). The project needs to become a part of the clinical governance agenda - good food = good care - the NPSA is very much geared towards risk management so in my opinion is a good place for the project to move forward.

As many of you will know the Council of Europe Recommendations on Food and Nutritional Care in Hospitals are to be implemented across the UK. The British Dietetic Association and the Hospital Caterers Association have a joint committee working on this.

In order to discover what is happening with regard to these recommendations across the country, a survey of hospitals in the UK is being conducted. With the help and support of the Better Hospital Food project in England, the results of the survey will be presented at a seminar/workshop day on the 3rd November 2004, at the Royal Lancaster Hotel, Hyde Park, London. We want to use that day to develop our implementation plan and I hope that many of you will be able to attend and contribute.

For further information please contact Clare Williams at NHS Estates (email: clare.williams@doh.gsi.gov.uk telephone: 0113 2547041)

Rick Wilson
Chair of the joint BDA/HCA Working Group BDA Representative on the BHF Panel

Media Update

The conference season is now underway and we are busy investigating media opportunities for BAPEN. The first event was the Nursing Practice Conference on the 8th and 9th September 2004 in London, where BAPEN had a Stand. More than 900 community nurses attended and our objective was to increase understanding of BAPEN within this group and how the charity can and does help the nursing profession tackle front-line issues.

An article on BAPEN by Lynne Colagiovanni was published in the August issue of Nursing in Practice and the September issue, which included details on all exhibitors, was distributed at the event.

With the BAPEN Symposium only a few months away, there will be intense media activity. In September, we issued media alerts to the medical and consumer media to raise interest. This will be followed by pre-event one to one media briefings and press release distribution on individual speakers and presentations. Post conference, we will produce articles for specific publications to maintain awareness of key issues debated at the Symposium in November.

News from Scotland

Scottish Intercollegiate Guidelines Network (SIGN)

Postoperative management in adults (2004)

Given the lack of strong evidence of effective practice for postoperative management this guideline has been developed using a combination of evidence based and consensus techniques. Initial systematic searches identified any relevant evidence. The critically appraised evidence, together with the clinical experience of the guideline development group, informed the formal consensus methods that were used to develop recommendations. These are presented in the form of consensus statements.

The guideline contains a comprehensive section on postoperative nutrition. The consensus points from this section are:

- Oral intake should commence as soon as possible after surgery
- Patients should not be fasted for any longer than necessary, either for investigations or surgery
- Hospitals should provide appetising food and assist patients to eat, if this is needed
- Anti-emetics should be used as required in order to promote an early return of oral intake
- Malnourished patients with benign disease requiring surgery should receive post operative nutritional support by the appropriate route
- Mild and moderately malnourished cancer patients should proceed with surgery and only receive artificial nutritional support if specifically indicated
- All malnourished cancer patients should be considered for nutritional advice and oral supplements in the post operative period and for a period following discharge
- Nutritional replacement should be discussed with the dietitian and tailored to the patients' requirements
- Enteral nutrition is the preferred method of postoperative nutritional support and should be used if possible
- For patients with ongoing postoperative complications enteral nutrition should be used whenever possible, combined with parenteral nutrition where necessary, to meet nutritional needs
- Enteral nutrition should be provided by the simplest technique possible. The feeding should be given in such a way as to interfere minimally with the stimuli to eating
- Parenteral nutrition should be provided through a dedicated intravenous catheter
- Nutritional and metabolic status should be assessed regularly and the nutritional prescription modified as necessary
- Quality of nutritional support is enhanced by the use of dedicated nutrition teams

The document gives a concise and well balanced overview of a large and often controversial area of nutritional care. It will be a useful starting point for development of local guidelines, taking into account individual resources and patient populations.

Interestingly, there was no dietitian on the list of contributors or specialist reviewers. However, there may have been involvement at the initial consultation stage. This is hopefully an issue that will be raised and addressed at local implementation stage.

For further information visit the SIGN website : www.sign.ac.uk

Carole Anne McAtear
Nutrition Support Dietitian
South Glasgow University Hospital Division

Clinical Nutrition Support Behind the dykes

The Dutch menu is very simple: Twice a day (usually breakfast and lunch) we have slices of buttered bread with cheese, meat eg; sausage or ham, peanut butter, jam or 'hagelslag' (a mixture of chocolate and sugar grains). Milk, tea or coffee is taken with this. One hot meal is eaten, generally in the evening. This meal consists of a piece of meat, boiled potatoes and vegetables. As a dessert we use yoghurt or custard.

With the increase of foreign foods and eating habits the 16 million Dutch are altering their eating patterns and pizzas, hamburgers, pasta and rice meals are frequent guests at dinner time. Also the age of snacking and craving is not bypassing the country behind the dykes. There is an increasing incidence of overweight adults and children. 50% of adult males and 40% of adult females have a BMI of over 25. Children are runners up - about 25% of them have an increasing bodyweight which is too much for their height. The Dutch have suddenly joined this global health problem! But this is mostly outside hospitals and in healthy people. But what happens if these healthy people become seriously ill? Clinical nutrition support will have to be started.

In 2000 the Dutch Dietetic Society started a nationwide campaign about malnutrition in patients. The slogan was: 'ZIEK ZIJN IS TOPSPORT', translated: 'Being ill is performing top level sports'. This campaign was run in - and outside hospitals, in the media and it was underpinned with a nice brochure in which the dangers of involuntary weight loss in disease were pointed out. The link between undernutrition and disease became well known to the public. In 2002, a national screening campaign was carried out among 8500 patients in over 100 institutions (hospitals, outpatient clinics) with the following results:[1]

	Good nutritional status	Weight loss 5–10% (risk patient)	Weight loss > 10% (Malnourished pt)
N (%)	5760 (75%)	962 (13%)	884 (12%)
Age	64 ± 17	68 ± 16	67 ± 16
Oncology	12%	23%	29%
Surgery	30%	29%	36%
BMI	26 ± 5	23	22 ± 4
Intervention dietitian	12%	40%	54%

So the problem was diagnosed: malnutrition is present in Dutch hospitals and especially in patients who are not underweight! In 2001 the European Council presented their report about malnutrition in European hospitals[2]. Dutch hospital food was mostly prepared following the guidelines for healthy eating drawn up by the Netherlands Nutrition Centre (www.voedingscentrum.nl) This has now changed to a totally different approach - that of a 24 hour food service with the goal of optimum nutrition provision for all patients. Optimum nutrition[3] is defined as 1.5 gram of protein/kg body weight and adequate energy provision with a basis of 35 kcal/kg body weight. The first results of this change will be available by the end of 2005.

Clinical nutrition in hospitals is mostly practiced by dietitians and nutrition support nurses. The following organisations focus on clinical nutrition: The IV Nurses Society, the Society of Dutch Nutrition Teams the scientific society of NESPEN and the Netherlands PEN society (www.nvge.nl). These organisations have one common goal: nutrition should be part of the treatment of the patient. Nutrition is a link in the chain of the treatment of the patient and it should be practised in the optimal way!

Cora F. Jonkers – Schuitema RD. Academic Medical Center, Amsterdam NL c.f.jonkers@amc.uva.nl

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2. Anne M Beck et al. Food and nutritional care in hospitals: how to prevent undernutrition – report and guidelines from the Council of Europe. Clin Nutr 2001 455-460
3. Jonkers CF, Prins F, van Kempen A, Tepaske R, S auerwein HP. Towards implementation pf optimum nutrition and better clinical nutrition support. CLin Nutr 2001;20(4):361-366

Wednesday 17th	**November 2004**
08:30	Registration
Symposium 1 Chairman	**"News at Ten"** Dr. Simon Gabe
10:00 – 10:10	Welcome and Introduction from the Chairman
10:10 – 10:30	"Payment by Results" Speaker to be confirmed
10:30 – 10:50	"Pharmacists Prescribing of TPN" Rebecca White
10:50 –11:00	"Are they NICE guidelines?" Dr. Mike Stroud
11:00 - 11:10	"MUST Highlights 2003 - 2004" Professor Marinos Elia
11:10 - 11:30	"The Resolution on Food and Nutritional Care in Hospitals" Speaker to be confirmed
11:30 – 11:40	Questions & Answers
11:40 – 12:00	**2003 BAPEN Research Award Winners**
12:00 - 13:30	Lunch and Exhibition Electronic Poster Sessions
	NNNG Annual General Meeting
Nutrition Society Symposium	**"End-Points in Clinical Nutrition Trials"**
13:30 -14:00	"Death, morbidity and economics are the only end-points for trials" Professor Ron Koretz
14:00 – 14:30	"Physiological function is an important end-point in clinical nutrition trials" Professor Peter Soeters
14:30 – 15:00	"Biochemical homeostasis and body growth are reliable end-points in clinical nutrition trials" Professor William Heird
15:00 – 15:15	Questions & Answers
15:15 –15:45	Tea and Exhibition
15:45 –16:15	**Nutrition Society Cuthbertson Medal Lecture**
16:15 – 16:30	BANS Update, 2004 Dr. Barry Jones
16:30 – 17:15	**BAPEN Annual General Meeting**
19:30 – 20:00	Drinks Reception for BAPEN Individual Affiliates

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20:00 – 01:00	**BAPEN Annual Dinner** Sponsored by the Main Industry Group of BAPEN: Abbott Laboratories, B Braun Medical, Baxter Healthcare, Fresenius-Kabi, Nestle Clinical Nutrition, Novartis Consumer Health, Nutricia Clinical Care

Thursday 18th November 2004

08:30	Registration
09:15 – 10:30	BAPEN Nutritional Assessment Workshop
Symposium 3 Chairman	**"From Beginners to Zimmers"** Bruce McElroy
09:30 – 09:50	"Nutritional Support in the Newborn" Dr. John Puntis
09:50 – 10:10	"Current Practices in feeding Neonates" Jamil Khair
10:10 – 10:50	"Undernutrition in Older People: Reflecting on practice" Leeds BMI Group
10:50 – 11:00	Questions & Answers
11:00 – 11:30	Coffee
11:30 – 12:30	**Oral Communications**
12:30 – 14:00	Lunch and Exhibition Electronic Poster Sessions PEN Group AGM and Award
14:00 – 14:45	**The Pennington Lecture** "Integrated Nutrition" Dr. Simon Allison
Symposium 4 Chairman	**"Challenges of Enteral Feeding from the Acute to the Community Setting"** Dr I W Fellows
14:45 – 15:05	"Food trials and supplement in the community" Dr. Rebecca J Stratton
15:05 - 15:20	"Practice and Problems with Gastrostomies" Gill McHattie
15:20 – 15:40	"The Parent's Perspective" Teresa Culverwell
15:40 - 16:00	"Patient follow-up and monitoring in the community" Kavita Biggin
16:00 – 16:15	Discussion
16:15	**Close of Conference**

To register your interest contact the Conference Organisers

Sovereign Conference, Secure Hold Business Centre, Studley Road, Redditch, Worcestershire, B98 7LG

Tel No. +44 (0) 1527 518777
Fax No. +44 (0) 1527 518718.
E-Mail. association@sovereignconference.co.uk

Psychological aspects of food and challenges for nutrition support

Introduction

From our first days as newborn babies, feeding (initially drinking, then eating) carries profoundly important value to us as humans - emotional value as well as nutritional. Feeding may involve periods of prolonged intimate contact between mother and baby, associated with sensuous touching and stroking, immense bodily pleasure, comprising sounds, tastes, smells, sensations and a shifting in and out of sleep. On other occasions there may be less idyllic feelings in both baby and mother - frustration, hunger, pain, irritability, impatience, non-satisfaction.

Parental attitudes

However, from those earliest moments onwards, feeding has immense emotional significance. In childhood, family battles are waged over feeding - too much, too little, the wrong type of food ('sweet tooth', too fat, too thin), and over the end result of feeding (potty and toilet training). Children are praised over their appetites, rewarded, scolded, punished, loved and resented, and if we think back to our earliest years, or look at our own children or others around us, it is evident how much emotional weight surrounds feeding, and elimination. Indeed Freud's earliest developmental stages, in his famous psychoanalytic theory of child development, are called the 'oral' and the 'anal' stages, referring to the immense importance of these areas of the body, and their emotional ramifications (Freud, 1905).

Parental attitudes towards feeding are hugely influential to the developing child. The parental attitude - generous or punitive, liberal or rigid, will affect not only the child's feeding habits, but also his/her developing body image, attitude towards food, and later on, attitudes towards other aspects of the body such as sexuality. An example of the importance of family attitudes towards food comes from studies of mothers who have suffered from eating disorders themselves (Stein, Wooley, Murray et al, 2001). These studies show that mothers with eating disorders, compared with mothers without an eating disorder, tend to use more strong verbal control, and are overall more verbally controlling of their children, especially during play. The authors of the study went on to conclude that such mothers "may need help to prevent the extension of the control they exert over themselves, to the interactions with their infants." So, food, control, freedom to play, and emotional development can all be seen to be linked. Food, and feeding, are invested with substantial emotional significance for each individual.

Social dimensions of eating and drinking

Alongside the personal signifcance of feeding lies the social dimension. Eating and drinking are often very social acts - arrangements to meet friends or partners are often made around places of eating (restaurants, coffee houses) or drinking (pubs). The first 'date' in a potential new relationship is often in a pub or restaurant. After-work socializing with colleagues, meeting up with old friends, business meetings, celebrating good news such as job promotions or passing an exam, and even mourners congregating after a funeral may all take place in venues of food and/or drink, and eating and drinking are regarded as part and parcel of such occasions.

Losses

So, when 'normal' eating or drinking becomes impossible, for whatever cause, there are numerous losses:

- The loss of the pleasure of the food and drink in its own right
- The loss of the social aspects of eating together with others
- The loss of the nutritional value in the food and drink
- The loss of a sense of adult independence
- The loss of the ability to share in these pleasures with others

On top of these losses there may be other difficulties

When the loss of oral feeding is also associated with the need for parenteral nutrition, there will be the additional risks; and when there is also a stoma, then not only is intake through the mouth 'abnormal', there is also an abnormality of 'output'. There is also the possibility of additional social, psychosexual and physical worries relating to the stoma and its appearance and functioning.

Mourning the loss of an organ

An additional loss is less often thought about. This is to do with the mourning for a part of one's body that is gone. We can easily consider the mourning for a leg or arm that has been amputated, and people often describe 'phantom' pains in the area of the limb that is no longer there. A leg or an arm is useful, and its absence is not only a hindrance, but also visually obvious. We can also quite easily think of a woman mourning her womb after a hysterectomy, primarily because of the emotions attached to a womb - it may feel as though the surgeon has removed the very essence of her femininity. And we often see in clinical practice women who become depressed after a hysterectomy, and complaining of abdominal pains which can only partly be explained by the surgery itself.

So is it possible that the loss of a part of one's bowel needs to be mourned? Just because it is invisible, does that mean one has no relationship to it? At St Mark's, many of my physician colleagues would agree that there seem to be patients who mourn the loss of parts of their bowels, and that this mourning, unless recognised and dealt with, can delay recovery,

requirement for pain relief and other medication.

External and internal support

How well one copes with any surgical procedure, or any illness depends on a large number of factors. Some are related to the procedure or course of illness itself:- Was the operation a success? Was recovery speedy? Was pain relief good? was the hospital setting supportive and competent, and so on. But there are psychological factors at play too, unique to each individual, to do with external and internal support. 'External support' refers to the extent to which there are people around who help with the practical and emotional issues that one is faced with, and here we are referring not just to the absolute number of people but the quality of that support. Is it offered in a generous, loving manner, or is it filled with conflict, resentment or conditions?

'Internal support' refers to how much one can draw on past experiences of being looked after, such that even in the absence of a loving friend or relative at the bedside, there is some sense of internal strength, even when things are going badly. The lack of some 'internal support' might mean panicking terribly at being left alone, being filled with terrifying thoughts and nightmares, and there might even be the predisposition to misinterpreting the intentions of nurses and doctors in a negative light. In other words, the absence of 'internal support' might also mean the patient, unwittingly, drives some of the external support away or makes it more difficult to be looked after by staff, family and friends alike.

Addressing the issues

In recognition of some of these complex psychological factors at play, in patients with nutritional problems, St Mark's Hospital has established a Psychological Medicine Unit (PMU). Here the PMU staff members (Psychotherapists, psychiatrist and social worker/ counsellor) work together with the medical and nutrition team to assess and support patients and offer psychotherapy where appropriate (Stern 2003). The 'external support' offered is crucial in some cases, in helping many patients with short bowel syndrome or other complex nutritional difficulties cope with the multiple losses mentioned above. It provides them with a forum outside the usual family support systems, to discuss and work through some of their dilemmas and anxieties. Over and above this, the PMU offers a weekly discussion forum for the Nutrition Team specialist nurses, providing them with a deeper understanding of the sorts of issues with which their patients are grappling.

This service is available only for patients currently being treated by the St Mark's Hospital for their bowel disorder. This is not only to ensure a manageable case-load, but is also in recognition of the fact that we are promoting an integrated approach, as opposed to one in which the medical and the psychological needs are dealt with by people who do not even know each other!

With this in mind, we would encourage and support other specialist units to develop similar models for their patients and staff, and would encourage the readers of this newsletter to discuss such models with their own specialist units!

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Dr Julian Stern
Consultant Psychiatrist in Psychotherapy
St Mark's Hospital

BAPEN Constitution - Members' views sought

What's in it for me?

BAPEN is a dynamic organisation - there are scientific discoveries, clinical innovations and new ways of working in every area of nutritional practice and it seems as though these are happening on almost a daily basis. We have to be in a position to respond to them. We have to make sure that our structure is flexible - yet credible, and that all our various initiatives are robust and well-supported. Additionally, we have to focus our attention on the future as well as celebrating our achievements of the past.

The framework within which this happens is governed by our Constitution. As you will know from previous editions of *InTouch*, BAPEN Council has spent considerable time reviewing and updating this to make sure that it reflects our purpose as closely as possible. The existing Constitution was written when BAPEN was first formed - over 10 years ago. Some parts of it have become obsolete, some need updating and some new sections need to be added. The initial part of this exercise has now been completed and the draft is available on the website for your comments.

Commenting on something which has been written by someone else is always daunting and, if it is a document written in 'legal-ese' it can be positively off-putting. Please don't be daunted! Your

continued on page 10

BAPEN Constitution - Members views sought (continued)

opinion is really important and, 'dry' as it might appear, this document is fundamental to the way in which we manage our affairs during the next few years. We are planning to present a final draft to the membership at the Annual General Meeting which will be held as part of the BAPEN 2004 meeting at Telford in November and we hope that you will be there to approve it. With this in mind, the deadline for your views will be October 23 2004.

If you want to make any comments about any aspect of the Constitution and do not want to use the website facility, please feel free to get in touch with any of the Officers of BAPEN. We look forward to hearing from you.

Pat Howard
Honorary Secretary

What's in the Journals - A Nurses Perspective

During 2003-2004 there has been the resurgence of the debate around appropriateness of artificial feeding in dementia. I have to admit to being a little phased by the quagmire of ethical and litigation implications involved in making the decision to use a percutaneous endoscopic gastrostomy (PEG) to feed patients who are unable to give informed consent.

A retrospective study looking at outcomes of PEG insertion in demented patients by Sanders et al (2004) was published recently in Clinical Medicine. The study aimed to analyse the efficacy of PEG placement in dementia patients. However, the study clearly demonstrates poor outcomes in the demented patient in which PEG's have been placed. The study included 361 patients with various diagnoses who had received a PEG over a five-year period in two local hospitals. Of the 361 patients involved in the study, 103 had been diagnosed with dementia from various causes.

It is evident that these patients suffered from poorer outcomes than many of those reported in the literature, with a local mortality of 54% at 1 month, 78% at 3 months, 81% at six months and 90% at a year. The researchers have tried to explore why this should be so and, as a nurse, I found it interesting that one of the variables identified was a lack of co-ordination of the PEG insertion process from referral to discharge. Comparison of their data to data collected in a study by Mitchell et al (1997) revealed similar trends in mortality. Mitchell found no difference in mortality in nursing home groups of demented patients, half of which had PEG's inserted and half of which did not. Sanders concluded that PEG insertion in demented patients was of limited value. He suggests that a framework for assessment and proactive selection is required which, in his words, 'may have modest effects on mortality and the number of PEG's inserted.'

Abuksis et al (2004) also undertook a smaller study with 61 patients. These were not specifically dementia patients. They concluded that in their experience in-patients undergoing PEG insertion did significantly worse than patients who waited for 30 days and had their PEG's fitted as outpatients. They demonstrated a 40% lower 30-day mortality rate from referral for these patients. The suggestion of a waiting period or cooling off period is similar to the recommendations made by Sanders. I suspect the cooling off periods worked by removing patients who were shortly to succumb to their illness, inadvertently increasing the appropriateness of the PEG insertions in the groups that were left. The evidence above does appear to add weight to the arguments against PEG insertion in demented patients. For me, these papers have reinforced the need for appropriate PEG assessment on referral to endoscopy and underlined the essential role played by the multi-disciplinary team when deciding if PEG feeding is truly in the patients' best interests.

References

Abuksis G, Mor M, Plaut S, Fraser G, Niv Y (2004) Outcome of percutaneous endoscopic gastrostomy (PEG): comparison of two policies in a 4-year experience. Clinical Nutrition. Vol. 23, No. 3, p. 341 – 346

Mitchell SL, Kiely DK, Lipsitz LA (1997) The risk factors and impact on survival of feeding tube placement in nursing home residents with severe cognitive impairment. Arch Intern Med, Vol. 157, p 327-32

Sanders DS, Anderson AJ, Bardhan KD (2004) Percutaneous endoscopic gastrostomy: an effective strategy for gastrostomy feeding in patients with dementia. Clinical Medicine. Vol.4, p 235-241.

Kate Pickering - Nutrition Nurse Specialist Leicester General Hospital Site, University Hospitals of Leicester

Diary Dates

National Dates

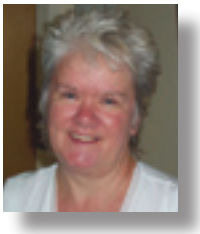
Date	Meeting	Venue and Contact Details
5th Oct 2004	Childhood Obesity 2004: A one day conference and an intensive practical workshop on childhood obesity for health professionals	University of Glasgow. For further information including programme and registration details, visit: http://www.nutritionsociety.org/!Docs/28052004/ChildObesity.pdf Contact: Carolyn Fraser, Conference Manager Division of Developmental Medicine, Human Nutrition, 1st Floor Tower Block QMH
12th Oct 2004	Nutrition and Obesity	Royal College of Physicians, 11 St Andrews Place London NW1. For further information contact: Tel: 020 7935 1174 email: conferences@rcplondon.ac.uk Yorkhill Hospital Glasgow, G3 8SJ. Tel: 0141-201-9264; Fax: 0141-201-0674 email: cf24f@clinmed.gla.ac.uk Website: www.gla.ac.uk/developmental/cpd/CPD.html
19th Oct 2004	London Intestinal Failure Day	London Contact: Dr Simon Gabe Tel: 020 8235 4177 Fax: 020 8235 4001 email: s.gabe@ic.ac.uk
25th Oct 2004	'MUST' Do Better Raising Standards in Nutritional Care	Walton Conference Centre, Southern General Hospital, Glasgow For further details and registration forms see BAPEN website: www.bapen.org.uk
1-4th Nov 2004	Fermented food, prebiotics	University of Surrey, Guildford GU2 7XX and probiotics For further details contact: Course Administrator Tel: 01483 686413 email: mromano@surry.ac.uk
3rd Nov 2004 6.30-8.30pm	PEG's: How, Why & When? Artificial Nutrition Support for Patients in the Community. A seminar for all Health Care Professionals	Dudley Medical Education Centre, Russels Hall Hospital Open to West Midlands BAPEN Members. Places may be limited, so please contact West Midlands Regional Reps for more information alison.fairhurst@dgoh.nhs.uk sue.merrick@rwh-tr.nhs.uk
17-18th Nov 2004	Feeding Problems: Helping Children who can't or won't eat	Conatct: Carolyn Fraser, Short Course Development and Conference Manager, Queen Mother's Hospital, Glasgow G3 8SJ. Tel: 0141 201 9264
23rd Nov 2004	Nursing in Practice event	Birmingham NEC. For further details and to register visit: www.nipevents.com
9-10th Dec 2004	5th Nutrition and Health Conference London	For further information please visit: www.nutritionandhealth.co.uk
14th April 2005	Northern Ireland Regional Meeting	Ramada Hotel, Belfast
2005	**Making Teams Work**	
25-27th Jan 2005	BAPEN Education & Training Course for Clinical Nutrition Teams	Wychwood Park, Crewe. For further details contact: www.ruthnewton@yahoo.com
27-30th Aug 2005	ESPEN Congress	Brussels. For further details see www.espen.org

Update from the Chair of the Programmes Committee

Having taken over as Chair of Programmes after last year's meeting, I feel I'm still settling in to the role and getting to know the other Committee members. One thing I do know is that when I stand down and become an 'ordinary delegate' again I'll be far more understanding about the difficulties of the job. Believe me it isn't as easy as many of you might suppose! The two days of the actual meeting represent many months of hard work by all of the Committee members.

Included in this year's programme is a symposium which will update you on both ongoing BAPEN projects as well as national initiatives in a format that you will hopefully find entertaining as well as informative! We also have sessions looking at nutrition issues in the very young and very old, enteral feeding in the acute and community sector, and a symposium debating suitable end points in clinical nutrition trials. The Education Committee are again running their workshop on assessment and we will have a full programme of original communications. Many of you will be pleased to know that we are changing the location of the poster boards this year following comments in your evaluations from 2003. Another very important point that came out of the evaluations was that many of you didn't like the sandwich fillings in the packed lunch! We're liaising with the caterers to try to change them for this year. You see, we do listen to what you tell us!

Following the great success of last year's dinner, Trevor T will again be providing the entertainment. However, watch out for a surprise guest! Myself and the rest of the Programme Committee look forward to seeing you all in Telford in November and hope that you'll enjoy the meeting.



Lynne Colagiovanni
Chair Programmes Committee

News from Ireland

CREST Guidelines for Enteral Feeding in Adults in Northern Ireland

In 2000 a sub-group was set up with the task of producing guidelines for health professionals about tube feeding, specifically in the home or community environment. After four years of hard work and debate, the guidelines, along with a risk assessment of patients susceptibility to infection and model of care for managing tube feeding were officially launched on the 1st April 2004.

The guidelines are divided into seven sections starting with the rationale for nutrition support and finishing with community follow up and review. The CREST guidelines provide specific guidance on the various clinical, ethical and practical issues raised by enteral feeding. Within all sections the aim was to provide guidance to heath professionals on how they should deal with issues that they may face when they have a patient who is tube fed including:

- Type of water to use
- Type and size of syringe
- Problems and possible solutions
- Medications
- Discharge documentation
- Frequency of review

Sections 5 and 6 are particularly important as they outline the management of the patient, the enteral feeding tube, the administration system and the discharge of the patient.

The model of care proposes a model to deliver a quality, patient-centered service. In developing the model the aim has been to clearly demarcate roles and responsibilities, design an integrated care pathway and focus on specific processes at each stage of management. Little comprehensive evidence exists around the area of service delivery for Home Enteral Tube Feeding. However, a model from the state of Victoria, Australia proved useful for the Northern Ireland context.

This is a starting point for health care professionals to now audit current practice against what would be deemed best practice. There are elements of the guidelines which may be more difficult to implement but again audit will identify these issues and feed into the next substantive update.

For those who wish to obtain copies of the above they can do so by visiting the CREST website at: www.crestni.org.uk.

Sharon Madigan
BAPEN Regional Representative NI

Regional Representatives

Scotland
Dr Alastair McKinlay Consultant Gastroenterologist
Tel: 01224 553628 Fax: 01224 550711
Email: a.w.mckinlay@arh.grampian.scot.nhs.uk

Ireland
Ms Sharon Madigan Community Dietitian
Tel: 02890 366 877 Fax: 02890 311 353
Email: s.madigan@ulster.ac.uk

Wales
Dr Campbell Edmondson Consultant Anaesthetist
Tel: 01978 725955 Fax: 01978 725932
Email: w.edmondson@new-tr.wales.nhs.uk

North West
Dr Jon Shaffer Consultant Gastroenterologist
Tel: 0161 787 4521 Fax: 0161 787 4690
Email: jon.shaffer@srht.nhs.uk

Northern & Yorkshire
Dr Nina Polanska Consultant Chemical Pathologist
Tel: 0191 454 8888 bleep 351 Fax: 0191 202 4145
Email: antonina.polanska@eem.sthct.northy.nhs.uk

Trent
Dr Jeremy Nightingale Consultant Gastroenterologist
Tel: 0116 2586324 Fax: 0116 2586985
Email: jnight@globalnet.co.uk

West Midlands
Alison Fairhurst (joint rep) Nutrition Support Dietitian
Tel: 01384 244017 Fax: 01384 244017
Email: alison.fairhurst@dgoh.nhs.uk

Sue Merrick (joint rep) Dietitian & Team Leader for Nutrition Support
Tel: 01902 643183 Fax: 01902 644945
Email: sue.merrick@rwh-tr.wmids.nhs.uk

Eastern - West
Jean Dart (Chief Dietition)
Marion O'Connor (Senior Dietitian)
Tel: 01865 221701/2 Fax: 01865 741408
Email: janeane.dart@orh.nhs.uk
Email: jpdod@doctors.org.uk (Marion O'Connor)

Eastern - Anglia
Dr Ian Fellows Consultant Gastroenterologist
Tel: 01603 288356 Fax: 01603 288368
Email: ian.fellows@nnuh.nhs.uk

North Thames
Dr Simon Gabe Senior Lecturer
Tel: 0208 235 4177 Fax: 0208 235 4001
Email: s.gabe@imperial.ac.uk

South Thames
Mr Rick Wilson Director Dietetics & Nutrition
Tel: 0207 346 3243 Fax: as telephone
Email: rick.wilson@kingsch.nhs.uk

South West (West)
Dr John Lowes Consultant Gastroenterologist
Tel: 01803 654865 Fax: 01803 654896
Email: john.lowes@nhs.net

South West (East)
Mr Peter Rhodes Principal Pharmacist
Tel: 0238 079 6090 Fax: 0238 079 4992
Email: peter.rhodes@suht.swest.nhs.uk

South East
Dr Paul Kitchen Consultant Gastroenterologist
Tel: 01634 830 000 Fax: 01634 833 922
Email: paul.kitchen@medway.nhs.uk

Industry Liaison
Carole Glencorse Nutritional Services Manager
Tel: 01628 644163 Fax: 01628 644510
Email: carole.glencorse@abbott.com