inTouch

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BAPEN
Advancing Clinical Nutrition

British Association for Parenteral & Enteral Nutrition
Is a multi-professional asscociation and registered charity estalished in 1992. Its membership is drawn from doctors, dietitians, 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

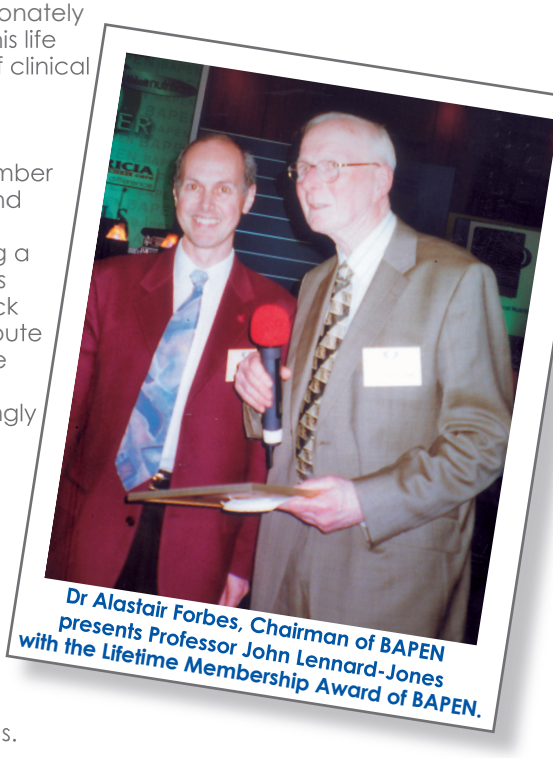
Communicate the benefits of clinical and cost-effective optimal nutritional care to all healthcare professionals, policy makers and the public

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

Contents

BAPEN Lifetime Membership Award

Professor John Lennard-Jones, known affectionately to many as simply LJ, has devoted much of his life and energy to the promotion of the cause of clinical nutrition and its potential for restored and maintained health and well-being.



Dr Alastair Forbes, Chairman of BAPEN presents Professor John Lennard-Jones with the Lifetime Membership Award of BAPEN.

Professor Lennard-Jones was a founding member and Trustee of BAPEN following the King's Fund Report and has remained active and highly influential within the charity ever since. Taking a lower profile role within BAPEN in recent years has not meant that LJ has been taking a back seat – far from it. He has continued to contribute to external and expert working parties, made himself available for consultation to many BAPEN committees and groups, and unstintingly supported students, clinicians and front-line healthcare professionals.

LJ is held in high regard by all who know and work with him.

In recognition of this substantial and highly effective contribution, BAPEN awarded LJ the first BAPEN Lifetime Membership Award. Presented with a scroll at the BAPEN Annual Meeting in Telford last November, LJ will be Guest of Honour at all future Annual Meetings.

Dr Alastair Forbes, Chairman of BAPEN said on presentation of this Award: "LJ's contribution to the field of clinical nutrition is immeasurable. No-one deserves this Honour and recognition more. "

Rhonda Smith
Media Coordinator

BAPEN Medical launched

BAPEN Medical was launched at the 2004 BAPEN Annual Meeting in November. A committee was elected and the remit of the new group discussed. This will include:

- Providing a home within BAPEN for those who are medically qualified, and those who have an interest in the scientific and clinical aspects of nutritional and metabolic medicine.
- Providing a forum for sharing research and development. Supporting doctors both in training and established in the field of nutritional support and metabolic medicine.
- Participating in relevant training issues.
- Seeking to be outward looking by holding meetings with other surgical, medical and scientific learned societies and with the BAPEN founder groups.

Committee members:
Dr Jeremy Powell Tuck - Chairman; Dr Simon Gabe - Treasurer; Dr Tim Bowling - Secretary; Dr Emma Greig and Dr Michael Colley.

If you would like to join please do so by completing the application form on the BAPEN website and return it to the BAPEN Office.

Dr Jeremy Powell-Tuck
Chairman BAPEN Medical

Editorial

What a splendid time we had in Telford at the Annual Meeting: the programme committee, Sovereign conference and, of course, the many speakers, who did an excellent job. On top of the academic sessions that seemed to me of uniformly high standard, we had the formal launch of BAPEN Medical and the first of our new-style annual general meetings. At the latter, the new constitution (over which you have collectively been pondering for the past few months) was formally adopted; even if your Chairman was a little too keen to avoid the niceties of providing the opportunity for anyone to vote against it or even to vote at all!

Considering that one of my motives for setting out on a new constitution in the first place was to improve the democratic accountability of the Association this was a nice irony! We also had the now accustomed knees-up after the conference dinner, and it is truly amazing how talented some of our members are!

Clearly this is a good opportunity to remind people (now that you have your 2005 diaries) that the next Annual Meeting will again be in Telford (last time before a move to another UK centre) on the 16th and 17th November. The final date for abstract submissions will be the 24th June 2005.

Now that we have the Constitution sorted out for a year or two we should give our fuller attention to the strategy document for BAPEN. The draft format is on the BAPEN website. We have already had some very useful and constructive comments from the Trustees, who have now been invited to take up their new roles as Members of the BAPEN Advisory Faculty. We will leave the strategy on the website for additional thoughts for a few more weeks but not indefinitely – please let us know what you think.

Finally, we have a very important team change amongst the Officers. After more years of service to BAPEN than is polite to mention Pat Howard has stood down as Honorary Secretary. I am delighted that she will be staying on Council as the ESPEN representative, but it is going to be very hard to restrain ourselves from calling on her encyclopaedic knowledge of all things BAPEN! Pat is succeeded by Dr Penny Neild from St George's in London and we look forward to getting her in harness. It will definitely not be an easy act for Penny to follow, but I have great confidence in her through the enthusiasm and commitment to the BAPEN ideals that she has already shown.

Dr Alastair Forbes
Chairman BAPEN

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Highlights from the annual meeting of

The British Association For Parenteral and Enteral Nutrition

November 2004.

The 14th Annual BAPEN meeting, held at the Telford International Centre hosted two days of presentations with four main symposia including: news items; clinical trial end-points; challenges of nutritional support at both ends of the life spectrum and enteral feeding in the acute and community setting. In addition, some 49 original contributions were given as oral presentations or posters. This short report aims to present just some of the topics covered during this lively and enjoyable meeting.

Government Issues: policy changes, approvals and guidelines

Payment by results or just another road block?

NHS Tariffs

The new government incentive to reward efficiency and stamp out variations in different parts of the country by a fixed tariff system is due to come into full use on April 1st 2005. **Peter Shanahan**, Deputy Chief Executive and Chief Financial Officer from the University Hospital Birmingham, outlined some of the aims and issues of this new policy, part of the overall public health reforms that aim for greater choice and diversity, devolution, flexibility and standards within the NHS. The concept is not only to stamp out variations but also to provide a financial incentive to improve management efficiency so that hospital stay is reduced, thus allowing savings to be put back into the system. The complexity of this financial modelling is likely to affect all areas of the NHS and just what is and what is not included from the 550 hospital and 39 outpatient tariffs is intricate. Generally expensive services and treatments such as chemotherapy and renal transplantation are excluded and some of these exclusions, for example, support services such as MRI, could act as a disincentive to their use. In addition, the volatility of tariffs which may be subject to year by year shifts, could seriously affect long-term development planning. The real impact of this new tariff system will not be felt until it has come into full operation, but many felt it was yet another form filling exercise that would impede the advancement of clinical practice.

Cost Savings from Inappropriate Parenteral Nutrition

The Tariff system aims to stimulate improved efficiency and to reward it - just such a scheme has already been put into action by a Nutritional Support Team (NST) in Cardiff. The effect of improving management techniques to make important cost savings was outlined in a poster presentation by members of NST from the University Hospital of Wales (OC19). **Amelia Jukes** and colleagues outlined the impact of the NST on the reduction of inappropriate parenteral nutrition (PN) usage and its associated complications over a five year period at the hospital. Within the first year PN use had been reduced by almost 50%, resulting in significant cost savings which have been sustained over the five year period and are now used to provide important funding for the NST. As PN usage has decreased in this hospital the NST faces different challenges and one result has been to redefine the role of the Clinical Nurse Specialists into parenteral and enteral lead nurses each with their own particular expertise.

A relationship of trust is key

Stamp of approval for PN prescribing by pharmacists

The Department of Health has, at long last, put the stamp of approval on the extension of pharmacists' prescribing to include unlicensed medications, thus allowing pharmacists who have qualified as supplementary prescribers within a nutritional care team to prescribe PN. As **Rebecca White** commented, "this is a logical and sensible move since it acknowledges the expertise of pharmacists within a nutritional team and gives them greater responsibility for the management of patients as well as highlighting the importance of using the abilities of the whole nutritional team". To date, 122 pharmacists have qualified as supplementary prescribers, the majority of whom are part of nutritional teams. Whilst this is a step forward that allows appropriate PN prescribing without the need for medical countersignatures, the real key to success of this extension of prescribing rights lies in the relationship of trust that is established between the independent prescriber, supplementary prescriber and the patient.

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'MUST' moves from strength to strength

The 'Malnutrition Universal Screening Tool' ('MUST') was launched in November 2003 with seals of approval from the Royal College of Nursing, British Dietetic Association, BAPEN and the Registered Nursing Home Association. Since then it has been supported by many other organisations and has gone from strength to strength in the year since its launch.

'The challenge for BAPEN is to integrate, co-ordinate and lead'

An Update

Professor Marinos Elia presented an overview of the uptake of 'MUST', which indicates a steady acknowledgement of the importance of malnutrition and the need for screening. 'MUST' has now been included in a number of educational courses and symposia, discussed by government ministers and used in scientific surveys that address critical public health problems such as the north south divide. Preliminary data on the annual cost of malnutrition suggest an annual cost of £7 to 8 billion. Such increasing momentum can only be good and with such growing interest there is a critical need for the clinical, political and public health activities to be co-ordinated in a strategic manner.

Increased education and awareness is vital

Barriers to 'MUST' usage

The long term aims are to make 'MUST' the standard nutritional screening tool across the whole of the UK. However, increased education and awareness is still important and this point was addressed by **L Carter** and colleagues in a poster looking at the barriers to the use of a nutritional screening tool (NST) at St Thomas's Hospital in London (OC21). Their study showed that lack of knowledge of the significance of unrecognised malnutrition and the use of simple screening methods for the identification of at risk individuals was the most frequently reported barrier to use. Such a lack of knowledge was cited by 42% of nurses who completed the questionnaire designed to investigate the uptake of the NST. They concluded that a continuous education programme is therefore an essential adjunct to the introduction of effective nutritional screening.

Carole Anne McAtear

Estimation of Weight and Height from 'MUST'

The need for good understanding of the full potential of 'MUST' was also highlighted in a poster from **Carole Anne McAtear** from the South Glasgow University Hospital (OC18). Height and weight are important measurements for BMI calculation and for screening of under nutrition, yet it is not always possible for these measurements to be made within one day of admission, currently part of the 'Food, Fluids and Nutritional Care in Hospital' Standards in Scotland. An audit carried out at this hospital by the Department of Nutrition and Dietetics suggests that only 46% of patients are weighed and only 6% have height recorded. As a consequence **Carole Anne McAtear** suggests that surrogate methods for estimating these essential parameters, such as those described in 'MUST', should be made known to health care professionals so that BMI may be calculated where possible and nutritional screening properly completed.

'MUST' is one of the best for the general identification of at-risk patients but vitamin status may need other approaches

Comparison with Other Screening Tools & Vitamin Deficiency

In an oral presentation, a comparison of 'MUST' with other screening tools in unselected admissions was made to assess which tools may be best at identifying patients at risk of developing complications and having a greater length of stay. **Charlene Foley** and colleagues from Northwick Park Hospital, London, showed that the prevalence of malnutrition ranged from 12-42% with 38-54% of patients already malnourished or at risk of malnutrition. They found that the Subjective Global Assessment (SGA) and 'MUST' were the best tools for identification of individuals at risk of complications. Identifying those patients at risk of malnutrition is important for the future management of such patients and a poster presented by **Marinos Elia** and **Rebecca Stratton** (OC28) outlined the use of 'MUST' in this context and discussed how other predictive devices may be helpful to further delineate categories of at risk patients. In an analysis aimed at investigating the vitamin status of elderly patients, they found that those identified as medium to high risk of protein energy malnutrition using 'MUST', were likely to have poorer circulating concentrations of some vitamins. These patients could be at risk of infection as a result of their poor vitamin status and the use of vitamin and mineral supplementation in this context has been the subject of a meta analysis by **A Stephen and Alison Avenell** from Aberdeen (OC25). They found that although there appeared to be no difference in the incidence of infection in patients supplemented and those not, subgroup analysis did suggest benefit if vitamin and mineral supplements are provided for over 6 months to those patients who are under nourished.

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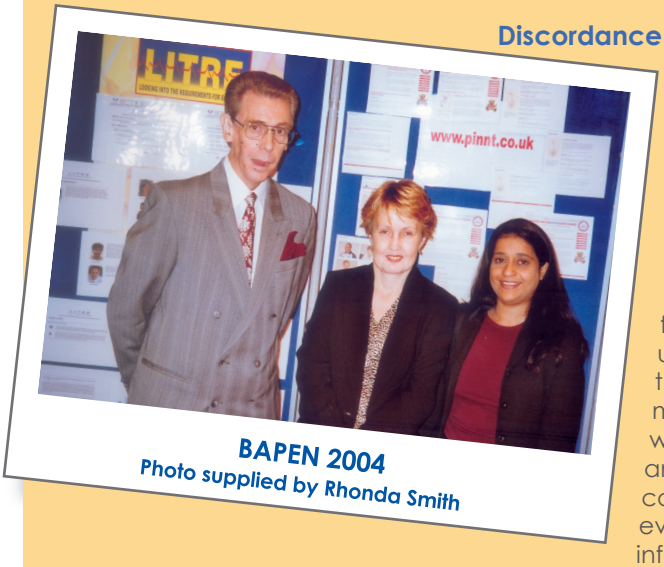
Nutrition Trials, Evidence of Benefit and End-Points

The Nutrition Society Symposium at this year's conference focussed on ways of evaluating nutritional intervention on disease outcome. Chaired by **Dr George Grimble**, this lively and often amusing session included presentations by three international speakers who discussed the use of various study end-points and current data for evidence of benefit of nutrition intervention.

Nutritional intervention as adjunctive therapy has no evidence of benefit!!



BAPEN 2004
Photo supplied by Rhonda Smith

Discordance of Clinical and Surrogate End-Points

Professor Ronald Koretz opened this session by showing how current clinical trials in nutrition can indicate little obvious benefit. Whilst most nutritionists intuitively know this to be wrong, it does highlight a need to look at things differently and to think about different methods for showing benefit in this multifactorial area of medicine. In an analysis of published studies looking at nutrition intervention as adjunctive therapy, Professor Koretz looked at both clinical and surrogate (intermediate) parameters for evidence of benefit. These trials were generally very small and underpowered and could therefore be misleading, so he theorised that for a surrogate outcome, such as a nutritional marker, to be a reliable measure of benefit, it must act in parallel with the clinical outcome. For example, if body weight improves and infectious complications improve in parallel, then he considered the data to be in 'concordance' and to provide good evidence of benefit. Conversely, if body weight improves but infectious complications do not, the data is 'discordant' and shows no evidence of benefit. Using trends and arithmetic differences, he showed a rate of complete discordance at ≥25% in 43 of the 48 studies included in his analysis and discordance in ≥ 50% in 13 of the 48 studies. Whilst this worrying result could have ramifications, above all it continues to point to the need for new techniques for evaluation and new thinking in those areas where nutrition intervention is used as adjunctive therapy.

Metabolic acidosis now rare

Potential and Contributions of Surrogate and Intermediate End-Points

Paediatrics and in particular, low birth weight infants, are a category of patient in which nutritional support is vital for life. **William Heird** from the Children's Nutrition Research Centre, Baylor College of Medicine, Texas considered the contributions made by both homeostatic and growth studies to the overall care of these patients since the mid 1960s. In general such studies have not only led to considerable improvements in PN but have helped to define the nutritional requirements of low birth weight infants and to expand understanding of the metabolism of essential fatty acids. Several of the more serious metabolic complications of PN such as metabolic acidosis are no longer seen as better parenteral amino acid mixtures are now available and the quality and quantity of micronutrients needed for optimal growth of infants and children requiring PN are better defined.

Experience is often overlooked and regarded as irrelevant

Whilst biochemical homeostasis and body growth have been essential end-points for helping to improve PN in infants and children, the need for evidence-based data to prove the case for nutritional intervention in other categories of patient have demanded the use of other end-points. "As a result", said **Peter Soeters** from the Department of Surgery, University of Maastricht, "experience is often overlooked and regarded as irrelevant". This pressing need for evidence-based medicine has also led to tendency-stretching techniques, publication of poor studies, increasing use of post-hoc analysis and the rejection of negative results. Yet, he believes end-points are valuable and the use of functional end points (intermediate or surrogate) could be more useful for nutritional studies than primary end-points. Functional end-points such as muscle strength, immune function changes and cognitive changes look directly at the intervention hypothesis and thus should provide greater insight and scientific knowledge and be less influenced by other factors. For such functional end-points to be more widely used in nutrition, however, they need clearer definitions and agreed parameters and they must be validated.

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Children – a special category of requirement

This year's conference included several presentations on children, who as a group probably represent the greatest users of PN in the hospital setting. In a symposium entitled 'From Beginners to Zimmers' two presentations (**John Puntis** and **Jamil Khair**) looked at the current status of nutritional support and feeding practices in pre-term and low birth weight infants, where, as Bill Heird had already pointed out in an earlier session, biochemical homeostasis and body growth studies have 'provided the impetus for virtually all recent advances in the nutritional management of these vulnerable infants.'

BAPEN 2004
Photo supplied by Rhonda Smith

Pre-term Infants

Nutrition in pre-term infants is a vast subject encompassing a diverse group of children with very different nutritional requirements. Whilst there is a very strong case for avoiding periods of starvation in these patients because under nutrition at this age can have permanent effects on brain development and later growth, the advantages of an aggressive approach to early PN has not yet been clearly demonstrated. Both speakers agreed that the provision of safe and effective nutrition support in pre-term infants continues to evolve and to provide an enormous challenge to the multi-disciplinary team.

PN clearly saves lives in these vulnerable patients but, multicentre trials are needed to delineate optimal feeding strategies

In the preterm infant factors such as nutritional reserve, risk of necrotizing enterocolitis (NEC) and coexisting organ failure all impact on the ability to use enteral feeding alone. As a result many infants who are <1.5kg at birth are likely to receive PN for at least the first two weeks of life. Yet this kind of nutritional support has a number of related risks such as direct tissue injury, intravascular thrombosis, and catheter-related sepsis and there are wide variations in policies across the country.

Breast milk plus supplements may get pre-term babies home sooner

For higher birth weight infants enteral feeding (via nasogastric tube) can often be tolerated. Whilst breast milk may be nutritionally inadequate alone, the addition of supplements has been investigated, particularly in the Netherlands. There is now a growing tendency to try to use supplemented breast milk in this group of pre-term babies where it appears to both protect against NEC and confer neuro-developmental advantage. "As a result", said John Puntis, "milk-banking may come back, but we will still need to be vigilant and to be aware of the need for good evidence on which to base any guidelines".

Aggressive glycaemic control could improve outcome in NEC

Hyperglycaemia and NEC mortality

Whilst the incidence of NEC may decrease as a result of using breast milk in pre-term infants, it is still an important cause of mortality in neonates. **Nigel Hall** and colleagues from the Institute of Child Health and Great Ormond Street Hospital, London, presented a poster describing the possible association between hyperglycaemia and NEC. They demonstrated that maximum glucose concentrations of greater than 11.9 mmol/l were significantly associated with an increase in late mortality (>10 days after ICU admission) and increased length of stay in the ICU (>10 days). This concurs with those results already found in critically ill adults and suggests that aggressive glycaemic control may improve outcome in children with NEC.

A child with enteral feeding requirements can generate particular management challenges

Enteral Feeding and the Parent's Perspective

The parents of children with enteral feeding requirements can often be confused by the multiplicity of professionals dealing with the different needs of their child. In these situations there is a need for a multi-agency approach, said **Teresa Culverwell** (PINNT) who discussed the needs of the parent in such situations. With a multi-agency approach, the parents are considered as an essential part of the team and are consulted, listened to and heard. In addition the input from different specialists within such a team should be respected and valued. Only by working together and providing consistent support and advice can such a child be happy and well cared for and its parent less stressed and more involved. Such a recipe should make challenges easier to overcome and improvement more likely.

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BAPEN 2004
Photo supplied by Rhonda Smith

Problems and Challenges in the Community Setting

Trying to stamp out mixed messages

Enteral Feeding – Need for Greater Communication, Co-ordination and Education

The use of gastrostomy tubes has greatly increased in popularity and as a result many more patients living in the community have such tubes. "In these situations", said **Gill McHattie**, "many different teams may be involved in the care of this heterogenous group of individuals and many patients can receive mixed messages from the different carers". Experience from South Glasgow has shown that if key members of each team caring for these patients meet on a regular basis many problems can be overcome and reduced. As a result of this improved communication, patients now receive the right standardised support which is individually tailored to their needs and associated with fewer complications. The need for co-ordinated support services was also discussed by **Kavita Biggin** from Oxford. She suggested that a community nutrition support team might be ideally placed to manage patients with home enteral tube feeding in the community who are steadily increasing in number and who often experience more problems in the community than in care homes for example. In addition, an audit of enteral feeding in the community, performed by the **Royal Wolverhampton Hospitals Trust** (OC45), pointed to the need for improved training of community nurses, patients and carers and the need for regular review of all patients on enteral feeding in the community. They found that 11% in the survey had gained or lost significant weight, 33% were making single use syringes last for 2 days or more and significant numbers of patients were not following proper recommendations for best practice.

Food or Supplements?

Whilst the identification of malnutrition in the community, particularly in elderly patients is increasing as a result of valid screening tools such as 'MUST', there is still little agreement on what is the best feeding strategy for malnutrition in these patients. **Rebecca Stratton**, David Cuthbertson Medal winner, outlined the most common strategies which include:

- **Food fortification**
- **Dietary counselling**
- **Oral multinutrient supplements**

She suggested that more discussion was necessary so that the most appropriate and effective strategies for oral feeding could be recommended as appropriate.

Home Parenteral Nutrition - Catheter Occlusion and Quality of Life

Occlusion is a common problem in home parenteral nutrition (HPN) according to the LITRE (Looking Into The Requirements for Equipment) committee who reported on a survey designed to investigate if this was more common following lipid infusion in HPN patients. The results said **Justin Bayes** (OC35) indicated that there was a significant association between infusion of lipids and catheter occlusion.

Effect of Lipid and Line Occlusion

	No Occlusion	Occlusion
Lipid	30	27
Separate lipid	9	11
No lipid	19	7* (*p<0.1)

BAPEN 2004
Photo: courtesy of Rhonda Smith

"HPN can have a significant impact on quality of life and this should be an important consideration in the management of these patients", said **Janet Baxter**, reporting on a survey of publications to assess this (OC23). Of the 31 publications identified, just under half used non-specific generic instruments to assess health status, whilst the remainder used non-validated questionnaires, a combination of the two or no formal tool. As a result many issues were identified but none could be ranked and the need for a standardised, validated, treatment-specific instrument was highlighted.

Annual Meeting Report written by Clare Gurton - Freelance Medical Writer
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Initial Announcement

BAPEN

Advancing Clinical Nutrition

Annual Meeting

of

The British Association for Parenteral and Enteral Nutrition

to be held at

The International Centre Telford

16th - 17th November 2005

Conference Organisers

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This meeting is approved for credits under the Continuing Medical Education (CME) Scheme by all Medical Royal Colleges

Registered Charity 1023927

Closing date for abstracts - June 24th 2005

Journal watch - A doctor's perspective

I have chosen two articles to review. The first article is the first critical appraisal of gastrointestinal therapeutic endoscopy procedures, conducted by NCEPOD (National Confidential Enquiry into Patient Outcome and Death). The second looks at justification of PEG (Percutaneous endoscopic gastrostomy) in patients with dementia.

National Guidelines on Endoscopy Procedures – by NCEPOD published on 14th October 2004

NCEPOD operate under the umbrella of NICE (National Institute for Clinical Excellence), whose main aim is to improve the quality and safety of patient care. A total of 252 hospitals and 11 non-NHS hospitals submitted 30 days patient death data on GI therapeutic endoscopies. Interventional gastrointestinal endoscopy included oesophagogastroduodenoscopy (OGD), percutaneous endoscopic gastrostomy (PEG), endoscopic retrograde cholangio – pancreatography (ERCP) and oesophageal dilatation and stent insertion.

Recommendations from this study included

- National guidelines for assuring competency of endoscopists
- Risks and benefits of endoscopic procedures to be clearly explained to the patient. Better documentation for demented patients
- Better monitoring and resuscitation equipment for patients
- Dedicated out of hours rota for emergency cases
- Clear protocols for the administration of sedation
- In-depth multi-disciplinary assessment for all patients referred for PEG

The recommendations for PEG were based on a sample of 719 patient episodes. 59% had acute neurological diease, 40% had nutritional failure as a result of non-malignant disease, 11% had malignant disease, 20% had a chronic or degenerative neurological disease and 18% had dementia. 63% of patients were felt to have a definite risk of death within 30 days of the procedure before it even took place and in 19% of people who died after PEG, NCEPOD advisors considered the procedure futile.

This has implications for all endoscopy units placing PEG tubes and may well need some national guidelines from NICE. Perhaps BAPEN should give consideration to developing guidelines for patient selection.

Full report available for free on NCEPOD website: **www.ncepod.org.uk**, "Scoping our practice".

David S Sanders, Alan J Anderson and KD Bardhan: Percutaneous endoscopic gastrostomy: an effective strategy for gastrostomy feeding in patients with dementia. Clinical Medicine 2004:4:235-41.

PEG feeding has been an accepted technique for long term enteral feeding since 1980.

The demand for PEG insertion has risen to include conditions where the implications for long term patient outcome are uncertain. Dementia is an ever more common reason for PEG insertion when the patient cannot or will not eat.

There is relative paucity of survival studies in such conditions. Studies suggest a 30-day mortality varying from 9.5 to 54% and a one-year mortality of 39 to 90%. Recent prospective studies looked at the 24- month follow-up, the number of survivors between those referred and not referred were same. The study done by the author had significant cognitive and functional impairment with a Barthel score less than 5. A score of 0-5 indicates total dependence.

Indicators of poor prognosis following PEG insertion (using multivariate analysis) are age, serum albumin, dementia, aspiration, swallowing abnormality and co-morbidity.

Feeding patients with dementia by PEG often poses difficult and emotional questions. Many gastroenterologists have simply adopted the role of technician, leaving the referring consultant to determine when a PEG is indicated. Some health care professionals believe feeding is a basic human requirement and that should not be denied, irrespective of cognitive function. On occasion PEG's have been inserted to reduce the burden upon carers. The insertion of a PEG may reduce the length of stay in hospital and alleviate the pressure on acute medical beds but may not be a decision taken in the best interest of the patient and may amount to forceful feeding.

The article compared two hospitals, which had similar policies in the past, but Hospital A changed its policy with new recommendations. Both hospitals were prospectively assessed from June 1998 to May 1999. The number of PEG insertions had been rising each year in both centres.

PEG referral strategy followed by hospital A

- Standardise PEG referral form including concomitant disease
- Endoscopy nurse triage and dissemination of published evidence
- Gastroenterology review where necessary
- Holistic and multidisciplinary approach
- Advise against PEG feeding in patients with dementia
- One-week waiting list policy

After changes in practice, the mortality in hospital A from PEG insertion decreased although did not reach statistical significance when compared with hospital B. Mortality at 1 month was 16%, at 6 months 39% and at 1 year 46% in hospital A as against 26% at 1 month, 58% at 6 months and 68% at the end of 1 year in hospital B.

Though PEG feeding in patients with dementia and other neuro-degenerative conditions is a contentious issue, the evidence to support clinical practice is minimal. As suggested by NCEPOD in its critical appraisal, a pragmatic strategy and a proactive role in the selection of patients may have modest effect on mortality. It is important that the common misperception that PEG feeding may improve the survival outcome of the patient should be challenged.

Dr Sunny Kadri, Specialist Registrar in Gastroenterology, Basildon University Hospital, Essex

A Focus on Professor Gil Hardy

Professor Gil Hardy is recognised as one of ***the*** leading nutrition czars and is well known to all of us at BAPEN. In all, **Gil Hardy** has presented approximately 150 scientific papers and educational lectures in the field of Clinical Nutrition. He is recognised as a world authority on the metabolic and clinical benefits of glutamine and is the founder and organiser of the internationally acclaimed Oxford Glutamine Workshops.

Gil began his career as a Biochemist, with degrees from Bristol and Cambridge Universities, but in 1977, together with Professor Jeremy Powell-Tuck at St Marks and Dr John Farwell at St Barts London, he achieved international recognition when he developed the first 3 litre TPN bag to be used clinically in the UK. This was a revolutionary development quickly adopted by the pharmaceutical industry and which, subsequently, changed the course of treatment for patients worldwide.

Through his company, Oxford Nutrition, Gil went on to pioneer work on the stability of amino acids and micro-nutrients in oxygen-impermeable plastics for improving long term stability of All-In-One TPN mixtures. In fact, Gil was the first in Europe to produce stable L-Glutamine intravenous solutions and more recently lyophilised L-Glutamine-enriched amino acid mixtures.

In 1982, he carried out post-doctoral research with Nobel Prize Winner, the late Professor Sir Hans Krebs ('Krebs Cycle') at the Metabolic Research Laboratory, University of Oxford. "I felt extremely honoured to have worked with Professor Krebs, who first stimulated my interest in Glutamine", says Gil, "It was certainly one of the life changing moments of my career."

Gil received his first professorship in 1998, when he was appointed Professor of Pharmaceutical Nutrition in the School of Biological and Molecular Sciences at Oxford Brookes University. It was here that he expanded his research interests and helped develop post-graduate courses and research projects in Clinical and Pharmaceutical Nutrition.

Gil retired from Oxford Nutrition in 2003, but not content to stay at home, he went on to establish the independent Pharmaceutical Nutrition Research Group. Since then, he has been appointed Visiting Professor to the School of Pharmacy, University of Auckland, New Zealand, where he will be co-supervising research and development projects and post-graduate students.

Professor Hardy is chairman and a founder member of the British Pharmaceutical Nutrition Group (BPNG). He edits the BPNG newsletter 'Feeding Times' and represents the Group on the BAPEN Scientific & Research Committee. Gil was also one of the original tutors for the BAPEN 'Grasmere' Course for Nutrition Support Teams, which he helped to establish. In 2002, ***BPNG*** created the annual `Allwood-Hardy' lecture jointly in his honour.

An active member of the international societies: ESPEN, SASPEN, AuSPEN and ASPEN, Gil has lectured on Glutamine, Antioxidants and Stability Issues at many of their annual Congresses. He serves on the Editorial Advisory Board of "On-line", the UK Home patients Newsletter, is a Section Editor for the journal 'Current Opinion in Clinical Nutrition and Metabolic Care' and edits the "Nutraceuticals" column for the international journal "Nutrition".

Sally Robinson
GCI Healthcare

Clips from Council

Clips from Council
BAPEN Council met in London in September 2004 and in Telford in November. As usual, there were full agendas and items discussed included the following:

BAPEN Strategy – Council have considered initial drafts of this document and we are now circulating it for wider comment from the general membership. Please visit the BAPEN website and let either myself or the BAPEN Office know what you think. This is your organisation and it must fulfil your needs – but you have to tell us what these are!

BAPEN Constitution – the final draft was approved by Council and has, subsequently, been agreed at the BAPEN AGM. It will now be available on the website.

Standing Committees – Council has, unanimously, agreed that there needs to be paediatric representation within BAPEN and that this needs to be more obvious. We are delighted to welcome Dr Mark Dalzell (Alderhey Children's Hospital, Liverpool) as the Chairman of the Paediatric Advisory Group and we are looking forward to developing a more explicit paediatric theme.

Malnutrition Action Group (MAG) – following the successful launch of the 'MUST', this Group has moved from being 'advisory' to being 'active'. Dr Alistair McKinley (Aberdeen Royal Infirmary) has agreed to succeed Professor Elia as Chairman of the MAG and he is now reviewing the priorities of the Group along with representation on the Committee. We wish him every success in this challenging post.

BAPEN 2004 – Many of you will have attended this meeting and I hope that you found it both enjoyable and useful. Planning is already under way for next year's meeting and , if you have any ideas or feedback ,please get in touch with the Programme Committee Chairman through the BAPEN Office.

British Pharmaceutical Nutrition Group – Council is very pleased to welcome Professor Gil Hardy as the Chairman of the BPNG. He advised us that the BPNG has produced a new leaflet for patients starting TPN. This can be viewed on their website **www.bpng.co.uk**. You may also want to look at their Strategy Document.

National Nurses Nutrition Group – This Group have been busy working on the official guidance about testing the placement of NG tubes. They were congratulated on this.

Parenteral and Enteral Nutrition Group of the BDA –you will be delighted to know that the 3rd Edition of the Clinical Handbook is now available. Further information and ordering details are posted on the PEN Group website **www.peng.org.uk**.

BAPEN Medical has 35 members and has now held its first meeting - at BAPEN 2004. This is an exciting initiative and, if you want to find out more, please visit the BAPEN website **www.bapen.org.uk**, or contact the Chairman, Professor Jeremy Powell-Tuck at **J.Powell-Tuck@mds.qmul.ac.uk**.

BANS report – this will be published shortly so keep your eyes open for it. It will be a range of information which could help you to move forward the services in your Trust. There is still an urgent need to recruit reporters in some areas. If you think that you can help, please contact the BAPEN Office urgently!

Pat Howard - Honorary Secretary

2005 Diary Dates

National Dates	Meeting - National	Venue and Contact Details
7th - 8th Feb	National Conference on Obesity and Health	Manchester Conference Centre For further information please contact: Index Communications Meeting Services, Crown House, 28 Winchester Road, Romsey, Hampshire, SO51 8AA. Telephone: 0194 511331/2 or ncoh@indexcommunications.com.
16th - 18th Feb	Royal College of Physicians of Edinburgh 9th Advanced Gastroenterology and Hepatology Course	Programme registration: www.rcpe.ac.uk
1st -2nd Mar	Trent BAPEN meeting	Gateway Hotel, Nottingham Contact:Melanie.baker@uhl-tr.nhs.uk
7th - 11th Mar	The Intercollegiate Course on Human Nutrition	Chilworth Manor, Southampton For further information please contact: Janice Taylor, Institute of Human Nutrition, Southampton General Hospital, SO16 6YD. Telephone: 02380 796317 or Jmt1@soton.ac.uk
5th April	Nutrition Through Life Study Day	Royal College of Physicians, 11 St Andrews Place London NW1 For further information contact: Mike Fryer, Tel: 01992 538001 e-mail: ntlday@cm-2.co.uk
12th April	Nutrition Society Meeting – Reaction to allergy	West Park Conference Centre, Dundee For further details please visit: www.nutritionsociety.org
14th April	Northern Ireland Regional Meeting - BAPEN	Ramada Hotel, Belfast. Contact Sharon Madigan. email: s.madigan@ulcer.ac.uk.
14th - 16th June	The British Dietetic Association 2005 Annual Conference	Thistle Hotel, Cardiff For further details please visit: www.bda.uk.com
15th - 17th June	Micronutrients through the lifecycle	Queen's University, Belfast Original communications submission deadline : 4 April 2005 For further information please visit: www.nutritionsociety.org
18th - 22nd June	Annual Practical Nutritional Symposium	Chilworth Manor, Southampton Details: Tel: 023 8079 6317
28th Jun - 1st July	Annual Summer Meeting hosted by the Institute of Food Research, Norwich	The University of East Anglia, Norwich. Nutrition Society Medal Lecture. Annual Postgraduate Symposium. Original communications submission deadline: 4 April 2005 For further information please visit: www.nutritionsociety.org
27th - 30th Aug	ESPEN Congress	Brussels. For further details see www.espen.com
4th - 7th Sept	Joint Symposium as part of Research on Alcoholism. Annual Conference Nutrition and Alcoholism	University of Kent, Canterbury. For further information: www.nutritionsociety.org
5th - 6th Sept	The Intercollegiate Course on Human Nutrition	Strathdon Hotel, Nottingham For further information please contact: Wendy Solis, School of Biomedical Sciences, Queens Medical Centre, NG7 2UH. Telephone: 0115 9249924
7th - 9th Sept	Seventh International Symposium in Vivo Body Composition Studies. Linking Structure to function	Southampton UK. Deadline for abstract submission: 1st June 2005 See www.bc2005.soton.ac.uk or e-mail bc2005@soton.ac.uk for more information.

	Meeting - International	
24th - 26th Feb	14th Annual Postgraduate Meeting. Irish Section of Nutrition Society	The Marine Hotel, Sutton, County Dublin For further information please visit: www.nutritionsociety.org.
4th - 7th May	6th International Gastric Cancer Congress – Japan	Further details: iacc6@sc.itc.keio.ac.jp.
14th - 19th May	Digestive Diseases Week: 106th Annual Meeting of AGA	The American Gastroenterology Association Chicago, Illinois Further details: AGA Website.
19th - 23rd Sept	Nutrition Safari 2005. 18th International Nutrition Congress	South African Society for Parenteral and Enteral Nutrition, ICC, Durban, South Africa www.saspen.com
15th - 20th Oct	13th United European Gastroenterology Week (UEGW)	Copenhagen, Denmark Further details: UEGW Website.

Attention! Attention! Attention!

Regional representatives in the regions listed below are up for election. This is an opportunity for anyone who is interested to put their names forward to become regional representatives. Please send your details to me (**s.gabe@imperial.ac.uk**). I will put all the names together and if there is more than one person for any region then there will be a voting slip attached to the next In Touch magazine.

As far as I am aware, all the current representatives for these regions will be putting themselves forward for re-election. The period of office is up to five years and responsibilities include organisation of local educational meetings, increasing the awareness of the role of BAPEN, acting as a media contact point if necessary and acting as a local contact point for questions relating to membership or other BAPEN issues.

Please send me your names if you are interested in this role and I am always available if you want to ask more about what it really involves.

Regions open for election:

1	Scotland	2	Wales
3	Eastern (Anglia)	4	North Thames
5	South Thames	6	South West (West)
7	South West (East)		

Dr Simon Gabe, Chairman
Regional Representatives

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 Dietitian) 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