inTouch

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BAPEN
Advancing Clinical Nutrition

British Association for Parenteral & Enteral Nutrition

Is a multi-professional asscication 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.

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BPNG launches Patient Information Aid

The British Pharmaceutical Nutrition Group (BPNG) have launched a Patient Information Leaflet for Parenteral Nutrition (PN). Early in 2004, BPNG received requests from members for appropriate educational information for adult in-patients receiving Parenteral Nutrition. While PINNT produces several useful information sheets, these are generally aimed at long term home PN. The BPNG decided to develop a more generalised patient information leaflet (PIL) for relatively short-term hospital in-patients, which could be used throughout the UK and Lucy Thompson was tasked with putting it together. PINNT and two hospital trusts kindly donated their existing leaflets and the process of assembling all the salient information in a succinct, easy to read and easy to understand format. Lucy and her team were advised that PN terminology needs to be understood by a 12 year old (supposedly the technical reading level of the general public!) so Lucy's two children were enlisted to check the reliability of the leaflet before PINNT and BPNG approved the final text.

The PIL is a double sided A5 open-up leaflet which explains:

- What is PN?
- What does it contain?
- Who are the members of the Nutrition Support Team?
- Who will visit the patient regularly to review the PN?
- What might patients expect to happen during treatment, together with some possible side effects?

Contact details for further advice and support are also included.

BPNG launched the PIL at the November 2004 BAPEN conference, where it was well received by delegates and it has since been endorsed by BAPEN Council.

A free sample PIL is included with 'In Touch' and additional copies can be purchased via the BAPEN website: www.bapen.org.

Further information on the PIL can be obtained from the BPNG Office, PO Box 5784, Derby DE22 1WU or email: conferenceteam@hotmail.com

Lucy Thompson
Associate Director of Pharmacy Aseptic Services, Kings College Hospital

BAPEN Questionnaire

BAPEN Council is interested to hear your views on the Annual Meeting and would be very grateful if you could spare a few moments to fill in the questionnaire enclosed with this edition of 'In Touch' . The questionnaire is also available on the website and can be submitted electronically. www.bapen.org.uk.

Editorial

The final date for receiving comments from the membership on the strategy, to be adopted by BAPEN over the next 5 years or so, has just passed as I write. The Executive Group and I will be trying to collate your comments into a revision to be considered by Council at our meeting in early May. All being well, this will be circulated to the entire membership in its final form shortly thereafter. This will be accompanied by some more pithy statements to complement our brief mission statement. I hope that this exercise will make it easier for members and non-members alike to see what BAPEN stands for and where our priorities lie.

I imagine that regular television viewers have been intrigued and most probably impressed by the efforts of Jamie Oliver in his battles for the provision of healthier school meals, and I wonder if this might also be an opportunity for BAPEN to reconsider our position on the importance of food, as opposed to artificial nutrition. We are now considered corporate opinion leaders on the latter (witness the prominent involvement of BAPEN members in the recent warnings from the National Patient Safety Agency on insertion of nasogastric tubes), but I am not so sure that we are seen to have a public voice on food issues. This may be changing to judge from the increasing number of phone calls that I receive from the lay media, asking about various aspects of the diet, but we have not developed a clear view on our relationship with the food industry in the way that we have done so successfully with the companies involved with artificial nutrition.

What do members think about us seeking a dialogue with a view to future links and perhaps sponsorship from the mainstream food manufacturers, wholesalers, supermarket chains and (dare one suggest) even the fast food industry? Please write to me or to 'In Touch' with your thoughts.

Dr Alastair Forbes
Chairman BAPEN

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Journal Watch from a Dietitian's Perspective

Enteral immunonutrition (IN) does not seem to be the hot topic it was five or six years ago at nutrition and critical care meetings. This is possibly because the ESPEN consensus statement [2], found that at best there was only fair evidence to support its use in trauma and surgical patients and the Canadian guidelines [1], advised against using arginine supplemented feeds in mechanically ventilated critically ill patients. Indeed, some IN products have recently been withdrawn by their manufacturers. However, a search of medline reveals that there are still many studies being carried out on IN. Two are reviewed here to see if they shed any further light on the use of IN feeds on the intensive care unit (ICU).

Kieft H, Roos AN, Van Drunen JD, Bindles AJ, Bindles JG, Hofman Z, Clinical outcome of immunonutrition in a heterogeneous intensive care population. Intensive Care Med 2005, 31 (4): 524-532.

This large, randomised, prospective double blind study from the Netherlands looked at the effects of IN on a typical mixed population of ICU patients. 597 adult ICU patients were randomised to receive either IN feed, enriched with arginine, glutamine, antioxidants and omega 3 fatty acids, or an isocaloric feed.

Outcome measures were ICU length of stay, hospital length of stay, ventilator time, ICU mortality, in hospital mortality and infectious complication rate. Statistical analysis found that there was no significant difference between the two feeds for these outcomes. The authors conclude that this, the largest randomised, controlled trial to date showed there was no beneficial effect of IN on general ICU population.

Some exponents of immunonutrition may argue that this study cannot be compared to others because it used a different blend of immunonutrients (arginine, glutamine, antioxidants and omega 3 fatty acids) to the blend that may have shown some advantages in certain ICU populations in previous studies (arginine, nucleotides and omega 3 fatty acids).

Farreras N, Artigas V, Cardona D, Rius X, Tiras M, Gionzalez JA, Effect of early postoperative enteral immunonutrition on wound healing in patients undergoing surgery for gastric cancer Clin Nutr. 2005, 24: 55-65.

In this relatively small study, 66 patients were randomised to receive either IN enriched with arginine, nucleotides and omega 3 fatty acids or an isocaloric, isonitrogenous control feed. The feeds were infused via a jejunostomy from the first day after a curative procedure for gastric cancer.

Variables were hydroxyproline deposition on subcutaneous polytetrafluorethylene implants, qualitative indicators of wound healing and infectious complication rates.

Enteral feeding was well tolerated in both groups. The IN group showed significantly higher local hydroxyproline levels and significantly lower levels of surgical wound healing complications. Infectious morbidity was also lower in the IN group. The authors conclude that this blend of IN increased hydroxyproline synthesis and improved surgical wound healing in patients undergoing surgery for gastric cancer.

These two studies probably serve to reinforce the conclusions that many of us have already drawn from the literature to date. That is, there is no justification for using IN feeds as standard in the heterogeneous group of all patients admitted to the ICU. However, there is some evidence to support the use of IN in select groups – in particular surgical and trauma patients.

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Pete Turner, Senior Nutritional Support Dietitian, Royal Liverpool University Hospital.

BPNG launches Research Awards

The **BPNG** is awarding **Research Grants** totalling **£3000** for innovative research projects related to the practice of Pharmaceutical Nutrition. The awards were first introduced in 1999, by past Chair Bruce McElroy, and have now been relaunched by Research Officer, Professor Mike Allwood and current Chairman Professor Gil Hardy, who announced "Our aim is to encourage more of our members to become involved in pharmaceutical nutrition research, thus raising the scientific profile of pharmacists and increasing awareness of the benefits of parenteral nutrition through good quality investigations".

The 2005 BPNG Awards will be allocated in three categories, including: PN catheter 'clogbusting', PN capacity constraints and any stability or clinical aspect of pharmaceutical nutrition.

Applications from BPNG members submitted by **13 May 2005** will be evaluated by the **BPNG Research Committee**, chaired by Professor Allwood. Winners will be announced at the **BPNG Summer Symposium, 18-19 June 2005**.

Further information on the 2005 Research Awards and of BPNG membership can be obtained from the BPNG Office, PO Box 5784, Derby DE22 1WU or Email: **conferenceteam@hotmail.com**

Professor Mike Allwood

ESPEN - The European Society for Clinical Nutrition and Metabolism

ESPEN update

In the last edition of 'In Touch', I reported on several initiatives being developed by ESPEN which will be important for the UK. One of these is the European Nutrition Day - which, as you will see, is part of a much larger project. I am delighted that Dr's Hiesmyr and Schindler, the project co-ordinators from Vienna, have agreed to write about this in more detail. Please think about how you can help! As you will see you need not involve your whole hospital: Indeed the more varied the units the more interesting the results are likely to be. Most of the information can be easily obtained and could involve any of the key members of the Nutrition Service. However, there must be an individual who will be responsible for ensuring that everything is correctly completed and returned!

Please get in touch if you want to know anything else or if you want to help!
Pat Howard, ESPEN Liaison Officer for BAPEN

'Nutrition Day in European Hospitals 2005-2007'

An ambitious project is being planned whereby hospitals throughout Europe will be asked to take part in a bench marking exercise, 'Nutrition Day in European Hospitals'. This will continue the work generated by the EC Directive on Hospital Food in November 2003 and the aim is to develop a European profile, reflecting how malnutrition is recognized and nutrition is managed in an organisational unit.

Major goals of the 'Nutrition Day in European Hospitals 2005'

- **Increase interest and awareness about malnutrition in hospitals**
- **Create a European network to improve nutrition in hospitals**
- **Support a multidisciplinary approach to malnutrition in hospitals**
- **Harmonise data collection tools in different languages**
- **Generate objective data on actual practice**
- **Determine most efficient strategies based on unit risk assessment**
- **Follow change management through repeated benchmarking**

The backbone of this 3 year project is an annual multicentre survey on nutritional practice and success in European hospitals. This backbone will allow us to create the necessary tools, create the information network and actively involve major stakeholders. The unit of interest is a distinct organisational unit within a hospital immediately caring for a group of patients (a "ward"). The main hypothesis is that an effective change management at the level of the structures directly caring for the patients, is only possible with adequate knowledge and in order to be successful, needs endorsement by hospitals as organisations and active support by patient organisations.

The data collected consist of four parts:

1. ***Unit organisation and structures:*** Structural information about the unit (one sheet/unit) to be filled by the unit supervising physician, together with the nursing head.
2. ***Caregiver questionnaire: all unit patients:*** Demographic profile, diagnostic category based on ICD 10 and nutritional interventions for all patients (one line/patient) to be filled by a responsible person from the staff.
3. ***Individual patient questionnaire:*** Each patient should document her/his nutritional intake during the study period. In addition, patients may be asked to fill in a questionnaire about changes in nutritional habits and reasons for decreased nutritional intake from the patient's perspective.
4. ***Individual patient outcome questionnaire:*** At hospital discharge or day 30, whatever comes first: date of unit discharge, date of hospital discharge, site of discharge and health status.

All questionnaires will be translated by the national representative for the used languages (English, German, French, Italian, etc) within the country and checked for cross-cultural applicability and reliability according to WHO criteria.

Develop the 'Nutrition Day in Europe' network:

Based on the EC and ESPEN initiative, the network will already be installed for the translation task and will be responsible for data collection at the national level. The responsibility also includes training, local support, feedback management and counselling in change management. The network is based on the National representatives in the ESPEN council, the interested national health authorities and industrial partners in health care.

...continued on page 5

Analyse Data and create Nutrition Unit Risk and Intervention Score

The primary outcome for the unit/ward will be the cumulative nutritional unit risk and intervention score, a two dimensional entity. The secondary parameter that will be used for between units benchmarking, will be the proportion of patients requiring nutritional interventions and a ranking of potentially modifiable factors with their respective importance. The efficacy of individual nutritional and structural interventions on outcome will similarly be quantified based on the total cohort.

The primary patient based outcome will be risk adjusted length of stay (LOS) in relation to the demographic and nutritional risk factors and the nutritional intervention intensity. The secondary patient-based outcome will be site of discharge and death during the actual hospitalisation. Variability in LOS will be analysed with Cox regression and dichotomous outcomes with logistic regression.

All data analysis will be done at the Dept. for Medical Statistics, Medical University, Vienna (Director: Prof. P. Bauer). After publication of the multinational results, all national datasets will be available for national publication based on a research plan, if the number of wards is large enough to ensure anonymity for the individual ward within the country.

All data will, of course, be strictly anonymised and this will be returned for national analysis/publication once the overall European results have been published.

Time Schedule

The project is being planned to last three years. Each country (and the UK counts as one country in this instance!) is being asked to recruit wards and, at the moment, only adult patients are being included;

2005: **25 units per country**
2006: **25-100 units per country**
2007: **100-200 units per country**

There has already been a pilot study in 3 countries which has yielded very useful and interesting information. The paperwork is currently being revised and the full study will be undertaken later this year once all the necessary permissions have been obtained.

We are now looking for volunteers to participate in this important project - (contact your national representative at ESPEN, Pat Howard) **pat.howard@ubht.swest.nhs.uk** or **nutritionday@gmx.net** (if you would like to be involved).

Dr Hiesmyr and Dr Schindler
Project co-ordinators from Vienna

Annual BANS Report - Trends in Artificial Nutrition Support in the UK 2000-2003 - Executive Summary

Introduction

About BANS, the British Artificial Nutrition Survey.

The BANS was set up as a committee of BAPEN in 1996 to collect and analyse data pertaining to enteral and parenteral nutrition support in adults and children in hospital and the community. The BANS Committee reflects the multidisciplinary nature of BAPEN as shown in the list of committee members on the inside back cover of the full report. An annual report is published each year and copies can be obtained from the BAPEN office. Executive summaries are available on the BAPEN website, **www.bapen.org.uk**

BANS is registered through BAPEN under the Data Protection Act. To avoid duplication of reported patients, reporters are requested to supply only the initials, date of birth, sex and the first part of their postcode. Without this level of detail, it is not possible to be certain of the accuracy of our data. The Chair of BANS would like to express on behalf of the Committee, his gratitude to all those reporters who make this unique venture possible. We hope that all centres in the UK will report to BANS, so that a complete picture of artificial nutritional support can be obtained each year.

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Annual BANS Report - - continued...

We have again focused on certain specific aspects of nutritional care. For the first time, we have produced national data for each constituent country in the UK. For Adult HPN, we have derived prevalence data by Strategic Health Authority. We are very grateful to Pat Howard and Ann Micklewright for providing independent adult and paediatric enteral data from the former South/West and Trent "regions". There is reassuring corroboration of BANS data. This is particularly important because we recognise the reality of a shortfall in data collection for a number of reasons. The BANS committee is striving to maximise the potential of BANS data but will continue to depend on the goodwill of almost 400 reporters across the UK.

Provision of HETF appears to be under resourced and future funding arrangements provide no reassurance of improvement. There are still too many patients receiving nutritional care outside of a proper multidisciplinary team environment.

This years BANS data have again identified how much is still to be done to ensure equity of access and high quality care across the UK for both adults and children on home enteral or parenteral nutrition. BANS would like to encourage data on standards of care in its next report.

Finally, BANS and BAPEN remain disappointed by the reluctance of central government to provide financial support for the only ongoing national nutritional audit.

Executive summary

In this years report, we have concentrated on data accrued since 2000. Data prior to this date have been published in previous reports. Whilst every effort has been made to ensure that data are as complete as possible, BANS acknowledges that there are variable shortfalls in some of the data due to under reporting or lack of postcode identifiers. All data referred to in this report therefore, relate to registered patients and those whose origin can be identified by post code. This data represents minimum levels of activity, not maximum. Reference will be made in the text to the reliability of the data in terms of completeness of data collection and interpretation.

Trends in Adult Home Enteral Tube Feeding (HETF)

- The period prevalence of adult patients on HETF grew by 8% during 2003 and the number of centres reporting point prevlence (319) and period prevalence (325) to BANS remained essentially constant. By contrast, the number of centres reporting new patients has fallen since 2000 from 275 to 251 in 2003.
- There were 6585 new adult HETF registrations in 2003, with 16890 receiving HETF at the end of 2003 (point prevalence) and 21028 recipients during 2003 (period prevalence). New registrations have levelled out whereas point and period prevalence continue to rise (11 and 8% respectively since 2002).
- In 2003, 84% adult HETF patients were resident in England, 7% in Scotland, 3% in N. Ireland and 6% in Wales (point prevalence). Growth in point prevalence from 2000 to 2003 has been similar in all of the constituent countries of the UK (43%, 39%, 38% & 46% respectively).
- Period prevalence per million population varies in the 4 constituent countries of the UK (England: 359, Scotland: 315, N. Ireland: 414 and Wales 386).
- The number of patients per reporting centre rose from 50 in 2000 to 65 in 2003 (period prevalence), although new registrations remained constant at around 25 per reporting centre over this period of time.
- The major diagnostic groups associated with new registrations for HETF were neurological diseases (58%) and gastroenterological disorders, 23%. Cerebrovascular accident accounted for 32% of new diagnoses, neoplasia 30% and dementia, 4%. The period prevalence of demented patients has increased from 341 in 2000 to 547 in 2003 and there were 254 new registrations for dementia in 2003. The increase in HETF of dementia has occurred despite increasing awareness of the ethical dilemmas associated with accruing evidence that HETF does not improve outcome.
- Outcome of adult patients 1 year after starting HETF reveals 36% mortality, 46% continuing on HETF and 16% returned to oral feeding.
- Gastrostomy continues as the most common access route with 85% receiving HETF via a gastrostomy, 12% via nasogastric tube and the remaining 3% via a jejunostomy (point prevalence).
- 45% of adults on HETF were 70 years of age and 30% were bed bound with only 19% having normal activity. 35% live in nursing homes and 75% require either total or some help with their HETF (point prevalence).

Trends in Paediatric Home Enteral Tube Feeding

- There has been a steady rise in paediatric HETF (period prevalence 4437 in 2000 rising to 5394 in 2003, a growth of 22%). This increase is not due to new registrations but to continuing cases.
- Centres reporting new patients rose from 155 in 2000 to 170 in 2002. Of some concern is a fall in the number of centres reporting to 149 in 2003. There was a similar pattern for those reporting point and period prevalence data between 2000 and 2003.
- Diagnostic categories do not define the largest group of children with "other" causes. BANS will address this problem next year. Cerebral palsy remains the single largest identifiable group at 19% of children receiving HETF at the end of 2003.
- Full activity was achieved in only 38% and limited activity in 52% while 91% were cared for in their own home (point prevalence).
- Nasogastric feeding (68%) is more common than gastrostomy (31%) in newly registered children, but gastrostomy becomes the most common route of access (54%) in established patients compared to nasogastric tubes (45%) and jejunostomy (1%). This is in contrast to the practice in adults and may reflect inadequate access for gastrostomy insertion in some areas.
- Mortality 1 year after first registration was 7%.

Trends in Adult Home Parenteral Nutrition (HPN)

- New registrations were constant between 2000 and 2003 (117), whereas period (517) and point prevalence (572) rose by 11 and 9% respectively since 2002. For both Adult HPN and HETF, new registrations have stabilised but point and period prevalence have yet to reach a steady state. However, the rise in adult HPN is slowing down as is the case for HETF.
- These trends in HPN are similar to those reported by the Scottish Managed Clinical Network which is believed to capture data on 100% of HPN patients in Scotland.

The IPANEMA-ASPEN Symposium: Safe and Efficacious Parenteral Nutrition was attended by 400 delegates during Nutrition Week at Orlando in January 2005.

President-elect of ASPEN, Dr Gordon Jensen from the Vanderbilt Center for Human Nutrition, addressed the question of variable standards in Nutrition Care, in his introduction entitled 'A Yank thinks globally'. Despite the fact that (NS) nutritional support is worldwide, with jet travel, electronic media and a multi-national healthcare industry, there are many inconsistencies. Gordon highlighted the differences between metric and 'imperial' units and the different practices for parenteral nutrition (PN) prescriptions (%, g/L, mequiv, mmol). He urged delegates to standardise terminology, disseminate research results more efficiently and to share resources. He also pledged to promote multidisciplinary education and improved methodologies through national and international societies such as ASPEN (American Society for Parenteral and Enteral Nutrition) and IPANEMA (International Parenteral Nutrition Education and Methodology Advancement).

Prof Yvon Carpentier, from the Free University of Brussels and President of ICNSO (International Confederation of Nutrition Support Organisations), addressed the problem of optimising delivery of nutrients and patient selection. The early aims of Nutrition Support (NS) were to restore weight, maintain organ function and achieve positive nitrogen balance. Unfortunately over the years, we have seen excessive delivery of macronutrients with poorly controlled plasma levels (Hyperalimentation), insufficient delivery of micronutrients, and development of incomplete amino acid and lipid products for PN. Little consideration was given to the effect of nutrients on metabolic regulation, nor on changes in NS priorities induced by acute pathological conditions. In addition to the classical indications for PN i.e where use of the gut is impossible, inefficient, or contraindicated, Yvon proposed that PN should complement insufficient oral intake or enteral nutrition (EN). PN also has a role providing metabolic regulators, including glutamine, selenium, or omega-3-fatty acids not readily absorbed by the intestine. Lipid nutraceuticals in particular could be used in prevention of cardiovascular complications prior to surgery, as adjuvant treatment of ischemia, modulation of inflammatory reactions and for high risk premature infants.

Avoiding technical complications of PN with pharmaceutical expertise encompasses the changing role of the PN pharmacist, according to Patrick Ball, Professor of Pharmacy at Charles Sturt University (Australian Society for Parenteral and Enteral Nutrition (AUSPEN) and BPNG). After the early excitement of pharmacy involvement in aseptic compounding of individualised regimens, the rising influence of Quality Controllers and 'bean counters' has lead to standardisation and 'dumbing down' of PN, in Patrick's opinion. Standard PN bags are certainly here to stay. They offer simplicity, documented stability data leading to extended shelf-life and lower costs for some patients. But, like EN, there are many instances where actual nutrient intake from standard products fails to equate with prescribed intake. Vitamins and trace elements must still be added, electrolytes may need adjustment and some drugs are best administered via a PN bag. All such additions should be individualised and aseptic facilities must be retained by pharmacists.

For over 30 years manufacturers and clinicians have introduced new techniques, equipment and devices to deliver PN more safely. However, as Lee Varella RN from Syracuse Upstate University Hospital (FELANPE (Latin-American Federation for Parenteral and Enteral Nutrition)) pointed out, patients can only benefit from these technological innovations if healthcare institutions regularly update guidelines and incorporate the changes into nursing protocols that will minimise catheter infections. Central venous catheters are life-saving devices for critically ill and home PN patients. Catheter occlusions are common, random and unpredictable events that have been associated with infections, and other line complications. PN filtration, now mandatory in the USA, but not in Europe, may protect against particulate and microbial contamination. Arguments about the relative costs of routine filter use from the audience provoked a lively debate with Lee and Patrick, but it was acknowledged that line blockage, retrograde flow, breaches of protocol etc could remain undetected without an in-line filter.

Acknowledging patient therapy preferences was the theme of the lecture by James Scolapio MD from the Mayo Clinic (ASPEN). He quoted publications from 1998 and 2001 that concluded there is no evidence that EN is better than PN. Indeed the meta-analyses showed no significant difference in mortality and more NS-related complications with EN. This supports the experience of the Mayo Clinic Team, who regularly observe malpositioned tubes, interrupted feeds with high gastric residuals, and gastric aspiration. It is Dr Scolapio's belief that PN complications are dependent on the skills and expertise of hospital staff, especially of nurses. Based on these experiences 200 patients were surveyed to indicate their personal NS preferences. The vast majority preferred PN. Gender, education level, physician's recommendations and cost did not influence preference, which was largely related to comfort.

In his concluding remarks, moderator Prof Gil Hardy from Oxford UK (BPNG) emphasised that PN is probably under-utilised and has an increasingly important role to play, especially as a vehicle to target metabolically active nutrients into specific tissues. However, we should ensure best practice guidelines are followed before drawing negative comparisons between EN and PN. It is easier to overfeed and a higher level of skill must be employed for PN, but the same could be said for many life saving therapies. Most PN complications can be prevented by ensuring tight glycaemic control and following strict aseptic nursing and pharmaceutical procedures. If we apply these rules we can consider PN to be risk-neutral compared with EN. We need more research into PN preparation, administration and monitoring procedures. Most importantly, patients need to be more involved in the decision making process to ensure that they receive optimum nutritional support, irrespective of cost.

For further information on IPANEMA visit
http://groups.msn.com/ParenteralNutrition-Ipanema

Professor Gil Hardy
On behalf of IPANEMA

Gaylord Palms, Florida. Venue for the 2005 ASPEN meeting.

Lee Varella

Speakers Group (L to R); Prof. Patrick Ball (AUSPEN & BPNG). Prof. Yvon Carpentier (ESPEN & ICNSO). Prof. Gil Hardy (BPNG). Dr Gordon Jenson (ESPEN).

- Over the last 8 years that BANS has been collecting data, BANS has records of 83 centres registering HPN patients. Since 2000, 22 of these have registered no patients and 31 have registered only a single patient. Only 15 have registered >6 and 4 >20. The 2 national intestinal failure centres account for only 38% of the total new registrants since 2000. These figures have implications for quality of care and planning of Adult HPN services, particularly in England.
- Period prevalence by country varies from 4.5 per million population in Wales to 14.3 per million in Scotland, 12.5 per million in N. Ireland and 9.5 per million in England.
- There is considerable variation in the period prevalence of adult HPN between the new Strategic Health Authorities (0 - 50 patients per million UK population and 1 - 21 per million in England).These variations greatly exceed those of the conditions such as Crohn's disease or small bowel infarction for which HPN is required. Similar data exists for Scottish Health Boards.
- Commercial home delivery companies now provide 93% new patients with their supplies.
- For new registrations, Crohn's disease is the commonest diagnosis (24%) and short bowel syndrome the most common indication (36%). Cancer remains a small minority of new UK HPN patients (12%).
- 87% of new registrants live in their own homes, 77% are independent and 97% retain full or limited activity.

Trends in Paediatric Home Parenteral Nutrition

- The number of children starting (11) and continuing (71) on HPN in 2003 is similar to the previous 3 years. However, due to the small number of reporting centres, caution should be taken when extrapolating these data.
- Of 20 reporting centres registering patients in 2003, only 5 centres had more than 3 patients (point prevalence). Case mix varies between centres making direct comparisons difficult.
- There is a need to encourage more centres to report t BANS in order to produce data that truly reflect current practice.
- Mortality 1 year after starting HPN was 10% in 2003.

Independent Adult and Paediatric HETF data

- Data collected independently in the former South and West (S&W) Region, and Trent Region, reveal large variations in prevalence of HETF in adults and children.
- Point prevalence in the S&W region ranged from 82-632 per million population and in Trent was between 211- 484 per million for different constituent areas within each region. BANS does not have explanations for these variations. Incomplete reporting, case mix, demography, proximity to major centres and availability of community based nutritional support may all contribute.
- Overall point prevalence for S&W was 331 per million and for Trent, 354 per million. These compare favourably with data collected by BANS, with a reported point prevalence for the UK of 367 per million.

Reporters and centres

- Of the 411 reporters registered with BANS 356 were active in 2003. Steps are being taken to identify those reporters who have become inactive and where appropriate to re-engage them. Many are redundant due to closure of centres or have already been replaced by other active reporters. There are currently 325 centres reporting data on adult HETF, 83 on adult HPN, 149 on paediatric HETF and 20 on paediatric HPN.

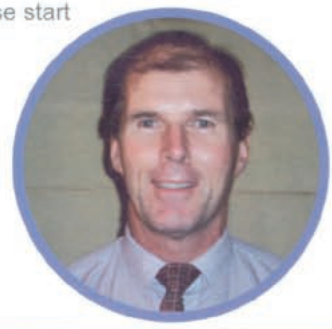
Organisational issues

- A revised annual questionnaire was sent to 380 BANS reporters. Responses were received from 151 adult reporters and 99 children's reporters, some of whom reported for both adults and children. These reporters represent approximately 12000 adults and children compared to an estimated total in the UK of 25000 – 27000.
- There appears to have been a higher proportion of nutrition support teams (NSTs) in this incomplete and perhaps unrepresentative sample than recorded in previous reports. 55% of responding adult centres and 27% of children's services had a team in 2003 as defined by BAPEN.
- A small minority provide for both hospital and community support.
- Clinicians and dietitians were involved in all of the respondents' teams.
- Teams still have problems with funding of nurses and speech and language therapists.
- Training of HETF carers and patients is diffused among many different health care professionals.
- Dietitians are the professionals most involved in managing HETF services and as BANS reporters.
- Only 13% of adult HETF and 29% children's reporters felt staffing levels were adequate
- 52% respondents identified a need for more dietitians. Since the majority of reporters are dietitians, reporter bias may have influenced this figure.
- Monitoring of HETF appears to be haphazard with no agreement on optimal care.
- The impact of future NHS funding arrangements on provision of HETF services is unclear.

BANS Plans for the future

- The committee believe the data are an important national resource and the best available on a national basis. However, we are not complacent and a number of measures are being taken to address concerns expressed by reporters, the BANS Committee and BAPEN that there are shortfalls in the number of registrations from across the UK.
- We are exploring the feasibility of electronic reporting as a means of simplifying the reporting process and ensuring more accurate data returns and report generation. This concept was welcomed by the majority of reporters following a survey undertaken in 2003.
- A shift of emphasis to assist hospital nutrition teams collect data on aspects of in patient enteral and parenteral nutrition is planned for next year. Central venous catheter sepsis rates will be targeted, so please start to collect your data!

Dr Barry JM Jones,
Chair of BANS



Call For Abstracts

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

- **ABSTRACTS** will be considered by **BAPEN** for Oral, E-poster and Static Poster Sessions. Method of presentation will be decided by the BAPEN Programmes Committee
- **ABSTRACTS should be submitted online according to the published guidelines, available on the BAPEN website.** *www.bapen.org.uk*

For full details please refer to Direction to Contributors, Abstract Submission Forms and Copyright Assignment Forms on the BAPEN website from January 2005.

CLOSING DATE FOR RECEIPT OF ABSTRACTS IS FRIDAY 24th JUNE 2005

Registered Charity 1023927

PEN Group comes of age ... Happy 21st Birthday !

The Parenteral and Enteral Nutrition Group of the British Dietetic Association

Nutritional Support - 'A Vision for the Future'

2nd – 3rd August 2005

William Goodenough House , London

2 Day clinical meeting with a celebratory dinner

Topics:

- Estimating and measuring nutritional requirements - current evidence and the future
- ERAS - enhanced recovery after surgery and the role of nutrition
- DEBATE : Dietary counselling and food fortification V oral supplements
- Nutritional outcomes - COPD and cancer
- Relevance of RNI'S in Artificial Nutritional Support
- Nutritional requirements in the critically ill and the obese
- NICE Nutritional Support – are we getting it completely wrong?
- Management of risk in Nutritional Support in the community
- Evidence for very low calorie feeds
- Audit of Nutritional Support - BANS

Book early to avoid disappointment. Application forms and further information available from the PEN group website: www.peng.org.uk

BAPEN in the media

BAPEN was referenced in an article in the Daily Telegraph by Barbara Lantin (16 March 2005). The article highlighted changes that have already taken place since the Government launch of the Better Hospital Food panel and those which are still to come. This included the Department of Health unveiling details of a pilot scheme that offers patients a wide choice of supermarket style ready-made meals that can be ordered in advance.

The Daily Telegraph article caused media interest and the Society Guardian (17 March 2005 - 60% of hospital patients arrive 'malnourished') followed this up with an article focusing on BAPEN and MAG's dedication to improving the management of malnutrition in hospitals. MAG was also referenced in: 'Real' (April 1 2005) – Nutrition toolkit.

Other stories of interest

Checking placement of nasogastric tubes

Over the last month there has been interest in the NG feeding tube checks, following two-year data showing 11 patients died due to NG tubes being placed in the lungs instead of the patients stomachs. (Hospital Doctor, 24 February 2005; Nursing Times 1 March 2005)

The NNNG (National Nurses Nutrition Group) helped the National Patient Safety Agency develop an alert, advising anaesthetists, doctors, nurses and carers who insert nasogastric tubes into patients that cannot feed themselves normally. The advice stressed that some tests commonly used to check NG feeding tubes are correctly placed are inaccurate. The only method that should be used to check NG tube placement is to test aspirated fluid with pH indicator paper, according to the patient safety alert issued by the National Patient Safety Agency.

The FOOD Trial

The results from the FOOD Trial Collaboration were also recently published (Lancet 26th February 2005). The Scottish researchers have found that using nasogastric tube feeding for dysphagic stroke patients is associated with better outcomes than percutaneous endoscopic gastrostomy (PEG) tube feeding.

Rhonda Smith - Media Coordinator, BAPEN

Internet Press coverage of Nutritional Support at The Vatican

Last month the world closely watched activity at the Vatican as Pope John Paul II's life came to a serene end. Many of us with an interest in artificial nutrition support noted that the 84 year old pontiff was being given artificial nutritional support via a nasogastric tube.

The BBC news website www.bbc.co.uk was also interested in the role played by nutrition support, asking, 'why is the Pope being fed by a tube?' and the actual process of how the Pope can be fed by a tube. They contacted The British Dietetic Association to ask for a spokesperson and were given my telephone details as Chair of the Parenteral and Enteral Nutrition Group. I received a call on 31.3.05 requesting a 20-minute telephone interview, which I agreed to, once assured that it wasn't an early April Fool!

Full article available at:
http://news.bbc.co.uk/1/hi/health/4396273.stm

The positive side was that I was able to get BAPEN, PEN group and PINNT websites listed as related internet links.

A word of caution for those of you who, like me, are unfamiliar with dealing with journalists. Whilst I discussed the ethical issues relating to artificial nutritional support and the process of decision making around routes of enteral feeding, I only did so with reference to the Pope's case: the BBC also included a brief discussion on the issue of Terri Schiavo and her NG tube, which the Vatican had commented on, but I had not!

Dietitians who are interested in learning more about working with the media can do so at a one-day training course run by the BDA, see www.bda.uk.com for more details and dates.

Carole Anne McAtear
Chair of PEN Group of The British Dietetic Association

2005 Diary Dates

BAPEN
Advancing Clinical Nutrition

National Dates	Meeting - National	Venue and Contact Details
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
18th - 19th June	Annual Summer Symposium	Hilton Hotel, Leciester. To book contact; Email: conferenceteam@hotmail.com Or view: www.bpng.co.uk
21st June	Palliative Care - great expectations or reality check? One-day conference	(UWIC) University of Wales Institute, Cardiff, Cyncoed Road, Cardiff, CF23 6XD. www.roysocmed.ac.uk
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
29th June	The Intensive Care Society Focus Meeting 2005 - Ethical Issues in Intensive Care	www.ics.ac.uk
29th June - 1st July	Obesity and its Management	Liverpool Medical Institution, Liverpool. For further information visit : www.aso.org.uk.
Sept	Developing Nutritional Support Skills	North England. Email: conferenceteam@hotmail.com Or view: www.bpng.co.uk
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
6th-9th Sept	23rd Leeds Course in Clinical Nutrition	St Jame's University Hospital, Beckett St, Leeds. Contact details: email: clinicalnutrition@leeds.ac.uk, www.clinical-nutrition.co.uk
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	
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.
27th - 30th Aug	ESPEN Congress	Brussels. For further details see www.espen.com
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.
	2006 Meetings	
22nd - 25th Feb	World Congress of the International Society for Diseases of the Oesophagus	Adelaide,Australia. Further details: Fax: +61 8 8274 6000 Email: isde@sapmea.asn.au Website: www.sapmea.asn.au/isde

BAPEN South West present a full day conference entitled "Nutrition Support when things get difficult"

Date: 2nd June Venue: Lyngford House in Taunton Price: £50.00

A varied programme of state of the art presentations, free papers and case reports. For a conference programme and registration form, please contact:

Vivien Mills, Endoscopy Unit, Torbay Hospital, Lawes Bridge, Torquay TQ2 7AA.

Tel: 01803 654865 or e-mail vivien.mills@nhs.net
email: vivien.mills@nhs.net

BAPEN Medical

BAPEN Medical is now a recognised Founder Group within BAPEN
Supporting practitioners in the medical aspects of the clinical practice of nutritional support

Joining fee: £20 (BAPEN members), £40 (not a BAPEN member)

To join: send this slip with a cheque to the BAPEN office with your name, address, e-mail, & occupation

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

Complete your details overleaf, cut along the dotted line and send to the

St Mark's Intestinal Failure Workshop

Friday 3rd June 2005

Small group in depth discusssions on: Oral & enteral nutrition, parenteral nutrition
Drug therapies, venous access & complications

Apply soon as limited to 40 places
Contact St Mark's Academic Institute: 020 8235 4046
or email: stmarks@imperial.ac.uk

Cost £95
incl refreshments

Trent Regional BAPEN Group

80 delegates attended the second annual meeting of the Trent BAPEN regional group, which was ambitiously held over two days on the 1st and 2nd of March, in Nottingham.

The first afternoon session, chaired by Dr Jeremy Nightingale (Regional Representative) was dedicated to nutritional issues around surgery and critical care, including lectures, a lively debate on the use of Albumen and a case-study presentation. The AGM was followed by the conference dinner, providing great opportunities for networking within the region.

Snow on day two did not seem to dampen anyone's enthusiasm. The meeting, chaired by Dr Stephen Morley (Consultant Chemical Pathologist) considered nutritional issues in palliative care and the practicalities of enteral nutrition. Both days were supported by industry.

The committee is already planning next years meeting and interest was expressed in increasing collaboration with nutritional research within the region.

Melanie Baker
Nutrition Team Dietitian
Organiser

BAPEN reps meeting dates

Date	Title	Region	Rep
25 May '05	Enteral feeding study day	N London	S Gabe
3 June '05	St Mark's Intestinal Failure workshop	N London	S Gabe
7 June '05	Eastern Region Nutrition Support team meeting	Eastern (Anglia)	I Fellows
17 June '05	Clinical Nutrition Course	Northern & Yorkshire	E Weinel
5 Oct '05	St Mark's Intestinal Failure study day	N London	S Gabe

To join, please complete your details below and return this slip, along with your cheque made payable to: BAPEN Medical, to the BAPEN Office.

Name:
Address:
Occupation:
Tel:
Email:

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