InTouch 48

BAPEN
Advancing Clinical Nutrition

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BAPEN Conference 2007 Report

The BAPEN 2007 Annual Conference was held in the picturesque Yorkshire village of Harrogate on the 27th and 28th November 2007. With BAPEN being held so late in November there was a very festive feel about the town that was enhanced by the attractive Christmas lights.

The Mayor of Harrogate welcomes delegates

Welcome

The conference was opened by the Mayor of Harrogate who talked about some of the investment in the International Centre and the town in general that make it a very appealing venue for conferences like BAPEN. He expressed his concern about the issue of malnutrition and offered his full support to BAPEN in their mission to recognise and treat it.

Following the Mayor's welcome, Ivan Lewis MP, Parliamentary Under Secretary of State for Care services, had been invited to discuss the Government's Nutrition Action Plan. Unfortunately, Ivan was unable to attend at the last minute and an update was given by BAPEN Chairman Professor Marinos Elia. He did this brilliantly with his own outline of the Nutrition Action Plan, followed by a review of the preliminary results of BAPEN's Nutritional Screening Week.

The Nutrition Action Plan aims to identify malnutrition and set up specific care pathways for malnutrition in different care settings. While the plan focuses on the over-65 population who have the highest incidence of malnutrition, it was stressed that all patients in hospital, and residents in care or special housing who are dependant on care professionals – no matter what their age – must receive appropriate nutritional care. The plan aims to achieve this by raising awareness, giving accessible guidance, encouraging screening, facilitating education and training and ensuring robust inspection.

Professor Elia highlighted that Nutritional Screening is mandatory in Scotland and reminded us that the Council of Europe in 2003 had produced over one hundred recommendations for improving nutritional care. It would of course be difficult to implement just a few of these in Health Care Trusts, so the 10 key characteristics of good nutritional care in hospital have been developed and can be found on the BAPEN website (**www.bapen.org.uk**).Implementing these will be quite a task and the challenge of doing so will involve Gordon Lishman of Age Concern. He will chair an implementation plan committee that will particularly focus on ensuring that the key recommendations in the Nutrition Action Plan are implemented.

It was great to see the first results of BAPEN's Nutrition Screening Week that took place across the UK from the 25th – 27th September 2007. The week was a huge success, with 372 institutions reporting data on a total of 11,665 subjects in hospitals, care homes and mental health institutions. Some interesting findings include:

Percentage of Individuals at Risk of Malnutrition on Admission;

- **30% in Care Homes**
- **28% in Hospitals**
- **20% in Mental Health Institutions**

Effect of Age: Percentage of Individuals at Risk of Malnutrition;

- **35% at > 80yrs**
- **25 – 30% at 60 – 80yrs**
- **25% at < 60yrs**

More details of this fascinating survey can be found on pages 6 and 7 of this newsletter and on the BAPEN website.

The excellent opening session was rounded off with details of BAPEN's new web-based information resource - Organisation of Food and Nutrition Support in Hospitals (OFNoSH). This can be down-loaded free from the BAPEN website and aims to support Trusts as they implement the Ten Key Characteristics of Good Nutritional Care in Hospitals.

Harrogate International Centre

BAPEN Chairman Marinos Elia stands in for Ivan Lewis

Contents

British Association for Parenteral and Enteral Nutrition

A multi-professional association and registered charity established 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.

Pancreatitis

Pharmacist Ruth Newton chaired one of the opening symposia – "Feeding in Pancreatitis". This was an interactive session surrounding an acute pancreatitis (AP) case study with the audience voting on key issues of treatment before an expert gave their view of the correct answers. After most of the audience had indicated that nasogastric (NG) feeding was the best option for feeding a patient with AP and a 'MUST' score of 2, Mr Ross Carter, Consultant Surgeon from Glagow Royal Infirmary attempted to answer the question "What is the best route for providing nutritional support in acute pancreatitis?".

In his excellent presentation Mr Carter stressed that one of the most important aims should be to do no harm. 80% of AP cases are mild and resolve in a week without artificial nutritional support (ANS). However in severe disease there can be a prolonged catabolic state and ANS is vital, although the optimum route remains controversial. In the 1970's and 80's it was felt that gut rest and TPN was vital to avoid exocrine stimulation and autodigestion of the pancreas, although there is little scientific evidence to support this. In the 90's this was questioned and towards the end of the decade nasojejunal feeding (NJ) became the vogue, with the view that if the tube is placed distal enough to the Ligament of Treitz (LOT) exocrine stimulation may be avoided. There is evidence that enteral feeding leads to improved survival by preserving gut barrier function and studies published this century suggest that NG feeding may be as good as NJ. The pain sometimes felt on oral or NG feeding may be due to gastric stasis and distension rather than enzyme release and pancreatic autolysis. Mr Carter's team therefore use a very sensible KISS (keep it simple stupid) approach to nutritional support – use oral feeding as a first line and if that fails use NG as it is less risky than placing an NJ tube beyond the LOT. If NG feeding is not tolerated, consider an NJ tube, and only if that is unsuccessful, start TPN. However as Dr Mike Stroud pointed out later, modern TPN is safe and we shouldn't withhold it for prolonged periods if enteral feeding cannot be established.

In the case study, the patient was given a dual lumen NJ tube and the audience were asked what type of feed they would give: polymeric, peptide or elemental. The majority voted for a polymeric formula before Olivia Boyd, Senior Specialist Dietitian from Manchester Royal Infirmary, looked at what evidence guides prescription of NJ feeds. Oliva gave a superb overview of the literature available and the issues involved. There are theoretical benefits to peptide formula in that they may lead to less exocrine stimulation and may not need enzymes for absorption. However, following a detailed literature search looking for randomised controlled trials only 3 small studies were identified as being of adequate quality and these did not fully support the theoretical benefits of peptide feeds. Her conclusion agreed with that made in the ESPEN 2006 guidelines for enteral feeding in pancreatitis – start with a polymeric feed and if that is not tolerated switch to a peptide feed.

Back to the case study and the audience were asked which routes of feeding stimulate exocrine secretion - NG, NJ or TPN. Most voted for NG, some voted for NG and NJ and one eminent member of BAPEN council appeared to vote for all three!

It was up to Professor Peter Layer, Professor of Medicine form the Israelitic Hospital, University of Hamburg to answer the question. Peter showed that there are three ways of stimulating exocrine secretion – cephalic, gastric and intestinal. Cephalic and gastric account for only 10 – 15% of stimulation and therefore intestinal is the most important. Infusion of nutrients into the duodenum and proximal jejunum elicit a full exocrine response, however feeding beyond the mid jejunum does not lead to enzyme release. If undigested nutrients reach the ileum, the "ileal brake" is operated and gut motility and exocrine secretion will be reduced leading to feed intolerance. TPN does not stimulate exocrine function and therefore the correct answer in the case study would appear to be NG and proximal NJ.

This was an excellent session that was clearly enjoyed by the audience - giving them a sound theoretic basis for a sensible practical approach to treating AP.

Mr Ross Carter – sensible approach to treating pancreatitis

Feeding the Older Person in the Community

The morning's parallel session was also well received with the audience's enthusiasm to answer questions, leading to it over-running by several minutes. Anne Holdoway's presentation highlighted the importance of Micronutrients in the Older Person.

The key take-home messages included:

- Many older people have sub-optimal micronutrient intakes and low status
- Vitamin and mineral status may be further compromised during illness
- Nutritional assessments need to take into account deficits in energy, protein and micronutrients
- **Oral Nutritional Supplements** (multinutrient) have been shown to improve intake and outcome
- Action plans should aim to ensure micronutrient requirements are met

Anne explained that data shows multinutrient oral nutritional support significantly increases dietary intake of all nutrients including micronutrients. Studies evaluating the effect of dietary advice on micronutrient intake are lacking at present. Dietitians should address the opportunity to evaluate effectiveness of common practice to establish whether dietary advice can influence both macronutrient and micronutrient intake and status in this vulnerable group.

Mary Hickson outlined appetite control and body composition changes during ageing. The implications for clinical practice were considered with the following key issues being highlighted:

- Identification of at-risk individuals
- Utilise high nutrient and energy density foods
- Employ little and often meal plans
- Offer foods that appeal to the patient
- Flavour enhancers can be useful

Mary also had some key messages for delegates in terms of what they could do now:

- Maximise your muscle mass and strength now
- Keep exercising to maintain muscle mass and strength
- Encourage all patients to be active – as much as they can
- 20-30 minutes' brisk walking (or similar) 5-7 days/week

The Mental Capacity Act Workshop

Dr Christina Lyons and Dr Ailsa Brotherton held workshops to outline the requirements of the Mental Capacity Act and consider the implications of the Act and its consequences for practitioners. The workshops provided an opportunity to share ideas, knowledge and experiences and to identify the issues that need to be addressed within everyday practice.

Key discussion topics included the value and importance of team decisions, clearly defined roles of multidisciplinary team members, record keeping, the roles of next of kin, advocates, LPAs and IMCAs, the need for comprehensive and accessible patient, relative & carer information and the need to consider the least restrictive alternatives where appropriate.

BAPEN
Advancing Clinical Nutrition

BAPEN 2008

4th - 5th November 2008

Harrogate International Centre

Closing dates for Abstracts will be Friday 27th June 2008.

Pennington Lecture

Professor Alan Jackson, Director of the Institute of Human Nutrition in Southampton, delivered this year's Pennington lecture "Counter-Intuitive Thinking in Nutritional Care". Alan's fascinating lecture demonstrated that the huge changes in metabolism occurring in extremely malnourished individuals make their treatment very difficult, and what would usually seem the most obvious course of treatment can be dangerous.

Alan Jackson delivers a fascinating Pennington Lecture

In severe starvation the body undergoes a process called reductive adaptation where physiological processes shut down in order to preserve energy. The loss of reserve capacity means that any insult will lead to dysfunction. Malnourished patients may often be hypothermic in the presence of infection, as their body does not have the energy to mount an inflammatory response. While it would seem illogical to treat them with antibiotics, as they are not pyrexial, delaying treatment with broad spectrum antibiotics may be fatal.

Professor Jackson then highlighted how reductive adaptation affects iron status and protein requirements. Although malnourished patients are often anaemic and emaciated, giving additional iron, which can be a powerful generator of free radicals or high protein intakes, can be extremely damaging. Reductive adaptation leads to a shut down of the sodium potassium pump that normally maintains the internal environment of cells. Protein cannot be used to synthesise new tissue until the internal environment of the cells has been restored with appropriate electrolyte therapy. An understanding of silent infection and the toxicity of excess iron and protein in starvation has led to the World Health Organisation 10 step approach to treating childhood malnutrition which has reduced mortality by 50%.

Nutrition in Liver Disease

Symposium 4 was chaired by Dr Mike Stroud and looked into the extremely complex subject of nutrition in liver disease. Professor Alan Jackson was the first speaker looking at the liver as a nutritional organ. He outlined the liver's role in regulating glucose metabolism through commutation between the gut, kidney and skeletal muscle. The liver also has vital roles in lipid and protein metabolism. In acute disease excess amounts of certain amino acids e.g. methianine can be toxic, so an appropriate level of protein provision is essential. As liver metabolism is so complex, nutritional management should only be undertaken by experts.

One such expert was the next speaker, Dr Marsha Morgan, Reader in Medicine and Honorary Consultant Physician at the ULC Institute of Hepatology, London, who focused on the nutritional management of chronic liver disease. Cirrhotic patients are frequently malnourished but assessing the degree of malnutrition is extremely complex due to fluid shifts and difficulty in establishing lean body mass. Dr Morgan's studies have shown that the gold standards for assessing fat free mass (FFM) in patients with cirrhosis are dual energy x ray absorbtiometry (DXA) in men and bioelectrical impedance analysis (BIA) in women. As it may not be feasible to use these methods clinically, Dr Morgan's team have devised the Royal Free Global Assessment which uses estimated dry body mass index (BMI), mid upper arm muscle circumference (MUAC) and dietary history to classify patients with cirrhosis as adequately nourished, moderately malnourished or severely malnourished. This method has been validated in men but not women and can be time-consuming, taking up to 75 minutes to complete. For this reason she has shown that grip strength can be employed as an easy to use surrogate measure in men. Urinary creatinine was the least accurate method of assessment of FFM in both sexes.

Continued on page 5

Nutrition in Liver Disease continued from page 4

Once a patient has been assessed, treatment of their malnutrition also is far from simple. Due to their inability to store hepatic glycogen, cirrhotic patients enter a starved state more rapidly. They should therefore be encouraged to have small frequent meals through the day and a bedtime snack. The current ESPEN (2006) guidelines on enteral nutrition in liver disease recommend high energy and nitrogen intakes, meaning a 70kg person would require 2800kcal and 105g protein per day. This may be difficult to achieve and since patients with cirrhosis are prone to big glycaemic swings, close monitoring is required to avoid doing more harm than good. Branch chain amino acid (BCAA) supplements may be useful as they stimulate hepatocyte growth factor and could improve glycaemic control.

The next speaker, Professor Rosemary Richardson, a dietitian from Glasgow, continued the topic of the complexity of nutritional support in liver disease. In her presentation "Thinking Differently about Feeding Patients with Liver Disease", Rosemary argued that breaking the cycle of increased requirements and decreased intake with nutritional support is simpler said than done. The metabolic changes in liver disease can directly affect the appetite centres in the brain and induce premature satiety. Poor understanding of the rationale for dietary recommendations by patients may contribute to poor compliance and improving health literacy could help to provide a solution.

Ethics

The final session of the first day was on the subject of ethics. John McFie, Professor of Surgery in Scarborough, discussed the principles of ethical practice and related them to nutritional support. Artificial hydration and nutrition constitute medical treatment and should be used in accordance with the following four principles: Beneficence – the provision of benefit, non-maleficence - the avoidance of harm, autonomy – the principle of self-determination, and justice – equitable provision. However applying them is far from clear-cut. There is no obligation for health professionals to provide a treatment they feel is futile but it is usually worth seeking a second opinion if there is any doubt about withholding or withdrawing nutritional support. If there is doubt, giving treatment for a time-limited period is often a wise option. For example, NG feeding could be given for a defined period in order to determine if the patient is likely to tolerate it and benefit.

Professor McFie then went on to chair some case studies from a variety of health professionals illustrating various ethical dilemmas in nutritional support. Although this was a very heavy subject for the end of the day, Professor McFie's entertaining style kept the audience captivated, with many contributing to the debate. One particular area of controversy was the principle of autonomy and how the Mental Capacity Act (MCA) may affect it. Unfortunately neither the experts or the audience could give a definitive answer!

BAPEN Annual Dinner

An outstanding first day was rounded off with the BAPEN annual dinner. Although there was no theme this year there was still an excellent turn out. Opera singers posing as waiters provided a pleasant surprise between courses and the following disco kept delegates and council members on the dance floor to the very end.

Mike Stroud and Life Time BAPEN member Carolyn Wheatley

NSW Nutrition Screening Week

BAPEN
Advancing Clinical Nutrition

With the support of

Royal College of Nursing

National Patient Safety Agency

NHS

BAPEN's National Nutrition Screening Week 25-27 September 2007

Why was the survey needed?

- The prevalence of malnutrition in UK is based on data collected in studies undertaken over 10 years ago involving a limited number of institutions. It may not reflect the magnitude of the problem today
- Different criteria were used to define malnutrition in these studies
- The BAPEN Nutrition Screening Week was the first prospective national survey of the prevalence of malnutrition on admission to hospital and care in the UK

What was the purpose of the survey?

- To complement the data collected during the European Nutrition Day audits
- To inform the Department of Health and other government departments, other organisations and the media of the current magnitude of the problem of malnutrition on admission to hospital and care homes

What will be the outcomes of the survey?

- The results of the survey will be presented at BAPEN 2007
- Data from participating centres will be analysed and returned to reporters to enable local data to be compared with national figures
- The results of the survey will also form the basis of launching or promoting other initiatives such as education and training of health professionals, including nurses, who usually undertake nutritional screening

Who supported the survey?

- The survey was a joint venture between BAPEN, the Royal College of Nursing, the British Dietetic Association with endorsement and support from the National Patient Safety Agency, the Department of Health and Ivan Lewis, Care Services Minister, the Welsh Assembly Government, the Scottish Government and the Chief Nursing Officer in Northern Ireland

Who took part?

- Over the three days 372 hospitals, mental health units and care homes across England, Scotland, Wales and Northern Ireland collected data on new patients being admitted to hospitals and acute mental health units, and on residents admitted to long term care over the past 6 months using criteria based on the 'Malnutrition Universal Screening Tool' ('MUST').*

Results

Total number subjects by care sector

	n =		n=	Total
General acute hospitals	9722	**Mental health acute**	40	9762
Care homes	1610	**Mental health long stay/rehab**	293	1903

% subjects by country

	Acute					Care homes					Mental health				
	E	NI	S	W		E	NI	S	W		E	NI	S	W	
%	76	7	7	10		78	10	10	~2		95		5		

E =England, NI = Northern Ireland, S = Scotland, W = Wales

Malnutrition risk – overall risk %

	%		%
General acute hospitals	28	**Mental health acute**	30
Care homes	28	**Mental health long stay/rehab**	18

Measurements taken on admission to acute hospitals or on those admitted in last 6 months to care homes or long stay units.

Malnutrition risk in hospital by type of ward and diagnosis

41% patients on oncology wards, 33% of those on care of the elderly wards, 31% on medical wards, 27% on surgical wards and 15% on orthopaedic wards were at risk of malnutrition.

42% patients with GI disease, 34% of those with disorders of the central nervous system, 33% of those with respiratory conditions, 24% of those with genito/renal disease, 22% of those with cardio vascular disease, and 18% of those with musculo/skeletal conditions were at risk of malnutrition.

Effect of age

Hospital patients

- 47% patients <65yrs of age. In the age range <20 – 59 yrs malnutrition risk ranged from 22-30%
- 53% patients > 65 yrs of age. In the age range 60->90 yrs malnutrition risk ranged from 26-38%

Patients of all ages in hospital are at risk but there is a significant increase in risk with age

Care Home residents

- In the age range <70 - >90 yrs malnutrition risk ranged from 26-36%.

There is a significant increase risk with age

Mental Health Acute Units (small numbers, only - 40 patients)

- < 40 yrs malnutrition risk 26%
- > 40 yrs malnutrition risk 33%

No significant difference

Mental Health long stay/rehab patients

- < 66.5yrs malnutrition risk 13%
- > 66.5 yrs malnutrition risk 23%

Significant increase with age

Further copies of this Briefing Sheet can be downloaded from BAPEN's website **www.bapen.org.uk**

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The Scottish Government
Llywodraeth Cynulliad Cymru Welsh Assembly Government
Chief Nursing Officer in Northern Ireland
DH Department of Health

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Nutrition and Cancer

Nutrition and cancer was a major theme for day 2.

The first symposium, chaired by Jeremy Powell-Tuck concentrated on Nutrition Support in Cancer therapy. Dr Jervose Andreyev, Consultant Gastroenterologist from the Royal Marsden Hospital in London, looked at some of the gastrointestinal (GI) symptoms that occur as a result of cancer and cancer treatments. These require sympathetic treatment as some, such as severe diarrhoea, can have a major impact on quality of life. Dr Andreyev was then joined by Dr Clare Shaw, the Consultant Dietitian he works with, to discuss some case studies that really illustrated the effectiveness of a multi-disciplinary approach in combating weight loss and GI symptoms.

Dr Jon Shaffer, Consultant Gastroenterlologist from the Intestinal failure Unit, Hope Hospital, tackled the controversial subject of Home Parenteral Nutrition (HPN) in Cancer. In his superb session, Dr. Shaffer said that it was time re-evaluate HPN for cancer in the UK. After dispelling the myth that nutritional support can feed the tumour, he suggested that there may be an element of postcode prescribing associated with HPN for malignancies in the UK. Compared to Europe, where about 75% of HPN is given to cancer patients, very little is prescribed in the UK – about 14%. However the UK is probably better at giving effective home enteral nutrition (HEN) to cancer patients. Patient choice may be very important in determining whether HPN or HEN is used but factors such as impact on quality of life and delay in discharge must be taken into account.

A very relevant paper was included in this session – "Randomised Controlled Trial of Early Enteral Nutrition (EEN) versus Conventional Management (CON) in patients undergoing Major Resection for Upper Gastrointestinal Cancer". It was presented by Rachel Barlow, a dietitian from Cardiff and Vale NHS Trust, and went on to win the award for best original communication. The main findings were that EEN via a feeding jejunostomy significantly reduced hospital stay and major complications.

Nutritional Science in Cancer

The BAPEN Medical/Nutrition Society symposium was chaired by Professor Gary Frost. The highlights included:

Professor Martin Wiseman's Overview of The second WCRF/AICR Expert Report - Food, Nutrition, Physical Activity and the Prevention of Cancer: A Global Perspective - detailing the complex methodology used to produce the evidence based guidance.

Dr Donald McMillan's presentation "Inflammation-based Prognostic Score and its role in the Nutrition Management of People with Cancer" which demonstrated the importance of CRP as a diagnostic tool in cancer and outlined the development of a tool based on CRP and albumin. He presented a large amount of evidence to demonstrate the predictive value and also suggested that if CRP could be manipulated this may have important survival outcomes.

Gary Frost from the Nutrition Society

Dr Damien Ashby's talk "Cancer Gut Hormones and Appetite". This brought a new area to the attention of BAPEN – the importance of gut hormones in appetite regulation of appetite.

Enteral Feeding – Safer Practice

Dr Jeremy Woodward, Consultant Gastroenterologist from Addenbroookes Hospital Cambridge, chaired a session that would be welcomed by anyone involved in the practical side of providing enteral nutrition. Dr Patricia Bain from the National Patient Safety Agency (NPSA) outlined the dangers of misplaced NG tubes and explained why two safety alerts were issued in 2005 to try to prevent further problems. These set out to stop unsafe practices such as using litmus paper or air auscultation to confirm NG tube position and made recommendations on how it should be done.

Another NPSA alert (19) was issued in March this year with the aim of preventing wrong route administration of drugs. There have been several adverse events and deaths as a result of drugs being given via the wrong tubes, for example a drug that was supposed be given via a gastrostomy being administered through a central line. Kate Pickering, Lead Nutrition Nurse Specialist at Leicester General Hospital and Becky White, Pharmacy Team Manger for surgery at John Radcliffe Hospital in Oxford outlined the NPSA recommendations that will hopefully prevent further errors occurring. These include setting up protocols, training and ensuring that all enteral feeding plastics such as syringes comply with the recommendations.

The final speaker, Lynne Colagiovanni, Nutrition Nurse Specialist from Queen Elizabeth Hospital in Birmingham, explained how we should be checking NG position. She clarified the reasons why using pH paper is the current method recommended by the NPSA and went on to give an overview of potentially better methods that are still under development.

Don't Go Home Early!

On

Wednesday 28th November

at 3.15pm

THE GLOVES COME OFF!

Bapen Promotions Presents

THE BATTLE OF THE BOWEL BOFFINS

In *Symposium 9*

"Choosing Enteral Feeds — Evidence based on gut reaction"

Six of enteral nutrition's most outspoken heavy weights will face off in 3 no holds barred debates from which no one can come out unscathed!

Round 1

All enteral feeds should contain fibre

Ceri 'Crusher' Green

VS

Tim 'Maximum Impaction' Bowling

Round 2

Peptide based formula must always be used for jejunal feeding

David 'QC' Silk

VS

Pete 'The Terrier' Turner

Round 3

Intensive Care Unit patients should be given high protein enteral feed

Richard 'Glutaminus Maximus' Griffiths

VS

Mike 'The Ice Man' Stroud

Master of Ceremonies and referee

Ian 'The Terminator' Fellows

LET'S GET READY TO RUMBLE!

Battle of the Bowel Boffins

Following an excellent Cuthbertson lecture from Dr Helen Budge, Associate Professor of Neonateology at the University of Nottingham, it was time for the debates symposium "Choosing Enteral Feeds – Evidence Based or Gut Reaction". Refereed by chairman Ian "The Terminator" Fellows, each speaker had just 8 minutes to make their case in the three mini debates.

The first motion was "All Enteral Feeds Should Contain Fibre." Taking to the stage to the strains of "Eye of the Tiger" in support of the motion was Dietitian Ceri "Crusher" Green. A preliminary poll of the audience showed that most agreed with the motion, and taking advantage of her early lead Ceri attempted to deal a crushing blow by claiming there are 51 studies in the literature demonstrating that fibre feeds are safe, well tolerated and help to modulate bowel function.

Attempting to argue against this, in plastic inflatable boxing gloves, was gastroenterologist Tim "Maximum Impaction" Bowling. Tim made a fantastic comeback by alleging the studies quoted by "Crusher" Green were of poor quality and that there was no really good scientific evidence to support the use of fibre. The audience were convinced and Tim took the winning vote.

The next round debated the proposal "Peptide-based feeds must always be used for jejunal feeding" and featured Gastroenterologist Professor David "QC" Silk making the case for and Dietitian Pete "The Terrier" Turner the case against. "QC" Silk eloquently argued that feed infused beyond the LOT does not stimulate exocrine function so polymeric feeds cannot be broken down and absorbed. Unfortunately he was not specific enough about the position of his tube and "The Terrier" took advantage of this, demonstrating that the evidence shows a tube must be in the mid to distal jejunum or at least 40 – 60cm beyond the LOT to avoid pancreatic stimulation. As most of the jejunal tubes we use in current practice are in the proximal jejunum there will be plenty of enzyme released to break down the proteins and fats in polymeric formula.

Furthermore, there may even be evidence that polymeric feeds infused in the distal jejunum can be tolerated, as there may be protease and lipase enzymes on the brush border capable of digesting slowly infused polymeric feeds. Despite being barely visible over the lectern, "The Terrier" won the audience vote and "QC" was defeated.

Two BAPEN heavyweights took to the stage for the last round. Debating the motion "Intensive Care Unit patients should be given high protein enteral feed" were Richard "Glutaminus Maximus" Griffiths (for) and Mike "The Ice Man" Stroud (against). In a surprise preliminary vote the audience sided with "The Ice Man". Undeterred Glutaminus Maximus gave a very entertaining talk highlighting the loss of skeletal muscle in catabolic patients and how this could possibly be combated by giving up to 1.5g of protein/kg/day – as the essential amino acids may have an anabolic effect. However, the "Ice Man", convinced the still-packed audience that the metabolic changes in critical illness mean the essential amino acids cannot be used effectively and excessive amounts can be toxic. The surprise victory for the "Ice Man" and his recommendation for a lower protein intake ended a really entertaining session that kept delegates glued to their seats to the very end.

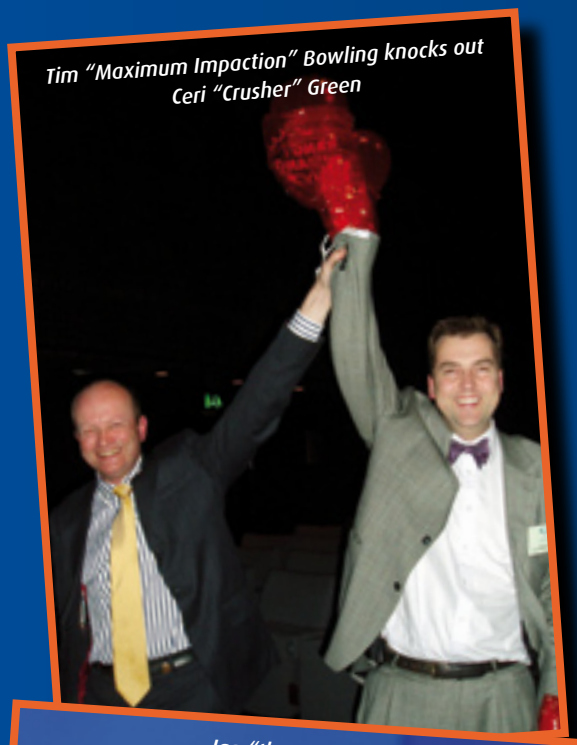
There were 700 hundred delegates at this year's conference and congratulations must go to Dr Mike Stroud and the Programmes Committee for organising such a successful event. Several delegates commented that it was the best BAPEN they'd been to and they were already looking forward to next year.

I would like to thank Dr Ailsa Brotherton and Dr Gary Frost for their help in preparing this report.

Pete Turner
Dietetic and Nutrition Department,
Royal Liverpool University Hospital

Despite being barely visible over the lectern, Pete "The Terrier" Turner takes victory

Bowel Boffins Mug Shots



Tim "Maximum Impaction" Bowling knocks out Ceri "Crusher" Green

Ceri "Crusher" Green gets serious

Ian "the Terminator" Fellows

Richard "Glutaminus Maximus and Mike "The Ice Man" Stoud

David "QC" Silk argues for peptide based feeds

My 90 minutes of anonymous fame as Nutrition and BAPEN hit the headlines – again!

A 5am start for me on the first day of BAPEN 2007 in Harrogate - as I head for BBC Radio Leeds and the challenge of a string of short local radio breakfast show slots across the UK to talk about the headline results from BAPEN's Nutrition Screening Week (NSW 2007). It takes 45 minutes to get there.

In case you haven't yet heard, the overall finding from 370+ hospitals and care homes throughout the UK is that 28% of all admissions into hospital and care are at risk of malnutrition, and that whilst there is a significant increase in risk with age, all age groups are at risk.

Anyway, back to my early morning of fame in the cause of BAPEN.

Shown into a claustrophobic cupboard which has seen better days - fondly known as 'the remote studio', I am brought a cup of just palatable instant coffee (my first refreshment of the day) and a large jug of water.

"You'll need this seeing as you're here for some time," says a cheery young man who is my minder. My first interview is due at 6.20am and the last at 7.55am.

The cheery young man speaks some indecipherable techy language to a disembodied voice emerging from the headphones, flicks a few switches, the recording red light comes on and he leaves me to it. I now have the headphones and the microphone.

A few minutes later, a voice speaks to me. I am now in the hands of the BBC's GNS (General News Service) which has been busy with us 'brokering' requests from BBC local radio stations who want to hear about the NSW 2007 results on malnutrition.

First up is the Good Morning programme on BBC Scotland, then Foyle (Northern Ireland), Coventry & Warwickshire, Cumbria, Cornwall, Gloucester, Wales, Southern Counties, Devon and finally Manchester.

What happens is that you get tuned in to the Radio Station you are going to speak to next, told who you are going to be speaking to by a succession of more cheery young things and then left to listen in to the item before. It's amazing what I learn that morning – everything from ratings for revenge activities for dumped girl and boyfriends to traffic chaos on local roads and petrol price wars. How come petrol is still so much cheaper in Scotland?

However, I give as good as I get and deliver the key messages on the results of NSW 2007, mentioning BAPEN's name as often as possible. I am most impressed – all the interviewers say BAPEN and its full title correctly – the BBC's GNS has been doing its job!

Two of the interviewers have had personal experience of malnutrition in hospital with older relatives and are planning radio visits to their local hospitals to ask if they took part in NSW 2007 and whether they screen all patients on admission. Two other stations invite listeners to call in with their experiences. All ask whether the Week will be repeated and what BAPEN hopes will happen next.

Local BBC radio has loyal, interested and usually older audiences which make such stations perfect channels for BAPEN's messages on malnutrition.

8am. The cheery young man returns, apologises for the dodgy coffee again and phones for a taxi. The traffic is heavy out of Leeds and into Harrogate, and two further requests for radio interviews come in as I travel back. One is from BBC Radio Norfolk – now who can I nab for that one as I arrive back at Harrogate International Centre for the tail-end of the VIP Reception and start of the Conference?

- As well as the BBC local radio coverage, national BBC radio provided a clip for Radio 4 and Radio 5 Live and Independent Radio News provided a news item for subscribing stations. BBC Health News Online covered the story on 27 November as did the Daily Mail, Health Service Journal, Nursing Standard and Nursing Times. NHS Networks and NHS Electronic Library carried information the same day. Further coverage will appear as longer lead titles are published. Regional and releases targeted specifically at hospital, care and community publications have been issued post the Conference, and further releases will be issued as new data segments are analysed
- BAPEN will organise NSW again in 2008. Watch the website for news of the dates
- If you see coverage of BAPEN 2007 and NSW 2007 do send it on to me at **rhonda.smith1@btinternet.com**
- BAPEN 2008 sees a return to Harrogate 4 - 5th November 2008. A date for your diary now!

Rhonda Smith
Media Co ordinator BAPEN

European Nutrition Day 2006-7

nutritionDay
IN EUROPEAN HOSPITALS

The preliminary results from this initiative were reported at the PEN Group AGM in 2006. It has been shown that there is a direct correlation between reported loss of weight pre-admission and increased length of stay in hospital. The point at which this becomes most obvious is between 14 - 20 days post admission. There is also an inverse relationship between reduced food intake on NutritionDay and adverse 30 day outcomes. The data for 2006 has been further examined and has been reviewed in terciles <60 years: 60 - 75 years and > 75 years. The relationships described above hold true independently in each of these groups. The mean BMI was as follows: <60 = 26 kg/m2; 60 -75 = 27 kg / m2 and > 75 = 23.8 kg / m2. The table below shows the degree of unintended weight loss in each group.

Table 1: Unintended weight loss

	Yes, I have lost weight (%)		No, I have not lost weight (%)		I am not sure (%)		Missing data (%)	
	UK	Ref	UK	Ref	UK	Ref	UK	Ref
< 60	30	34	34	39	8	4	14	14
60 - 75	40	38	29	34	9	5	13	15
>75	38	37	26	29	14	10	15	17

It is important to recognise the potential need for education about the importance of weight loss as a prognostic indicator for clinical outcomes. This is equally relevant for the general public and for healthcare professionals, so that possible problems can be identified and managed at an earlier stage in the community. Undernutrition is not simply a hospital based phenomonen.

Patients were reviewed in a variety of clinical areas - <60: infectious diseases, neurosurgery and cardiothoracic surgery were the three top specialities; 60 -75: psychiatry, cardiothoracic surgery and cardiology; > 75 geriatrics, orthopaedic surgery and "others". The terciles were as follows <60 = 23%; 60 -74 = 24% and >75 years = 53%. This is significantly different from the reference data set where only 29.2% patients were aged more than 75 years old.

Food intake on NutritionDay varied as much as might be expected (see Table 2). However, the important point to recognise is that all groups are vulnerable whether or not the disease state is acute (when intake might be limited because of tests or because patients are simply too ill to eat) or chronic disease when there are the burdens of long term illness possibly concurrent with socio-economic challenges which compromise nutritional intake.

Preliminary data is now also available from the pilot studies in ICU's and nursing homes. The former was more widely representative with 62 participating units and 830 patients - although there were no units from the UK. Key findings included the fact that the median age of patients was 64 with 53% of these being emergency admissions and 27% were ventilated. All patients were included regardless of status and 75% of these had some form of central line feeding regimen. 33% were fed enterally with a 30 day mortality of 33.5 %; 25% were fed orally and the mortality rate was 37.3%;13% had no nutritional intervention at all with a 30 day mortality of 37.8%. Overall the mortality rate at 30 days was 34%, 14% were still in hospital and 14% had been transferred to other facilities. Planned caloric intake was achieved earlier with patients being fed parenterally and the greatest difference between enteral and parenteral achievement of nutritional prescription was shown between 3 and 6 days.

Table 2: Food intake on NutritionDay

nutritionDay IN EUROPEAN HOSPITALS

Nutritional intake: Summary

Age	Meal	All	50%	25%	Nil	No Info.	Missing
<60yrs	B/fast	40.28	10.00	8.00	26.29	6.57	8.86
	Lunch	31.14	16.28	12.00	22.29	9.43	8.86
	Supper	27.71	16.86	12.00	18.00	16.57	8.86
60 - 75 yrs	B/fast	44.69	13.09	8.17	14.44	7.36	11.04
	Lunch	35.15	17.71	16.34	11.72	7.63	11.04
	Supper	36.24	17.43	13.62	8.45	12.80	11.04
>75yrs	B/fast	45.90	15.86	7.10	13.20	5.80	12.00
	Lunch	31.50	23.50	13.20	11.20	8.63	12.00
	Supper	30.83	20.30	13.96	12.18	10.65	12.00

NutritionDay 2008 D 31st January

Only Austria and Germany took part in the Nursing Home pilot and the principle findings show that a key risk factor for undernutrition is cognitive impairment and this is particularly apparent in patients on tube feeding regimens. It was concerning to note that 25% patients were nutritionally screened if it was thought to be necessary - but, when staff were asked to categorise their patients in terms of being well-nourished, at risk of being undernourished or malnourished, 60% patients with a BMI< 20 kg/m2 were not classified as being malnourished - another key point to be considered in any proposed educational initiatives. This study also showed the significant amount of time involved in supporting patients who needed help to eat (47%) but further showed that no additional staffing resources were available to meet this need. Although no UK units took part in this pilot, the results are of interest because these problems are universal.

NutritionDay 2008 will be on January 31

Please support this project which is hugely important. Not only does it provide an enormous amount of information (approximately 30,000 patients to date) against which to benchmark local practice but it is being used to influence strategic development and obtain funding at both European and national levels. We are going to compare this data with the information which has been gathered from the BAPEN Screening Week and this, in turn, will be used in the case being presented to the government in support of the need for dedicated resources to provide appropriate nutritional education, training and support as outlined in the recent national strategy document.

Your key contacts for NutritionDay 2008 are;
Mrs Pat Howard,
pathoward@mac.com

Dr Jon Shaffer,
Hope Hospital, Salford.
Tel: 0161 206 5148
e-mail: jshaffer@srht.nhs.uk

You can also register your interest directly on the NutritionDay website:
www.nutritionday.org

NNNG Conference 2008 – First Announcement

Supporting Clinical Practice: The 3R's
Rights, Responsibilities and Research in Nutritional Support

DATE: 23rd & 24th June 2008, VENUE: Knebworth Barns, Hertfordshire

	DAY 1
09.45 – 10.30	What's happening in nutrition: updates on national initiatives
10.30 – 11.00	Normal swallow reflex and Dysphagia: the use of fluoroscopy
11.00 – 11.30	Coffee break
11.30 – 13.00	DEBATE: This house believes that the use of nasal bridles is ethically justified
13.00 – 14.00	Lunch & exhibition
14.00 – 14.45	Nutritional support in patients with learning disabilities
14.45 – 15.30	Nurses responsibility in feeding patients with Dysphagia
15.30 – 16.30	Coffee & AGM of the NNNG
19.30 – 'til late	NNNG annual conference dinner & entertainment. Theme: 'School disco'

	DAY 2
0900 – 0930	Registration & coffee
0930 – 1015	Outcomes from the NNNG Granuloma Working Group
1015 – 1045	Detecting and dealing with Buried Bumper in PEG patients
1045 – 1100	1 x mini communication Member presentation – Abstracts to be invited
1100 – 1130	Coffee break
1130 – 1200	2 x mini communications Member presentations – Abstracts to be invited
12.00 – 12.30	EPIC II Guidelines and the care of intravenous devices used for Parenteral nutrition.
12.30 – 13.15	Empowering patients' independence in Home Parenteral Nutrition
13.15 – 14.15	Lunch & exhibition
14.15 – 15.00	Strategies to support the Psychological needs of HPN patients
15.00 – 15.30	Metabolic and Biochemical complications in Parenteral Nutrition
15.30 – 15.45	Close & Tea - Safe Journey Home!

Contact Jane Fletcher, NNNG Secretary for booking form and conditions - **Jane.fletcher@uhb.nhs.uk**

Programme subject to change without notice

Diary Dates 2007/8

Dates	Meetings – International	Venue and Contact Details
10th - 13th February	**ASPEN's Clinical Nutrition Week 2008**	Hyatt Regency, Chicago. **www.nutritioncare.org/ClinicalNutritionWeek/**
13th - 16th September	**ESPEN Congress 2008:** **"Nutrition Renaissance from Care to Cure"**	Florence. **www.espen.org**

30th ESPEN Congress

THE EUROPEAN SOCIETY FOR CLINICAL NUTRITION AND METABOLISM

FLORENCE

13-16 September 2008

Nutrition Renaissance from care to cure

Main topics of ESPEN 2008

Scientific programme

The chronic critically ill patient
Oxygen delivery and tissue metabolism in sepsis
Metabolic therapies in ICU: controversies or consensus?
The impact of anesthesia on metabolism
Phytochemicals and cancer
Obesity and cancer risk
Nutrition-related cancer risk
Tumor-specific metabolic changes
Fatty acids modulation of anti-cancer therapy
Preventing cancer-related malnutrition
Protein kinetics in the elderly
Metabolomics and proteomics in nutrition
Chronic intestinal failure
Growing up on parenteral nutrition
Strategies to prevent hepatosteatosis
Brain metabolism and nutrition
Nutritional support in wounds and pressure ulcers
Nutritional control of immunity
Amino acid metabolism in the gastrointestinal tract

Educational activities

ECPC Programme

Food in aetiology/prevention of cancer
Nutritional consequences of cancer treatment
Home artificial nutrition in cancer patients
Malnutrition in the elderly - hospital
Malnutrition in the elderly - community
Long-term nutritional issues in ICU
Complications of central venous catheters
Screening and ESPEN's NutritionDay
Severe obesity and bariatric surgery
Case reports/examples
Global guidelines on nutritional support
Launch of PN guidelines

ESPEN LLL Courses

New LLL modules on nutritional support

Renal disease
Pulmonary disease
Gastrointestinal - the compromised gut
Diabetes/hyperlipidaemia

Old 12 LLL modules

Thank you

On behalf of the BAPEN executive committee, I would like to thank a number of individuals who have made outstanding contributions to the activities of BAPEN, and who I have been privileged to work with.

Dr Penny Nield has been Honorary secretary for the last three years, and her tireless efforts at liaising and communicating with all members of Council, the BAPEN office, and external organisations and agencies cannot be under-emphasised. She has also led on the development of the BAPEN database, which I hope will shortly be operational, and has effectively linked with the Royal College of Physicians (Committee on Nutrition) and Intercollegiate Group on Nutrition Education.

Carolyn Wheatley, who has also been a member of the BAPEN Executive committee for the last three years, represents what BAPEN is all about; Patient care. She was a founder member of BAPEN and has been involved with its activities as long as anyone. I do not know of anyone who has promoted the patient perspective more that Carolyn. Her influence and contributions over the last 14 years have been appreciated so much that at the annual meeting she was honoured with a life long membership to BAPEN. Only one other BAPEN member has been offered this, Professor John Lenard-Jones, who became the first BAPEN chairman.

Other major contributions have been made by the chairs of the Research and Science Committee (Professor Agostino Pierro) and Educational and Training Committee (Dr Ian Fellows), who are also rolling off their committees after a well earned period of activity.

I would like to thank all these individuals for their support, advice and hard work over the years.


Carolyn Wheatley receiving the lifetime award

Professor Marinos Elia
Chairman, BAPEN

Intestinal Failure (IF) Module

This module is open to the multidisciplinary team (those working with IF patients) and academically validated by King's College London (15 credits at Masters level).

Dates:

24-25 January 2008, 14-15 February 2008, 17-18 March 2008

Course location:

Burdett Institute of Gastrointestinal Nursing, St Mark's Hospital, Harrow, Middlesex.

For further information contact:
Annmarie Nunwa, Lecturer Practitioner
Burdett Institute of Gastrointestinal Nursing, St Mark's Hospital, Harrow, Middlesex.

email: **annmarie.nunwa@nwlh.nhs.uk** Tel: **0208 869 5432**
This course has been endorsed by BAPEN.

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