In this issue:

Consensus Statement: When is enteral nutrition indicated?

Publication: *Journal of Parenteral and Enteral Nutrition*. September 2022;46(7):1470-1496.
Authors: Bechtold ML, Brown PM, Escuro A, Grenda B, Johnston T et al.

This consensus statement from the ASPEN Enteral Nutrition Committee provides recommendations based on eight essential clinically relevant questions regarding the initiation and safety of enteral nutrition (EN) in adults. They are intended to provide healthcare providers assistance in difficult clinical everyday decisions to improve patient outcomes and patient safety. However, circumstances in clinical settings and patient indications may require actions different from these recommendations and the judgment of the treating provider should take precedence. We provide a brief summary of the eight (8) topics in this very comprehensive document, encouraging you to peruse the complete statement.

1. Initiation	a. High-risk or malnourished patient: within 24-48 hours of hospital admission b. Well-nourished patient: delay in EN can be considered if oral intake is likely to resume in 5-7 days of admission c. Patients at risk for refeeding and patients with symptoms of gastrointestinal (GI) intolerance: advance EN cautiously
2. Oncology	a. Indications, route, and schedule for EN in oncology patients depends on the patient's diagnosis, treatment modality, nutrition status, energy and protein requirements, and estimated duration of nutrition intervention. b. Nutrition support algorithms may be useful for deciding which patients would benefit from nutrition support intervention and timing (see Figure 1 in the publication).
3. GI diseases	a. Consider when the patient is at risk or has emerging malnutrition due to inadequate oral intake b. Exclusive enteral nutrition should be considered as a first-line therapy for the induction of remission in children with Crohn's Disease (CD), and as an alternative to corticosteroid therapy for remission in adults with CD
4. Specific non-GI diseases	a. Stroke: evaluate as soon as possible to establish need and appropriate route of nutrition support b. Cystic fibrosis, chronic kidney disease, or COPD: Initiate EN support in adults with malnutrition who are unable to meet their nutrition needs with diet and oral supplements alone
5. Hemodynamic Instability	a. ASPEN/SCCM recommend administering EN when the patient is hemodynamically stable. One of the parameters to monitor the patient's stability is mean arterial pressure (MAP). According to the guidelines, EN may be administered if the MAP is ≥60 mm Hg but should be held for MAP <50 mm Hg.
6. Paralytic Therapy	a. Do not hold or delay EN in patients undergoing paralytic therapy
7. Noninvasive ventilation (NIV)	a. Requires careful consideration of the patient's overall medical and nutrition status b. EN tubes with standard NIV masks cause additional air leaks. Therefore, it is recommended to use a mask with an adaptor or sealing pad c. Post-pyloric placement is preferred due to higher risk of aspiration
8. "Catch-up feedings"	a. Consider the use of a volume-based feeding (VBF) protocol to improve the likelihood that the full amount of prescribed EN is received b. Consider patient condition factors in formulating the feeding regimen to promote tolerance and meet energy, protein, and fluid needs safely

Access Article

Summary prepared by Nestlé Health Science

Causes of readmissions for patients discharged on enteral nutrition

Publication: *Journal of Parenteral and Enteral Nutrition*.22;46:1672-1676
Authors: Palchaudhuri S, Mehta SJ, Snider CK, Parsikia A, Hudson L et al.

Patients using enteral nutrition (EN) at home are known to have increased hospital re-admissions. This study was undertaken to determine the contributing factors responsible for readmissions of patients discharged on enteral nutrition (DCENs) with an enteral access device (EAD).

Over the 30-month study period, EN-related readmissions accounted for 20.5% of 30-day readmissions and 16.7% of 90-day readmissions. The most common causes, accounting for 95% of readmissions, were GI symptoms of intolerance, issues with the EAD, and sodium imbalance from dehydration. A significant number of readmissions not related to EN also received EN plan adjustments, suggesting there was a need to better optimize EN discharge planning.

Quality improvement plans with enhanced discharge planning for patients DCEN would improve quality of life, reduce complications, and reduce costs by decreasing readmissions for these patients. In addition, close follow-up within the first 90 days of initiating EN may identify 52% of the problems leading to readmission, allowing for home-based solutions which could prevent readmission.

Access Article

Summary prepared by Nestlé Health Science

Nestlé HealthScience®

Outcomes of blenderized gastrostomy feeding in children at Rouen University Hospital

Publication: *Pediatric Medicine, Health, and Therapeutics*,22;13:271-277.
Authors: Allabas F and Dumant C

This retrospective, monocentric seven-year study followed 10 pediatric patients (mean age of 6.2 years) who used blenderized tube feeding (BTF) through gastrostomy. Study participants had a neuromuscular disability or had undergone surgery due to congenital esophageal atresia. BTF was prescribed at the family's request or due to persistent gastrointestinal (GI) symptoms resulting from complications of their standard enteral nutrition. The study aimed to assess the clinical and biochemical effect of BTF on the childrens' overall health, and determine the psychosocial effect of BTF on their families.

Registered dietitians worked closely with the families to tailor the childrens' diets to their unique requirements and family preferences. The number of BTF meals varied from one to four meals per day. Blended meals were delivered by boluses during the day or at night, over a 10–20-minute period. Most caregivers gave either homemade or commercial blended diets, including vegetables, fruits, different meat types, and baby cereals mixed with milk. Some enriched the meals by adding ingredients such as oil and honey.

GI symptoms such as vomiting improved rapidly after the introduction of BTF in six children. Four experienced complete symptom regression and two showed marked improvement. Gagging, retching, and diarrhea were alleviated in all cases. Constipation improved in three out of four patients.

One concern with a BTF is the nutritional adequacy of the diet and its effect on growth. In this study, nutritional statuses were appropriate, and all patients had regular growth curves. Two of the patients had a mild deficiency in vitamin A; however, vitamin A levels were not measured before BTF. No other deficiency in macronutrients or micronutrients was observed. Another concern of homemade BTF is the possibility of foodborne illness. This was not observed, possibly because the food was given rapidly by boluses without allowing time for microbial growth at room temperature. Gastrostomy tube sizes used were either 12 FR or 14 FR. Tube blockage was reported only once and was easily flushed.

Caregivers' satisfaction levels were unanimous; they were very happy to introduce real foods into the childrens' diets and reported that their children were more comfortable with BTF. The one disadvantage noted was the time taken to deliver blended food via syringe versus using a delivery pump.

The authors of this small study concluded that BTF can be a useful tool to improve quality of life and digestive symptoms in neurologically impaired children.

Access Article

Summary prepared by Nestlé Health Science

NEST-15326-0123