Individualised nutritional support in medical inpatients – a practical guideline

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Summary

Malnutrition has been defined as a “state resulting from lack of uptake or intake of nutrition, leading to altered body composition and body cell mass, as well as to diminished physical and mental function and impaired clinical outcome from disease.” Particularly for the multimorbid medical inpatient, there are multiple research studies linking malnutrition to adverse clinical outcomes independent of type of acute and chronic illnesses. Importantly, recent trials have shown that malnutrition is indeed a modifiable risk factor with specific individualised nutritional support interventions started at hospital admission having positive effects on the risk of complications, mortality, functional outcomes, rehospitalisation and quality of life. Understanding the optimal use of nutritional support in patients with acute illness is complex – as timing, route of delivery, and the amount and type of nutrients can all affect patient outcome. The aim of this narrative review is to provide a practical guideline for pragmatic and evidence-based assessment and treatment of medical inpatients at nutritional risk. We thereby focus on screening, patient assessment, definition of individual nutritional goals and nutritional support interventions that help patients to reach these goals.

Keywords: nutrition, malnutrition, nutritional support

Introduction

Hippocrates, one of the founders of medicine as a scientifically orientated profession, had already recognized nutrition as a major factor to help cure diseases. The significance of nutrition in clinical practice, however, has never quite fulfilled those expectations [1, 2]. Many physicians still do not consider nutrition as a medical treatment but rather as a supportive treatment [3]. As recent trials demonstrated that early, individualised nutritional support improves clinical outcomes of patients, it is now time for a paradigm shift [4–7]. We must now think of clinical nutrition as a medical treatment that, by decreasing metabolic stress responses, preventing apoptosis, reducing oxidative stress in other organs and modulation of the body’s immune response, has a measurable impact on disease development and recovery [8, 9]. This is particularly true for patients with malnutrition, a condition that has been associated with increased risks of adverse clinical outcomes [10]. In such patients, a nutritional strategy needs to be established in order to provide optimal nutritional support. There are three basic prerequisites:

1. Routine screening with a well-tested and validated tool for early identification of patients with manifest malnutrition or those at high risk of developing malnutrition;
2. Shared interdisciplinary and multiprofessional responsibilities for a thorough clinical assessment and the implementation of an up-to-date nutritional therapy based on current evidence where appropriate;
3. Clinical decision making regarding optimal nutritional care for an individual patient guided by a systematic consensus algorithm.

This review article provides an example of a nutritional support strategy and discusses basic principles of nutritional therapy for medical inpatients. The nutritional support interventions discussed are mainly based on consensus guidelines issued by the European Society of Clinical Nutrition and Metabolism (ESPEN) [11]. As the underlying evidence, however, is variable in quality and reliability, some of the recommendations are supported only by expert opinions and may need to be adapted once new evidence becomes available.

Implementation of a nutritional care strategy: cornerstones

Establish a nutritional care team

Interdisciplinary as well as multiprofessional support and shared decision making is needed for optimal nutritional care [12]. Appropriate duties and responsibilities must be assigned in order to ensure that each involved profession can provide important contributions. Interdisciplinary communication should be integrated into daily routine on the ward. Responsibilities may be shared as follows:
Nursing team

Involvement in nutritional screening of patients. Documentation of oral intake and weight changes; physical and motivational support during meals.

Dieticians

Detailed nutritional assessment. Meal planning according to predefined goals and special needs, with special adjustments according to the underlying disease and current clinical circumstances. Building connection to hospital kitchen for food enrichment.

Physicians

Nutritional assessment and exclusion of drugs leading to weight loss. Adaptation of nutritional interventions according to on-going medical treatment particularly considering potential interaction with other medications. Responsibility for clinical and laboratory monitoring as part of the daily routine, also regarding the management of the refeeding syndrome.

Hospital kitchen

Preparation of specific and fortified foods to facilitate oral nutritional therapy.

Implement routine nutritional risk assessment

Screening for malnutrition should be performed at the time of patient admission to the medical ward or at least within the first 24–48 hours. The use of a validated screening tool for nutritional risk is recommended; for example, the Nutritional Risk Screening 2002 (NRS 2002) or the Mini Nutritional Assessment short form (NMA-sf) \[11, 13, 14\]. Several recent studies have used the NRS 2002 and provided evidence that this score has strong prognostic implications and identifies patients who benefit from nutritional support interventions \[6, 9, 15, 16\]. The NRS 2002 (see fig. 1) includes an assessment of the patient’s nutritional status (based on weight loss, body mass index [BMI] and general condition or food intake) as well as disease severity (stress metabolism), and indicates any increased risk of adverse outcomes \[13\]. Each risk predictor is scored from 0 to 3 points and patients receive 1 extra point if they are aged 70 years or older \[13\].

If the screening test is positive, a more detailed assessment of nutritional status is recommended. Table 1 gives an overview of anthropometric and laboratory parameters useful for baseline examination of a patient at risk. In some cases of severe or chronic malnutrition, there may be a need for additional diagnostic studies (e.g., if pancytopenia is present). These patients may benefit from the involvement of an experienced specialist in malnutrition.

Create a nutritional care plan for the medical ward

If malnutrition is manifest or presents an imminent risk, an individualised nutritional support strategy should be established within 48 hours after hospital admission. In a first step, a trained dietician should calculate individual goals for daily energy and protein requirements for each patient. Details on establishing individual nutritional objectives will be discussed in the following text. We recommend introducing a nutritional care plan flow chart system to guide further management, achieve individual nutritional goals and assure decision-making consistency within the

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**Nutritional Risk Screening (NRS 2002)**

![NRS 2002](http://example.com/nrs2002.png)

**Nutritional status**

- **None**: 0
  - Weight loss > 5% in 3 months or
  - 50 – 75% of the normal food intake in the last week
- **Mild**: ★
  - Weight loss > 5% in 2 months or
  - BMI 18.6 – 20.9 kg/m² and reduced general conditions or
  - 25 – 50% of the normal food intake in the last week
- **Moderate**: ★★
  - Weight loss > 5% in 1 month (15% in 3 months) or
  - BMI < 18.5 kg/m² and reduced general conditions or
  - 0 – 25% of the normal food intake in the last week

**Severity of the disease (stress metabolism)**

- **None**: 0
- **Mild**: ★
  - Hip fracture, chronic disease especially with complications, e.g., liver cirrhosis, COPD, diabetes, cancer, chronic hereditary disorders
- **Moderate**: ★★
  - e.g., stroke, hematologic malignancy, severe pneumonia, extended abdominal surgery
- **Severe**: ★★★
  - e.g., head trauma, hematopoietic stem cell transplantation, intensive care patients (APACHE-II > 10)

<table>
<thead>
<tr>
<th>Points</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 2 points</td>
<td>Repeat screening weekly.</td>
</tr>
<tr>
<td>3 – 7 points</td>
<td>Patient is at nutritional risk. Nutritional care plan should be set up.</td>
</tr>
</tbody>
</table>
hospital. Figure 2 presents a pragmatic algorithm for nutritional management of patients (adapted from the EFFORT trial [15]).

**Define nutritional targets**

**Estimate energy needs**

Terms and abbreviations:

Resting energy expenditure (REE) or resting metabolic rate = energy required for the preservation of metabolic functions in a biologic equilibrium under resting conditions, and fasting.

Total energy expenditure (TEE) = REE + dietary-induced thermogenesis + physical activity

The formula of TEE is based on the energy balance of healthy probands. Diseases affect energy requirements by their impact on metabolic processes, in particular by increasing catabolism. Therefore for patients, the general formula has to be further adjusted by adding a disease-specific factor. Disease-specific factors range between 5 and 50% of the REE.

There is not one single validated method to estimate energy requirements [11]. The gold standard to estimate energy needs is indirect calorimetry, which is, however, time consuming, resource intensive and technically complex [18]. REE also varies according to the severity of the illness (hypermetabolism). Repeated measurements would have to be taken in order to ensure continuity. As a result of these factors, energy needs are in clinical routine often estimated using equations based on the calculation of resting metabolic rates. There is a multitude of evaluated prediction equations using sex, weight, height and age (e.g., Harris-Benedict-Formula 1919, FAO/WHO/UNU 1985, Mifflin-St Jeor 1990) or simple weight-based formulae (e.g., 25–30 kcal / kg bodyweight / day; BASA-ROT-Table) [11, 19, 20]. Most of these equations provide good estimates for groups of patients but show significant imprecision in individual cases; which can lead to both over- and underestimation of energy expenditure [19]. It is therefore recommended to use a tool that is easier to implement but still reliable in clinical practice. Estimates of energy expenditure are helpful to define a starting point but need adaptation during the course of the hospitalisation. In the case of uncertainty, additional indirect calorimetry may be performed [11].

Recommendations for weight-based formulae according to ESPEN guidelines are [11]:

- REE for patients aged ≥65 years or polymorbid patients: 18–20 kcal / kg bodyweight / day
- TEE for patients aged ≥65 years or polymorbid patients: 27 kcal / kg actual bodyweight / day
- REE for severely underweight patients (i.e., <50kg): 30 kcal / kg bodyweight / day

**Protein requirements**

Overall, there are few studies assessing the effect of different amounts of protein intake on outcome. Some clinical data suggest that a protein intake of >1 g / kg bodyweight / day appears to reduce the risk of complications and weight loss [21]. In terms of clinical and functional outcome, older and polymorbid patients may benefit from a higher protein intake, for example 1.5–2 g / kg bodyweight / day [17, 22]. Also, a daily protein intake of 1.2–1.5 g / kg bodyweight to adjust for targets for patients suffering from acute renal failure (0.8 g / kg bodyweight / day) [11, 17, 24].

There are several uncertainties regarding the optimal use of proteins in clinical nutrition. First, there is uncertainty whether calculations of protein requirements should use actual or ideal body weight as their reference [25]. This is relevant particularly in obese patients, where protein goals calculated from the actual body weight result in very high quantities and often are difficult to reach. Based on pathophysiologic considerations, calculating protein needs according to ideal body weight should provide adequate quantities and should be preferred in clinical practice [26]. However, so far, there is no evidence supporting this assumption. Second, in addition to protein quantity, it remains largely unknown which type of protein has most beneficial effects on patient outcomes.

**Micronutrients**

Malnourished patients are at risk for micronutrient deficiency as a result of decreased intake or increased requirements [11]. Thus, screening for micronutrient deficiencies such as iron, vitamin B₁₂, folic acid and vitamin D are recommended. According to patient history and clinical presentation, in particular in cases of severe or chronic malnutrition, more comprehensive screening including vitamin B₁₂, vitamin B₆, vitamin A, vitamin E, vitamin C, zinc and selenium, as well as the international normalised ratio (INR) or Quick test as an indirect measure of vitamin K should be considered. Analytic prerequisites for all laboratory parameters, in particular for vitamin E, should be followed carefully in order to ensure reliable results.

Cases of general vitamin depletion are also at increased risk for serious trace element deficiency. In absence of specific toxicity risks or known micronutrient adequacy, supplements should cover both, ideally in a multivitamin/multi-trace-element formula [11]. The recommended daily...

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**Table 1: Basic assessment at admission.**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Significance and implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>NRS 2002</td>
<td>Screening for malnutrition</td>
</tr>
<tr>
<td>Iron, holotranscobalamin, folic acid in erythrocytes</td>
<td>Diagnostic assessment of anaemia. Substitution in the case of deficiency</td>
</tr>
<tr>
<td>Electrolytes (sodium, potassium, calcium, magnesium, phosphate)</td>
<td>Screening for deficiency and assessing risk for refeeding syndrome. Substitution according to the cited consensus paper by Friedli et al., Nutrition, 2018 [20].</td>
</tr>
<tr>
<td>Creatinine</td>
<td>Baseline assessment of renal function. Possible sign for low muscle mass if low</td>
</tr>
<tr>
<td>Liver function tests</td>
<td>Baseline assessment of hepatic status</td>
</tr>
<tr>
<td>International normalised ratio</td>
<td>Indication of vitamin K deficiency, if low. Substitution if clinically indicated. Caveat: elevated/reduced by coumarins and direct-acting oral anticoagulants.</td>
</tr>
<tr>
<td>Vitamin D</td>
<td>Baseline assessment because of frequent deficiency and frequent association of osteoporosis in malnutrition. Substitution in the case of deficiency</td>
</tr>
</tbody>
</table>
Nutritional algorithm as evaluated in the EFFORT study

Set up of the individual nutritional care plan after detailed assessment of nutritional status in patients at risk according to the NRS 2002 (score > 3).

**Nutritional goals**

<table>
<thead>
<tr>
<th>Energy requirement</th>
<th>Protein requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>REE × (AF × DF - 1)</td>
<td>1.2 - 1.5 g per kg body weight/day</td>
</tr>
<tr>
<td>REE as calculated by the Harris Benedict equation with weight adjustment or indirect calorimetry</td>
<td>0.8 g in severe renal failure without dialysis (GFR &lt; 30 ml/min/1.73 m²)</td>
</tr>
</tbody>
</table>

**Micronutrients**

Vitamins and minerals in accordance with 100% RDA

**Special goals**

Disease and clinic-specific adjustments

**Oral nutrition**

- Adjustment of preferences
- Snacks
- Protein-energy enrichment
- Oral nutritional supplements

Vitamins and minerals in accordance with 80% RDA

24-48 h

Re-Assessment

≥ 75% of protein and energy requirement

Yes

No

Achievement of goal not foreseeable. Stage 2 offer a maximum of 5 days

**Enteral nutrition**

No vitamins required orally when 100% of RDA is obtained via enteral nutrition

24-48 h

Re-Assessment

≥ 75% of protein and energy requirement

Yes

No

Achievement of goal not foreseeable. Stage 3 offer a maximum of another 5 days

**Parenteral nutrition**

Supplement vitamins and minerals in accordance with 100% RDA

**Enteral and/or oral nutrition**

Aim for concomitant enteral and/or oral nutrition (to avoid villous atrophy, among others)
intake may temporarily be exceeded in order to replace depleted stores [11]. General prescription of a multivitamin/multi-trace-element supplement does not seem to be cost-effective but, depending on circumstances, it might be reasonable to prescribe one to prevent recurrent multivitamin/multi-trace-element deficiency after repletion and/or in the presence of persisting risk factors for malnutrition [27]. Particularly in patients at risk for refeeding syndrome, careful monitoring and substitution of vitamins and micronutrients is important [28, 29].

Disease-specific supplementation

Immuno-nutrition (e.g., antioxidants, omega-3-fatty acids, branched-chain amino acids), prebiotics and probiotics. Multiple new formulas with potential immune-modulating capacities are currently gaining attention for use in specific patient populations, particularly in intensive care units and surgical wards. To-date there is no strong evidence for their beneficial influence on clinical outcome in medical or polymorbid non-critically ill patients [11].

Amino acids for wound healing in pressure ulcers. According to a randomised controlled trial by Wong et al., wound healing might be improved by adding a combination of amino acids (β-hydroxy-β-methylbutyrate [βHMB], glutamine and arginine) to a hypermetabolic diet (energy goals 30–35 kcal / kg bodyweight / day) in patients with pressure ulcers [30].

Fibre

Fibre supplementation has been recommended to improve bowel function and feeding tolerance and reduce diarrhoea with enteral nutrition [31]. Although the pathogenesis of diarrhoea in patients receiving enteral nutrition in most cases is multifactorial, the fibre content of enteral formulas might be one of the relevant factors. Fibre content also influences clinical parameters such as gastrointestinal transit time, bowel frequency and daily stool wet weights [32, 33]. In an attempt to prevent diarrhoea, the fibre content of enteral formulas has been adapted to better reflect the fibre content of normal food. Results have so far been inconclusive, with heterogeneity among study protocols in terms of fibre type, blended versus single fibre source and dose of fibre content. This heterogeneity may be explained by the dependence of gastrointestinal effects on fibres solubility in water and fermentability by the microbiota. Still, according to a recent meta-analysis formulas containing fibre may reduce risk of diarrhoea as compared with fibre-free formulas particularly in non-critically ill medical patients [32]. One randomised controlled trial included in the meta-analysis, which focused on elderly non-critically ill patients with relevant protein malnutrition, came to a conclusion similar to the overall conclusion by Elia et al. [31, 32]. Additionally, formulas containing a blend of soluble and insoluble fibres resulted in better gastrointestinal tolerance and reduced diarrhoea in comparison with single source fibre [33]. Further, formulas predominantly containing partially hydrolysed guar gum as their source of soluble fibre seem to be better than other fibre types in the prevention of diarrhoea. Hence, it is recommended to use an enteral nutrition formula enriched with a mix of soluble and insoluble fibres, particularly in patients receiving enteral nutrition and experiencing diarrhoea.

Maintenance fluid supplementation

In general, electrolyte-free fluid requirements of adults range from about 1500–2000 ml or 25–30 ml / kg bodyweight / day for routine maintenance of fluid balance [36, 37]. Particularly in older patients, fluid needs should be closely monitored in order to ensure that minimum goals are met regularly [37]. During the course of the hospitalisation fluid supplementation should be re-evaluated daily. An appropriate re-evaluation takes several parameters into account: electrolytes, particularly sodium, clinical fluid balance, oral intake, fluid supply by enteral or parenteral nutrition, fluid losses and clinical circumstances such as inflammation.

Parameters of nutritional support

Indication and timing

Systematic screening of at-risk patients at the time of hospital admission for malnutrition using the NRS 2002 enables the nutritional care team to plan a thorough and rapid assessment of nutritional status, and concomitantly allows the establishment of nutritional support within the first 48 hours. It is important to note that outside critical care, there are few clinical studies comparing the effects of early with late start of nutritional intervention on clinical outcome. A randomised controlled trial by Heregova found less loss of lean body mass, as well as improved recovery to baseline lean body mass, in patients treated with early nutritional support and low intensity exercise [38]. In addition, the intervention group retained more independence for performing activities of daily living [38]. In intensive care settings, studies have suggested that early start of (over-)nutrition, particularly when parenteral nutrition is used, may have harmful effects [11]. Still, evidence from intensive care settings should not unconditionally be adopted on medical wards because of differences in underlying disease, extent of inflammation and resulting catabolism. Thus, for the medical inpatient, early start of nutritional support is recommended.

Route of administration

For a patient who tolerates oral nutrition, the paradigm “If the gut works, use it!” should be followed for both the intensive care setting and the medical ward. Several high-quality, randomised controlled trials in critical care settings favour enteral over parenteral nutrition owing to reduced risk of infectious and noninfectious complications [11]. For medical ward patients, a step-wise escalation of nutritional support should be made as follows.

Oral nutritional support through fortification of the standard hospital diet or oral nutritional supplements

The positive effect of oral nutritional supplements (ONSs) has been documented in several high-quality randomised controlled trials with medical inpatients. The effects included preservation of lean body mass and retained independence for activities of daily life, as well as reduced complications during hospitalisation and nonelective readmissions [21, 38–40]. ONSs did not negatively affect oral food intake and therefore did not disguise or inhibit increasing appetite of patients, particularly if given in between meals or in the evening [38].
Enteral nutrition via nasogastric tube in the event of insufficient oral intake

Insufficient oral intake has been defined by the ESPEN as an oral intake ≤75% of the estimated daily energy needs [11]. The most frequent limiting factors for enteral nutrition in clinical practice are intolerance of the nasogastric tube, nausea and diarrhea. Diarrhoea in particular may present a relevant problem. To improve gastrointestinal tolerance of enteral nutrition, we propose the following:

- Start with small portions and adjust slowly to target quantities;
- Use formulas containing soluble and non-soluble fibres;
- Consider switching to a formula containing oligopeptides instead of proteins in the event of persistent diarrhoea

Parenteral nutrition via central or peripheral venous catheter

Parenteral nutrition is mainly indicated in patients not tolerating oral and enteral nutrition as a result of intestinal dysfunction and oral or enteral intake ≤75% of the estimated daily energy needs.

Discontinuation

Discontinuation or de-escalation of nutritional support is recommended if gastrointestinal tolerance, appetite and oral intake improve. No significant suppression of appetite was seen in one high-quality randomised controlled trial on ONSs, but data on enteral and parenteral nutrition remain controversial [41].

We expect a partial reduction of appetite. In our own experience, the appetite-suppressing effect is lower in patients experiencing fast recovery or those ready to transition to the early rehabilitation phase.

Nutritional therapy should be withdrawn if ≥75% of recommended energy needs are met orally [11].

Monitoring/reassessment

A regular evaluation of effects of nutritional therapy as well as screening for undesirable side effects are recommended during a nutritional therapy regimen.

In order to evaluate the improvement of a patient’s nutritional status, we recommend reassessing the anthropometric and laboratory parameters as shown in Table 2. Oral intake and gastrointestinal tolerance in case of enteral nutrition should be evaluated every 24–48 hours. An escalation from oral to enteral and parenteral nutrition is recommended if there is no favourable development within 5 consecutive days. The adequacy and achievements of nutritional goals should be re-evaluated every 24–48 hours, always under consideration of the severity of the acute illness.

Screening for negative side effects of nutritional therapy includes screening for refeeding syndrome, as well as for hyperglycaemia and hypertriglyceridaemia in patients receiving parenteral nutrition (metabolic monitoring).

Historically, albumin has been considered as one of the main nutritional laboratory parameters [42]. Yet its reliability is as a marker of malnutrition is limited. The interpretation of albumin levels is, among other reasons, mainly complicated by its long half-life of about 21 days and its property as a negative acute phase protein [43]. Pre-albumin, with a half-life of about 3 days, is a better marker of recent food intake, yet is often not available in routine laboratory testing and its interpretation remains challenging if a patient presents with inflammation. It is therefore not generally recommended to consider albumin as a nutritional parameter, nor is it recommended in the basic work-up of malnutrition. Exceptionally, it might complement an extensive malnutrition work-up in the hands of experienced clinicians.

Risk of refeeding syndrome

Refeeding syndrome (RFS) is a condition resulting from an anabolic reaction caused by nutritional therapy and is associated with serum electrolyte shifts (mainly potassium, magnesium and phosphate), thiamine deficiency and clinical symptoms (e.g., oedema, tachypnoea, tachycardia) resulting from metabolic changes and an imbalance of fluids. The main trigger for RFS is a switch from a catabolic to an anabolic state, as a normal physiological reaction during the beginning of the replenishment phase [29]. In most cases, RFS appears within the first 3 days of initiating nu-

Table 2: Monitoring during nutritional therapy.

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Significance and implications</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight</td>
<td>Evaluation of nutritional support. Caveat confounded by fluid retention</td>
<td>Daily</td>
</tr>
<tr>
<td>Oral food consumption</td>
<td>Evaluation of nutritional support</td>
<td>3 × daily</td>
</tr>
<tr>
<td>Laboratory parameters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sodium, potassium, magnesium,</td>
<td>Screening and follow-up of RFS</td>
<td>Daily</td>
</tr>
<tr>
<td>phosphate</td>
<td>Follow-up if supplemented</td>
<td>Daily</td>
</tr>
<tr>
<td></td>
<td>Follow-up in gastrointestinal loss</td>
<td>Daily</td>
</tr>
<tr>
<td></td>
<td>Steady state after resolution of deficiency or RFS</td>
<td>Twice weekly</td>
</tr>
<tr>
<td>Ionised calcium</td>
<td>At the beginning of supplementation</td>
<td>Daily</td>
</tr>
<tr>
<td></td>
<td>Under established supplementation</td>
<td>Weekly</td>
</tr>
<tr>
<td>Glucose</td>
<td>Treatment control in diabetics</td>
<td>3–6 × daily</td>
</tr>
<tr>
<td></td>
<td>Screening under EN and PN</td>
<td>Daily at start and after dose adjustment</td>
</tr>
</tbody>
</table>
tritional support [44]. It commonly occurs with all types of nutritional support, but the risk is higher in patients receiving enteral or parenteral nutrition [45]. Clinically, RFS may present as a mild form with almost no clinical signs and no risk to the patient, or as more severe forms causing clinical deterioration, including sudden cardiac death [46]. In patients with a high risk of developing RFS, daily monitoring of electrolytes is recommended, at least during the first 2–4 days following initiation of nutritional support or relevant dose adjustments of enteral and parenteral nutrition. Additionally, physical examination focusing on balance of fluids and a daily electrocardiogram in high-risk situations should be performed. RFS can be prevented by low levels of energy administration during the first phase of feeding and a slow progression of dose adjustments. Recently, a clinical practice guideline (consensus paper) has been published discussing risk assessment, prevention, treatment and monitoring of patients with RFS in more detail [28].

Summary and outlook

Until recently, interventional research proving that nutritional support improves clinical outcomes has been lacking. There have been several publications on the beneficial aspects of nutritional interventions, which showed improvement of nutritional parameters and quality of life, but did not evaluate the influence on overall survival [47]. Recent high-quality trials such as the NOURISH and the EFFORT trials have provided important new evidence linking nutritional support to better clinical outcomes in terms of reduction of mortality and severe complications, as well as functional outcomes and quality of life [48–50]. The results strongly support the systematic screening for malnutrition of medical inpatients followed by nutritional assessment and initiation of individualised nutritional support in patients at risk. These recommendations are also supported by a recent systematic review and meta-analysis demonstrating a 25% reduction in mortality and hospital readmission in patients receiving nutritional support [51]. It is now time to consider nutrition as a medical treatment to complement organ and disease-specific therapies.

Algorithm-guided clinical decision making for nutritional support is the backbone of an evidence-based nutritional strategy. It facilitates the management of individual patients on the ward, enables consistency of nutritional strategies within a clinic and improves harmonisation of nutritional strategies between clinics. This will potentially lead to enhanced comparability and better conditions for further research, which is urgently needed in order to maximise efficacy, minimise side effects and reduce the cost of nutritional support. In-hospital management of nutritional therapy may also be time-consuming than its preservation, early interventions aimed at prevention are important. In patients already experiencing significant muscle loss, nutritional therapy (as well as guided exercise during hospitalisation) might not be enough to rebuild muscle mass. Subsequent out-patient programmes to optimise nutritional status and encourage lean body mass gain could become part of the comprehensive management of malnourished patients in the near future. There are several small outpatient studies that demonstrated the benefit of hHMB on the build-up of lean muscle mass [57, 58]. These results, however, must be confirmed by larger trials before they can be accepted as general recommendations.

Finally, further personalisation of the above-mentioned general nutritional strategy will be necessary to maximise the effect of nutritional interventions and exercise. The term “personalised” highlights the fact that not all patients respond in the same way to medical interventions. Whether or not a patient benefits at any given point in time from nutritional therapy and exercise may be affected by illness-specific (e.g., comorbidities, inflammation, oxidative stress) or patient-specific factors (e.g., age, sex, genetic predisposition). The field of metabolomic research presents a promising new approach to personalise interventions based on metabolic clusters and specific patient phenotypes.

Disclosure statement

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Page 8 of 9

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