



Nuove proposte per le schede di valutazione -Screening nutrizionale –

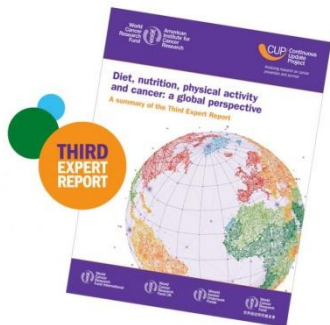
Andrea Pezzana
SC Nutrizione Clinica
ASL Città di Torino



1997



2007



THIRD
EXPERT
REPORT

LIMIT CONSUMPTION
OF RED AND
PROCESSED MEAT



LIMIT CONSUMPTION
OF SUGAR
SWEETENED DRINKS



LIMIT ALCOHOL
CONSUMPTION



DO NOT USE
SUPPLEMENTS
FOR CANCER
PREVENTION



FOR MOTHERS:
BREASTFEED YOUR
BABY, IF YOU CAN



AFTER A CANCER
DIAGNOSIS: FOLLOW OUR
RECOMMENDATIONS,
IF YOU CAN



LIMIT CONSUMPTION
OF 'FAST FOODS' AND
OTHER PROCESSED
FOODS HIGH IN FAT,
STARCHES OR SUGARS



EAT A DIET RICH
IN WHOLEGRAINS,
VEGETABLES,
FRUIT AND BEANS



BE PHYSICALLY
ACTIVE



BE A
HEALTHY WEIGHT



World
Cancer
Research
Fund International

OUR CANCER PREVENTION RECOMMENDATIONS

Not smoking and avoiding other exposure to tobacco and excess sun are also important in reducing cancer risk. Following these Recommendations is likely to reduce intakes of salt, saturated and trans fats, which together will help prevent other non-communicable diseases.

wcrf.org

The Skeleton in the Hospital Closet

As awareness of the role of nutrition in recovery from disease increases, physicians are becoming alarmed by the frequency with which patients in our hospitals are being malnourished and even starved. One authority regards physician-induced malnutrition as one of the most serious nutritional problems of our time.

by CHARLES E. BUTTERWORTH, Jr., M.D.



In recent years there has been growing concern over the rapidly mounting costs of hospitalization. In 1968, for example, short- and long-term hospital care costs were \$20,751,000,000 in a total national health expenditure of \$57,103,000,000, according to the Office of Research and Statistics of the Social Security Administration. Obviously, enormous savings could be achieved if hospital stays could be shortened by even a day, or prevented altogether. Under these circumstances it seems strange that so little attention has been paid to the essential role of good nutrition in the maintenance of health, and particularly in recovery from acute illness or injury. Stranger still, however, is how frequently one sees the hospital stay prolonged and the patients' suffering made worse by what we are now recognizing as frank mismanagement, if not downright neglect, of the patients' nutritional health in our hospitals.

I am convinced that iatrogenic malnutrition has become a significant factor in determining the outcome of illness for many patients. [Since "iatrogenic" is merely a euphemism for "physician-induced," perhaps it would

Dr. Butterworth is Professor of Medicine and Pediatrics and Director of the Nutrition Program at the University of Alabama in Birmingham. He is also Chairman of the Council on Foods and Nutrition of the American Medical Association.

be better to speak forthrightly and refer to the condition as "physician-induced malnutrition." I suspect, as a matter of fact, that one of the largest pockets of unrecognized malnutrition in America, and Canada, too, exists, not in rural shacks or urban ghettos, but in the private rooms and wards of big city hospitals.

Having patients in our hospitals who are malnourished or starving only because they are there may be nothing new. Perhaps it has always been so. Perhaps it's getting worse because of the rapid depersonalization of patient care. One thing seems certain, and that is that any physician who can recognize the signs and symptoms of malnutrition and starvation will have plenty to observe if he'll look around any large, city hospital.

Surely, the general public, most physicians, dietitians, nurses and others involved in patient care share the conviction that when a sick person commits himself to the total, unquestioning care of his doctor, his nutritional health, at least, should be assured. Entering a hospital and placing oneself in the hands of doctors engenders a feeling of security akin to that experienced by a fugitive when he reached the sanctuary of the cathedral doors in legendary times. Certainly one doesn't expect to suffer because of the experience. Yet, there is evidence that many people do, as I will show shortly with case histories.

I believe that we are beginning to

see the inevitable consequences of the neglect of nutrition education in our medical schools. While the principles of good nutrition are practiced in some institutions and by some individuals, this seems to be the exception rather than the rule. It is, therefore, fallacious for either the public or the medical fraternity to assume that good nutrition is automatically provided to hospitalized patients in this country.

I find this situation particularly tragic in the face of the technological advances that have been made in some highly specialized areas of medical, nursing, and dietetic care. It is well known, for example, that malnutrition interferes with wound healing and increases susceptibility to infection. It thus becomes imperative to ensure that preventable malnutrition does not contribute to the mortality, morbidity, and prolonged bed-occupancy rates of our hospital population. So it's time to swing open the door and have a look at this skeleton in the hospital closet.

During the last several years I have been involved in the training of medical students and house officers, as well as in the evaluation and care of hospitalized patients. This has given me the opportunity to observe the actual practices as they are carried out under a physician's orders. Some of the patients I observed were desperately ill with complicated illnesses, others had relatively minor or straightforward problems. I have been concerned that not enough attention is being given to

Strumenti



PERCORSO NUTRIZIONALE



SCREENING

Identificare i
soggetti a rischio di
malnutrizione

Utilizzare test
validati

NRS 2002, MUST,
MNA, SGA

VALUTAZIONE NUTRIZIONALE

Gravità della
malnutrizione

- Dati anamnestici,
esame clinico.
- Introiti alimentari
- Antropometria
- Parametri biumorali
- Parametri funzionali

SUPPORTO NUTRIZIONALE E MONITORAGGIO

Modificazioni dietetiche
Integratori alimentari
Nutrizione artificiale

Monitoraggio
nutrizionale

The Management of the Patient with Malnutrition: From Evidence to Clinical Practice

- Screening
- Assessment
- Intervention
- Malnutrition in patients at higher risk:

Poggiano MR, 2017



Comparison of five malnutrition screening tools in one hospital inpatient sample

Floor Neelemaat, Judith Meijers, Hinke Kruiuzenga, Hanne van Ballegooijen and Marian van Bokhorst-de van der Schueren

Aims and objectives. The purpose of this study is to compare five commonly used malnutrition screening tools against an acknowledged definition of malnutrition in one hospital inpatient sample.

Background. Early identification and intervention of malnutrition in hospital patients may prevent later complications. Several screening tools have reported their diagnostic accuracy, but the criterion validity of these tools is unknown.

Design. A cross-sectional study.

Methods. We compared quick-and-easy screening tools [Malnutrition Screening Tool (MST), Short Nutritional Assessment Questionnaire (SNAQ) and Mini-Nutritional Assessment Short Form (MNA-SF)] and more comprehensive malnutrition screening tools [Malnutrition Universal Screening Tool (MUST) and Nutritional Risk Screening 2002 (NRS-2002)] to an acknowledged definition of malnutrition (including low Body Mass Index and unintentional weight loss) in one sample of 275 adult hospital inpatients. Sensitivity, specificity, positive predictive value and negative predictive value were determined. A sensitivity and specificity of $\geq 70\%$ was set as a prerequisite for adequate performance of a screening tool.

Results. According to the acknowledged definition of malnutrition 5% of patients were at moderate risk of malnutrition and 25% were at severe risk. The comprehensive malnutrition screening tools (MUST, NRS-2002) and the quick-and-easy malnutrition screening tools (MST and SNAQ) showed sensitivities and specificities of $\geq 70\%$. However, 47% of data were missing on the MUST questionnaire and 41% were missing on MNA-SF. The MNA-SF showed excellent sensitivity, but poor specificity for the older subpopulation.

Conclusions. The quick-and-easy malnutrition screening tools (MST and SNAQ) are suitable for use in an hospital inpatient setting. They performed as well as the comprehensive malnutrition screening tools (MUST and NRS-2002) on criterion validity. However, MUST was found to be less applicable due to the high rate of missing values. The MNA-SF appeared to be not useful because of its low specificity.

Relevance to clinical practice. Insight in what is the most valid and practical nutritional screening tool to use in hospital practice will increase effective recognition and treatment of malnutrition.

Key words: malnutrition, nurses, nursing, nutrition, older people, screening



Ministero della Salute

LINEE DI INDIRIZZO
PERCORSI NUTRIZIONALI
NEI PAZIENTI ONCOLOGICI

GRUPPO DI LAVORO

Giuseppe Ruocco, Adriana Bonifacino, Roberto Copparoni,
Denise Giacomini, Andrea Lenzi, Paolo Marchetti,
Silvia Migliaccio, Giuseppe Plutino

1. RAZIONALE
2. INTRODUZIONE
3. OBIETTIVI DEL DOCUMENTO
4. SCREENING NUTRIZIONALE DEL PAZIENTE ONCOLOGICO
5. LA RISPOSTA ORGANIZZATIVA ATTRAVERSO UN PERCORSO INTEGRATO PER UN PROGRAMMA NUTRIZIONALE PERSONALIZZATO E INTEGRATO AL TRATTAMENTO ONCOLOGICO
6. FORMAZIONE ED INFORMAZIONE AGLI OPERATORI SANITARI
7. *APPENDICE: LA NUTRIZIONE ARTIFICIALE*
8. *APPROFONDIMENTO: IL MICROBIOMA*

Come siamo arrivati al MST ?

- Gruppo di medici e dietisti in staff alla Direzione Rete Oncologica
- Utilizzo di 2 test accreditati in parallelo (SNAQ e MST)
- Analisi dei dati
- Scelta condivisa

1. Have you lost weight recently without trying?	
No	0
Unsure	2
If Yes, how much weight (kg) have you lost?	
1 – 5	1
6 – 10	2
11 – 15	3
> 15	4
Unsure	2
Weight Loss Score: <input type="text"/>	
2. Have you been eating poorly because of a decreased appetite?	
No	0
Yes	1
Appetite Score: <input type="text"/>	
Total MST Score (weight loss + appetite scores) <input type="text"/>	



Oncology Evidence-Based Nutrition Practice Guideline for Adults

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Editor's note: [Figure 4](#) and [Tables 1, 2, 3, and 4](#) that accompany this article are available online at www.andjnl.org.

CANCER IS A TERM USED TO describe a group of more than 100 multifactorial diseases in which abnormal cells reproduce in an uncontrolled manner and are able to spread to other parts of the body and invade healthy tissues.¹ Numbers of cancer-related deaths have fallen steadily since the 1990s, and the number of cancer survivors has increased.² The National Cancer Institute has estimated that 1,685,210 new cases will be diagnosed and 595,690 deaths will occur in 2016.² Cancers develop from complex interactions between genes and the environment.³ Although many of the specific pathways by which nutritional status can impact cancer remain poorly un-

derstood,⁴ it is well recognized that nutrition plays important roles in cancer prevention and treatment.⁴⁻⁸

In 2007, the Academy of Nutrition and Dietetics (Academy) published guideline recommendations on the Evidence Analysis Library (EAL) related to nutrition interventions for specific types of cancer and cancer treatments. In 2010, a new evidence analysis workgroup was formed to supplement the original guideline, which was subsequently published on the EAL during November 2013. The current guideline focuses on comprehensive oncology nutrition practice for the care of adult patients with cancer. Although the recommendations are written for registered dietitian nutritionists (RDNs), others may find them helpful.

The guideline developed by the workgroup will be reviewed, beginning with the recommendations that are based on the related EAL systematic review, followed by a brief review of recommendations based on organization guidelines outside of the Academy.⁹⁻¹¹ The latter were included to further expand the scope of the evidence-based recommendations. Finally, a brief review of the consensus-based recommendations will be provided to further guide the RDN, where there is less nutrition research or the research is difficult to elucidate.

DEVELOPMENT OF CONCLUSION STATEMENTS AND RECOMMENDATIONS

The Academy's 5-step systematic review process¹² was followed throughout the project. The Oncology Workgroup chose to principally target four areas of oncology nutrition in adults where there was an adequate pool of evidence related to nutritional status and nutrition interventions:

- validity of malnutrition screening and nutrition assessment tools;
- the association among nutritional status and morbidity and mortality outcomes;
- the effect of medical nutrition therapy (MNT)¹³ on patients undergoing chemotherapy (CT) and radiation treatment (RT); and
- cancer cachexia and the effect of dietary supplements and medical food supplements (MFS) containing fish oil (specifically eicosapentaenoic acid [EPA]), on body weight and lean body mass (LBM).

A comprehensive literature search was conducted using PubMed and Cumulative Index to Nursing and Allied Health Literature databases, with search inclusion dates 1993 to 2011. For the final questions on fish oil, search inclusion dates were 1990 to 2013 to adequately evaluate the body of literature on this topic. Additional articles were identified by hand searching reference lists from pertinent review articles. [Figure 1](#) shows the criteria applied to the inclusion and exclusion of studies for each question. [Figure 2](#) illustrates the search strategy and study selection process.¹⁴ A total of 102 primary research articles were included in the final analysis.

Following the research analysis, conclusion statements were written and the strength of the evidence was graded by the workgroup based on quality, consistency, sample size, clinical impact, and generalizability of the studies. Full conclusion statements are found on the EAL (www.andeal.org). Conclusion statements were graded as I (Good/strong), II (Fair), III (Limited/weak), IV (Expert

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Review

ESPEN expert group recommendations for action against cancer-related malnutrition

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¹NC=Nutriólogo Certificado (the credential for licensed nutritionists in Mexico).

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REVIEW

Cancer wasting and quality of life react to early individualized nutritional counselling! ☆

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KEYWORDS

Cancer;
Nutritional
counselling;
Diet;
Nutritional status;
Morbidity;
Quality of life

Summary

To devise a meaningful nutritional therapy in cancer, a greater understanding of nutritional dimensions as well as patients' expectations and disease impact is essential. We have shown that nutritional deterioration in patients with gastrointestinal and head and neck cancer was multifactorial and mainly determined by the tumour burden and location. In a larger cohort, stage and location were yet again the major determinants of patients' quality of life (QoL), despite the fact that nutritional deterioration combined with intake deficits were functionally more relevant than cancer stage. Based on this framework, the potential role of integrated oral nutritional support on outcomes was investigated. In a pilot study using individualized nutritional counselling on a heterogeneous patient population, the achieved improvement of nutritional intake was proportional to a better