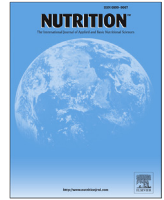
Nutrition 31 (2015) 598–602

Contents lists available at ScienceDirect

Nutrition

journal homepage: www.nutritionjrnl.com



Special article

Nutritional support of the elderly cancer patient: The role of the nurse

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A R T I C L E I N F O

Article history:
Received 20 November 2014
Accepted 23 December 2014

Keywords:
Nutritional care
Cancer
Elderly
Education and training
Nurse

A B S T R A C T

Cancer in the geriatric population is a growing problem. Malnutrition is common in cancer. A number of factors increase the risk for malnutrition in older people with cancer, including chronic comorbid conditions and normal physiological changes of aging. Nurses have an important role in the nutritional support of older cancer patients. To contribute to the improvement of nutritional support of these patients, nurses need appropriate training to be able to identify risk for malnutrition and offer a range of interventions tailored to individual need. Factors to consider in tailoring interventions include disease status, cancer site, cancer treatment, comorbidity, physiological age, method of facilitating dietary change, and family support. This article identifies ways in which nurses can contribute to the nutritional support of older cancer patients and thus help mitigate the effects of malnutrition.

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Introduction

Cancer in older people is a growing problem. In almost every country, the proportion of individuals aged >60 y is growing faster than any other age group and is forecast to reach 2 billion by 2050 [1]. Cancer is primarily a disease of older people [2]. It is estimated that by 2050 in the United States, 42% of the cancer population will be $\geq$ 75 y [3]. Currently, in the United Kingdom, 63% cancers are diagnosed in people ages $\geq$65 [2].

The prevalence of malnutrition in cancer patients is reported to range from 33% to 85%, depending on cancer site and stage of disease [4]. Malnourishment is associated with poor clinical outcomes that include greater morbidity and mortality, reduced quality of life, and increases in hospitalization and hospital length of stay [5]. A number of factors increase the risk for malnutrition in older people with cancer. These include chronic comorbid conditions and normal physiological changes of aging that can have a negative affect on nutritional intake, such as functional impairment, poor sight, and loss of taste.

Nurses are an important interface between patients and health services. All patients meet nurses across their cancer journey. Nurses have an important role to play in the nutritional support of older cancer patients. This article identifies ways in which nurses can contribute to the nutritional support of these patients and thus help mitigate the effects of malnutrition.

To enable nurses to provide nutritional support, they must be able to use indicators of nutrition risk and act on them appropriately.

Using indicators of nutrition risk

Tools have been designed and validated to identify individuals with cancer who are malnourished, or at risk for malnutrition. These screening tools are used to grade or score nutritional status. The grade or score is then used to inform clinical intervention.

The Patient-Generated Subjective Global Assessment [6], the Mini Nutritional Assessment (MNA) [7], and the Malnutrition Universal Screening Tool [8] are examples of screening tools validated in cancer patients. These tools have been designed to provide a simple and rapid assessment of nutritional status. MNA has been designed specifically for older cancer patients. Each tool combines information on indicators of nutrition risk, such as involuntary weight loss, poor food intake, low body mass index, acute illness, symptoms that affect food intake (e.g., nausea) and distress, to identify patients who may benefit from nutritional support.

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http://dx.doi.org/10.1016/j.nut.2014.12.013
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It should be remembered that nutritional risk indicators in older cancer patients, such as involuntary weight loss, could be caused by many factors. Some, but not all, factors are cancer-related.

First, a nutritional risk indicator may not be caused by undernutrition, but rather by cancer cachexia syndrome. It would thus be a consequence of tumor-induced metabolic change, which is more likely with some cancers such as pancreatic cancer.

A second reason for a nutritional risk indicator can be the cancer treatment. For example, systemic chemotherapy can cause nausea that affects food intake.

Alternatively, nutritional risk indicators in older cancer patients can be the consequence of the normal aging process. In the geriatric population, there is a propensity for unintentional weight loss and a protein-deficient diet [9], in part because of age-related changes such as changes in taste. Other significant age-related changes include the loss of cognitive function and deteriorating vision, all of which hinder good health and dietary habits in this age group [10]. It is important to remember that physiological age differs from chronologic age; “as people grow old, the probability of important losses of function increases, but the ageing process remains highly individual” [11]. It is a mistake to assume that someone of a certain age actually has a problem that is associated with age, such as loss of appetite.

Finally, it is likely than older people with cancer will also have comorbid conditions common in the age group and impacting nutritional status, such a depression. Indicators of nutrition risk can thus have different underlying causes.

Existing standards and protocols for nutritional care may not be appropriate for those with palliative care needs, when disease is the most likely cause of any identified nutritional risk. In this situation, wider issues need to be taken into account to address the patient’s psychological and social malnutrition [12]. It is difficult to make judgments about the likelihood of nutritional intervention having benefit in patients with incurable disease. One approach is for the judgment to be a multidisciplinary team decision, based on discussion and consensus agreement [13].

Given the potential for multiple causes of nutritional risk in older cancer patients, many of which cannot be identified using a tool that screens for risk of malnutrition or actual malnutrition, an alternative approach should perhaps be considered. The comprehensive geriatric assessment (CGA) is one possibility. The CGA typically includes assessment of nutritional status but also assesses for a wide range of other factors that can affect nutritional status, such as frailty and polypharmacy. Knowledge from both geriatrics and oncology may be needed to provide appropriate nutritional support to older cancer patients [14]. Recognition of the need for other members of the health care team to contribute to the nutritional support of the older cancer patient is an important nursing role. Most often, this would be identification of a need to refer the patient to a specialist dietitian. However, it also could include consideration of involving other allied health care professionals and/or experts from other fields, such as gerontology.

In summary, indicators of nutritional risk that can alert nurses and the multidisciplinary teams of a need for nutritional support include:

- Low body mass index
- Evidence of involuntary weight loss
- Loss of appetite
- Changes to the experience of eating (e.g., changes in taste or to texture)
- Physical barriers to the act of eating (e.g., dysphasia or nausea)
- Barriers to the absorption of food (e.g., vomiting or diarrhea)
- Concern about eating expressed by the patient or family member
- Mental health barriers (e.g., depression or confusion)
- Exacerbating factors (e.g., frailty, medications, lack of social support, or poor dental health)

In clinical practice, it is difficult to know if indicators of malnutrition are due to age, disease, comorbidity, or undernutrition. Nutritional support is usually warranted to test if presenting problems are due to undernutrition and can therefore be arrested or reversed.

Nurse-supported interventions

Nurses can be trained to offer nutritional advice and this has been found acceptable to patients [15–17]. There is also evidence that supportive nutritional care offered by nurses can have a positive effect on patient behavior and health outcomes (Table 1). Randomized controlled trials have found nurse-delivered nutritional counseling to slow decline in performance status in cancer patients [18] (Dixon 1984) and to improve physical function and depression in patients with angina [19]. A Cochrane review found no evidence of nutritional advice from a nurse versus a dietitian being inferior in lowering blood cholesterol [20]. Nurse-delivered approaches found to have benefit include providing information and advice and involving family caregivers in the patient’s nutritional care.

Running alongside these approaches is a need to tailor interventions to each patient’s physiological, psychological, and social circumstances. The purposes of intervention may differ depending on whether the patient is undergoing curative treatment, palliative treatment, or is in a position of survivorship post-curative treatment. The primary purpose of an eating intervention delivered to a patient with advanced cancer might be to improve the patient’s quality of life. In this circumstance, the nutritional balance of food intake might be less important than helping the patient to identify what he or she can eat [21]. For a colorectal cancer patient receiving treatment, the goal should be improvement in nutritional status [22], whereas for a breast cancer survivor, the goal is to support a healthy diet and lifestyle that reduces the risk for recurrence and other morbidity [23]. What is appropriate support will thus differ according to disease stage, cancer site, and whether or not the person is receiving treatment. Intervention choices also should take into account available social support and the implications of comorbidity. Actions required by nurses also may include overcoming barriers that may prevent patients receiving adequate food and drink [24], such as frailty. Eating well with cancer and support for eating well is not the same for all cancer patients.

Information and advice

Nutritional counseling can be described as the use of education informed by psychological theory to facilitate changes in eating behavior. Its importance for people with cancer is to encourage optimal dietary intake to minimize nutritional risk, while taking into account individual circumstances, such as food preferences. Tailoring advice to individual patient need is an essential part of the process of facilitating dietary change. Consideration should be given to use of theory-based approaches to behavioral change to communicate nutritional information

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