

Nutritional Considerations in the Patient with Gastroparesis



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KEYWORDS

• Diet • Nutrition • Nutritional assessment • Enteral • Nutritional support

KEY POINTS

- Patients with gastroparesis (GP) are at high risk for nutritional compromise, not only because of chronic nausea and vomiting, which can result in poor intake, but also because of potential anatomic changes such as gastric resection or bypass.
- Target weight should be set for patient and intervention provided before a patient becomes severely malnourished.
- Use of parenteral nutrition (PN) should be reserved only for those patients who fail enteral feedings.

INTRODUCTION

A 57-year-old woman presents to the gastrointestinal (GI) clinic with myositis, poorly controlled diabetes mellitus (DM), nausea, vomiting, dehydration, and a 10-lb (4.5-kg) unintentional weight loss. GP is confirmed by gastric emptying study. Oral diet modification failed with continued nausea, vomiting, further weight loss, and aggravated glycemic control due to steroid therapy. On her third admission and a weight loss of 30 lb (210 to 180 lb [95.3 to 81.6 kg]), the decision was made to place a percutaneous endoscopic gastrostomy (PEG) with a jejunal extension (PEG/J) for enteral nutrition (EN), hydration, and medication delivery. Feedings went well initially in the hospital, but the patient continued to eat and drink after discharge when she felt better, resulting in 2 more admissions due to failed therapy and poor glycemic control. In an effort to give her some relief and keep her hospital free, the patient was strongly encouraged to stop eating and drinking anything other than a few ice chips, and she was miserable enough that she agreed. Tube feeding goals were met nocturnally, glycemic control improved, and she was discharged without readmission. She then followed up in GI nutrition clinic to ensure nutritional goals continued to be met.

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Gastroenterol Clin N Am 44 (2015) 83–95

<http://dx.doi.org/10.1016/j.gtc.2014.11.007>

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Gastroparesis

GP, defined as delayed gastric emptying for greater than 3 months, is documented by a delayed gastric emptying study in a patient devoid of mechanical or functional obstruction, can be profoundly incapacitating. This debilitating process alters one's ability to work, attend school, or carry out other normal daily activities. GP can affect the patient's emotional, mental, and social well-being, as well as the body's ability to function normally; basically, it compromises life.¹ Eating becomes a chore and is not pleasurable, and as a result, weight loss and compromised nutritional status are common in moderate to severe cases. Furthermore, in those with DM, glycemic control can become difficult.² The following outlines a practical approach to nutritional care of the patient with GP from nutritional assessment and oral dietary intervention to, finally, nutritional support.

NUTRITIONAL ASSESSMENT

Initial and ongoing nutritional assessment and intervention are critical aspects of care of the patient with GP.^{3,4} Thorough assessment distinguishes those patients who need simple dietary changes from those who are so malnourished that nutritional support is justified. For example, a patient who develops nausea while eating the usual 3 large meals per day may not require supplemental calories, but rather smaller, more frequent meals. In contrast, the patient with severe GP who has significant vomiting after intake of clear liquids may require gastric decompression and jejunal feeding to provide not only nutrients, fluids, and medications but also symptom relief.

Unintentional Weight Loss

Unintentional weight loss over time is one of the most basic yet undeniable indicators that a patient's nutritional status is in trouble.⁵ Comparing a current weight (once the patient has been rehydrated) with the patient's usual weight and documenting the percentage of total weight loss over time can stratify the degree of nutritional risk and help guide therapy. Use of an ideal body weight instead of a patient's actual weight is not recommended, as it may overestimate or underestimate the degree of nutritional risk.

Glycemic Control

In patients with DM, it is often difficult to sort out which came first, poor glucose control or GP. Regardless, good glycemic control (especially any wide swings in glucose control) is necessary for improving gastric emptying, nutrient utilization, and preventing catabolism.⁶ In addition, out-of-control DM may be the primary reason the patient is losing weight. Glycemic control can be monitored by patient glycemic records and periodic measurement of glycosylated hemoglobin (HbA1C) level.

Bowel Habits

Constipation can worsen the symptoms of GP, and chronic constipation may be a sign of a more generalized intestinal dysmotility.⁷ When practitioners justifiably pay so much attention to the upper gut in patients with chronic nausea and vomiting, they sometimes tend to overlook the lower tract; in fact, this author's experience is that while the gastroenterologist focuses on the GP, the primary care physician is taking care of the bowels, and sometimes their interventions are at odds with one another. For example, the addition of fiber bulking agents to help with constipation only exacerbates delayed gastric emptying. Identifying normal bowel habits is also important, particularly with inpatients who are on bed rest and perhaps pain medications,

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