SPECIAL HOSPITAL DIETS – DO WE REALLY NEED THEM?
Which are unnecessary, harmful, desirable?

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INDIVIDUAL REQUIREMENTS

- SERVES AS THE BASIS FOR:
  - Regular of general diets
  - Enteral feeding
  - Parenteral feeding
REGULAR OF GENERAL DIETS: serves as the basis for modified diets

- Modified in **nutrients**  •  Modified in **consistency**
  - Fiber
  - Fat
  - Proteïn
  - Carbohydrates
  - Sodium
  - ...
Hospitalized patients have a relatively high risk of malnutrition. While some of this problem may be related to factors such as preexisting malnutrition, lack of appetite, or inability to eat, it is not known to what degree clinically indicated restricted diets contribute to such deficiencies.
Nutritional content of hospital diets
(Wright JE, JAMA 2004)

The recommended energy intake for elderly individuals is 25-30 kcal/kg per day. The recommended energy intake for older individuals weighing 50-75 kg would be between 1250-2250 kcal/d.

Recommended protein intake is 1.0-1.5 g/kg per day. For older individuals weighing 50-75 kg, the recommended protein intake would be between 50-112.5 g/d.
Nutritional content of hospital diets
(Wright JE, JAMA 2004)

While the DRI for elderly individuals is 90 mg/d, research-supported recommendations for those ≥70 years range from 200–1000 mg/d for prevention, immune function, and collagen synthesis. The 200 mg/d intake level was used for this study.

Vitamin D is important for bone health, calcium absorption, and cell growth differentiation. In this study, we used the DRI, 15 μg/d, as the minimum intake necessary for elderly individuals.
Nutritional content of hospital diets
(Wright JE, JAMA 2004)

Elderly individuals should have a minimum of 1200 mg/d (the DRI) to maintain bone mineral density.²

The DRI for folate in elderly individuals is 400 μg/d, based on its role in preventing megaloblastic anemia and in metabolizing nucleic and amino acids, and on the amount needed to minimize homocysteine levels.²
Nutritional content of hospital diets
(Wright JE, JAMA 2004)

The DRI in elderly individuals is 11 mg/d. Older individuals may require a minimum of 12-15 mg/d for immune function.
HOSPITAL DIETS

• DO NOT COVER THE REQUIREMENTS IN GENERAL

• DO WE REALLY NEED THEM IN SPECIAL DISEASE STATES?
• Clinical evidence for lifestyle changes:
  – Stop smoking
  – Weight loss when necessary
  – A healthy and varied dietary intake, low in total fat, saturated fat and rich in fruit, vegetables and skimmed dairy products.
  – Include physical activity

• Clinical trial evidence supports the JNC-7 recommendations for dietary lifestyle modification for the prevention and treatment of high BP.

• These recommendations include:
  – The DASH dietary pattern
  – Reduced sodium intake (< 2400 mg)
  – Weight loss in the obese and overweight
  – Moderation of alcohol intake

• Goals of medical nutrition therapy that apply to all persons with diabetes:
  
  – Attain and maintain optimal metabolic outcomes
  – Prevent and treat the chronic complications of diabetes
  – Improve health through healthy food choices and physical activity
  – Address individual nutritional needs taking into consideration personal and cultural preferences and lifestyle while respecting the individual wishes and willingness to change.

- Carbohydrate and monounsaturated fat together should provide 60-70% of energy intake. However, the metabolic profile and need for weight loss should be considered when determining the monounsaturated fat content of the diet.

- Sucrose and sucrose-containing foods should be eaten in the context of a healthy diet.

- There is no evidence that usual protein intake (± 15 EN%) should be modified if renal function is normal.
Evidence-based nutrition principles and recommendations for the treatment and prevention of diabetes and related complications.  


- Individualized food/meal plans and intensive insulin regimens can provide flexibility for children and adolescents with diabetes to accommodate irregular meal times and schedules, varying appetite and varying activity levels.

- Nutrient requirements for children and adolescents with type 1 or type 2 diabetes appear to be similar to other same age children and adolescents.
ESPEN guidelines for nutrition in liver disease and transplantation: CONSENSUS STATEMENT 1997, Plauth et al.

- No evidence-based dietary guidelines!

**Recommendations**
- Energy/protein malnutrition: frequent
- Energy requirements: normal
- Protein requirements: elevated
- Attention for vitamins A, D, E, K, B₁, B₁₂, FA, B₆
- Zn, Se
- No alcohol
- Frequent Meals
Cholecystolithiasis.
VVKVM Consensus 2005. Ysebaert D.

- Identification predisposing factors
- No nutritional intervention studies.

No evidence based arguments for specific diet
• Diet in early phase of mild acute pancreatitis may be usefull; no evidence in chronic pancreatitis.

• No alcohol: most important for prevention.

• Acute severe pancreatitis: early jejunal enteral nutrition, when necessary in combination with parenteral nutrition.
Gastro-oesophageal reflux.
VVKVM Consensus 2005. Hiele M

- Diet is only of limited value
- Based on physiological data and epidemiological evidence
- Only limited clinical data
- Logical measures:
  - Decreased fat intake
  - Avoiding lying down after eating for 2-3 h
  - Avoid certain foods (chocolate, alcohol, peppermint, coffee, onions and garlic)
  - Avoid carbonated drinks
  - Avoid high caloric meals
  - Increase fiber intake.
- Treatment based on diet.

- Only few clinical studies: little evidence-based data.

- Clinical experience, physiopathological concepts.
Dumping: diet  VVKVM Consensus 2005. Hiele M.

- Frequent (6), small meals
- Replacement of simple sugars by complex CHO
- Less CHO and more protein and fat
- No lactose
- No drinking during meals
- Lying down after eating (especially after liquid meals)
- Soluble fibers (pectin, guar)
- Extra Iron, FA, B₁₂, Ca
- Cave B₁ deficiency with vomiting post-op
Ulcus, gastritis and complications. VVKVM Consensus 2005. Hiele M

No evidence for dietary restrictions!
Diverticulitis, colon cancer, diarrhea, obstipation. VVKVM Consensus 2005. Mana F.

• No evidence based dietary guidelines (restrictive).

• Evidence to promote a healthy, varied diet with enough dietary fiber and calcium.
GENERAL CONCLUSION

• In most disease states: little few evidence-based arguments for restrictive diets.

• The more restrictive a diet, the higher the risk for malnutrition in the long term.

• Changes in lifestyle, which includes a healthy and varied dietary pattern are very important in prevention and treatment of several diseases.