Malnutrition at the Time of Surgery Affects Negatively the Clinical Outcome of Critically Ill Patients with Gastrointestinal Cancer

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ABSTRACT

Introduction: Malnutrition is a frequent concomitant of surgical illness, especially in gastrointestinal cancer surgery. The aim of the study was to assess the prevalence of malnutrition in the GI cancer patients and its relation with clinical outcome. We also examined associations between the energy balance and clinical outcomes in these patients. Methods: Prospective study on 694 surgical patients treated in the ICU of the UHC of Tirana. Patients were divided into well-nourished and malnourished groups according to their nutritional status. Multiple regression analysis was used to analyze the effect of malnutrition and cumulated energy balance on clinical outcome. Results: The prevalence of pre-operative malnutrition was 65.3% for all surgical patients and 84.9% for gastrointestinal cancer patients. Malnutrition, as analyzed by a multivariate logistic regression model, is an independent risk factor for higher complications, infections, and mortality, longer stay in the ventilator and ICU. Also this model showed that cumulated energy balance correlated with infections, and mortality and was independently associated with the length ventilator and ICU stay. Conclusion: This study shows that malnutrition is a significant problem in surgical patients, especially in patients with gastrointestinal cancer. Malnutrition and cumulated energy deficit in gastro-intestinal surgery patients with malignancy is an independent risk factor on increased post-operative morbidity and mortality.

Key words: surgical critically ill, malign disease, nutritional status, cumulated energy deficit, morbidity, mortality.

1. INTRODUCTION

Malnutrition is a frequent concomitant of surgical illness. Studies have reported 40%-50% of surgical patients to be malnourished on admission to hospital (1, 2). There is a high incidence of malnutrition in hospitalized patients undergoing gastrointestinal surgery. Gastrointestinal patients, especially with underlying malignancy, are at high risk of developing malnutrition, and surgical stress can also accentuate this catabolic problem. Malnutrition can occur in gastrointestinal (GI) cancer due to increased metabolic demands, insufficient nutrient intake, or nutrient loss (3). Many patients with gastrointestinal cancers will require surgical intervention, which imposes further metabolic demands and compounds preexisting nutritional disorders. Patients who undergo gastrointestinal surgery are at risk of nutritional depletion from inadequate nutritional intake; both preoperatively and postoperatively, the stress of surgery and the subsequent increase in metabolic rate. If a gastrointestinal cancer patient requires surgery during treatment, their metabolic condition should be optimal at the time of intervention (3).

Studies reported that up to 40% of patients were malnourished at the time of their admission and the majority of these patients continued to be nutritionally depleted throughout their hospital course (2). In general, surgery-related causes of malnutrition are hypercatabolism, postoperative fasting, prolonged ileus, fistula, malabsorption syndrome, intestinal obstruction, and gastric atony (4). Malnutrition in hospitalized patients often goes unrecognized (5, 6).

It is important to identify these patients and be aware of nutritionally related complications which may occur. The deleterious role of malnutrition in hospitalized patients is widely recognized (7-9). Routine evaluation of nutritional status allows the identification of patients who are at risk of complications, particularly in the postoperative setting (10, 11). These patients should be targeted for specific nutritional support (12).

The aim of the study was to assess the prevalence of malnutrition in the GI cancer patients and its relation with clinical outcome. We also examined associations between the energy balance and clinical outcomes in these patients.

2. MATERIALS AND METHODS

2.1. Study design and patient population

A prospective cohort study in surgical patients with GI cancer admitted to the surgical and the medical intensive
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2.2. Demographic and medical information

Demographic and medical information including sex, age, date of ICU admission, ICU diagnosis, Acute Physiology and Chronic Health Evaluation (APACHE II) prognosis score (13), ICU discharge, mechanical ventilation, were collected.

2.3. Nutrition risk screening

Nutritional status before surgery was assessed according to Nutritional Risk Screening 2002 (14). It contains one scale to examine nutritional status (0-3 points) and one scale to assess potential changes in stress metabolism (0-3 points.) A total score ≥ 3 indicates that nutrition support should be initiated.

Patients were divided into well-nourished and malnourished groups, according to their nutritional status (NRS 2002 < 3, and NRS 2002 ≥ 3, respectively).

2.4. Nutritional data and calculations

Determination of energy requirements: As in our clinic is not available indirect calorimetry (15), and predictive equations often over- or underestimate requirements (16), energy target was set at 25 kcal/kg/day, as is recommended by ESPEN (17,18).

Energy delivery: total delivery includes energy from enteral and parenteral feeds, from non-nutritional sources (glucose and gluco-saline infusions used for drug dilution and fluid support).

Energy balance was calculated as energy delivery – energy target, on daily basis. Data were collected on the cumulated energy balance on discharge from ICU.

2.5. Complications, mortality and length of ventilator and ICU stay

Complications were defined to be the appearance of a disease condition in addition to the preexisting condition which motivated ICU admission, without a specific relationship between the two. Complications can be ICU-acquired infections (sepsis or systemic inflammatory response syndrome (19), pneumonia, urinary tract infection, central venous catheter sepsis, and wound infection) and other complications: post-operative, metabolic disorders and organ’s failure (by SOFA) (20). Length of ICU stay was measured in days, from the day of ICU admission to ICU to the time of discharge or death.

Data were collected prospectively to determine length of ventilator stay, ICU stay, rate of complications and mortality.

2.6. Statistical analysis

Data are presented as means, medians and ranges for numerical variables and as number or percentages for categorical variables. Linear and logistic regression was conducted to test the relation between the nutrition status and the clinical outcomes (length of ICU stay, length of ventilator stay, total complications, infectious complications and mortality). Also, this model was used to analyze the effect of cumulated energy balance on length of ICU stay, length of ventilator stay, total complications, infectious complications and mortality.

Statistical significance was considered at the level of p ≤ 0.05. All tests were two-tailed. SPSS 15.0 statistical package used to analyze the data.

3. RESULTS

A total of 694 post operative patients admitted to the ICU were studied. The mean age was 63.06 ± 14.63 years old (range: 18-91) with 54.5% (n = 378) being male. According to NRS 2002 the prevalence of malnutrition before surgery was 65.3% (n = 453). The mean APACHE II score was 17.13 ± 5.71 (range: 8-32). ICU length of stay was 8.44 ± 7.06 days (range: 4-62); Mechanical ventilation lasted 1.76 ± 3.75 days (range: 0-20). ICU mortality was 33.0% (n = 229).

25.8% of the patients (n = 179) were with malignant disease, their median age was 61.89 ± 12.2 years (range 26-82) and 58.7% of patients were men. 152 patients (84.9%) were with malnutrition before surgery (figure 1). Prevalence of malnutrition was higher in the surgical patients with malignancy than in patients without malignancy (84.91% vs. 57.28% respectively, p < 0.0001.

Risk factor for malnutrition in the gastrointestinal surgical patients

Presence of malignancy, as analyzed by logistic regression model, is an independent risk factor on malnutrition: OR = 3.28; 95% CI 2.14 – 5.02; p < 0.0001.

Average age was significantly higher in those with malnutrition compared to those without (64.93 ± 13.87 and 59.68 ± 15.37, respectively). As analyzed by logistic regression model, age ≥ 65 years is an independent risk factor on malnutrition: OR = 1.50; 95% CI: 1.10-2.05; p = 0.01.

Presence of APACHE II score ≥ 15, as analyzed by logistic regression model, is an independent risk factor on malnutrition: OR = 2.18; 95% CI 1.58 – 3.01; p < 0.0001.

Severely ill, elderly patients who underwent surgery for gastrointestinal malignancy are a group of patients particularly in risk for malnutrition. Malnutrition was not related to the type of hospital admission (emergency or elective) or to the gender.

No one of the patients did receive nutritional support at least one week before surgery; no one did receive immunonutrition in perioperative period, as is commonly recommended in recent guidelines.

Effects of malnutrition and cumulated energy balance on the post-operative outcome of gastrointestinal surgical patients with malignancy

![Figure 1. Prevalence of malnutrition according to the presence of malignant disease](image)
Malnutrition in gastrointestinal surgical patients with malignancy, as analyzed by a multivariate logistic regression model, is an independent risk factor for higher complications: OR = 6.07, 95% CI: 4.27-8.64, P < 0.0001, higher nosocomial infections: OR = 3.14, 95% CI: 2.13-4.64, P < 0.0001, increased mortality: OR = 2.08, 95% CI: 1.44-2.99; P < 0.0001, longer stay in the mechanical ventilation: F = 29.96, P < 0.001 and longer ICU stay F = 24.54, P < 0.001.

All the patients had a negative energy balance at the end of their ICU stay [( - 9062.01) ± (- 4856.17) kcal]. The regression analysis identified cumulated energy deficits during the ICU stay as being independently associated with infectious complications (OR = 2.98, 95% CI: 2.42-3.68, P < 0.0001), and with mortality (OR = 1.43, 95% CI: 1.22-1.69, P < 0.0001). Energy deficit during the ICU stay correlated with ICU length of stay: F = 695.49, P < 0.001; and the length of stay on mechanical ventilation: F = 108.06, P < 0.001. It did not find any association of negative energy balance with the total number of complications (OR = 1.13, 95% CI: 0.97-1.32, P = 0.09).

4. DISCUSSION

Malnutrition is a common problem, affecting a high percentage of cancer patients, it is frequently observed in 60-85% of surgical patients with an upper gastrointestinal cancer (21). The prevalence of malnutrition in gastrointestinal surgical patients (65.3%) and in gastrointestinal cancer patients (84.9%) admitted to the intensive care unit confirms the severity of this problem in the Albanian clinical settings. Previously, the presence of cancer was reported as an independent risk factor for malnutrition (22), also in the present study we confirmed this correlation.

Elderly patients admitted to the ICU are an exception to the rule about the prevalence of malnutrition in the elderly patients was 68.87%. The prevalence of malnutrition in the present study is much higher, perhaps because we considered only surgical patients that stayed more than 24 hours in ICU, not all the patients admitted to the ICU.

Despite improved surgical techniques, post-surgical complications in gastrointestinal patients remain high. Surgery may be associated with complications, such as pain, asthenia, anorexia, and disorders in digestion processes, which interfere with a patient's normal intake patterns (24).

Numerous studies have clearly demonstrated that protein-calorie malnutrition is a significant risk factor of postoperative complications in patients undergoing major abdominal surgery or gastric cancer surgery (25-30). Our results do not differ from the results of other studies in gastrointestinal surgery about complications, including infectious complications (8,31-33).

Many reviews have highlighted the high prevalence of malnutrition in cancer patients and the relation with adverse effects on outcome (9, 34).

Our study supports the data that malnourished patients undergoing surgery have higher rates of morbidity and mortality as well as longer hospital stays compared with adequately nourished patients (31, 35).

Malnutrition is associated with poor tolerance to treatment, decreased quality of life, and increased health care costs (36). Patients with or at risk of malnutrition should receive the most appropriate nutritional support (3,12).

Our study documented low rates of “optimal” use of nutrition support in the surgical patients with malignancy. Furthermore, all the patients that received nutrition support were in negative balance at the end of their stay in the ICU.

Some factors that contributed in the inappropriate nutrition practice in our ICU were underestimation of energy requirements, delay in starting nutrition support and interruptions in parenteral or enteral feeding (37-39). The delayed/no nutrition support in these patients is consequence of depressed gastrointestinal activity during the first days after injury or surgery and the delay of restoration of organ function.

No one of the patients did receive nutritional support at least one week before surgery; no one did receive immunonutrition in perioperative period, as is commonly recommended in recent guidelines (12,40). The present study indicates that the gap between recommended nutrition care and practice regarding it still exists. Some recent studies had shown that infectious are a classical complication of malnutrition and underfeeding (41,42). The present study as other studies (41), confirms that negative energy balance cumulated during inadequate nutrition support was associated with a higher rate of infections, complications, mortality, and longer ICU stay.

5. CONCLUSION

This study shows that malnutrition is still a significant issue in hospitalized patients, it is a significant problem in

Figure 2. Length of post-operative intensive care stay (ICULOS) according to the nutritional status of surgical patients with malignancy.

In a study was found that 23–34% of elderly patients were malnourished at the time of admission to the medical or surgical ICU (23), in the present study the prevalence of malnutrition in the elderly patients was 68.87%. The prevalence of malnutrition in the present study is much higher, perhaps because we considered only surgical patients that stayed more than 24 hours in ICU, not all the patients admitted to the ICU.

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5. CONCLUSION

This study shows that malnutrition is still a significant issue in hospitalized patients, it is a significant problem in
surgical patients, especially in patients with malignancy treated in the ICU.

Malnutrition, particularly in gastro-intestinal cancer surgery patients, may cause ongoing energy deficits in the postoperative period, resulting in an increased risk of infectious complications and poorer clinical outcome. Poor nutritional status coupled with delayed and inadequate post-operative nutrition practices are associated with worse clinical outcomes. Our findings suggest the need for implementation of Nutritional Risk Screening and Guidelines for nutrition support in the perioperative period for the patients with GI malignancy.

CONFLICT OF INTEREST: NONE DECLARED

REFERENCES


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