A 71-YEAR-OLD FEMALE WITH PANCREATIC-DUODENECTOMY

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BACKGROUND

A 71 -year-old female who had undergone a pylorus preserving pancreatico-duodenectomy 4 years previously for pre-malignant disease. Since then she has experienced significant abdominal discomfort and change in bowel habit. She had been investigated for coeliac disease, bile acid malabsorption and small intestinal bacterial overgrowth. These tests were negative, but investigations had revealed gastroparesis, with an extensive build-up of partially digested food visible at endoscopy and a dilated stomach on CT scan. She did not have diabetes. She lived with her partner and was independent of activities of daily living.

She was due to undergo a revision of her gastro-jejunostomy with distal gastrectomy. She was referred to the dietitian for pre-operative nutritional support.

Her weight was 63kg (BMI 22.9 kg/m^2). Her weight was stable but she was unable to gain any weight. Her normal weight prior to her initial surgery was 79kg (20% weight loss over 4 years). She was persistently nauseated with severe reflux symptoms, and intermittently vomited. Initial oral intake was estimated at 280kcal, 14.5g protein (requirements 1890kcal; 94g protein).

RATIONALE AND USE OF PEPTISIP ENERGY HP

The dietetic aim was to optimise nutrition using a liquid diet to facilitate increased activity, and prevent any further weight loss in the build up to surgery. She was keen to avoid the insertion of a feeding tube, but the plan was in place, that should she lose any further weight she would be admitted for pre-operative naso-jejunal feeding.

The patient was only managing small volumes of liquid diet, and whilst this helped manage her nausea, she was struggling to take her pancreatic enzymes at appropriate times with these. She experienced erratic bowel habit with some loose pale stools and intermittent constipation. As it is not possible to accurately assess the absorption of the polymeric ONS, and given the limited time scale to surgery and the steady improvements needed, the decision to try a peptide ONS was made. She was weighed weekly and was making efforts to walk further and use the stairs several times per day.

RESULTS

After 3 weeks her oral intake had improved with the use of a blender (1432kcal, 48.1g protein), and the peptide ONS regime was reduced from 4 bottles to 2 per day. After 6 weeks of peptide ONS the patient had maintained her weight (63kg and 22.9 kg/m^2), and been able to increase her physical activity. Her bowel symptoms were well controlled, with no evidence of malabsorption and no constipation. She reported to be feeling stronger, and successfully underwent her surgery. She was fed via a naso-jejunal tube post operatively before being weaned back onto a soft diet with further use of peptide ONS until oral diet was adequate for this to be stopped.

SUMMARY

The use of a peptide ONS in this context facilitated the delivery of an energy and protein intake closer to her requirements, and whilst insufficient to achieve weight gain, they did facilitate increased physical activity as part of her improvement in fitness prior to surgery without the need for a naso-jejunal feeding tube.

Where rapid improvements are required in a short time period, such as in this case, the use of a peptide ONS maybe considered to reduce the potential for malabsorption, which would slow down the rate of nutritional progress.