4. Prise en charge nutritionnelle en contexte chirurgical

4.1. Évaluation du grade nutritionnel

Le risque nutritionnel peut être classé en trois catégories (cf. **Tableau 26**) (111).

Grade Nutritionnel 2 (GN 2)	Patient non dénutri
Grade Nutritionnel 3 (GN 3)	Patient dénutri et chirurgie sans risque élevé de morbidité
Grade Nutritionnel 4 (GN 4)	Patient dénutri et chirurgie à risque élevé de morbidité*

**La chirurgie thoracique (résection pulmonaire majeure) est considérée comme un acte à risque élevé de morbidité*

Tableau 26 – Stratification du risque nutritionnel

4.2. Nutrition pré-opératoire

Tout patient GN 2 ou 3 **doit probablement** bénéficier d'une prise en charge nutritionnelle pré-opératoire :

- Patients GN 2 : conseils diététiques et compléments nutritionnels.
- Patients GN 3 : compléments nutritionnels, nutrition entérale ou parentérale.

Tout patient GN 4 **doit** recevoir une assistance nutritionnelle pré-opératoire : nutrition entérale ou nutrition parentérale d'au moins 7 à 10 jours.

Chez la personne âgée, les stratégies nutritionnelles pré-opératoires sont les mêmes que chez le sujet plus jeune.

4.3. Nutrition dans la période post-opératoire

Il est recommandé de reprendre le plus rapidement possible, au cours des 24 premières heures post-opératoires, une alimentation orale, selon la tolérance du patient, sauf contre-indication chirurgicale.

- Chez les patients non dénutris (GN 2) :
  Si une assistance nutritionnelle post-opératoire est proposée, elle ne doit pas être inférieure à 7 jours.

Il **est recommandé** d'instaurer une assistance nutritionnelle quand le patient a des apports alimentaires post-opératoires inférieurs à 60% de ses besoins quotidiens depuis 7 jours.

- Chez les patients dénutris (GN 3 et 4) : Il faut instaurer, dès les 24 premières heures post-opératoires, un support nutritionnel.
  En chirurgie programmée non compliquée, il n'est probablement pas recommandé de prescrire systématiquement de la glutamine en péri-opératoire. Par contre, en cas de complications post-opératoires majeures, il est recommandé de prescrire de la glutamine par voie intraveineuse (en cas de nutrition parentérale exclusive), à forte dose (0,2 à 0,4 g/kg par jour soit 0,3 à 0,6 g/kg par jour de glutamine sous forme de dipeptide) (112).(Recommandations de bonnes pratiques cliniques sur la nutrition péri-opératoire. Actualisation 2010 de la conférence de consensus de 1994 sur la « Nutrition artificielle péri-opératoire en chirurgie programmée de l'adulte »).

Recommandations

- Les patients non dénutris (GN2) doivent probablement bénéficier d'une prise en charge nutritionnelle par conseils diététiques et compléments nutritionnels en pré-opératoire. Une assistance nutritionnelle post-opératoire d'une durée inférieure à 7 jours n'est pas recommandée. Il est recommandé d'instaurer une assistance nutritionnelle quand le patient a des apports alimentaires post-opératoires inférieurs à 60% de ses besoins quotidiens depuis 7 jours.
- Les patients dénutris et devant subir une chirurgie sans risque élevé de morbidité doivent probablement bénéficier de compléments nutritionnels, nutrition entérale ou parentérale (GN 3) en période pré-opératoire.
- Tout patient dénutri et devant subir une chirurgie avec risque élevé de morbidité (GN 4) doit recevoir une assistance nutritionnelle pré-opératoire (nutrition entérale ou nutrition parentérale) d'au moins 7 à 10 jours.
- Chez les patients dénutris (GN 3 et 4) il est recommandé d'instaurer dès les 24 premières heures post-opératoires, un support nutritionnel.

5. Prise en charge nutritionnelle en contexte de radiothérapie ou radio-chimiothérapie concomitante

En l'absence de dénutrition ou de toxicité œsophagienne limitant les apports nutritionnels par voie orale, une nutrition artificielle systématique n'est pas recommandée lors d'une radiothérapie thoracique (113).

6. Prise en charge nutritionnelle en contexte de chimiothérapie

Il est recommandé un conseil diététique personnalisé, intégrant, si nécessaire, la prescription de compléments nutritionnels oraux en cas de dénutrition et/ou de diminution des ingesta et/ou à la demande du patient ou de la famille.

7. Prise en charge nutritionnelle en situation de soins de support exclusif

7.1. Alimentation

A visée orexigène, une corticothérapie peut être prescrite en cure courte de 2 semaines à la dose de 0,5 à 1 mg d'équivalent prednisone/kg/jour, avec ré-évaluation et pour une durée maximale de 4 semaines.
De manière générale, la phase terminale d'une maladie grave s'accompagne le plus souvent d'une anorexie ou d'une satiété précoce. A l'inverse, les apports d'hydrates de carbone (sucres) interrompant le jeûne entraînent une sévère sensation de faim (114,115).
Dans cette situation, la nutrition artificielle doit être l'exception.

7.2. Hydratation

La sensation de soif est souvent liée à une sécheresse buccale et à une absence de déglutition. Les soins de bouche réguliers la soulagent (116).
Il n'existe aucun consensus quant au maintien ou non d'une hydratation dans ce contexte de fin de vie. En 2013, un essai randomisé a même montré qu'une hydratation parentérale au-delà de 500 cc / j, n'apportait aucun bénéfice pour le patient (117).

Recommandations

Dans les situations de fin de vie, le recours systématique à une hydratation parentérale (> 500 ml/j) n'est pas recommandé et la prescription doit être évaluée au cas par cas.
En situation de soins de support exclusifs, la nutrition artificielle doit être l'exception.

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