

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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