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 (109).

6. Prise en charge nutritionnelle en oncologie médicale hors contexte palliatif terminal.

Il est recommandé un conseil diététique personnalisé, intégrant, si nécessaire, la prescription de compléments nutritionnels oraux voire la mise en place d'une alimentation artificielle. Les apports recommandés sont de 30 à 35 kcal/kg/j et 1,2 à 1,5 g de protéines/kg/j avec un rapport calorique glucido-lipidique d'environ 60/40 (101).

L'activité physique est à promouvoir, elle est la seule mesure ayant fait la preuve d'une diminution de la fatigue (versus traitement médicamenteux) (110), de plus elle augmente la qualité de vie. En cancérologie une activité physique minimale d'endurance de 30minutes 5 fois par semaine, d'intensité moyenne à élevée est recommandée ainsi que du renforcement musculaire 2 fois/semaine, et de limiter les comportements sédentaires.

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

Alimentation :

Favoriser l'alimentation plaisir et proposer des compléments nutritionnels oraux. Limiter l'hydratation intra-veineuse à 500 ml/j (pourvoyeur d'oedèmes) et favoriser les soins bucaux contre la soif.
Une alimentation artificielle ne doit pas être débutée si l'espérance de vie est estimée à moins de 3mois ou si le Performans status est supérieur à 3.
Si une alimentation artificielle est déjà initiée, discuter de façon collégiale l'arrêt.
Le niveau de preuve des orexigènes (corticothérapie, mégestrol…) est insuffisant.

Recommandations

- 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.
- Les patients non dénutris (GN2) doivent probablement bénéficier d'une prise en charge nutritionnelle par conseils diététiques et compléments nutritionnels en pré-opératoire.
- En oncologie médicale : l'objectif est de viser à couvrir les besoins par des conseils diététiques +/- nutrition artificielle.
- Il faut encourager une activité physique adaptée.
- En situation de fin de vie, une nutrition artificielle ne doit pas être débutée. Il faut également limiter l'hydratation intra-veineuse.

8. Les moyens de prise en charge

8.1. Conseils hygiéno-diététiques

A proposer dans toutes les situations, particulièrement en cours de traitement anti néoplasique :

- Fractionner l'alimentation, manger ce qui fait plaisir, éviter le « forcing », enrichir par produits caloriques (fromages, crèmes.)
- Supprimer les régimes restrictifs.
- Proposer compléments nutritionnels oraux.

8.2. Nutrition artificielle :

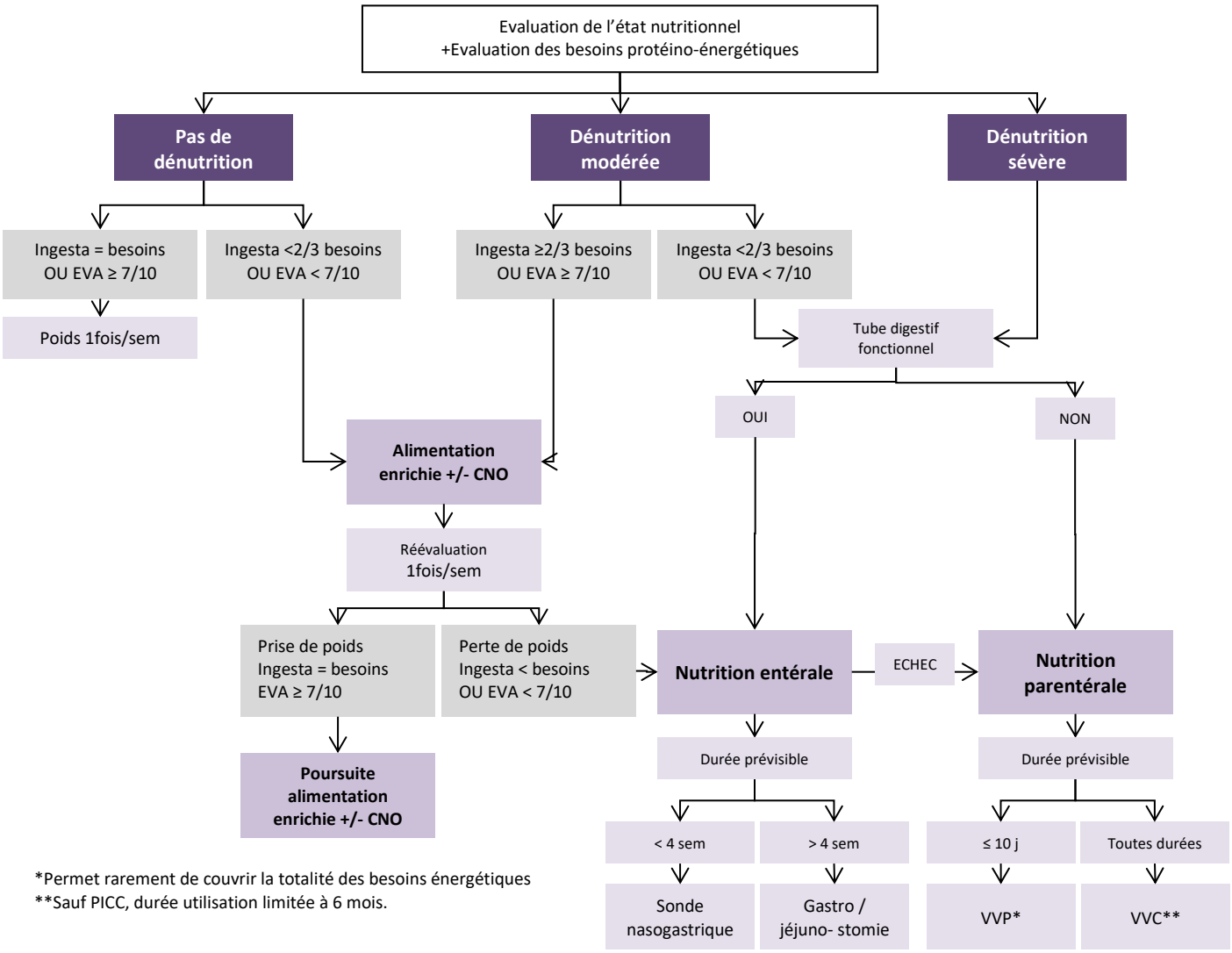

Figure 6 – Arbre décisionnel du soin nutritionnel de la SFNCM

Lors de la mise en place d'une nutrition artificielle chez un patient dénutri : supplémentation et surveillance ionique (phosphore ++) journalière et supplémentation systématique en vitamine B1 (prévention syndrome renutrition inapproprié)

- Nutrition entérale
  - La nutrition entérale est à privilégier si le tube digestif est fonctionnel, car moindre effets secondaires et favorise l'autonomie du patient.
  - Si risques d'inhalation ou vomissements : préférer un site jéjunal.
  - Si durée estimée > 4 semaines discuter gastrostomie percutanée.
  - Après une explication adéquate, le taux d'adhésion sont souvent élevés (111)
- Nutrition parentérale
  Compte tenu de ses risques métaboliques et infectieux, l'alimentation parentérale intraveineuse ne doit être réalisée **que dans des situations où l'alimentation entérale est contre indiquée**.
  A domicile obligatoirement par voie veineuse centrale.
  Prévention des infections de cathéter par verrous de taurolidine sont efficaces en prévention primaire et secondaire (112).

8.3 Régimes restrictifs et jeûnes

- Très utilisés, à la mode, beaucoup de confusion sur ces sujets. Peu avoués.
- A l'heure actuelle, les régimes restictifs (cétogène, hypocaloriques.) et jeûnes ne peuvent être promus. Ils majorent le risque de dénutrition et n'ont pas apporté leur preuve en prévention ou pendant un traitement contre le cancer. Les données expérimentales obtenues sur des modèles animaux apparaissent souvent hétérogènes et les données épidémiologiques et cliniques trop peu nombreuses (Tableau 27).

TYPE DE REGIME	ETUDES CHEZ L'ETRE HUMAIN		ETUDES CHEZ L'ANIMAL
	CLINIQUES	EPIDÉMIOLOGIQUES	
Jeune	Pas d'étude	Pas d'étude	+/-
Restriction Calorique	Pas d'etude sur l'incidence des tumeurs	Pas d'étude	+/-
Restriction Protéique	Pas d'étude	+/-	+/-
Restriction Glucidique / Régime Cétogène	Pas d'étude	Pas d'étude	+/-

+: effet favorable; -: effet délétère ou absence d'effet

Tableau 27 - Synthèse des résultats sur l'effet du jeûne et des régimes restrictifs en prévention des cancers. Rapport NaCRE 2017 (Extrait de : INCa, Fiche Repère Jeûne, régimes restrictifs et cancer[M]).

[M] INCa, Fiche Repère Jeûne, régimes restrictifs et cancer, disponible à https://www.e-cancer.fr/Actualites-et-evenements/Actualites/Fiche-reperes-Jeune-regimes-restrictifs-et-cancer (consulté le 02.01.2019)

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