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**) (107).

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) doit être considérée comme un acte à risque élevé de morbidité*

Tableau 26 – **Stratification du risque nutritionnel**

4.2 Nutrition pré-opératoire

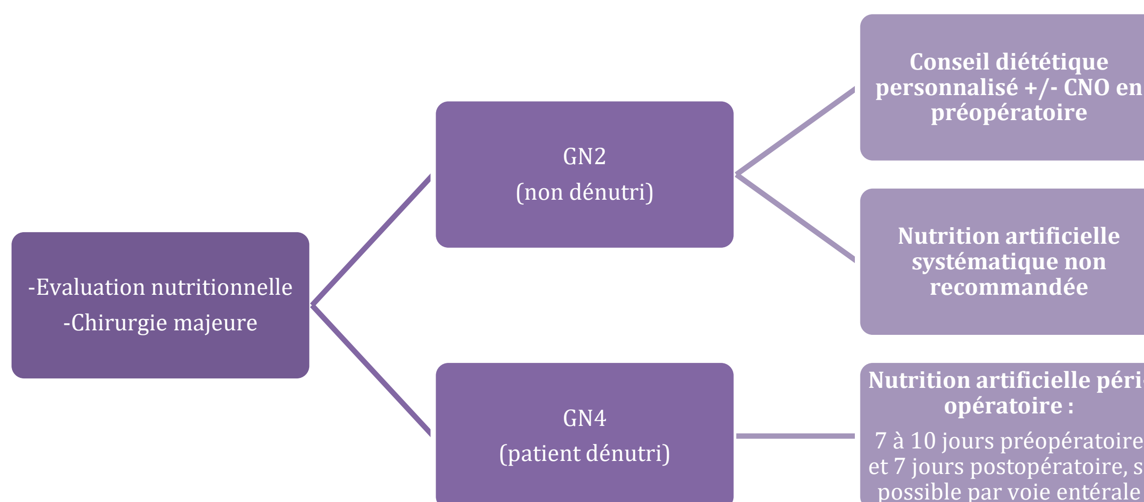

Figure 5 – Orientation en pré-opératoire

Les apports recommandés sont de 25 à 30 kcal/kg/jour dont 1,2 à 1,5 g de protéines /kg/jour (107). La pratique d'une activité physique ou un reconditionnement en périopératoire semblent avoir un impact sur la récupération en postopératoire, sur la diminution des complications et de la mortalité **(108).**

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.

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, et dès les 24 premières heures post-opératoires, si le patient est dénutri. Discuter la glutamine s'il existe des complications post opératoires majeures et si une nutrition parentérale est en cours.

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.

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