

COMMENTARY

Optimizing Nutrition Support in Cancer Care

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Abstract

Involvement of a multidisciplinary team in cancer care may have added benefits over the existing system of patient management. A paradigm shift in the current patient management would allow more focus on nutritional support, in addition to clinical care. Malnutrition, a common problem in cancer patients, needs special attention from the early days of cancer care to improve quality of life and treatment outcomes. Patient management teams with trained oncology dietitians may provide quality personalized nutritional care to cancer patients.

Keywords: Malnutrition - nutritional status - intervention - cancer care

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Introduction

The European Partnership Action Against Cancer consensus group in their recent policy statement anticipates the cancer care to undergo a paradigm shift from disease-focused management to a patient-centered approach (Borras et al., 2013). A multidisciplinary and holistic cancer care team of clinicians, nurses, nutritionists/dietitians, psychologists, physiotherapists and spiritual practitioners through their synchronized and congruent efforts may substantially raise the quality of cancer care processes, treatments and patient outcomes. As we aspire to improve the quality of present cancer care, the role of nutrition and the application in cancer care gains more attention.

Malnutrition is common in cancer patients and often considered as an indicator of poor treatment outcome and quality of life, morbidity and mortality (Van Cutsem and Arends, 2005). The tumor type, tumor location, stage of disease, and the treatments received determine the prevalence and severity of malnutrition in cancer patients. A higher prevalence of malnutrition is observed in patients with upper gastrointestinal cancer and lung cancer even at the time of diagnosis with a significant weight loss (Bruera and MacDonald, 1988). In addition, the empirical evidence from the routine clinical settings suggests that mild to moderate disease-related malnutrition exists in the newly diagnosed cancer patients. On the contrary, there has been a rise in the number of overweight and obese cancer patients. The present routine clinical settings focus primarily on the clinical management of the disease; nutritional screening and support at the time of diagnosis are frequently overlooked.

The benefits of nutritional screening and support include improved response to treatments, quality of life,

and morbidity (Paccagnella et al., 2011; Lis et al., 2012; Moon et al., 2013). In addition to the emphasis on optimum nutritional support for malnourished cancer patients, the timing of these personalized nutrition interventions is important. In the present scenario, especially in the developing country settings, majority of the referrals for nutritional support are provided to the severely malnourished cancer patients who are terminally ill or compromised. The nutrition interventions during this phase are challenging due to poor prognosis of the disease, thus, may provide limited benefits to the cancer patients. It is certain that the nutritional support should be provided to the malnourished cancer patients or patients who are at higher risk for malnutrition irrespective of stage at diagnosis, treatment modalities, time of introduction, and severity of the disease, however, evidence suggest marginal improvements in terms of quality of life and morbidity with limited effects on mortality.

Alternately, an early nutritional screening at the time of diagnosis and preemptive interventions to correct the existing malnutrition in patients have shown improved response to treatment, functional status, quality of life and reduced patient hospital stay and costs (Marin Caro et al., 2008). Further, introduction of intense, sustained and early nutritional therapy to address the disease-related malnutrition might improve the nutritional status over the time and yield better psychosocial and physical wellbeing to the patients. Although evidence on the effects of nutritional therapy on the cancer outcomes are limited, ensuring adequate or good nutritional status might improve the ability to tolerate the toxic effects of chemotherapeutic agents and to reduce the associated co-morbidities (Bozzetti et al., 2009). A person centered nutritional counseling and intervention that considers the disease stage and treatment modalities might enhance the

patient response to the clinical management. In addition, the progress in alternate feeding strategies, availability and access to quality nutritional supplements, and the evidence based nutritional intervention strategies might have a higher potential to support the cancer care and decrease the incidence of malnutrition among cancer patients.

With the advent of newer aggressive pharmacotherapies and treatment modalities, the nutritional support in the entire continuum of cancer care has become inevitable to improve the clinical outcomes and reduce mortality. The inclusion of trained oncology dietitians in the cancer care team from the time of diagnosis is important. The oncology dietitians will perform the nutritional screening using standard protocols to identify the existing malnutrition. Subsequently, the multidisciplinary team could discuss the nutritional support in light of various existing treatment modalities to reach a consensus on patient management. Such conscious and integrated efforts with other disciplines in the care of cancer patients will pave way for the holistic management of the disease with adequate support strategies to improve the treatment outcomes, morbidity and mortality.

Conclusion

In conclusion, nutrition support needs to be optimized in cancer care to provide more personalized and balanced care that address the existing malnutrition as early as at the time of diagnosis. Such an approach, with the inclusion of oncology dietitians in the multidisciplinary team for the patient management, will improve the quality of cancer care, treatment outcomes and quality of life

References

- Borras JM, Albrecht T, Audisio R, et al (2014). Policy statement on multidisciplinary cancer care. *Eur J Cancer*, **50**, 475-80.
- Bozzetti F, Arends J, Lundholm K, Micklewright A, Zurcher G, Muscaritoli M (2009). ESPEN Guidelines on Parenteral Nutrition: Non-surgical oncology. *Clinical Nutrition*, **28**, 445-54.
- Bruera E, MacDonald RN (1988). Nutrition in cancer patients: an update and review of our experience. Issues in symptom control. Part 3. *J Pain Symptom Manage*, **3**, 133-40.
- Lis CG, Gupta D, Lammersfeld CA, Markman M, Vashi PG (2012). Role of nutritional status in predicting quality of life outcomes in cancer a systematic review of the epidemiological literature. *Nutr J*, **11**, 27-45.
- Marín Caro MM, Gómez Candela C, Castillo Rabaneda R, et al (2008). Nutritional risk evaluation and establishment of nutritional support in oncology patients according to the protocol of the Spanish Nutrition and Cancer Group. *Nutr Hosp*, **23**, 458-68.
- Moon SH, Lee DT, Son Y (2013). Adherence to health-related lifestyle behavior recommendations and association with quality of life among cancer survivors and age-matched controls in Korea. *Asian Pac J Cancer Prev*, **14**, 2949-54.
- Paccagnella A, Morassutti I, Rosti G (2011). Nutritional intervention for improving treatment tolerance in cancer patients. *Curr Opin Oncol*, **23**, 322-30.
- Van Cutsem E, Arends J (2005). The causes and consequences of cancer-associated malnutrition. *Eur J Oncol Nurs*, **9**, 51-63.