Introduction

The Lung Cancer Nutritional Care Pathway (see page 6) is a practical guide for optimising the nutritional status of patients with lung cancer in order to maximise treatment outcomes. In the absence of a dedicated dietitian, the Pathway provides guidance to enable the multidisciplinary team (e.g. oncologist, radiographer, lung cancer clinical nurse specialist, oncology outpatient nurse, healthcare assistant and community healthcare professionals) to screen and monitor the nutritional status of patients throughout their journey.

Even if there are no apparent symptoms such as weight loss, poor appetite or muscle wasting, the Lung Cancer Nutritional Care Pathway recommends screening all patients at diagnosis to identify malnutrition risk and monitor those patients likely to become malnourished. Monitoring and regular reviews at each visit are recommended. Guidance is provided for patients at low risk, moderate risk and high risk of malnutrition, with recommendations for nutritional intake and appropriate nutritional support at all stages of the patient journey.

The Lung Cancer Nutritional Care Pathway was developed by a panel of healthcare professionals experienced in working with oncology patients, based on expert opinion and in accordance with the current evidence-base.

Lung cancer overview

Lung cancer is the second most common cancer in the UK accounting for 13% of all new cases\(^1\). In 2012 there were 35,371 deaths from lung cancer in the UK\(^2\). More than half of all people with lung cancer die within six months of the diagnosis\(^3\). Lung cancer currently accounts for 6% of all deaths in the UK and is the most common form of cancer death for both men and women\(^1\). In 2011 there were 43,463 new cases of lung cancer in the UK: 55% in men and 45% in women\(^2,4\).

The emergence of highly specialised treatments and new developments in different therapies to treat lung cancer contribute towards more patients having the opportunity to be treated with potentially curative therapies\(^5\). However, the impact of treatment together with unintentional weight loss, pain, sickness, changes in appetite and breathlessness all add to the decline in nutritional status of these patients.

There is a lack of studies relating specifically to nutrition and lung cancer but there is an acceptance that nutritional screening should be performed systematically, early and repeatedly.

Discussion panel

Dr Carrie Ashby | General Practitioner | Hampshire and RCGP GP Nutrition Group
Eileen Baldock  | Clinical Nurse Specialist | Sussex Cancer Centre | Royal Sussex County Hospital | Brighton
Mhairi Donald   | Macmillan Consultant Dietitian | Sussex Cancer Centre | Royal Sussex County Hospital | Brighton
Professor Rosemary Richardson | Dietitian and Researcher | Macmillan Scotland
Fiona Simmons   | Macmillan Dietitian | Heart of England NHS Foundation Trust | Heartlands Hospital | Birmingham
Maureen Thomson | Consultant Radiographer | Beatson West of Scotland Cancer Centre | Glasgow

Contributors

Dr Rohit Lal | Consultant Medical Oncologist | Guy’s and St. Thomas’ NHS Foundation Trust | London
National Lung Cancer Forum for Nurses | www.nlcfn.org.uk

This document has been produced with the assistance of an education grant from Nutricia Advanced Medical Nutrition (www.nutricia.co.uk)
Malnutrition and cancer

Disease-related malnutrition occurs frequently in patients with cancer and is a major cause of morbidity and mortality\(^6\).

The incidence of malnutrition in cancer patients ranges between 40% and 80%, the prevalence ranges from 50% to 80% depending on the tumour type, tumour location, stage of disease, treatment received and the type of nutritional assessment method used\(^7-9\).

A study of almost 1500 patients with cancer who attended the out-patient department found that 32% were at nutritional risk and this was higher than expected for the patient group\(^10\). In addition the nutritional risk was associated with common clinical variables which are usually recorded in the patient records and could easily alert the oncologist to the need for further nutritional assessment and/or nutritional support\(^10\).

Decreased dietary intake, cancer cachexia (characterised mainly by loss of appetite, weight loss and muscle wasting), and nutritional status may all contribute to cancer-related malnutrition\(^8\). The nutritional status may result from the local effects of the tumour itself, the host response to the tumour, and/or the treatment modalities involving combinations of chemotherapy, radiotherapy and surgical regimens which produce various acute and chronic symptoms that all limit eating.

Malnutrition can be identified by using a validated screening tool such as the ‘Malnutrition Universal Screening Tool’ (‘MUST’) and/or local screening tools (see page 7).

For further information on malnutrition visit www.malnutritionpathway.co.uk

The consequences of malnutrition in cancer patients include the impairment of immune function, performance status, muscle function and associated debilitating morbidities such as depression and fatigue\(^6\).

In addition, responses to chemotherapy are decreased, chemotherapy-induced toxicity increases, and complications are more frequent and severe\(^6\). However, the major consequence of progressive weight loss and nutritional deterioration is reduced survival\(^6\). Cancer-related malnutrition is also associated with significant healthcare-related costs\(^6\).

Consequences of malnutrition in cancer patients\(^6\)

- Immune function impairment
- Reduced performance status
- Decreased muscle function
- Depression
- Fatigue
- Decreased response to chemotherapy
- Increased chemotherapy-induced toxicity
- Increased frequency and severity of complications

\[\text{Reduced survival time}\]

Patient quality of life (QoL) is an extremely important outcome measure for cancer patients, their carers and families. How patients feel, physically and emotionally, whilst living with cancer can have an enormous effect on their recovery, ability to carry out normal daily functions, as well as their interpersonal relationships and ability to work.

A systematic review of the epidemiological literature concluded that correcting malnutrition in patients with cancer improves QoL\(^11\).
Nutritional screening and support

The nutritional status of patients diagnosed with cancer and entering the Care Pathway will vary from patient to patient. Early nutrition screening can help to identify malnutrition risk and any problems that may affect how well the patient’s body can deal with the impact of the subsequent cancer treatment. Nutritional support is required for cancer patients to prevent and manage malnutrition and improve treatment efficacy; it may reduce the side effects of anti-cancer treatment and improve QoL. Nutritional support can help patients maintain their weight or prevent weight loss, decrease problems with the treatment and aid recovery. Nutritional screening is recommended on first contact with the care setting. Once an individual has been highlighted at risk of malnutrition, regular screening and monitoring is recommended to determine any improvement or deterioration and action required. Nutritional interventions can include dietary advice, oral nutritional supplements (ONS), enteral tube feeding (ETF) and in some instances parenteral nutrition (PN). Nutritional support can help patients to maintain weight, improve tolerance to treatment, maximise outcomes and improve QoL.

Patients may require nutritional support from the onset at diagnosis, during treatment and throughout the whole patient journey; with early use of oral nutritional supplements (ONS). ONS can improve energy intake and reduce weight loss in cancer. Nutritional intervention with ONS can also improve QoL in patients who are malnourished and may also result in cost savings. Patients may require ONS to meet their daily nutritional requirements. Systematic reviews and NICE Clinical Guidance 32 have demonstrated ONS clinical efficacy and cost-effectiveness in the management of malnutrition, particularly amongst those patients with a low Body Mass Index (BMI<20kg/m²). There is also a low threshold in particular patients undergoing radiotherapy to progress to ETF if they are unable to meet their nutritional requirements orally.

Dietary advice for patients with lung cancer

Many patients with lung cancer not only lose weight, but also find it difficult to eat and drink due to the presence of the tumour and the impact of cancer treatment. They may also have difficulty preparing and sourcing meals and drinks. Dietary advice is therefore important to help them manage these issues. Patients can be given advice on eating energy and protein-rich meals and snacks, maintaining a varied diet so that their vitamin and mineral needs are met, food fortification and consuming small frequent meals and snacks. In addition consideration should be given to those patients requiring a texture-modified diet due to swallowing problems. Certain chemotherapy agents require an empty stomach to optimise absorption and therefore healthcare professionals may need to advise patients to avoid eating one hour before or up to two hours after taking such medication. In terms of tumour and treatment related side effects impacting on normal food intake symptom control using appropriate pharmaceutical agents should be prioritised individually for each patient. Seek advice from a doctor or oncology pharmacist as appropriate.

Dietary advice – hints and tips

- Aim for 3 small meals and 3 small snacks a day
- Encourage high energy and protein-rich food choices e.g. full fat milk instead of semi-skimmed, mix grated cheese or cream into foods such as mashed potato and soups
- Keep high-energy snacks within easy reach. Cheese and crackers, biscuits, cakes, nuts, crisps, dried fruit and peanut butter on toast are a good way to get extra calories and protein throughout the day
- Have nourishing drinks in between meals other than tea, coffee and water
- Avoid drinking too much fluid with meals
Range and selection of oral nutritional supplements

There are a wide range of ONS styles (milkshake, juice, yoghurt, savoury), formats (liquid, powder, puddings, pre-thickened), types (high protein, low volume, fibre containing) energy densities (1-2.4 kcal/ml) and flavours available to suit a wide range of patient needs. Most ONS provide approximately 300 kcal, 12g protein and a full range of vitamins and minerals per serving.

Many patients requiring ONS can be managed using 1.5-2.4 kcal/ml. The amount of fluid in a standard ONS is approximately 200ml; however, for patients with a small appetite and/or those who are breathless or who have difficulty drinking larger volumes of fluid, there are more concentrated supplements available which contain the same amount of nutrition, but in only 125ml. When commencing ONS the considerations outlined are important.

Nutrition starter pack

A nutrition starter pack for patients and carers, which gives them some basic nutritional support information, has been developed in conjunction with the National Lung Cancer Forum for Nurses.

Three two page A4 leaflets are available to download from the patient information section of the National Lung Cancer Forum for Nurses.

Considerations when commencing ONS

- Establish preferred flavours, likes and dislikes e.g. milk or juice, sweet or savoury
- Test preferences and compliance with a prescribable ‘starter pack’
- Prescribe preferred product/flavour; 2 ONS/day (range 1-3/day – see Pathway on page 6)
- Refer to a Dietitian where possible and particularly if ONS is the sole source of nutrition or patients have complex needs
- Modular ONS – that provide one or two nutrients – in either powdered or liquid format should only be used under dietetic supervision
- If the patient is also diabetic their blood sugars may need to be monitored more closely if appropriate

Further advice on nutrition in cancer can also be found at www.nutritionincancer.co.uk

References

23. Bito M (ed). The cost of disease-related malnutrition in the UK and economic considerations for the use of oral nutritional supplements (ONS) in adults. A report by BAPEN.
**ALL PATIENTS**

- Nutritionally screen at diagnosis with local or national tool e.g. ‘MUST’
- Identify barriers impacting on nutritional intake as part of a holistic needs assessment e.g. ‘Distress Thermometer’
- Consider:
  - Eating and drinking difficulties
  - Appetite loss
  - Early satiety
  - Nausea and other GI issues
  - Sore mouth or swallowing problems including pain
  - Impact of fatigue and breathlessness
- Encourage mouth care strategies

**LOW RISK**

- Offer a ‘Nutrition Starter Information Pack’
- Rescreen at next visit

**MEDIUM RISK**

As for low risk patients plus:

- Agree care plan with patient and carer
- Involve other members of the Multidisciplinary Team (MDT) if required e.g. Speech and Language Therapist
- Optimise symptom control and nutritional intake e.g.:
  - Food fortification advice and texture modified diet
  - Small and frequent meals/snacks/nourishing drinks
- Consider appropriate use of oral nutritional supplements (ONS) as per local guidelines e.g. 2 ONS** per day (range 1-3)³, ⁴
- Monitor and review at next visit and/or consider Dietitian referral

**HIGH RISK**

As for low/medium risk patients plus:

- Refer to dietitian for assessment and treatment plan
- If food intake is insufficient (<50% of 3 meals per day) recommend:
  - ONS e.g. 2 ONS per day (range 1-3) alongside oral intake, 12 week duration, according to clinical condition/nutritional needs²,⁷ as per local guidelines
- Consider enteral tube feeding as appropriate
- Appropriate dietary advice if oesophageal stent is in situ
- Ongoing monitoring and review regularly:
  - Check compliance and adjust nutritional intervention as required to maximise intake

**ACTIVE SUPPORTIVE CARE**

- Optimise nutritional care
- Liaise with patient, family, carer, and MDT regarding ethics i.e. provision of nutrition as treatment/basic care
- Liaise with palliative care team as required

---


* A nutrition starter pack for patients and carers, which gives them some basic nutritional support information has been developed in conjunction with the National Lung Cancer Forum for Nurses and is available via www.nlcfn.org.uk

** ONS: Oral Nutritional Supplement


NB: Pathway aimed at adults as lung cancer in children is incredibly rare.
‘Malnutrition Universal Screening Tool’ (‘MUST’) Flowchart

**Step 1**
BMI score
- BMI kg/m² Score
  - >20 (~30 obese) = 0
  - 18.5-20 = 1
  - <18.5 = 2

**Step 2**
Weight loss score
- Unplanned weight loss in past 3-6 months
  - % Score
    - <5 = 0
    - 5-10 = 1
    - >10 = 2

**Step 3**
Acute disease effect score
- If patient is acutely ill and there has been or is likely to be no nutritional intake for >5 days
  - Score 2

**Step 4**
Overall risk of malnutrition
- Add Scores together to calculate overall risk of malnutrition
  - Score 0 Low Risk
  - Score 1 Medium Risk
  - Score 2 or more High Risk

---

See Lung Cancer Nutritional Care Pathway on page 6

---

**All risk categories:**
- Treat underlying condition and provide help and advice on food choices, eating and drinking when necessary.
- Record malnutrition risk category.
- Record need for special diets and follow local policy.

**Obesity:**
- Record presence of obesity. For those with underlying conditions, these are generally controlled before the treatment of obesity.

---

Re-assess subjects identified at risk as they move through care settings
See the ‘MUST’ Explanatory Booklet for further details and the ‘MUST’ Report for supporting evidence.

---

Malnutrition Universal Screening Tool (‘MUST’) is reproduced here with the kind permission of BAPEN (British Association for Parenteral and Enteral Nutrition). For more information and supporting materials see: http://www.bapen.org.uk/musttoolkit.html