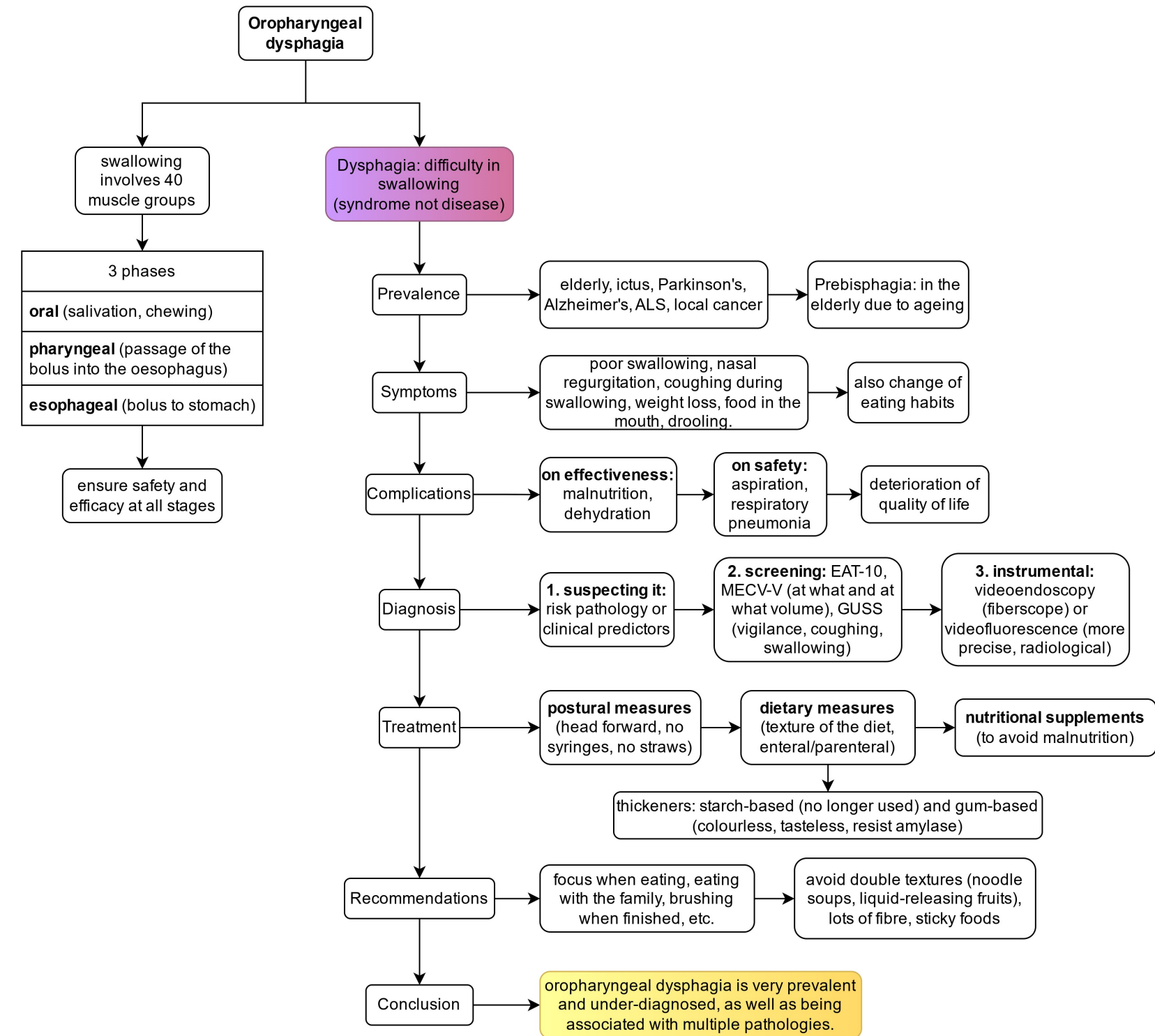
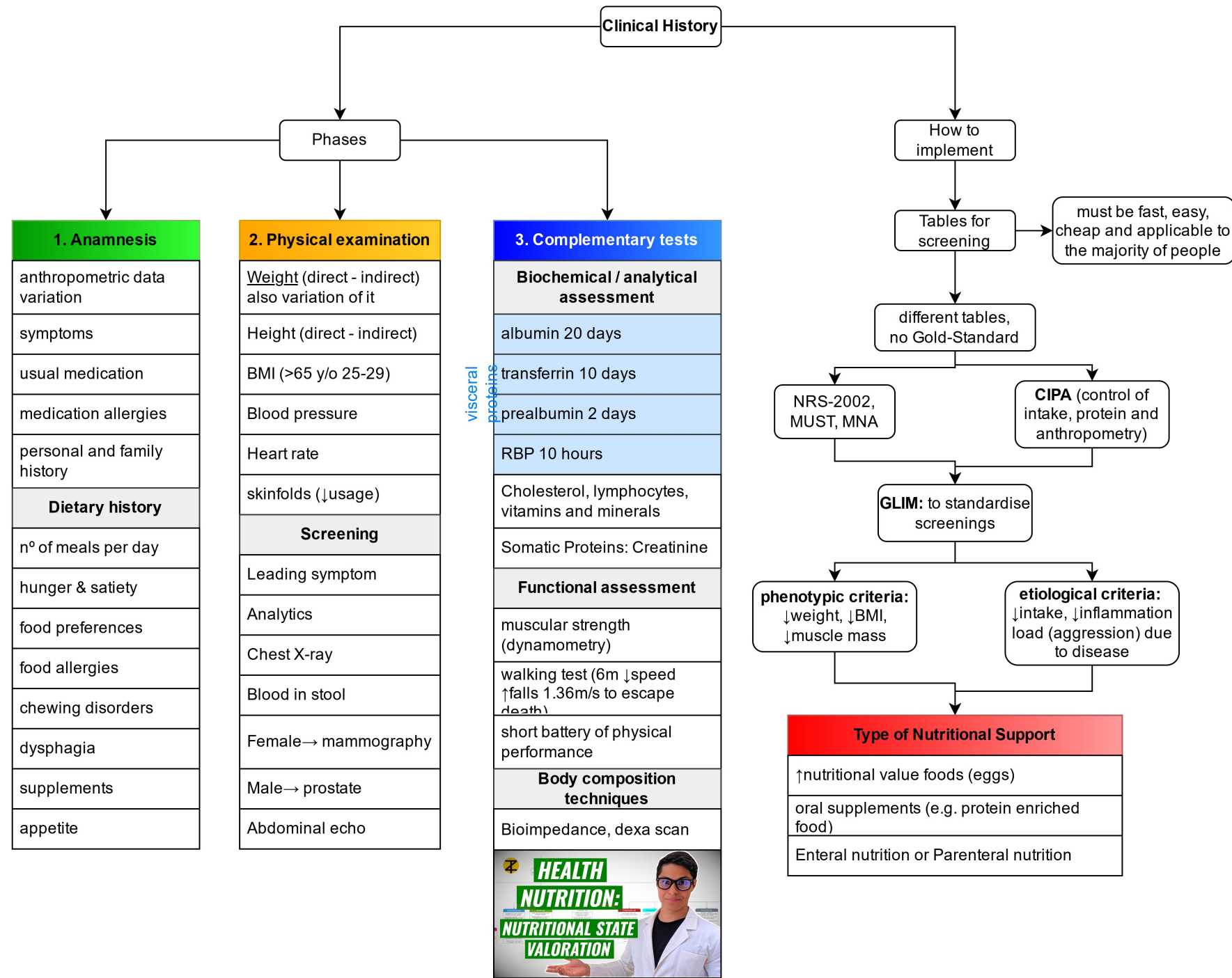
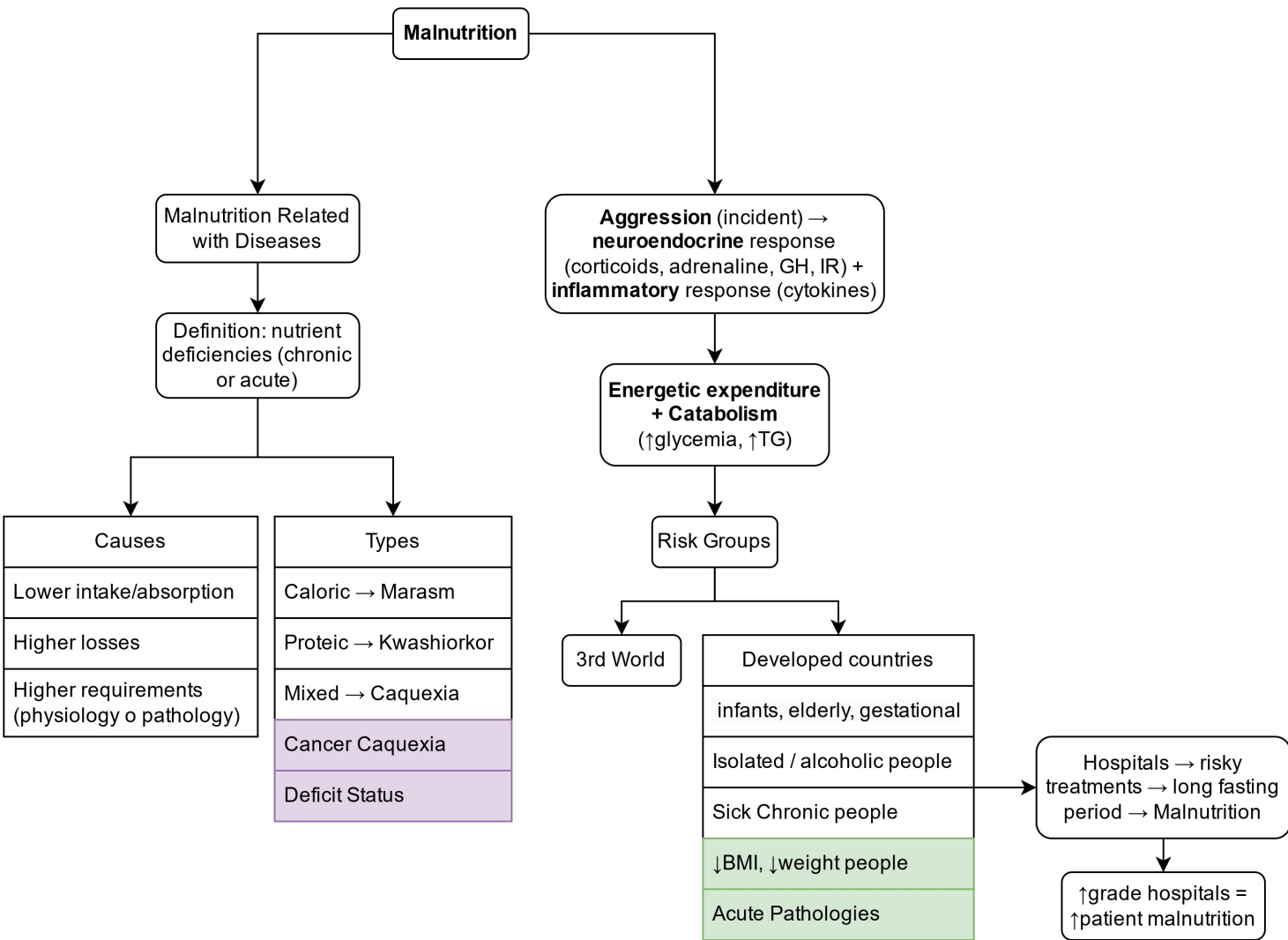
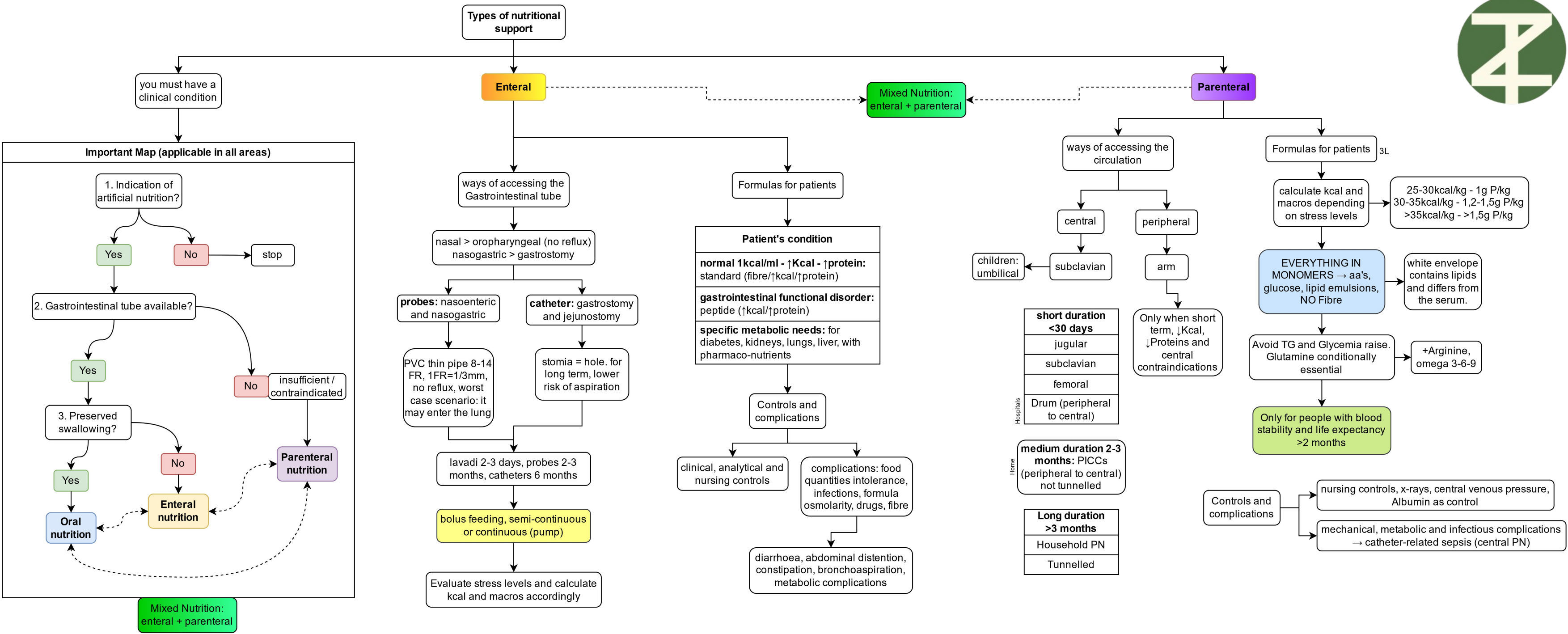
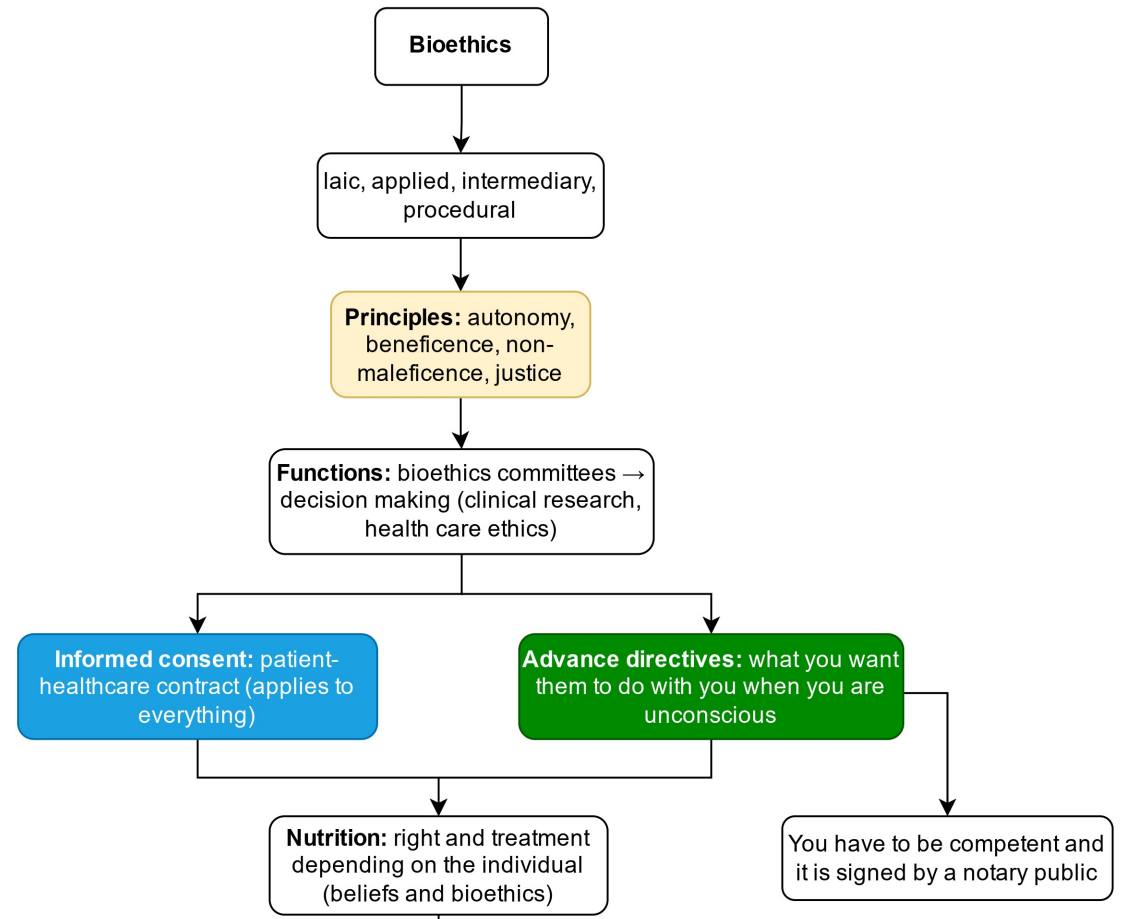
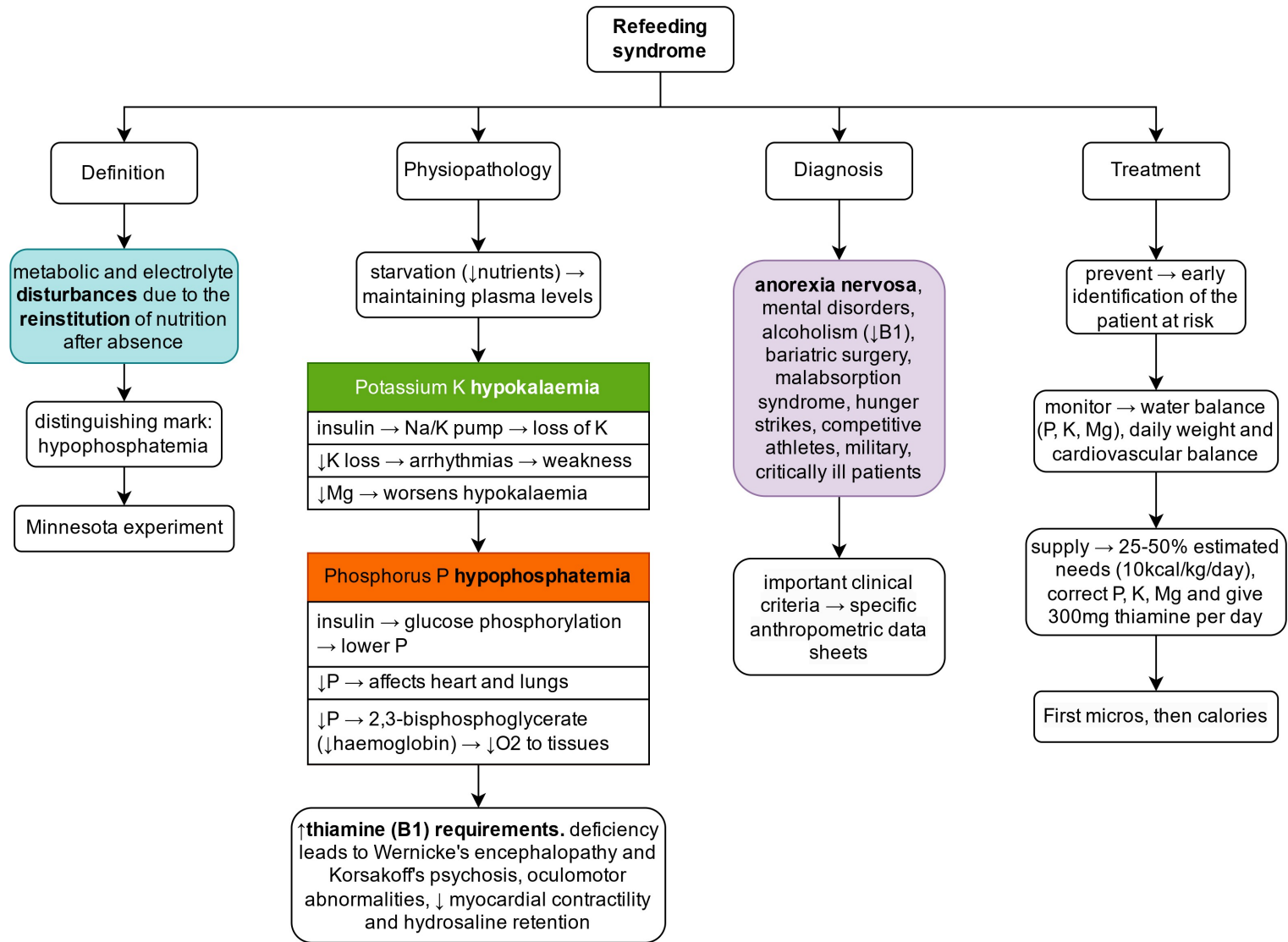


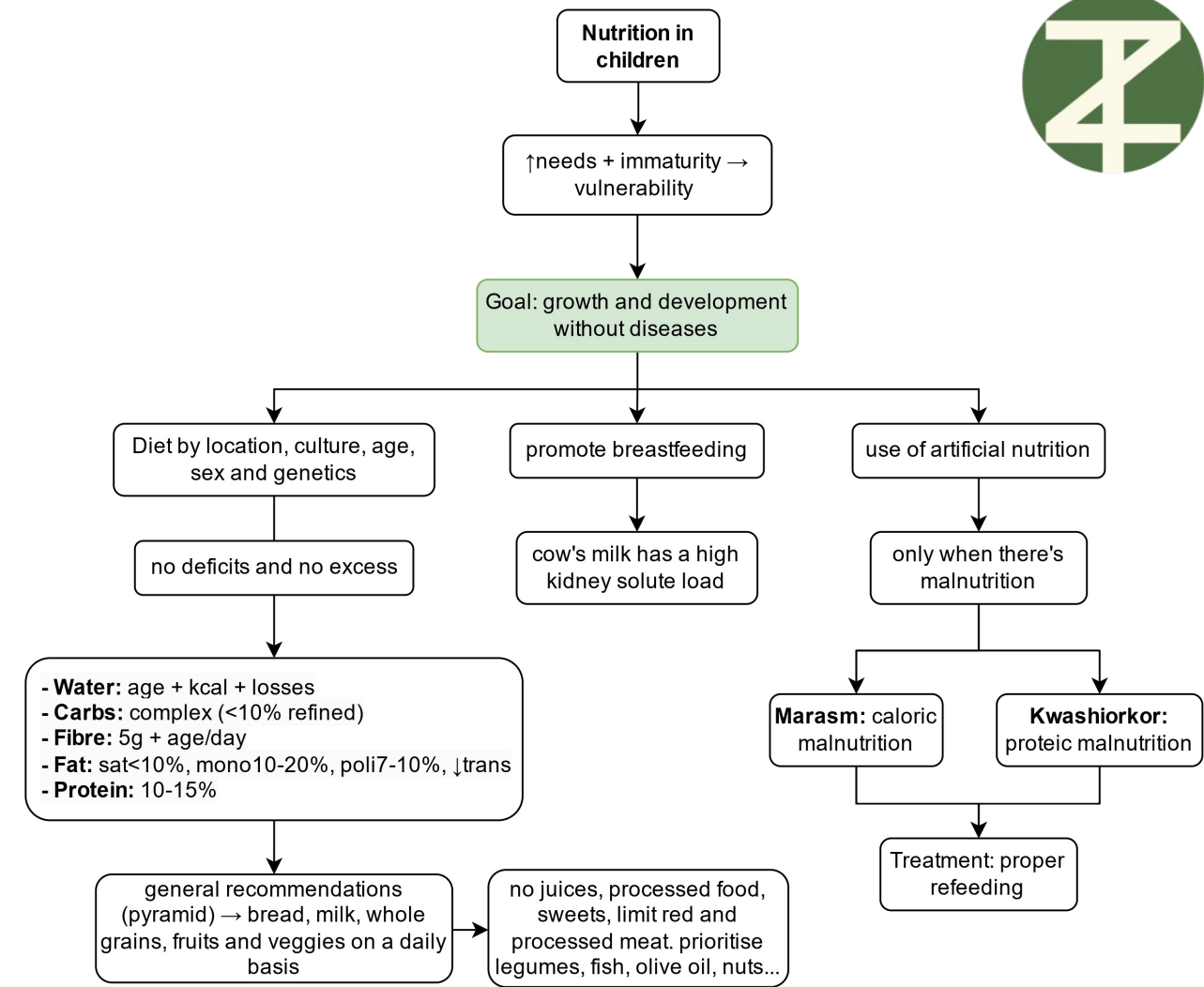
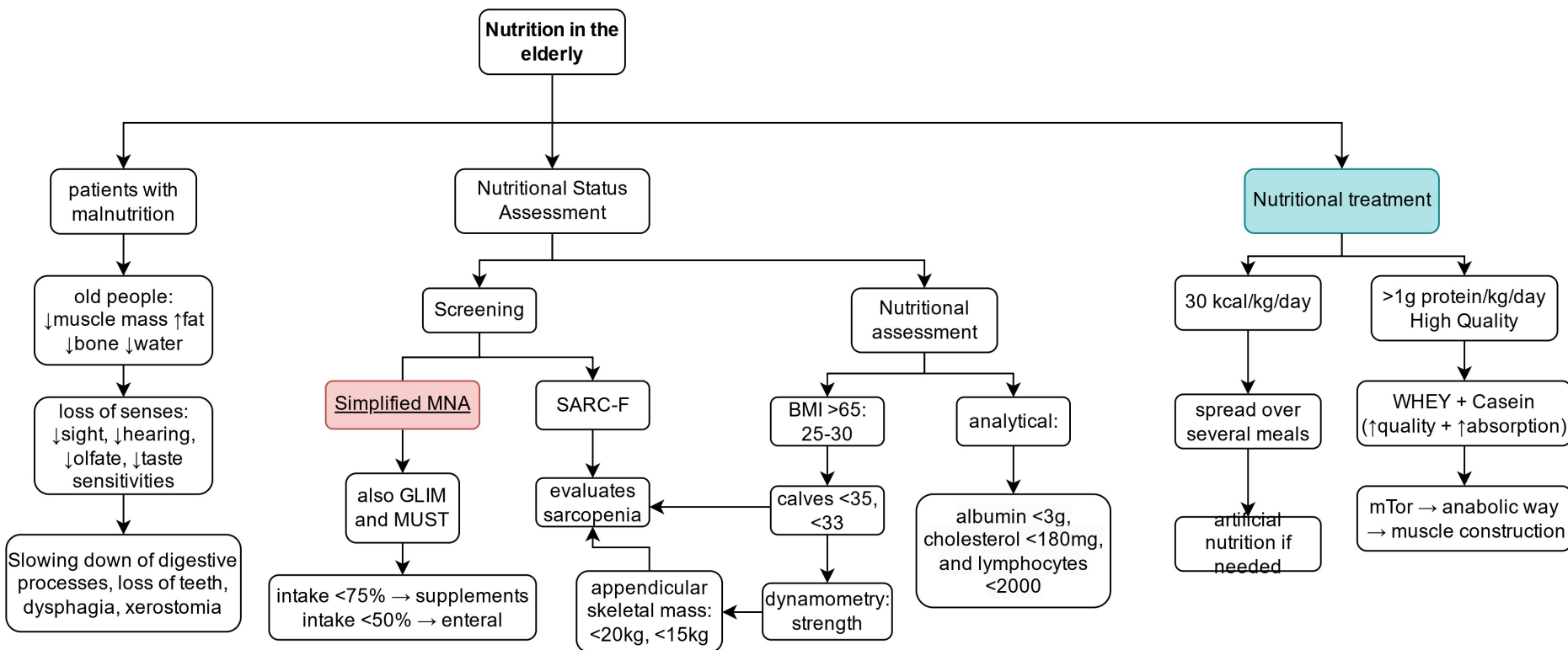


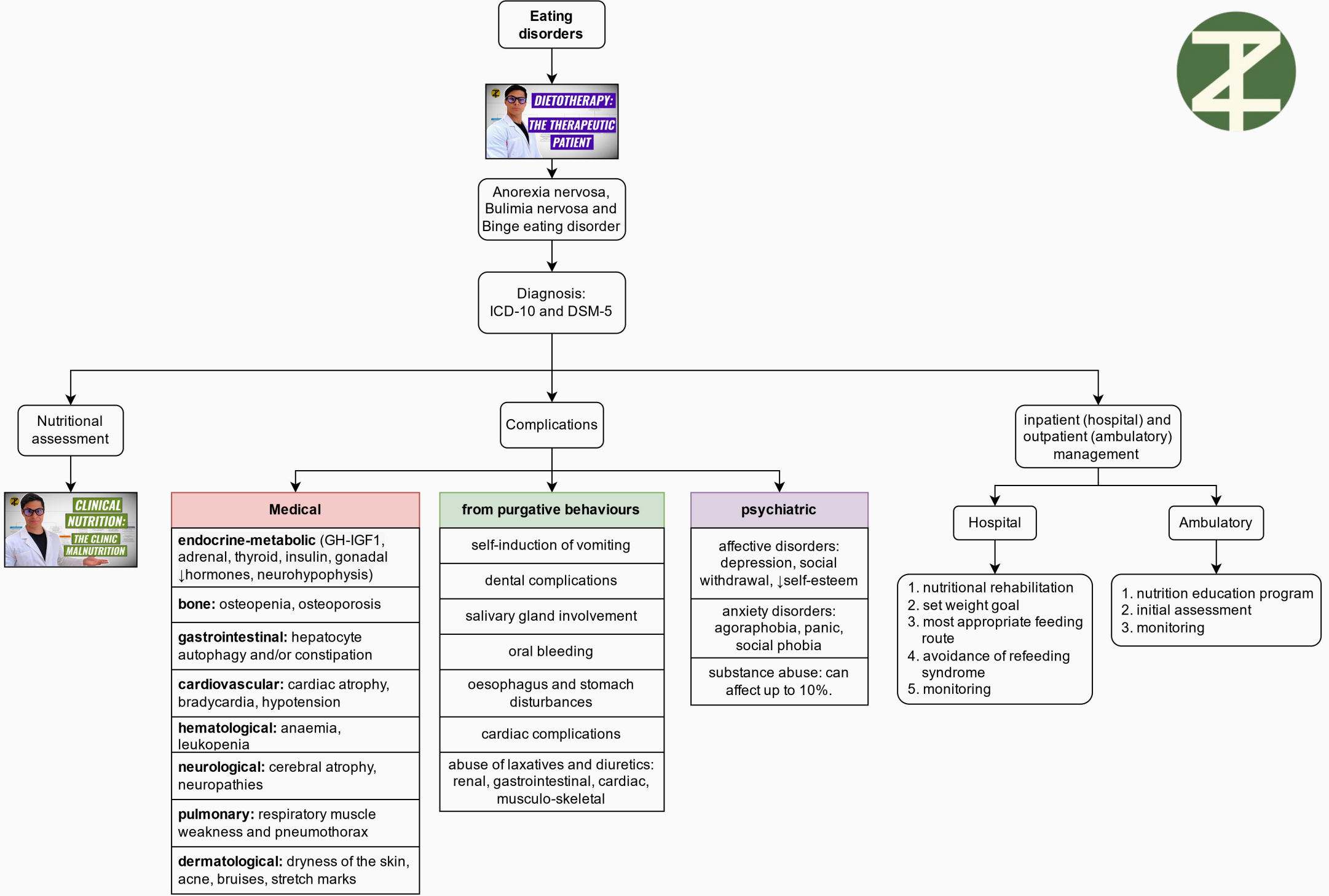
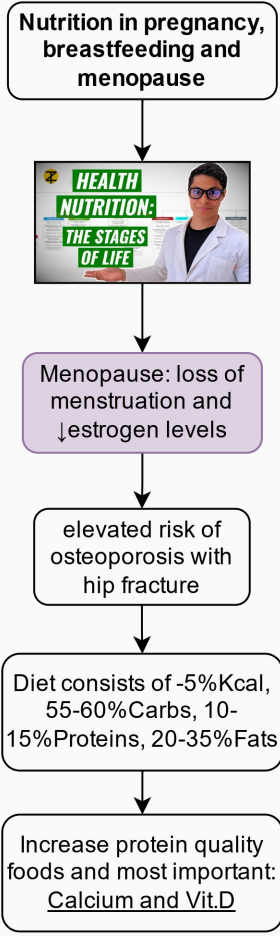


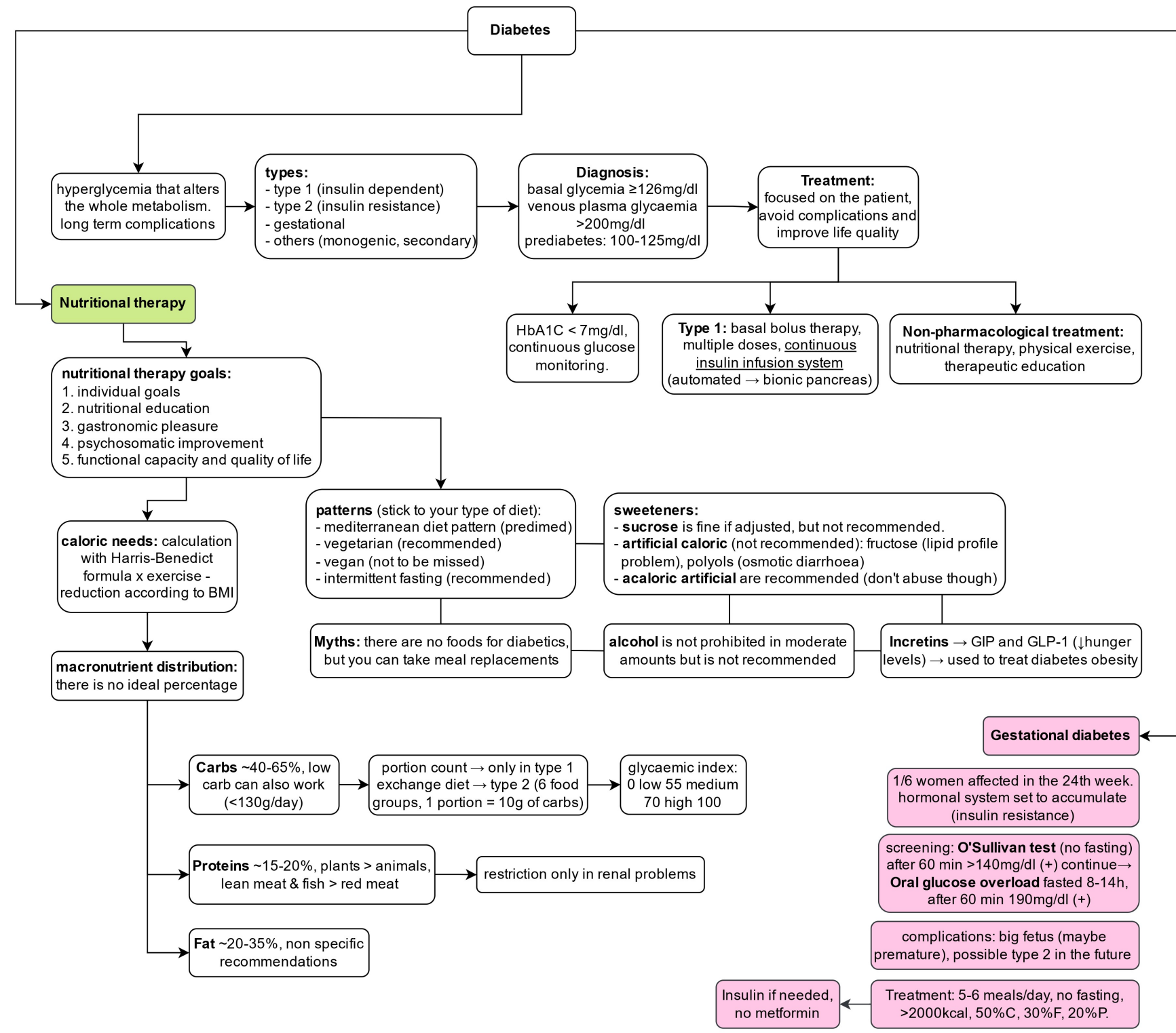
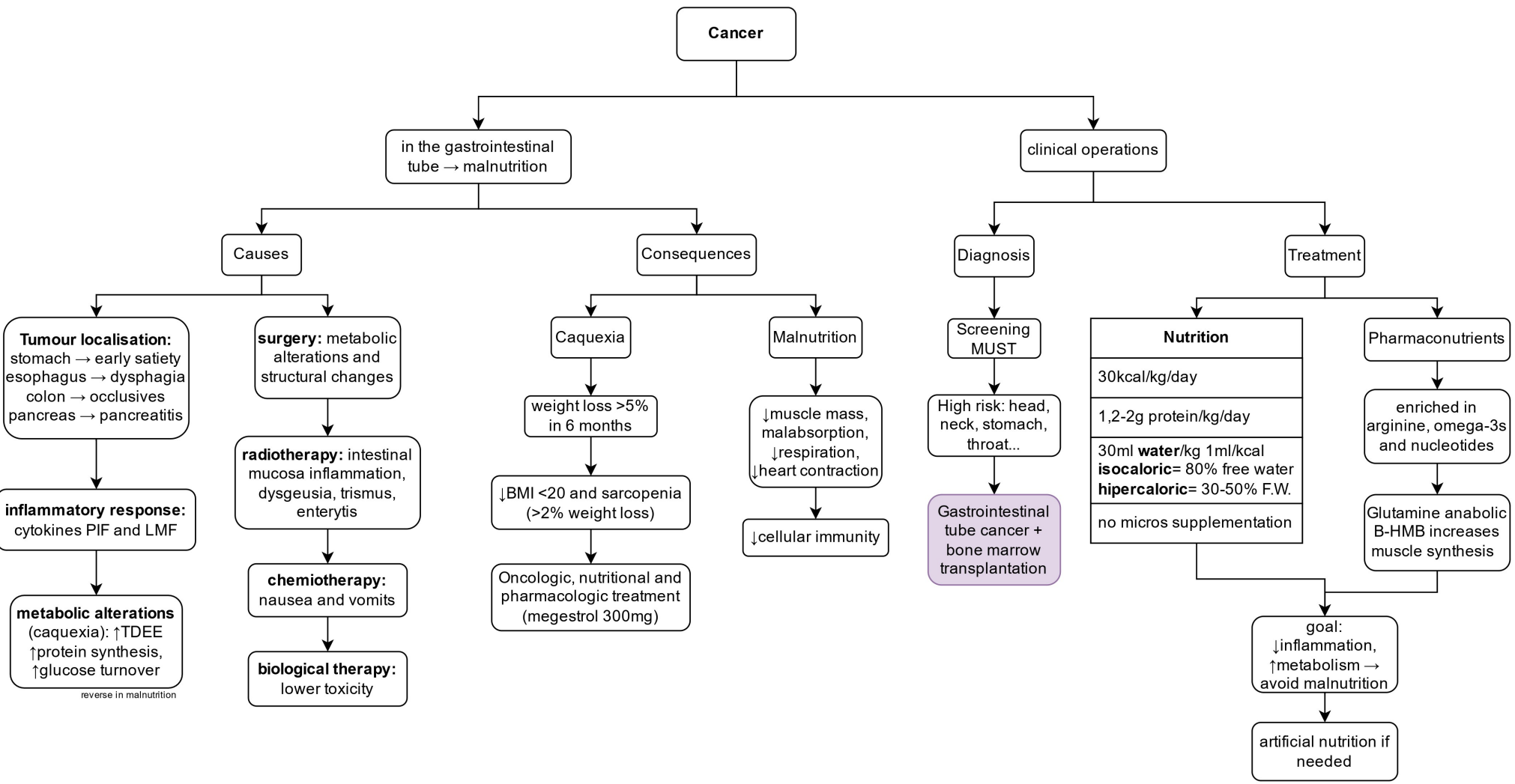


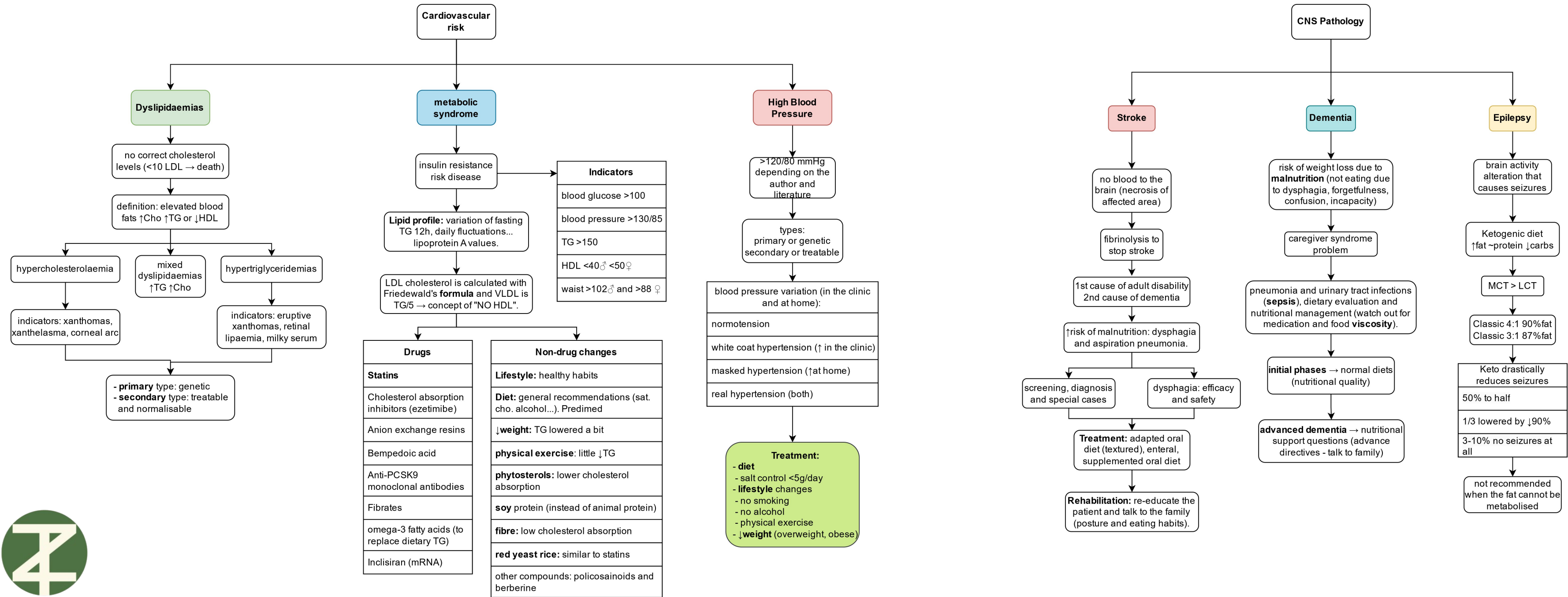
Bioethics and diseases
Dementia: no artificial nutrition, treat pain and constipation, no matter the quality of the diet.
Parkinson: 20% with dementia, often have dysphagia → right to euthanasia
ALS: respiratory failure and dysphagia → ventilator and gastrostomy
Oncology: ↓ingestion → supplementation ↑protein. autonomy? IC and/or AD
ED: anorexia nervosa → mental disorder (principle of beneficence overcomes autonomy) They don't know they are sick
Voluntary fasting: terrorist who does not want to eat (respectable as long as it is not life-threatening). Depends on the country, you are ready to die? probes

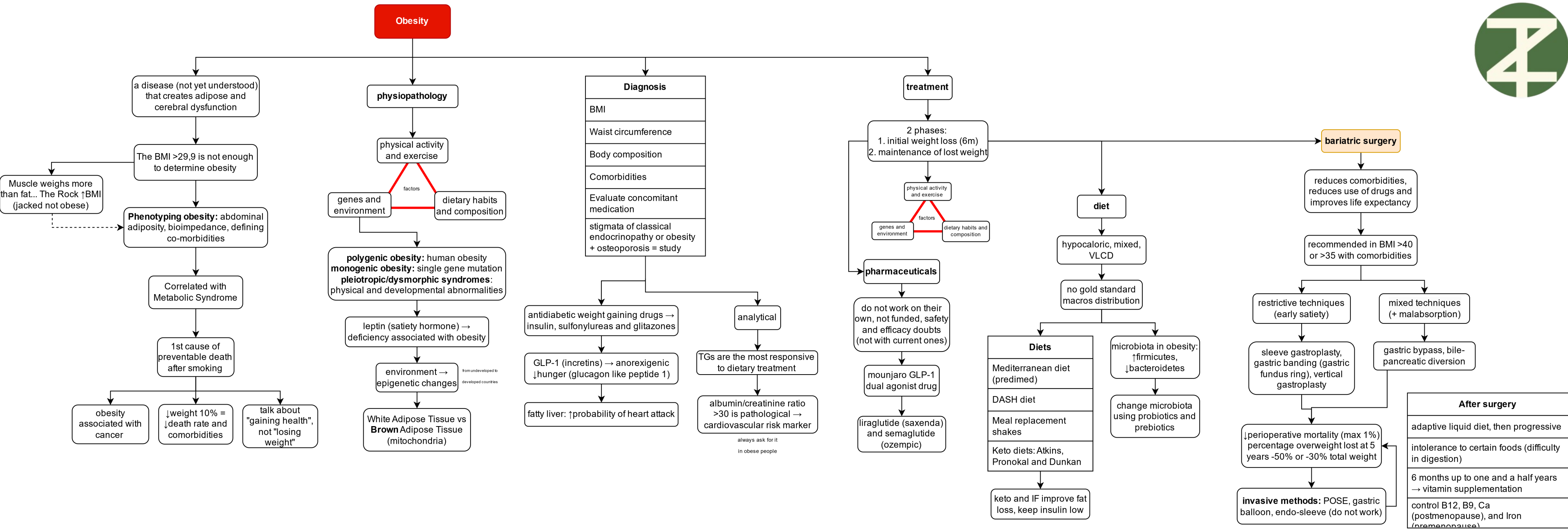


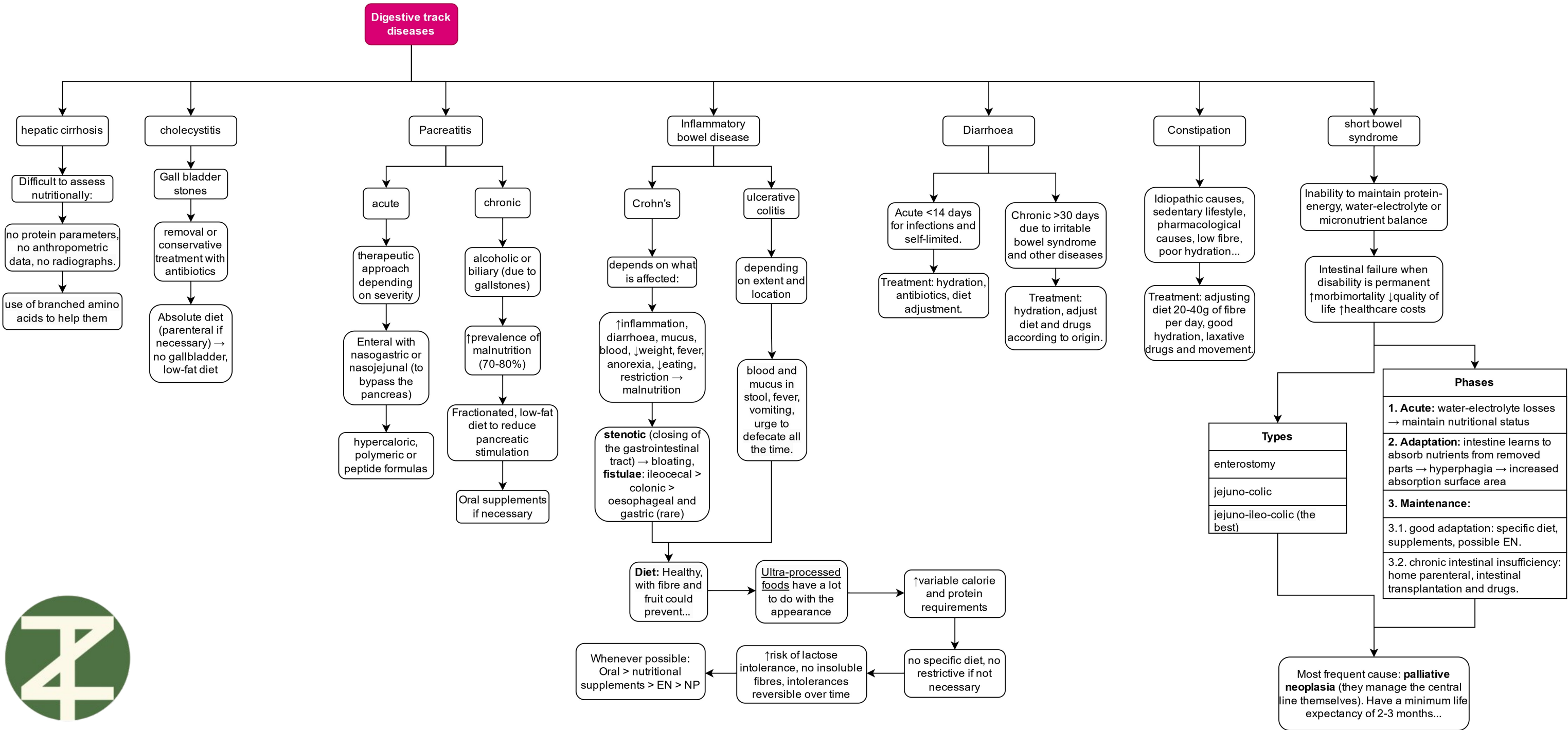














Dietary code and perioperative care

Dietary code

A set of diets available in a hospital centre, adapted to the pathophysiological situation.

Types
Basal (10) all other diets are based on this one. 2200-2400Kcal (55%C - 30%F - 20%D)
Diabetes
Easy chewing (60)
Dysphagia (41)
Digestive pathology: astringent, ↓residuuous, ↑residuuous, gluten-free...
Renal insufficiency: ↓K ⁺ , ↓proteins, haemodialysis
Post-operative tolerance: liquid, semi-liquid, semi-soft, easily digestible.

↓salty, not eating as usual: **2 NO rule** (maximum 2 foods you don't like), **standardised menu**, mediocre quality due to different tastes.

therapies

abdominal surgery

malnutrition → complications
better to wait 10-14 days...

Parameters
↓ weight >10% in 6 months
BMI <18.5
Subjective global assessment grade C
albumin <3g/dl

fast track

ERAS - Multimodal rehabilitation:

perioperative oral nutrition, carb overloading (no fasting anymore), no nasogastric tubes (fed immediately).

Improvements: ↓thirst, ↓hunger, ↓immunoresistance
↓anxiety → multiple benefits.

Phased diet after abdominal surgery

Hydric → water
liquid (20 phase 1) → broths
semi-liquid (20 phase 2) → still without prots.
semi-soft (20 phase 3) → with protests but incomplete
easily digested (90) → complete

gastrectomies

Removal of part of the stomach

nutritional deficiency, satiety nausea, iron and vitamin B12 anemia, exocrine pancreatic insufficiency.

Dumping

early. "Cut of digestion when you swim in the pool after eating", pallor, dizziness, malaise, nausea

late. Due to hypoglycemia, takes a little while → palpitations, sweating, weakness, ↑insulin.

due to eating too fast (accumulation of blood in the area).

Recommendations: eat slowly, no liquid with meals, no sugars (cause Dumping), acarbose (old drug for diabetes, but gives flatulence and gas).

Bread, meat and milk are not well tolerated.

bariatric surgery

	%weight loss	Possible indications	Complications
Restrictive or tubular (sleeve)	25-30%	BMI<45	gastric leakage, reflux disease (esophageal cancer)
Mixed or gastric bypass (BPG)	30-35%	BMI 35-55. No snacking, Reflux, metabolic syndrome and DM2.	Gastrojejunal stenosis, marginal ulcer, micronutrient deficits
Malabsorptive or DBP and DBP-CD (in disuse)	35-45%	BMI>45	Malabsorption (fat-soluble v.it.), denutrition, liver disease

Recommendations after bariatric surgery

liquids in ↓amounts, protein foods, no alcohol, no sugary drinks, chew slowly. progressive

Post-surgical follow-up

monitoring of nutritional deficiencies, bone status, evolution of comorbidities, monitoring of regain.

ileostomy

Ileus = intestine, stomia = hole

liquid with nutrients comes out.

High debit to watch: dehydration → renal failure, hypokalemia, hypomagnesemia, hypocalcemia, hyponatremia (↓Na, Ca, and Mg, P).

Malabsorption (bile salts, ↓B12, liquid stool).

Diet: separate liquids from solids, eat slowly, no coffee, no spicy, no insoluble fiber (soluble helps), no condiments.

diverticulitis

Outward excretions from the colon (polyps are inward).

a lot of outward excretions + inflammation

If it explodes it can even create peritonitis

Uncomplicated: bowel rest, fluid therapy, dietary progression.

Complicated (fistulas and peritonitis): parenteral.

intestinal fistulae

Rupture of the bowel wall due to chron's disease, tumors and so on.

May be into the vagina or into the bladder (poop through the urethra).

types:

debit: high >500ml - medium - low <200ml.

location: high duodenal, mid-jejuno-ileum (worst), low jejuno-colon

enterocutaneous → one of the worst

Nutritional management

medium fistula → Parenteral, replenish what is being lost by vein until fistula is repaired

high fistula → nasojejunal tube (duodenal bypass)

low fistula → oral or enteral with nasojejunal tube (nasogastric tube)

if < 100% of requirements are met → mixed with parenteral