Under kræftbehandling
Ernæring ved kræft – what's new?

Årsmøde i klinisk ernæring
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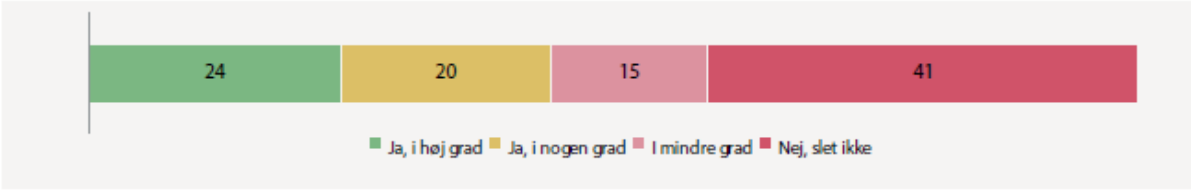
Ernæring ved kræft – What's new?

Kræftpatienters behov og oplevelser med sundhedsvæsenet under udredning og behandling

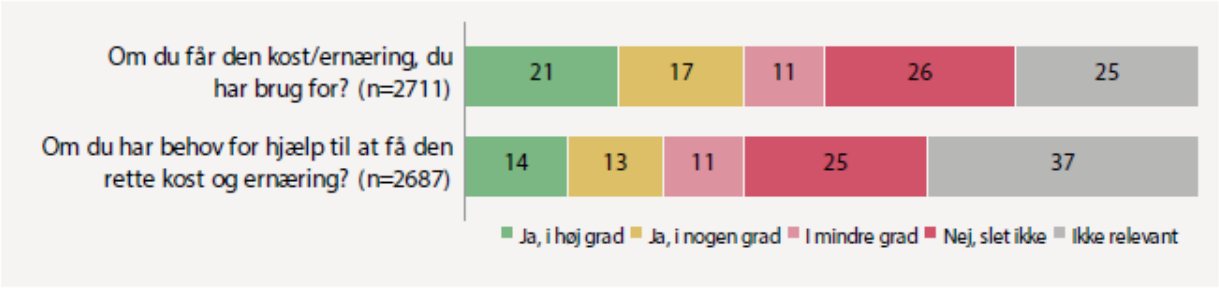
Kræftens Bekæmpelses Barometerundersøgelse, 2023 - del 1

FIGUR 35: Har du fra sundhedsvæsenet/kommunen fået den hjælp, du har haft behov for til at få den rette kost og ernæring? (n=908)



Delpopulation: Kun opgjort blandt de personer, der har haft behov for hjælp til at få den rette kost og ernæring.

FIGUR 36: Har en sundhedsprofessionel talt med dig om:



Ernæringsbehandling virker

- Indtag
- Kropsvægt
- Livskvalitet

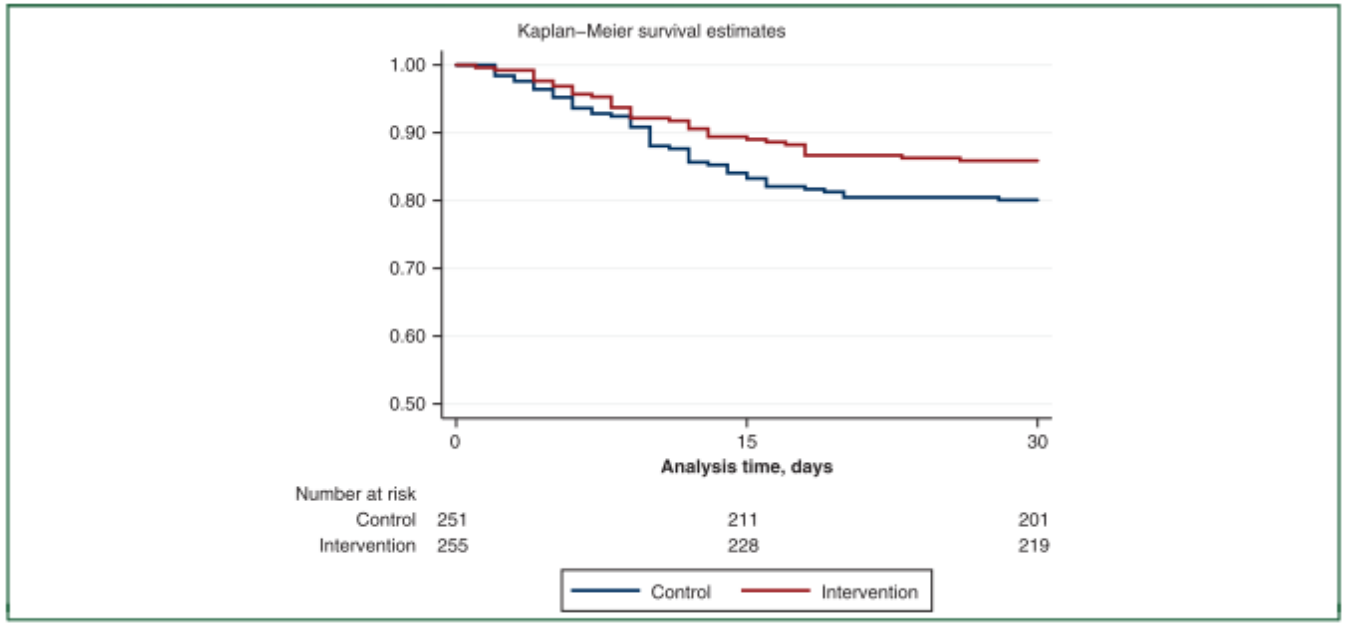


Figure 2. Kaplan-Meier estimates of cumulative incidence of all-cause mortality within 30 days according to randomization group.

Bargetzi et al 2021

Individuel ernæringsbehandling

- Opsporing af ernæringsrisiko
- Ernæringsudredning
- Ernæringsdiagnose
- Ernæringsintervention
- Ernæringsmonitorering og evaluering

Kostbegrænsende faktorer

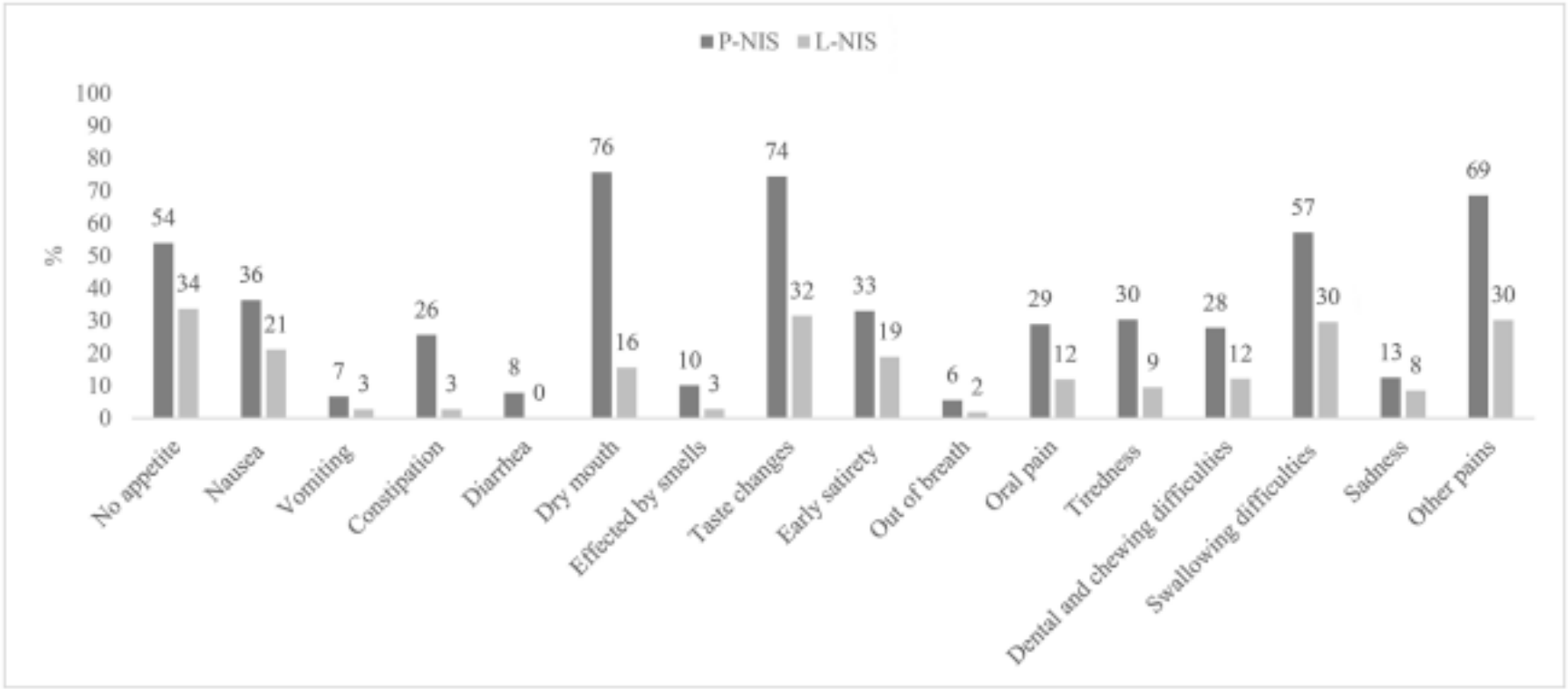


Fig. 2. Nutrition impact symptoms (NIS) presented as both present (P-NIS) and nutritional limiting (L-NIS).

Engelstrup et al. 2023

Hvad skal Hanne spise?

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Behov:
Energi: 25-30 kcal/kg/dag
Protein: 1-1,5 g/kg/dag

Kostform

Hyppige små måltider

Energi- og proteinrige fødevarer

Energi- og proteinberigelse

Drikkevarer

Ernæringsdrikke

Sondeernæring

Parenteral ernæring

Multivitamin

8) We recommend not to use dietary provisions that restrict energy intake in patients with or at risk of malnutrition. (Recommendation B3-2; strength of recommendation strong – Level of evidence low – strong consensus)

Commentary

We recommend against all forms of diets that are not based on clinical evidence, have no proven efficacy, and that potentially could be harmful. There are no diets known to reproducibly cure cancer or prevent cancer recurrence. In many cases, the supporting arguments are neither based on scientific reasoning nor solid evidence and the supporting information is derived from anecdote and unverifiable sources in the popular literature and Internet rather than peer-reviewed literature [24]. These diets increase the risk of insufficient intake of energy, fat, and protein, as well as the general risk of micronutrient deficiency.

There are no clinical trials demonstrating a benefit of a ketogenic diet in cancer patients [25,26]. Due to their low palatability, ketogenic diets may lead to insufficient energy intake and weight loss [25]. A small observational series and a small randomized trial reported good tolerability of fasting in humans [27,28], but without evidence of a benefit of fasting during chemotherapy, we do not recommend the use of this approach before, during or after the application of anticancer agents The reason for this recommendation is also due to the known risks of malnutrition and because patients might be tempted to prolong fasting episodes.

16) In patients with advanced cancer undergoing chemotherapy and at risk of weight loss or malnourished, we suggest using supplementation with long-chain N-3 fatty acids or fish oil to stabilize or improve appetite, food intake, lean body mass, and body weight. (Recommendation B5-7; strength of recommendation weak – Level of evidence low – strong consensus)

Due to the inconsistencies in the reported effects but with several positive trials published during the last few years reporting nutritional benefits, a plausible biological rationale, only mild side effects and no convincingly serious safety issues a weak recommendation for the use of fish oil and long-chain N-3 fatty acids has been made.

ESPEN practical guideline: Clinical Nutrition in cancer 2021