

Considerations on Perioperative Nutritional Support Management in Surgical Oncology During Covid-19 Pandemic

Considerações sobre gerenciamento de suporte nutricional perioperatório em oncologia cirúrgica durante a pandemia de Covid-19

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ABSTRACT

Nutritional guidance to help oncologic and general surgeons to improve perioperative outcomes during the COVID-19 pandemic is provided. Each institution should adapt its current routine and approach based on this article. The information provided can also be helpful in the non-pandemic period.

Keywords: Pandemics. Nutritional Status. Surgical Oncology. Perioperative Period. Fasting. Sarcopenia

RESUMO

É fornecida orientação nutricional para ajudar cirurgiões oncológicos e gerais a melhorar os resultados perioperatórios durante a pandemia de COVID-19. Cada instituição deve adaptar sua rotina e abordagem atual com base neste artigo. As informações fornecidas também podem ser úteis no período não-pandêmico.

Descritores: Pandemia; Estado nutricional; Oncologia cirúrgica; Período perioperatório; Jejum; Sarcopenia.

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There is no scientific evidence indicating the need to modify usual perioperative nutritional support in oncologic surgery during COVID-19 pandemic. The only exception, based on recent recommendations on social distancing, is to avoid presential assessment.

Cancer patients are at risk for malnutrition and should routinely undergo a thorough nutritional assessment. Regarding the feeding pathway, oral diet remains preferable and has to be stimulated. If not available, we have to consider a non-surgical enteral route, such as nasoenteral tube, as an alternative alone or in combination with oral feeding. To date, there is no nutritional supplement or food used to prevent coronavirus infection.

Outpatient nutritional assessment (pre and postoperative) cannot be omitted. In these times, it is preferable to use telemedicine as an alternative to presential appointment, as well as subjective tools of screening and nutritional assessment. In the absence of such tools, we can maintain at least a single on-site consultation. Sarcopenia should be investigated and treated. We can use preoperative rehabilitation through home exercises (avoid group activities) with multimedia platform for proper orientation. Sarcopenic and malnourished patients at high risk for surgical complications should be referred for non-operative cancer treatments along with adequate physical and nutritional rehabilitation. Further assessment for surgery should be done, reconsidering indication and fitness for surgery.

In the perioperative period, we should prescribe immunonutrition (500ml estimated volume daily) for at least 10 days, comprising 5 days at preoperative and 5 days after hospital discharge. Preoperative oral administration of clear fluids (carbohydrates \pm protein) up to 2h before initiation of anaesthesia shall be used for all cases, except in situations such obesity, important gastroesophageal reflux, documented delayed gastric emptying or gastrointestinal motility disorders as well as in patients undergoing emergency surgery. Inpatient nutritional assessment should be early (within 48 hours after hospitalization/surgery) and should avoid direct contact with the patient (i.e. calling the patient room), using subjective tools for nutritional screening, diagnosis and evaluation of sarcopenia. Oral diet should be resumed as soon as possible at postoperative period and enteral nutrition is recommended if oral nutrition is inadequate or not feasible. Also, parenteral nutrition can be used as an alternative if oral or enteral nutrition are contraindicated. Appropriate protein intake (food and supplements) is essential at postoperative recovery time, aiming for 1.5g/kg body weight per day.

We recommend keeping multidisciplinary online meetings for better management of patients, as well as an adaptation of this paper according to the resources of each institution. The recommendations

described here may change according to pandemic evolution and government guidance.

AUTHOR'S CONTRIBUTION

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