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Question: 1

The following patients have all had extensive bowel resections requiring long-term TPN. In which patient is it most appropriate to recommend a change to a cyclic TPN schedule?

A. A 15-year-old girl with a history of hypoglycemia
B. A 30-year-old woman stable on mechanical ventilation
C. A 6-month-old stable infant getting ready for discharge
D. A 73-year-old man with a history of CHF receiving intensive physical and occupational therapy

Answer: A

Explanation:
Long-term total Parenteral nutrition (TPN) may be indicated for a few conditions such massive small bowel resection, intensive chemotherapy, and other reasons. For patients requiring long-term TPN, a change to a cyclic schedule is often recommended in order to give the patient time away from the infusion pump. Cyclic TPN may also reduce the risk of liver complications associated with long-term TPN. The best candidates for this type of schedule would be stable patients who are not ventilated, those requiring intensive rehabilitative services such as physical or occupational therapy, or patients who will be receiving home TPN. The patients who are less likely to be candidates include those under the age of 3 (especially neonates with low glycogen reserves), patients with sensitive fluid issues such as congestive heart failure (CHF), and patients with uncontrolled blood sugar requiring insulin drips or long-acting insulin. A history of hypoglycemia would not preclude opportunity for cyclic TPN as long as blood glucose is monitored closely and the rate is tapered before discontinuation.

Question: 2

A 60-year-old man is admitted with dysphagia and a 15-pound weight loss. He is diagnosed with esophageal cancer. Before treatment is to begin, he has a portacath and a PEJ tube placed in preparation for chemotherapy and radiation prior to surgery. He has good bowel sounds and is having bowel movements. He is not able to eat more than sips of liquids throughout the day. The dietitian has estimated his calorie needs to be approximately 2275 kcals (35 kcal/kg), 98 grams protein (1.5 grams/kg), and 1950 cc fluid (30 cc/kg). Which of the following is the most appropriate plan for initiating and advancing tube feedings?

A. Start 20 cc/hour of elemental formula and advance by 20 cc/hour every 4 to 6 hours as tolerated until goal rate of 95 cc/hour is reached.

B. Start bolus feedings of standard isotonic fiber containing formula, 120 cc, every 4 hours for 24 hours. On the second day increase the bolus feedings to 240 cc per feeding every 4 hours. On the third day increase to goal of 360 cc every 4 hours.
C. Start 30 cc/hour of a standard isotonic formula and advance by 30 cc/hour per day until goal of 90 cc/hour is reached.
D. Start 25 cc/hour of standard isotonic fiber containing formula and advance by 25 cc/hour every 6 to 8 hours, as tolerated, until the goal of 90 cc/hour is reached.

Answer: D

Explanation:
Patients with head and neck cancer will frequently have some type of feeding tube placed either before or during surgery depending upon the treatment plan. In this case, because chemotherapy and radiation are planned prior to surgery, a portacath needed to be placed for chemotherapy administration and at the same time, a PEJ was placed. A feeding tube in the jejunum is a good choice because it will help to reduce the risk of aspiration and the tube is placed below the potential surgical site. This patient's GI function appears to be within normal limits, so an elemental formula is not required. Most patients can tolerate isotonic fiber-containing formula delivered into the jejunum at full strength without difficulty. Generally, a low rate can be initiated and if the patient is tolerating the formula without problem, the rate can be increased every few hours up to goal. In a PEJ tube, the recommendations for increases vary between 6 to 12 hours. Bolus feedings are contraindicated with jejunal feeding tubes.

Question: 3

A 38-year-old woman is transferred to the general surgery floor from an outside hospital with a small bowel obstruction. She has been receiving a 2-in- 1 central TPN solution consisting of 1970 kcal (390 grams dextrose, 70 grams protein in 1550 ml) with 250 ml 20% lipids. Her current weight is 59 kg and her height is 5'6". Laboratory data is remarkable for blood glucose of 250 mg/dL. Upon reassessment, which of the following is the most appropriate step to take?

A. Reduce dextrose concentration.
B. Reduce total calories.
C. Reduce both total calories and dextrose concentration.
D. Reduce dextrose concentration and increase lipids.

Answer: C

Explanation:
The TPN solution of 390 grams of dextrose and 70 grams protein in 1550 mL with 250 mL of lipids provides this patient with approximately 2106 kcal. She is receiving 1.2 grams/kg protein, 0.8 grams/kg lipid, and 36 kcal/kg. The glucose infusion rate is 4.6 mg/kg/minute. The solution is approximately 63% dextrose, 13% protein, and 24% lipid. The recommendations for this patient would be

approximately 30 kcal/kg, 1.2-1.5 grams/ kg protein, 20-40% of total calories from lipids, and 40-60% of total calories from dextrose. Based on this information, the patient is likely being both overfed and receiving excessive dextrose as evidenced by hyperglycemia. The best action would be to reduce total calories and dextrose. A change to a solution of 250 cc 20% lipids with 290 grams dextrose and 70 grams protein in 1550 cc would provide 1766 kcal (30 kcal/kg) and reduce the glucose infusion rate to 3.4 mg/kg/minute. The solution would be 56% dextrose, 16% protein, 28% lipid.

Question: 4

A patient had a lung transplant 1 week ago. She was moderately malnourished prior to transplant. She has been receiving a high-protein polymeric tube feeding via a nasogastric tube at goal rate with good tolerance. She is beginning an oral diet. What is the next step in treatment?

A. Discontinue tube feedings when oral diet meets at least 50% of her nutritional needs.
B. Change to nocturnal tube feedings when she is consuming at least 50% of her nutritional needs.
C. Continue 24-hour tube feedings until she is consuming 80% of her nutritional needs.
D. Hold tube feedings for 3 days to see if she is able to meet her nutritional needs with an oral diet.

Answer: B

Explanation:
Given that the patient had moderate malnutrition in the pre-transplant period, it is best not to discontinue enteral nutrition too quickly. Calorie needs post-transplant are not significantly elevated in the post-transplant period; however, sufficient calories are required for repletion and for the patient to be able to regain strength to perform activities of daily living and physical therapy. Protein needs are elevated in the immediate post-transplant period at approximately 1.5-2.0 grams/kg due to corticosteroids and healing. Once the patient is meeting at least 50% of her nutritional needs orally; the tube feeding schedule can be changed to nocturnal feedings to allow her oral intake to improve. Close monitoring of laboratory data and of calorie and protein intake and weight should also continue.

Question: 5

When making decisions about artificial nutrition and hydration (ANH) for a patient with advanced dementia, which of the following takes precedence?

A. Whatever the patient decides
B. The surrogate decision maker
C. Health care proxy
D. Advance directive, such as living will

Answer: D

Explanation:
The patient's own wishes would take precedence in the determination for artificial nutrition and hydration (ANH); however, a patient with advanced dementia would not be able to make this decision in their current state. An advance directive such as a living will, written at a time when the patient was of sound mind, would take precedence over the surrogate decision maker, health care proxy, power of attorney, or close family member. A living will is a legal document that provides specific written instructions for making end-of-life decisions if the person is unable to do so. Durable power of attorney or health care proxy is also an advance directive that designates a specific person to make decisions in the event the patient is unable to. A surrogate decision maker is appointed by the court to act as a surrogate in making decisions if there is no other advance directive available.

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