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Clinical case

Impact of undernutrition on the survival of cancer patients in a medical oncology department in sub-saharan africa: about a case at the Treichville university hospital

Impact de la dénutrition sur la survie des patients atteints de cancer dans un service d'oncologie médicale en afrique subsaharienne : à propos d'un cas au centre hospitalier universitaire de Treichville

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Résumé

La dénutrition est un facteur péjoratif dans la prise en charge oncologique du patient qui s'associe à une augmentation de la morbimortalité, à une diminution de la qualité de vie entraînant un long séjour d'hospitalisation. Nous rapportons le cas d'un patient de 62 ans, suivi au CHU de Treichville admis en hospitalisation pour asthénie physique sur adénocarcinome du colon gauche métastatique hépatique et pulmonaire vierge de tout traitement spécifique chez qui l'examen physique retrouve :

- PS OMS 3
- Amaigrissement important (perte de 28% du poids habituel en 3 mois), (poids 37 KG, Taille : 165cm, IMC : 13, 59kg/M2)
- Sarcopénie - Réduction de plus de 50% de la prise alimentaire - Albumine : 17, 9g/l
- Score MNA :3

Á ce tableau dénutrition s'est associé - Désordre métabolique (HypoNa+ sévère :117 meq/L, HypoK+ : 2,61 meq/L) - Anémie modérée(7,1g/dl) microcytaire hypochrome IL a bénéficié de la correction des troubles métaboliques et une réhabilitation nutritionnelle. L'évolution fut marquée par une stabilisation du bilan métabolique et nutritionnel, de l'état clinique avec un gain de poids et un score OMS 2 ; Nous avons poursuivi son traitement et à J35 d'hospitalisation, il a bénéficié de première cure de chimiothérapie. La tolérance post chimiothérapie était bonne et l'évaluation de l'état nutritionnel était favorable. Il a été décidé de poursuivre le protocole de nutrition. Cependant, il s'est posé un problème de moyen financier car dans notre contexte cette prise en charge nutritionnelle est à la charge du patient. Le patient est sorti contre avis médical et il est décédé 7 jours plus tard. Le processus de rénutrition étant lent, il rallonge la durée d'hospitalisation des patients et retarde les soins spécifiques.

Mots-clés : cancer, dénutrition, hospitalisation, Abidjan.

Abstract

Undernutrition is a pejorative factor in the oncological management of the patient which is associated with an increase in morbidity and mortality, a decrease in quality of life leading to a long hospital stay. We report the case of a 62-year-old patient, followed at the Treichville University Hospital admitted to hospitalization for physical asthenia on adenocarcinoma of the left colon metastatic hepatic and pulmonary without any specific treatment in which the physical examination finds:

- PS WHO 3
- Significant weight loss (loss of 28% of usual weight in 3 months), (weight 37 KG, Height: 165cm, BMI: 13, 59kg/M2)
- Sarcopenia- Reduction of more than 50% in food intake- Albumin: 17.9g/l
- MNA score: 3

Metabolic disorder (severe HypoNa+: 117 meq/L, HypoK+: 2.61 meq/L)- Moderate anaemia (7.1 g/dl) microcytic hypochromiumHE benefited from the correction of metabolic disorders and nutritional rehabilitation. The evolution was marked by a stabilization of the metabolic and nutritional balance, of the clinical state with weight gain and a WHO score 2; We continued his treatment and on D35 of hospitalization, he benefited from the first course of chemotherapy. Post-chemotherapy tolerance was good and the assessment of nutritional status was favourable. It was decided to continue with the nutrition protocol. However, there was a problem of financial means because in our context this nutritional care is the responsibility of the patient. The patient was discharged against medical advice and died 7 days later. As the renutrition process is slow, it lengthens the length of hospitalization of patients and delays specific care.

Keywords: cancer, undernutrition, hospitalization, Abidjan.

Introduction

Undernutrition is a pathological condition resulting from the imbalance between the body's nutritional intake and energy expenditure (HAS, France) [1]. It represents a pejorative factor in the oncological management of the patient. Its prevalence is about 40% for all cancers. It is associated with an increase in morbidity and mortality, a decrease in quality of life, an increase in grade 3 and 4 toxicity leading to a reduction in the doses of chemotherapy molecules; it also leads to a lengthening of the length of hospitalization and an increase in health costs. Its management is multidisciplinary involving nutritionists, medical oncologists, surgeons, pharmacists and paramedics.

In the cancer department of the Treichville University Hospital, the care of malnourished patients faces enormous constraints in terms of human resources. We report a case of malnutrition in cancer confronted with this problem

Clinical case

Patient, 62 years old, Ivorian, with no known pathological history, teacher, resident of San PEDRO, not insured, followed for adenocarcinoma of the left colon initially metastatic hepatic and pulmonary in whom an indication for palliative chemotherapy FOLFOX protocol was decided in a multidisciplinary consultation meeting (RCP).

He was admitted to hospital for a deterioration in his general condition with significant malnutrition. The physical examination finds:

- PS WHO 3
- Significant weight loss (loss of 28% of usual weight in 3 months), (weight 37 KG, Height: 165cm, BMI: 13, 59kg/M2)
- Sarcopenia- Reduction of more than 50% in food intake- Albumin: 17.9g/l
- MNA score: 3

Severe undernutrition was associated with this picture:

- Metabolic disorder (severe HypoNa+: 117 meq/L, HypoK+: 2.61 meq/L)

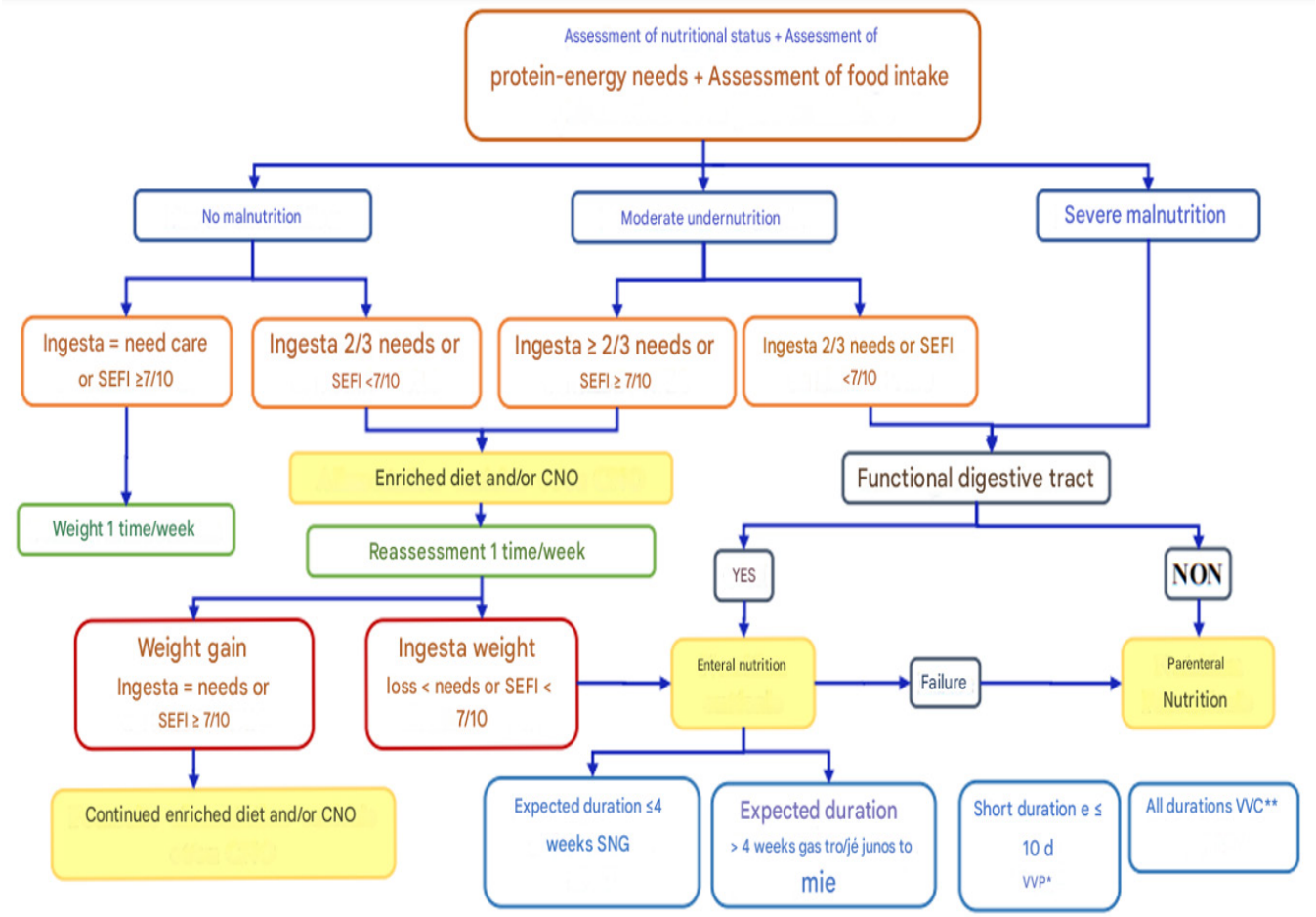
- Moderate (7.1g/dl) hypochromic microcytic anaemia

He has benefited from nutritional rehabilitation in hospitalization (enriched diet, meal splitting, oral nutritional supplements, and parenteral nutrition sometimes due to functional problems of the digestive tract), correction of hydroelectrolyte disorders, blood transfusion and psychological support. The evolution was marked on day 30 by a return of the patient's appetite, an improvement in the general condition, a weight gain: BMI 17Kg/m2, an increase in albumin to 28g/l, a correction of the anaemia from 7g/dl to 10.5g/dl.

He then benefited from his first course of chemotherapy on day 35 of hospitalization according to the FOLFOX4 protocol indicated after a decision on the RCP. Post-chemotherapy tolerance was good and the assessment of nutritional status was favourable with an MNA score of 7. It was decided to continue with the nutrition protocol. However, there was a problem of financial means because in our context this nutritional care is the responsibility of the patient. The patient was discharged against medical advice and died 7 days later.

Discussion

The management of undernutrition is an integral part of oncology care and requires as many resources as the specific treatment of cancer; The definition of undernutrition and its management is well codified in the various guidelines. This algorithm proposed by Christoph GOURC, dietician at the Transversal Nutrition Unit (UTN), describes it well [2].



Reference article: C Bouteloup et al. Nutr Clin Metabl 2014 :28
http://www.sfnep.org http://em-consulte.com/revue/nutcli

This care involves several practitioners (nutritionists, medical oncologists, surgeons, pharmacists, nurses and even nursing assistants). However, it is left to the care of the patient and his family.

JC Melchior et al., in an inventory of nutritional care in hospitals in Europe, found five major points of dysfunction:

- Lack of clearly identified precision
- Insufficient nutrition training for all categories of people
- Lack of influence and ignorance of patients
- Lack of cooperation between the different categories of staff
- Lack of involvement of hospital administrators [3].

These dysfunctions can be superimposed on those found in our context of practice.

As the renutrition process is slow, it lengthens the length of hospitalization of patients and delays specific care [4]. Hua H. et al. observed a difference of 4.61 days of hospitalization between malnourished and non-malnourished patients awaiting surgery for digestive cancer [5]. The same observation was made by Vaillant MF et al. in hematology-oncology. The median length of stay was 15 days (mean 19.2 days) in the undernutrition group

and 09 days (mean 13.2 days) in the group with comorbidities other than malnutrition[6].

It should be noted that these relatively short hospital stays compared to ours (60 days and more) are observed in several cases and in health centers with an integrated palliative care team including seasoned nutritionists and a high technical platform. This is not the case in our context where palliative care is expanding rapidly and the financial burden for treatment falls almost exclusively on the patient. The patient in our context spends not only on renutrition, specific treatment, but also on hospitalization. He ends up exhausting himself financially and compromises the prognosis.

Conclusion

The management of undernutrition in oncology is an emergency. The inadequacy of collaboration between the various actors involved, the inadequacy of the technical platform in our work context are all factors that impact the proper management of undernutrition in oncology and thus lengthen the duration of hospitalization.

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Conflict interest : None

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