

Entry Level Clinical Nutrition Part II

First appointment procedure

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Extra Vitamin D and Calcium Aren't Necessary, Report Says

By GINA KOLATA

The very high levels of vitamin D and calcium that are often recommended by doctors and testing laboratories — and can be achieved only by taking supplements — are unnecessary and could be harmful, an expert committee says.

The group said most people have adequate levels of vitamin D in their diets and natural sources like sunshine, the committee says in a report that is to be released on Tuesday.

"For most people, taking extra calcium and vitamin D supplements is not indicated," said Dr. Clifford J. Rosen, a member of the panel and an osteoporosis expert at the Maine Medical Center Research Institute.

Dr. J. Christopher Gallagher, director of the bone metabolism

unit at the Creighton University School of Medicine in Omaha, Neb., agreed, adding, "The onus is on the people who propose extra calcium and vitamin D to show it is safe before they push it on people."

Over the past few years, the idea that nearly everyone needs

the nation.

With calcium, adolescent girls may be the only group that is getting too little, the panel found. Older women, on the other hand, may take too much, putting themselves at risk for kidney stones. There also is tentative evidence that excess calcium can increase the risk of heart disease, the group wrote.

As for vitamin D, some promi-

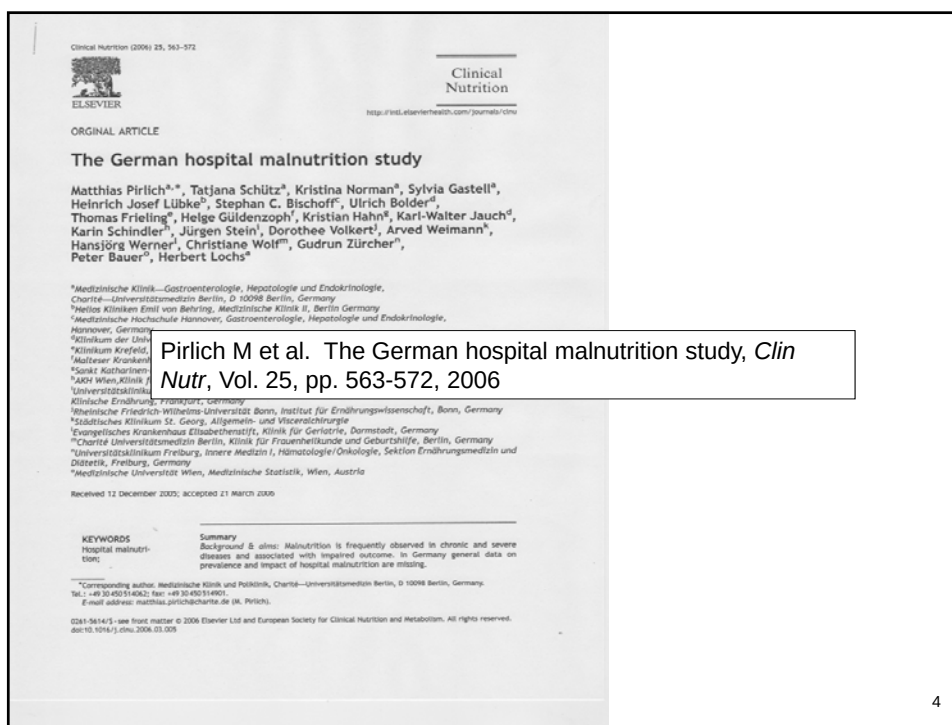
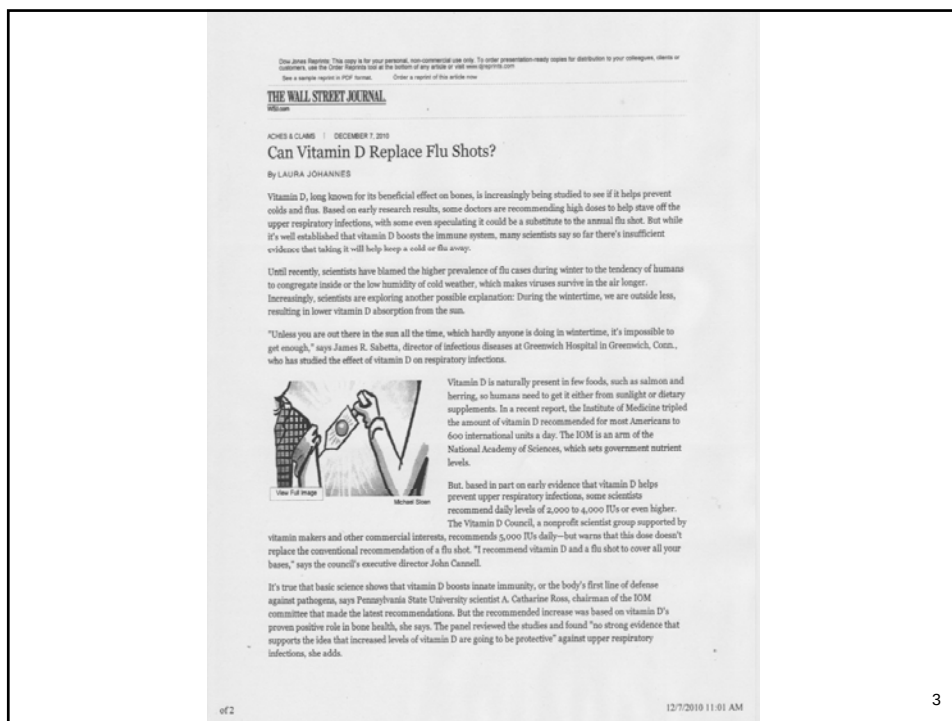
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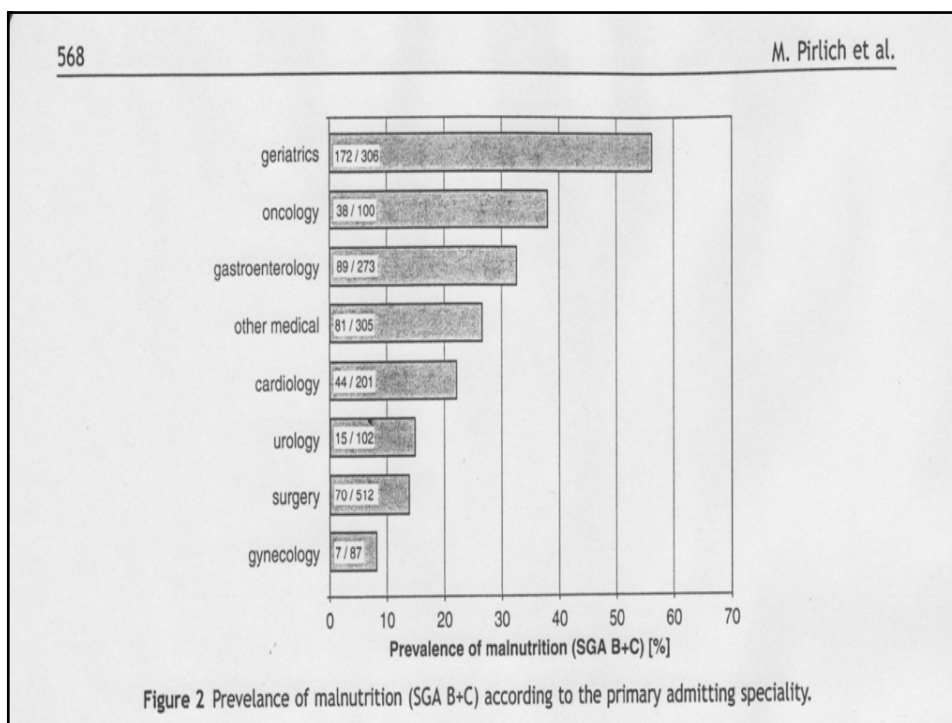
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Original Article
Short-term individual nutritional care as part of routine clinical setting improves outcome and quality of life in malnourished medical patients^a
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Conclusion: Malnourished patients profit from routine support regarding nutrition status and quality of life. They have fewer complications, need fewer antibiotics and are less often re-hospitalized.
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1. Introduction
An insufficient nutritional status judged by low BMI, for example,
“Malnourished patients profit from nutrition support regarding nutrition status and quality of life. They have fewer complications, need fewer antibiotics and are less often re-hospitalized.”

Abbreviations: BMI, body mass index; LOS, length of stay; NRS-2002, Nutrition Risk Screening 2002; OR, oral nutritional supplement; PFS, physical activity level; RFS, resting energy expenditure; SE, stress factor; SGA, quality of life Short Form 36 Questionnaire; TEE, total energy expenditure.
^a Conference presentation: State of the art was presented at a poster at the 14th Congress of the European Society for Clinical Nutrition and Metabolism (ESPEN), Vienna 2009 and in a talk at “Nutrition 2010” in Zurich in 2010.
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Articles

Effect of daily aspirin on long-term risk of death due to cancer: analysis of individual patient data from randomised trials

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Summary
Background: Treatment with daily aspirin for 5 years or longer reduces subsequent risk of colorectal cancer. Several lines of evidence suggest that aspirin might also reduce risk of other cancers, particularly of the gastrointestinal tract, but proof in man is lacking. We studied deaths due to cancer during and after randomised trials of daily aspirin versus control drugs originally for prevention of vascular events.

Methods We used individual patient data from all randomised trials of daily aspirin versus no aspirin with mean duration of scheduled trial treatment of 4 years or longer to determine the effect of allocation to aspirin on risk of cancer death in relation to scheduled duration of trial treatment for gastrointestinal and non-gastrointestinal cancers. In four large UK trials, long-term post-trial follow-up of individual patients was obtained from death certificates and cancer registries.

Results In eight eligible trials, pooled odds ratio (OR) of available from seven trials cancers, hazard ratio (HR) risk of cancer death (95% CI) in control groups (all solid cancers, 0.48, 0.34-0.68). Effect on deaths was also observed, colorectal, and prostate cancer. For lung and oesophageal cancers benefit was confined to adenocarcinomas, and the overall effect on 20-year risk of cancer death was greatest for adenocarcinomas (HR 0.46, 0.34-0.63, p<0.001). Benefit was attenuated to aspirin dose (75 mg upwards), sex, or smoking, but increased with age—the absolute reduction in 10-year risk of cancer death reaching 7.44% (2.42-11.74) at age 65 years and older.

Interpretation Daily aspirin reduced deaths due to several common cancers during and after the trials. Benefit was observed, colorectal, and prostate cancer. For lung and oesophageal cancers benefit was confined to adenocarcinomas, and the overall effect on 20-year risk of cancer death was greatest for adenocarcinomas (HR 0.46, 0.34-0.63, p<0.001). Benefit was attenuated to aspirin dose (75 mg upwards), sex, or smoking, but increased with age—the absolute reduction in 10-year risk of cancer death reaching 7.44% (2.42-11.74) at age 65 years and older.

Incidence or growth rate, or both, of several cancers in animal models mediated at least in part by inhibition of the cyclooxygenase (COX) enzymes and reduced production of prostaglandins and other inflammatory mediators, but these findings might not be applicable to humans. Observational studies in humans also suggest that aspirin reduces risk of certain cancers,¹⁻⁴ but results effect on other cancers is lacking. 10-year follow-up of the Women's Health Study, a randomised trial of 100 mg of aspirin on alternate days versus control, showed no reduction in incidence of cancers.⁵ However, aspirin also failed to prevent colorectal adenomas in this study, which is consistent with observational studies suggesting that daily aspirin is required for

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“...since the effect of aspirin on risk of cancer death increased with scheduled duration of trial treatment, the roughly 30% reduction in 20-year risk of cancer deaths observed in patients with scheduled trial treatment of 7.5 – 10 years may well underestimate the benefit that would result from longer-term treatment (eg, from age 50-75 years).”

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Doctor-patient rapport lacking

And both agree communication can be matter of life or death

By Elizabeth Weise
USA TODAY

Doctors and patients alike say that when they communicate well, even make the difference between life and death.

But a national survey of doctors and hospitalized patients finds that, in reality, effective communication often is sorely lacking.

Only 48% of patients said they were always involved in decisions about their treatment, and 29% of patients didn't know who was in charge of their case while they were in the hospital.

"That's terrible," says Beth Lown, medical director of the Schwartz Center for Compassionate Healthcare at Massachusetts General Hospital, which commissioned the survey by Marttila Strategies in Boston. These patients "are orphans" in the hospital, she says.

Eighty-one percent of patients and 71% of doctors agreed communication made a difference in "whether a patient lives or dies," according to the survey of 500 doctors and 800 patients.

"So there's a disconnect between what people say they want and what's happening," says Gregory Makoul, chairman of the American Academy on Communication in Healthcare.

There is on better communication has increased in recent years as the medical community has become more aware of its effect on patient healing. Since 1995, U.S. medical students have been required to get training in communication skills. And in 2005, the United States Medical Licensing Exam began to include testing on interpersonal and communication skills.

Communication skills and high patient-satisfaction scores can give hospitals a competitive edge as well as reduce malpractice claims, says Debra Roter, a professor at Johns Hopkins University in Baltimore.

USA Today, December 6, 2010

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First appointment diagnostic procedure

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First appointment diagnostic procedure

- At the time the patient makes the first appointment, request that the following be submitted before the first appointment (This will “weed out” those who are serious about making changes to improve their health versus those who are looking for “magic pills”):
 - Any lab test that has been performed within the last two years.
 - A written history of the chief complaint.
 - A three day dietary history. Specifically request “everything that goes into your mouth for three days” as the patient will often neglect to include important items such as liquids, chewing gum, breath mints, snack foods, etc. if the request only states “a three day dietary history.” Please remember that many if not most patients today are creating most of the diet related metabolic imbalances at snack time, not a meal time.

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First appointment diagnostic procedure

- Review the above before the first appointment to gain familiarity so that repore can be created as soon as possible upon meeting the patient. Upon meeting the patient, make sure you indicate that you read this information by thanking the patient for doing such an excellent job in providing it.

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First appointment diagnostic procedure

- Upon first meeting the patient, examine the patient visually. Take mental note of any of the following:
 - Look for any signs of loss of muscle mass such as “floppy” triceps, “saggy” gluteal muscles, and overall muscle definition in arms and legs.
 - Look at the face and any other exposed areas to see skin tone. Is it smooth and supple with healthy coloring or wrinkled, hard, shiny, or pasty?
 - Look at the posture and gait. Does it suggest confidence, fear, anger, resentment, or despair?

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First appointment diagnostic procedure

- Take a detailed history by asking key questions (See enclosed questionnaire). It is strongly advised not to use only history or symptom “forms” that the patient fills out for the following reasons:
 - Truly understanding the patient’s concerns, fears, desires, etc. and establishing a caring and friendly relationship is probably more important than gaining factual information in terms of successful resolution of chief complaints.
 - Key information that may be most important to understanding how the patient became chronically ill is often sensitive and potentially embarrassing. Very rarely will patients indicate this information on a form.

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First appointment diagnostic procedure

- Patients often forget key information or do not completely understand the questions.
- Every patient has a story to tell. Odds of resolution of chief complaints increase dramatically if the patient is allowed to tell this story even though you have heard variations of this story from many patients many times.
- Patients generally dislike filling out long detailed forms, especially since the practitioners seen before you rarely indicated to the patient that these forms were carefully and diligently read. In turn, starting out with several lengthy forms can often lead to the formation of negative attitudes towards you even before the critical first encounter.

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First appointment diagnostic procedure

- Get body weight and analysis of body composition using bioelectric impedance scale.
- Perform grip strength test.
- Perform zinc taste test.

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First appointment diagnostic procedure

- Give roll of pH paper and explain first morning urine pH procedure (Measure first morning urine pH upon rising for five days). If the patient indicates that he or she wakes up several times during the night, urine pH should be measured at the time the patient arises to start the day's activities. ***Make sure you charge for the roll of pH paper as this will help "weed out" those who are serious about working with you.***

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First appointment diagnostic procedure

- Provide a basic explanation of why the first appointment was conducted in the manner just described and a preliminary hypothesis concerning the cause of the patient's chief complaints and how they will be addressed. This preliminary description should include the following:

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First appointment diagnostic procedure

- A general overview of what will be required of the patient in terms of lifestyle modifications (Be prepared to compromise with the patient, if possible).
- Time commitments.
- Cost, including supplements and future laboratory testing.
- A disclaimer that this explanation is preliminary and will be followed by a formal presentation of findings and treatment plan at the next appointment.

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First appointment diagnostic procedure

- **The duration of the first appointment should be approximately 1.5 – 2.0 hours in length.**
- **Make sure you charge an appropriate fee for this time.**

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First appointment questions

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First appointment questions

- Age
- Do you smoke? Have you ever smoked?
Do you currently or have you ever lived with
someone who smoked, even as a child?
- Do you take prescription drugs, including
birth control pills? If taking birth control
pills, is it for health reasons or
contraception?

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First appointment questions

- Tell me about your chief complaint(s) (Ask clarifying questions using written history that the patient submitted as a guide)? Make sure you find out how long the chief complaints have existed in any form as you want to find out if the chief complaints are truly recent in origin or, as what happens most often with chronically ill patients, current manifestations that were so severe that the patient felt compelled to seek help.
- Have you ever used prescription drugs at any time in the past, i.e., antibiotics during childhood? (Today's GI problem may have begun with chronic antibiotic use 50 years ago)
- Do you have any history of physical trauma or surgeries? Have you ever had your tonsils, appendix, or gall bladder removed? (These questions can help "jog" the memory of those who maintain that they had perfect health right up to the onset of the chief complaint)

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First appointment questions

- Do you have any history of miscarriages or abortion? (Ask delicately with the proper timing as this can be a very emotionally charged issue that can be related to many chronic health issue)
- Do you consume alcoholic beverages? If so, how much? What was your frequency of alcoholic beverage intake at any time in the past?
- Do you consider yourself overweight, underweight, or ideal weight? (Patient body image can often be as important as actual body weight in terms of resolution of chief complaints)

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First appointment questions

- Do you live in a urban or rural area? (Ask about sources of airborne pollutants such as golf courses, farms, factories, landfills, etc.)
- Is your water source city or well? (If it is well water, ask about discoloration of sinks and toilets as well as proximity of golf courses, farms, etc.)
- Who do you live with? (The quality of social relationships plays a major role in most chronic chief complaints)

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First appointment questions

- How many hours do you sleep at night? Do you have trouble falling asleep? Do you wake up in the middle of the night? (Quality sleep is an essential, anabolic “nutrient.” Most chronic symptoms will not resolve without optimal quality sleep.)
- Tell me about your job? (You are looking for job satisfaction, sources of repetitive motion or sedentary stress, and sources of exposure to chemical or metal toxins. Key jobs relating to toxic exposure usually involve beauticians, automobiles, photography, landscaping, farming, etc.)
- Do you work second or third shift? (Patients who sleep during the daytime can have many disturbances in hormone balances that are subject to circadian rhythms. In turn, their chief complaints may be more difficult to resolve no matter how well the patient complies with dietary, lifestyle, or supplemental recommendations)

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First appointment questions

- Tell me about your hobbies? (You are looking for quality of life, sources of repetitive motion or sedentary stress, and sources of toxic exposure, i.e., use of clay for potting, paints, etc.)
- Tell me about your exercise habits now and in the past? (Over exercise, either during recreational activities or organized sports can be a major metabolic stressor. Also, compulsive exercisers may present significant compliance challenges)
- Do you have problems with constipation or diarrhea? How often per day do you have bowel movements? If a problem exists, how long has it persisted?

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First appointment questions

- Do you have any problems with urination relating to frequency or pain? If so, how long?
- Do you have ongoing pain in any part of your body? If so, how long? (Sometimes this important issue is not a chief complaint)
- Have you used recreational drugs at any time in the past? If so, what was used, how long was it used, and what was the frequency? (Assume the answer is yes with baby boomers, 45-64 yrs, until proven otherwise.)

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First appointment questions

- Do you currently use recreational drugs?
- Have you ever traveled to foreign countries, including Mexico? If so, did you ever suffer from “Montezuma’s revenge” or any other GI disturbances? (You are looking for any history that would suggest exposure to parasites or dysbiotic organisms. This question is particularly important when the chief complaint involves GI related symptoms)
- What was the health of your mother during your pregnancy? (Many chronic illnesses begin in utero. This is important to know as these cases can be particularly difficult to resolve).

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First appointment questions

- Did either of your parents smoke or ingest significant amounts of alcohol before, during, or after the pregnancy?
- Do you know if the delivery was difficult? (Difficult deliveries can be a contributing factor to a lifetime of chronic health problems)
- Were you delivered via vaginal birth or Caesarian section? (Birth method can be a major determinant of the initial gut microflora)

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First appointment questions

- What was your overall health status during your first five years of age? (Many chronic illnesses began in a minor form during early childhood)
- What was your family life like during your first five years of age? (Issues of physical and sexual abuse and neglect can be a major cause of chronic illness).
- Were you a happy child during the first five years of age? (Today's adrenal "burnout" may have begun during early childhood)

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First appointment questions

- Ask the last three questions about ages 6-13, 13-18, and 19 to adulthood. (Different stages of life present different challenges and different opportunities for chronic illness to begin)
- Tell me about all your previous jobs? (You are looking for job satisfaction, sources of repetitive motion or sedentary stress, and sources of exposure to chemical or metal toxins. Key jobs relating to toxic exposure usually involve beauticians, automobiles, photography, landscaping, farming, etc.)
- Did you ever have any type of eating disorder such as bingeing or purging? (Many chronic illnesses can begin with eating disorders. Also, a history of eating disorders can give valuable information about state of mind and ability to comply with your recommendations)

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First appointment questions

- How fast do you eat? What do you think about when you eat? Do you ever eat standing or “on the run?” (Poor eating behaviors can explain why many patients have not seen improvement in symptoms when ingesting a quality diet).
- Is there anything else I should know about you that we have not yet discussed?

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Thank you!!

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