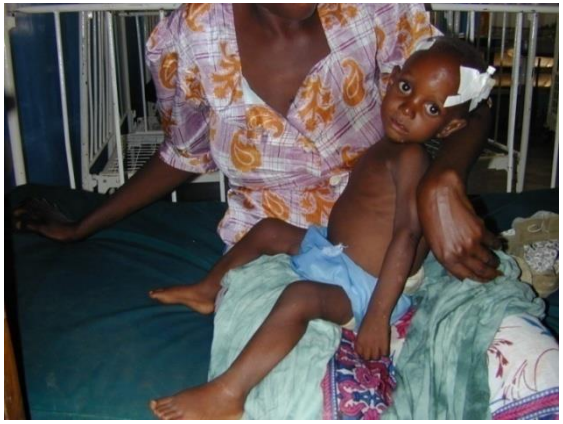
Gentle nutritional rescue – the process of feeding



- Immediate feeding
- Small volume / frequent feeding because of small stomach capacity and precarious physiology
- Vomiting is NOT a contraindication to feeding
- Routine insertion of a naso-gastric tube should be considered
- Feeds are the ‘drug’ to cure malnutrition, they are a priority (after correction of dehydration if required).

First feeding – Prescribing F75

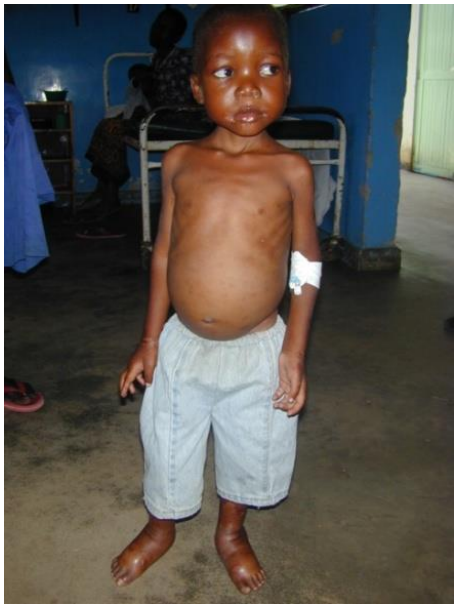
- What is the weight?
- Marasmus
  - 130 ml/kg/day start-up feed
- Kwashiorkor / marasmic kwashiorkor:
  - 100 mls/kg/day start-up feed
- 8 three hourly feeds
- ***…..this means at night too!***

F75 can be made from water, skimmed milk, oil and sugar – it is cheap, recipes are in the book!

Why don’t we feed aggressively?

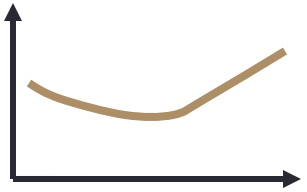
- The body really cannot tolerate more
- Too vigorous re-feeding has been associated with increased mortality.
- Too much sugar can cause an osmotic diarrhoea
- Higher protein contents cannot be handled by the liver
- Salt can make oedema worse and precipitate heart failure.

When to change from F75 ?



- Appetite test
  - If the child is clearly very hungry then use RUTF immediately – ***does this child need to be in hospital?***
- Return of appetite after starting on F75:
  - Usually between 2 – 7 days
  - Transition to F100 or RUTF if available
- Oedema:
  - You <u>do not</u> have to wait for resolution of oedema before changing if the child has a good appetite.
- Feed with cup / cup and spoon

Weight gain in the first week

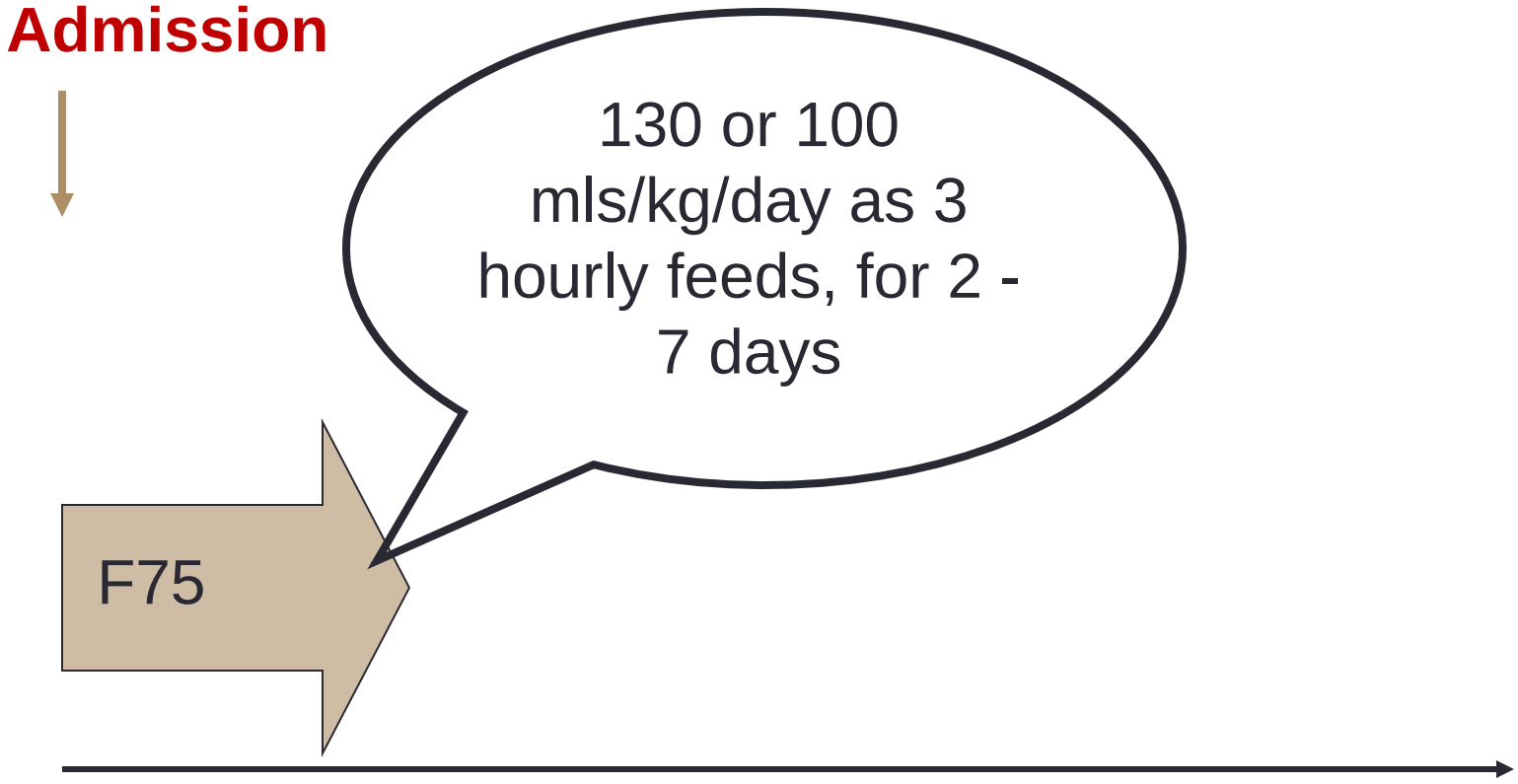


- F75 feeding is usually NOT associated with weight gain
- Weight loss may even occur in children whose oedema is improving
- Appetite and activity level denote recovery in the first week, not weight change.

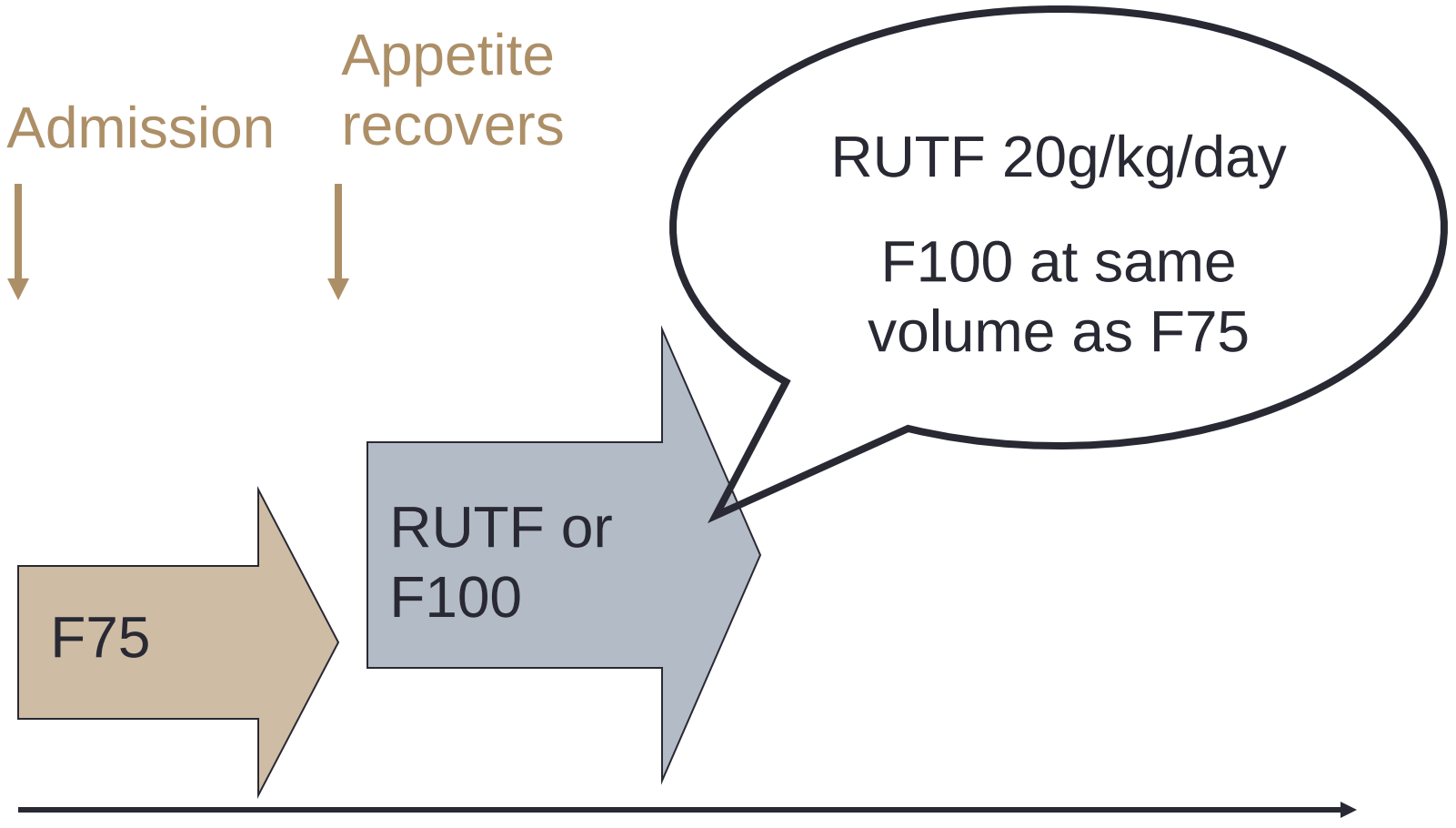
Contents of 100mls of F75 & F100

	F75	F 100
Energy (kcal)	75	100
Protein (g)	1.1	2.9
Lactose (g)	1.3	4.2
Potassium	4.2	6.3
Sodium	0.6	1.9

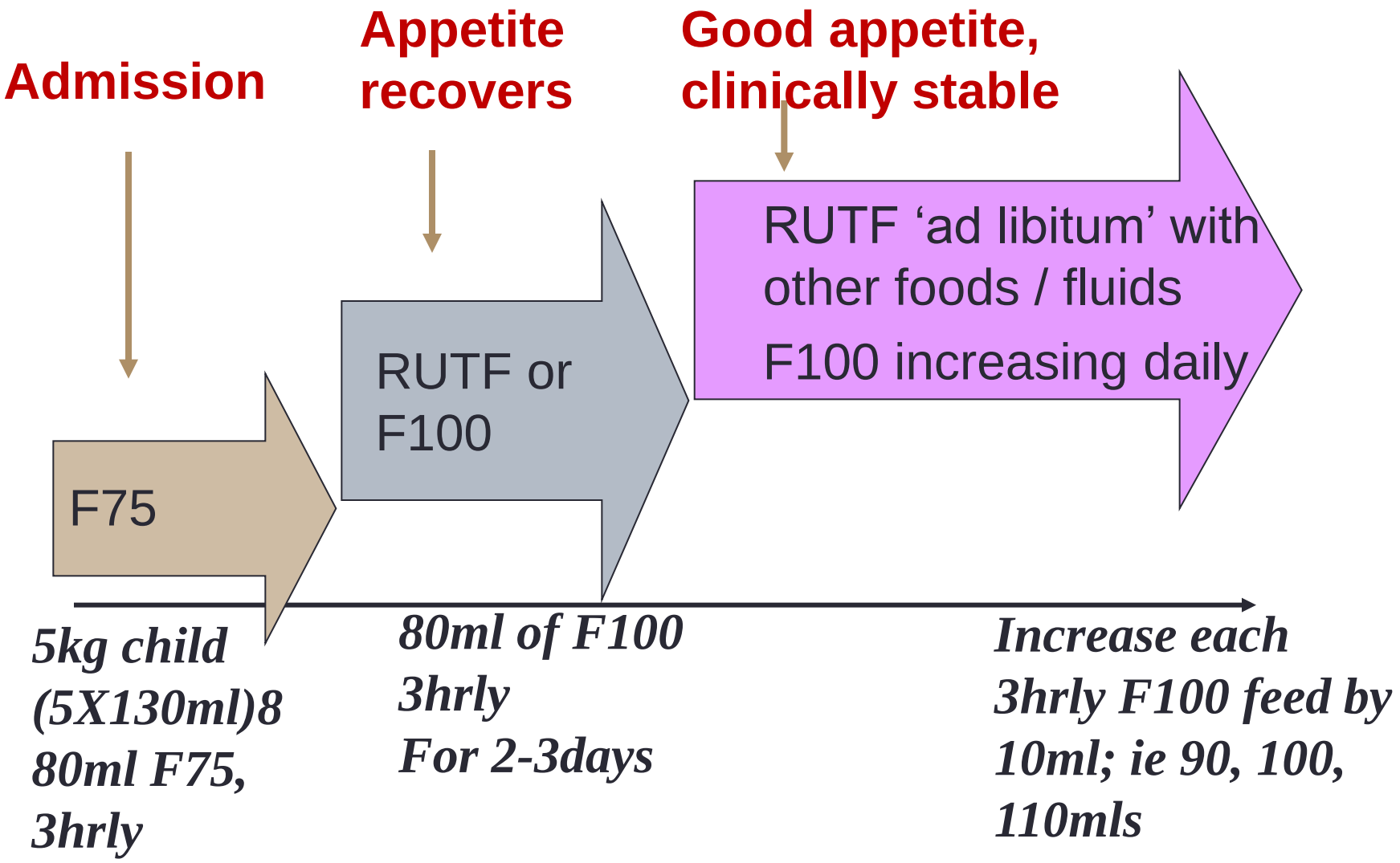
A feeding plan if seriously ill



A feeding plan



A feeding plan

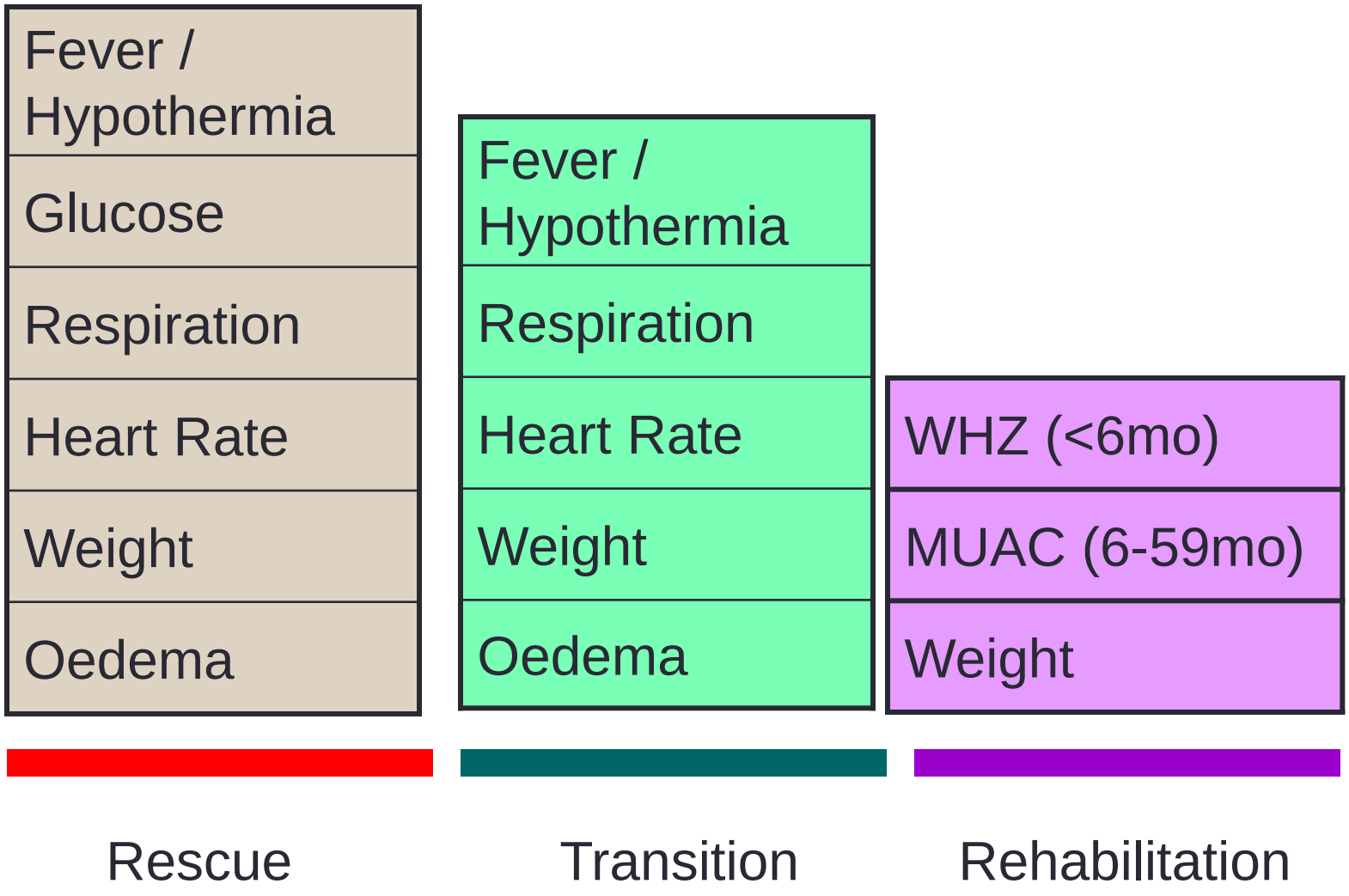


Then what?

Rehabilitation

- Introduce solid foods and increase to 5 appropriate meals a day.
- Continue RUTF / snacks in between
- Continue breast feeding
- Start oral iron and mebendazole therapy **after 1 week**
- Monitor progress
- Provide stimulation / play
- Educate the family and prepare for discharge

Monitoring 1



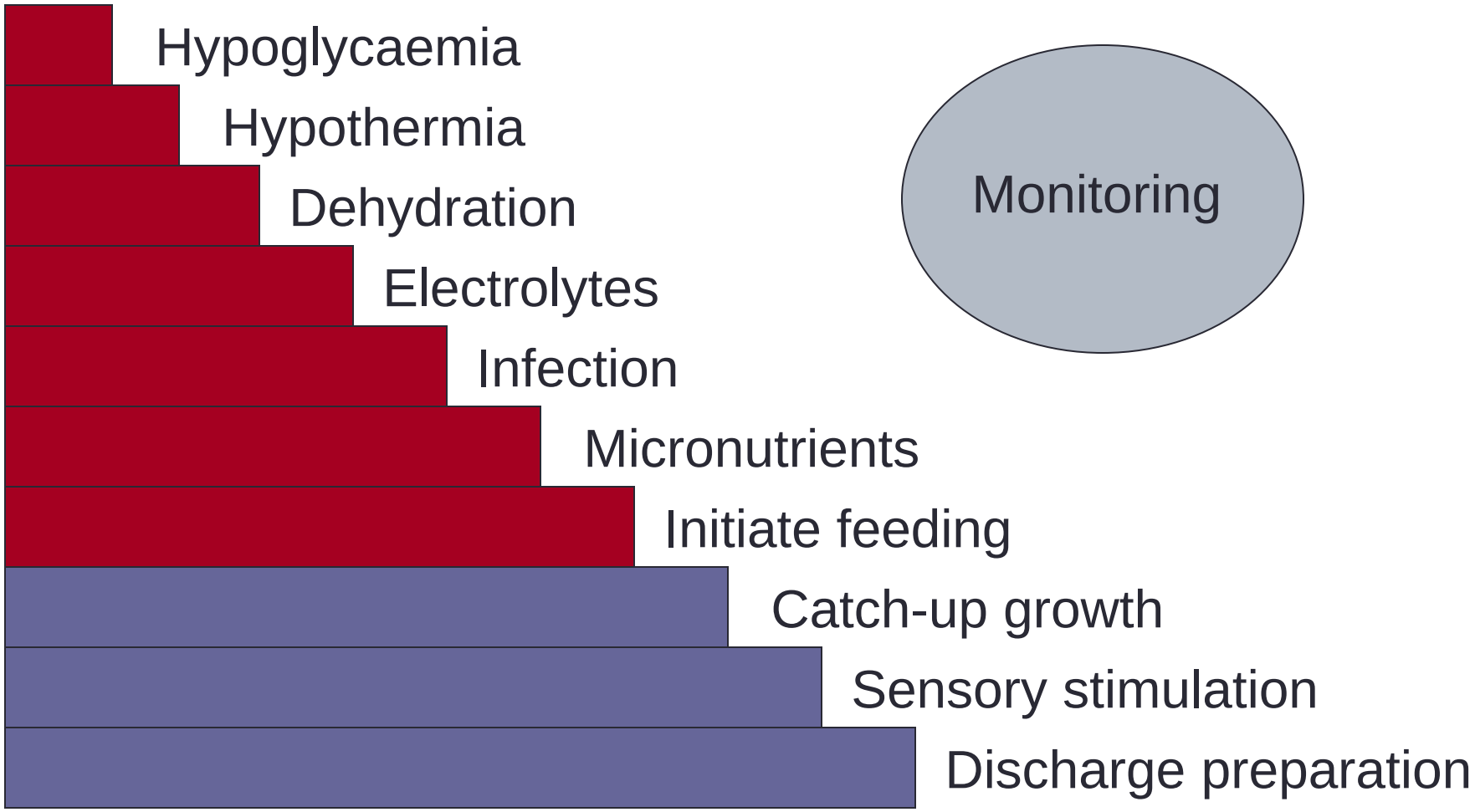
Monitoring 2

- Feed **intake must be monitored** throughout
- If there is concern for heart failure reduce feed amount / volumes for 24 hours.
- Weight gain in recovery / rehabilitation phases:
  - Poor, <5g/kg/day, full re-assessment
  - Moderate, 5 – 10g/kg/day, check intake adequate, is there untreated infection
  - Good, >10g/kg/day

When to discharge?

- Completed antibiotics
- Medical complications have resolved
- Good appetite and gaining weight
- Lost any oedema
- Appropriate support in the community or home
  - Should discharge on RUTF
- Mother / carer:
  - Available
  - Understands child’s needs
  - Able to supply needs

10 Step Approach



QUESTIONS?

Summary

- The rescue phase of nutritional support requires gentle introduction of calories and small amounts of protein.
- Pre-manufactured F75, F100 and RUTF are used because they contain adequate potassium, vitamins and ideally other minerals.
- Recovery feeding starts as the appetite returns and is gradually scaled up.