4ème Journée COmmune de Réanimation

Hôtel The Russelior Hammamet

Samedi 31 Mai 2025

NUTRITION ENTERALE EN REANIMATION

Etat des lieux et recommandations

Dr REBAI Aïcha

aicha.rebai@fmt.utm.tn

D A R

H M P

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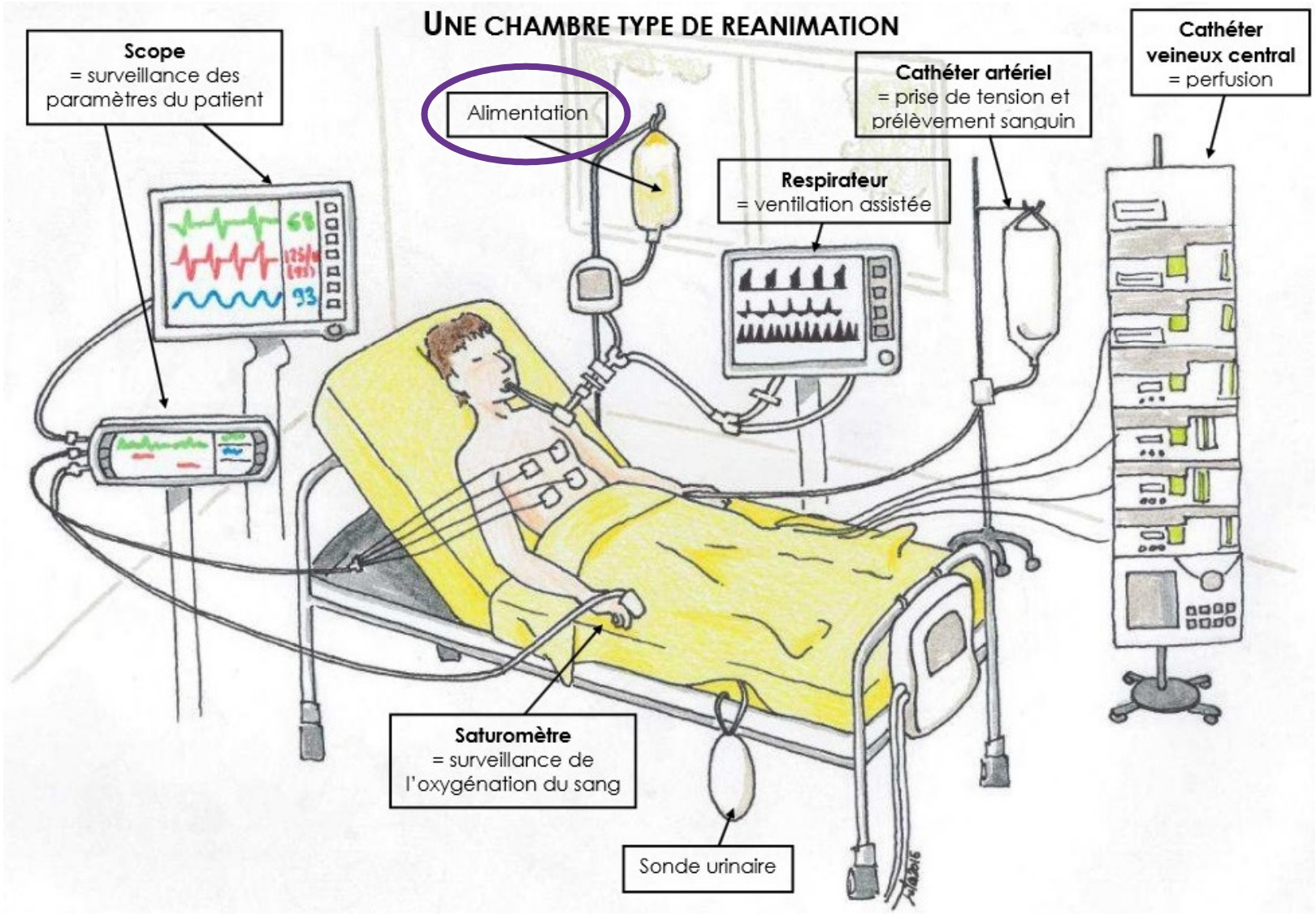
CONFLITS D'INTERE

Pourquoi doit-on en parle



Quelques chiffr

Admission : **30 – 60%** Dénutris ou à risque

Lew CCH, et al. Crit Care Med. 2017
Moisey LL, et al. JPEN J Parenter Enteral Nutr. 2020

Feeding-Gap : **50 – 70%** besoins calorico-protéïques à la 1ère semaine

Cahill NE, et al. Crit Care Med. 201
JPEN J Parenter Enteral Nutr. 201

Initiation : **25 – 40%** de nutrition entérale (NE) initiée à H48

Heyland DK, et al. International Nutrition Surve

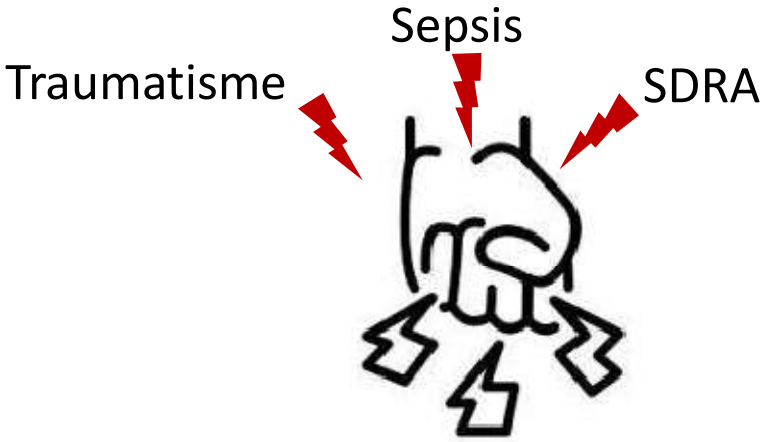
Interruption : **20 – 25%** de son temps d'administration (NE)

Macdave SA, et al. JPEN J Parenter Enteral Nutr. 2009 (étude observationnell

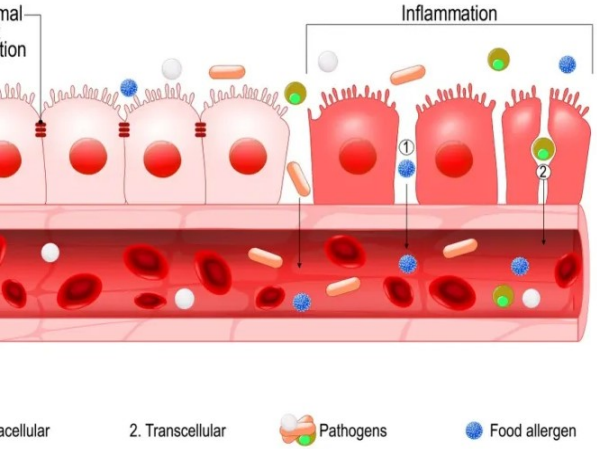
Over-feeding : **15-25%**

Zusman O, et al. Crit Care. 2016
Singer P, et al. Clin Nutr. 2019 (guidelines ESPEN)

Ce que l'on sait



ALTERATION
BARRIERE

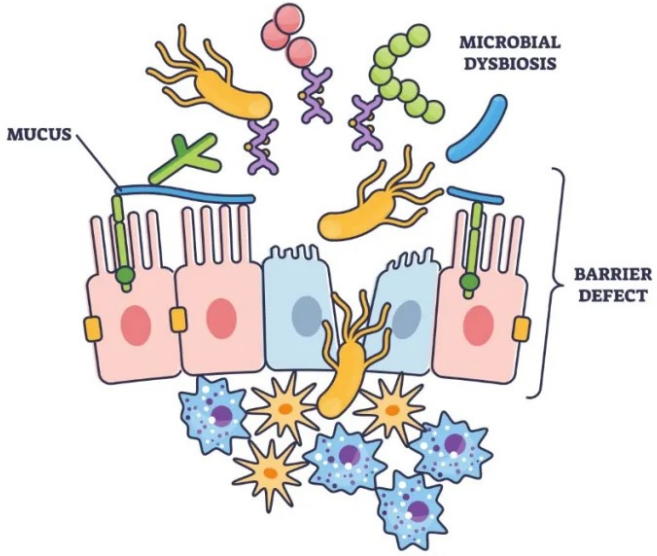


Ce que l'on sait

Traumatisme
Sepsis
SDRA

ALTERATION BARRIERE

DYSBIOSE INTESTINALE



Ce que l'on sait

Sepsis

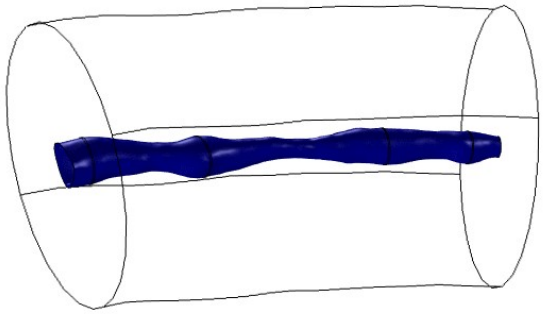
Traumatisme

SDRA

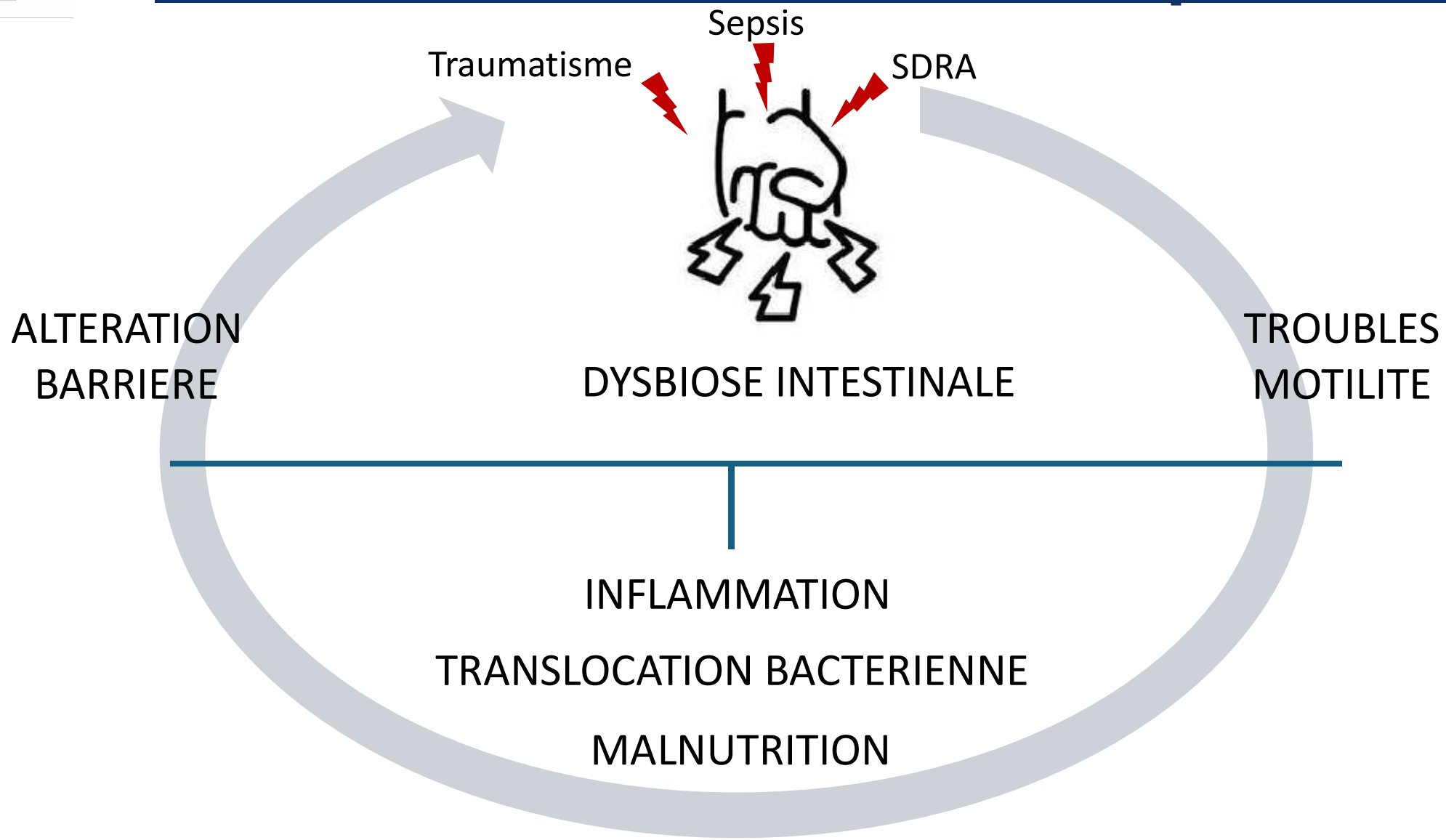
ALTERATION BARRIERE

DYSBIOSE INTESTINALE

TROUBLES MOTILITE



Ce que l'on sait



Ce que l'on sait

ORIGINAL ARTICLE

Negative impact of hypocaloric feeding and energy balance on clinical outcome in ICU patients

Clinical Nutrition (2005) 24, 502–509

Stéphane Villet[a], René L. Chiolero[b], Marc D. Bollmann[b], Jean-Pierre Revelly[b], Marie-Christine Cayeux RN[b], Jacques Delarue[c], Mette M. Berger[b,*]

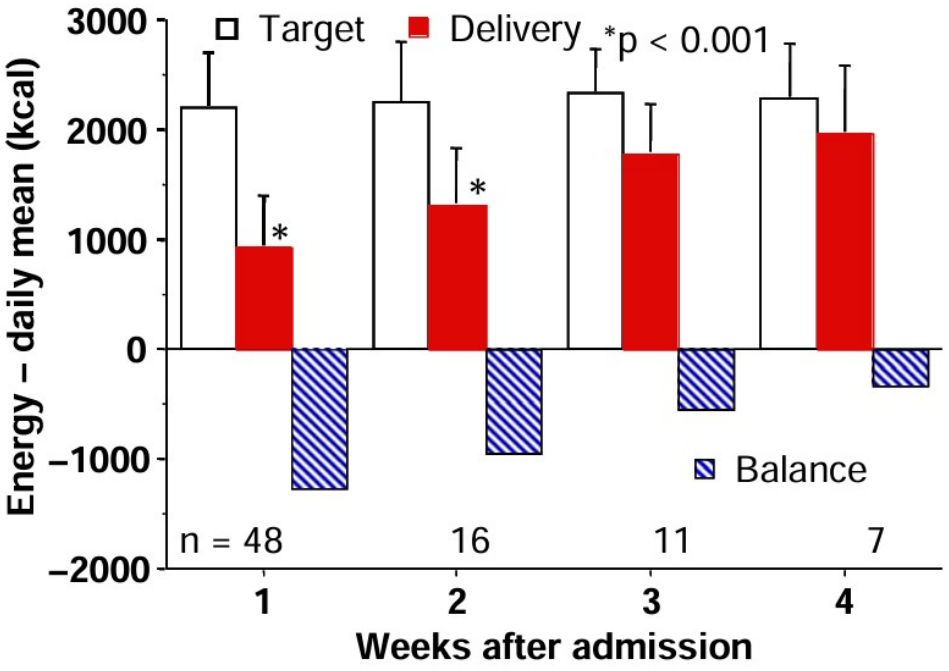


Table 4 Relationship between complications a cumulated energy deficit by regression analysis.

Variables	*F*	*P*
Length of stay	25.18	0.00
Complications	15.15	0.00
Infections	9.14	0.00
Days on antibiotics	17.48	0.00
Start of nutrition	17.17	0.00
Days of mechanical ventilation	17.12	0.00

Ce que l'on sait

APPORT
ALORICO-
ROTEIQUE

MAINTIEN
BARRIERE

BAISSE
LAMMATION

SOUTIEN
IMMUNITAIRE

Qui en parle

CLINICAL GUIDELINES

aspen

J Parenter Enteral Nutr. 2022;4

Guidelines for the provision of nutrition support therapy the adult critically ill patient: The American Society for Parenteral and Enteral Nutrition

Charlene Compher PhD, RD[1] | Angela L. Bingham PharmD[2,3] | Michele McCall N
RD[4] | Jayshil Patel MD[5] | Todd W. Rice MD, MSc[6] | Carol Braunschweig PhD[7]
Liam McKeever PhD, RDN[7]

Clinical Nutrition 42 (2023) 1671–1689

Contents lists available at ScienceDirect

Clinical Nutrition

journal homepage: http://www.elsevier.com/locate/clnu

Guideline

N practical and partially revised guideline: Clinical nutrition in
ntensive care unit

Singer [a, *], Annika Reintam Blaser [b, c], Mette M. Berger [d], Philip C. Calder [e],
el Casaer [f], Michael Hiesmayr [g], Konstantin Mayer [h],
arlos Montejo-Gonzalez [i], Claude Pichard [j], Jean-Charles Preiser [k],
ch Szczeklik [l], Arthur R.H. van Zanten [m], Stephan C. Bischoff [n]

Clinical Nutrition. 2023;42:

1

Quel Timing

1 Quel timing

Clinical nutrition in ICU

very critically ill patient staying for more than 48 h
e ICU should be considered at risk for
nutrition. (S1, 96%)

2) Medical nutrition therapy shall be considered f
all patients staying in the ICU, mainly for more tha
48 h. (R1, GPP, 100%)

Oral Nutrition possible ?

Oral nutrition
least partial oral nutrition)

al diet shall be preferred over EN or PN in
lly ill patients who are able to eat. (R3,
)

Contreindic ation for EN

No

arly enteral
nutrition

4) A general clinical assessment should be performed to assess malnutrition in the ICU, until a specific tool has been validated. (R2,100%)

1 Quel timing

Early enteral nutrition ← *No* — **Contreindication for EN** — *Yes* → **Parenteral nutrition partial if possible**

t de choc non contrôlé

oxémie, Hypercapnie ou Acidose non trôlée

morragie gastro-intestinale supérieure ve

émie intestinale

ule intestinale à haut débit

drome du compartiment abdominal

ume d'aspiration gastrique>500 mL/6h

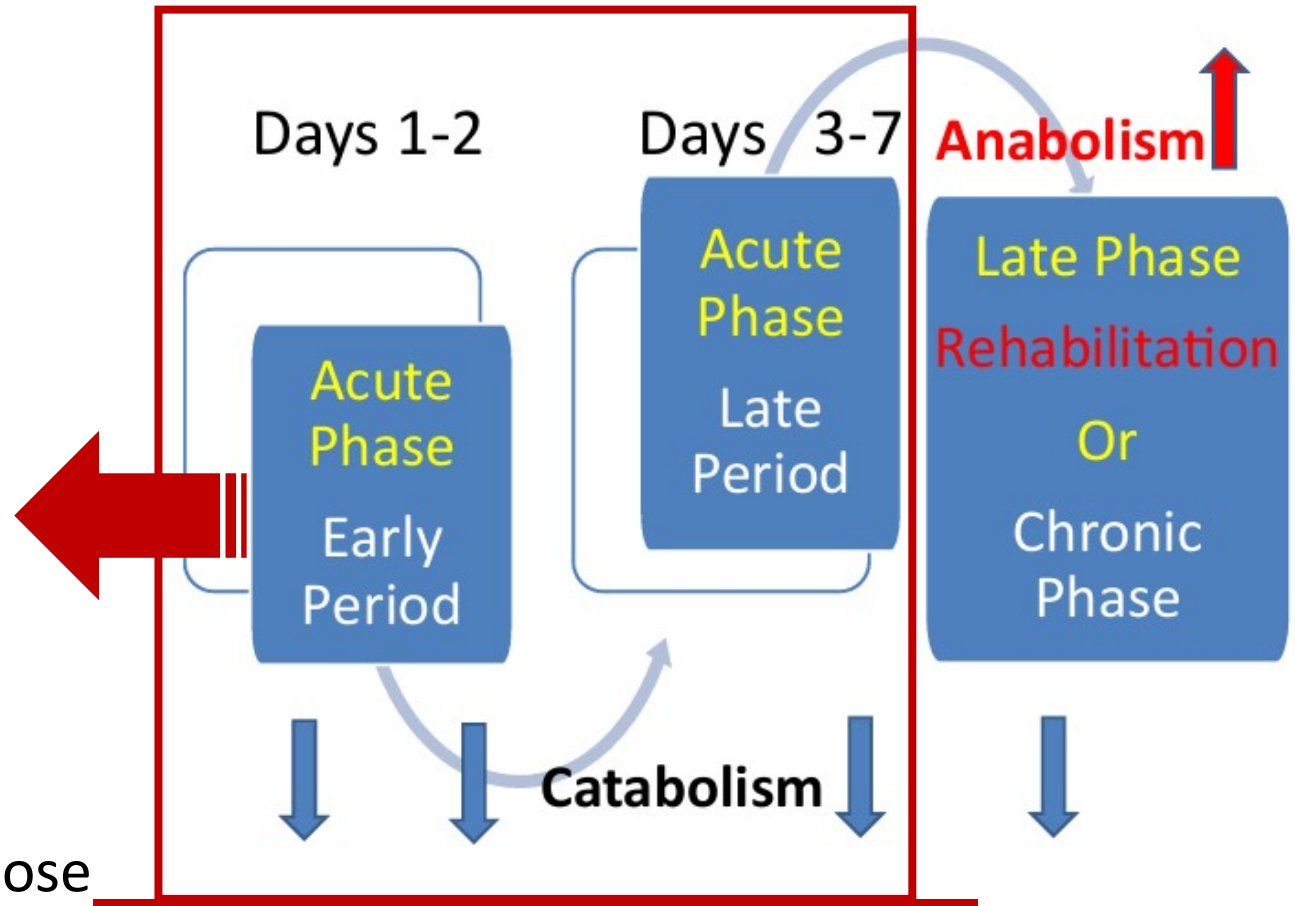
- Hypothermie thérapeutique
- Hypertension intra abdominale sans syndrome du compartiment abdominale
- Insuffisance hépatique aiguë

1 Quel timing

Apport calorique endogène :
1200 kcal/J : Non modulable, non mesurable

Perte de muscle :
1,5 à 3 kg de muscle/sem

- Insulino-résistance
- Protéolyse musculaire
- Production endogène de glucose



APPORTS CALORIQUES CACHES

Clinical Nutrition 2009;28:

1 Quel timing

re Med (2009) 35:2018–2027
7/s00134-009-1664-4

SYSTEMATIC REVIEW

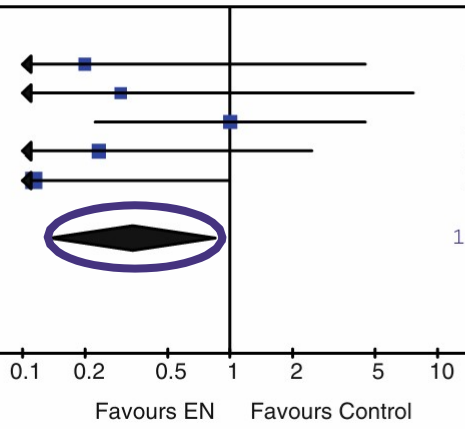
. Doig
T. Heighes
apson
A. Sweetman
R. Davies

Early enteral nutrition, provided within 24 h of injury or intensive care unit admission, significantly reduces mortality in critically ill patients: a meta-analysis of randomised controlled trials

Early EN (<24h) vs Control (Primary Analysis)
n: 01 early EN vs Control
01 Mortality, Intention to treat analysis

egory	early EN (<24 h) n/N	Control n/N	OR (fixed) 95% CI	Weight %	OR (fixed) 95% CI
990	0/10	0/10			Not estimable
999	0/17	2/19		13.40	0.20 [0.01, 4.47]
004	0/27	1/25		8.89	0.30 [0.01, 7.63]
008	6/14	6/14		19.95	1.00 [0.22, 4.47]
kul 1996	1/21	3/17		18.38	0.23 [0.02, 2.48]
01	1/30	7/30		39.38	0.11 [0.01, 0.99]
CI)	119	115		100.00	0.34 [0.14, 0.85]

ts: 8 (early EN (<24 h)), 19 (Control)
terogeneity: Chi² = 3.20, df = 4 (P = 0.52), I² = 0%
erall effect: Z = 2.31 (P = 0.02)



rimary analysis: mortality. *EN* enteral nutrition, *OR* odds ratio

Early enteral wit
adequate calorie
< 24h

Vs

EN>24h

1 Quel timing

r et al. Critical Care (2021) 25:424
://doi.org/10.1186/s13054-021-03847-4

Critical Care

EVIEW Open Access

guide to enteral nutrition in intensive care nits: 10 expert tips for the daily practice

-Charles Preiser[1*], Yaseen M. Arabi[2], Mette M. Berger[3], Michael Casaer[4], Stephen McClave[5], C. Montejo-González[6], Sandra Peake[7,8], Annika Reintam Blaser[9,10], Greet Van den Berghe[4], ur van Zanten[11], Jan Wernerman[12] and Paul Wischmeyer[13]

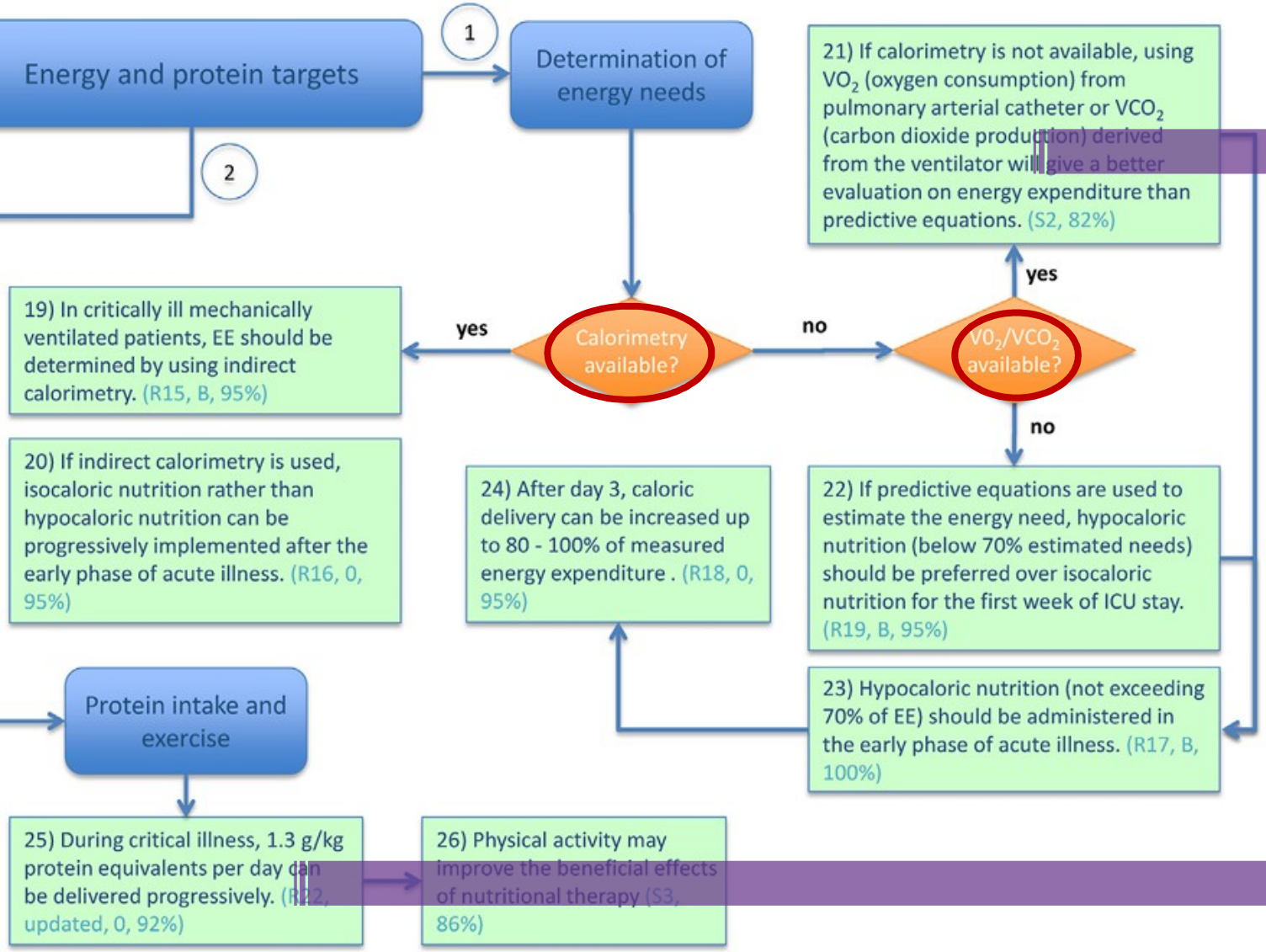
tion	Suggested answer	ASPEN/SCCM guidelines [6]	ESPEN guidelines [7]
to start?	Start within 24–48 h of ICU admission	Recommendation: start early EN within 24–48 h (quality of evidence: very low)	Start early EN (within 48 h) rather tha ing EN (grade of recommendation: E consensus) Start early EN (within 48 h) rather tha (grade of recommendation: a strong

1 **Quel Timing**

2 **Quel Objectif**

QUELS OBJECTIFS CALORIQ
PROTEIQUES

2



20 à 25 kcal/kg/J
(1500 à 2000 kcal/J)

1.3g/kg

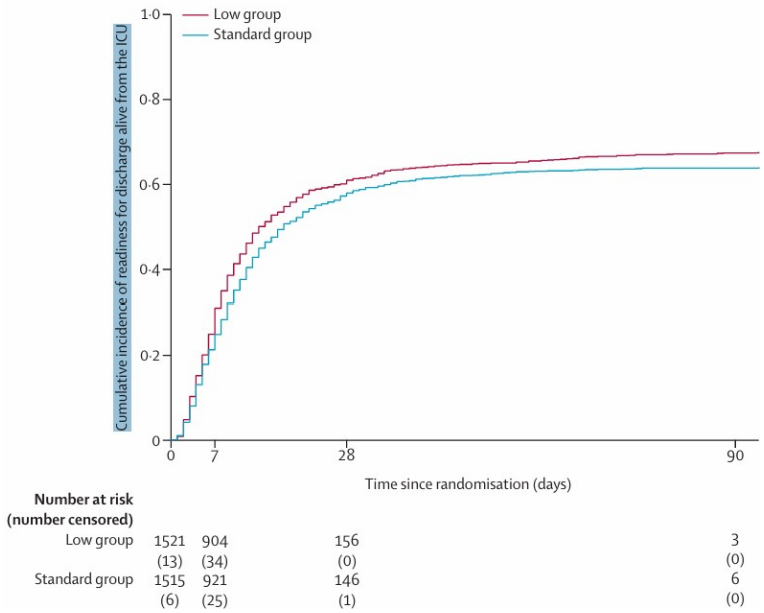
Clinical Nutrition. 2023;42:

QUELS OBJECTIFS CALORIQ
PROTEIQUES

2

versus standard calorie and protein feeding in ilated adults with shock: a randomised, controlled, ticentre, open-label, parallel-group trial (NUTRIREA-3)

er, Gaetan Plantefeve, Jean-Paul Mira, Laurent Argaud, Pierre Asfar, Nadia Aissaoui, Julio Badie, Nicolae-Vlad Botoc, Laurent Brisard, m Bui, Delphine Chatellier, Louis Chauvelot, Alain Combes, Christophe Cracco, Michael Darmon, Vincent Das, Matthieu Debarre, bove, Jérôme Devaquet, Louis-Marie Dumont, Olivier Gontier, Samuel Groyer, Laurent Guérin, Bertrand Guidet, Yannick Hourmant, r, Fabien Lambiotte, Christophe Leroy, Philippe Letocart, Benjamin Madeux, Julien Maizel, Olivier Martinet, Frédéric Martino, axime, Emmanuelle Mercier, Mai-Anh Nay, Saad Nseir, Johanna Oziel, Walter Picard, Gael Piton, Jean-Pierre Quenot, Florian Reizine, ult, Jack Richecoeur, Jean-Philippe Rigaud, Francis Schneider, Daniel Silva, Michel Sirodot, Bertrand Souweine, Fabienne Tamion, zi, Didier Thévenin, Guillaume Thiery, Nathalie Thieulot-Rolin, Jean-Francois Timsit, Francois Tinturier, Patrice Tirot, nderlinden, Isabelle Vinatier, Christophe Vinsonneau, Sebastian Voicu, Jean-Baptiste Lascarrou, Amélie Le Gouge, for the -3 Trial Investigators and the Clinical Research in Intensive Care and Sepsis (CRICS-TRIGGERSEP) Group



10 767 patients assessed for eligibility

3044 randomly assigned

	Low group (n=1521)	Standard group (n=1515)		Hazard ratio (95
Daily intakes				
Calories, kcal/kg per 24 h*	7·4 (5·8–9·5)	22·0 (17·5–24·9)	..	
Protein, g/kg per day	0·2 (0·2–0·3)	0·9 (0·7–1·0)	..	
Fluids, L	11·1 (6·1–16·4)	17·2 (9·7–23·4)	..	
Secondary outcomes				
Day 28 mortality	504 (33·2%; n=1519)	533 (35·2%)	−2·0 (−5·4 to 1·4)	..
ICU mortality, cumulative incidence	29·6%	32·7%	..	0·89 (0·78 to
Hospital mortality, cumulative incidence	32·2%	34·5%	..	0·93 (0·83 to
ICU length of stay, days†	9·0 (5·0 to 15·0)	10·0 (6·0 to 17·0)	..	..
Acute-care hospital length of stay, days†	21·0 (12·0 to 38·0)	22·0 (14·0 to 39·0)	..	..
Time to weaning from vasopressor support, days	3·0 (2·0 to 4·0)	3·0 (2·0 to 4·0)	..	1·07 (0·99 to
Time to invasive mechanical ventilation weaning, days	5·0 (2·0 to 11·0)	6·0 (3·0 to 12·5)	..	1·12 (1·03 to 1
Received dialysis, cumulative incidence	30·1%	31·9%	..	0·93 (0·82 to
Infections, cumulative incidence				
ICU infection‡	15·3%	17·5%	..	0·85 (0·71 to
Ventilator-associated pneumonia	11·2%	10·9%	..	0·98 (0·79 to
Bacteraemia	4·0%	5·5%	..	0·73 (0·53 to
Central venous catheter infection	1·5%	1·9%	..	0·81 (0·48 to
Urinary tract infection	0·7%	0·8%	..	1·20 (0·54 to
Soft-tissue infection	7 patients	5 patients	..	..
Other infection	1·7%	2·4%	..	0·78 (0·48 to
Gastrointestinal events, cumulative incidence				
Vomiting	20·2%	25·5%	..	0·77 (0·67 to
Diarrhoea	28·9%	33·3%	..	0·83 (0·73 to
Constipation	27·8%	28·7%	..	0·97 (0·86 to
Bowel ischaemia	0·9%	1·8%	..	0·50 (0·26 to
Acute colonic pseudo-obstruction	8 patients	2 patients	..	..
Liver dysfunction, cumulative incidence§	61·7%	65·8%	..	0·92 (0·86 to

Lancet Respir Med 2023; 1

QUELS OBJECTIFS CALORIQUES PROTEIQUES

2

Energy and protein targets

1

Determination of energy needs

2

Calorimetry available?

yes

19) In critically ill mechanically ventilated patients, EE should be determined by using indirect calorimetry. (R15, B, 95%)

20) If indirect calorimetry is used, isocaloric nutrition rather than hypocaloric nutrition can be progressively implemented after the early phase of acute illness. (R16, 0, 95%)

no

VO_2/VCO_2 available?

yes

21) If calorimetry is not available, using VO_2 (oxygen consumption) from pulmonary arterial catheter or VCO_2 (carbon dioxide production) derived from the ventilator will give a better evaluation on energy expenditure than predictive equations. (S2, 82%)

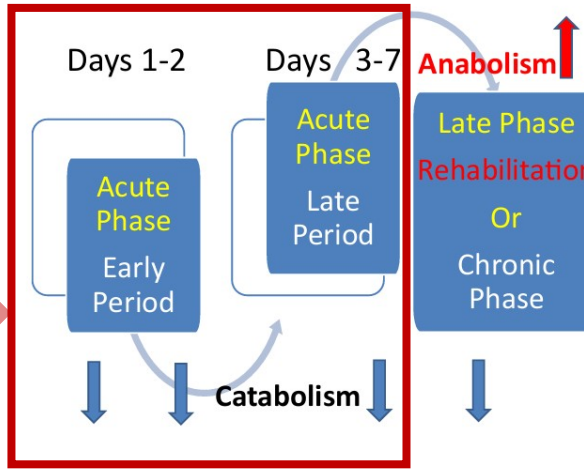
20 à 25 kcal/kg/J
(1500 à 2000 kcal/J)

no

22) If predictive equations are used to estimate the energy need, hypocaloric nutrition (below 70% estimated needs) should be preferred over isocaloric nutrition for the first week of ICU stay. (R19, B, 95%)

24) After day 3, caloric delivery can be increased up to 80 - 100% of measured energy expenditure . (R18, 0, 95%)

23) Hypocaloric nutrition (not exceeding 70% of EE) should be administered in the early phase of acute illness. (R17, B, 100%)



Protein intake and exercise

25) During critical illness, 1.3 g/kg protein equivalents per day can be delivered progressively. (R22, updated, 0, 92%)

26) Physical activity may improve the beneficial effects of nutritional therapy (S3, 86%)

1.3g/kg

Clinical Nutrition. 2023;42:

QUELS OBJECTIFS CALORIQUES PROTEIQUES

2

.10643

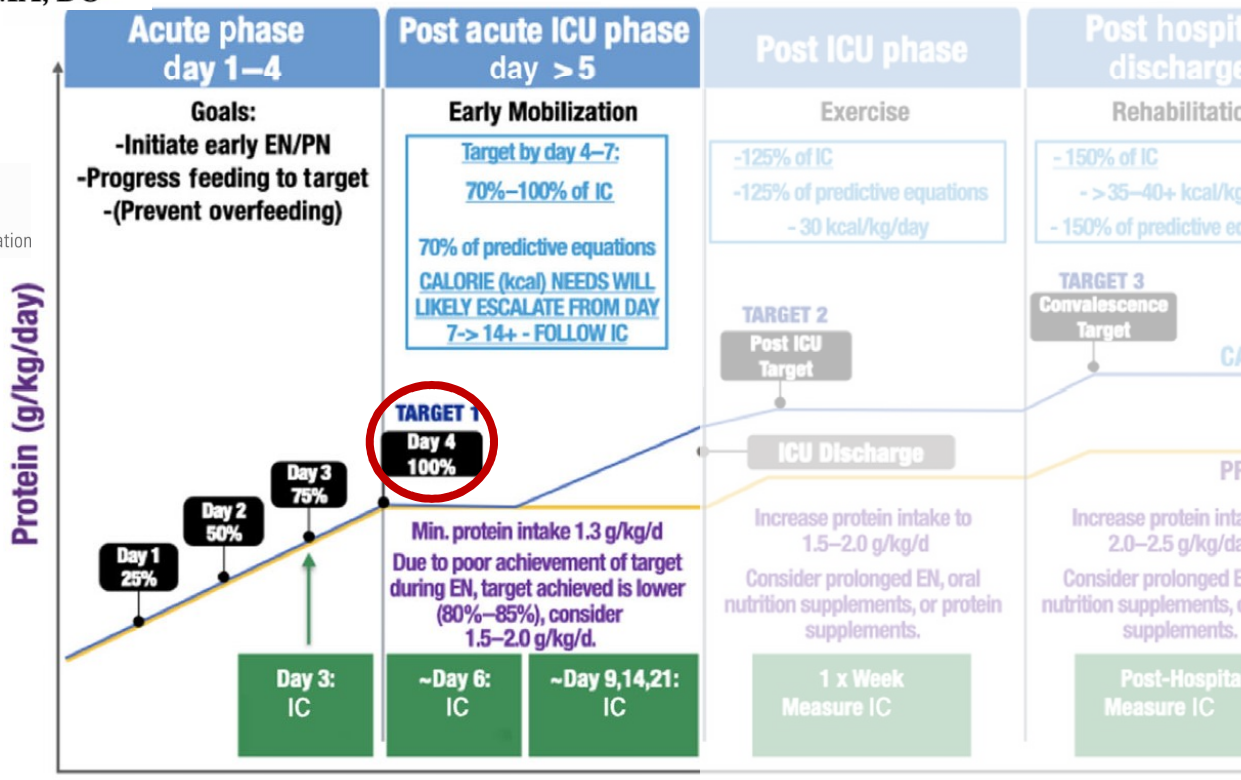
L CONTROVERSY

Nutr. Clin. Pract. 2021;36:275–281

int-Counterpoint: Indirect Calorimetry Is Essential for nal Nutrition Therapy in the Intensive Care Unit

Vischmeyer MD, EDIC[1] | Jeroen Molinger MSc[2] | Krista Haines MA, DO[3]

SFAR
Société Française d'Anesthésie et de Réanimation



QUELS OBJECTIFS CALORIQ
PROTEIQUES

2

t al. Critical Care (2021) 25:424
doi.org/10.1186/s13054-021-03847-4

Critical Care

EVALUATION ET PERSONNALISAT

J1 < 70%
12-15 kcal/kg/J
1 g/kg/J

→

J4 : 100%
25 kcal/kg
1.3 g/kg/

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guide to enteral nutrition in intensive care its: 10 expert tips for the daily practice

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stion	Suggested answer	ASPEN/SCCM guidelines [6]	ESPEN guidelines [7]
w much energy?	Accept below energy expenditure during the early phase and increase energy to match energy expenditure later (4–7 days)	Recommendation: No significant difference in clinical outcomes was found between patients with higher vs lower levels of energy intake. We suggest feeding between 12 and 25 kcal/kg (the range of mean energy intakes examined) in the first7–10day sof ICU stay.	Administer hypocaloric EN (not excee of EE) in the early phase of acute illnes of recommendation: B strong consen Increase caloric delivery can be increa 80–100% of measured EE after day 3 (recommendation: 0 strong consensus
w much proteins?	Low dose (e.g., 0.8 g/kg/day) during the early phase—to be increased to > 1.2 g/kg/day later	Suggestion: Administer sufficient (high-dose) protein in the range of 1.2–2.0 g/kg actual body weight per day and may likely be even higher in burn or multitrauma patients (quality of evidence: very low)	During critical illness, 1.3 g/kg protein lents per day can be delivered progres (grade of recommendation: 0: strong c sus)

2

QUELS OBJECTIFS CALORIQ
PROTEIQUES

FORMULE :

Iso ou Hypercalorique
Hyperprotéïque
Avec ou sans fibres

1 Quel Timing

2 Quel Objectif

3 Quel site

3UEL SITI

Early enteral nutrition ← *No* — **Contreindication for EN** — *Yes* → **Parenteral nutri partial if possib**

EN Route of administratio

hould be delayed :
ock is uncontrolled and hemodynamic and tissue
usion goals are not reached, whereas low dose EN
e started as soon as shock is controlled with
s and vasopressors/inotropes, while remaining
nt for signs of bowel ischemia
se of uncontrolled life-threatening hypoxemia,
rcapnia or acidosis, whereas EN can be started in
nts with stable hypoxemia, and compensated or
issive hypercapnia and acidosis
tients suffering from active upper gastrointestinal
ding, whereas EN can be started when the
ding has stopped and no signs of re-bleeding are
rved
tients with overt bowel ischemia
tients with high-output intestinal fistula if reliable
ng access distal to the fistula is not achievable
tients with abdominal compartment syndrome
tric aspirate volume is above 500 mL/6 h.

12) Low dose EN should be administered in patients:

- Receiving therapeutic hypothermia and increasing the dose after rewarming
- In patients with intra-abdominal hypertension without abdominal compartment syndrome, whereas temporary reduction or discontinuation of EN should be considered when intra-abdominal pressure values further increase under EN
- In patients with acute liver failure when acute, immediately life-threatening metabolic derangements are controlled with or without liver support strategies
- In dependent on grade of encephalopathy

15) Gastric access should be used as standard approach to initiate EN. (R1 100%)

Clinical Nutrition. 2023;42:

QUEL SITE ?...Comment y arrive

	Sonde Salem	SNG	SNJ	Gastrostomie	Jejunosto
ype de onde	Naso-gastrique Double courant	Naso-gastrique Simple lumière	Naso-jejunal Post-Pylorique	Gastrique	Post-pylori
nction	Aspiration gastrique Décompression NE possible	Nutrition entérale exclusive	Nutrition entérale exclusive Contourne l'estomac	Nutrition entérale exclusive	Nutrition ent exclusiv Contourn l'estoma
Durée ilisation	Courte < 5j	Moyenne (4-6 sem)	Moyenne (4-6 sem)	Longue durée > 4 – 6 sem	Longue du > 4 – 6 se
lité pose	Facile	Facile	Modérée à difficile	Modérée (procédure invasive, nécessite une expertise)	Difficile (procédu chirurgica invasive
onfort	Faible Rigide / Gros calibre	Bon > Souple / Petit	Faible à bon (Irritation)	Bon	Bon

3UEL SITI

çaises d'Anesthésie et de Réanimation 33 (2014) 202–218

SFAR
Société Française d'Anesthésie et de Réan

MMANDATIONS FORMALISÉES D'EXPERTS

ition artificielle en réanimation

elines for nutrition support in critically ill patient

frant [a,*], D. Hurel [b], N.J. Cano [c,d,e], C. Ichai [f], J.-C. Preiser [g], F. Tamion [h]

ncadré 6.2 – Il faut probablement privilégier la sonde alimentation naso- ou oro-gastrique en première intention en raison de sa simplicité d'utilisation et du moindre ût (Accord fort).

Encadré 6.5 – Il faut installer le patient en position semi-assise (> 30°) pendant le NE (Accord fort).

Encadré 6.7 – Il faut probablement poser une gastrosto lorsque la durée anticipée d'une NE dépasse 4 sema (Accord faible).

3UEL SITI

Early enteral nutrition

No

Contreindication for EN

Yes

Parenteral nutri
partial if possib

- Incapacité à protéger les VA
- VNI
- Âge >70 ans
- AEC + Déficit neurologique
- Mauvais état bucco-dentaire
- Ratio inf/mde insuffisant
- DD
- RGO

EN Route of administratio

13) In patients deemed to be at high ri
aspiration, postpyloric, mainly jejunal
can be performed. (R12, 95%)

15) Gastric access should be used as
standard approach to initiate EN. (R1
100%)

3UEL SITI

Early enteral nutrition

No

Contreindication for EN

Yes

Parenteral nutri
partial if possib

EN Route of administratio

13) In patients deemed to be at high ri
aspiration, postpyloric, mainly jejunal f
can be performed. (R12, 95%)

14) Continuous rather than bolus EN s
be used. (R9, 95%)

15) Gastric access should be used as
standard approach to initiate EN. (R1
100%)

16) In patients with gastric feeding
intolerance not solved with prokinetic
postpyloric feeding should be used (R
100%)

1 Quel Timing

2 Quel Objectif

3 Quel site

4 Quelle surveillance

Q④ELLE SURVEILLAN

N should not be started until all
nable strategies to improve EN
nce have been attempted. (R 21,
ed, 100%)

- Surveillance des complications associées à la N
  - Distension abdominale
  - Remplissage gastrique excessif
  - Vomissements, régurgitations alimenta
  - Distension intestinale jusqu'à Ogilvie
  - Ischémie intestinale
  - Diarrhée
- Surveillance du **volume gastrique résiduel**
- Mesure de la pression intra-abdominale

t al. Critical Care (2021) 25:424
doi.org/10.1186/s13054-021-03847-4

Critical Care

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guide to enteral nutrition in intensive care its: 10 expert tips for the daily practice

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stion	Suggested answer	ASPEN/SCCM guidelines [6]	ESPEN guidelines [7]
v to assess gastrointestinal tolerance?	At the start of low-dose EN: high gastric residual volume (optional—threshold 500 ml/6 h), vomiting, pain, distension, elevated/increasing intra-abdominal pressure, absent bowel sounds—dynamic ileus	Suggestion: Do not use GRVs as part of routine care to monitor ICU patients receiving EN Suggestion: for those ICUs where GRVs are still utilized, avoid holding EN for GRVs < 500 mL in the absence of other signs of intolerance (quality of evidence: low)	The measurement of GRV for the assessment of gastrointestinal dys is common and may help to identi intolerance to EN during initiation progression of EN. However, moni established EN with continued measurements of GRV may not be necessary. We suggest that enteral feeding sh delayed when GRV is > 500 mL/6 h situation, and if examination of th abdomen does not suggest an acu abdominal complication, applicati prokinetics should be considered.

QUELLE SURVEILLAN

NAL ARTICLE

l Ultrasonographic-measurement of Gastric Residual me in Critically Ill Patients for Prediction of Gastric Tube Intolerance

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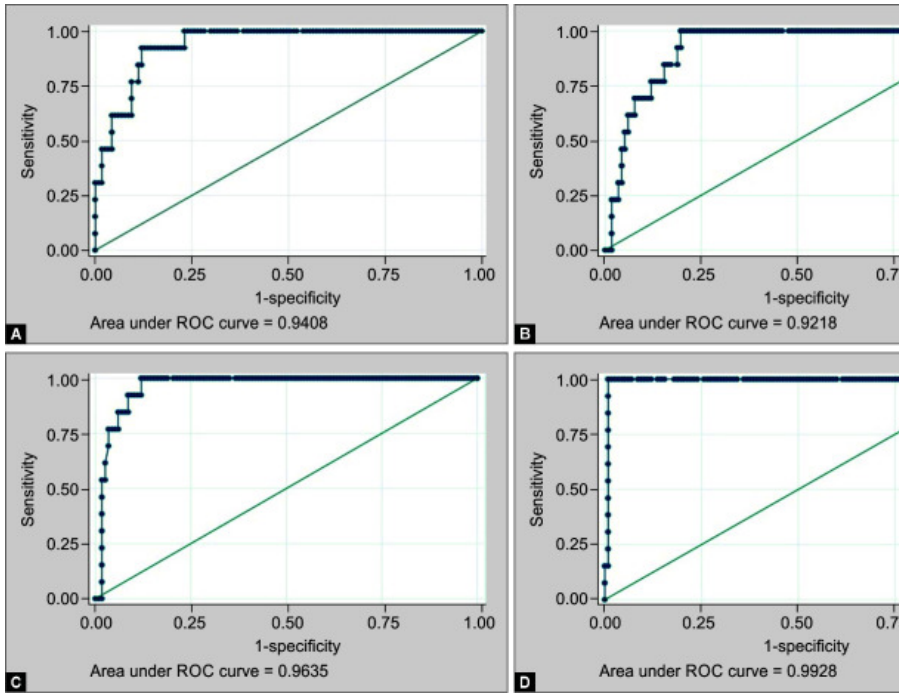
NCLUSION

l ultrasonographic measurement of GRV can be used in ally ill patients for prediction of gastric tube feed intolerance edical or surgical ICU patients receiving enteral tube feed. sound can be used to measure GRV to predict feed intolerance a sensitivity of 92% and specificity of 96%, (3 hours) and with sitivity of 100% and specificity 99%, and AUROC of 99.3% urs). Hence, in critically ill patients, receiving gastric tube feed gh continuous infusion, serial ultrasonographic measurement RV identifies feed intolerance with good sensitivity and ficity.



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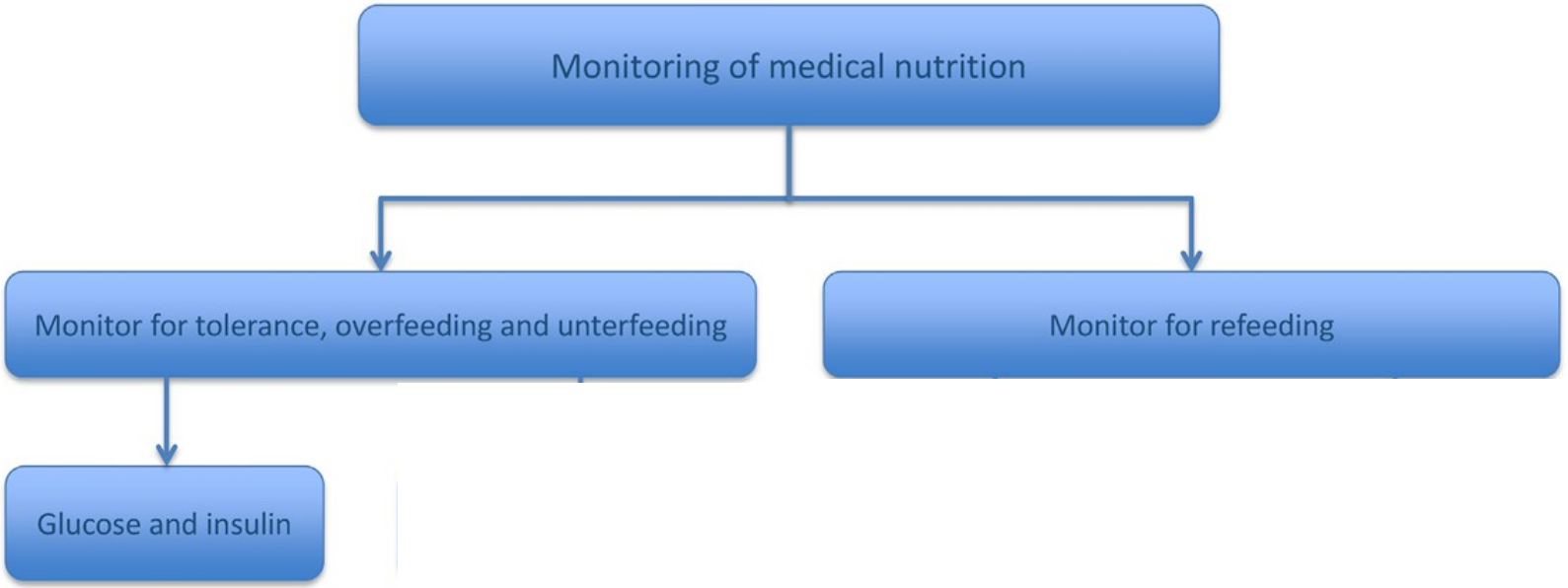


53) Blood glucose should be measured initially (after ICU admission or after artificial nutrition initiation) and at least every four hours, for the first two days in general. (R53, GPP, 93%)

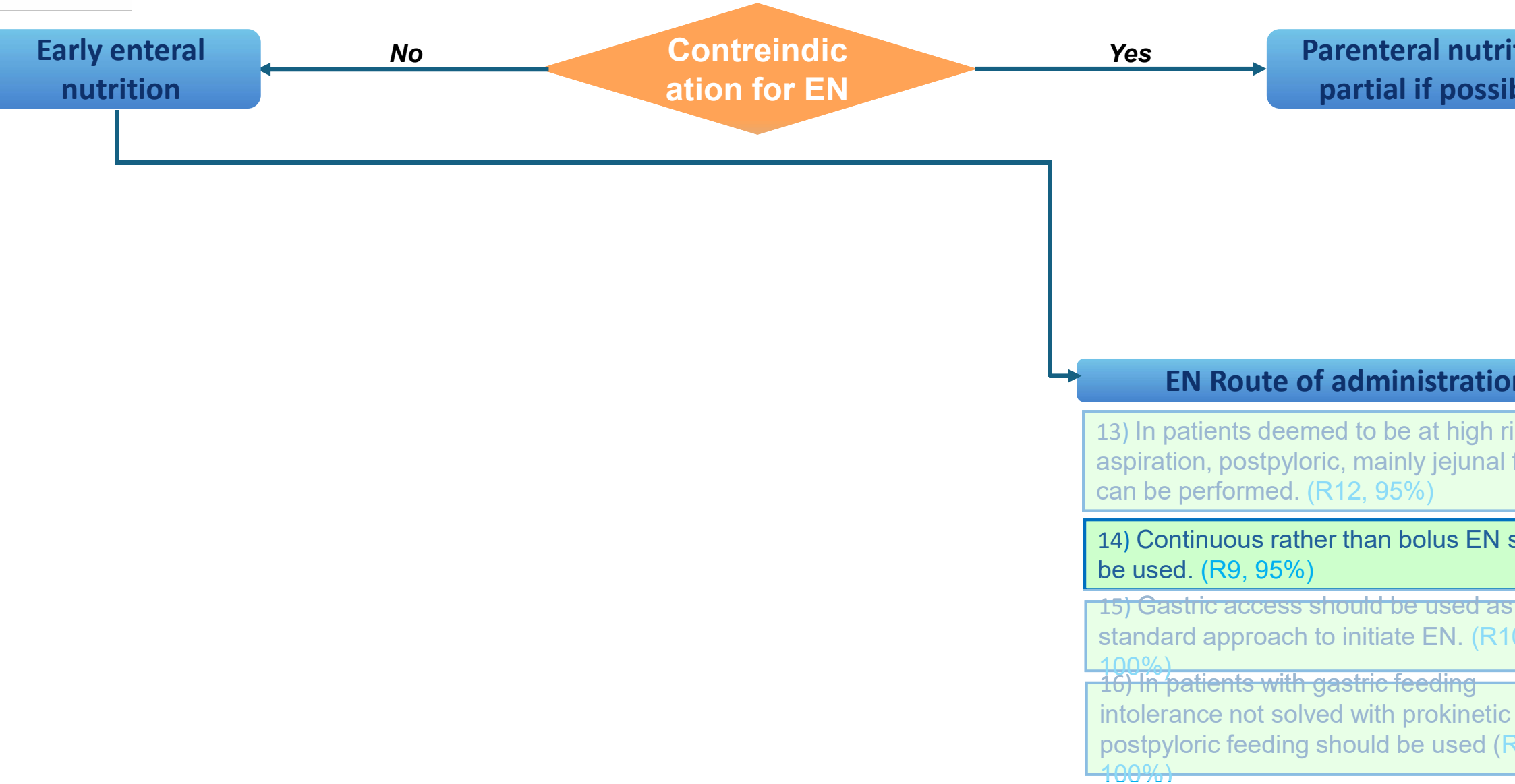
54) Insulin shall be administered, when glucose levels exceed 10 mmol/L (R54, A, 93%)

c. 7.8 – 10 mmoL/L

- **Erythromycine : 100 – 250 mg x 3 / j**
- **Metoclopramide : 10 mg x 3 / j**

1. Quel Timing
2. Quel Objectif
3. Quel site
4. Quelle surveillance
5. Quelle modalité

QUELLE MODALITE D'ADMINISTRATI



1. Quel Timing
2. Quel Objectif
3. Quel site
4. Quelle surveillance
5. Quelle modalité
6. Quelles particularité

Q6 ELLES PARTICULARIT

Medical nutrition in special cases

The non-
bated patient

Patient brûlé

30) In patients with burns > 20% bodysurface area, additional enteral doses of glutamine (GLN) (0.3e0.5 g/kg/d) should be administered for 10 - 15 days as soon as EN is commenced. (R26, 95%)

Encadré 9.8.1 – Les besoins énergétiques du patient gravement brûlé sont fortement augmentés, mais variables dans le temps. Cette augmentation est proportionnelle à la surface corporelle atteinte, mais plafonne à partir d'une surface corporelle brûlée (SCB) de 60 % (Accord fort).

Encadré 9.8.3 – Il faut utiliser des mesures non nutritionnelles pour atténuer l'hypermétabolisme et l'hypercatabolisme tant chez l'adulte que chez l'enfant (température ambiante, chirurgie d'excision précoce, bêtabloquants non sélectifs, oxandrolone). Contrairement à l'adulte, il faut substituer en rh-GH les enfants brûlés à plus de 60 % (Accord faible).

Encadré 9.8.2 – En l'absence de calorimétrie indirecte, il faut déterminer les besoins énergétiques avec la formule de Toronto car les formules fixes conduisent à une sous ou à une surestimation des besoins (Accord fort).

Q6 ELLES PARTICULARIT

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MMANDATIONS FORMALISÉES D'EXPERTS

ition artificielle en réanimation

elines for nutrition support in critically ill patient

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SDRA

Encadré 9.4.1 – Il ne faut pas interrompre systématiquement la nutrition entérale lors de la mise en décubitus ventral (Accord fort).

Insuffisant rénal

Encadré 9.2.1 – Il faut probablement majorer l'apport protéique quotidien du patient sous épuration extrarénale continue pour atteindre un niveau de 1,7 à 2 g/kg par jour (Accord faible).

1 Quel Timing

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EXERCICE PHYSIQUE

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Encadré 6.6 – Il faut instituer une stratégie multidisciplina
formalisée de NE (Accord faible).

PERSPECTIV

- PRECISION NUTRITION : Phénotype du patient, métabolome, microbiome ?
- BIOMARQUEURS FIABLES : Etat nutritionnel et efficacité de la nutrition
- BIG DATA et IA : Optimisation des stratégies nutritionnelles
- OPTIMISATION DU SEVRAGE

to be continu

CONCLUSI

Alimenter c'est soigner !

- DENUTRITION : Ennemi bien installé en réanimation
- FONCTION NUTRITION = Fonction vitale
- EVALUATION obligatoire
- PERSONNALISATION : Maître-mot → Quand ? Combien ? Comment ?
- MONITORAGE → Gestion pro-active des complications

Que ton alimentation soit ta première Médecine