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Attitudes to National Institute for Health and Clinical Excellence guidance on refeeding syndrome

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National Institute for Health and Clinical Excellence (NICE) guidelines on nutrition support were issued in 2006[(1)]. Those parts relating to refeeding syndrome (RFS) are contentious as they are based on expert opinion rather than clinical evidence. The aim was to characterise UK practice in relation to NICE guidance on RFS.

An electronic questionnaire relating to RFS was sent to a multidisciplinary group of individuals with an interest in nutrition. All members of the following groups dealing with nutritional issues within the UK were included: British Association for Parenteral and Enteral Nutrition Medical (doctors); National Nurses Nutrition Group (nurses); British Pharmaceutical Nutrition Group (pharmacists); Parenteral and Enteral Nutrition Group (dietitians).

In total, 146 individuals (19%) replied to the 770 questionnaires sent out. Of the responders 72% felt that NICE guidance had changed their practice, being most notable amongst dietitians (74%) and least notable amongst doctors (58%). Only 44% of doctors as opposed to 70% of dietitians actually followed NICE guidance. Only 39% of all responders felt the guidance represented safe practice whilst 36% felt they were excessively cautious. NICE state that parenteral nutrition (PN) should be started at 50% of estimated requirements for the first 48 h feeding. In total 43% of professionals who believe they follow NICE guidelines start PN at rates >50%. Perceived incidence of electrolyte abnormalities due to RFS varied markedly, with 4% feeling they had never seen RFS, whilst 10% felt they saw RFS in >20% of their patients.

NICE guidelines on RFS are contentious to some, partly because they are perceived as adding unnecessary costs to the nutritional care of these patients. They feel that the additional costs of biochemical analyses, close monitoring, electrolyte infusions and slow restoration of nutrients are not justified by any increased risk of harm to patients from RFS.

Others believe that injudicious quick restoration of adequate nutrition leads to RFS or significant hyperglycaemia, which, in addition to potentially harming the patient, may in fact increase hospital costs by prolonging their length of stay as well as incurring added costs relating to the treatment of complications such as electrolyte imbalance, hyperglycaemia or infection.

These data show that practice relating to RFS is split within the UK and highlight the importance of trying to obtain clinical evidence to inform practice when dealing with groups at risk of RFS.

1. National Institute for Health and Clinical Excellence (2006) *Nutrition Support in Adults. Clinical Guideline* 32. London: NICE.