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Summary

Intestinal failure and parenteral nutrition

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Small Intestine & Nutrition | Surgery | Neurogastroenterology & Motility

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Common prescribing mistakes in intestinal failure and parenteral nutrition management can be avoided through multidisciplinary care, careful attention to allergy status, compatibility, infection recognition, and individualised micronutrient replacement.

KEY POINTS

- The speaker stated that micronutrients should be interpreted in the context of serum CRP, as acute phase response redistributes micronutrients when CRP rises above 10 or 20, with vitamin A, zinc, and selenium decreasing while copper and ferritin increase.
- Allergy status must be checked before prescribing parenteral nutrition, as lipid emulsions can contain soybean oil, fish oil, peanut protein, and egg phospholipids, with many commercial preparations containing egg lecithin.
- Catheter-related bloodstream infections require early recognition through paired blood cultures taken from the catheter hub and peripherally before antibiotics, with differential time to positivity used diagnostically.
- The speaker stated that deranged liver function tests in intestinal failure are typically multifactorial, with infection causing derangement in about one-third to one-half of patients, and overfeeding with both lipids and glucose can contribute.
- Many patients on home parenteral nutrition 3 to 6 nights per week can still absorb nutrients orally since most vitamins and minerals are absorbed in the proximal small bowel, requiring individualised micronutrient replacement based on residual anatomy.
- The speaker emphasised that patients with intestinal failure score similarly to end-stage kidney disease patients on haemodialysis across quality of life domains, with effects extending to family and carers, requiring counselling with validated tools.

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