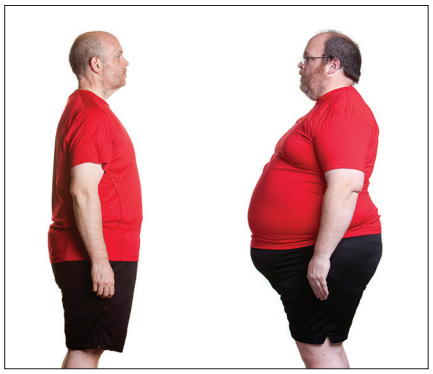
Editorials

Be nutrition aware in primary care:

making every contact count



The role of nutritional status and dietary intake in influencing health and disease cannot be overstated, impacting at all stages of the life cycle. There is unequivocal evidence that risk of non-communicable disease, including cardiovascular disease, the leading cause of death in the UK, is strongly associated with obesity, nutritional status, and diet quality. As such, diet and lifestyle advice are important components in the management of many chronic diseases and disorders. Less well recognised is the role of protein-energy undernutrition (referred to as malnutrition herein) in negatively impacting on disease risk, progression, and prognosis. As the first point of contact for most people accessing health care is via primary care, GPs are in a good position to identify and manage those patients who would benefit from nutritional care. This editorial will focus specifically on the 'dual burden' of obesity and malnutrition, although there are many other areas of health and disease in which nutrition is also fundamental.

NUTRITION IS FUNDAMENTAL TO GOOD CLINICAL PRACTICE

Proper nutritional care has been highlighted by the Royal College of Physicians as a core area of responsibility for doctors in the care of their patients.[1] Key recommendations include that doctors should encourage patients to avoid becoming, and treat those who are, overweight; doctors should have a key role in the detection and management of malnutrition; and that nutritional screening should be integral to clinical practice. Despite this, there are concerns that nutrition is inadequately represented in the curriculum during medical training. In response, the Need for Nutrition Education Programme[2] was developed to raise awareness of the importance of nutrition in the prevention and treatment of non-communicable disease. Nutrition is also included in the General Medical Council's outcomes and standards for undergraduate medical education.[3]

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OBESITY: A WEIGHTY PROBLEM

Obesity and weight management arguably represents one of the most significant public health issues in the UK. Never has the need to intervene been more urgent, particularly in view of the alarming proportion of overweight or obese children. With the apparent upward trend in body weight with age, these children are destined to become overweight or obese adults without intervention. The increasing risk of developing comorbidities with increasing body mass index (BMI) are well documented, with obesity, particularly centrally distributed adiposity, increasing the risk of developing non-communicable disease including cardiovascular disease, type 2 diabetes, and certain cancers. However, as demonstrated by the Foresight obesity system map, obesity is a complex, relapsing, multifactorial disorder,[4] which makes its prevention and management complex.

COST BENEFITS OF MANAGING OBESITY

Obesity comes at a high price. In 2007 the Foresight Report projected approximately half the adult population and 25% of children would be obese by 2050, costing the NHS approximately £10 billion annually, with £50 billion wider costs to society.[4] The National Obesity Forum (NOF) suggests that this is a conservative estimate based on more recent data.[5] The majority of the cost to the NHS comes from treating the clinical consequences of obesity, rather than obesity treatment itself.

Furthermore, obesity directly impacts on GP caseload burden and costs, with obese patients accessing GP services on significantly more occasions than patients of normal weight.[6] There are therefore clear financial reasons to identify and treat obesity in primary care. A recent sensitivity analysis found a primary care weight management programme (Counterweight) to be highly cost-effective in the long term, with the programme cost more than counteracted by savings from reduced consequent costs of treating obesity-related disorders.[7]

GPs HAVE A KEY ROLE IN OBESITY MANAGEMENT AND PREVENTION

The NOF recently highlighted the key opportunity that GPs have to identify and treat those who are overweight and obese, due to the broad range of patients accessing their services.[5] Early identification and treatment will reduce the risk of future referral to secondary care. Even a modest weight reduction, particularly when achieved concurrent to an increase in physical activity, can bring about considerable and measurable improvements to overall health risk. Realistic and achievable weight goals based on the patient's comorbidities and risk profile (based on BMI and waist circumference) are recommended, with an aim of optimising health, increasing quality of life, and reducing risk of disease.

MALNUTRITION MATTERS TOO

On the other side of the coin is malnutrition, a common clinical and public health

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problem that often remains undetected in the community. Recent estimates suggest more than 3 million people are malnourished or at risk of malnutrition in the UK, the majority of whom (93%) are living in the community, with 5% in care homes and 2% in hospital at any one time.[8] In a series of surveys carried out by the British Association of Parenteral and Enteral Nutrition (BAPEN), 29% of adult patients were found to be at 'medium' or 'high' risk of malnutrition upon admission into hospital.[9] The majority were admitted from their own homes, suggesting that malnutrition is originating in the community. It was estimated that 80% of those 'at risk' of malnutrition upon admission could have been identified and treated in the community prior to admission,[10] which could potentially reduce the number and duration of hospitalisations.

PAYING THE PRICE OF MALNUTRITION

Malnutrition can have a profound negative impact on disease risk, progression, and prognosis, with a vicious cycle resulting whereby malnutrition is both caused by, and impacts on, disease pathophysiology. Malnutrition results in greater healthcare needs in the community, including more frequent access to GP services and increased care needs at home. Consequentially malnutrition has a high financial burden, estimated to amount to £13 billion per annum.[8] Appropriately planned treatment therefore has potential for considerable cost savings in the NHS.

IDENTIFICATION AND MANAGEMENT OF MALNUTRITION

Early identification and treatment of a patient 'at risk' of malnutrition can significantly reduce the clinical risks associated with malnutrition, including vulnerability to illness, clinical complications, and mortality. As most malnutrition starts in the community, early identification is most likely to occur in the primary care setting. Early detection and treatment of malnutrition by GPs could prevent further complications, hospitalisations, and minimise associated costs. Identification of those 'at risk' is best achieved by routinely using a validated nutrition screening tool,[11] such as the Malnutrition Universal Screening Tool (MUST).[12]

In primary care, nutrition screening should be completed on all patients on registration at a GP surgery and when there is cause for clinical concern.[11]

Additional opportunities to identify those 'at risk' include incorporation into general health checks or when seeing the practice nurse or community pharmacist. Despite these recommendations, opportunities to detect malnutrition risk in primary care are often missed.

GPs CAN MAKE A DIFFERENCE

In summary, primary care is an ideal setting in which to identify and manage those with and 'at risk' of malnutrition, obesity and non-communicable diseases who would benefit from diet and lifestyle counselling. GPs are in a unique position to be able to influence change due to the broad range of patients accessing primary care services and the relationship and familiarity patients often have with the primary care team. Aim to 'make every contact count', as advocated by the NHS Future Forum, by taking the opportunity, when appropriate, to support patients to improve their nutritional health.

Julia Darzi,
Lecturer in Nutrition and Dietetics, School of Medicine, King's College London, UK.

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ADDRESS FOR CORRESPONDENCE

Julia Darzi
School of Medicine, King's College London, Franklin-Wilkins Building, London, SE1 9NH, UK.
E-mail: Julia.darzi@kcl.ac.uk

REFERENCES

1. Kopelman P, Lennard-Jones J. Nutrition and patients: a doctor's responsibility. *Clin Med* 2002; **2(5):** 391–394.
2. The Need for Nutrition Education/Innovation Programme. *Laying the foundations of nutrition knowledge relevant to clinical and public health practice*. http://www.nnedpro.org.uk (accessed 10 Oct 2014).
3. General Medical Council. *Tomorrow's Doctors: outcomes and standards for undergraduate medical education*. 2009. http://www.gmc-uk.org/Tomorrow_s_Doctors_0414.pdf_48905759.pdf (accessed 10 Oct 2014).
4. Butland B, Jebb S, Kopelman P *et al. Tackling obesities: future choices — project report. 2nd edn*. London: Government Office for Science, 2007. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/287937/07-1184x-tackling-obesities-future-choices-report.pdf (accessed 10 Oct 2014).
5. National Obesity Forum. *State of the nation's waistline. Obesity in the UK: analysis and expectations*. http://www.nationalobesityforum.org.uk/index.php/136-news_/688-state-of-the-nation-s-waistline-obesity-in-the-uk-analysis-and-expectations.html (accessed 10 Oct 2014).
6. Frost GS, Lyons GF; Counterweight Project Team. Obesity impacts on general practice appointments. *Obes Res* 2005; **13(8):** 1442–1449.
7. Trueman P, Haynes SM, Felicity Lyons G, Counterweight Project Team, *et al*. Long-term cost-effectiveness of weight management in primary care. *Int J Clin Pract* 2010; **64(6):** 775–783.
8. Elia M, Russell CA. *Report from the Advisory Group on Malnutrition, led by BAPEN. Combating malnutrition: recommendations for action*. http://www.bapen.org.uk/pdfs/reports/advisory_group_report.pdf (accessed 10 Oct 2014).
9. Russell CA, Elia M, on behalf of BAPEN and collaborators. *Nutrition screening surveys in hospitals in the UK, 2007–2011: a report based on the amalgamated data from the four Nutrition Screening Week surveys undertaken by BAPEN in 2007, 2008, 2010 and 2011*. 2014. http://www.bapen.org.uk/pdfs/nsw/bapen-nsw-uk.pdf (accessed 10 Oct 2014).
10. Russell CA, Elia M. Malnutrition in the UK: where does it begin? *Proc Nutr Soc* 2010; **69(4):** 465–469.
11. National Institute for Health and Care Excellence. *Quality standard for nutrition support in adults*. NICE quality standards [QS24]. http://publications.nice.org.uk/quality-standard-for-nutrition-support-in-adults-qs24 (accessed 10 Oct 2014).
12. Todorovic V, Russell C, Marinos E, *et al. The 'MUST' explanatory booklet*. A guide to the 'Malnutrition Universal Screening Tool' ('MUST') for adults. http://www.bapen.org.uk/pdfs/must/must_explan.pdf (accessed 10 Oct 2014).