



**An Independent Chapter of the
American Society for Parenteral
and Enteral Nutrition**

Virginia Society for Parenteral and Enteral Nutrition

President's Column – Marianne Opilla, RN, CNSC

The November educational meeting was very successful with over 130 attendees from various nutrition support disciplines and locations. I would like to thank the 2011 Board for all their hard work before, during, and after the conference. Now it is time to start to prepare for our next meeting in 2012. The Board will be using suggestions and comments from the evaluation forms completed at the meeting to begin the search for quality speakers and topics.

We also welcome new Board Members for 2012:

Laura Johnson, Augusta Health	President
Joe Krenitsky, UVA Health System	President Elect
Leslie Collier, Spotsylvania Medical Center	Secretary
Felicia Schaps, Home Choice Partners	Director Nurses
Christie Rogers, UVA Health System	Newsletter Editor

Thank you for volunteering to serve.

Clinical Nutrition Week, ASPEN's yearly conference, is being held in Orlando Florida, January 21-24, 2012. If you are unable to attend, consider registering for "Virtual" sessions that are accessed in real time from your computer. There are 11 course offerings to choose from, and membership in ASPEN provides a significant discount. These sessions are eligible for continuing education credits. Gather a group of nutrition support clinicians and sign up today. www.nutritioncare.org/cnw

It has been a wonderful and interesting experience serving as VASPEN President this year. I look forward to assisting the Board in planning another informative conference for 2012.

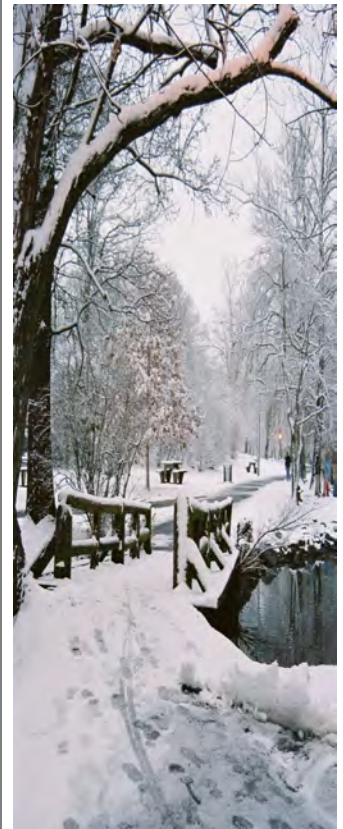
Marianne Opilla, RN, CNSC

Volume 19, Issue 1

January 2012

Inside this issue:

<i>President's Column</i>	1
<i>Treasurer's Report and Board Members</i>	2
<i>Continuing Education Column</i>	3-5
<i>Announcements</i>	6,7



VASPEN 2012 Board of Directors

Laura Johnson, PhD, RD, CNSC	President
Joe Krenitsky, MS, RD	President-Elect
Marianne Opilla, RN, CNSC	Past President
Leslie Collier, RD	Secretary
Ed Pickett, PharmD, BCNSP	Treasurer
Felicia Schaps, RN, CRNI, OCN, CNSC, CQA	Director of Nurses
Puneet Puri, MD	Director of Physicians
Nora Decher, MS, RD, CNSC	Director of Dietitians
Gisela Barnadas, MS, RD	Director of Industry
Bill Peard, RPh, BCNSP	Director of Pharmacy
Christie Rogers, MS, RD, CNSC	Newsletter Editor
Stacey McCray, MS, RD, CNSD	Trusted Advisor

TREASURER'S COLUMN

Checking \$9,256.17

Treasury CD \$6,020.93

Patillo Donald Fund* \$15,266.65

* The Patillo Donald Fund provides funding for the annual Patillo Donald Memorial Lecture. This fund is held in perpetuity in memory of Patillo Donald, a UVA researcher and clinician who provided VASPEN with invaluable leadership and support before her untimely death. Donations may be made to the fund at :

VASPEN

c/o Ed Pickett, Treasurer

PO Box 1386

Staunton, VA 24402

**Send us your ideas and updates!**

We welcome new ideas for newsletter content, job openings, or current events for inclusions in the VASPEN Newsletter. Please send any announcements to:

Christie Rogers, MS, RD, CNSC

VASPEN Newsletter Editor

UVA Health System

P.O. Box 800673

Charlottesville, VA 22908

E-mail: christierogers@virginia.edu

**CONTINUING EDUCATION SERIES:****Evaluating the Patient with Non-Responsive Celiac Disease**

Nora Decher, MS, RD, CNSC

Celiac disease (also known as gluten-sensitive enteropathy) is an inflammatory, autoimmune disorder thought to affect approximately 1% of Americans. Prevalence in the United States seems to have increased by four to five times over the past three to four decades.¹ Celiac disease results from an inappropriate T-cell mediated immune response to ingested gluten that causes injury to the small intestine in genetically susceptible individuals (HLA-DQ2 or –DQ8 genes). A strict, gluten-free (GF) diet for life is currently the only treatment for celiac disease and it is widely effective.² Untreated celiac disease is associated with a host of complications, which may include gastrointestinal (GI) symptoms, malnutrition, bone loss, infertility, increased mortality and risk for intestinal T-cell lymphoma.

The majority of individuals have improved symptoms within the first several weeks of a gluten-free diet. However, 5% to 7% of celiac patients continue to have symptoms or clinical manifestations despite being (supposedly) on a gluten-free diet.^{3,4} This problem is generally referred to as nonresponsive celiac disease (NRCD). The most common cause of failure to respond to the gluten-free diet is ingestion of gluten, which may be intentional or not. Other causes include coexisting conditions/incorrect diagnosis and refractory celiac disease. This article will describe NRCD and outline a process for evaluation and treatment, similar to the algorithm for diagnosing and treating NRCD published by Abdallah et al.⁵

The first step in evaluating NRCD is to review the patient's level of understanding of the gluten-free diet along with the patient's diet and medication history. A dietitian who specializes in celiac disease is critical in this step. Positive serology (anti-tTG antibodies) is also helpful to identify continued gluten ingestion. Noncompliance with the gluten-free diet is common and has been estimated to occur in 5% to 70% of diagnosed patients (depending on patient age and assessment of adherence).³ Inadvertent gluten ingestion can occur regardless of the patient's level of understanding. Sources of inadvertent gluten include communion wafers, cross contamination (from salad bars, buffet lines, bulk bins, toasters, condiment jars, deep fried foods and/or dining restaurants). The most common non-food source of inadvertent gluten is medications. Cases of inhaled gluten have been reported in farmers working in enclosed spaces with wheat-based cattle feed, however this is rare.⁵

Despite common misconceptions in the media and other patient resources, topical agents such as lotions, creams, and shampoos do not need to be gluten free (unless the patient is actually ingesting them).⁶ Dermatitis herpetiformis, a dermatological manifestation of celiac disease, is a result of intestinal gluten sensitivity and not a response to direct dermal contact with gluten (gluten proteins are too large to be absorbed through the skin). It is treated effectively with a gluten-free diet alone. Another common misconception about the GF diet is that the patient can eat some gluten without harm, as long as they are not having symptoms. This is just not true. The process of determining if a patient is ingesting gluten requires extensive interviewing and may require several clinic visits. In some cases, a defined formula-based diet or tube feeding are very useful in ruling out inadvertent dietary gluten ingestion (assuming the patient will be compliant and use only the enteral formula). In these cases, the patient is

CONTINUING EDUCATION SERIES:

Evaluating the Patient with Non-Responsive Celiac Disease

Nora Decher, MS, RD, CNSC

instructed to drink a set amount of a standard, gluten-free nutritional formula. If the patient cannot drink formula or the patient is failing to thrive with oral nutrition alone, feeding through a nasogastric tube may be appropriate.

The next step in evaluating the patient with NRCD is to consider the possibility of a coexisting condition. Lactose intolerance is common in the general population as well as those with celiac disease and a trial of a lactose-restricted diet should be considered. Unfortunately, a diagnosis of celiac disease does not preclude a patient having another GI disorder. A patient who is still not responding to a gluten-free diet at this point should work with a gastroenterologist for a continued workup. In the case of normal small bowel histology, conditions such as irritable bowel syndrome, small intestinal bacterial overgrowth (SIBO), microscopic colitis, pancreatic insufficiency, eating disorders and food allergies should be considered. In cases of abnormal histology, SIBO, peptic duodenitis and immunodeficiency states should be considered. In some cases, the clinician may need to re-evaluate whether the diagnosis of celiac disease is correct.

Refractory celiac disease (RCD) is defined as persistent or recurrent malabsorption and villous atrophy despite strict adherence to a GF diet for 6 to 12 months (in the absence of other causes of nonresponsiveness). RCD is rare and affects less than 1% of patients with celiac disease. It is generally considered a diagnosis of exclusion. It ranges in severity from type I (relatively mild) to type II (fatal). Type II RCD is categorized by the presence of T-cell gene rearrangement on molecular genetic study. Patients with type II RCD eventually develop lymphoma and the 5-year survival rate is reported to be 58% (vs 96% for type I).⁷ Initial treatment for RCD includes fluid/electrolyte management and nutrition assessment. Nutrition assessment should include evaluation of weight loss, extent of malabsorption (could include a 72 hr quantitative fecal fat test) and evaluation for deficiencies of vitamins (mainly D, E, B₁₂, and folate) and minerals (mainly calcium, iron, and zinc). Some patients may have enough absorptive capacity to support themselves on an oral diet, however many will require enteral or even parenteral nutrition support if they fail enteral therapy. In cases of severe mucosal damage, pancreatic enzyme therapy can be beneficial to aid digestion until the mucosa heals and resumes production of brush border enzymes. Nutrition management is the mainstay treatment of both types of RCD. The use of immunosuppression (budesonide, azathioprine, cyclosporine, infliximab, tacrolimus) has been supported by anecdotal reports and is used, however large scale controlled studies have not been done.^{5,9} Autologous stem cell transplant has been attempted as a treatment for Type II RCD.¹⁰

Treatment of the patient with NRCD requires systematic evaluation of gluten ingestion, other potential coexisting conditions and, although rare, refractory celiac disease. Nutritional assessment is essential at each step of this process. Enteral nutrition support can be valuable in the workup and both enteral and parenteral nutrition support may be required as a primary source of nutrition.

CONTINUING EDUCATION SERIES:

Evaluating the Patient with Non-Responsive Celiac Disease

Nora Decher, MS, RD, CNSC

Bibliography

1. Rubio-Tapia A, Kyle RA, Kaplan EL, et al. Increased prevalence and mortality in undiagnosed celiac disease. *Gastroenterology*. 2009;137(1):88-93.
2. Anon. AGA Institute Medical Position Statement on the Diagnosis and Management of Celiac Disease. *Gastroenterology*. 2006;131(6):1977-1980.
3. Crowe SE. In the clinic. Celiac disease. *Ann. Intern. Med.* 2011;154(9):ITC5-1-ITC5-15; quiz ITC5-16.
4. O'Mahony S, Howdle PD, Losowsky MS. Review article: management of patients with non-responsive coeliac disease. *Aliment. Pharmacol. Ther.* 1996;10(5):671-680.
5. Abdallah H, Leffler D, Dennis M, Kelly CP. Refractory celiac disease. *Curr Gastroenterol Rep.* 2007;9(5):401-405.
6. Kasim S, Moriarty KJ, Liston R. Nonresponsive celiac disease due to inhaled gluten. *N. Engl. J. Med.* 2007;356(24):2548-2549.
7. Garioch JJ, Lewis HM, Sargent SA, Leonard JN, Fry L. 25 years' experience of a gluten-free diet in the treatment of dermatitis herpetiformis. *Br. J. Dermatol.* 1994;131(4):541-545.
8. Al-Toma A, Verbeek WHM, Hadithi M, von Blomberg BME, Mulder CJJ. Survival in refractory coeliac disease and enteropathy-associated T-cell lymphoma: retrospective evaluation of single-centre experience. *Gut*. 2007;56(10):1373-1378.
9. Brar P, Lee S, Lewis S, et al. Budesonide in the treatment of refractory celiac disease. *Am. J. Gastroenterol.* 2007;102(10):2265-2269.
10. Tack GJ, Wondergem MJ, Al-Toma A, et al. Auto-SCT in refractory celiac disease type II patients unresponsive to cladribine therapy. *Bone Marrow Transplant.* 2011;46(6):840-846.

Continuing Education and Events

ASPEN Clinical Nutrition Week

January 21-24, 2012

Orlando, Florida

Walt Disney World Swan and Dolphin Resort

Nutrition Support Education at the University of Virginia Health System

The University of Virginia Health System is offering week-long and weekend warrior Nutrition Support **Training Programs** as well as a Nutrition Support **Webinar Series**.

Please visit: www.GInutrition.virginia.edu for session calendar and for information on how to register for programs. You may also contact Stacey McCray at sf8n@virginia.edu with additional questions.

*****Next Weekend Warrior*****

"GI-Focused Weekend Warrior"

March 10th and 11th, 2012

This two day program will focus on the nutritional management of patients with GI disease or disorders.

*****Upcoming Webinars 2012*****

February 21, 2012: Nutrition Support in Pancreatitis

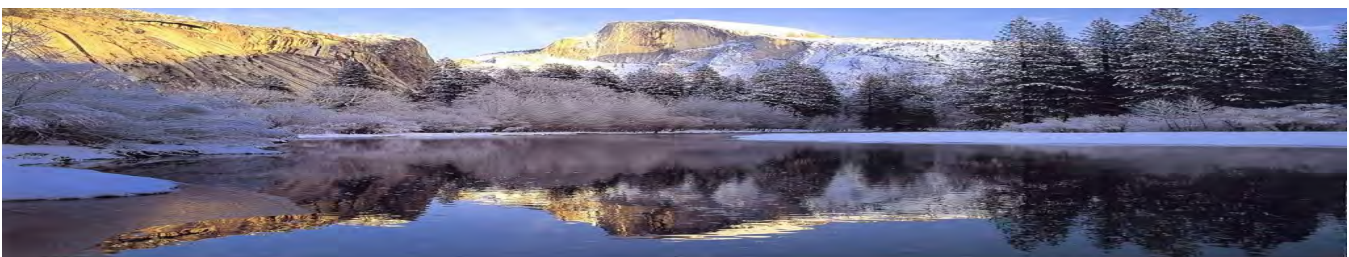
Carol Rees Parrish, MS, RD

March 21, 2012: Liver Disease, Part I: Hepatic Encephalopathy

Neeral Shah, MD

April 2012 (Date TBA): Liver Disease, Part II: Nutrition Support in Liver Disease

Joe Krenitsky, MS, RD



Announcements

Job Openings

Job Title: Clinical Nutrition Specialist

Job Category: Sales

Office Location

Home Solutions Infusion Therapy
8701 Park Central Drive; Suite 600
Richmond, Virginia 23227

www.infusioncare.com

Job Description and Requirements

Due to growth in our Richmond area market, Home Solutions is recruiting another full-time dietitian. Responsibilities include management of home parenteral and enteral nutrition support patients and sales and marketing of Home Nutrition Support Services to physicians, case managers and managed care payers. Coordinate nutrition support team rounds and assist with Medicare and Medicaid coverage issues for nutrition support patients. Assist with the development of CEU programs to market core infusion therapies. Serve as a clinical nutrition education resource for staff pharmacists and nurses. In-service intake staff and patient care representatives on documentation, Medicare coverage and formulas as needed. Provide sales training on Home Nutrition Support Program for Territory Managers.

Requirements: B.S. in Nutrition, Applicant must be a registered dietitian and a member of the American Dietetic Association.

Qualifications: 4-5 years of nutrition support experience managing patients on parenteral and enteral nutrition. CNSC, plus adult and pediatric experience preferred.

Comprehensive benefits including: Medical, Dental, Vision and Disability Insurance, 401K plan and paid ASPEN. Position includes company car, gas card, EZpass, GPS, AMEX card, laptop and PDA/ cell phone.

Contact:

If you are interested in the position please email your resume to jberardi@infusioncare.com

