Nutrition Guidelines for Alcoholic Hepatitis

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Electrolyte abnormalities: Daily monitoring and repletion of magnesium, phosphorus, and potassium should be undertaken. Patients with AH have often been on a diet of alcohol alone for prolonged periods and have substantial deficiencies that may take several days to correct. Patients with electrolyte disturbance and severe malnutrition are at risk for refeeding syndrome and thus electrolyte abnormalities should be corrected prior to initiating nutrition support therapy (enteral or parenteral feeds).

- See electrolyte replacement protocol

Nutrition management: A nutrition consult should be placed whenever a diagnosis of AH is suspected or established. Studies have shown improved outcomes with aggressive nutritional support even when compared to steroids. (Foody 2001)

Nutritional support goals include aggressive caloric intake (35-40 kcal/kg/day) and protein intake (1.2-1.5 grams/kg/day) (Plauth 2009) which is not often met by oral intake alone and thus nasoenteric tube placement is necessary

- Use of nasoenteric tube feeding is strongly recommend and should be instituted early since the great majority of patients are not able to meet requirements via oral intake (this should be assessed by very early and accurate assessment of calorie and protein intake during the first 1-2 days of hospital admission) (Plauth 2009) Tube feedings in one randomized study reduced mortality by 40%. Continuous feeding is strongly advised over intermittent feeding or cycling of infusions.

- Nocturnal nutrition supplementation via tube feeding is advised in patients with cirrhosis to help prevent muscle wasting and improve lean muscle mass (Plank 2008) and continuous feeding is advised for those patients with more severe sarcopenia

- Consider intravenous lipids, 500 ml/day (~1000 kcal/day), as an adjunctive means of nutrition support in those with large caloric requirement and severe AH. It is recommended the lipids IV be administered over 12-20 hours to prevent line related infections. It is recommended that tubing used to administer fat emulsion IV be replaced within 24 hours of initiating the infusion (O’Grady 2011).
  - Triglycerides should be checked after first dose of intravenous lipids and then 1-2 times per week or as needed. Triglyceride levels should be at least 4 hours after completion of lipid infusion (Szesyck 2005). If post-infusion triglyceride levels are near baseline levels then it can be assumed IV fat is clearing. If post-infusion triglyceride levels exceed baseline levels then a slower rate of lipid infusion is recommended (e.g. 20 vs. 12 hours) but should not exceed 20 hours. Triglycerides should be held if post-infusion levels are > 400-500 mg/dL
Vitamin deficiencies: Other vitamin deficiencies are very common including thiamine, folic acid, zinc, selenium, fat-soluble vitamins (A, D, E, K), and testosterone (in men) and need aggressive replacement.

- Vitamin K 10 mg subcutaneous x 3 days.
- Thiamine 100 mg daily
- Folic acid 1 mg daily
- Multivitamin daily
- Zinc 220 mg daily
- Rally bag: 1L normal saline with 100 mg thiamine, 1 mg folic acid, MVI, 3 grams magnesium sulfate typically given over 4-8 hours
- Selenium 200 mcg daily

References


