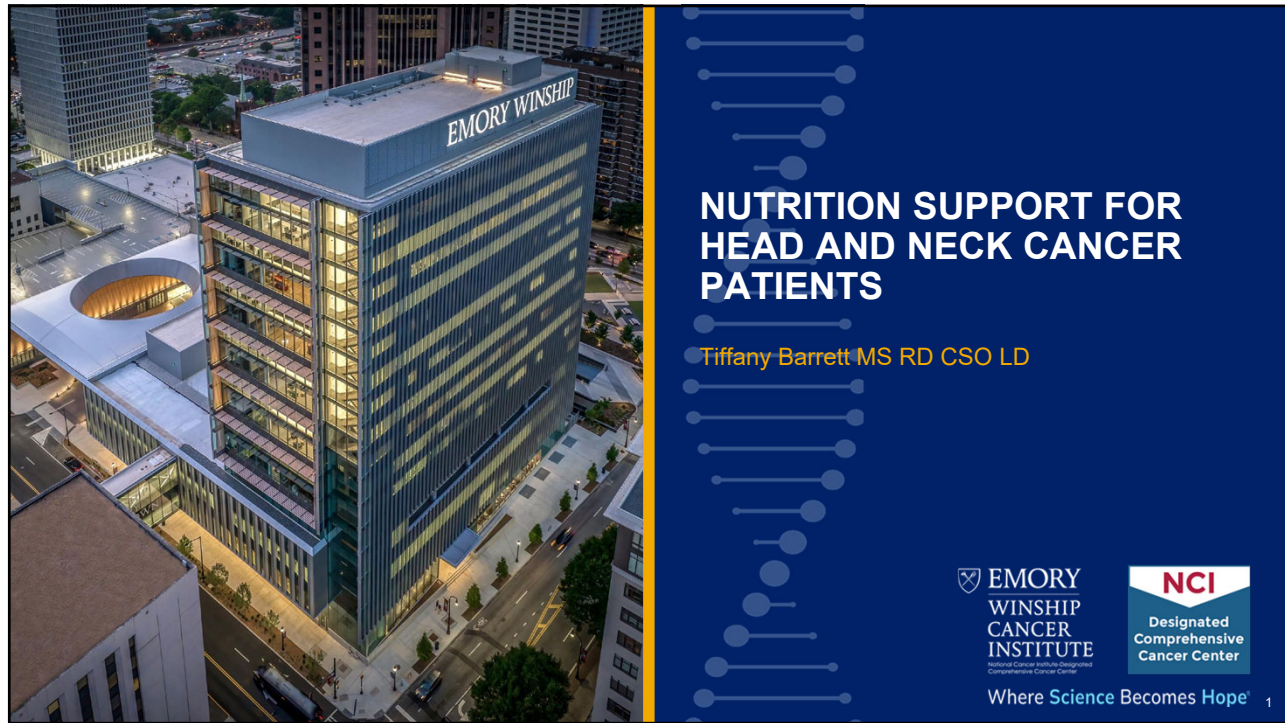




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OBJECTIVES

- Describe nutrition challenges and goals in Head & Neck cancer
- Identify evidence-based enteral nutrition support assessment and interventions
- Describe appropriate enteral access: proactive and reactive

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Which objective is most relevant to your practice right now?

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HEAD AND NECK CANCER

Includes tumors: Oral Cavity (tongue, palate, FOM), Pharynx (throat), Larynx, Nose, Sinus, Salivary Glands

7th most common cancer worldwide

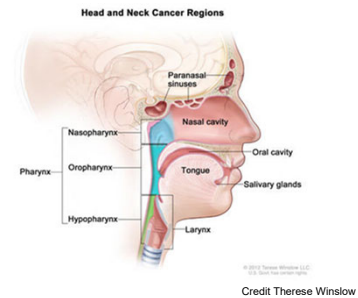
Account for 4% of cancers in US

Twice as common among men

Risk: Alcohol and Tobacco, HPV (type 16), Betel nut, Occupational exposure, Radiation, Epstein-Barr Virus, underlying genetic disorders

Often malnourished at presentation ***

Increased nutrition requirements due to tumor burden



https://www.cancer.gov/types/head-and-neck/hp/oral-prevention-pdq#_239_toc

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NUTRITION GOALS

- Maximize nutrition intake: oral and/or enteral
- Promote wound healing: post-op, radiation, recovery
- Weight stability
- Lean body mass
- Minimize treatment delays or disruptions
- Hydration

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HEAD AND NECK CANCER TREATMENT

Include surgery, radiation therapy, chemotherapy, immunotherapy or combination of treatments

Common surgeries: Laryngectomy, Hemiglossectomy, Partial Glossectomy, Mandibulectomy, Parotid, TORS

- Free Flap Reconstruction: strict NPO guidelines

Surgery

- Dysphagia
- Trismus
- Aspiration
- Pain/swelling
- Chewing
- NPO: NGT vs G tube

Radiation

- Dysphagia/odynophagia
- Trismus
- Xerostomia
- Mucositis
- Thick saliva
- Fatigue
- Dysgeusia (taste changes)
- RT alone or combined with systemic (6-7 weeks)

Chemotherapy

- Appetite
- Nausea/vomiting
- Dysgeusia
- Hydration
- Electrolyte abnormalities (sodium, Magnesium, Phosphorus, Potassium)
- Malabsorption

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ENTERAL NUTRITION PLACEMENT AND INDICATIONS

NG Tube:

- Nutrition support expected <4-6 weeks
- Post-op NPO protocols
- Can be placed at bedside, urgently in clinic
- Immediate use after confirmed placement

• G-tube

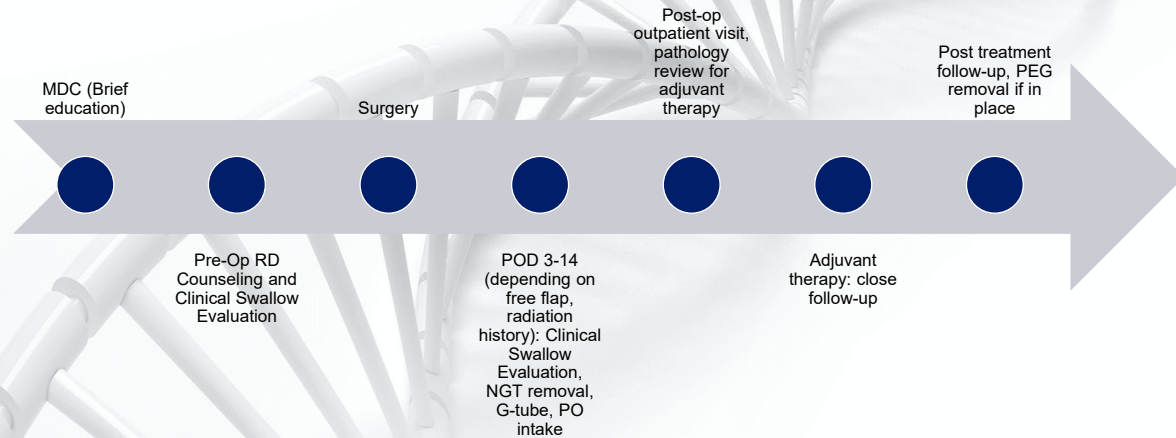
- Longer duration for nutrition support
 - Consider recovery of concurrent chemoradiation
- Significant weight loss prior to treatment (surgery, radiation, chemotherapy)
- Severe swallowing/aspiration

- **J-tube:** severe gastroparesis, previous surgeries, high aspiration risk

- **Parenteral:** rare use, safety of enteral access

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SAMPLE TREATMENT FLOW



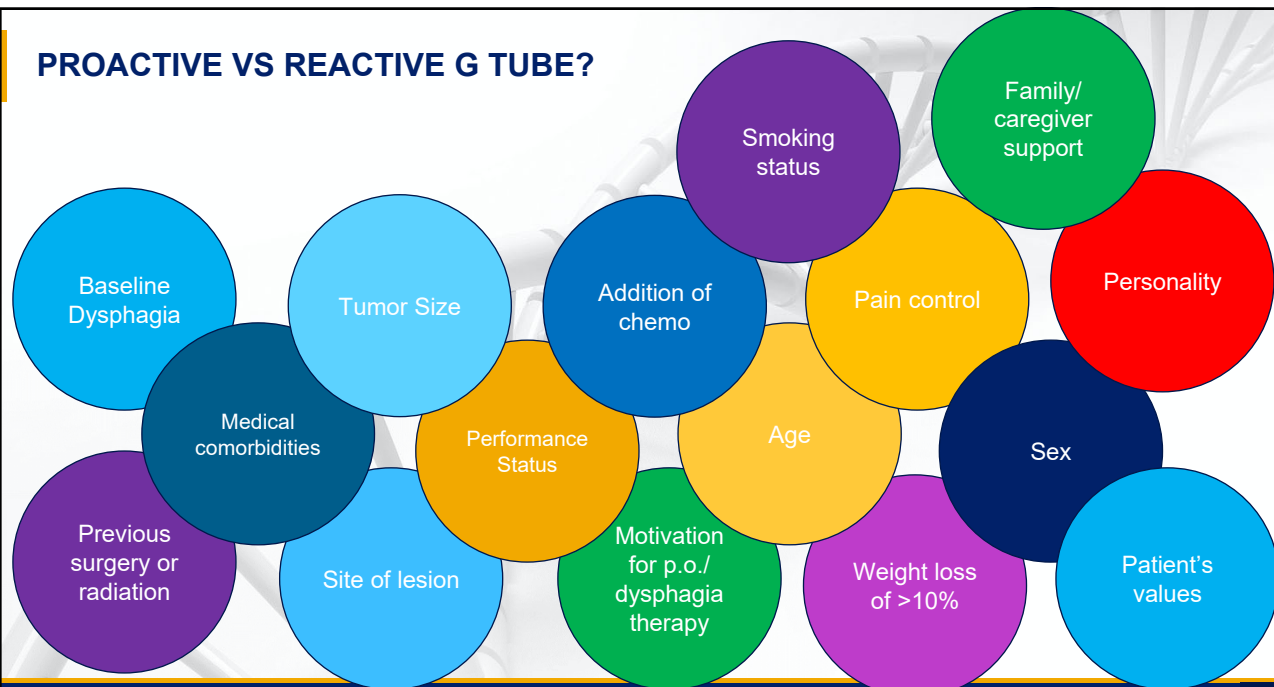
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PROACTIVE VS REACTIVE G TUBE?



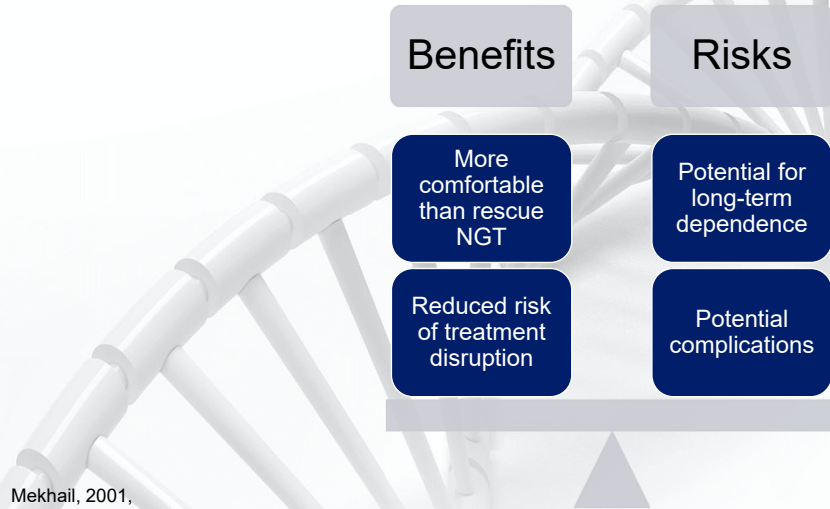
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PROPHYLACTIC PEG PLACEMENT



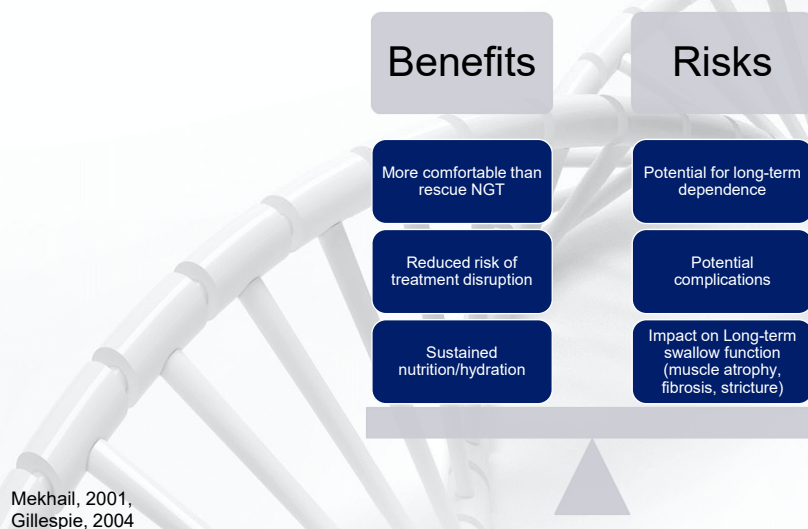
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PROPHYLACTIC PEG PLACEMENT



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TO G-TUBE OR NOT TO G-TUBE?

- Mixed results: Trials that include RD and SLP limited, study size, selection bias
- Weight loss lower G-tube group: reduced admission rates, mucositis, and malnutrition. No mention of PEG removal timeframe.
- Mellors et al.
 - Prophylactic PEG reduction short term weight loss (>10%) and improved QOL after 6 months
- Brown et al.
 - Screened at diagnosis for referral to RD and SLP
 - Non-PEG group: 43% required feeding tube or >10% weight loss
 - Timing of initiation of enteral feedings
- NCCN Guidelines

Yanni et al 2019

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NCCN GUIDELINES: MAY 2026

Prophylactic feeding tube placement considered:

- Severe weight loss prior to treatment: 5% 1 month, or 10% over 6 months
- Ongoing dysphagia or dehydration, anorexia or pain interfering with ability to eat/drink
- Significant comorbidities
- Severe aspiration or mild aspiration in patients with compromised cardiopulmonary function
- Receiving large fields of high dose radiation to mucosa

Reactive

- Inadequate food intake (60% of estimated energy expenditure) anticipated >10 days
- Weight loss of >5% in 1 month
- Severe mucositis, pain, odynophagia, dysphagia or aspiration

Version 2.2026 National Comprehensive Cancer Network (NCCN) https://www.nccn.org/professionals/physician_gls/pdf/head-and-neck.pdf

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ENTERAL CONSIDERATIONS

Bolus: consider treatment schedule, tolerance

- Initiate once cleared post placement (varies by provider/institution)
- Avoid discharge delays
- Initial feeding: 120-240mL
- Increase based on tolerance every 3-4 hours
- Goal based on PO intake

Cyclic: pump, gravity bags

Continuous:

- Full strength in stable patients: depending on weight loss, malnutrition risk
- 20-25mL/hr advance in increments of 20-30mL/hr every 4-8 hours

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ENTERAL SELECTION

- Formula selection
 - Standard: High protein, high calorie
 - 1.2, 1.5, 2.0
 - Fiber?
 - Over the counter oral based
 - Plant based
 - Elemental and semi-elemental
 - Disease specific: Renal, Glycemic control (assess cause?)
 - Blenderized: commercial vs homemade
 - Intestinal microbiome benefit
 - Caregiver and patient driven
 - Cost, time
- Modular

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ENTERAL SELECTION

- Insurance, financial concerns
- Time considerations for patient, caregiver
- **Patient education:** coping, short- and long-term goals, PO intake
 - Who should provide education?
- Fluids:
 - Flushing protocols
 - Water source
 - Oral rehydration solution: when to consider?
- Medications
- Monitoring and complications: call clinic, RD follow up
 - Clogs, displacement, skin irritation

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Guidelines for Nutrition in Adults with Head and Neck Cancer: The American Society for Parenteral and Enteral Nutrition: Summary

Guideline Recommendations

1a. Receiving radiation with or without chemotherapy: Suggest initiation of enteral feeding where there is clinical evidence that nutritional intake is comprised, despite other strategies (texture, ONS) have been attempted. Should be individualized

1b. Suggest early (within 24 hours) nutrition intake (EN, Oral) to meet estimated needs. In consultation with surgical team, RD, and SLP. Oral intake increased gradually, and supplementary enteral feeding maintained until sufficient oral intake is established.

1c. Recommend weekly consultation with RD during treatment and every 2 weeks for up to 6 weeks after treatment.

3a. Recommend protein intake of 1.2-1.5g/kg/day, Actual BW.

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Guidelines for Nutrition in Adults with Head and Neck Cancer: The American Society for Parenteral and Enteral Nutrition: Summary

Guideline Recommendations

3b. Recommend energy intake of at least 30kcal/kg/day. Actual BW. Combination of oral intake, ONS, EN. Should be tailored to symptom burden and nutrition status while considering treatment plans, clinical, psychosocial and SE Status.

4a. Insufficient evidence to demonstrate a benefit individualizing needs based on body composition, suggest using Actual BW. Risk of overestimating in patients with obesity is higher. May use higher end of IBW, while using clinical judgement.

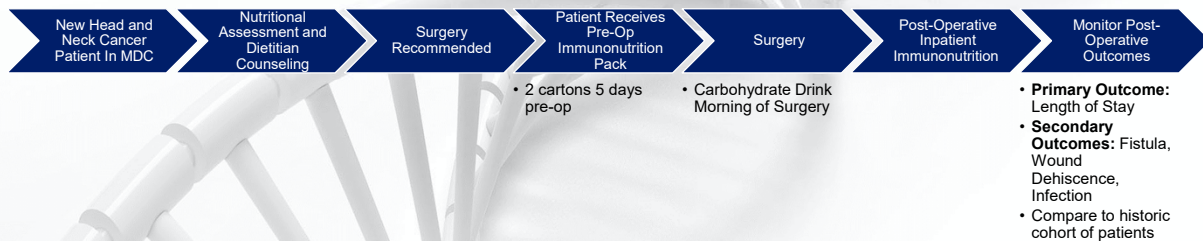
5. Decision to place PEG vs NGT is made through interdisciplinary team. Based on clinical situation, symptom burden, treatment plan, psychosocial, and duration of enteral.

9. Suggest continuing any degree of oral intake may be beneficial for maintaining swallow function. Volume and timing of enteral feeding should be adjusted according to what is consumed orally.

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IMMUNONUTRITION

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IMMUNONUTRITION

- Stimulates immune system
- Reduced inflammatory mediators
- Promotes wound healing
- Reduce post-surgical complications
- Randomized controlled trial with 116 patients:
 - 60 in immunonutrition group vs. 56 in regular diet group
 - Significant decreases in:
 - Fistula (8% vs. 23%)
 - Length of stay (5 day difference)



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I have provided hands on tube feeding education


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CASE : PA

- History T4N2b left tongue SCC, completed CRT 10/2023
 - G tube during treatment, removed 12/2023
- New diagnosis Metastatic Esophageal SCC 12/2025
 - Systemic therapy: FOLFOX + Nivolumab
 - Palliative radiation to bone mets 4/30/2026
- 5/4/2026: Full liquids only, globus sensation, MBS
 - 1000 calories daily, 15% weight loss in 6 months
 - Patient consider G-tube
- 5/14/2026: referral to GI for dilation. Referral to ICC for IVF
- 5/15/2026: consult to IR for G-tube

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CASE STUDY

- 5/18/2026: RD recommend admission for urgent G-tube
 - Na 138, K 3.4, Cr .5,
- Stent place during admission
 - PO intake improved: 50% of needs (Na 131, K 4.0, Mg 1.9, Phos 3.3)
 - Re assessment of G-tube placement with RD and SLP
- 5/27: G-tube placed and initiated on continuous feedings
 - Na 134, K 4.1, Mg 1.7, Cr .28
- Pt requested to discharge without HH, DME (Sunday)
 - Weekend, outpatient infusion appt

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CASE STUDY

- Patient preferred to discharge on weekend and purchase over counter product
 - Change to bolus (Sunday)
 - Nursing provided G-tube education, supplies as needed
 - Discharge team messaged outpatient RD
 - DME: formula delivered within 24 hours Monday night
 - Education: Enteral and PO intake(moist soft)
 - G-tube Skin care
 - Na 133, K 3.8, Glucose 118, Mg 1.6
- Success
 - Avoid chemotherapy delays

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CASE STUDY #2 CRT

- 58yo male with Oropharyngeal cancer arising from L Tonsil
- Recommendation: definitive concurrent chemoradiotherapy (CRT)
- Nutrition Assessment:8/28/2025
 - Stable weight. Tolerating regular diet. No PO complaints with diagnosis
 - Lives 3 hours from Atlanta with supportive wife
 - Educated on expected side effects
 - Recommend IR consult for G-tube
- Initiate treatment 35 fractions with weekly Cisplatin 9/19/2025
 - ***Educated on expected side effects, antiemetics, role of RD***

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CASE STUDY # 2 CRT

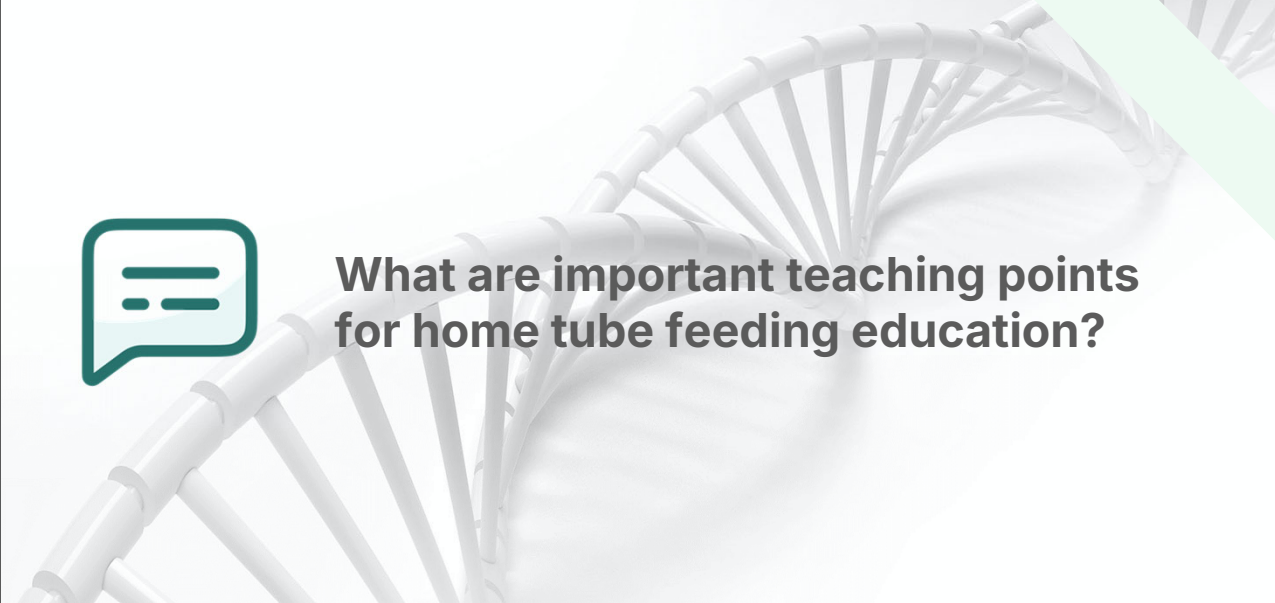
- Week 2: reflux, early satiety, constipation, regular diet
- **IR consult 9/28/2025 (following day)**
- Week 3 (10/2): soft foods due to pain, 8-pound weight loss, **Sodium 130**
- Week 4 (10/18): PO liquids(Oral Nutrition supplement, soup, Electrolyte beverage) only due to pain and mucositis, Weight loss 3.7% one week, **Sodium 134**
- 10/19: G-tube placed
- 10/20: G-tube education with patient and wife
 - Initiate 120mL Oral Nutrition Supplement (Plus) flushed with 120mL water
 - Continue 120mL every 3 hours, goal if 240mL within 3 days
 - Assist with insurance coverage: Standard formula 1.5
 - PO intake liquids: swallowing function (SLP following every 2 weeks)

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CASE STUDY #2 CRT

- 10/30: tolerating 4 cartons 1.5 formula
 - Gravity bag feedings: increase 5 cartons
 - Weight loss 8% in 5 weeks (155 lbs)
- 11/3/25: Completed CRT
- 2/6/25: assessment with RD and SLP (MBS)
 - Weight 164 lbs
 - G-tube for water flushes past 4 weeks
 - Cleared for G-tube removal
 - PO intake of soft foods, 1 ONS Daily

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What are important teaching points for home tube feeding education?

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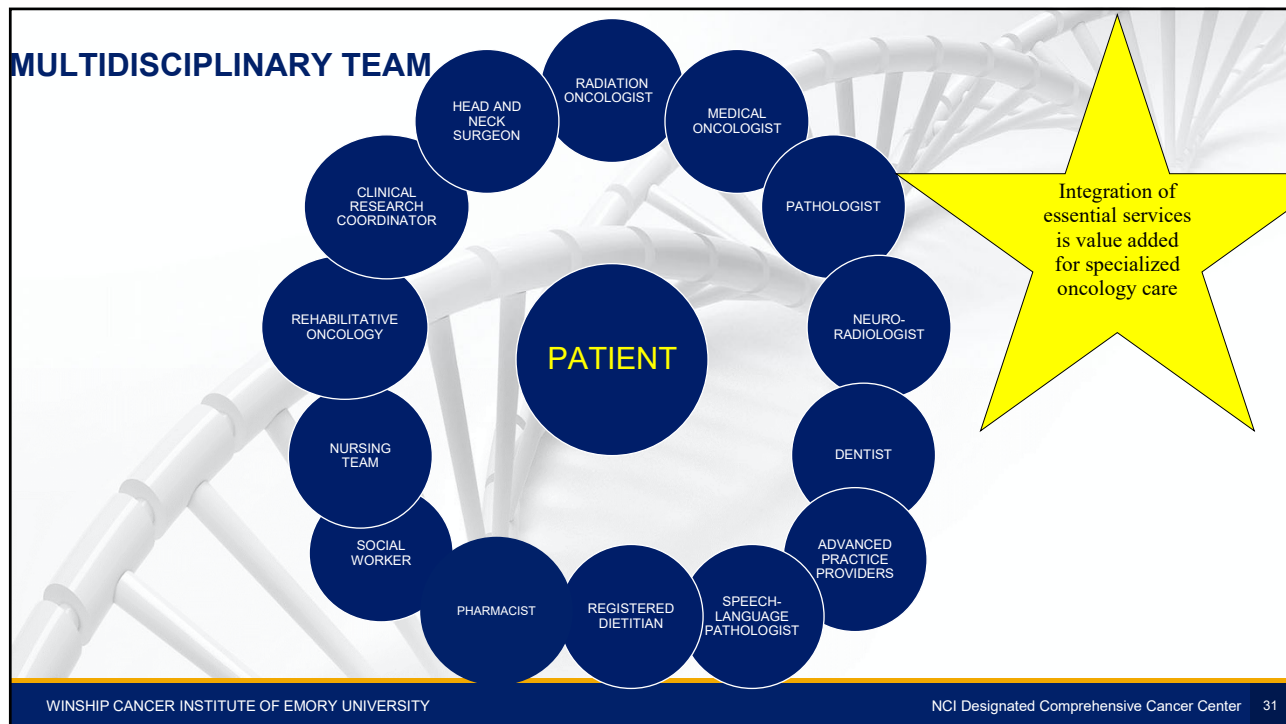
EDUCATION, EDUCATION, EDUCATION

Dietitians plan crucial role in educational process

- Transition from hospital to home care
- Home initiation : G-tube or NGT
- Teaching safe, tolerated administration
- Trouble shooting complications
- Understanding equipment
 - ENFit, Legacy, valves
- Multidisciplinary approach: Not solely nursing

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Assessment questions

Which objective is most relevant to your practice right now?

What is the target daily energy intake recommended by ASPEN guidelines?

Poll: I have provided hands on tube feeding education

What are important teaching points for home tube feeding education?

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