Preface
Making Nutrition Accessible to the Generalist

Dear Reader:

We hope that this issue will make nutrition accessible and understandable to the generalist. Nutrition is fascinating but can be frustrating. It is often confusing and counterintuitive. Generalists often report not knowing what to tell patients, and, if they believe they do, not knowing how to instruct them in such a way as to engender successful adherence. The quality of evidence is often very poor, given that most of what we believe comes from observational studies, so we nutrition experts often do not really know what to tell people, either.

It is easy to understand how nutrition is often felt to lack credibility when guidelines have changed so dramatically and frequently. I am often asked whether eggs are “in or out this time.” While this usually engenders a smile when I mention it to trainees, the stakes could not be higher and the consequences more dire. People follow public health guidelines to live healthier and longer and disregard those who they feel have betrayed them.

From my perspective, as a nutrition support practitioner, finding high-quality evidence to drive the feeding of the sick or those with intestinal failure is no less daunting. Confusion abounds due to conflation of phenomena, such as the wasting of muscle due on the one hand to illness and on the other to starvation, into single syndromes. In this case, I refer to the term malnutrition, which is often not equivalent to being malnourished (see the Malnutrition and Enteral Nutrition article for a more robust discussion of this).

Fortunately, the iconoclastic view, that randomized control trials are the appropriate source for data to determine causal relationships, is gaining traction in nutrition.

In this issue, the authors and I have strived to provide a practical evidence-based guide for the generalist. I have gathered some of those most expert and experienced
in their field, but also authors willing to write transparently. We have endeavored to ensure the authors call out where the quality of evidence is high and low.

One very important article is missing. That being the article on sodium. Unfortunately, the author had health challenges that precluded completion in time for it to be included. So much has changed in the field. Now, huge cohort studies (mind you, they are still observational) suggest that our guidelines for sodium restriction may in fact be harmful. All of the world’s heart associations, with the exception of the American Heart Association, have changed their recommendations from strict restriction (eg, 1500 mg) to avoiding excess (eg, <5000 mg). The new discovery of a large sodium storage system in the skin explains the lack of substantial blood pressure rise when sodium is loaded in normal volunteers and also explains why patients with heart failure go into pulmonary edema with a slice of pizza. Dietary sodium is rapidly scavenged and bound to glycosaminoglycans and becomes nonosmotic. In patients with hyperaldosteronemic states, such as those with heart failure, the storage system becomes saturated and dietary sodium remains oncotic.

It is our hope that this issue provides a practical tool and helps the reader better understand how to apply nutrition in any medical or surgical practice.

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