

between the two groups (21.4±2.9 in EEN vs 20.5±2.5 in DEN, 87% vs 93%). Compared with the DEN group, there were more patients in the EEN group who were in SICU (56% vs 17%; $p=0.0056$), while there were fewer patients on mechanical ventilation in the EEN group (57% vs 89%; $p=0.0093$). Nutritional adequacy from EN was higher in the EEN group (69±31% of caloric requirement vs 52±28%; $p=0.0450$), but overall nutritional adequacy (EN+PN) did not differ between the two groups (70% vs 83%). ICU-LOS was shorter in the EEN group compared with the DEN group (10.4±7.4 d vs 19.6±14.4 d; $p=0.0135$) based on multivariate analysis. MV-length was shorter in the EEN group, but the difference was not significant (9.4±6.4 d vs 12.4±8.6 d).

Conclusion: Early EN is able to increase nutritional adequacy from EN and is associated with improvements in clinical outcomes. Thus, early start of enteral nutrition should be encouraged in critically ill cancer patients.

Disclosure of Interest: None Declared

LBO21-MON

NUTRITIONAL STATUS, BODY COMPOSITION AND PHYSICAL PERFORMANCE IN COMMUNITY-LIVING INDIVIDUALS AFTER STROKE: A CROSS-SECTIONAL STUDY

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Rationale: Stroke incidents may unfavorable effect nutritional intake and mobility. Thus we explored nutritional status, body composition, physical activity and their impact on mobility 1–3 years after stroke.

Methods: Nutritional status was measured by Mini Nutritional Assessment-Short Form (MNA-SF, 0–14 points). Body composition, i.e. fat free mass index (FFMI; kg/m²), fat mass index (FMI; kg/m²) and fat mass percentage (FM %) was calculated by bioelectrical impedance analysis (BIA, Tanita inc.). Mobility was measured by Short Physical Performance Battery (SPPB, 0–12 points). Self-reported Physical Activity Scale for the Elderly (PASE, ≥0 points) was registered.

Results: 134 community living individuals (74±5 years, 69% men) participated. Body mass index (BMI, kg/m²) indicated that 71% were overweight or obese. 14% were at risk for under-nutrition. FM% was above reference (20) in 86% of the men, and above 30 in 90% of the women. Sarcopenia, defined as a combination of FFMI <25th percentile (of a reference population) and walking speed <1 m/s, was observed in 10%. Sarcopenic obesity, i.e. FFMI <25th and FMI >50th percentile (of a reference population) was observed in 28%. PASE was low (mean 108±65 p). Median SPPB was 10 points. SPPB was not associated to either FFMI or FMI. Multivariate logistic regression indicated that low mobility, i.e. SPPB ≤9 p was related to risk for under-nutrition (MNA-SF <12); OR 5.8 (CI 1.6–21.1), low PASE (tertile 1); OR 8.2 (CI 2.8–24.2) and high age (decade increase); OR 2.78 (CI 1.24–6.24).

Conclusion: One in four was classified as having sarcopenic obesity. Fat free mass was not related to mobility, whereas risk for malnutrition, self-reported physical activity and age were. Thus, actions for improved nutrition and physical

activity may represent potential opportunities for more effective rehabilitation after stroke.

Disclosure of Interest: None Declared

LBO22-MON

NUTRITIONDAY IN NURSING HOMES 2012 – PARTICIPATION OF THE REGION STYRIA, AUSTRIA

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Rationale: Since 2007, the nutritionDay (nD) in nursing homes (NH), a single-day cross-sectional study with 6-month follow-up, takes place yearly with the aim to call the attention of care givers to malnutrition of NH residents. In 2012, NHs in the region Styria (ST) in Austria (AT), took part nearly area-wide. Aim of the present analysis is a comparison of participants (units) from ST and AT.

Methods: All participating units from ST (2012) and AT (2010–2012) with mean age ≥65 y. were included. Data were analysed on unit-level (mean values of all residents in the unit).

Results: 2845 residents from ST and 3326 from AT participated. Women were less prevalent in units from ST than in AT [median (IQR): 69.4% (57.1–80.0) vs. 86.4% (79.1–92.3), $p<0.001$; t-test] and residents in Styrian units were younger (mean±SD age 82.0±3.8 y vs. 87.4±2.8 y, $p<0.001$). Characteristics and nutritional status of the groups are presented in the table.

	ST units (n=97)	AT units (n=102)
Severe cogn. impairment [%] ^a	25.0 (15.1–34.2)	33.3 (22.1–41.7)
Immobility [%] ^a	20.7 (12.8–31.9)	36.4 (21.1–47.1)
BMI <20 (age ≥65 y) or <18.5 (<65 y) [%] ^a	11.1 (6.0–16.7)	16.7 (11.1–24.6)
Malnutrition (staff assessment) [%] ^a	7.7 (1.0–13.6)	12.1 (4.1–20.8)
Weight loss previous year [%] ^a	34.2 (23.3–45.3)	38.1 (26.5–50.3)
Nutritional intake at nD <1/4 portion [%] ^a	6.3 (0–13.7)	10.0 (4.5–16.7)

^aMedian (IQR).

Conclusion: Mean age in units of ST was lower, and severe cognitive impairment as well as immobility were less prevalent in units of ST in comparison to units from AT. As possible consequence, nutritional problems like low BMI, weight loss and low intake were also less prevalent in ST. Styrian nursing homes may be subject to different conditions with regard to health care system.

Disclosure of Interest: None Declared