Hyperglycemia During Total Parenteral Nutrition
An important marker of poor outcome and mortality in hospitalized patients

Francisco Pasquel, Emory University
Ronnie Spiegelman, Emory University
Megan McCauley, Emory University
Dawn Smiley, Emory University
Denise Umpierrez, Emory University
Rachel Johnson, Emory University
Mary Rhee, Emory University
Chelsea Gatcliffe, Emory University
Erica Lin, Emory University
Erica Umpierrez, Emory University

Only first 10 authors above; see publication for full author list.

Journal Title: Diabetes Care
Volume: Volume 33, Number 4
Publisher: American Diabetes Association | 2009-12-29, Pages 739-741
Type of Work: Article | Final Publisher PDF
Publisher DOI: 10.2337/dc09-1748
Permanent URL: http://pid.emory.edu/ark:/25593/fkzrj

Final published version: http://care.diabetesjournals.org/content/33/4/739

Copyright information:
© 2010 by the American Diabetes Association
This is an Open Access work distributed under the terms of the Creative Commons Attribution-NonCommerical-NoDerivs 3.0 Unported License (http://creativecommons.org/licenses/by-nc-nd/3.0/).

Accessed September 13, 2019 4:47 PM EDT
BRIEF REPORT

Hyperglycemia During Total Parenteral Nutrition

An important marker of poor outcome and mortality in hospitalized patients

OBJECTIVE — To determine the effect of total parenteral nutrition (TPN)-induced hyperglycemia on hospital outcome.

RESEARCH DESIGN AND METHODS — The study determined whether blood glucose values before, within 24 h, and during days 2–10 of TPN are predictive of hospital complications and mortality.

RESULTS — Subjects included a total of 276 patients receiving TPN for a mean duration of 15 ± 24 days (±SD). In multiple regression models adjusted for age, sex, and diabetes status, mortality was independently predicted by pre-TPN blood glucose of 121–150 mg/dl (odds ratio [OR] 2.2, 95% CI 1.1–4.4, P = 0.030), 151–180 mg/dl (3.41, 1.3–8.7, P = 0.01), and >180 mg/dl (2.96, 1.2–6.9, P = 0.01). A blood glucose within 24 h of initiation (within 24 h) and during days 2–10 of TPN; Acute Physiology and Chronic Health Evaluation (APACHE) II score; length of hospital stay; hospital complications; and mortality.

CONCLUSIONS — Hyperglycemia is associated with increased hospital complications and mortality in patients receiving TPN.

Data analysis

For comparison of baseline demographics and clinical characteristics between groups, we used two-sample Wilcoxon’s tests for continuous variables and χ² test for categorical variables with Bonferroni’s corrections when applicable. Multiple logistic regression and adjusted odds ratios (ORs) were used to determine the influence of clinical characteristics on mortality and complications. A P value of 0.05 was considered significant.

RESULTS — The study population included 276 consecutive medical (33%) and surgical (65%) patients (mean age 51 ± 18 years, BMI 26 ± 7 kg/m², known diabetes 19.2%, intensive care unit admission 78.2%). TPN was started 12 ± 12 days after admission and was given for a mean duration of 15 ± 24 days.

The mean blood glucose level on admission was 139 ± 85 mg/dl. The mean blood glucose level before TPN was 123.2 ± 33 mg/dl and increased to a mean blood glucose of 146 ± 44 mg/dl within 24 h of TPN and remained elevated (147 ± 40 mg/dl) during days 2–10 of TPN infusion (P < 0.01 from baseline).

The overall hospital mortality was 27.2%. Deceased patients were older, were more likely to be in the intensive care unit, and had higher admission APACHE II scores versus nondeceased patients (all, P < 0.01). Deceased patients had a higher pre-TPN blood glucose (129 ± 37 vs. 121 ± 32 mg/dl, P = 0.08), a higher blood glucose within 24 h...
TPN-induced hyperglycemia and mortality

(162 ± 55 vs. 139 ± 37 mg/dl, \( P = 0.003 \)), and a higher blood glucose during days 2–10 of TPN (161 ± 53 vs. 142 ± 34 mg/dl, \( P = 0.013 \)) than nondeceased patients.

In multiple regression models adjusted for age, sex, and history of diabetes, the likelihood of death was independently predicted by elevated pre-TPN blood glucose between 121 and 150 mg/dl (OR 2.2, 95% CI 1.1–4.4, \( P = 0.030 \)), 151 and 180 mg/dl (3.41, 1.3–8.7, \( P = 0.010 \)), and >180 mg/dl (2.2, 0.9–5.2, \( P = 0.077 \)) or by the blood glucose within 24 h >180 mg/dl (2.8, 1.2–6.8, \( P = 0.020 \)) versus patients with a mean blood glucose \( \leq 120 \) mg/dl. In multivariate analysis adjusting for age, sex, and history of diabetes, the blood glucose within 24 h of TPN >180 mg/dl was associated with increased risk of pneumonia (OR 3.6, 95% CI 1.6–8.4) and acute renal failure (2.2, 1.02–4.8) compared with patients with blood glucose <120 mg/dl. Patients with higher blood glucose levels during TPN had a longer hospital stay (\( P = 0.011 \)) and intensive care unit (\( P = 0.008 \)) length of stay.

CONCLUSIONS — Malnutrition is reported in up to 40% of critically ill patients (1,7) and is associated with increased risk of hospital complications, longer hospital stay, and mortality (8). Despite improving the nutrition state and immunologic competence (9), TPN therapy has been associated with increased risk for infections and mortality (2,10–13). The increased risk of complications appears to be related, among other factors, to the development of hyperglycemia (4,14). Observational studies have reported a 33% mortality rate in TPN patients who developed hyperglycemia (15), as well as an increased risk of cardiac complications, infections, systemic sepsis, and acute renal failure (3,4,6). In agreement with these reports, we found a strong correlation between TPN-induced hyperglycemia and poor clinical outcome. Of interest, we observed that values before and within 24 h of initiation of TPN are better predictors of hospital mortality and complications than blood glucose during the entire duration of TPN (Fig. 1).

In multiple regression models adjusted for age, sex, and diabetes status, mortality was independently predicted by pre-TPN blood glucose values between 151 and 180 mg/dl (OR 3.41, 95% CI 1.3–8.7, \( P = 0.01 \)) and >180 mg/dl (2.2, 0.9–5.2, \( P = 0.077 \)), as well as by blood glucose within 24 h of TPN >180 mg/dl (2.8, 1.2–6.8, \( P = 0.020 \)) versus patients without hyperglycemia. In addition, blood glucose >180 mg/dl within 24 h of initiation of TPN was associated with increased risk of pneumonia (3.1, 1.4–7.1) and acute renal failure (2.3, 1.1–5.0).

The mechanisms underlying the detrimental effects of hyperglycemia relate to alterations in immune functions and inflammatory response (16,17). Hyperglycemia impairs leukocyte function, phagocytosis, and chemotaxis (18). Hyperglycemia also increases counterregulatory hormones, inflammatory cytokines, and oxidative stress (16,17), which can lead to endothelial dysfunction and cardiovascular complications (17). In addition to hyperglycemia, the administration of Intralipid in TPN solutions may worsen clinical outcome. Intralipid infusion, a soybean oil-based emulsion rich in n-6 polyunsaturated fatty acids (19), has been associated with exaggerated inflammatory response, immunosuppression, insulin resistance, increased blood pressure, endothelial dysfunction, and oxidative stress (19).

In summary, TPN-induced hyperglycemia is associated with increased length of hospital stay, increased risk of complications, and higher mortality in hospitalized patients. Our study indicates that blood glucose values before and within 24 h of initiation of TPN are better predictors of hospital mortality and complications than the mean blood glucose during the entire duration of TPN. These results suggest that early and aggressive intervention to prevent and correct hyperglycemia may improve clinical outcome in patients receiving TPN.

Acknowledgments — We appreciate the support of the Medical Records Department staff at Grady Memorial Hospital. G.E.U. is supported by research grants from the American Diabetes Association (7-03-CR-35) and the National Institutes of Health (M01 RR-00039).

No potential conflicts of interest relevant to this article were reported.

This work was presented in abstract form at the 69th Scientific Sessions, American Diabetes Association, New Orleans, Louisiana, 5–9 June 2009.

References

4. der Voort PH, Feenstra RA, Bakker AJ, Heide L, Boerma EC, der Horst IC. Intravenous glucose intake independently re-

Figure 1—Mean blood glucose (BG) levels and mortality rate. □, blood glucose levels pre-TPN (BG Pre-TPN), \( P = 0.167 \); ■, blood glucose levels within 24 hours of TPN (BG-24h TPN), \( P = 0.004 \); ■, blood glucose levels during days 2–10 of TPN (BG D2–10 of TPN), \( P = 0.060 \).
lated to intensive care unit and hospital mortality: an argument for glucose toxicity in critically ill patients. Clin Endocrinol (Oxf) 2006;64:141–145