Nutrition for Cancer Patients: Overcoming Taste Changes, Appetite Loss & More

**Speaker 1** 00:02

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**Dr. Bill Evans** 00:20

Well, welcome to the cancer assist show with your host, Dr Bill Evans, and today we're going to be talking about nutrition and supporting cancer patients during their journey, and how they should what they should eat, and how they should eat and so on. This is a really important and big topic, and I'm just delighted to have two dieticians with me today, registered dieticians, Karen Biggs, who works at the cancer center and has been there for many years. Good to see you again. Karen, thank you. And Renee Willette, a younger dietitian, but I'm sure just as well versed in the subject material. So we're really looking forward to having this conversation, because I think just about every cancer patient has some issues about their diet, their nutrition, because no matter what kind of cancer therapy we offer, whether just surgery or radiation, systemi therapy, immune therapy, they're gonna have some difficulties with eating normally. It's just not the same. So why don't we start off there with a little bit of explanation about what a dietitian does the training you both had and maybe a little bit of history about what attracted you into cancer medicine, as opposed to being a dietician in general hospital or dietician in some other circumstance, what drew you to cancer? So what's it take to be a dietician?

**Renée Ouellette, RD** 01:36

The dietician is a registered healthcare provider, so we go through specific credentialing and training to get the letters beside our name, RD, RD, exactly. So we all have to go through an accredited undergraduate degree in nutrition. Mine, in particular, I did that at the University of Guelph in the applied Human Nutrition Program. And then we can go on to either do an internship program which is also accredited, or a combined Master's in internship program myself. I completed that at the Toronto Metropolitan University, previously known as Ryerson University, and I completed my internship with them as

**Dr. Bill Evans** 02:16

well. And what's an internship? What does that mean? So

**Renée Ouellette, RD** 02:19

we get placed by lovely coordinators that find some supervisors in the community that are willing to supervise us through some practical training. So for me, that involved some work with a company that produces nutrition supplements for hospitals, another private practice who worked with women's health populations, and then I did some hospital rotations at Joseph Brandt Hospital in Burlington, and I was able to rotate with all the different dietitians there, so I had coverage in all the different units of a hospital,

**Dr. Bill Evans** 02:50

so a whole variety of different experiences, but kind of hands on in all of them to gain practical experience with it, the things you've been learning from textbooks and lectures and so on in your training. As it changed its own, Karen, or is that what you did way back? Yeah, I

**Karen Biggs RD., MHSc.** 03:05

was gonna say boy. So I did my undergrad as well at the University of Guelph, and at that point they didn't have combined master internship streams. So we had streams if you were more interested in a food service type of dietitian role, or they had clinical internships. So you, I ended up going to Sunnybrook Medical Center, and it was a very intense 10 months. So you're in all the different areas. It's It's funny, every area that you spend four to six weeks and you come out of there, you know, thinking, Oh, I think I have diabetes, or I think I have a heart issue. And I really enjoyed the cancer part of my rotation. I noticed that back then, and I actually worked there a little bit after I completed my my internship there, then I got hired, as a lot of people might know, is the Henderson so I started there, and I worked on the oncology board and and I, I I just loved it. So then everyone, you know, the physicians and whatnot were were saying you should be over in the cancer center, but the cancer center didn't have any type of dietician or whatever, and and I was really finding, you know, I went over and kind of volunteered for half a day, and that half a day filled up really quickly all the time with patients. And I enjoyed that. So eventually, when the new cancer center opened, they posted a position for a dietician. You

**Dr. Bill Evans** 04:53

jumped at it. I

**Karen Biggs RD., MHSc.** 04:54

jumped at it. And I always remember my dad saying, Oh, you're the. First one there. You better make an impression, and I hope I have. So then when I was in the midst of doing that, a physician and I were talking, and he said, you ask a lot of interesting questions. Have you ever thought about going back and doing your masters? So I ended up doing that, and I got my Master of Health Sciences at the McMaster University, and been just plugging along ever since. So that's

**Dr. Bill Evans** 05:29

a great story. I'm interested. They just ask you a little bit You said you love the oncology part, like, what's what attracts you to it? Because certain people abhor the idea of going and working with cancer patients and others are very attracted to so what was a forgiveness? It's

**Karen Biggs RD., MHSc.** 05:44

interesting because, you know, so many of my friends say that must be awful working there, you do get that. And I have never felt that way working there. I always have felt I feel useful, right? Patients are so appreciative of any time that you spend with them, any advice you can give them little tips here and there, a handout, you know, it makes all the difference in the world and and they're motivated to follow what you're recommending, whereas in some of my other, you know, rotations like diabetes and that they're not, they're not motivated, you kind of feel like, wow, did they? Did they hear anything that I just said, and I just, I just find that very rewarding, a lot of positive feedback. And we work with, I'm telling you, we work the great staff. So when there's sad moments, I think we all get them together, yeah, come together and acknowledge it. And, you know, sometimes situations aren't that great, and and we get each other through it. So it's very

**Dr. Bill Evans** 06:58

I think, is, I think special people are attracted to the oncology sphere. But what you said about people reacting, you know, why would you want to work in that area? Is exactly what I experienced going into oncology, going to Princess Margaret for rotation. Why would you do that? Must be terribly depressing, and it wasn't. It was quite the opposite. It was uplifting. And to see the the strength of people confronting cancer the way they usually do, with dignity and courage. And you know, you gained, you gain something from them. I think you're very rewarded for for caring for them. Well, I think there's a lot of people would like to know more about how to manage their their diet during cancer, because our treatments are are becoming more effective, but they still take a toll on individuals, and it doesn't really matter whether it surgery, radiation or any of the what we call systemic therapies of different types of drugs that we Use could be hormones, could be chemotherapy, could be these new immune oncology drugs or targeted therapies. They all play havoc with your digestion or how you feel. Commonest thing is just feeling fatigued. And when you feel fatigued, you don't feel like eating right, and you probably don't feel like cooking the food, if you're the person who has to prepare the meals. So there's a whole lot of tricks and tips I think that we could share with our listening audience today that would be helpful. Maybe we could work through the effects of of the different treatment modalities on appetite and and digestion. Surgery is pretty obvious. If you cut something out that's part of the digestive tract, be a part of the stomach or bowel, or you're going to interfere with a person's ability to eat for a while, while they heal. And if you change the length of the intestinal tract, they're going to interfere with their ability to absorb. So that that has special issues for for the patient, if they've had a lot of intestinal tract removed, you want to speak to what the impacts would be from a dietary point of view, and how you might confront that you

**Renée Ouellette, RD** 09:16

can cover a little bit more on radiation, just the the main treatment of your population. I work with a variety of different populations at the cancer center, including our breast populations, our genital urinary populations, brain and spinal tumors and our lung cancer patients as well. So I see a quite a variety of different treatment modalities, just given that I see so many different populations, so that can include different chemotherapy regimens, immunotherapy and targeted therapies as well as well as hormone therapy. So I kind of see the whole gamut, as well as radiation. But I'll let Karen kind of touch more on that, but particularly with the chemotherapy and the immunotherapy. Therapy, we see a lot of bowel related side effects when it comes to the immunotherapy class of medications, we see that tend to come in the form of more loose bowels and diarrhea, as it can cause some amount of kind of colitis or inflammation of the gut. And that's a side effect that our teams look out for when patients are on immunotherapy. But as far as nutrition goes, having diarrhea can increase a patient's nutrient losses, and it also just makes you feel unwell. So we get a lot of patients that say, I'm not eating anymore because it's just going right through me. I don't feel like eating. So you get a bigger discrepancy or difference between the intake, the needs, and the losses, leading to pretty rapid decline in nutrition status. So I mean the main treatment, as far as managing an immunotherapy related diarrhea, is to be discussed with the doctor. However, there's supportive measures that the dieticians can help with. So optimizing hydration is one of our top priorities, making sure that the patient is replenishing the fluids that they're using. So that could be by using oral rehydration solutions, which I believe one of the nutrition professionals that you have previously chatted with on this podcast review. So I'd recommend listening to that good when it comes to that. And then the other thing that we can look at is a patient's fiber intake. So we don't want to be adding fiber or any component of the diet that will stimulate more bowel movements. That could also mean restricting caffeine. For example, we don't want to, you know, increase bowel movement. So we're trying to slow the digestion down by reducing fiber intake, reducing caffeine, and then compensating with some good oral hydration. Occasionally, some IV hydration might be required as well. So that is kind of what we see with the immunotherapy. Most commonly, as far as chemotherapy, we kind of see the opposite side of the bowel side effect. So people tend to say, you know, I haven't had a bowel movement in, you know, far longer than my baseline, unfortunately, and that tends to be related to be a treatment side effect of the chemotherapy, but also a side effect of some of the medications that are given to manage other side effects of chemotherapy, mostly nausea and voc, Medic, so sometimes those anti nausea medications can slow digestion down as well, leading to constipation. A lot of patients, you know, they don't really know why it's so important to manage constipation. And from a nutrition perspective, you know, if things aren't moving through, it leaves very little room to add anything in, right? So again, nutrition status can be really compromised because of that. So in this case, the opposite is true about increasing fiber. Trying something like prune juice is a nice practical tip to help move the bowels along, and often it does mean using some medications over the counter. Laxatives can be very helpful, and patients are often kind of fearful of the side effects of those. But, you know, it's very common for our patients to rely on them, and we always talk about how this is temporary. It's a measure to kind of keep things moving along in your GI tract while you're on your treatments, to prevent any complications that can come from not managing your bowels, which can be quite severe.

**Dr. Bill Evans** 13:20

Of course, a lot of our treatments go out for a long period of time. These immunotherapies can run for a couple of years. Chemotherapy is commonly six months, or could be longer. So But why should we worry? Why should we care about the nutritional status, caring what will happen to the patient if we just ignore it? That's

**Karen Biggs RD., MHSc.** 13:40

a great question, and a lot of the time patients needs are increased just because they have a cancer diagnosis. So we know that the body burns more calories and uses calories at the expense of muscle. So breaking down muscle, yes, yes. So in a in a patient who doesn't have a cancer and they get sick or, you know, they're in a unwell state, their body has mechanisms that they reduce how much calories or energy they need, and they preferentially burn fat rather than muscle. However, a cancer patient is in a similar stress state as someone like in the ICU, in burn units, they will increase their metabolic rate so you're burning more calories than usual, and you preferentially burn protein or fat, and that's where we see a lot of weakness in patients so very frail. I tell a lot of my patients, you may see people in wheelchairs and walkers. It's not because. Of their cancer, it's because they've lost so much muscle mass, so we've got a halted as soon as possible. And it's always better to prevent something than to try and play catch up. So we like to be more proactive than reactive, getting patients, you know, more calories and more protein. We have lots of different tip sheets that just go over ways to add additional protein. We have protein powders that patients can use. Skim milk powder is one of the best you know protein powders going and it's a lot cheaper than the $100 containers you know that people are buying and just adding that to different things, can up the protein, but not the volume, which a lot of times that patients are having poor appetite or symptoms. We want to make every bite count. So

**Dr. Bill Evans** 15:59

you're making some interesting points here is different from sort of a normal, healthy diet. When you're a cancer patient, your metabolism is changing, so you're tending to burn more calories, but you're eating your muscle to do it basically, so you're trying to get a change in nutritional input so there's more protein going in, and more calories and carbs going in, right? So that you're got the carbs to burn, but you're trying to maintain the muscle, or maybe rebuild the muscle, if you possibly can. This really applies to virtually every cancer patient, though, yeah, so every cancer patient should see one of you guys. Well, that would be fantastic. It'd be very exhausted, though. You have to sort of quadruple your staff or something or greater. How do you get it identify the patients you're going to see? Because it's I know from my own experience. Physicians know almost square root of zero about nutrition, and we agree with not. Well, there's really very little in the course of medical training, at least I was involved in, or the curriculum renewal that I tried to create when I was in another university about nutrition. And so I think that doctors tend to refer to dietitians when it's so obvious that patient's not eating and they're wasting away. But as you just said, prevention is more invaluable than trying to play catch up when a person's lost a huge amount of weight, right? It's virtually impossible to recover from that. How do we resolve this issue where virtually everybody would benefit from nutritional advice and clear education about the kinds of things that would be helpful versus the smaller number of patients are actually being helped by dietary interventions that you would provide. You mentioned, you know, tip sheets and so on. Do all patients get that at the German stage,

**Karen Biggs RD., MHSc.** 18:05

some, depending on where their cancer is. So we know, for example, when patients have cancer in the oral cavity, tongue, base of tongue, esophagus, they do get some basic information. We also work very closely with the residents and the nurses to help them kind of screen who they think would be a good patient for us to be involved with. We've worked with the patient, library, Patient and Family Library on getting in books that are relevant, and we've created some. They're called Pathfinder, it sheets with lots of information for cancer patients. We're looking at doing some kind of video five minute, 10 minute videos that would be helpful for patients, like protein 101, you know, giving them information on that. We also use a lot of oral nutrition supplements that are high in calories in protein, you know. So that's something that patients quite often use on their own, knowing that. So there's only three and a half dieticians at the cancer center. So we really work. We We do have what we call automatic referrals for certain sites as well. But our staff is really good at kind of a they've started to be really good at identifying, you know,

**Dr. Bill Evans** 19:50

who the higher risk individuals and gather you work with that population that has that higher risk because patients with head and neck. Cancers tend to have difficulties with eating and the treatments they get with radiation and common, commonly combined with chemotherapy. Yes, really causes havoc with the lining of the mouth and throat, and and, and and you Rene or you mentioned lung cancer patients, so they commonly get combinations of chemotherapy and radiotherapy, so then their swallowing tube or esophagus is getting a burn that makes it impossible to eat. So maybe talk a little bit about the specific interventions that are helpful when when you've got a really raw mouth from radiation, because it's almost Well, it's very difficult to eat. State, what? What do you advise an individual in that situation? Right?

**Karen Biggs RD., MHSc.** 20:45

So usually, when they it's, it's, it's like a burn in their mouth. And pain medications are really important. Softer foods, mixing foods with, you know, gravies or casseroles that slide down easy, but sometimes just anything, even some of the oral medication, like Tylenol, three, elixir that we give for pain, can cause that burning sensation. There are a couple of over the counter remedies like a lidocaine, which we tell people to swish in their mouths, spit, let it sit for a bit, and that can kind of numb and take the edge off that. And there's also another one called Ginger gel, and we sell them both in the pharmacy at the cancer center because they do help with that, but really it's just trying to get down whatever they can. And usually the liquids go down a lot easier. I'd sometimes tell people they use a straw so that, you know, it's kind of directing it where it is, and not anywhere else. And that's when we really rely on a lot of like smoothie recipes, that we have a nice little package for calories and protein that's they're at their height right now of burning and burning calories and protein, and evidence suggests that they burn 20% more. So their requirements are 20% higher than if they weren't getting radiation and chemo. So it's a very challenging side effect,

**Dr. Bill Evans** 22:31

and are there things that they should specifically avoid in that situation to just make it worse? It

**Renée Ouellette, RD** 22:39

comes down to a loud trial and error with most of our patients, and each individual tolerates things a little bit differently. Across the board, most patients that have sensitivity of their mouth as a result of the radiation probably shouldn't be eating, you know, hot sauce and other spicy foods, quite painful, yeah, and sort of limiting, like crunchy hard foods, things like chips, whole nuts, that kind of thing, because it can be both painful, but can also get kind of stuck in sores and lead to infections as well. Some people find it stings if they have anything too salty either. So often, we do suggest patients use a homemade baking soda mouthwash to help kind of keep the oral cavity nice and clean. It can help a little bit with pain management. That recipe does suggest salt in it, and so for some people, they have to actually remove the salt from that recipe because it can sting a little bit more so trial and error, even with the citrus too. Citrus, anything, tomato juice, tomato sauces, those types of things too. But I was just gonna say, even with using a straw, like, it's a great suggestion, depending on where the sores are, right. Like, if they've got sores on the inside of their cheeks, probably a good suggestion. But if they've got sores on their lips, kind of making that mouth motion around the straw can be quite difficult and painful too. So it's very much an individually tailored approach with our patients.

**Dr. Bill Evans** 24:08

Some of those patients who are in your head and neck population have got there unfortunately because of smoking. And so what advice do you have for brown smoking? Because I gather that irritates when you already have a raw mouth,

**Karen Biggs RD., MHSc.** 24:21

absolutely and I think that that's kind of drilled into them at their initial appointments with the physicians and the nurses, and we offer smoking cessation products and programs and whatever. There's a lot of people that continue however,

**Dr. Bill Evans** 24:40

it's an addiction, and it's hard to stop, and I feel for the individuals, but it's the most important thing they could do for themselves, if they could get the supports they need and make team replacement therapy to help them with cravings and so on. It really is an important part of the overall management of. Of their with their cancer. So we talked about the sores, you know, later on, sometimes the problem is just almost the opposite, in that radiation of the head and neck often dries up the salivary secretions, so then you have a dry mouth to deal with, and then, right also interferes with nutrition. So the advice then has to change,

**Renée Ouellette, RD** 25:22

yes, yes. And I mean, certainly smoking can also make the dry mouth drawers, particularly during treatment, and we give the same recommendations as far as alcohol consumption too, because it could heighten some of those side effects as well. So limiting that would be another Hot Tip.

**Dr. Bill Evans** 25:39

Hot Tip, very good. So the dry mouth, how is that managed when the patient's got a chronically dry mouth and isn't producing much saliva as a result of the treatment that they had? We

**Renée Ouellette, RD** 25:52

recently had a discussion about this and how it's one of the most challenging side effects, I think, could be work at managing the main kind of suggestions as far as nutrition goes, are to again, add things that bring moisture to your meal, so things like sauces, gravies, dips, that kind of thing, so that you're adding moisture to dry foods and making them more tolerable. Sometimes we even find patients with dry mouth have difficulty swallowing because of the dryness. There's no lubrication to help move the food bolus through the oral cavity and down the esophagus. So really, having moist foods can be helpful, sometimes even to the extent of kind of pureeing foods in the blender, if that's easier to tolerate, meeting hydration needs is also really important. We don't want dehydration to be a contributing factor to the lack of salivary production. So we talk to patients regularly about how much fluid they would require and how to optimize their hydration, because it's not always just drinking more water. Anecdotally, some patients have found it helpful to, like, use an oil in their mouth. And I know Karen, you can speak to that a little bit. And quite some patients have success there. Yeah. So just taking

**Karen Biggs RD., MHSc.** 27:05

any kind of oil, olive oil, vegetable oil, and kind of rubbing or coating their mouth, and it just gives that extra lubrication when they're swallowing. So

**Dr. Bill Evans** 27:17

they do this before they were gonna try and eat their meal. Oh, yeah, I've heard of that. Yes, interesting, and it works, so sounds like a good tip. Yeah, wonderful. Actually,

**Karen Biggs RD., MHSc.** 27:28

I know that I first heard that with a speech language pathologist told my one patient to try that, and I've been using it ever since. And I think that people need to understand how horrible that dryness is. And I always remember it really hit home for me. I was in the room when the doctor was examining a patient and had their gloves on and went to take the gloves at like, take the finger out and the gloves stuck, stuck in the mouth. And I, I'll never forget that, right? And so, you know, always trying to, you know, read or find extra things that you know, anything that could could help patients with that

**Dr. Bill Evans** 28:19

that's a good place to maybe pause for a moment, and we'll take a brief break and come back and talk with our two dietary specialists about some of these challenges that cancer patients face. And Mindy. Talk a bit about the how the taste can be sort of perverted by the by treatments, and sometimes bitter or too sweet or too salty and so on. Talk about some of those things, and then how you might prepare yourself if you're about to embark on cancer treatment, To be best prepared for supporting your nutrition during that treatment journey. So we'll be right back after this word from the cancer Assistance Program. We'd

**Speaker 1** 28:59

like to take a moment to thank our generous supporters, the Hatton Family Fund and Banco creative studio who make the cancer assist podcast possible. The cancer Assistance Program is as busy as ever providing essential support to patients and their families. We remain committed to providing free services for patients in our community, including transportation and equipment, loans, personal care and comfort items, parking and practical education. These services are made possible by the generosity of our donors through one time gifts, monthly donations, third party fundraising, corporate sponsorships and volunteer opportunities. Visit cancer assist.ca to see how you can make a difference in the lives of cancer patients and their families.

**Dr. Bill Evans** 29:42

So we're back with Renee wolette And Karen Biggs talking about nutritional support of cancer patients. We've already had a lot of really great tips, but maybe some more will come out at this next segment, because I know from my own experience as an oncologist, patients often get some really. I'm gonna call them weird thing tastes and changes in how they perceive their food, things that used to they really, really enjoyed eating a steak, and now it tastes bitter, or maybe they have a metallic taste to their everything. And so there are, I gather, ways we can sort of help these situations, if it's if things are too salty, too sweet, too metallic, what do we advise patients?

**Renée Ouellette, RD** 30:28

The approach is very individual, and it's based a little bit on what their taste is like at the current moment. So I've had patients say everything tastes like soap or sawdust or garbage, the whole gamut. So

**Dr. Bill Evans** 30:48

really haven't heard that one?

**Renée Ouellette, RD** 30:51

Yeah. So very, very different patient to patient. One of the I think top questions that we get from our patients, particularly in the head and neck population is, how long do these taste changes last for? And to me, it's just the hardest question to answer, because the answer is always, I don't know, it depends. Everyone's different, and it's it's a side effect that sometimes we need to be very patient with, and that's easy to say as the provider, and probably difficult to receive as the patient. As far as tips to manage that, we do have a few strategies, but I would probably say that it might be the most difficult side effect that we manage, because there's no medications on the market to help with that. So we're really just left to our own innovative kind of strategies with diet. So some people experience significant increase in the intensity of flavor, so that, like you said, could be saltiness or sweetness, so often we'd recommend sort of compensating with the opposite flavor. So you know, if sweetness is excessive, and you know, the only thing you're able to get down right now is some ice cream because your throat sore. Topping it with a little bit of salt can help tame down that that sweetness to make it a little bit less intense. Similarly, you know, if you're having a meal that you know is savory but tastes far too salty, or, you know, isn't supposed to be as salty as it tastes, adding a sprinkle of sugar can be helpful. So use counterbalance. Counter balancing exactly and a lot of trial and error with trying different foods, and when a patient presents with taste changes, I often recommend trying new foods because you don't have that you know, previous knowledge of what this is supposed to taste like. So let's try it and see, even if it doesn't taste how it's meant to taste, it might still be acceptable because it's a completely new flavor. So trying some new foods might be a good option. Then there's the balance of Do you want to kind of maximize? You know, eating foods that a patient typically likes or avoiding them not to cause an aversion to some of their favorite foods. So again, depends on the patient. If they find their favorite foods are still the best thing you know, that they can taste, we'd encourage to kind of maximize intake of those foods. But again, it depends on the patient truly, if they are finding that you know, their favorite foods are just tasting awful. Then sometimes we do recommend staying away from them so that when that symptom resolves, they can go back to enjoying their regular favorite foods

**Dr. Bill Evans** 33:31

mentioned. I've heard about people who find meat becomes bitter, and now we're trying to get more protein into them. What? What? What can you do in that situation. I don't know how common it is, but it's something you do in Kelsey from time to time. And how would you manage

**Renée Ouellette, RD** 33:46

it? Yeah, we often get the metallic taste, particularly with red meat, so marinating red meat in like an acidic marinade can help cut that metallic taste a little bit. Sometimes it's it's not enough, so we'd rely more on other protein sources and more kind of bland food. So, you know, chicken might be a little bit more tolerable than a red meat. Plant based proteins can sometimes be a little bit more tolerable. So things like tofu, beans, lentils and dairy products are kind of nice and bland. So things like yogurt and milk can be, you know, perceived as a little bit more tolerable from a taste perspective, as well. As far as the metallic taste goes, some other strategies outside of kind of the protein side of things. You know, limiting use of metal cutlery can be helpful. So temporarily swapping over to plastic or they've got, you know, the bamboo or wooden cutlery now can be a good choice, and then avoiding foods that come in metal containers, so canned foods can sometimes, you know, patients can perceive that metallic taste more than someone who's not had cancer treatment and is experiencing that side effect. Yeah. This

**Dr. Bill Evans** 35:00

is fascinating to me, because I imagine that 99.9% of patients have never heard any of these things. You know. I really think you know all of this, all these kind of fine details that can make a difference to the person's quality of life are really important. But getting the information, unless they see someone with fewer kind of knowledge they're not going to ever hear that if I have a metallic taste, I should stop using my my stainless steel cutlery at home, and switch over to plastic or bamboo. These are amazing little tips, and I think the the information you have is so important that like to see how we could get it out more, we'd try and do it this way, but there are many other ways. I'm sure. That's all I find very fascinating.

**Karen Biggs RD., MHSc.** 35:47

I think too. Just to add patients, you know that we're seeing as well, particularly in the head and neck group, they're having a dry mouth, they're having taste alterations, they're having a lot of pain. Swallowing is very difficult. And eventually we, we may need to take a step back and kind of look, I think that patients think if they need a feeding tube, that it's a failure on their part. You know, they just, and we really try and encourage patients, no, it's, it's a hiccup, right? You need the treatment. We're full, you know, going full steam ahead with the treatment. We need to support you, because if we can't support patients, then they may have to decrease the dose of chemotherapy, and that's what we're trying to avoid. So quite often, a lot of these patients end up with a feeding tube and and a lot of them indicate, thank God I have it. I had one gentleman. Name is tube you know, Joe and I are going out, you know, and it's so important, because he said it saved my life, right? And so that's the other part more, the clinical stuff that we get into as well, you know, recommending tube feeds, working with patients on tolerance, we usually get gastrostomy tubes placed so a small tube directly into the stomach, so it's not noticeable. A lot of the patients are sitting in the clinic and have feeding tubes, and other patients don't are even aware. Yeah, yeah. And so that's come a long way since even when I first, you know, started, we used to have to put patients in the hospital to have a feeding tube inserted. Now we have a really well oiled tube feeding program. It's done as an outpatient.

**Dr. Bill Evans** 37:57

We were even a tube placement as an outpatient.

**Karen Biggs RD., MHSc.** 38:00

Yeah, yeah, yeah. So all that works very, very

**Dr. Bill Evans** 38:03

well, excellent. Yeah. But do you still use the tube through the nose and down into the esophagus, or would you be going directly

**Karen Biggs RD., MHSc.** 38:10

we yeah, we usually give patients the option, you know, we can use a nasal gastric so starts in the nose, goes down to the stomach. It's aggravating for some patients. Sometimes getting the tube in is difficult because of the radiation side effects that are going on. Other patients seem to manage fine, and so we often give them the choice, most choose the stomach to know

**Dr. Bill Evans** 38:42

that it's an outpatient procedure, and sounds like it's pretty newly done. We work very

**Karen Biggs RD., MHSc.** 38:47

closely with the home care community as well with that. So now when

**Dr. Bill Evans** 38:53

they have that, is it, it's not like Meals going in. And is it continuous, or is it just intermittent? So how's it done? Yeah,

**Karen Biggs RD., MHSc.** 39:02

so they're still encouraged to take as much as they can by mouth, right? Because the whole swallowing mechanism is, is a muscle, right? And if you don't use them, yeah, if you don't use a muscle, you lose it. And we've had lots of patients, you know, who forget how to swallow, really, and it's, it's the people. What do you mean like that? That just sounds so weird. We do give all our head and neck patients swallowing exercises that they should be doing as well, two to three times a day. I nag them. You know, I say your wife is nagging you at home, and I'm nagging you here because they are so important, and they've done studies where they've given head and neck patients swallowing exercises versus not, and they recuperate thicker. So I really, I really, you know, encourage. Encourage them to do that. If you're in the hospital, you'll usually get what we call a continuous feed. So they might hang, you know, so many containers in a bag, and it would run over hours, but that's not really practical when you're at home, right? So we try and do it, what we call bolus feeds, and I usually do mine, breakfast, lunch, dinner, evening, you have so many cans, so many containers, you have so much water. If you're not taking any of that by mouth, then it goes through the tube. I

**Dr. Bill Evans** 40:37

learned something. I learned a lot. Actually, one of the things I stumbled across in reading too, that I'd like you to comment on is just food safety during chemotherapy because or cancer therapy because many of our interventions impair our immune system or open us up to infections by breaking down the natural barriers, and people don't really think a lot about how the foods that we eat could be causing an infection to them at their or bacteria on on foods as well. Could Can you talk a little bit about that?

**Renée Ouellette, RD** 41:17

So there's different extents of food safety that we recommend for different population, I would say the population that needs to be the most strict on food safety is the hematology population undergoing stem cell transplant, particularly if their stem cells are coming from another source, not from their their own stem cells. And we do have dieticians that work specifically with our stem cell transplant patients, who provide that more extensive dietitians at the jurisdiction with our patients undergoing chemotherapy. We know that can suppress the immune system. We generally recommend pretty standard food safety guidelines that most people should be following, so things like avoiding cross contamination with raw meats, washing your fruits and vegetables under running water, you know, scrubbing your root vegetables, so scrubbing your potatoes and ideally scrubbing any fruits and vegetables With hard surfaces. A few things that I typically recommend to my patients are avoiding, like raw fish. So sushi would be off the table for our chemotherapy patients, just because the high risk for contamination. Another thing to consider is raw sprouts can be quite high risk for contamination. So I say just avoid those during the duration of your treatment. But for the most part, there's nothing extensive beyond what most of us should be following.

**Dr. Bill Evans** 42:51

What about lettuce? Once bred, the lettuce can be contaminated with Pseudomonas when there's a nasty bacteria, euphoria, isn't? There's a risk, to just wash your lettuce leaves or your salad. We

**Renée Ouellette, RD** 43:03

just recommend washing it under rotating water and washing it well, maybe extra care. Yeah, exactly, exactly. One other thing that my friend has come up a number of times with their patients, particularly when we encourage them to boost their protein intake, is some patients will take the sort of bodybuilder approach to that and start putting raw eggs in their smoothies. That is something that we would advise against, particularly if you're receiving chemotherapy, just again for the food safety standpoint. So no raw eggs. Now

**Dr. Bill Evans** 43:34

we mentioned a little bit too at the beginning, preparing for you're going to start treatment, and you're in a pretty good shape. You haven't lost a whole lot of weight, but cancer has been found fairly early, but you're going to go through some pretty intensive treatment. What advice can you give to people? You probably don't even get to see them, but if you had an opportunity to get to see them. What would be the advice you'd give them about preparing, like, what would they what should they do in terms of, you know, getting nutrients ready because they're going to go into a period of poor ability to eat? Shall we say? Well, what's the advice that you have in

**Karen Biggs RD., MHSc.** 44:19

life? I usually so with a lot of the patients I see, particularly, we know they're gonna run into, you know, they're gonna need softer foods or smoothies and that kind of thing. We have some really nice handouts that go over that, and I tell them to go through it, pick out things that you think, are, you know, things you would want to eat and pick them up now or stockpile some food? Yes, yes. And everybody asks you, What can I do? What can what can I do? Anything? Yeah, make a lasagna. Yet and put it into different containers and give it, you know, give it to that patient, because then they can freeze it away. Yeah, yeah. They have different things that they can go to because a lot of time, if they're there all day, like some people are there for a good chunk of the day they get home, the last thing you want to do is try and make something. So if you have things that are ready to go, we have a really cool list of snack foods, right? Quick, easy, high calorie, high protein snacks. Go through that, you know, cheese and crackers, cut up some cheese, fruit with cottage cheese, you know, just have things ready in the fridge so that you can come home and grab it and and take it, especially when your appetites not that that great just sitting smelling foods. You know, can, can that can be it, it can just turn you right off. So if you have things that are easy to grab, usually cold foods when you're having a poor appetite or better tolerated. So have those things available to you to grab and

**Dr. Bill Evans** 46:10

go and you mentioned accepting help. I imagine I'm just thinking the typical couple men don't tend to work in kitchens as much as women do. More young men, I think, are doing that, but a traditional I'm on safe ground here. But anyway, most men don't do quite so well in the kitchen, as Lees do so. And then when the women are on treatment for, say, breast cancer or some other malignancy, and the husbands are trying to make the meals. That must be a bit of a challenge, because they're unfamiliar, number one, with preparing food. Number two, lack of awareness of the things we just were talking about so they might create a nice meal, they think. And then the house is full of the smell of food, and wife walks in, and that's carita. So what about counseling for the spouse?

**Karen Biggs RD., MHSc.** 47:09

I hear this a lot, and in my case, a lot of the time, the wife is the caregiver, and they'll make they'll make gourmet meals, or, you know, I always remember a gentleman saying, Oh, don't worry, my wife's Italian. I'll eat Don't worry. And then all of this happens, you know, and the wives are making it, and they just can't eat it. And it is a lot of work. Just, you know, going over with couples. This is normal. Let's try this. Let's try some nutrition drinks. You know, the wives are saying, well, I'm gaining all the weight here because, you know, I'm making all the food, and then they're not able to get things down. So it is a conversation that you want to have right because you don't want them to get frustrated with providing care and and not acknowledging it, but at the same time, the patients can't get physically get it down. So it happens a lot,

**Dr. Bill Evans** 48:16

and understanding that the smell of food and so on can be very off putting to someone who's on treatment for cancer and must cause a little strife in the home, and some it's gone to a lot of effort to make a really nice meal, and then their spouse comes from the cancer center and can't eat that. That's I don't like that. It doesn't smell right to me or something, it must be very unsettling, and change

**Karen Biggs RD., MHSc.** 48:43

a little tight, and sometimes they just keep to know. Just need to understand that that's common and and that, you know most patients experience this, and what you're doing is helpful, but maybe not right now. Yeah, let's

**Dr. Bill Evans** 49:01

hope a lot of people listen to this podcast. I

**Karen Biggs RD., MHSc.** 49:05

had one couple she said, I'm going to be a divorce court when this

**Dr. Bill Evans** 49:10

is over. And it's so it's very real phenomenon.

**Renée Ouellette, RD** 49:15

I think another challenge that I find a lot of couples go through is when, particularly when they're used to eating a classically healthy diet at baseline, variety of fruits and vegetables, lots of plant based proteins. You know, the typical healthy diet, and everything changes once they they start treatment and you know their counterpart is saying, you know, they're not eating enough fruits and vegetables, or why are they eating any whole grains anymore? So I think kind of letting go a little bit of previous diet parameters is important, is an important part of the preparation going into cancer treatment, and knowing that we don't expect our patients to stick to you. Also exactly what they for

**Dr. Bill Evans** 50:03

a lot of things for people to learn. And yeah, we doctors said we didn't learn them. You both have done an amazing job of explaining a whole host of things that I I really do hope people have an opportunity to listen to, to understand. Are there any things that you want, final messages you'd like to get. Like to get across to our listeners about diet and cancer that we haven't talked about.

**Karen Biggs RD., MHSc.** 50:29

I I really want to talk to people about the some of the oral nutrition supplements that are out there and and people talk in the clinic and and rightfully so, right? It's good to everybody, yeah, share information. And some patients meet certain criteria to have the oral nutrition supplements, like the answers, the boost, whatever covered, whereas other patients don't. And then so the patients who don't have them covered will say, Well, why can't I get them on a prescription or whatever? And there are certain there's certain criteria. And the first is that it's got to be your sole source of nutrition. So if it's not your sole source, then that's the first thing, and then paying for those. So even though someone may qualify, if they are not on any kind of social assistance program like Ontario Works or ODSP, then it wouldn't be covered. Now, if they're on home care services, one of the services that Home Care provides, like they provide nursing or various allied health professionals, supplies you know they have, they supply a drug card, and that drug card is active for as long as the service is active. So a lot of our younger patients, so if you're 65 or over, then the government pays for your medications, right? So if you're under 65 not on any kind of social assistance program, but you are on home care, which a lot of patients are, then we can get those supplements covered if they're your sole source. And I remember I called the Ontario Drug Benefit people, and I asked, like, Well, what do you mean sole source? Like, if someone gets up and has a tea and toast and that's it, then do they qualify? They said, yes, they would qualify for that. So, and then the doctor also has to complete an Ontario Drug Benefit form that goes with the prescription to the pharmacy. So sometimes, you know, we can give samples out to patients, and I know that the cancer Assistance Program also does that. If they're not kind of having it as a sole source, and they want to take, you know, one or two a day to optimize their diet, then that's not a scenario that would be covered. So,

**Dr. Bill Evans** 53:35

so that's where the cancer Assistance Program is of help to them. Absolutely. A little extra citrition, absolutely. And one of the benefits of having that program in our city, Renee. Any other last minute key points you want to make, drive home some of the suggestions that you've already made this as we wind up. I

**Renée Ouellette, RD** 53:58

think when it comes down to nutrition. I think patients do need to advocate for their own care a little bit. As you said, you know, it's hard for us to get to all the patients that might need us. We do have, you know, set criteria for certain populations so those automatic referrals do come in, but for patients that have not necessarily been in contact with a dietitian, some of the red flags to sort of look out for would be rapid and unintended weight loss or uncontrollable side effects of your treatments, whether that's oral or throat pain related mouth sores, nausea, vomiting, bowel issues that are not being managed well enough with medical management. So those would all be reasons that you might, you know, consider chatting with your care team about a referral to a dietitian. And I think the other point, just to drive home, is for patients to be open and upfront with their care team about the side effects and symptoms that they're experiencing. Okay, so that we can get on top of managing them early, and hopefully get on top of the nutrition aspect early as well. I

**Dr. Bill Evans** 55:09

think you're making two really good points there, the particularly the one of advocating and speaking up your needs. Because I think a lot of patients are kind of reticent to ask for more. They feel like, well, the doctor's busy. He's prescribing this treatment and not feeling well and not eating well. But I won't trouble them with the but really, we've had this comment in previous podcasts that you have to you or your spouse or your friend or whoever comes with you, needs to help advocate and to ask questions. Well, what can we do about that? And maybe it's a dietitian to name you see an occupational therapist or physiotherapist or some other person to help you with the totality of care that you need to have a good outcome from your cancer. But being an advocate for yourself or having someone with you who can advocate is really, really important and not to hide your symptoms, as though you know, telling a doctor that you're constipated is something you don't share with them to someone physician needs to know to help manage your total care as well. So it was a really, really good point, but Julia made some remarkable comments and suggestions and helps for patients going through cancer. And I am just really, really pleased that both of you would participate in this podcast and share your your knowledge and your experience with our our listeners. I'm sure it'd be a great help to them, because I don't think many people hear a lot about how to manage a diet during the course of treatment, and all the little tips that you provided should be so helpful. So I just want to thank you both so much for participating in this podcast today.

**Renée Ouellette, RD** 56:47

Thanks for having us absolutely.

**Speaker 1** 56:53

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