



Nutritional Dietary Recommendations for Acute Ischemic Stroke and their Outcomes

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DESCRIPTION

Nutritional intake is a key component of stroke care that can influence the recovery and outcome of acute ischemic stroke patients. An early screening and assessment of dysphagia and nutritional status is recommended for all stroke patients. Adequate hydration energy protein micronutrients fatty acids intake should be ensured while avoiding foods that can increase the risk of recurrent stroke or aspiration pneumonia. Dietary modifications may be needed depending on the patient's comorbidities swallowing ability preferences needs.

A multidisciplinary approach involves physicians, nurse, dietitian speech-language pathologists pharmacists caregivers is essential for providing optimal nutritional care for stroke patients. Ensure adequate energy and protein intake to prevent or treat malnutrition, which is common in stroke patients and can impair recovery and increase mortality. The recommended energy intake ranges from 25 to 35 kcal/kg/day, and the recommended protein intake ranges from 1.2 to 1.5 g/kg/day. Provide oral nutritional supplements or enteral nutrition (tube feeding) if oral intake is insufficient or unsafe due to dysphagia or reduced appetite. Enteral nutrition should be initiated within 24 to 48 hours after stroke onset if oral intake is less than 50% of the estimated needs. Monitor fluid and electrolyte balance to prevent dehydration or overhydration, which can worsen cerebral edema or increase blood pressure. The recommended fluid intake ranges from 30 to 40 ml/kg/day, depending on the patient's condition and urine output.

The optimal nutritional intake for stroke patients depends on several factors, such as the type, severity, and location of the stroke, the presence of comorbidities, the level of disability, and the individual preferences and needs of the patient. However, some general principles can be applied to guide the nutritional management of acute ischemic stroke patients. First, adequate hydration should be ensured, as dehydration can worsen cerebral

ischemia and impair cognitive function. Fluid intake should be monitored and adjusted according to the patients fluid balance, renal function, and electrolyte levels. Second, adequate energy and protein intake should be provided, as malnutrition can impair wound healing, immune function, muscle strength, and functional recovery. The energy and protein requirements of stroke patients vary depending on their age, weight, activity level, and degree of inflammation. A common recommendation is to provide 25-30 kcal/kg/day and 1.2-1.5 g protein/kg/day for most stroke patients.

However, these values may need to be individualized based on the patient's nutritional status and clinical condition. Third, adequate intake of micronutrients and fatty acids should be ensured, as several studies have shown lower blood levels of vitamins B1, B2, B6, A, D, E, selenium, choline, coenzyme Q10, Docosahexaenoic Acid (DHA), and Eicosapentaenoic Acid (EPA) in stroke patients compared to healthy controls. Fourth, dietary modifications may be needed to prevent or treat complications such as dyslipidemia, hypertension, diabetes mellitus, or obesity that can increase the risk of recurrent stroke or cardiovascular events.

The diet which is high in potassium, low in sodium, and rich in vegetables, fruits, cereal fiber, and whole grains may reduce stroke risk. Eating a diet rich in fruits and vegetables, and following the Mediterranean diet, which emphasizes olive oil, fruit, nuts, vegetables and whole grains may also be helpful. However some foods should be avoided after an ischemic stroke such as foods rich in additives, bean cultures, radish, turnips, strongly brewed tea, coffee, mushroom broth. Fifth dietary consistency may need to be adjusted according to the patient's swallowing ability. Dysphagia can increase the risk of aspiration pneumonia which can be fatal for stroke patients. Therefore a careful evaluation of the patient's swallowing function by a speech-language pathologist is essential before initiating oral feeding.

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CONCLUSION

Therefore, supplementation of these nutrients may be beneficial for stroke recovery. However, more evidence is needed to determine the optimal doses and timing of supplementation for different stroke subtypes and outcomes. Based on the results of the swallowing assessment different textures of food and liquids

may be recommended such as pureed minced soft or regular foods thin nectar honey or spoon-thick liquids. The patient should also be instructed on how to eat safely such as sitting upright chewing well taking small bites avoiding distractions etc. These nutrients have various roles in modulating oxidative stress, inflammation, neurogenesis, neuroprotection, and neuroplasticity after stroke.