Nutritional support in chronic obstructive pulmonary disease: a systematic review and meta-analysis

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Key words: nutritional support, COPD, malnutrition, meta-analysis.

Word count
Abstract: 252 (including titles)
Document: 4945 (including titles and within text references)

Abbreviations
COPD – chronic obstructive pulmonary disease
DA – dietary advice
DXA – dual emission X-ray absorptiometry
ETF – enteral tube feeding
FFM – fat-free mass
IBW – ideal body weight
MAMC – mid-arm muscle circumference
ONS – oral nutritional supplements
RCT – randomized controlled trial

Funding
No funding was received.

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ABSTRACT

**Background:** The efficacy of nutritional support in the management of malnutrition in chronic obstructive pulmonary disease (COPD) is controversial. Previous meta-analyses, based only on cross-sectional analysis at the end of intervention trials, found no evidence of improved outcomes.

**Objectives:** To conduct a meta-analysis of randomized controlled trials (RCTs) to clarify the efficacy of nutritional support in improving intake, anthropometry and grip strength in stable COPD.

**Design:** Literature databases were searched to identify RCTs comparing nutritional support versus control in stable COPD.

**Results:** Thirteen RCTs (n 439) of nutritional support (dietary advice (1 RCT), oral nutritional supplements (11 RCTs), and enteral tube feeding (1 RCT)) versus control were identified. Analysis of the changes induced by nutrition support, as well as those obtained only at the end of the intervention, revealed significantly greater increases in mean total protein and energy intake with nutritional support by 14.8 g and 236 kcal daily. Meta-analyses also demonstrated greater improvements in favor of nutrition support for body weight (1.94 SE 0.26 kg, p<0.001; 11 studies, n 308) and grip strength (5.3%, p<0.050, 4 studies (n 156)), which could not be demonstrated by analysis of values at the end of the intervention, largely due to bias associated with baseline imbalance between groups.

**Conclusion:** This systematic review and meta-analysis shows nutritional support, mainly in the form of oral nutritional supplements, improves total intake, anthropometry and grip strength in COPD. These results are in contrast to previous analyses that were based only on cross-sectional measures at the end of intervention trials.
**BACKGROUND**

Malnutrition is a common problem in individuals with chronic obstructive pulmonary disease (COPD) with prevalence rates of between 30-60% of inpatients and 10-45% of outpatients (1). Malnourished COPD patients demonstrate greater gas trapping, lower diffusing capacity and a reduced exercise capacity when compared to heavier, non-malnourished patients with a similar severity of disease (2). Observational studies have shown that if nutritional assessment includes only body weight and unintentional weight loss, some patients with normal body weight for height (body mass index (BMI)) would go undetected despite being fat-free mass (FFM) depleted (3, 4). A cross-sectional survey by Cano et al (3) in 300 outpatients with COPD requiring long-term oxygen therapy found 17% of patients to have a low BMI, whereas the prevalence of FFM depletion was more than two-fold higher (38%). This accelerated loss of lean tissue, which may lead to sarcopenia and cachexia, is facilitated by robust inflammatory responses, which may also limit or prevent accretion of lean tissue following nutritional support (5). Wasting of muscles not only detrimentally affects respiratory function, including reduced ability to expectorate to clear a chest infection, but it also promotes fatigability and reduces exercise tolerance and ability to work. However, it has not been possible to establish the exact causality between malnutrition and COPD as malnutrition may be the consequence of a greater disease severity leading to a compromised nutritional intake (loss of body weight) and reduced physical activity (muscle atrophy). Conversely, severe respiratory disease may be preceded by wasting of the muscles involved in breathing. The effect of nutritional support in malnourished patients has also been controversial. Traditional thinking has tended to regard weight loss as an irreversible consequence of COPD, a view that has been reinforced by recent meta-analyses (6, 7). Such analyses have not only concluded that nutritional support has no significant effect on improving anthropometric measures such as weight and muscle mass, but also that it produces no demonstrable improvements in lung function and muscle strength. Several nutritional intervention studies have challenged this idea (8-13) with the result that there remains confusion about whether there is a need to identify and treat
malnutrition in COPD. For example, in its 2010 updated report on COPD, the
National Clinical Guideline Centre, which develops clinical guidelines for the
National Institute for Health and Clinical Excellence (NICE), referred to the
failure of a previous meta-analysis to demonstrate significant changes in
weight and other outcomes with nutritional support (7), whilst referring to a
previous study which demonstrated such improvements with the use of oral
nutritional supplements (ONS) (14). Despite these apparent inconsistencies
the guideline recommended that ONS should be given to patients with a low
BMI (<20 kg/m²) stating this was based on grade D evidence (lower quality)
rather than the evidence from published systematic reviews and meta-
analyses, and evidence from at least one RCT, which according to the NICE
criteria qualify for grade A evidence (15).

On examining previous systematic reviews of nutritional support, differences
in the methods of analysis were found (1, 6, 7, 16). Unlike previous reviews
(1, 6), the latest Cochrane review (7) examined the differences between
control and intervention groups at the end of the intervention period, but not
the changes induced by either intervention or control, or the impact of
baseline imbalance on the final point estimates. Treatment effect within
groups as well as information on the presence of any variability between the
two groups at baseline, beyond the fact that they were not significantly
different, was not reported. Therefore, we undertook a systematic review of
randomized controlled trials (RCTs) of nutritional support in patients with
COPD to examine such issues more closely and to establish greater clarity of
the evidence base for nutritional support in order to inform policy.

SUBJECTS AND METHODS

Search strategy and identification of trials

The review was planned, conducted and reported according to published
guidelines (17-19). A systematic search of the literature was conducted in July
2010 to identify RCTs investigating nutritional support in COPD. Potentially
relevant studies were identified by searching electronic databases. The
In order to identify the largest number of trials a broad search strategy was implemented however trials were restricted to English language citations only. The search terms and mesh headings used included: chronic obstructive pulmonary disease, COPD, emphysema, weight, depletion, diet*, nutrition*, supplement*, protein, carbohydrate, calori*, feed*, malnutrit*, nourish*, sip feed (ready made liquid oral nutritional supplement), nutrition intervention, nutrition support. A combination of these search terms was also used to identify trials. In addition to electronic database searching, manual searching of previous reviews on nutritional support in COPD as well as references of identified trials was undertaken.

Studies were initially screened by reading the abstract and where a study could not be excluded the full article was reviewed. The assessment of trial eligibility was done by two independent assessors (PFC and ME), with two disagreements resolved through discussion with a third assessor (RJS) prior to inclusion.

**Inclusion and exclusion criteria**

Studies were deemed eligible for inclusion in the review if they conformed to the pre-determined inclusion and exclusion criteria. To investigate the overall efficacy of nutritional support (food strategies (food fortification, food snacks), dietary advice (DA), oral nutritional supplements (ONS), and enteral tube feeding (ETF)) the following inclusion criteria for trials was devised: (i) randomized trials, (ii) intervention with food strategies, DA, ONS or ETF, (iii) duration of intervention > 2 weeks, (iv) control group receiving placebo or no dietary intervention (e.g. usual care, which could include advice and encouragement to eat) and (v) stable patients with a diagnosis of COPD (not exacerbating), (vi) human studies only, (vii) English language only.

The intervention could provide either a proportion or all of the daily nutritional requirements for energy, protein and micronutrients and where feeds were
used (e.g. ONS), these could be nutritionally complete or incomplete. Studies using parenteral nutrition were excluded.

**Data extraction**

Outcome data sought included total nutrient intake (energy and protein), body weight, upper arm anthropometry, body composition, and handgrip strength. Data were collected at baseline and at the end of the intervention phase where possible. Data were collected within data extraction tables allowing data synthesis and analysis from studies with varying populations (nourished/undernourished), intervention types (food strategies, DA, ONS, ETF) and intervention duration. Where data were not reported in the text but illustrated within a figure, the figure was expanded and the data extracted. This was done for energy intake (20, 21) and weight (20, 22). In some papers where mean values were reported without standard deviations (SD) or standard errors (SE), it was possible to calculate SD and SE using reported p values. In one study assessing handgrip strength (10), data reported in kg was considered to be unrealistic and therefore assumed to be in pounds.

**Quality assessment**

The quality of included studies was assessed using the most commonly used scoring system (Jadad scoring system) which comprises three components addressing whether a study is described as randomized, whether the study is described as double blind and whether drop-outs were accounted for. It then scores according to the appropriateness of randomization and blinding (23). Quality assessment of trials was performed by one researcher (PFC) and independently verified by another assessor (RJS). Disagreements were resolved by discussion with a third assessor (ME).
Synthesis of data and statistical analysis

Following the extraction of data from included trials, where appropriate and feasible, the results of comparable outcome measures were combined and meta-analysis performed. Statistical analysis was performed using SPSS (version 16.0, Chicago, IL) and meta-analysis (random effects model) using Comprehensive Meta-analysis (Biostat Inc, NJ USA version 2). Analysis was carried out in order to explore differences between groups as well as changes within groups. The effect size was reported as difference in means and standard error. Only a minority of the values reported in the various studies adjusted for baseline values (11, 13, 24, 25). The correlation coefficient between baseline and end measurements was calculated (26). Any computed values that were slightly greater than 1.000 due to rounding of reported or calculated SDs, were assumed to have a value of 1.00.

Pre-specified sub-group analysis was performed according to type of nutritional support (oral nutritional supplements (ONS), enteral tube feeding (ETF), dietary advice (DA)) and baseline nutritional status (nourished ('non-depleted') versus malnourished ('depleted')). Malnutrition was considered to be present if the mean BMI was less than 20 kg/m² or mean ideal body weight was less than 90%. Meta-regression analysis was used to investigate whether duration or amount of intervention influenced the effect size for each outcome. The overall treatment difference was considered statistically significant if the p value was <0.05 and forest plots were used to present effect size.

RESULTS

A total of 44 studies were identified as potentially eligible from the literature search (5, 8, 9, 11, 13, 20-22, 24, 25, 27-59) and of these 31 were excluded (Figure 1). Exclusion reasons included 4 unsuitable study design (38, 41, 56, 58), 5 non-randomized trials (5, 28, 47, 55, 59), 3 target population not suitable (27, 54, 57), 6 no control or placebo group (29, 31, 32, 34, 35, 53), 11 unsuitable intervention (30, 33, 36, 39, 40, 43, 45, 49-52), 2 inadequate intervention duration (44, 60). A large randomized trial comparing an intensive management program versus usual care was not included as nutritional
support was provided to only a subgroup of patients where indicated in both arms (48). A summary of the search process is shown in Figure 1. The review included 13 RCTs of 439 individuals with COPD randomized into either a treatment group (n = 224) or a control group (n=215), (Table 2). Eight studies were performed completely within the outpatient setting (8, 14, 20, 22, 24, 25, 37, 46) three in inpatients (11, 13, 21) and two studies involved both outpatient and inpatient settings (9, 10). Separate analysis of the trial by Schols et al., (11, 13) was performed according to whether the subjects were non-depleted or depleted (Table 2). Patients recruited to the trials had a diagnosis of COPD (<70% predicted FEV₁) and were in a stable condition free from exacerbation. Patients recruited to the trials were classified as having severe COPD, range 30-40% predicted FEV₁ (FEV₁ <50% predicted (stage III)) (61). No study provided results on acute phase proteins or cytokines, and of four studies reporting circulating albumin, three had normal values (20-22) and one close to the lower limit of normal (14).

The majority of trials (11, n 189 intervention vs. 185 control) provided nutritional support by ONS (8-11, 13, 14, 20, 22, 24, 37, 46), mostly liquid supplements, some of which were specifically formulated for use in patients with COPD (Percentage energy: 60% carbohydrate, 20% fat, 20% protein (Respifor ®, Nutricia Ltd) (24, 46), 28.2% carbohydrate, 55.1% fat, 16.7% protein (Pulmocare ®, Abbott)) (37). One trial used nocturnal ETF (n 6 vs. 4) (21) and one trial used tailored dietary advice delivered by a dietitian and the provision of a milk powder supplement (n 30 vs. 25) (25). There were no trials of food snacks or food fortification alone. The intervention period ranged from 16 days (21) to 6 months (25), with the amount of nutritional support prescribed ranging from 355 kcal/day (37) to 1080 kcal/day (9).

The majority of studies (n 8) (8-10, 14, 21, 22, 25, 37) were principally of malnourished (‘depleted’) individuals (BMI < 20 kg/m² or % ideal body weight < 90%). The trials by Schols et al., (11, 13) and Steiner et al., (24) included both nourished and undernourished patients as part of a rehabilitation exercise program and performed, or allowed for, subset analysis according to nutritional status (11, 13, 24). Two other studies included both undernourished
and nourished subjects, with a predominance of underweight, since in one the mean BMI was <20 kg/m² (<90% IBW) (46) and in the other, %IBW ranged from 61 -108% (20) (Table 2).

All trials (13 RCT) included in the review reported weight and weight change (or it could be calculated). The next most frequently reported anthropometric measures were triceps skinfold thickness and mid arm muscle circumference. Other outcomes included energy (n 11) and protein (n 5) intakes and the functional measure, handgrip strength (n 5) (Table 1).

Dietary intake

Data on total energy intake was available in 11 studies (8, 9, 11, 13, 20-22, 24, 25, 37, 46). When limiting analysis to those studies where nutrition was ingested orally meta-analysis was possible on 5 studies (20, 22, 24, 25, 37). There were no significant differences in daily energy intake between supplemented and control groups at baseline (mean difference 11 SE 87 kcal, p= 0.903) (20, 22, 24, 25, 37) but at the end of nutritional treatment a significant difference was found in favor of the supplemented group (diet + ONS or DA); 236 SE 71 kcal, p<0.001. Information on the mean changes in energy intake was available from 6 studies (after excluding the ETF trial) (21) although measures of variation were available in only 2 trials. In all 6 studies the mean changes in energy intake were greater in the intervention group than control group by 318 SD 157 kcal/day (p=0.004, weighted for sample size). Similar significant results were also obtained from the five studies that involved ONS (413 SD 175 kcal/day, p=0.006) (8, 20, 22, 24, 37). Two studies were amenable to meta-analysis (24, 25) with the change in intake favoring the supplemented group (234 SE 63 kcal, p<0.001). Each study, one involving ONS and the other tailored dietary advice and milk powder supplementation, independently yielded significant results favoring intervention.

Information on mean changes in protein intake was available in 5 studies (8, 22, 24, 25, 37) (but measures of variation were available in only two of them) (24, 25). All 5 studies reported mean daily protein intakes that were greater in
the supplemented than control group by 16.5 SD 10.3 g/day (p=0.023, weighted for sample size). Similar results were also obtained in the 4 studies involving ONS (18.2 SD 7.0 g/day, p=0.014). Considering only the two studies that were suitable for meta-analysis (24, 25) protein intake favored the supplemented group by a similar amount 14.8 SE 3.6 g/day, p <0.001. As with energy, both studies were significant in their own right (p<0.001).

**Body weight**

The trials of nutritional support showed a consistent increase in weight, which was significant in 7 out of 8 individual studies. However, a detailed analysis is undertaken below for comparison of conclusions from previous meta-analyses. Using information on body weight obtained from 8 studies, three sets of meta-analyses were carried out to compare control and intervention groups. These involved baseline weight, end weight, and change in weight (9-11, 13, 14, 21, 24, 25). **Figure 2 (upper)** shows that baseline weight in the intervention and control groups was not statistically different (p=0.240) but on average the control group was 1.217 SE 1.10 kg heavier than the treatment group. **Figure 2 (middle)** illustrates that after nutritional intervention the difference between control and intervention groups remained non-significant (p=0.506; with individual study results on both sides of the reference line) but this time the control group was lighter than the supplemented group by 0.746 SE 1.12 kg. **Figure 2 (lower)** shows that the mean improvement (increase) in weight in the intervention group was greater than in the control group in all eight primary studies, and this was significant in seven of the individual studies. Not surprisingly the overall effect size of the meta-analysis was highly significant, with a mean increase in weight in favor of the intervention group of 1.83 SE 0.262 kg, p<0.001. This corresponds to 3% of initial body weight.

Inspection of the Forest plots (Figure 2) also shows that the variability (indicated by the 95% confidence intervals) between the intervention and control groups, both for the primary studies and the summary effect of all the studies combined, is much smaller for the change in weight (lower plot) than for the baseline weight (upper plot) and end weight (middle plot). Table 3 summarizes these results, and shows that not only is the overall change in
weight significantly greater in the intervention than the control group (by almost 2 kg), the observed variation (SE) at both baseline and end is approximately four times greater than the variation in the change in weight. This is due to a high correlation between pre- and post-weight in both the intervention group and the control group. For the primary studies, r values obtained through meta-analysis were 0.995 (95% CI 0.979, 0.999) for the control group and 0.997 (95% CI 0.974, 1.000) for the intervention group. Simple correlation analysis of mean results (without measures of variation) obtained from the same studies also indicated a very high relationship between baseline and end weight (r = 0.993 and 0.991 for the control and intervention groups respectively and r = 0.985 for the two groups in combination).

A sensitivity analysis (Figure 3) was carried out by combining the above eight studies with another five studies that lacked information on variation of weight change, in either the control or intervention groups (8, 20, 22, 37, 46). The SD of the final weight for one trial (37) was obtained from a previous review (7). For these studies a very large estimate of the SD of the change was assumed, (SD of the change corresponding to 10% of baseline weight). All 13 primary studies reported a mean weight change in favor of the intervention group (Figure 3). The summary effect size and its significance remained similar (1.69 SE 0.30 kg, 95% CI 1.1, 2.3 kg. p<0.001) to those obtained with the 8 primary studies with complete information (Figure 2). A similar, significant result was also noted when only studies involving ONS were analyzed, 1.63 SE 0.23 kg, p<0.001. The meta-analysis of 13 studies for weight change revealed no evidence of publication bias using funnel plots and tests such as the Begg and Mazumdar (p=0.502) and Egger tests (p=0.686).

When the 13 primary studies were analyzed according to nutritional status (studies with malnourished ('depleted') subjects versus studies that included normally nourished ('non-depleted') subjects) both groups showed a significant increase in weight in favor of the intervention group (non-depleted 1.319 SE 0.368 kg, p<0.001 versus depleted 1.940 SE 0.257 kg, p<0.001), but the difference between nourished versus malnourished groups was not
significant. Undernourished subjects had a more pronounced response to nutritional support but it should be noted that the two trials including nourished individuals were performed within an exercise rehabilitation program that may have augmented the effects of nutritional support. Meta-regression did not reveal a significant relationship between the magnitude of the weight increase, which favored the intervention group, and the following individual covariates: %IBW at baseline (13 RCTs, slope -0.021 %IBW/kg; p=0.228), target intake from the nutritional intervention (11 RCTs, slope <0.001 kcal/kg; p=0.847), excluding two trials which did not report the target intervention amount (10, 20) and duration of intervention (13 RCTs, slope <0.004 kg/week; p=0.937).

Body composition

Assessment of FFM was carried out in 4 studies (11, 13, 24, 37) and although 3 out of the 4 trials showed slight improvements in fat-free mass with supplementation (0.17 - 1.0 kg; 0.7 - 2.0 % of baseline), these were not significant. All four studies used different methods to assess FFM (bioelectrical impedance (11, 13), dual energy X-ray absorptiometry (DXA) (24) and skinfold thickness (37)). Seven trials reported data on measured mid-arm muscle circumference (MAMC) (8, 11, 14, 20, 22, 25, 37), an indirect measure of FFM. In six of the seven trials, the mean change favored the intervention group compared to the control group by a mean of 2.4% (range -1.0 - 5.5%, p=0.045, one sample t-test when weighted for sample size). Only 3 trials were amenable to meta-analysis (14, 22, 25) and these showed an improvement in favor of the intervention group (effect size 0.296 SE 0.158 cm, p=0.061).

Nine studies (8-10, 14, 20-22, 25, 37) used one or more skinfold thicknesses to describe body fat, 7 used triceps skinfolds and 2 studies used the sum of 4 skinfold sites (S4SF) (14, 25). It was possible to calculate changes from eight studies (8-10, 14, 20, 21, 25, 37). The mean changes in eight studies favored nutritional support (p=0.008 (sign test)). Two primary studies using S4SF
were appropriate for meta-analysis (14, 25) both of which were significant in their own right. The test of overall effect was +4.2 (SE 1.2) mm, p<0.001.

**Maximum voluntary grip strength**

Five studies (four with ONS) reported mean changes in handgrip strength, (8, 10, 24, 25, 62) with all studies favoring the intervention group (range 0.3-5.2kg or 1.3-18.5%). Four studies were amenable to meta-analysis (8, 10, 24, 25) with results also favoring the intervention group (+5.3% SE 2.7%, p<0.05).

**Quality of studies**

The review identified 3 studies assessed to be of high quality (≥4) (14, 21, 24), and ten of lesser quality (≤2) using the Jadad scoring system (23) (Table 2).

**DISCUSSION**

This systematic review with meta-analyses aimed to investigate controversies regarding the evidence base for the efficacy of nutritional support in patients with COPD. It found that nutritional support leads to improvements in nutritional intake, body weight, muscle mass (mid-arm muscle circumference) and fat mass (skinfold thickness), as well as an improvement in peripheral muscle strength (handgrip strength). These findings are completely in contrast to those of previous reviews and meta-analyses (6, 7, 42, 63, 64), which reported no significant differences between intervention and control groups. The previous meta-analyses (6, 7, 42) did not examine changes in dietary intake. If total dietary intake in the intervention group did not increase significantly above that of the control group it could explain why these reviews and meta-analyses reported a lack of demonstrable effect of nutritional support on a range of outcomes. However, the current review did examine nutritional intake and found that nutritional support resulted in a significantly greater increase in both protein and energy intake (dietary intake + nutrition support). The magnitude of these changes are similar to those reported in other reviews involving various clinical conditions including COPD, in which clinical outcomes were improved through nutritional support in (1). It therefore
appears that the discrepancies between the current review and previous ones are mainly due to methodological differences, two of which are clarified below. First, the current study explored the possibility that pre- and post-intervention variability can mask significant within- and between-group changes, even when no significant differences between groups exist at either time point. This analysis shows that the end values, which are mostly unadjusted for baseline, have been used as the basis of calculations in previous meta-analyses. These end values may primarily reflect those at baseline, rather than the changes induced by the intervention e.g. for body weight a non-significant difference existed between groups at baseline favoring the control group, in order for any improvements to be significant after intervention they would first have to overcome this deficit (masking the magnitude of the effect) and variability associated with it. In contrast, when the weight changes induced by the intervention were used as the basis of the calculations there was a substantial increase in precision, resulting in a significant improvement in favor of nutritional support, which was also observed in several of the primary studies. Second, unlike the previous systematic reviews and meta-analysis on COPD, the current review included another simpler approach to analyzing randomized controlled trials (t-test and sign test) so that trials without measures of variation could be included. Whilst this approach is not as sophisticated as the standard type of meta-analysis, which involves measures of variation, it adds a broader quantitative perspective of the evidence base, and supports the overall conclusions of the meta-analyses by considering trials that would not otherwise have been included. It is also more informative and complementary to a narrative description of individual studies. The combined approach adds confidence to the conclusions of the review by supporting all the major findings of the more sophisticated meta-analyses, both with respect to statistical and substantive (clinical) significance of the effect size (energy and protein intake, weight, arm muscle circumference, and grip strength).

A different type of methodological problem concerns the four studies that measured body composition to establish fat- and fat-free mass, all using different techniques (skinfold, bioelectrical impedance, DXA). Currently, there are no reference values for body composition in COPD and the different
methods employed in primary studies have not been adequately validated in this patient group. Although in three out of the four studies the changes favored the intervention group, the effect was generally small (overall ~1% fat-free mass or less than 1% body weight) and statistically not significant. In contrast, a more consistent methodological approach using anthropometric measurements (MAMC) to estimate muscle mass, the largest component of fat-free mass, yielded significant results in favor of the intervention group. Similarly, use of the raw skinfold measurements also indicated improvements in favor of the intervention group.

The statistical findings of this systematic review also need to be considered from a clinical perspective. We have previously reported that a weight gain of approximately 2 or more kg in COPD (similar to the magnitude of the mean weight change in favor of the intervention group observed in this review) is likely to be associated with functional and clinical benefits (1). In addition, post-hoc observational analysis of a prospective nutritional intervention trial (11, 13) found that weight loss was reversible through nutritional support, and that a significant improvement in survival occurred in depleted and non-depleted patients who gained weight (>2 kg). However, it was not clear from these studies whether the improved survival rates were adjusted for disease severity, and in addition the analysis is confounded by the inclusion of a number of individuals from the placebo group who gained >2 kg (12).

Although the improvements in arm muscle circumference and muscle strength observed in this study are only mild to moderate (~3% on average but as high as 7% in one study), in patients who have already become depleted and who have already lost a substantial amount of weight and function (which seems likely for most of the malnourished patient groups included in this meta-analysis), small changes in muscle mass might be expected to produce substantial functional or clinical benefit in those who are close to the threshold of disability. In addition, studies included in the present analysis also reported improvements in other clinically relevant outcomes such as respiratory muscle strength, quality of life and walking distance (65).
Policies and guidelines on nutritional support also need to consider the plausibility of the results and how they may be inter-related. For example, a causal pathway can be proposed, whereby nutritional interventions increase total dietary intake of protein and energy, with resulting increases in weight and muscle mass, which can lead to improvements in muscle strength. The findings of this systematic review are consistent with such a pathway. They are also consistent with a variety of other functional and clinical outcomes previously mentioned (65).

This review has also identified the limitations of the current literature on nutritional support in COPD. First, the conclusions are based on a limited number of studies (n 13), most that were judged to be of poor quality (n 10), with only three studies considered to be of high quality (score of 4) on the Jadad scale (0 (poorest quality), 5 (highest quality)). A limitation of the Jadad grading system is that it does not account for statistical power, which meant one trial involving only 10 subjects received a score of 4 (21). Second, due to lack of data in the primary papers it was not possible to examine the effect of inflammation on nutritional status and response to nutritional support, nor characterize the subjects as cachectic, according to an endorsed definition (66). Third, of the 13 primary studies included in this systematic review 11 involved ONS, one involved nocturnal enteral tube feeding and the other involved dietary advice given by a dietitian and provision of milk powder. Therefore, the current evidence is largely based on ONS and it is weak or lacking for other forms of nutritional support, such as snacks, or dietary modification/fortification. This has clinical implications for the first line treatment of malnutrition as The British Dietetic Association currently recommends the first step to improving nutritional intake is done via ordinary foods and fortification with the use of ONS as a secondary step once the initial intervention has failed (67). Finally, of the 13 RCTs, 10 targeted malnourished patients and three targeted malnourished and non-malnourished patients (11, 20, 24) with some trials allowing for subset analysis according to nutritional status (11, 13, 24). Therefore, the evidence base for nutritional support primarily involves malnourished rather than well-nourished patients, although in those undergoing a rehabilitation program there is an anabolic potential...
through increased physical exercise that may augment the effects of
additional nutrition.

The fact that 10 of the 13 trials included in the current review were carried out
before 2000 may reflect that 2000 coincided with the publication of the first
Cochrane Collaboration review, including the majority of the current evidence,
concluding that nutritional support has no effect in COPD. This may have
dampened interest in the field, however it is hoped the positive findings of this
review will highlight the need to undertake further work, including an
examination of the interactions that might exist between nutritional
supplementation and factors such as malnutrition, inflammatory status and
graded physical activity in both stable disease and those with infective
exacerbations of COPD.

Acknowledgements

Author’s contributions

PFC, RJS and ME designed research; PFC performed the systematic review;
PFC and ME analyzed the data and reviewed by RJS; ME had primary
responsibility for final content. All authors wrote, reviewed and approved the
final manuscript.

Competing interests

Peter Collins RD (none declared).
Marinos Elia MD, FRCP (none declared).
Rebecca Stratton PhD RD RNutr is also an employee of Nutricia Ltd.
REFERENCES


Figure legend

Figure 1 Study selection process.

Figure 2 Forest plots (Meta-analysis. Random effects model) for 8 studies demonstrating the difference in weight (kg) between control and intervention before (upper) and after intervention (middle) and the change in weight (bottom) induced by the intervention. (* = p<0.0005).

Figure 3 Meta-analysis of the influence of nutritional support on weight (kg) change for 13 studies grouped according to nutritional status (nourished = non-depleted; malnourished = depleted). 4 studies provided nutritional support as part of an exercise rehabilitation program (11, 13, 24, 46). (* = p<0.0005). Overall summary effect (depleted + non-depleted) = 1.69 SE 0.30 kg, p<0.001.
Table 1 Outcome measures of randomized controlled trials included in the systematic review and meta-analyses.

<table>
<thead>
<tr>
<th>Outcome measure</th>
<th>Systematic review</th>
<th>Meta-analysis†</th>
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<tbody>
<tr>
<td></td>
<td>No. studies</td>
<td>No. participants treatment/control</td>
</tr>
<tr>
<td>Energy intake</td>
<td>11</td>
<td>195/184</td>
</tr>
<tr>
<td>Protein intake</td>
<td>5</td>
<td>88/92</td>
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<td>Weight</td>
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<td>115/115</td>
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<tr>
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<td>124/125</td>
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<td>Skinfold thickness</td>
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<td>117/107</td>
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<tr>
<td>Handgrip strength</td>
<td>5</td>
<td>87/90</td>
</tr>
</tbody>
</table>

* 8 studies if no assumptions were made in order to obtain data on variation (SDs).
† Meta-analysis with measures of variation.
<table>
<thead>
<tr>
<th>Study</th>
<th>Sample size</th>
<th>Characteristics/setting (intervention vs. control)</th>
<th>Nutritional intervention (type/prescribed amount/duration)</th>
<th>Control group</th>
<th>Outcome measures</th>
<th>Study quality (Jadad score)†</th>
</tr>
</thead>
<tbody>
<tr>
<td>DeLetter 1991(37) <em>(thesis)</em></td>
<td>18/17</td>
<td>Malnourished 82.8% IBW Outpatients</td>
<td>ONS (Pulmocare, 1.5kcal/ml) ONS target: 355 kcal/day and 15g protein/day, 8 weeks</td>
<td>Usual diet</td>
<td>Energy, Protein, Wt, FFM, MUAC, MAMC, TSF</td>
<td>11000 (2)</td>
</tr>
<tr>
<td>Efthimiou et al., 1988(8)</td>
<td>7/7</td>
<td>Malnourished 79.5 vs. 81.3% IBW Outpatients 60 vs. 64 years</td>
<td>ONS (Build Up, 1.13kcal/ml) ONS target: 640-1280 kcal/day and 36-72g protein/day Encouragement to eat provided to both groups, 12 weeks</td>
<td>Usual diet (with encouragement)</td>
<td>Energy, Protein, Wt, %IBW, MAMC, TSF, HGS</td>
<td>10000 (1)</td>
</tr>
<tr>
<td>Goris et al., 2003*(46)</td>
<td>11/9</td>
<td>Nourished and malnourished* 19.8 kg/m² (~87% IBW) (19.6 vs. 20* kg/m²) Outpatients 61 vs. 62 years</td>
<td>ONS (Respifor, 1.5kcal/ml) ONS target: 563 kcal/day and 28g protein/day. Encouragement to eat provided to both groups, 12 weeks</td>
<td>Usual diet (with encouragement)</td>
<td>Energy, BMI</td>
<td>11000 (2)</td>
</tr>
<tr>
<td>Knowles et al., 1988(20)</td>
<td>13/12</td>
<td>Nourished and malnourished 61-108% IBW Outpatients 68 vs. 70 years</td>
<td>ONS (Sustacal, 1kcal/ml, 0.043 g protein/kcal) ONS target: To increase total EI by 50%. Weekly encouragement 8 weeks</td>
<td>Usual diet</td>
<td>Energy, Wt, MAMC, TSF</td>
<td>11000 (2)</td>
</tr>
<tr>
<td>Lewis et al., 1987(22)</td>
<td>10/11</td>
<td>Malnourished 86.3 vs. 84.6 % IBW Outpatients 65 vs. 59 years</td>
<td>ONS (Isocal HCN, 2kcal/ml) ONS target: 500-1000 kcal/day and 19-38g protein/day Encouragement 8 weeks</td>
<td>Usual diet</td>
<td>Energy, Protein, Wt, MAMC, TSF, HGS</td>
<td>10000 (1)</td>
</tr>
<tr>
<td>Study</td>
<td>Participants</td>
<td>Intervention Details</td>
<td>Control Details</td>
<td>Outcomes</td>
<td>Study Duration</td>
<td>Reference</td>
</tr>
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<tr>
<td>Otte et al., 1989(14)</td>
<td>13/15 Malnourished 77 vs. 73% IBW outpatients 57 years</td>
<td>ONS (Novo, 1kcal/ml) ONS target: 400 kcal/day and 20g protein/day. Encouragement 13 weeks</td>
<td>Placebo (blinded) (encouragement) Wt, %IBW, MAMC, skinfold thickness (s4SF)</td>
<td>10111 (4)</td>
<td></td>
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<tr>
<td>Fuenzalida et al., 1990(9)</td>
<td>5/4 Malnourished inpatients and outpatients 78.5% IBW 62 years</td>
<td>ONS (Sustacal HC, 1kcal/ml) ONS target: Up to 1080 kcal/day and up to 46g protein/day 3 wks inpatient + 3 wks outpatient (6 wks total)</td>
<td>Usual diet Energy, Wt, MAMA, TSF</td>
<td>10000 (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rogers et al., 1992(10)</td>
<td>15/12 Malnourished 78 vs. 79% IBW 64 years outpatients (intervention group admitted for first 4 weeks)</td>
<td>ONS (various, self-selected) Tailored to individual dietary habits and dietary advice ONS target: Intakes &gt;1.7 x REE and minimum 1.5g/kg/day protein, 15 weeks</td>
<td>Usual diet Wt, %IBW, MUAC, TSF, HGS</td>
<td>10000 (1)</td>
<td></td>
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<tr>
<td>Schols et al., 1995(11)</td>
<td>33/38 Nourished 102.4% IBW inpatient PR program (not hospital) mean age unclear</td>
<td>ONS (Mixture of Nutridrink, Protifar, Fantomalt, Oil; seven mixtures of different flavors; 2.1kcal/ml). ONS target: +420 kcal/day and 15g protein/day Encouragement to eat regular meals, 8 weeks</td>
<td>Usual diet (and encouragement with oral diet) Energy, Wt, MAMC, FM, FFM</td>
<td>10001 (2)</td>
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<tr>
<td>Schols et al., 1995(13)</td>
<td>39/25 Malnourished 84.1% IBW inpatient PR program (not hospital) mean age unclear</td>
<td>ONS (Mixture of Nutridrink, Protifar, Fantomalt, Oil; seven mixtures of different flavors; 2.1kcal/ml). ONS target: +420 kcal/day and 15g protein/day. Encouragement to eat regular meals, 8 weeks</td>
<td>Usual diet (and encouragement with meals) Energy, Wt, FM, FFM</td>
<td>10001 (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Study</td>
<td>Sample Size</td>
<td>Nourished/Malnourished</td>
<td>Weight Status</td>
<td>Energy, Protein, Wt, FM, FFM, HGS Duration</td>
<td>ONS (Respifor, 1.5kcal/ml)</td>
<td>ONS Target</td>
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<tr>
<td>Steiner et al., 2003(24)</td>
<td>25/35</td>
<td>nourished/ malnourished</td>
<td>~105% IBW (23.9 vs. 23.5 kg/m²)</td>
<td>7 weeks</td>
<td>ONS: +570 kcal/day and 28g protein/day</td>
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<tr>
<td>Enteral tube feeding</td>
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<tr>
<td>Whittaker et al., 1990(21)</td>
<td>6/4</td>
<td>malnourished</td>
<td>76 vs. 82% IBW</td>
<td>16 days</td>
<td>Nocturnal ETF (Isocal)</td>
<td>ETF target: Feed delivered: at least 1000 kcal/day or 1.7 x REE whichever greater and 34 g protein (Nasoduodenal / jejunal tube feeding).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inpatients</td>
<td>71 vs. 64 years</td>
<td></td>
<td></td>
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<tr>
<td>Dietary advice, dietary leaflet plus milk powder</td>
<td></td>
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<tr>
<td>Weekes et al., 2009(25)</td>
<td>30/25</td>
<td>malnourished</td>
<td>~88% IBW (~19.8 kg/m²)</td>
<td>6 months</td>
<td>Tailored dietary advice (DA) + leaflet of information + milk powder</td>
<td>DA target: 600 kcal/day (no specific protein target)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>outpatients</td>
<td>69 years</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Goris et al., (2003)(46): control group referred to as depleted however, according to UK guidelines the subjects would not be considered to be so (68); Schols et al., (1995) [11, 13]: a third arm investigating anabolic steroids (n 32) was not included in analysis; ONS = oral nutritional supplements; DA = dietary advice (education); ETF = enteral tube feeding; Wt = weight; BMI = body mass index; % IBW = percentage ideal body weight; FM = fat mass; FFM = fat free mass; FFMI = fat-free mass index; MUAC = mid-upper arm circumference; MAMC = mid-arm muscle circumference; MAMA = mid-arm muscle area; TSF = triceps skinfold; s4SF = sum of 4 skinfolds; HGS = handgrip strength; PR program = pulmonary rehabilitation program; REE Resting energy expenditure.
†The number in parenthesis represents the overall score. The five individual scores represent scores for description and appropriateness of randomization/blinding as well as any description of withdrawals.
Table 3 Summary statistics of effect size and its variation based on 8 primary studies with data on baseline weight, end weight and change in weight

<table>
<thead>
<tr>
<th></th>
<th>Effect size: difference between groups (kg)†</th>
<th>Standard error of the difference (kg)</th>
<th>p value for effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline weight (kg)</td>
<td>-1.217</td>
<td>1.036</td>
<td>0.240</td>
</tr>
<tr>
<td>End weight (kg)</td>
<td>+0.746</td>
<td>1.122</td>
<td>0.506</td>
</tr>
<tr>
<td>Change in weight (kg)</td>
<td>+1.830</td>
<td>0.262</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

† Intervention group minus control group (meta-analysis, random effects model). Small discrepancies in the sum of the effect size (change in weight) are due to extraction from different data sets provided within manuscripts (Table 3 and Figure 2).