Goals
- Provide appropriate medical care to patients participating in a hunger strike
- Identify patients at risk during fasting
- Identify patients at risk for refeeding syndrome
- Safely refeed patients after fasting

Definitions
Individual Hunger Strike: The conscious decision to refuse food or fluids for political, mental health or other grievance-related reasons.
Individual Hunger Strike Participant: An inmate who is identified by California Department of Corrections and Rehabilitation (CDCR) custody staff as a participant in an individual hunger strike.
Mass Organized Hunger Strike: An organized hunger strike including multiple inmates with a common goal and set of demands.
Mass Organized Hunger Strike Participant: An inmate who is identified by CDCR custody staff as a participant in a mass organized hunger strike.

Refeeding Syndrome (RFS): Refeeding syndrome describes a potentially fatal medical condition that may affect fasting, malnourished and/or ill patients in response to feeding. (See page 7)

Diagnostic Criteria/Evaluation of Fasting & Refeeding Syndrome

<table>
<thead>
<tr>
<th>Fasting</th>
<th>Negligible Risk</th>
<th>Modest Risk</th>
<th>High Risk</th>
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</thead>
<tbody>
<tr>
<td>Patients may be at high risk for complications from fasting with any of the following:</td>
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<tr>
<td>Pregnancy</td>
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<td>Elderly (≥ 65 years of age)</td>
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<td>Baseline BMI less than 18.5 kg/m²</td>
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<td>Taking medications that may pose a risk during prolonged fasting (e.g., insulin, antacids, diuretics).</td>
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<td>Chronic medical conditions such as: diabetes, hypertension, cancer, malabsorption, end stage liver disease, renal disease, inflammatory bowel disease, congestive heart failure, ischemic heart disease, etc.</td>
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<td>Less than 15 days of hunger strike participation without identified medical risks of fasting.</td>
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<td>Patients requiring monitoring due to medical risks.</td>
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<tr>
<td>A BMI &gt; 16 but ≤ 18.5 kg/m² during food refusal.</td>
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<tr>
<td>Loss of &gt; 10% but ≤ 15% of body weight during food refusal.</td>
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<tr>
<td>Food refusal of 15-28 days.</td>
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<td>BMI ≤ 16 kg/m²</td>
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<tr>
<td>Weight loss &gt; 15% of body weight since starting food refusal.</td>
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<tr>
<td>Low potassium, magnesium, or phosphate levels before resumption of feeding.</td>
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<tr>
<td>Food refusal for more than 28 days.</td>
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<tr>
<td>Medical or mental health conditions creating high risk of complications from fasting.</td>
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</tbody>
</table>

Treatment Summary
1. Designated licensed health care staff shall observe all participants daily and determine any need for immediate medical attention. (Sec. III.C.5)
2. Health information on starvation, refeeding, and patient care resources should be distributed to hunger strike participants within one week of notification by custody of a hunger strike participant.
3. When custody notifies health care executives of mass hunger strike participants, staff shall adhere to the following timelines:
   Within 72 hours:
   a. Health care staff shall review the health record to determine if the participant is at a high-risk for complications of starvation and refeeding.
   1) High-risk hunger strike participants may be scheduled for a primary care provider (PCP) visit, vital signs, and Body Mass Index (BMI) determinations.
   2) Refusals shall be documented in the health record.
   3) If participants are prescribed high-risk medications, a PCP may discontinue or adjust the medication dosage without a PCP visit.
   4) Participants shall be notified in writing regarding medication changes. (Sec. III.C.7.b)
   b. Individual hunger strike participants who are in the MHSDS or DDP shall undergo mental health evaluations.
   4. Within seven calendar days, the participant shall be scheduled for a face-to-face triage assessment by an Registered Nurse (RN) who shall provide education on the adverse effects and risks of fasting and the refeeding syndrome. (Sec. III.C.7.c)
5. The CME or designee may decide, based on a participant’s health care condition, to either place the participant in an Outpatient Housing Unit or to immediately transfer to a licensed health care facility (for services that are not available at the institution). (Sec. III.D.1)
6. After 14 calendar days, and at least weekly thereafter, health care staff shall schedule all identified participants (even if not in a high-risk group) for a PCP visit which will include a BMI determination. (Sec. III.C.7.d)
7. After the initial 72-hour evaluation, participants in the MHSDS or DDP shall have a mental health evaluation scheduled every 14 calendar days or more frequently, as clinically indicated. (Sec. III.C.7.e)
8. After 21 calendar days of participation in a hunger strike, participants shall be provided with written information about advance directives and the CDCR 7465, Physicians Orders for Life Sustaining Treatment. (Sec. III.C.7.f)
9. Refeeding: **Negligible Risk:** Participants can eat and drink freely and require no specific monitoring.
   **Modest Risk:** Most participants may be refeed with a modified CDCR heart healthy diet for the first 48 hours by providing "1/2 CDCR diet."
   **High Risk:** Refeeding will usually occur in a licensed medical setting. Intake is increased from 10 kcal/kg/day to 30 kcal/kg/day over one week. Patients are monitored for fluid, electrolyte, and cardiac abnormalities. (See pages 4-5 for specific refeeding recommendations).

Information contained in the Care Guide is not a substitute for a health care professional’s clinical judgment. Evaluation and treatment should be tailored to the individual patient and the clinical circumstances. Furthermore, using this information will not guarantee a specific outcome for each patient.
### Management Recommendations During Fasting

<table>
<thead>
<tr>
<th>Day</th>
<th>Initiate the CCHCS Mass or Individual Hunger Strike Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Health care staff shall not prescribe meal replacements including milk, juice, or nutritional supplements to patients participating in a mass hunger strike unless medically necessary. (Sec. III.C.4)</td>
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<tr>
<td></td>
<td>(For refeeding at any stage, see Refeeding Management page 4-5)</td>
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</tbody>
</table>

#### Nursing
- Designated licensed health care staff shall observe all participants daily and determine any need for immediate medical attention. (Sec. III.C.5)
  - Observations should include:
    - Visual check of inmates on the hunger strike
    - Brief verbal contact
    - Observation of any obvious health issues
    - Documentation of findings in the health record
  - Education should include:
    - Encouraging 1.5 liters or more/day fluid intake
    - Providing patient education hunger strike fact sheet at initial contact regarding fasting and refeeding facts, and medical care information
  - Within 24 hours, health care staff shall notify each participant that they are eligible for sick call evaluations during the hunger strike. (Sec. III.C.7.a)
  - Health care staff will notify the Primary Care (Clinic) RN of all participants with any change in condition that might indicate that the patient needs a housing change or higher level of care. Patients needing immediate health care will be transported to the TTA for evaluation.

#### Primary Care Provider:
- Evaluation as clinically indicated.

#### 1-3 Days After Notification of Participation

#### Nursing: Daily observation

#### Primary Care Provider:
- **Identify High Risk Patients:** Within 72 hours of notification of participation in mass or individual hunger strike, health care staff will review records to identify patients with conditions or medications placing them at risk for complications during fasting (see page 1).
- **Medication Adjustment:** Within 72 hours of notification of hunger strike participation:
  - Medications may be dose adjusted or discontinued for patients if their use increases the risk of complications during fasting. (Note: a PCP visit is not required to adjust/discontinue medications)
    - Medications which may require adjustment or discontinuation due to potential risk to fasting individuals include insulin, oral hypoglycemic agents, antihypertensive agents, nonsteroidals (NSAIDs), antacids (may interfere with phosphate absorption), diuretics (discontinue if possible, especially in those refusing fluids.)
- **PCP Visit:** Based on clinical judgment, high-risk participants may be scheduled for a PCP visit, vital signs, and Body Mass Index (BMI) determinations. (Sec. III.C.7.b.1.a)
  - The PCP visit should include:
    - Recording vital signs, weight, and BMI (see page 12)
    - Consideration of baseline labs: CBC, CMP, magnesium, phosphate
    - Counseling regarding the medical risks of starvation
    - Counseling of the medical risks of refeeding after prolonged fasting
    - Encouraging consumption of 1.5 liters or more of fluid each day
    - Consider reissuing patient education fact sheet
- **Refusals:** Refusals of scheduled PCP visits shall be documented in the health record.

#### Mental Health
- Within 72 hours of notification by custody that patients are mass (or individual) hunger strike participants:
  - **Mass Hunger Strike:** Mental health staff shall review the health care Mass Hunger Strike Participant List for patients in the Mental Health Services Delivery System (MHSDS) and/or Developmental Disability Program (DDP) and shall conduct a mental health evaluation for those patients on the list. For the purposes of the hunger strike mental health evaluation, the clinician shall rule out mental health or cognitive issues that may impact decisional capacity. The clinician shall ensure the patients understand the implications and potential consequences of not eating and that the patients are not being coerced. (Sec. III.C.7.b.2)
  - **Mass and Individual Hunger Strikes:** After the initial 72-hour evaluation, participants in the MHSDS or DDP shall have a mental health evaluation scheduled every 14 calendar days or more frequently, as clinically indicated. (Sec. III.C.7.e)
### MANAGEMENT RECOMMENDATIONS DURING FASTING

| 4-7 days of mass or individual hunger strike participation | **NURSING**<br>Within seven calendar days, the participant shall be scheduled for a face-to-face triage assessment by an RN who shall provide education on the adverse effects and risks of fasting and the refeeding syndrome. (Sec. III.C.7.c) This assessment should include:<br>♦ Education (see patient education page PE-1)<br>  - The adverse effects and risks of fasting and the refeeding syndrome. (Sec. III.C.7.c)<br>  - The need to consume 1.5 liters or more of fluid each day.<br>  - Providing the hunger strike patient education fact sheet regarding starvation and refeeding facts, and medical care information.<br>  - Signs and symptoms of dehydration, potential for dizziness when moving quickly.<br>♦ Height and weight (noting presence of restraints), scale should be identifiably marked, whenever possible the same scale should be used at each weighing session (record scale used)<br>♦ Vital signs<br>♦ Additional focused system assessment to assess for signs of dehydration, altered mental status, and other physical abnormalities that would require referral to a higher level of care.<br>Nursing staff shall document the encounter or refusal in the health record. (Sec. III.C.7.c.2)<br>**PCP**<br>If participants are prescribed high-risk medications, a PCP may discontinue or adjust the medication dosage without a PCP visit. (Sec. III.C.7.b.1.c) Participants shall be notified in writing regarding medication changes. (Sec. III.C.7.b.1.d) |
| 7-14 days of mass or individual hunger strike participation | **MENTAL HEALTH**<br>For individual hunger strike participants who are in the MHSDS or DDP, a mental health evaluation will be completed/performed every two weeks or more frequently as clinically indicated.<br>**NURSING**<br>Daily nursing observation<br>**PCP**<br>PCP evaluation as clinically indicated |
| 14-20 days of mass or individual hunger strike participation | **NURSING**<br>Daily nursing observation<br>**PCP**<br>After 14 calendar days, and at least weekly thereafter, health care staff shall schedule all identified participants (even if not in a high-risk group) for a PCP visit which will include a BMI determination (Sec. III.C.7.d) and baseline labs as clinically indicated.<br>After 21 calendar days of participation in a hunger strike, participants shall be provided with written information about advance directives and the CDCR 7465. (Sec. III.C.7.f)<br>(See prolonged fasting patient education handout, page PE-2)<br>Consider need for higher level of care (especially with > 15% weight loss or BMI of < 19 kg/m²)<br>Patients offered:<br>  - Thiamine, 100 mg by mouth daily<br>  - B complex, one by mouth daily<br>  - Multivitamin, one by mouth daily |
| 21-34 days of mass or individual hunger strike participation | **NURSING**<br>Daily nursing observation<br>At 21-28 days of participation in a hunger strike: Consider referral for evaluation of need for higher level of care (especially with > 15% weight loss or BMI of < 19 kg/m²)<br>**PCP**<br>At least weekly PCP visit<br>If the participant accepts a PCP visit, the PCP should assess and document:<br>  - Clinical assessment including hydration status and need for closer observation or a higher level of care<br>  - A determination of capacity for informed consent as defined by California Code of Regulations, Title 15, Section 3353.1. (Sec. III.C.7.f.1)<br>  - Participants who lack capacity for informed consent shall be reported to the Chief of Mental Health, Supervising Dentist, CME, CNE, or CEO. (Sec. III.C.7.f.4)<br>  - Need for lab testing (CBC, CMP, magnesium, and phosphate). |
| 35 days or more of mass or individual hunger strike participation | **NURSING**<br>Daily nursing observation<br>**PCP**<br>At least weekly PCP evaluation, consideration of higher level of care placement |
VOLUNTARY REFEEDING AFTER HUNGER STRIKE
Refeeding: Assessment of Risk and Management

Assessment of Risk of Refeeding Syndrome

The relative risk of the refeeding syndrome is based on an assessment of:
- BMI
- Percentage weight loss from initial weight (if known)
- Comorbid illness
- To some degree the duration of participation in the hunger strike, though the length of participation may not accurately reflect the level of starvation

Management of Refeeding Syndrome

General Principles
- Correct biochemical abnormalities and fluid imbalances.
- Perform a medication review and a screening exam.
- Prevent symptoms (4 fundamental factors):
  - Early identification of at risk individuals
  - Lab evaluation before starting feeding
  - Monitoring during refeeding
  - Appropriate feeding regimen

Treat based on the refeeding risk assessment according to guidelines below and Table 1, page 8

NEGLIGIBLE RISK OF REFEEDING SYNDROME

Patients who have not been identified as requiring closer monitoring (no significant preexisting medical conditions and baseline BMI > 18.5 kg/m²) and have been hunger strike participants for \( \leq 14 \) days are at little risk of refeeding problems.

REFEEDING RECOMMENDATIONS WITH NEGLIGIBLE RISK
- May be allowed to eat and drink freely and no specific monitoring of refeeding is necessary.
- Careful assessment of hydration status and possible tests of renal function are indicated if patient has refused fluid for several days.

MODEST RISK OF REFEEDING SYNDROME

Patients who have been identified as requiring closer monitoring during hunger strikes (preexisting medical condition or baseline BMI \( \leq 18.5 \) kg/m²), or meet one of the following criteria:
- BMI > 16 but \( < 18.5 \) kg/m²
- Loss of > 10% but \( < 15\% \) of their body weight during food refusal
- Refused food for 15-28 days
- BMI > 18.5 and weight loss \( \leq 10\% \) and 15-28 days of refusal of food

REFEEDING RECOMMENDATIONS WITH MODEST RISK

Location
- Refeeding can take place in a general population setting

Monitoring
- Continue daily cell side observation for two days
- RN will discuss with or refer to PCP, patients with identified signs or symptoms, in particular those on chronic care medications

Refeeding

Calorie limitation:
- Recommend \( \leq 20 \) kcal/kg/day for the first two days (1/2 of usual CDCR diet– max 4-5 carbohydrate “servings”).
- If no problems arise over first 48 hours, patient may be advised to increase consumption of the standard CDCR heart healthy diet to consume 3/4 of normal caloric intake for next two days as tolerated, then regular diet without restrictions.

Route: Oral

Nutritional Source: CDCR heart healthy diet (limited to 4-5 carbohydrate “servings” per meal see Table 4, page 11).
- Depending on institution factors and number of inmates involved, can provide “1/2 CDCR diet” by:
  - Group feeding inmates from hunger strike alone so the kitchen can prepare trays with 1/2 portions and only four to five carbohydrate “servings”/meal
  - Cell feeding inmates using trays with 1/2 portions and only 4-5 carbohydrate “servings”/meal
  - Prepare sack “lunches” for each meal that contain only 4-5 carbohydrate “servings”/meal

Fluid: Should generally be limited to around 30 ml/kg/day. This figure could be doubled if dehydration is diagnosed either clinically or on BUN/creatinine results. (Example 170 lb man = 77 kg x 30 ml/kg = 2310 ml/day)

---

Refeeding: Assessment of Risk and Management (cont)

**HIGH RISK OF REFEEDING SYNDROME**

- BMI < 16 kg/m²
- Weight loss > 15% of body weight since starting food refusal
- Low potassium, magnesium, or phosphate levels before the onset of feeding
- Hunger strike participant for more than 28 days
- Significant mental health or medical comorbidities
- BMI ≥ 16 kg/m² and > 28 days of refusal of food

**REFEEDING RECOMMENDATIONS WITH HIGH RISK**

**Location**
- Refeed in a licensed medical setting with 24 hour nursing, availability of daily labs, pharmacy, and dietary services.

**Monitoring**

- Na, K, Mg, Ca, glucose, BUN, Cr BEFORE refeeding, then DAILY for at least 2-3 days
- Liver function tests BEFORE refeeding, then REPEAT several days after refeeding resumes
- EKG BEFORE refeeding, then DAILY for at least 48 hours

- Normal or high serum electrolytes does not preclude the risk of refeeding syndrome as these patients may have whole body electrolyte depletion, which may amount to thousands of millimoles.
- Watch for signs of fluid overload, infection, or general deterioration, and have a low threshold for moving patient to a higher level of care should any clinical or biochemical abnormalities become concerning.
  - Likely causes of concern: potassium < 3.0 mmol/l, magnesium < 0.5 mmol/l, phosphate < 0.5 mmol/l
- Look for EKG evidence of electrolyte disturbance: potassium, calcium, magnesium, especially QT prolongation.
- Feeding should not be withheld if potassium, magnesium, or phosphate are low since electrolyte deficits are mostly intracellular and cannot be corrected without starting low levels of simultaneous feeding.

**Refeeding**

- **Calorie limitation:** Intake 5-10 kcal/kg/day for the first 24 hours
  - If no problems occur, intake can be increased by increments of 5-10 kcal/kg/day
  - Restrictions can be lifted after 5-7 days if no problems and patient taking > 35-40 kcal/kg/day
- **Route:** Oral feeding is preferred, if safe.
  - Nasogastric (NG) tube (continuous or every 2 – 4 hour bolus) if the patient cannot safely take food orally.
- **Nutritional source:**
  - Liquid nutritional supplement (LNS) [by mouth or NG]) which meets the specifications for refeeding in Table 1. Most LNS contains 1 kcal/ml so daily volumes are likely to be in the 300 – 400 ml range. (See Table 2, page 9)
  - CDCR heart healthy diet (composition is consistent with Table 1). Amount is limited in kcal/kg/day as outlined in Table 3, page 10.
- **Fluid:** should generally be limited to no more than 30 ml/kg/day. (May need to be increased if dehydration is assessed either clinically or on BUN/creatinine results.) Attempt to maintain a “zero” fluid balance. (See Table 1)
  - (Example 170 lb man = 77 kg x 30 ml/kg = 2310 ml/day)
- **Multivitamin and trace element supplement** should be provided:
  - Thiamine, 100 mg by mouth daily X 7 days
  - B complex, 1 by mouth daily X 7 days
  - Multivitamin, one by mouth daily x 60 days
- **Mineral supplements:** strongly consider phosphate, potassium, and magnesium as outlined in Table 1 (page 8) even if baseline levels are normal. Due to whole body depletion, even patients with renal failure (who may have elevated serum electrolytes) are likely to need supplementation as refeeding and fluid replacement progresses and renal function improves.
- If the patient is at a community hospital and stable after 72 hours, the sending institution/utilization management nurse shall contact the hospital to discuss discharge.
STAGES OF FASTING

Fasting is generally well tolerated for up to 2 weeks as long as fluid intake is sufficient. Early fasting weight loss can be 1-2 kg per day.

**Baseline (Day 0)**

| Usual Diet | Carbohydrates are the primary calorie source (approximately 60% of normal diet). After eating a meal → blood sugar rises → insulin is released. Insulin:  
| - Promotes glucose uptake and storage (glycogenesis)  
| - Inhibits fat breakdown  
| - Increases uptake of intracellular potassium |

**Day 1-3 Fasting**

Hunger pangs and stomach cramps disappear after the 2nd to 3rd day.

Glucose levels begin to fall → glucagon is released and insulin secretion falls.

Glycogen stores are depleted in an effort to maintain glucose levels. Glycogen stores rarely last more than 72 hours.

**Day 4-13 Fasting**

Brain and RBCs require glucose as energy source. With depletion of glycogen stores, glucose is made from non-carbohydrate sources (e.g., from muscle protein) (this is gluconeogenesis).

Fatty acids are broken down to provide energy as well (for organs other than brain and RBCs). Body fat and protein (muscle) are lost, as well as total body potassium, phosphate, magnesium.

Serum electrolyte levels are maintained at the expense of intracellular stores.

**Day 14-34 Fasting**

Symptoms may include: dizziness, ‘feeling faint’, difficulty standing, ‘lightheadedness’ or ‘mental sluggishness’, sensation of cold, weakness, loss of thirst, fits of hiccoughs.

Physical findings: severe ataxia, bradycardia, orthostatic hypotension.

Hydration status needs to be closely monitored. Excess saline administration may cause hypokalemia.

Thiamine deficiency occurs in the second or third week of fasting. The average weight loss in this phase is 0.3 kg per day.

**Day 35-42 Fasting**

This is considered the most unpleasant phase by those who have survived prolonged fasting due to the symptoms of thiamine deficiency:

- Oculomotor symptoms develop due to progressive paralysis of ocular muscles from thiamine deficiency, these include:
  - Uncontrollable nystagmus
  - Diplopia, converging strabismus
  - Vertigo (very unpleasant)
  - Vomiting
- Extreme difficulty swallowing water
- Medical complications arise at ≥18% loss of initial body weight

**Day 43 and Later Fasting**

Progressive asthenia (malaise, fatigue)

- Increasing confusion, incoherence
- Profound concentration problems
- Somnolence, indifference to surroundings

More serious complications:

- Loss of hearing and/or eyesight
- Hemorrhage: gingival, esophageal, other gastrointestinal sites

Organ failure: extreme bradycardia, Cheyne-Stokes respiration, disruption of all metabolic activity

Life-threatening symptoms develop at 30% loss of initial body weight

**Day 45–75 Fasting**

Death from cardiovascular collapse and/or severe ventricular dysrhythmia (e.g., prolonged QT).

More rarely, lactic acidosis from sepsis due to immune system dysfunction, small bowel obstruction, or multiple organ failure.
<table>
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<tr>
<th>REFEEDING SYNDROME (RFS) ¹</th>
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**Definition:**
- Refeeding syndrome (RFS) describes the biochemical changes, clinical manifestations, and complications that can occur as a consequence of feeding a malnourished catabolic individual.
- RFS is not defined by a clear set of signs and symptoms.
- There is no internationally agreed definition of RFS; it is a term referring to a wide spectrum of biochemical abnormalities and clinical consequences.
- Hypophosphatemia is the adopted surrogate marker to diagnose RFS though low serum phosphate is not pathognomonic.
- There are limitations to relying on low serum phosphate as levels may be normal in patients with multiple organ failure, in the presence of impaired renal function, or in patients in a stable state of starvation prior to onset of feeding.

**Physiology:**
- Reintroduction of nutrition to a starved or fasted individual results in a rapid decline in both gluconeogenesis and anaerobic metabolism mediated by the rapid increase in serum insulin.
- Insulin stimulates the movement of extracellular potassium, phosphate, and magnesium to the intracellular compartment with rapid fall in the extracellular concentration of these ions.
- Sodium and water are retained to maintain osmotic neutrality.
- Reactivation of carbohydrate-dependent metabolic pathways increases demand for thiamine, a cofactor required for cellular enzymatic reactions.
- The deficiencies of phosphate, magnesium, potassium, and thiamine occur to varying degrees and have different effects in different patients.

**Clinical Manifestations:**
- Symptoms of RFS are variable, unpredictable, may occur without warning, and may occur late.
- Symptoms occur because changes in serum electrolytes affect the cell membrane impairing function in nerve, cardiac, and skeletal muscle cells.
- Variable clinical picture in RFS reflects the type and severity of biochemical abnormalities.
- Mild derangements in electrolytes may cause no symptoms.
- More often, the spectrum of presentation ranges from simple nausea or vomiting to lethargy, respiratory insufficiency, cardiac failure, hypotension, arrhythmias, delirium, coma, and death.
- Clinical deterioration may occur rapidly.
- Low serum albumin concentration may be an important predictor for hypophosphatemia.

The optimum timing for correcting abnormalities in established RFS has been controversial. The view that correction of electrolyte abnormalities must occur before commencement of feeding has been revised and recent National Institute of Health and Clinical Excellence guidelines from the United Kingdom indicate that feeding and correction of biochemical abnormalities can occur in tandem without deleterious effects to the patient, but no randomized control trial data is available to support either view.

**Summary**

**Decision Support**

**Patient Education/Self Management**

### Table 1: Refeeding Calorie & Supplement Recommendations for High Risk Participants

<table>
<thead>
<tr>
<th>Day</th>
<th>Calorie Intake (All feeding routes)</th>
<th>Monitoring and Treatment Supplements</th>
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<tbody>
<tr>
<td>Day 1</td>
<td><strong>Refeeding</strong></td>
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<tr>
<td></td>
<td>For extreme cases: 5 kcal/kg/day(^\dagger)</td>
<td>Mineral Supplements:</td>
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<tr>
<td></td>
<td>Other cases: 10 kcal/kg/day(^\dagger)</td>
<td>Phosphate: 0.5-0.8 mmol/kg/day</td>
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<tr>
<td></td>
<td>Composition of refeeding diet:</td>
<td>Potassium: 1-3 mmol/kg/day</td>
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<tr>
<td></td>
<td>Carbohydrate: 50-60%</td>
<td>Magnesium: 0.3-0.4 mmol/kg/day</td>
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<tr>
<td></td>
<td>Fat: 30-40%</td>
<td>Sodium: &lt; 1 mmol/kg/day (restricted)</td>
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<tr>
<td></td>
<td>Protein: 15-20%</td>
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<td></td>
<td>If RFS is suspected based on clinical and biochemical assessment or the patient develops</td>
<td>IV fluids:</td>
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<tr>
<td></td>
<td>intolerance to artificial nutritional support, the energy intake should be reduced or stopped.</td>
<td>Restricted, maintain “zero” fluid balance</td>
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<td></td>
<td></td>
<td>Vitamins:</td>
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<td></td>
<td></td>
<td>IV Thiamine + vitamin B complex 30 minutes prior to feeding</td>
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<td></td>
<td></td>
<td>Cardiac and lab monitoring as required</td>
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<tr>
<td>Day 2-4</td>
<td>Increase by 5 kcal/kg/day(^\dagger) as tolerated.</td>
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<td></td>
<td>If RFS is suspected based on clinical and biochemical assessment or the patient develops</td>
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<tr>
<td></td>
<td>intolerance to artificial nutritional support, the energy intake should be reduced or stopped.</td>
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<tr>
<td>Day 5-7</td>
<td>Increase up to 20-30 kcal/kg/day(^\dagger)</td>
<td>Check electrolytes, renal and hepatic function and minerals</td>
</tr>
<tr>
<td></td>
<td>If RFS is suspected based on clinical and biochemical assessment or the patient develops</td>
<td>Fluid: maintain “zero” fluid balance</td>
</tr>
<tr>
<td></td>
<td>intolerance to artificial nutritional support, the energy intake should be reduced or stopped.</td>
<td>Consider iron supplement from day 7</td>
</tr>
<tr>
<td></td>
<td>Feeding rate should be increased to meet full requirements for fluid, electrolytes, vitamins,</td>
<td>Cardiac and lab monitoring as required</td>
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<tr>
<td></td>
<td>and minerals if the patient is clinically and biochemically stable.</td>
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</tr>
<tr>
<td>Day 8-10</td>
<td>30 kcal/kg/day(^\dagger) or increase to full requirement</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Feeding rate should be increased to meet full requirements for fluid, electrolytes, vitamins,</td>
<td>Cardiac and lab monitoring as required</td>
</tr>
<tr>
<td></td>
<td>and minerals if the patient is clinically and biochemically stable.</td>
<td></td>
</tr>
</tbody>
</table>

\(^\dagger\) Measure weight daily to use for all calculations

- Much of the literature on Refeeding Syndrome comes from experience with severely ill, catabolic patients in the Intensive Care Unit. Often these patients had underlying chronic illnesses as well and/or were post-op.
- Experience with two prior mass hunger strikes at CDCR (in 2011), both lasting 21 days, demonstrated that most inmate participants refused to be weighed or be evaluated by health care staff. Participants ended their hunger strike after various lengths of time. Even those who accepted no CDCR food for 21 days did well and did not manifest any problems with refeeding, even though they declined to follow recommendations for gradual reintroduction of kcal.

* High risk of refeeding syndrome:
  - Food refusal more than 28 days
  - BMI < 16 kg/m\(^2\)
  - Weight loss > 15% during the hunger strike
  - Low potassium, magnesium, or phosphate levels before resumption of feeding
  - Medical or mental health conditions creating high risk of complications from fasting

---

April 2019

CCHCS Hunger Strike, Fasting, & Refeeding Care Guide

CCHCS Hunger Strike, Fasting, & Refeeding Care Guide
**Table 2: Suggested Refeeding Regimen for Hunger Strike Patients Using Liquid Nutritional Supplement Based on Recommended Requirements in Table 1**

- Patients at high risk for refeeding syndrome initially may require liquid nutritional supplement (LNS) feeding.
- LNS meets the recommended requirements for use in refeeding and can be given orally or via tube feeding.
- LNS may also be indicated for patients who do not gain weight upon refeeding and who have lost > 10% of body weight. (IMSP&P Vol 4., Ch 20.2 Outpatient Dietary Intervention Procedure)
- Generally start with 10 kcal/kg/day (5 kcal/kg/day in very severe cases)

<table>
<thead>
<tr>
<th>Day</th>
<th>kcal/kg/day</th>
<th>Kcal/ml</th>
<th>Protein Source</th>
<th>NPC:N Ratio</th>
<th>N6:n3 Ratio</th>
<th>Osmolality (mOsm/kg water)</th>
<th>Free water</th>
<th>Appropriate for these diets</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>10</td>
<td>10 kcal</td>
<td>Calcium-Potassium Caseinate</td>
<td>133:1</td>
<td>4.1:1</td>
<td>370</td>
<td>85%</td>
<td>Lactose-free, gluten-free, low residue, kosher, low-sodium, low -cholesterol</td>
</tr>
<tr>
<td>2</td>
<td>15</td>
<td>15 kcal</td>
<td>Calcium-Potassium Caseinate</td>
<td>133:1</td>
<td>4.1:1</td>
<td>370</td>
<td>85%</td>
<td>Lactose-free, gluten-free, low residue, kosher, low-sodium, low -cholesterol</td>
</tr>
<tr>
<td>3-4</td>
<td>20</td>
<td>20 kcal</td>
<td>Calcium-Potassium Caseinate</td>
<td>133:1</td>
<td>4.1:1</td>
<td>370</td>
<td>85%</td>
<td>Lactose-free, gluten-free, low residue, kosher, low-sodium, low -cholesterol</td>
</tr>
<tr>
<td>5-6</td>
<td>25</td>
<td>25 kcal</td>
<td>Calcium-Potassium Caseinate</td>
<td>133:1</td>
<td>4.1:1</td>
<td>370</td>
<td>85%</td>
<td>Lactose-free, gluten-free, low residue, kosher, low-sodium, low -cholesterol</td>
</tr>
<tr>
<td>7-8</td>
<td>30</td>
<td>30 kcal</td>
<td>Calcium-Potassium Caseinate</td>
<td>133:1</td>
<td>4.1:1</td>
<td>370</td>
<td>85%</td>
<td>Lactose-free, gluten-free, low residue, kosher, low-sodium, low -cholesterol</td>
</tr>
</tbody>
</table>

**Nutren® 1.0 (Product Code Number 9871616210)**

<table>
<thead>
<tr>
<th>Kilocal/ml</th>
<th>1.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caloric Distribution (% Kcal)</td>
<td></td>
</tr>
<tr>
<td>Protein</td>
<td>16%</td>
</tr>
<tr>
<td>Carbohydrate</td>
<td>50%</td>
</tr>
<tr>
<td>Fat</td>
<td>34%</td>
</tr>
</tbody>
</table>

**Or other Liquid Nutritional Supplement that has a caloric distribution that falls within the following ranges: protein 15-20%, carbohydrate 50-60%, and fat 30-40%**

Day 1

- 10 kcal x 72 kg\(^\dagger\)=720 kcal x 1 kcal/ml = 720 ml/day
- Provide in 6 small feedings of **120 ml/feeding**
- Approximate feeding times are as follows: 6:00 AM, 9:00 AM, 12:00 PM, 3:00 PM, 6:00 PM, 9:00 PM

Day 2

- 15 kcal x 72 kg\(^\dagger\)= 1080 kcal x 1 kcal/ml = 1080 ml/day
- Provide in 6 small feedings of **180 ml/feeding**
- Approximate feeding times are as follows: 6:00 AM, 9:00 AM, 12:00 PM, 3:00 PM, 6:00 PM, 9:00 PM

Day 3-4

- 20 kcal x 72 kg\(^\dagger\)= 1440 kcal x 1 kcal/ml = 1440ml/day
- Provide in 6 small feedings of **240 ml/feeding**
- Approximate feeding times are as follows: 6:00 AM, 9:00 AM, 12:00 PM, 3:00 PM, 6:00 PM, 9:00 PM

Day 5-6

- 25 kcal x 72 kg\(^\dagger\)= 1800 kcal x 1 kcal/ml = 1800ml/day
- Provide in 6 small feedings of **300 ml/feeding**
- Approximate feeding times are as follows: 6:00 AM, 9:00 AM, 12:00 PM, 3:00 PM, 6:00 PM, 9:00 PM

Day 7-8

- 30 kcal x 72 kg\(^\dagger\)= 2160 Kcal x 1 kcal/ml = 2160ml/day
- Provide in 6 small feedings of **360 ml/feeding** for gradual introduction.
- Approximate feeding times are as follows: 6:00 AM, 9:00 AM, 12:00 PM, 3:00 PM, 6:00 PM, 9:00 PM

\(^\dagger\)Daily weights should be taken and used for calculations

* High risk, see page 5
# Table 3: Suggested Refeeding Regimen for Hunger Strike Patients Using CDCR Heart Healthy Menu

(For patients who can tolerate solid food.)

Based on Recommended Requirements in Table 1

<table>
<thead>
<tr>
<th>CDCR heart healthy diet</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Daily Calories 2750</td>
</tr>
<tr>
<td>Approximately Caloric distribution (% kcal)</td>
</tr>
<tr>
<td>- Protein 15 %</td>
</tr>
<tr>
<td>- Fat 30%</td>
</tr>
<tr>
<td>- Carbohydrate 55%</td>
</tr>
</tbody>
</table>

Note: Limiting “carbs” in the initial phase of refeeding is important. Most CDCR meal menus provide 7-9 carbohydrate “servings” (15 grams of carbohydrate = 1 serving/meal). When adjusting/preparing refeeding trays/sacks, limit carbohydrate servings to 4-5/meal. (See Table 4).

The table below illustrates how to refeed using CDCR Heart Healthy Menu for a patient whose current weight is 158 lbs / 72 kg after coming off a hunger strike for over 14 days.

<table>
<thead>
<tr>
<th>High Risk for RFS</th>
<th>Sample Heart Healthy Diet Menu Choices</th>
</tr>
</thead>
</table>
| **Day 1**  
10 kcal/kg/day | **10 kcal x 72 kg\(^1\)=720 kcal/day**  
Breakfast- 4 oz nonfat milk, 2 oz hot cereal, 1 oz breakfast meat or eggs, 2 oz juice  
Lunch- 1 slice bread, 2 oz meat with 1 package mustard or 2 oz peanut butter, 1 small fresh fruit, 8 oz salt free (SF) beverage  
Dinner- 2 oz meat, 4 oz vegetables, 2 oz starch, 4 oz fruit, 8 oz SF beverage |
| **Day 2**  
15 kcal/kg/day | **15 kcal x 72 kg\(^1\)= 1080 kcal/day**  
Breakfast- 4 oz nonfat milk, 2 oz breakfast meat or eggs, 4 oz hot cereal, 2 oz juice  
Lunch- 3 slices bread, 2 oz meat with 1 package mustard, 1 small fresh fruit, 8 oz SF beverage  
Dinner- 3 oz meat, 4 oz vegetables, 4 oz starch, 4 oz fruit, 8 oz SF beverage |
| **Day 3-4**  
20 kcal/kg/day | **20 kcal x 72 kg\(^1\)= 1440 kcal /day**  
Patient to eat ½ portion of foods/beverages with provision of 4-5 carbohydrate “counts”/ meal at each meal served. (SF beverage 100%) |
| **Day 5-6**  
25 kcal/kg/day | **25 kcal x 72 kg\(^1\)= 1800 kcal /day**  
Patient to eat ¾ portion of all foods/beverages with provision of 4-5 carbohydrate “counts”/ meal at each meal served. (SF beverage 100%) |
| **Day 7-8**  
30 kcal/kg/day | **30 kcal x 72 kg\(^1\)= 2160 kcal/day**  
Patient to eat ¾ portion of all foods/beverages with provision of 4-5 carbohydrate “counts”/ meal at each meal served. (SF beverage 100%) |

\(^1\)Daily weights should be taken and used for calculation.

* High risk, see page 5
Typical CDCR heart healthy meals contain 7-9 “servings” of carbohydrate/meal. (15 gram carbohydrate = 1 serving) Carbohydrate (CHO) counts are calculated for each meal and the current CHO counting menu can be found on Medical Services → Dietary Services → Lifeline page under Diabetic Education materials (Note: AE is “Alternate Entrée” for religious diets)

<table>
<thead>
<tr>
<th>Breakfast</th>
<th>Lunch</th>
<th>Dinner</th>
<th>Carb Choices</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 OZ 100% FRUIT JUICE</td>
<td>1/2 LUNCH MEAT</td>
<td>3/4 CPMI EA</td>
<td>0</td>
</tr>
<tr>
<td>6 OZ CRACKED WHEAT CEREAL</td>
<td>1/2 LUNCHMEAT</td>
<td>3/4 CPMI EA</td>
<td>0</td>
</tr>
<tr>
<td>3 EA PANCAKES</td>
<td>2 OZ P BREAD</td>
<td>3/4 CPMI EA</td>
<td>0</td>
</tr>
<tr>
<td>2 OZ Sunflower Seeds</td>
<td>1 PK SUNFLOWER SEEDS</td>
<td>3/4 CPMI EA</td>
<td>0</td>
</tr>
<tr>
<td>2 OZ SYRUP</td>
<td>1/2 WHEAT BREAD</td>
<td>3/4 CPMI EA</td>
<td>0</td>
</tr>
<tr>
<td>2 OZ ABARAGE CRACKERS</td>
<td>1/2 COCKTAIL SAUCE</td>
<td>3/4 CPMI EA</td>
<td>0</td>
</tr>
<tr>
<td>2 OZ FRESH FRUIT</td>
<td>1 EA MARGARINE READIES</td>
<td>3/4 CPMI EA</td>
<td>0</td>
</tr>
<tr>
<td>8 OZ NONFAT MILK-PA</td>
<td>1 PK ICED CAKE</td>
<td>3/4 CPMI EA</td>
<td>0</td>
</tr>
<tr>
<td>1 CHEESE SLICE 2/3 OZ (AE)</td>
<td>1/2 SUGAR FREE BEVERAGE</td>
<td>3/4 CPMI EA</td>
<td>0</td>
</tr>
<tr>
<td>4 OZ FRUIT SERVING</td>
<td>1/2 LUNCH MEAT</td>
<td>3/4 CPMI EA</td>
<td>0</td>
</tr>
<tr>
<td>2 EA OATMEAL</td>
<td>1/2 LUNCHMEAT</td>
<td>3/4 CPMI EA</td>
<td>0</td>
</tr>
<tr>
<td>2 EA EGGS-PIA</td>
<td>1/2 LUNCHMEAT</td>
<td>3/4 CPMI EA</td>
<td>0</td>
</tr>
<tr>
<td>2 EA WHEAT TOAST/BREAD</td>
<td>1/2 LUNCHMEAT</td>
<td>3/4 CPMI EA</td>
<td>0</td>
</tr>
<tr>
<td>2 EA MARGARINE READIES</td>
<td>1/2 LUNCHMEAT</td>
<td>3/4 CPMI EA</td>
<td>0</td>
</tr>
<tr>
<td>8 OZ NONFAT MILK-PA</td>
<td>1/2 LUNCHMEAT</td>
<td>3/4 CPMI EA</td>
<td>0</td>
</tr>
<tr>
<td>8 OZ COFFEE-PIA</td>
<td>1/2 LUNCHMEAT</td>
<td>3/4 CPMI EA</td>
<td>0</td>
</tr>
<tr>
<td>3 EA蘝OEG SBISSING</td>
<td>1/2 LUNCHMEAT</td>
<td>3/4 CPMI EA</td>
<td>0</td>
</tr>
<tr>
<td>2 OZ HOMMY Gffi</td>
<td>1/2 LUNCHMEAT</td>
<td>3/4 CPMI EA</td>
<td>0</td>
</tr>
<tr>
<td>1 EA COFFEE CAKE, 4x4”</td>
<td>1/2 LUNCHMEAT</td>
<td>3/4 CPMI EA</td>
<td>0</td>
</tr>
<tr>
<td>2 OZ P BREAD</td>
<td>1/2 LUNCHMEAT</td>
<td>3/4 CPMI EA</td>
<td>0</td>
</tr>
<tr>
<td>1 EA ALMONDS-PIA</td>
<td>1/2 LUNCHMEAT</td>
<td>3/4 CPMI EA</td>
<td>0</td>
</tr>
<tr>
<td>8 OZ NONFAT MILK-PA</td>
<td>1/2 LUNCHMEAT</td>
<td>3/4 CPMI EA</td>
<td>0</td>
</tr>
<tr>
<td>8 OZ COFFEE-PIA</td>
<td>1/2 LUNCHMEAT</td>
<td>3/4 CPMI EA</td>
<td>0</td>
</tr>
<tr>
<td>1 CHEESE SLICE 2/3 OZ (AE)</td>
<td>1/2 LUNCHMEAT</td>
<td>3/4 CPMI EA</td>
<td>0</td>
</tr>
<tr>
<td>4 OZ FRESH FRUIT</td>
<td>1/2 LUNCHMEAT</td>
<td>3/4 CPMI EA</td>
<td>0</td>
</tr>
<tr>
<td>1 EA COLD CEREAL, FORTIFIED</td>
<td>1/2 LUNCHMEAT</td>
<td>3/4 CPMI EA</td>
<td>0</td>
</tr>
<tr>
<td>1 EA COUNTRY BREAKFAST</td>
<td>1/2 LUNCHMEAT</td>
<td>3/4 CPMI EA</td>
<td>0</td>
</tr>
<tr>
<td>4 OZ OVEN BAKED POTATO WEDGES</td>
<td>1/2 LUNCHMEAT</td>
<td>3/4 CPMI EA</td>
<td>0</td>
</tr>
<tr>
<td>1 EA BISCUIT, 3 OZ</td>
<td>1/2 LUNCHMEAT</td>
<td>3/4 CPMI EA</td>
<td>0</td>
</tr>
<tr>
<td>8 OZ NONFAT MILK-PA</td>
<td>1/2 LUNCHMEAT</td>
<td>3/4 CPMI EA</td>
<td>0</td>
</tr>
<tr>
<td>8 OZ COFFEE-PIA</td>
<td>1/2 LUNCHMEAT</td>
<td>3/4 CPMI EA</td>
<td>0</td>
</tr>
<tr>
<td>3 EA CHEESE SLICE 2/3 OZ (AE)</td>
<td>1/2 LUNCHMEAT</td>
<td>3/4 CPMI EA</td>
<td>0</td>
</tr>
<tr>
<td>4 OZ FRUIT SERVING</td>
<td>1/2 LUNCHMEAT</td>
<td>3/4 CPMI EA</td>
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</tr>
<tr>
<td>2 EA COCONUT MUSH</td>
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<td>3/4 CPMI EA</td>
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</tr>
<tr>
<td>6 EA BEEF HASH-PIA</td>
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<td>3/4 CPMI EA</td>
<td>0</td>
</tr>
<tr>
<td>1 EA EGGS-PIA</td>
<td>1/2 LUNCHMEAT</td>
<td>3/4 CPMI EA</td>
<td>0</td>
</tr>
<tr>
<td>2 SL WHEAT TOAST/BREAD</td>
<td>1/2 LUNCHMEAT</td>
<td>3/4 CPMI EA</td>
<td>0</td>
</tr>
<tr>
<td>2 EA MARGARINE READIES</td>
<td>1/2 LUNCHMEAT</td>
<td>3/4 CPMI EA</td>
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</tr>
<tr>
<td>8 OZ NONFAT MILK-PA</td>
<td>1/2 LUNCHMEAT</td>
<td>3/4 CPMI EA</td>
<td>0</td>
</tr>
<tr>
<td>8 OZ COFFEE-PIA</td>
<td>1/2 LUNCHMEAT</td>
<td>3/4 CPMI EA</td>
<td>0</td>
</tr>
<tr>
<td>1 CHEESE SLICE (AE)</td>
<td>1/2 LUNCHMEAT</td>
<td>3/4 CPMI EA</td>
<td>0</td>
</tr>
</tbody>
</table>
# BMI Calculator:

## Body Mass Index Table

<table>
<thead>
<tr>
<th>Height (inches)</th>
<th>Normal</th>
<th>Overweight</th>
<th>Obese</th>
<th>Extreme Obesity</th>
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</thead>
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<tr>
<td>76</td>
<td>156</td>
<td>164</td>
<td>172</td>
<td>180</td>
</tr>
</tbody>
</table>

To the Emergency Department (ED) and Hospital Staff:

This patient is at risk for refeeding syndrome

Thank you for caring for our patient. This patient has been on a protracted hunger strike with no documented nutritional intake of state provided meals over the past ______ days.

- His or her oral intake may have consisted of water only.
- Some patients may have had access to canteen food or food from other sources but this cannot be confirmed or assumed.

Please **DO NOT FEED THE PATIENT IN THE EMERGENCY DEPARTMENT**

It is safe to administer intravenous fluid (including dextrose) in the ED, but **IV Thiamine** should be added to the IV fluid along with supplementation of **potassium**, **magnesium**, and **phosphate** as outlined in the CCHCS refeeding guidance on page 14, labeled Table 1.

Please monitor carefully for **hypokalemia**, **hypophosphatemia**, and **hypomagnesemia**. While baseline electrolytes will likely be normal prior to administration of fluids or food, these will rapidly shift intracellularly following refeeding. Problems can arise at any time in the first week after refeeding has begun.

**Once admitted**, please continue to monitor the patient’s labs with particular attention to phosphate, potassium, magnesium, calcium, creatinine, and glucose.

Cardiac monitoring may be indicated.

- Refeeding regimens will vary depending on the severity of the patient’s starvation, weight loss, pre-fast BMI, and comorbid medical conditions.
- All refeeding regimens suggest starting feeding at 5-10 kcal/kg/day (depending on severity).
- Composition of feeding should be lower glucose (**no Ensure**)! Khan recommends 50-60% carbohydrate, 30-40% fat and 15-20% protein.
- Kcal/kg is increased as tolerated over 5-10 days. **(If this patient is stable at 3 days and is taking at least 20 kcal/kg please contact the sending institution or UM for discussion of discharge timing.)**

**Helpful references:**


2.) *Refeeding syndrome: what it is, and how to prevent and treat it*, Hisham M Mehanna, consultant and honorary associate professor, BMJ 2008;336:1495-1498

Please contact our institution for questions: Telephone # _________________________

**Note to health care staff:** Send pages 13 and 14 of this guide to ED with patient.
To the Emergency Department and Hospital Staff:

This patient is at risk for Refeeding Syndrome

**TABLE 1: REFEEDING CALORIE & SUPPLEMENT RECOMMENDATIONS FOR HIGH RISK PARTICIPANTS**

<table>
<thead>
<tr>
<th>Day</th>
<th>Calorie Intake (All feeding routes)</th>
<th>Monitoring and Treatment Supplements</th>
</tr>
</thead>
</table>
| Day 1 Refeeding | For extreme cases: 5 kcal/kg/day<sup>†</sup>  
Other cases: 10 kcal/kg/day<sup>†</sup>  
Composition of refeeding diet:  
Carbohydrate: 50-60%  
Fat: 30-40%  
Protein: 15-20%  
If Refeeding Syndrome (RFS) is suspected based on clinical and biochemical assessment or the patient develops intolerance to artificial nutritional support, the energy intake should be reduced or stopped. | Mineral Supplements:  
Phosphate: 0.5-0.8 mmol/kg/day  
Potassium: 1-3 mmol/kg/day  
Magnesium: 0.3-0.4 mmol/kg/day  
Sodium: < 1 mmol/kg/day (restricted)  
IV fluids:  
Restricted, maintain “zero” fluid balance  
Vitamins:  
IV Thiamine + vitamin B complex 30 minutes prior to feeding  
Cardiac and lab monitoring as required |
| Day 2-4 | Increase by 5 kcal/kg/day<sup>†</sup> as tolerated.  
If RFS is suspected based on clinical and biochemical assessment or the patient develops intolerance to artificial nutritional support, the energy intake should be reduced or stopped. | Check all biochemistry and correct any abnormalities  
Thiamine + vitamin B complex orally or IV until day 3  
Cardiac and lab monitoring as required |
| Day 5-7 | Increase up to 20-30 kcal/kg/day<sup>†</sup>  
If RFS is suspected based on clinical and biochemical assessment or the patient develops intolerance to artificial nutritional support, the energy intake should be reduced or stopped.  
Feeding rate should be increased to meet full requirements for fluid, electrolytes, vitamins, and minerals if the patient is clinically and biochemically stable. | Check electrolytes, renal and hepatic function and minerals  
Fluid: maintain “zero” fluid balance  
Consider iron supplement from day 7  
Cardiac and lab monitoring as required |
| Day 8-10 | 30 kcal/kg/day<sup>†</sup> or increase to full requirement  
Feeding rate should be increased to meet full requirements for fluid, electrolytes, vitamins, and minerals if the patient is clinically and biochemically stable. | Cardiac and lab monitoring as required |

<sup>†</sup> Measure weight daily to use for all calculations

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* Much of the literature on Refeeding Syndrome comes from experience with severely ill, catabolic patients in the Intensive Care Unit. Often these patients had underlying chronic illnesses as well and/or were post-op.

* Experience with two prior mass hunger strikes at CDCR (in 2011), both lasting 21 days, demonstrated that most inmate participants refused to be weighed or be evaluated by health care staff. Participants ended their hunger strike after various lengths of time. Even those who accepted no CDCR food for 21 days did well and did not manifest any problems with refeeding, even though they declined to follow recommendations for gradual reintroduction of kcal.

* **High risk of refeeding syndrome:**
  - Food refusal more than 28 days
  - BMI < 16 kg/m<sup>2</sup>
  - Weight loss > 15% during the hunger strike
  - Low potassium, magnesium, or phosphate levels before resumption of feeding
  - Medical or mental health conditions creating high risk of complications from fasting

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<sup>†</sup>Measure weight daily to use for all calculations
HUNGER STRIKE PATIENT FACT SHEET

RISKS OF FLUID REFUSAL

- Not drinking fluid can cause death within days.
- Not drinking fluid can cause lasting organ damage.
- You will get symptoms very soon if you do not drink fluids.
- You should drink at least 6 cups of fluid every day.

RISKS OF FASTING

- Not eating food for a long time (prolonged fasting) can cause death.
- Not eating food can cause lasting organ damage.
- You may become dizzy during your hunger strike. You should move slowly and carefully to avoid falls.
- You may get many other symptoms the longer you refuse food such as: weakness, confusion, vomiting, stomach pain, and higher risk of infections.
- If you are in good health when you start to refuse food and you keep on drinking water, you will probably survive for weeks.
- After prolonged fasting (starvation) you may have lasting organ damage even after you start eating again and gain weight.

RISKS OF REFEEDING

- Death may happen when you start eating after not eating for a long time. This is called refeeding syndrome.
- If you have lost more than 10 lbs or have not eaten for more than 14 days, talk to health care staff before you eat again.
- Your risk of death is less if you start eating under medical care.
- If you have not eaten for many days, you should start to eat by taking only small amounts of food the first few days and then step up to normal eating over 5-7 days.

ABOUT YOUR HUNGER STRIKE

- MONITORING: Health care staff will watch you for signs of serious illness during your hunger strike.
- ACCESS TO HEALTH CARE: You may access health care services at any time during your hunger strike just like when you are not on a hunger strike.
- MEDICATION CHANGES: Your primary care provider may change or stop some of your medications during your hunger strike to lower your risk of problems.
Information for Patients with Prolonged Fasting

WHAT YOU NEED TO KNOW

♦ You have not been eating for such a long time that you are in danger of lasting medical harm, even with medical care.
♦ You may die, even after you start to eat again.
♦ Now is the time for you to think about what medical care you want when you are no longer able to talk to health care staff.
♦ Health care staff is concerned about your health so they will check with you to see if you understand that you may die if you refuse food or fluid and that you have clear reasons for refusing food or fluid.
♦ If you go into a coma or your heart stops, you will get all the medical care needed to try to save your life, including CPR, food, and fluids.
♦ Health care staff will not give you food or fluid if you make it clear that you do not want them to.

Advance Directive for Health Care
(Form Number, CDCR 7421)

♦ You should fill out the Advance Directive form if you want to name someone who can make medical decisions for you when you are unable to speak for yourself. This person should be someone who knows your wishes and is willing, able, and available to make these decisions.
♦ An Advance Directive also lets health care staff know what medical care you want or do NOT want when you are unable to speak for yourself.
♦ If you want to complete an Advance Directive, ask health care staff for the form. Before you sign it, return the completed form to your health care provider to talk about your choices.

Physician Orders for Life-Sustaining Treatment (POLST)
(Form Number, CDCR 7465)

♦ A POLST form is a doctor’s order that stays in your medical record. The POLST form records your wishes about specific life saving treatments.
♦ This form is completed by you and your health care provider.

If you have questions or are concerned about changes in your health you may contact health care staff at any time.
FOLLETO SOBRE LA HUELGA DE HAMBRE

RIESGOS SI UD. REHUSA BEBER LÍQUIDOS

♦ Si no bebe líquidos puede morirse dentro de días.
♦ Si no bebe suficiente líquido puede causarle daño permanente a sus órganos internos.
♦ Si no bebe líquidos sentirá síntomas dentro de poco tiempo.
♦ Debe beber por lo menos seis vasos de líquido cada día.

RIESGOS DEL AYUNO

♦ Puede morirse si no come durante mucho tiempo (ayuno prolongado).
♦ Si no come puede causarle daño permanente a sus órganos internos.
♦ Podrá marearse durante su huelga de hambre. Debe moverse lentamente y con cuidado para evitar las caídas.
♦ Entre más tiempo rehúsa comer, podrá experimentar muchos otros síntomas tales como la debilidad, la confusión, el vómito, el dolor de estómago, y un riesgo mayor de infecciones.
♦ Si está bien de salud cuando empieza a rehusar comida pero sigue bebiendo agua, es probable que podrá sobrevivir por semanas.
♦ Después de un ayuno prolongado (inanición) podrá sufrir daño permanente en los órganos internos aunque empiece a comer y aumentar de peso.

RIESGOS CUANDO EMPIEZA A COMER DE NUEVO

♦ Puede morirse cuando empieza a comer de nuevo después de ayunar por mucho tiempo. Este fenómeno se llama Síndrome de Realimentación.
♦ Si ha perdido más de diez libras o no ha comido durante más de catorce días, hable con el personal médico antes de empezar a comer.
♦ El riesgo de muerte es menor si empieza a comer bajo atención médica.
♦ Si no ha comido durante muchos días, debe empezar a comer solamente pequeñas cantidades de comida los primeros días y luego pasar a una alimentación normal durante un periodo de cinco a siete días.

ACERCA DE LA HUELGA DE HAMBRE

♦ OBSERVACIÓN: El personal médico le observará para detectar señales de una enfermedad sería durante la huelga de hambre.
♦ ACCESO A LA ATENCIÓN MÉDICA: Puede acudir a los servicios de salud en cualquier momento durante su huelga de hambre al igual que cuando no está en huelga de hambre.
♦ CAMBIOS EN MEDICAMENTOS: Su médico (de cabecera) podrá cambiar o descontinuar algunos de sus medicamentos durante la huelga de hambre para reducir el riesgo de problemas.
Información para el Paciente en Ayuno Prolongado

**LO QUE NECESITA SABER**

- No ha estado comiendo por tanto tiempo que hay peligro de daño médico permanente aunque reciba atención médica.
- Podrá morir aún después de empezar a comer de nuevo.
- Este es el momento para pensar en qué tipo de atención médica desea recibir cuando ya no tenga la capacidad de hablar con el personal médico.
- Su salud es muy importante para el personal médico de esta institución y a consecuencia van a consultar con usted para ver si entiende que puede morir si rehúsa comer o beber y que existen razones claras para tomar esta decisión.
- Si cae en un estado de coma o sufre un paro cardiaco, recibirá toda la asistencia médica necesaria para tratar de salvar su vida incluyendo reanimación cardiopulmonar, comida, y líquidos.
- Si usted indica claramente que no desea alimentos ni líquidos, el personal médico respetará su decisión.

**Directiva Anticipada para Atención Médica**  
(Form Number, CDCR 7421)

- Usted debe llenar una Directiva Anticipada si desea nombrar a alguien que pueda tomar decisiones médicas por usted cuando usted ya no tenga la capacidad de hablar por sí mismo.
- Una Directiva Anticipada también le comunica al personal médico qué tipo de atención médica usted desea o no desea cuando ya no tenga la capacidad de hablar por sí mismo.
- Si desea completar una Directiva Anticipada, puede pedirle un formulario a cualquier integrante del personal médico. Antes de firmar el formulario, devuélvalo al médico para que le expliqué todas sus opciones.

**Órdenes del Médico de Tratamiento para el Mantenimiento de la Vida**  
(Form Number, CDCR 7465)

- Este formulario es una orden médica que permanece en su expediente médico indicando sus deseos sobre tratamientos específicos para mantener la vida.
- Este formulario es completado por usted y su proveedor de atención médica.

Si usted tiene preguntas o está preocupado sobre cambios en su salud, puede notificar en cualquier momento al personal médico.