mean ± SEM. Food records identified 67% with intake deficiency of calories of RDA nutrients. To assess adherence to supplements, a telephone survey of pts completing at least 30 days on study was conducted: data on 49 pts (mean 68 days of supplement use) follows. Adherence of HIV infected pts to the enteral supplement program was excellent as measured by daily can intake (460 ± 20 cc, mean ± SEM) representing additional intake of 465 kcal/d to 566 kcal/d (for Ensure and new formula, respectively). Subjective benefit of supplement use included: increased weight, 33% moderate, 25% definite; increased well-being, 30% moderate, 33% definite; and increased energy, 30% moderate, 30% definite. Eight pts terminated supplement use for: diarrhea (3), taste (1), weight gain (1), or other (3). Reported diarrhea (27% moderate, 12% definite); and nausea (17%) were manageable. We conclude: excellent adherence to an enteral supplement program can be achieved in ambulatory patients with HIV infection. Follow-up for nutritional and clinical endpoints continues.

O.32 Prospective study on the outcome of nutritional therapy including formula diets in malnourished HIV-infected

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Objective: Evaluation of the first two stages of an intervention scheme planned for malnourished HIV-infected (pat.).

Patients and methods: 44 consecutive pat. (weight loss 5/10% in 3/6 months [3–30 kg; $\bar{x}$ = 8 kg]; age: 36 [26–62]; CD4 cells/μl: 40 [0–260]) underwent a prospective nutritional counselling (= stage 1) and were followed over a period of 3 months. Failure of stage 1 (= no weight gain) lead to an escalation of treatment and additional formula diets (FD [= 1000–1500 kcal]) were prescribed (= stage 2). Outcome of treatment was analyzed by course of nutritional status with the parameters: body weight, bioelectrical-impedance-analysis and 7-day-food-records (household-measure-method) at 4–6 weeks-intervals.

Results: 37/44 pat. reached stage 2; of these 27 tolerated FD longer than 4 weeks, 22/37 longer than 8 weeks and only 8/37 longer than 12 weeks. Weight gain was achieved in 53% of the treated pat.; stop of weight loss with 19% of pat. and 28% had to face further weight loss. The average intake as FD was <500 kcal in 11/27; 500–750 kcal in 7/27; 750–1000 kcal in 6/27 and >1000 kcal in 3/27. Astonishingly the outcome of therapy was not influenced by the average intake of FD.

Conclusion: HIV-associated malnutrition can be stopped or reversed by an intensified oral nutritional intervention including FD in more than 70% of the treated pat. Those pat. who cannot profit from an oral nutritional intervention alone might benefit from artificial nutrition (enteral or parenteral) as stage 3 and 4 of the intervention scheme. Reasons for the limited tolerance of FD (amount and duration of intake) might be taste and texture of FD as well as early repletion and anorexia. Nevertheless, FD may help to overcome mismatches between caloric intake and needs without side effects and are worth a try as a therapeutic intervention of HIV-associated malnutrition.