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LETTER TO THE EDITOR

Complementary considerations in the evaluation of malnutrition in hospitalized elderly patients with type 2 diabetes mellitus☆

Consideraciones complementarias en la evaluación de desnutrición en pacientes ancianos hospitalizados con diabetes mellitus tipo 2

Dear Editor,

Malnutrition in elderly people is a multifactorial health problem.[1] It usually goes undetected by medical personnel during hospitalisation, resulting in further functional decline, risks of infection, mortality and hospital expenses.[2] If these patients suffer from type 2 diabetes mellitus (T2DM), the situation is even more complicated.

The study by Serrano et al.[3] used the Mini Nutritional Assessment (MNA) and the Malnutrition Universal Screening Tool (MUST), tools for detecting malnutrition with high validity, sensitivity and specificity compared to the Subjective Global Assessment (SGA), which is considered to be the most suitable technique.[1] The MNA was exclusively designed for elderly people and its use is recommended by the Dietitians Association of Australia.[4] The MUST, for its part, is quick and simple to apply, and it includes objective and subjective information that curbs bias.[1] The two methods have similar reliability and are suitable for geriatric patients,[2] as a point in the study's favour.

The discrepancy lies in the use of the Nutritional Risk Index (NRI), which detects problems linked to malnutrition or the seriousness of a patient's postoperative condition.[1,5] However, the NRI is aimed at young surgical patients, and therefore is not reliable in elderly patients.[6] The Geriatric Nutritional Risk Index (GNRI) was developed as a counterpart to the NRI. The GNRI replaces the usual weight used in the NRI with the ideal weight of the elderly patient using the Lorentz formula. It detects different degrees of risk associated with nutrition and can predict a tendency towards a longer hospital stay.[5,7]

Studies by Poulia et al.[1] and Abd et al.[8] support our assertion and report that the GNRI exhibits greater specificity and negative predictive value than the NRI. In addition, the GNRI uses height, weight and albumin, rendering it a simple, practical method sensitive to disease stress. Furthermore, the GNRI can classify hospitalised elderly patients according to multiple types of malnutrition when combined with the MNA.[8] Therefore, we believe that the study should have used the GNRI instead of the NRI, as it was better suited to the study population.

Moreover, it would have been interesting to know the details of the patients in the study by Serrano et al.,[3] such as their nutritional history prior to their hospitalisation, time since diagnosis, and treatment for T2DM; this would have made it possible to deduce whether malnutrition was caused by age and/or T2DM.

We would consider two important aspects in addition to the above: first, the type of nutritional support offered by the hospital and the circumstances under which it was offered, since a non-specific diet for patients with T2DM, poorly balanced meals, a lack of time to eat and fasting before medical tests can exacerbate malnutrition and lengthen hospital stays[2,9] compared to personalised diets when offered by hospitals; and second, record the finding of malnutrition upon admission, during hospitalisation or from admission to discharge, as this could supplement the results of the study.

Therefore, a suitable method for screening, history-taking and nutritional support in hospitalised elderly patients with T2DM would provide for a comprehensive evaluation and a correct diagnosis of malnutrition. It would also facilitate the implementation of specific diets and timely treatment, in order to prevent further complications and longer hospital stays.

Conflicts of interest

None.

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