REUE | Editorial

New spaces and possibilities to implement screening for disease-related malnutrition

Nuevos espacios y posibilidades para implementar el cribado de la desnutrición relacionada con la enfermedad

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At the 44th Congress of the European Society for Clinical Nutrition and Metabolism (ESPEN), held in Lyon in 2002, the International Declaration on the Human Right to Nutritional Care was signed. This declaration represents a call to action for policymakers, medical associations, and civil society organizations to take urgent measures against disease-related malnutrition (DRM). It is the first global consensus of its kind and is supported by major international clinical nutrition societies—ESPEN, ASPEN, FELANPE, and PENSA—as well as SENPE (Spanish Society of Clinical Nutrition and Metabolism), the European Federation of Dietetic Associations, the European Patients' Forum, and 75 other scientific organizations worldwide. Although this document is not legally binding, it represents a moral commitment by its signatories to take concrete measures promoting access to nutritional care. To understand the importance of this global initiative, it is essential to review the historical background and key milestones that contributed to the evolution and recognition of nutritional care as a human right[1] (Figure 1).

In public health and political contexts, the beneficiary of the right to food is understood as an active individual, to whom the State must provide an enabling environment to "feed oneself." In the clinical context, however, the question arises: should the right of individuals be to "feed themselves" or to "be fed"? The ill person is inherently at greater risk of nutritional deterioration simply by being ill. This is not only due to food deprivation but also to the effects of inflammation and metabolic alterations. Therefore, every sick person who comes into contact with a health care institution should have access to nutritional care and support.

The link between malnutrition and poor outcomes in surgical patients has been known for more than 80 years. In 1936, surgeon Dr. Hiram O. Studley documented that a 20% (or greater) loss of body weight could explain a large proportion of postoperative complications.[2] In 1944, Cannon *et al.* highlighted the association between protein depletion and postoperative infections,[3] and in 1955, Rhoads and Alexander drew attention to nutritional problems observed in patients awaiting surgery.[4]

In 1974, Butterworth,[5] in his landmark article "The skeleton in the hospital closet," introduced the term "iatrogenic malnutrition" to describe alterations in body composition among hospitalized patients caused by the actions (or omissions) of the healthcare team. The author noted the paradox that healthcare professionals often failed to detect and treat early signs of malnutrition, despite their obligation to ensure the best possible well-being for their patients. Butterworth also emphasized the practical implications of timely nutritional management: he identified a relationship between the patient's nutritional deterioration and the length and cost of hospital stay. Once malnutrition developed, it worsened the patient's condition, increased medical costs, and prolonged hospitalization, thereby perpetuating a vicious cycle that often led to death.

The most enduring contribution of Butterworth's work lies in his identification of 14 unacceptable healthcare practices that negatively affect patients' nutritional status (Table 1).

At that time, evidence on the prevalence of DRM in hospitals was limited and fragmented—but the situation has changed in recent years.

The PREDyCES multicenter observational study,[6] published in 2012 using data from 2009, revealed that 23% of patients were malnourished upon hospital admission and 23.4% at discharge. The mean length of stay for malnourished patients was 11.5 ± 7.5 days vs 8.5 ± 5.8 days in controls ($P < .001$), and the mean cost of care was €8,590 ± 6,127 versus €7,085 ± 5,625 ($P < .015$). Extrapolated to the entire Spanish National Health System, the estimated annual cost of hospital malnutrition was at least €1.143 billion per year. In 2021,

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Figure 1. Vienna Declaration: Nutritional Care Is a Human Right.
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the SeDREno study[7] (with data from 2019) reported that 29.7% of patients met GLIM criteria for malnutrition on admission (12.5% severe, 17.2% moderate), increasing to 34.8% among patients older than 70 years. Notably, 72% of

Table 1. Practices detrimental to the nutritional status of hospitalized patients

1. Absence of patient weight and height records.
2. Frequent rotation of healthcare team members.
3. Diffusion of responsibility in patient care.
4. Prolonged use of saline and glucose parenteral solutions as the sole source of energy supply.
5. Failure to record patients' food intake.
6. Repeated fasting periods due to diagnostic procedures.
7. Administration of enteral feedings in inadequate quantities, with uncertain composition, and under unhygienic conditions.
8. Lack of knowledge regarding the composition of vitamin mixtures and other nutritional products.
9. Failure to recognize increased nutritional requirements caused by inflammation associated with the underlying disease.
10. Performing surgical procedures without first confirming that the patient is in optimal nutritional status, and failure to provide necessary postoperative nutritional treatment.
11. Failure to appreciate the role of nutrition in the prevention and treatment of infection; excessive reliance on antibiotics.
12. Lack of communication and interaction between physicians and dietitians. As members of the healthcare team, dietitians should be concerned with the nutritional status of every hospitalized patient.
13. Delay in initiating nutritional therapy until the patient has reached an advanced—and sometimes irreversible—state of malnutrition.
14. Limited availability of laboratory tests for assessing the patient's nutritional status, or failure to use those that are available.

Translated from "The Skeleton in the Hospital Closet." Nutrition Today. 1974;9:4–8.

these patients had been admitted through emergency departments (EDs). A decade later, the prevalence of DRM on hospital admission had risen from 1 in 4 to 1 in 3 patients.

Given the current evidence regarding the prevalence and significance of DRM, is it time to consider new strategies for early detection and management? If successful screening initiatives for other diseases have been implemented in EDs,[8] why not for DRM?

DRM fulfills all criteria that justify screening: it has a high prevalence (especially in older adults or those with chronic disease), simple screening tools exist (with a key role for nursing staff),[9] and early intervention can improve prognosis with proven cost-effectiveness.[10,11] Recording a patient's current weight, body mass index (BMI), and percentage of weight loss (relative to habitual weight) would be a simple but powerful advance in the early detection of DRM.[12]

It is essential to raise awareness among ED teams about their crucial role in the early detection of DRM. Emergency physicians work in high-pressure environments, often with critically ill patients, and may perceive nutrition screening as beyond their scope—unless they realize that it is simple, quick to record, and clinically relevant to the disease prompting admission.

Screening could be targeted at patients admitted through the ED who belong to high-risk groups where nutritional status strongly influences clinical outcomes—those older than 70 years, with chronic diseases, or surgical conditions.[13,14] It is both feasible and necessary to ensure that medical nutritional therapy begins in the emergency department.[15] Likewise, it is crucial to promote research initiatives that include EDs and contribute to improving knowledge and management of DRM. Let's get to work.

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