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Top Strategies for Recognizing & Treating Malnutrition

Announcer:
You're listening to *Clinician's Roundtable* on ReachMD, and this episode is sponsored by Nestlé Health Science. Here's your host, Dr. Charles Turck.

Dr. Turck:
Welcome to *Clinician's Roundtable* on ReachMD. I'm Dr. Charles Turck, and joining me to share how we can better recognize and treat malnutrition is Dr. Dejan Micic, an Associate Professor of Medicine at UChicago Medicine who specializes in managing gastrointestinal conditions that cause nutritional disorders. Dr. Micic, thanks for being here today.

Dr. Micic:
Thank you for having me.

Dr. Turck:
So to start us off Dr. Micic, what are the early signs of malnutrition?

Dr. Micic:
To start with, the criteria that I look for in clinic are percent weight loss. When looking at weight loss like this, five pounds means a very different thing if the baseline weight is 100 pounds as compared to 200 pounds. Then I will look for subtle changes in intake and functional capacity. Basically, is the patient able to eat the same amount of their favorite food? Or is there a reduction in their usual daily activities? With greater and greater weight loss, there are often subtle changes in the patient's daily routine.

Dr. Turck:
And how do you actually diagnose malnutrition?

Dr. Micic:
Well, the diagnosis part has really been challenging, given differing opinions on criteria for a diagnosis of malnutrition. Attempts to standardize the patient assessment and diagnosis of malnutrition really started with Drs. Bruce Bistrian and George Blackburn at Harvard in the 1970s. The problem until really now has been a lack of consensus agreement on the diagnosis of malnutrition. Various scales and scores were utilized, and different opinions existed, let's say in Europe, Canada, and in the United States.

Recognizing this, a group of international experts convened in 2016 and then published in 2018 a consensus statement called the Global Leadership Initiative on Malnutrition, or GLIM Criteria for short.

This relatively broad definition of malnutrition incorporates weight loss, a low BMI, reductions in muscle mass, reductions in calorie intake or assimilation, and underlying the disease process into a scale for the diagnosis of malnutrition, with the severity of malnutrition based on weight loss and reductions in muscle mass. Now frankly, there's some work that still needs to be done on formal measurements, let's say of things like muscle mass, but this document gives us a broad view of both the causes and definition of malnutrition that we can move forward with.

Dr. Turck:
And if we notice any signs of malnutrition in the patient, what screening tools might we turn to?

Dr. Micic:
Alright, a formal assessment of one's nutritional status can take time and include objective measures like the ones we discussed of muscle mass and oral intake. In the United States and most hospitals, this is reserved for an evaluation by a registered dietitian.

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However, we cannot call on their services unless we recognize the problem. Therefore, knowing the time that it takes to evaluate an individual patient, various screening tools have been developed. I personally like to look at how the screening tools were developed to understand which ones might be best for a select population.

Some were performed specific to the geriatric literature, others for cancer or liver disease, and others specifically for inpatient or outpatient settings. These screening tools are often two and three question screenings that assign points to weight loss, oral intake, or underlying disease state. From there, patients are usually classified as well-nourished or at risk for malnutrition, which then leads to further assessment.

The Malnutrition Screening Tool, which is often abbreviated to the MST, has been validated both in inpatients and outpatients. And this is the tool that we use at our hospital on hospital admission. The score grades weight loss and asks if the patient has been eating poorly because of a decreased appetite.

If scoring two or more points, the patient is flagged as at risk for malnutrition. And then a dietitian is assigned to see the patient. The survey is performed by an admitting nurse, and the dietitian will then perform the formal nutritional assessment.

The MST and the similarly named Malnutrition Universal Screening Tool, or MUST, are probably the two most commonly utilized screening tools in the United States.

Dr. Turck:
And as a follow-up to that, would you share some best practices for adopting those screening tools into practice?

Dr. Micic:
The main points to implementation would be to first thoughtfully select a tool that is ideally validated within your population.

The screening tools can differ slightly for inpatients versus outpatients and for elderly versus non-elderly adults. Ideally, disease-specific screening tools can be used utilized, and I would expect more literature on this topic in the coming years. The second place is to design the screening within the workflow of the visit. In one of our affiliated oncology clinics, we included a patient-specific questionnaire including screening for malnutrition before the clinic visit.

Patients deemed at risk for malnutrition were then seen by that dietitian in that visit. We found that patients completed the questionnaires routinely before coming to the visit. Alternative strategies would be to use iPads at the check-in or intake questionnaires that can all be completed with minimal time requirements.

Dr. Turck:
For those just tuning in, you're listening to *Clinician's Roundtable* on ReachMD. I'm Dr. Charles Turck, and I'm speaking with Dr. Dejan Micic about the management of adult malnutrition.

So Dr. Micic, if we turn our attention to the treatment of malnutrition, what do the guidelines from the American Society for Parenteral and Enteral Nutrition have to say?

Dr. Micic:
Screening and making a diagnosis of malnutrition is really worthless if we're not going to put together a meaningful intervention. This is something that I think most physicians are really uncomfortable with. There's now acceptable data that screening for malnutrition and hospital admissions reduces the risk of morbidity and readmission risk. So most hospitals have incorporated some screening, intervention, and intervention protocols.

The American Society for Parenteral and Enteral Nutrition, or ASPEN, has a variety of clinical guidelines for both adult and pediatric patients, addressing malnutrition and nutrition support in a variety of clinical settings. Their 2011 guidance on screening and intervention recommends screening of all hospitalized adults, and when it comes to treatment or intervention, we often refer to nutrition support as personalized interventions.

Now I wish I could just say that all individuals should take in two calorie replacement drinks per day. But this is often not the solution. We have to take into account the patient's ability to swallow the supplements, absorb the nutrients, and tolerate the additional calories. Some individuals based on anatomy need feeding tubes into the stomach or small bowel, or in the setting of intestinal failure, even IV nutrition. So often nutrition support plans are personalized and put together with physicians and dieticians working together in the care of a patient.

Dr. Turck:
So how might we address the complications associated with malnutrition?

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Dr. Micic:
Well really, it's about what we've been discussing today. First, we have to recognize the problem. In my field in inflammatory bowel disease, up to 1/3 of newly diagnosed patients are malnourished. Many providers will focus on the underlying diseases as opposed to also creating a plan to combat the malnutrition. We know that malnourished patients undergoing surgery have both longer and more complicated post-operative stays and an increased risk of infection. So in order to fight these complications, for me, it's about educating physicians—not just on the diagnosis of malnutrition, but also making them more comfortable with managing malnutrition.

Whether this is through the use of oral calorie supplements or enteral nutrition or parenteral nutrition, these are basic interventions that any physician can incorporate into their practice. Frankly, I find it fun learning and understanding what we are recommending to put into a patient's body, whether it's in the in their stomach or via an IV. Managing nutrition support is an imperfect science. But it is fascinating to see how quickly individuals can improve when we address both their underlying disease and malnutrition at the same time.

Dr. Turck:
Before we close Dr. Micic, let's bring all this together. Do you have any final thoughts on how we could better recognize and treat malnutrition?

Dr. Micic:
Yes. As I mentioned previously, it is about becoming familiar with the management of malnutrition. Anyone can make the diagnosis, but we will all ignore it if we are uncomfortable with managing malnutrition. Provision of calories enterally or parenterally really requires an understanding of some very basic principles. And frankly, we are able to get most of our fellows proficient and understanding nutrition support in a remarkably quick time. On a national scale at conferences, we have to include nutrition-related topics since patients and physicians alike want to learn more about this. Locally, we are arranging conferences aimed at educating physicians on nutrition support, recognizing the deficit in training programs. So we have to get the word out on the role of the physician in the management of nutrition support. Once we have physicians that are comfortable in its management, we will then be able to include this training earlier and more broadly into training programs.

Dr. Turck:
Well with those final thoughts in mind, I want to thank my guest, Dr. Dejan Micic, for joining me to share best practices for identifying and treating adult malnutrition. Dr. Micic, it was great having you on the program.

Dr. Micic:
Thank you for having me.

Announcer:
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