

# Inpatients in the pulmonology department are screened for nutrition

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Malik S. Inpatients in the pulmonology department are screened for nutrition. *J. Pulmonol* .2022; 6(3):29-31.

### ABSTRACT

Screening is advised since undernutrition is linked to worse clinical outcomes. It is crucial that this topic be researched due to the lack of knowledge on nutritional status and the clinical effects of undernutrition in hospitalized Pulmonology patients. Undernutrition was assessed using the Malnutrition Universal Screening Tool as part of a longitudinal study of patients who had been consecutively admitted to a pulmonology hospital department. The risk of undernutrition was quantified as a function of length of hospital stay, pathology type, and discharge location. It was discovered that a significant number of patients

were at high and moderate risk for undernutrition. Hospital deaths were more likely to occur in patients who were at risk of undernutrition. outcome in therapeutic trials, it should be regularly assessed using validated questionnaires. The danger of undernutrition affects one out of every three patients admitted to this unit, with chronic obstructive pulmonary disease being the pathology most strongly linked to the risk. A screening for undernutrition should be done upon admission, according to the most recent statistics.

**Key Words:** Screening; Undernutrition; Pleural disease; Interventional pulmonology

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### INTRODUCTION

The fact that hospitalized patients are undernourished and that around of patients are at nutritional risk upon admission to the hospital is becoming more commonly acknowledged. Pathologies include Chronic Obstructive Pulmonary Disease (COPD), lung cancer, and tuberculosis appear to be linked to malnutrition. Although the risk of undernutrition in these illnesses has been researched, there is relatively little information available on the nutritional condition of patients hospitalized to pulmonology departments. The necessity of determining if the severity of this issue is proven in Portugal was supported by the frequency of undernutrition risk in a pulmonology unit. Female gender and advanced age are two of the characteristics that raise the risk of undernutrition that have already been addressed. The disease must exist since it raises the danger of infection, organ malfunction, and the need for pharmaceutical treatment. The significance of assessing and keeping track of nutritional status measures wasn't given enough emphasis in the past, but today it is commonly acknowledged that undernutrition screening is necessary. Undernutrition has negative effects on health since it increases a person's susceptibility to disease

and hinders their ability to recover, therefore screening for it is necessary. According to reports, people who are undernourished spend more time in the hospital than patients who are of normal weight. In addition to raising the risk of infections and multiorgan malfunction, death, and the strain on healthcare systems, undernutrition also has a negative impact on the economy. To the best of our knowledge, the relationship between the risk of undernutrition and hospital admission pathology, time of admission, and clinical outcomes has not been quantified for pulmonology patients. As a result, this research is necessary to increase our knowledge of the scope of the issue and determine whether the relationships previously described for other classes of diseases apply to pulmonology patients. The current study aims to characterize the undernutrition risk that patients admitted to the pulmonology unit face and to quantify any potential relationships between undernutrition risk (as determined by the Malnutrition Universal Screening Tool) and the pathology of admission, the length of hospitalization, the location of discharge. All of the patients participated in a longitudinal study that we carried out in the department of pulmonology. The Ethics Committee and Board of

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Received: 03-May-2022, Manuscript No. *puljp-22-5965*; Editor assigned: 06-May-2022, PreQC No. *puljp-22-5965* (PQ); Reviewed: 18-May-2022, QC No *puljp-22-5965* (Q); Revised: 24-May-2022, Manuscript No. *puljp-22-5965* (R); Published: 30-May-2022, DOI: [10.37532/puljp.2022.6\(3\).29-31](https://doi.org/10.37532/puljp.2022.6(3).29-31).

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Directors of this Hospital Center approved this study, and participant confidentiality was ensured. The Declaration of Helsinki's recommendations were followed when gathering all the data. The clinical files were used to gather information on age and sex demographics, clinical traits, the ailment that led to admission, length of hospital stay (number of days between admission and discharge), and destination post hospital (home, transfer to Continuing Care Unit (CCU), or death). Within the initial few hours of arrival, the must was used to assess the risk of undernutrition. Three factors form the basis of this tool: Body Mass Index (BMI), accidental weight loss over the previous three to six months, and a considerable reduction in food consumption resulting from an acute sickness lasting more than five days. It has been approved for usage in hospitals compared must to other screening and nutritional evaluation tools, such as the Mini Nutritional Assessment, Patient-Generated Subjective Global Assessment, Malnutrition Screening Tool, Malnutrition Risk Score, and Nutrition Risk Score in hospitals, and found that must was quicker and easier to use, had reasonable to excellent validity, and showed excellent reproducibility across different settings. The anthropometric assessment was carried out in accordance with protocol. A Seca scale with a built-in audiometer was used to measure both height and weight. Where these measures could not be obtained, the alternative BMI was calculated using the stated height and weight along with the Mid-Upper Arm Circumference (MUAC) according to the must recommendations. The average weight listed in the medical record was taken into account to determine the percentage of weight lost over the past three to six months. The patient's reported weight was used if available. The final must score was determined by summing the scores for each of the three factors assessed, classifying the risk of malnutrition as low, moderate, or high, depending on whether the score was more than or equal to, respectively. Calculations were made for the variables' frequencies, means, and standard deviations. Patients who passed away while hospitalized and those who were released on demand were removed from the comparison of length of hospital stay by must categorization. Using the Kruskal-Wallis test, continuous variables were compared. Comparing proportions among categorical variables was done using the Chi-square test. By applying unconditional logistic regression and further adjusting for sex and age, the Odds Ratio (OR) and its associated confidence intervals were generated to determine the strength of the relationship between the studied characteristics and the risk of undernutrition. One in three patients admitted to this unit has a high or moderate risk of undernutrition at the time of hospital admission, according to research on the frequency of pulmonology patients. Using the nutritional risk screening performed recently on patients admitted to a Chinese pulmonology unit who were at a higher risk of malnutrition than was discovered in the current investigation. The same approach. Based on a sample of patients whose risk of undernourishment was present when they were admitted to an Italian pulmonology department.

The must has been used in prior research to assess the incidence of undernutrition risk in patients from other medical specialties. Patients in one internal medicine department displayed a greater-than-average risk of malnutrition. Patients undergoing surgery also had a high risk. The features of the sample and the methodology may be used to explain these disparities. Among the illnesses that sent patients who were at a high risk of

malnutrition to the hospital, COPD, lung cancer, and pneumonia stood out. Patients with pneumonia have been found to have a higher prevalence of weight loss and nutritional status-related biochemical abnormalities, like hypoalbuminemia. These modifications could be the cause of the significant incidence of undernourishment in these patients. Tumors have a significant risk of undernutrition, according to the research. Research done on hospitalized lung cancer patients revealed a risk for undernutrition. Despite using a different undernutrition screening instrument than the one employed in the current investigation (the Mini Nutritional Assessment), a sizable number of lung cancer patients were found to be at risk for undernutrition. There may have been a lower incidence of undernutrition risk than previously thought due to the fact that some lung cancer patients have previously received nutritional counseling. Inpatient COPD patients were found to be undernourished in research that was undertaken on them. In the current study, a significant number of COPD patients had a high risk of malnutrition. Comparisons cannot be made since it is unknown if the earlier study that examined the link between the cause of admission and the risk of undernutrition was conducted in a setting similar to that of the current investigation. The majority of patients with a low risk of undernutrition were discharged home, while the number of deaths was higher in patients who were at risk for undernutrition, according to a study that compared the frequency of hospitalization outcomes according to those risks. These outcomes are in line with findings that suggest undernutrition raises the chance of death. In contrast to what has traditionally been said, it has been discovered that men are more likely to have a medium or high risk of undernutrition, and there are no differences in the length of hospital stays according to different undernutrition risk classes. This study has certain advantages; it is heterogeneous since it includes patients who were admitted for a variety of causes and it covers the whole range of illnesses managed in a pulmonology department. Because it is advised for use in hospitals and has been validated for this use, the study employed must as the undernutrition screening tool. The probability of interobserver differences and the possibility of misclassification in the undernutrition risk assessment are decreased because only one researcher collected all the data. The present study has a number of intrinsic design flaws as well as other constraints. Despite obtaining a pertinent sequential sample, patients hospitalized in the department may not fully represent the range of nutritionally pertinent Pulmonology diagnoses and phases, particularly those that are seasonal. Additionally, the statistical analysis and the inference for specific patient types were hampered by the limited sample sizes obtained in some diagnostic groups. We may infer that there was a considerable rate of undernutrition risk among patients in the pulmonology department, and those with lung cancer or COPD had the highest risk. Hospital deaths were more likely to occur in patients at risk for undernutrition. These findings highlight the importance of screening for undernutrition risk in all patients receiving pulmonology hospital care. Protection of subjects, including humans and animals. The authors state that neither humans nor animals were used in any research for this study. Information privacy. The authors affirm that they have adhered to their work center's policies on the publication of patient data and that all of the study's participants supplied written informed consent after receiving all necessary information. a right to privacy and knowledge-based consent. The patients or subjects

who are discussed in the article have provided the writers with written informed consent. This document has been produced by the corresponding author. It is becoming more and more common knowledge that hospitalized patients are malnourished and that nearly all patients are at nutritional risk upon admission. Pathologies that frequently have a connection to malnutrition include Chronic Obstructive Pulmonary Disease (COPD), lung cancer, and tuberculosis<sup>9</sup>. Despite research on the incidence of undernutrition risk in these illnesses, there is very little information available on the nutritional state of patients referred to pulmonology departments. A recent multicenter investigation was done. It was necessary to determine whether the severity of this issue is validated in Portugal after research in China showed a frequency of 55.9% of undernutrition risk in a pulmonology unit. Some of the risk factors for undernutrition, such as female gender and advanced age, have already been highlighted. The disease must be present for treatment to be effective because it raises the risk of infection, organ dysfunction, and drug use. The significance of assessing and keeping track of nutritional status measures wasn't given enough emphasis in the past, but undernutrition screening is now universally acknowledged to be necessary. Undernutrition has negative effects on health since it increases a person's susceptibility to disease and hinders their ability to recover, therefore screening for it is necessary. Patients who are malnourished are said to remain in the hospital for roughly. Times longer than patients of average weight. In addition to raising the risk of infections and multiorgan malfunction, death, and the strain on healthcare systems, undernutrition also has a negative impact on the economy. To the best of our knowledge, the relationship between the risk of undernutrition and hospital admission pathology, time of admission, and clinical outcomes has not been quantified for patients with pulmonology. As a result, this research is necessary to increase our knowledge of the scope of the issue and determine whether the relationships previously described for other classes of diseases apply to patients with pulmonology.