

Hospital Malnutrition

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ABSTRACT

Malnutrition (DN) can be defined as a pathological state determined by the lack of adequate supply of energy and / or nutrients according to the biological needs of the organism, which produce a catabolic, systemic and potentially reversible state; This may be a unique initial disorder, with all the varied symptomatic courtship of its different degrees, or it may appear secondarily as a syndrome injected along with infectious or other conditions, and then its symptoms and manifestations are more localized and precise [1]. DN can be a unique initial disorder, with all the varied symptomatic courtship of its different degrees, or it can appear secondarily as a syndrome injected along with infectious conditions or another disease, and then its symptoms and manifestations are more localized and precise [2]. Patients and the association with clinical complications, longer hospital stay and increased mortality, and the association with costs increased for the institution and society in general. The prevalence of DN in hospitalized patients has been widely documented and ranges between 19% and 80% depending on the method applied and age group [3]. Other sources dictate prevalence between 7% and 72%, the reality is unknown since it varies the criteria and methods to define it, of course, a greater number of days of hospital stay, surgical events, aggregate morbidities, medical treatment and especially dietary intake and inadequate nutrition leads to this phenomenon [4]. The nutritional risk, we reiterate, increases in patients with chronic diseases, in a state of poverty and in those with limited access to medical care; In addition, the prevalence of DN increases with age. Among the reasons why patients are at greater risk of DN is the limitation of the diet to easily digestible or chewable foods, according to their particular oral health status and the contraction capacity of the mastication muscles is diminished even with incidence in the loss of dental pieces. Limited chewing capacity makes it difficult to consume enough calories to ensure the required energy intake, since they usually consume less food, almost always a third less than the necessary calories, which results in a decrease in body weight, this combined with DN increases hospitalization time and the cost of medical care [5]. Malnutrition and the risk of suffering from it are frequent characteristics in studies on nutritional and health status [6]. A relevant point among these etiological factors is the absence of established strategies to avoid fasting, identify patients at risk of malnutrition, periodically reassess said risk, and establish prevention and treatment measures [7]. We must consider the nutritional status is the situation in which a person is in relation to ingestion and physiological adaptations that take place after the entry of nutrients [8].

Long-term DN has negative effects on cognitive and motor development, immunity and perhaps the incidence of chronic degenerative diseases. Recent reports show that malnourished patients have long, long hospital stays, and a higher cost than well-nourished patients [9,10]. With a higher prevalence in critical care units, among cancer patients and those with the highest comorbidity rates of Charlson [11]. We must strengthen health and social development programs that include nutrition and food components that have proven effective, ensuring adequate coverage and focus, as well as quality services according to the cultural situation of the communities, with special emphasis on vulnerable groups (children, older adults, marginalized communities). Develop a system for monitoring child growth and development, in real time, promoting exclusive breastfeeding during the first six months of life, and timely complementary feeding in accordance with the recommendations of the leading organizations in item [12].

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