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Opinion

Clinical Nutrition and Hydration in Geriatric Patients

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OPINION

Malnutrition and dehydration are common among the elderly, and obesity is on the rise. It's not always clear which tactics are appropriate and effective in combating these major health threats. In elderly people, nutrition is an essential modulator of health and well-being. Inadequate nutrition has a role in the progression of many diseases, and it's also thought to be a part in the complicated aetiology of sarcopenia and frailty.

A person is considered elder if he or she is 65 years old or older. A geriatric patient is not defined by their age, but rather by a high level of frailty and several active diseases, which are more common in those over the age of 80. Limitations in physical, mental, and/or social functions develop as a result of acute and/or chronic disease in combination with age-related degenerative changes. The ability to independently execute essential daily activities is compromised or lost. The person requires more rehabilitative, physical, psychological, and social care, and a comprehensive approach is required to prevent partial or complete loss of independence. Geriatric medicine's major goal is to improve an older person's functional status, allowing them to live as independently as possible while maintaining the highest possible quality of life. Older patients, on the other hand, have a lower adaptive and regenerative ability, and thus a lower capacity for rehabilitation, making it more difficult to return the patient to an unconstrained or former state.

Sarcopenia is one of the most important geriatric disorders, defined by a disproportionate loss of muscle mass and strength, as well as deterioration in physical activity, usefulness, and performance. Physical impairment, fragility, infirmity, and reliance on others occur from an excessive loss of muscle mass and strength. Sarcopenia also makes it difficult to respond to stress and disease metabolically. Despite its close resemblance to sarcopenia, frailty is a unique clinical disease marked by an increased sensitivity to stress as a result of a progressive decrease in several physiological systems as people age. Frailty is linked to an increased risk of negative health outcomes and is predicted to afflict roughly 25% of people aged 85 and up.

Nutritional intake is frequently impaired in older people due to a variety of causes, increasing the risk of malnutrition. In this setting, ageing anorexia is critical. Nutritional issues are common, especially in the case of acute and chronic sickness, and a reduced dietary intake combined with the consequences of catabolic disease quickly leads to malnutrition. Malnutrition is linked to poor outcomes in older people, including increased rates of infections and pressure ulcers, longer hospital stays, longer convalescence following acute illness, and increased mortality. In terms of malnutrition definition, we follow the ESPEN consensus and language. In this context, the presence of either a startling unexpected loss of body mass or a markedly reduced body mass or muscle mass in older people should be considered serious indicators of malnutrition that require further investigation of the underlying reasons [1-5].

The recent global consensus approach (GLIM) recommends combining at least one phenotype criterion (i.e. non-volitional weight loss, low BMI, or reduced muscle mass) with at least one aetiology criterion (i.e. reduced food intake/malabsorption or severe disease with inflammation) for the diagnosis of malnutrition. If oral intake is significantly reduced in older people, they are at danger of malnutrition (e.g. below 50 percent of requirements for more than three days) or if there are risk factors (e.g. acute disease, cognitive issues, immobility, chewing problems, swallowing problems) that may lower nutritional intake or raise requirements. Malnutrition is more likely to occur if one's functional and health status deteriorates. The prevalence rates reported vary widely depending on the criterion employed, but they are often less than 10% in independently living older people and up to two-thirds among older patients in acute care and rehabilitation facilities.

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