To be malnourished or not to be malnourished: that is the question!

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To the Editor:

In the *European Respiratory Journal*, MAITRE *et al.* [1] analysed 17 290 cases of chronic pulmonary aspergillosis (CPA) retrieved between 2009 and 2018 in the French nationwide administrative hospital database (PMSI). They demonstrated high rates of mortality, which was almost one third at 1 year. In multivariate analysis, they showed that mortality was increased in patients with malnutrition with the highest hazard ratio: 2.49, 95% confidence interval 2.05–3.04. Malnutrition, present in 33.4% of patients, was extracted from the database using the ICD-10 code. This implies that the malnutrition diagnosis should have been overtly diagnosed and collected in patients' charts or discharge reports. Because the study used the national health database it was not possible for the authors to report on which criteria was diagnosed malnutrition. We could speculate that body mass index (BMI) below 21 $kg \cdot m^{-2}$ was probably the main criteria used, since it is the commonest diagnostic tool and the cut-off value for chronic respiratory diseases such as COPD [2]. The mean BMI has been recently shown as even below this threshold (20.8±4.9 $kg \cdot m^{-2}$) in a recent cohort of CPA patients [3]. As it is well known that malnutrition is highly underdiagnosed at hospital as well as in the community setting [4], we could speculate that the prevalence of malnutrition could have been even higher than 33.4% if a systematic and multimodal assessment of malnutrition was performed. In 2019, new international guidelines for malnutrition diagnosis have been published by the Global Leadership Initiative on Malnutrition (GLIM) [5] to increase the screening and the treatment of malnutrition all over the world. The GLIM guidelines recommend assessing nutritional status by integrating five criteria: BMI, weight loss, loss of muscle mass (by bioimpedance analysis for example) or function, and reduced food intake, using semi-quantitative tools, or the presence of an inflammatory disease such as CPA. Undoubtedly, the use of a full assessment of malnutrition could have identified more malnourished patients and may have strengthened the relation between malnutrition and mortality. Therefore, based on the latter and the report of MAITRE *et al.* [1], and as we proposed in idiopathic pulmonary fibrosis patients [6], the respiratory care community should propose a more systematic and integrative screening of malnutrition in all patients with chronic respiratory diseases [7]. It is needed to better understand the relation between malnutrition and clinical outcomes, and optimise patient's care. It could be as simple as assessing weight and height at the first visit, in order to calculate BMI, assessing food intake (for example, by using the Simple Evaluation of Food Intake (SEFI®) which is a 10-point visual analogue scale) [8], measuring weight and calculating weight loss at each visit. By improving the awareness of health caregivers and stakeholders towards malnutrition, we would improve patients' quality of life and clinical outcomes as shown in COPD patients [9, 10].

Shareable abstract (@ERSpublications)
Physicians in charge of patients with chronic respiratory diseases, including chronic pulmonary aspergillosis, should be aware of the high prevalence of malnutrition. Despite simple diagnosis, it is underdiagnosed and associated with worse prognosis. https://bit.ly/3uEgEJn

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