

Editorial

Over 65s make up an ever-increasing percentage of the population, especially in Western countries. In the United States, for example, the population group living 85 years or longer is the fastest rising. Acute, hp15% of community-dwelling older people were malnourished. Exton Smith and colleagues estimated a 4% malnutrition rate in the older population of the United Kingdom in 1977. The primary causes are described in their diagram in Figure 8.5, which can also be memorised using the mnemonic MEALS-ON-WHEELS. Erdington discovered a 10% prevalence rate of malnutrition among patients living at home and suffering from cancer or chronic disease in a large general practise database in the South of England, based on BMI and anthropometric measures. McWhirter and Pennington discovered that not only were 40% of older patients malnourished when they arrived at the hospital, but that this remained largely unnoticed, with just 5% of the undernourished receiving dietary assistance. During their hospital stay, these people gained weight, whilst the majority of people lost weight [1,2].

The elderly have distinct characteristics. Body Mass Index (BMI) and standardised mortality have a link. Overweight is the greatest risk early in life. The emphasis switches decade by decade, with individuals with a low BMI having the highest mortality among the elderly. There was a clear link between mortality and anthropometrically measured nutritional status in our first broken femur investigation. We confirmed this seven years later, demonstrating that MAC was the best predictor of prognosis. The probabilities of dying rose by a factor of 0.89 for each cm drop in MAC, $p=0.0087$. Age, dementia, and TSF were all found to be significant predictors of mortality following a femur fracture. A number of studies have also found an inverse association between nutritional status on the one hand and the rate of complications, the length of convalescence, and the length of stay on the other. Nutritional intervention, on the other hand, has been found to result in faster

4. French DJ, Tait RJ (2004) Measurement invariance in the General Health Questionnaire-12 in young Australian adolescents. *Eur Child Adolesc Psychiatry* 13:1-7.
 5. Textor J, Zander BVD, Gilthorpe MK, Liskiewicz M, Ellison GTH (2016) Robust causal inference using directed acyclic graphs: the R package "dagitty". *Int J Epidemiol* 45:1887-1894.
 6. Jensen GL, Cederholm T, Correia MITD, Gonzalez MC, Fukushima R, et al. (2019) GLIM Criteria for the Diagnosis of Malnutrition: A Consensus Report from the Global Clinical Nutrition Community. *JPEN J Parenter Enteral Nutr* 43:32.
 7. Cereda E, Pedrolli C, Klersy C, Bonardi C, Quarleri L, et al. (2016) Nutritional status in older persons according to healthcare setting: A systematic review and meta-analysis of prevalence data using MNA®. *Clin Nutr* 35: 1282.
 8. Zawada ET (1996) Malnutrition in the elderly. Is it simply a matter of not eating enough? *Postgrad Med* 100:207.
 9. Kondrup J, Rasmussen HH, Hamberg O, Stanga Z (2003) Nutritional risk screening (NRS 2002): a new method based on an analysis of controlled clinical trials. *Clin Nutr* 22:321.
 10. Vellas B, Guigoz Y, Garry PJ, Nourhashemi F, Bannahum D, et al. (1999) The Mini Nutritional Assessment (MNA) and its use in grading the nutritional state of elderly patients. *Nutrition* 15:116.
-