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Letter to the Editor

Response to the letter: Comment on "GLIM criteria for the diagnosis of malnutrition – A consensus report from the global clinical nutrition community". Some considerations about the GLIM criteria – A consensus report for the diagnosis of malnutrition by Drs. LB da Silva Passos and DA De-Souza

Dear Editor,

Thank you for giving us the opportunity to respond to the comments on the GLIM consensus report submitted by our honored colleagues Dr. da Silva Passos and Dr. De-Souza. This allows us to clarify potential uncertainties in the GLIM report.

The first issue is that the NUTRIC Score was not highlighted as a screening tool in the GLIM report. However it is clearly stated that any validated screening tool could be used in the first screening step, meaning that the NUTRIC score is not excluded. We further agree that "performing nutritional screening is already well established". The GLIM report emphasizes that assessment by the GLIM diagnostic criteria do not replace screening, but rather that screening is a fundamental first step.

Perhaps the major issue raised by Drs. Da Silva Passos and De-Souza is that the GLIM criteria are difficult to apply to critically ill patients, due to prevalent fluid retention and shifts in fluid balance leading to weight gain and high body mass index. However no claims were made in regard to application of the GLIM criteria to critically ill patients. Critically ill patients usually are in states of severe catabolism and consequently at high nutritional risk. We agree that it is difficult to diagnose overt malnutrition in these patients. To define malnutrition under such conditions is a challenge that should be met primarily by the professionals within the critical care community. The validity or lack thereof for application of the GLIM criteria in critically ill patients remains to be established. While use of a low body mass index criterion is problematic in the ICU, it should be noted that the other phenotypic criteria, history of prior weight loss and decline in muscle mass, are both relevant to critically ill patients, as are both of the etiologic criteria, reduced food intake or assimilation, and inflammation or disease burden.

The next issue raised was that the criteria chosen are the same as those used in other validated tools. We clearly state that the GLIM criteria were selected precisely because they are common to existing validated approaches, including SGA. Since there is no single approach to malnutrition diagnosis that has captured broad global acceptance, we secured consensus around key phenotypic and etiologic criteria that have near universal acceptance. It is emphasized that the GLIM criteria may be readily used in combination with existing approaches of regional preference.

Finally, concerns were raised that the GLIM approach may be too sensitive, with a risk of excessive false positive diagnoses. This hypothesis remains to be confirmed. It is possible that many patients that previously were identified as being at risk for malnutrition will be diagnosed as moderately malnourished by the GLIM criteria. This may be justified by the fact that being "at risk", or already at displaying any of the five criteria separately, is linked to negative clinical outcomes. Cost-generating nutritional interventions that promote improved outcomes need to be started before the onset of severe malnutrition.

Some of the questions raised should be addressed by on-going validation studies. It is likely that diagnostic criteria and thresholds will evolve over time. Future knowledge, evidence and experience will be the foundation for coming up-dates of the GLIM diagnostic approach.

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