

Research article

## Prediction of malnutrition using Modified Subjective Global Assessment- dialysis Malnutrition Score in patients on chronic Hemodialysis

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### Abstract

**Background:-** Malnutrition is a relatively common problem in patients on hemodialysis (HD) and is associated with increased morbidity and mortality in affected patients. Many factors may contribute to malnutrition in these patients . There is no single measurement that can reliably predict the risk for malnutrition. With the aid of subjective global assessment (SGA), the malnutrition score (MS), has been developed. The MS incorporates advantages of the SGA while extending the reliability and precision.

**AIM OF STUDY:** Our aim was to determine the prevalence and severity of malnutrition among hemodialysis (HD) patients in Merjan hospital / dialysis center in Iraq by using modified subjective global assessment , and to examine the relationship between various nutritional and non-nutritional factors in those patients .

### PATIENTS AND METHOD

This cross-sectional study was undertaken in Merjan hospital dialysis center in Babylon during the period from 1<sup>st</sup> of March to 30 of June 2013. Seventy five participants diagnosed with end-stage renal failure (ESRD) were enrolled. These participants who underwent hemodialysis treatment were recruited using a convenience sampling technique. Modified Subjective global assessment (m-SGA), anthropometry, and biochemical measurements were used as evaluative tools.

**RESULTS:** Nutritional status of the patients was assessed. Mean age of the study population was 51.16±15.03years. males were older than females . The mean of malnutrition score was 18.61 ± 6.17 This study show that 32% of our patients were Diabetic , while 68% of them were hypertensive, About 68 % of those patients had dialysis in frequency of twice per week. Based on MS, (71%) had mild to moderate malnutrition, (23%) patients were having severe malnutrition and remaining (6%) had normal nutrition score. There was no significance of the nutritional status with age , sex, occupation or smoking habit , while there was a significance

with residence of patients , cause of renal failure and frequency of dialysis that our patients had regarding the laboratory investigation , nutritional status show a significance only with serum albumin , and serum phosphate. 99% of our patients were anemic. The anthropometric measurements done were basal metabolic rate BMI , waist / hip ratio W/H ratio ,mid arm circumference MAC . the nutritional status was significant with the mid arm circumference MAC , while there was no significance between nutritional status and basal metabolic rate BMI, and waist / hip ratio W/H ratio .

#### CONCLUSIONS:

We conclude from this study that the frequency of malnutrition is high among patients in our dialysis center , mostly the mild to moderate malnutrition .Most of our patients on maintenance hemodialysis had nutritional problem, according to the malnutrition score which includes many variables .In addition , this study show that the nutritional status affected by frequency of hemodialysis and a single measure is not enough for nutritional assessment for patients on maintenance hemodialysis .We conclude also that there is many indicator show deterioration in nutritional status of patients on maintenance hemodialysis including HB%, S. albumin .The malnutrition score is compatible with some of the anthropometric measurement (mid arm circumference ) results and can be used as a reliable, rapid, and precise method for nutritional assessment in office, hospital and HD centers. Furthermore, malnutrition score is preferred in comparison with other time-consuming methods for nutritional assessment .This study also show that the main causes of chronic renal failure are Diabetes mellitus and hypertension.

Finally, malnutrition severity correlate with residence more severe malnutrition is more in rural area population..

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## Introduction

Chronic kidney disease (CKD) is currently a public health problem (SBN *et al.*,2009) .More than 60 million worldwide people lose their lives annually due to the risk of kidney failure (Mojahedi *et al.*, 2008). CKD is a slow, progressive, and irreversible loss of kidney function(SBN *et al.*, 2009) Because this loss is slow and progressive, it results in an adaptive process in which the patient remains asymptomatic for some time(Romão *et al.*,2004) .When the kidney fails to perform most of its function, the clinical state is labeled end-stage renal disease (ESRD), and dialysis or transplantation is required to sustain life.( ceciél 2007) Hemodialysis (HD) is the most common renal treatment today. (Sesso *et al.*, 2010)

Malnutrition is common in haemodialysis patients and may affect as many as 40% of patients ,and is associated with increased mortality and morbidity.( Beekley *et al.*,2007) The cause of malnutrition is multifactorial and includes: inadequate food intake, hormonal and gastrointestinal disorders, dietary restrictions, drugs that alter nutrient absorption, insufficient dialysis, and constant presence of associated diseases. Furthermore, uremia, acidosis, and HD procedure are hyper catabolic and associated with the presence of an inflammatory state(Shah *et al.*,2009).Management of the nutritional aspects of chronic kidney disease (CKD) presents a number of challenges. Most of the standard methods for assessing nutritional status can be applied to patients with renal failure, however , some of these parameters are altered by uremia Currently, with the use of modern technology in dialysis, malnutrition is less prevalent in those patients undergoing maintenance haemodialysis .However

,there is evidence suggesting that many factors that promote malnutrition in renal failure even with modern methods of haemodialysis treatment.(Beekley *et al.*,2007)

Nutritional status may be assessed by measuring Anthropometric variables , using several methods. These methods include dual-energy X-ray absorptiometry, bioelectric impedance analysis, and total body protein. (Sarkar *et al.*,2005) However, these methods are expensive, cumbersome , rarely available, and impractical for routine use (Bollag *et al.*,2000) More recently, subjective global assessment (SGA) was used to assess nutritional status in hemodialysis patients. It was reported that the use of SGA in detecting malnutrition is simple, valid, noninvasive, and applicable,( Anees *et al.*, 2004), and its use correlates Significantly with nutritional parameters (Julien *et al.*, 2001).

Subjective Global Assessment (SGA) is a tool used by health care providers to assess nutritional status and aid in the prediction of nutrition -associated clinical outcomes, such as postoperative infections (Detsky *et al.*,1987) and/or mortality.( Canada 1996) The tool has many strengths in the clinical and research setting: it is inexpensive; is rapid to conduct ; can be used effectively by providers from different disciplines, such as nursing, dietitians, and physicians; and in some studies has been found to be reproducible, valid, and reliable(Jones *et al.*,2004)Because of its strengths, SGA has been recommended by the National Kidney Foundation (NKF) Kidney Disease/Dialysis Outcomes and Quality Initiative (K/DOQI) for use in nutritional assessment in the adult dialysis population.( K/DOQI 2000)

The incidence of patients with end-stage renal disease being treated by renal replacement therapy varies enormously depending on the level of affluence of the country. The highly developed countries such as North America, Europe, and Japan have the highest incident rates of treated end-stage renal failure, whereas the emerging countries have very low incident rates. There are now over 1 million dialysis patients worldwide, with an incidence of about a quarter of a million new patients each year ( Moeller *et al.*, 2001).

Malnutrition is considered a marker of poor prognosis in CKD(Shah *et al.*,2009). The patients' nutritional status is inversely associated with increased risk of hospitalization and mortality; thus constituting an important risk factor for the outcome of these patients(Pupim *et al.*, 2006). Therefore, assessing the nutritional status of patients is essential both to prevent malnutrition and to indicate appropriate intervention in malnourished patients(Segall *et al.*,2009).

### **Patients and methods:-**

Across sectional study was conducted in Hilla city, in a Merjan Medical City (the Center for dialysis), during the period from 1<sup>st</sup> of March to 30 of June 2013.A 75 patients was collected by study application during the period from 16 of March to 30 of June 2013.The sample was convenient( any patient present at time of data collection was included in the study) . The inclusion criteria for patient were:

1) age 18 years or older; 2) hemo- dialyzed for at least six months with continuing dialysis at least one time a week; 3) not hospitalized or discharged from hemodialysis sessions ; and 4) absence of enteral or parenteral feeding.5) who agreed to participate in the study by verbal consent. While the Exclusion criteria for patients:

1) patients who were unable to answer the questionnaire (difficulty in understanding questions, visual or hearing impairment ,severely ill patient or uncooperative family );2) those who refused to answer the screening criteria( because they are ill or tired ) ;3) those admitted to the hospital or discharged from dialysis (defined as having acute renal failure); 4)those transferred for renal failure monitoring in another city or without

identification of the transfer site;5) and those who answered less than 50% of the questionnaire( incomplete answer for all questions ).

The approval of the ethics committee in the hospital was obtained.

All patients were informed about the nature of the study. They were also informed that their participation in this study is voluntary and they have the right to withdraw at any time without any penalization and their refusal to participate and withdraw will not affect their treatment at the Center.

A specially designed data sheet was used; to assess the risk factors of malnutrition of maintenance hemodialysis patients at dialysis center in Merjan Medical City and this sheet contain:

1. Questionnaires.
2. anthropometric measurements (post –dialysis weight, height, BMI, WC, WHR,MAC,).
3. Biochemical investigations

The patient read and signed the consent form. However, if the patient was illiterate, the caregiver read the consent form to him/her and then the patient made a simplified mark or thumb print on the consent form. After obtaining consent, the patient was asked questions from the Personal, Diet, and Health Questionnaire

Data collection took place in three steps. The first step was to interview with patients and to fill out the questionnaires, and the second steps was to perform the anthropometric measurements and the last one to take the biochemical investigations

### **Questionnaires:**

Divided into four sections:

**Section 1:**include socio demographic factors :- name, gender, age , residential location(urban or rural), employment, income, number of people living in the same household, and smoking

**Section 2:** include health-related risk factors: - include the number of years the patient has lived with kidney disease, the number of years on hemodialysis, number of dialysis session per week , the presence or absence of co-morbid diseases DM and its duration , Hypertension and its duration, IHD, history of obstructive uropathy, SLE ,history of analgesia intake

**Section 3 modified Subjective Global Assessment:** The modified SGA has been indicated as a reliable and valid tool for the nutritional assessment of hemodialyzed patients .The modified SGA includes two major categories: the history and physical examination. The history portion of five sections: weight/weight change; dietary intake; gastrointestinal symptoms; functional capacity; and disease state/co-morbidities as related to nutritional status. For weight/weight change, the patient's weight loss from the preceding six months is recorded along with the current weight. To obtain the dietary intake of the patient, the patient was asked to recall all foods and beverages consumed during the previous 24 hours. Gastrointestinal symptoms such as, nausea, vomiting, and/or diarrhea, anorexia were recorded from the patient's self report. The gastrointestinal symptoms are considered significant if most or all symptoms have persisted for at least two weeks. Short term or intermittent symptoms are not considered significant. To assess physical functional status, patients were asked to describe their physical capabilities. The functional capacity must be related to changes associated with nutritional status (e.g. anemia, low dietary intake), and changes in the previous six months. The final feature of the history portion is co-morbid diseases related to nutritional needs (e.g. hypertension, diabetes). The second major category of the modified

SGA is the physical examination. The physical examination includes an evaluation of the patient for fat and muscle wasting and edema. The area below the eye and around the triceps and bicep muscles was evaluated to determine subcutaneous fat loss. Muscle wasting was assessed by examining the temporalis muscle, prominence of the clavicles, the contour of the shoulders (rounded indicates well-nourished; squared indicates malnutrition), visibility of the scapula, interosseous muscle between the thumb and forefinger, and the gastrocnemius muscle. The area of the ankles was evaluated to determine edema. In HDP, it is critical that weight change and edema be assessed in tandem to determine if tissue wasting is masked by fluid retention. Each component has a score between one (normal) to five (very severe). After completion of physical examinations, patients were placed in one of three groups: well nourished, mild to moderate malnutrition and severe malnutrition. Thus MS has a total score between 7 and 35. Patients having MS score between 7-10 are considered as well nourished patients. MS score between 11-22 are considered as having mild to moderate malnutrition. Likewise score between 23 and 35 are considered as severely malnourished. (Reza afshar *et al.*, 2007). Therefore, a lower score denotes tendency towards a normal nutritional status. A higher score however is considered to be an indicator of the presence of malnutrition elements, i.e. the higher the nutritional score, the stronger the tendency towards protein calorie malnutrition.

Total nutritional scoring for each patient was assessed within 20 min. Nutritional assessment by means of the modified quantitative SGA was performed on all 75 dialysis patients. The measurements were:

1. Body mass index (BMI):

Measured according to the formula of  $[\text{Wight (kg)} / \text{Height (m}^2)]$  in which the weight was measured in (kilogram) using the balanced digital scale for all subject (wearing light clothing) with an accepted error of 0.1 kg. Height was measured (in meter) using a flexible tape measures to the nearest 0.5 cm with the patient standing without shoes, heels together and the head in the horizontal plane. BMI classification is: **<18.5** (Under weight), **18.5-24.9** (normal), **25-29.9** (pre-obese), and **30 or more** (obese).

2. Waist circumference (WC) and waist to hip ratio (WHR):

The (WC) can be calculated to assess the central obesity, which was taken to the nearest 0.5 cm with a flexible non stretchable tape measure on the horizontal plane at the level midpoint between the lower rib margin and the iliac crest.  $WC \geq 102$  cm for men and  $\geq 88$  cm for women were regarded as indicators of risk of co morbidities. The (WHR) measured by the ratio between waist circumference (WC) to hip circumference (HC) which was taken as the maximal circumference around the buttocks posteriorly and pubic symphysis anterior to the level of a greater trochanter, we depended on the criteria of NCEP/ATPIII for the cutoff points, the ratio of (WHR) was considered as indicators of increased risk of co morbidity if  $>1$  in male and  $>0.85$  in female.

3. Mid-arm circumference was measured with a flexible non stretchable measure tape. The patient was asked to stand with his/her feet together, shoulders relaxed, and arms hanging freely at the sides. The non access (fistula free) arm was located to avoid the possibility of an inaccurate measurement due to fluid retention in the arm with the fistula. The midpoint on the posterior aspect of the upper arm was established between the acromial and olecranon and marked with a pencil. The measuring tape was placed around the upper arm at midpoint and pulled snugly enough to ensure contact with the arm. The measurement was recorded to the nearest centimeter.

With the patient's permission, the patient's file was examined to acquire the necessary biochemical data such as, s. creatinine, blood urea, s. calcium, s. albumin, s. phosphate, s. potassium, s. sodium and PCV.

A questionnaire form was prepared by researcher and supervisors, following a review of related literature and our reference about risk assessment of malnutrition in adults on maintenance hemodialysis.

## The results

This study has been carried out at Merjan Medical City. Out of patients visited dialysis unit at the time of data collection, seventy five patients had been selected and data was collected using questionnaire.

Table 3 shows mean differences of age of study population by gender. There was significant difference between the mean age of male ( $54.34 \pm 13.69$ ) years old and female ( $47.32 \pm 15.86$ ) years old,  $t= 2.056$ ,  $df=73$ ,  $p= 0.043^*$ .

Figure 1 shows the distribution of the study population by the cause of renal failure . (32%) of study population presented with diabetic nephropathy , (26%) presented with hypertensive nephropathy while only (7%) presented with obstructive uropathy and pyelonephritis as a cause of renal failure .

Figure 2 shows the distribution of the study population by body mass index . Majority (51%) of study population were normal (18.5-24.9) while only (8%) were underweight (<18.5) .

Figure 3 shows the distribution of the study population by type of functional impairment . (48%) of study population presented with difficult ambulation ,(16%) of them presented with bed or chair ridden and only (12%) presented with other types of functional impairment .

Figure 4 shows the distribution of the study population by smoking habit . Majority (69%) of study population were non smoker while only (5%) of them were smoker .

Figure 5 shows the distribution of the study population by frequency of dialysis . Majority (68%) of study population presented with twice per week dialysis frequency .

Figure 6 shows the distribution of the study population by modified subjective global assessment score to assess the nutritional status for patients with renal failure . Majority (71%) of study population presented in mild to moderate malnutrition while only (23%) of them presented with severe malnutrition .

Table 4 shows the association of nutritional status (well nourished ,mild to moderate malnutrition and severe malnutrition) by study variables including (age , sex , occupation , residence , smoking habit , cause of renal failure and dialysis frequency).There was significant association between nutritional status with cause of renal failure and dialysis frequency, meanwhile there was no significant association between nutritional status and other study variables . (59%) of those patients with severe malnutrition presented with age of (40-60) years , (53%) of them were male ,(76%) of them were not employed, (65%) of them came from rural area ,(23%) of them presented with diabetic nephropathy as cause of renal failure and (94%) of them presented with once per week frequency of dialysis .

Table 5 shows the association of nutritional status (well nourished ,mild to moderate malnutrition and severe malnutrition) by laboratory investigation including (serum creatinine , serum calcium , serum sodium , phosphate , serum potassium , serum albumin and packed cell volume).There was significant association between nutritional status with phosphate and serum albumin levels, meanwhile there was no significant association between nutritional status and other laboratory investigation,(100%) of patients with severe malnutrition with high serum creatinine, (53%) of them with hypocalcaemia, (100%) of them with

hyponatremia, (65%) of them with normal serum potassium level , (65%) of them with high serum phosphate level, (94%) of them with low serum albumin level and (100%) of them presented with anemia .

Table 6 shows the association of nutritional status (well nourished ,mild to moderate malnutrition and severe malnutrition) by body mass index and waist to hip ratio .There was no significant association between nutritional status with body mass index and waist to hip ratio . (47%) of patients with severe malnutrition presented with normal body mass index (18.5-24.9) while only (23%) of them presented with high risk waist to hip ratio (> 1 in male or >0.85 in female) .

Table 7 shows the mean differences of mid arm circumference by nutritional status (well nourished ,mild to moderate malnutrition and severe malnutrition) among patients with renal failure . There were significant differences between means of mid arm circumference for study groups .

## DISCUSSION

Malnutrition is a frequent complication which affects quality of life and is associated with increased risk of mortality and morbidity in maintenance hemodialysis patients(Neumayer *et al* .,2001)(Heys *et al* ., 1999). Compounding factors for malnutrition in hemodialysis patients are numerous. Nevertheless, the nutritional status of dialysis patients is frequently ignored. Most indicators, especially biochemical markers such as serum albumin, are useful in identifying high risk patients with malnutrition. They do not necessarily correlate with changes in other parameters and can be influenced by non nutritional factors, such as concomitant liver disease, iron deficiency anemia and chronic inflammation(Smedley *et al*.,2004)(Potter *et al* .,1998). Several methods of nutritional state evaluation are available .However, these methods are costly and time-consuming, which restricts their use to a few research centers. Detsky *et al* . (Detsky *et al* ., 1984) defined special methodology, named Subjective Global Assessment which was designed to circumvent many of these problems. SGA is a reproducible and useful method for assessing the nutritional status of MHD patients. It is inexpensive, can be performed rapidly, requires only brief training and gives a global score of protein energy nutritional status(Persson *et al* ., 1999).

In this study the mean of age of maintenance hemodialysis patients was

51.16 ±15.03 , the average of dialysis malnutrition score (DMS) was 18.61± 6.17 while in study of Soodeh., *et al* 2010 in Iran(Soodeh., *et al* 2010) ,The mean of DMS was 16.6 ± 5.19 ,in another study done in India by Vansantha .,*et al* 2011(Vansantha .,*et al* 2011), the mean of DMS was 17.9±2.85 .regarding the means of BMI &WHR of our patients they were 25.21± 5.80, 0.95±0.09 respectively .

Twenty four of these patients had Diabetes (32%) ,7% of those were type- I DM and 25% were type - II DM. Fifty one of our patients were hypertensive (68%) while only seventeen of them (23%) had ischemic heart disease ,in study performed by Al Saran K in Saudi Arabia(Al Saran(1) *et al*.,2011), (81%) were hypertensive, (45%) were diabetic, (27%) had ischemic heart diseases.

Most of the patients were male (55%) ,the mean of age for them was 54.34±13.69 years. The male were older than the female ,for the female (45%) the mean of age was 47.32±15.86 years old (table 1).

Regarding the causes of chronic renal failure in our study the main causes were Diabetes nephropathy (32%) and hypertensive nephropathy (26%), while least one was that for obstructive uropathy and pyelonephritis (7% for each one) these results agree with a study in Iran done by Malkmakan *et al* 2009 (Malkmakan *et al* 2009) in which the main causes of chronic renal failure were hypertension (30.5%) and Diabetes (30.1%). Another study in Iraq Al-Anbar by Awad SM 2011 (Awad *et al*., 2011) found that Diabetes mellitus (33%) and hypertension (22.6%) were the most common causes of chronic renal failure in Iraq, followed in order by obstructive uropathy in 17.3%, and pyelonephritis in only 4.7%. These results attributed to sedentary lifestyle, lack of healthy diet (most of our diet rich in fat and carbohydrate), lack of exercise and these certainly increase the risk of obesity and its complication.

Most of patients have normal BMI (BMI=18.5-25) (51%), while 8% of total patients were underweight (BMI<18.5), and (21%, 20%) of them were pre-obese (BMI=25-30), and obese (BMI>30) respectively. In a prospective multicenter cohort study, researchers from the Netherlands found that baseline BMI was: below 20 kg/m<sup>2</sup> (7.5%), 20 to 25 kg/m<sup>2</sup> (47.0%), 25 to 30 kg/m<sup>2</sup> (34.5%), and 30 kg/m<sup>2</sup> or higher (11.0%) (Nancy, 2011). In a study done at large Saudi center for dialysis by Al Saran *et al.*, 4% of the patients were found to be underweight, 49% had average weight, 27.5% were overweight, 14% were obese, and 5.5% had morbid obesity (Al Saran(2) *et al.*, 2011)

In addition to the physical limitations in functioning caused by renal failure and its co-morbidities, HD patients have various restrictions resulting from HD therapy requiring radical lifestyle changes. Therefore, HD patients tend to have both physical and psychosocial problems (Hideyo *et al.*, 2011). In spite of that 12% of patients in our study have no physical impairment, the majority of them (48%) presented with difficult ambulation, while only 16% of them were bed or chair ridden.

Regarding the smoking habit 5% of population of the study were smoker, the majority (69%) were non smoker and (26%) were x-smoker, in USA, Mc Causland *et al* found that 17% of hemodialysis patients were current smokers and 32% were former smokers (Mc Causland *et al*., 2012). Another study in New Zealand by Geoffrey Braatvedt *et al*., show that Seventeen percent of the total cohort study population were current smokers, 45% former smokers and 38% lifetime non smokers at dialysis commencement (Geoffrey *et al.*, 2006).

Regarding the frequency of dialysis, 24% of them get dialysis once per week, while 8% for that who get it trice per week, the majority was for those who get dialysis twice per week (68%)

The modified subjective global assessment score in our patients show that there is 6% of total study population were well nourished, 71% were classified as mild to moderate malnourished, and 23% were defined as severely malnourished, in India by Vansantha *et al* Based on the modified SGA scoring method, 91% patients were mild to moderately malnourished (Vansantha *et al* 2011), the study of Dr. Dhiraj Narayan Manandhar found (84.6%) had mild to moderate malnutrition, (7.7%) patients were having severe malnutrition and remaining (7.7%) had normal nutrition score (DN Manandhar *et al*., 2008). Soodeh *et al* found that in a study done Iran on hemodialysis patients that (32.1%) patients were classified as well nourished, (49.1%) as mildly to moderately malnourished, and the (18.8%) as severely malnourished (Soodeh., *et al* 2010), another study in Iran by Reza Afshar *et al.*, 2007 found that, based on the MS, 59.3% of patients were well nourished (MS = 7-10), 35.1% had mild to moderate malnutrition (MS = 11-22), and 5.6% had severe malnutrition (MS = 23-35) (Reza Afshar *et al.*, 2007). In a study of Swedish patients on hemodialysis,

Qureshi et al. (Qureshi *et al.*, 1998) showed that 36% were well nourished, 51% were mildly malnourished, and 13% were severely malnourished. Forty-six percent of patients on hemodialysis were found to be well-nourished, whereas 34% were moderately nourished, and 20% were poorly nourished, according to SGA, in New York, NY (Kalantar *et al.*, 1998).

Many factors play a role in causing variations in the prevalence of malnutrition in different studies. These factors include variations between the countries that conducted those studies, sample heterogeneity, and diversity in dietary patterns, socioeconomic status, co morbidities, and medical care at hospitals from one country to another, or even within the same country. In addition, the dose and conditions of dialysis may influence the rate of developing malnutrition (Schulman *et al.*, 2004). The experience of the caregiver who administers the SGA may also influence the classification process (Raguso *et al.*, 2004). The cause that there was high percentage of this study's population had severe malnutrition may be due to low dose of dialysis (inadequate, non efficient dialysis) in our center, as there is interrelation between adequacy of dialysis and malnutrition in patients on maintenance hemodialysis. All the available evidence in hemodialysis patients confirms the close association between dialysis dose and biochemical outcome. A body of evidence also highlights the existence of relationship between malnutrition and outcome among these patients. Dose of dialysis and nutrition are considered to be interrelated (Azar *et al.*, 2007).

This study shows no significance with age of the patients, this agrees with study of Vansantha *et al.* (Vansantha *et al.* 2011) which shows that there is no correlation between age and malnutrition, also study by Soodeh *et al.* (Soodeh *et al.* 2010), show no significance between malnutrition and age of the patients, other study by Kalantar *et al.*, show a significance between age and malnutrition (Kalantar *et al.*, 1999).

In addition there is no significance between degree of malnutrition and the gender of the patients of this study. The study of Soodeh *et al.* (Soodeh *et al.* 2010), as well as study of Vansantha *et al.* (Vansantha *et al.* 2011), and Kalantar-Zadeh *et al.* (Kalantar *et al.*, 1999).

show no significance of malnutrition and sex of the patients. 53% of those with severe malnutrition were male, while 47% of them were female.

Only (24%) of our patients in the study were employed, while the rest of them (76%) were non employed, in a study in Saudi Arabia by Khadija *et al.*, the majority of the patients (80.3%) did not earn an income (retired, housewife, student, unemployed) (Khadija *et al.*, 2012). In another study done in Saudi Arabia by Zaki S., 22.6% of patients are employed and 1.6% are businessmen (Zaki, 2004).

There is a significance between residence and malnutrition. Most people with moderate or severe malnutrition, were from rural area (61%), this may be due to low educational level of the patients with co-morbidity like those with Hypertension, or Diabetes regarding the complication of the disease and the need for good control.

In addition there was significance between malnutrition score and frequency of dialysis, the least the dialysis frequency, the more severe degree of malnutrition.

Regarding the laboratory finding in population of the study, the table 4 shows a significance between malnutrition and serum phosphate, and albumin level, other studies like Vansantha *et al.*, show a significance between malnutrition score and s. albumin while there was no significance with s. creatinine (Vansantha *et al.* 2011). The research shows that serum albumin can be used as an indicator of malnutrition in severe cases. Inflammation is considered the major contributor in the decreased serum albumin of patients on hemodialysis (Visser *et al.*, 1999). However, Desbrow *et al.* (

Desbrow *et al.*,2005) found a significant inverse correlation between degrees of SGA and serum albumin ( $r = -0.28$ ,  $P = .038$ ). Tirmentajn-Jankovic and Dimkovic (Tirmentajn *et al.* , 2004) demonstrated the presence of a significant reduction in total protein and serum albumin as SGA grades increased. Regarding the serum creatinine , our study show that 99% of our patients had s. creatinine more than normal ,this agree with study done in Iraq Al-Najaf by Ibrahem A. Kadhum *et al.*, the results show that all the study subjects (100%) present with high level of S.creatinine above the normal level(Ibrahem *et al.* , 2012).

Measurements of hemoglobin revealed the presence of anemia in all study populations, including patients in mild malnutrition . Anees et al(Anees *et al.* ,2004) demonstrated that 41 of 51 patients on hemodialysis were anemic. In ESRD, a low level of hemoglobin may result from many causes; hence, it is unreasonable to measure hemoglobin when assessing nutritional status. Ibrahem A. Kadhum *et al.*, also show that 100% of his study population were anemic (Ibrahem *et al.* , 2012).

There was no significance between the malnutrition status and the BMI, 47% from those with severe malnutrition had normal BMI. Many studies show that there was a significance of malnutrition status with BMI, as in study of Kalantar *et al.* (Kalantar *et al.* , 1999), Khadija *et al.* ( Khadija *et al.* , 2012) in Saudi Arabia . However , Demirag A. *et al.* ( Demirag *et al.* , 2009), found that there is no significance between malnutrition status and BMI. This variation may be due to in adequate dialysis in those patients , and as a result , the remained edema affects the weight measurement and BMI calculation . for this reason we cannot depend on BMI in nutritional assessment of those patients.

Regarding MAC measurement , it was significant with nutritional status , many studies show significant relationship between MAC and malnutrition such as Ibrahem A. Kadhum *et al.*, in Al-Najaf Al ashraf (Ibrahem *et al.* , 2012), study of Kalantar *et al.* ,in USA (Kalantar *et al.* , 1999), DN Manandhar *et al.* ,in Nepal(DN Manandhar *et al.* , 2008), Vasantha et al ., in India (Vansantha .,et al 2011),and Soodeh et al ., in Iran (Soodeh., et al 2010). However , Demirag A. *et al.* ( Demirag *et al.* , 2009), show that there was no correlation between nutritional status and MAC.

### **Limitations:**

1. Not all responders gave their consent to fill the questionnaire.
2. Limited time for data collection.
3. The data are based on self-reports of the patients, possibly leading to under or over reporting therefore, information bias cannot be excluded.

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**Table 1: Mean ± SD of study variables of study population**

Variable	Mean ±SD
Age (years)	51.16 ± 15.03
Serum creatinine (µmol/l)	674.16 ± 290.26
Potassium (mmol/l)	4.81 ± 0.93
PCV	26.86 ± 4.79
Body mass index (Kg/m <sup>2</sup> )	25.21 ± 5.80
Waist to hip ratio (WHR)	0.95 ± 0.09
Modified SGA score	18.61 ± 6.17

\*Modified SGA : Modified subjective global assessment

**Table 2 : Distribution of study population by medical history**

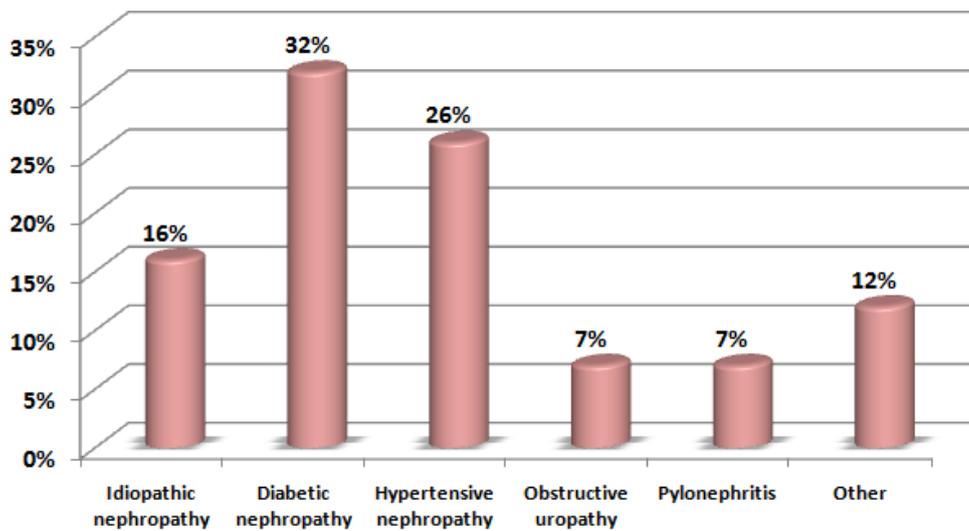
Variable	Number	%
<b>Diabetes</b>	<b>24</b>	<b>32%</b>
Type 1	5	7%
Type 2	19	25%
<b>Hypertension</b>	<b>51</b>	<b>68%</b>
<b>Ischemic heart disease</b>	<b>17</b>	<b>23%</b>
<b>Hepatitis (B and C)</b>	<b>7</b>	<b>9%</b>
Hepatitis -B	4	5%
Hepatitis -C	3	4%
<b>Bed ulcer</b>	<b>2</b>	<b>3%</b>
<b>Asthma</b>	<b>3</b>	<b>4%</b>
<b>Malignancy</b>	<b>1</b>	<b>1%</b>
<b>SLE</b>	<b>1</b>	<b>1%</b>

**Table 3 : The mean differences of age of study population by gender**

Variable	Categories	N	Mean ± S.D	t-test	df	P value
<b>Age</b>	Male	41	54.34 ± 13.69	2.056	73	<b>0.043*</b>
	Female	34	47.32 ± 15.86			

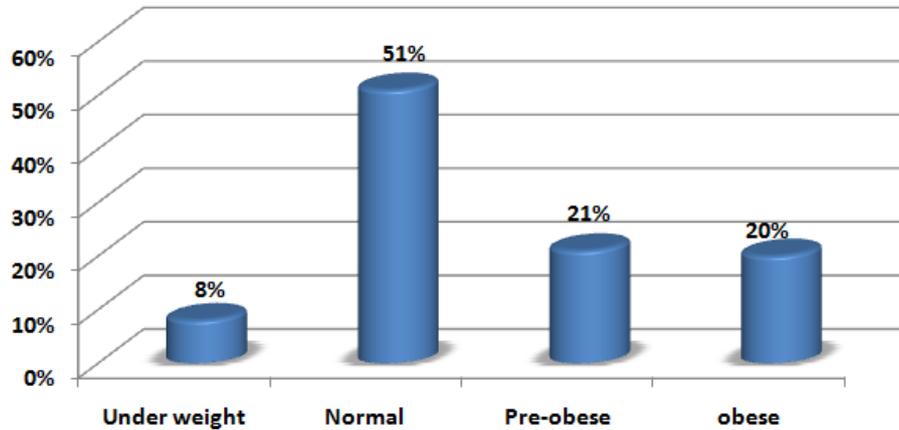
\*p value ≤ 0.05 was significant

\*\*p value ≤ 0.01 was significant



**\*Other including : brucellosis , polycystic kidney, schistosomiasis and SLE nephropathy**

**Figure 1 : Distribution of study population by the cause of renal failure**



**\*Under weight (<18.5),normal(18.5-24.9),pre-obese(25-29.9)and obese(30 or more)**

**Figure 2 : Distribution of study population by body mass index**

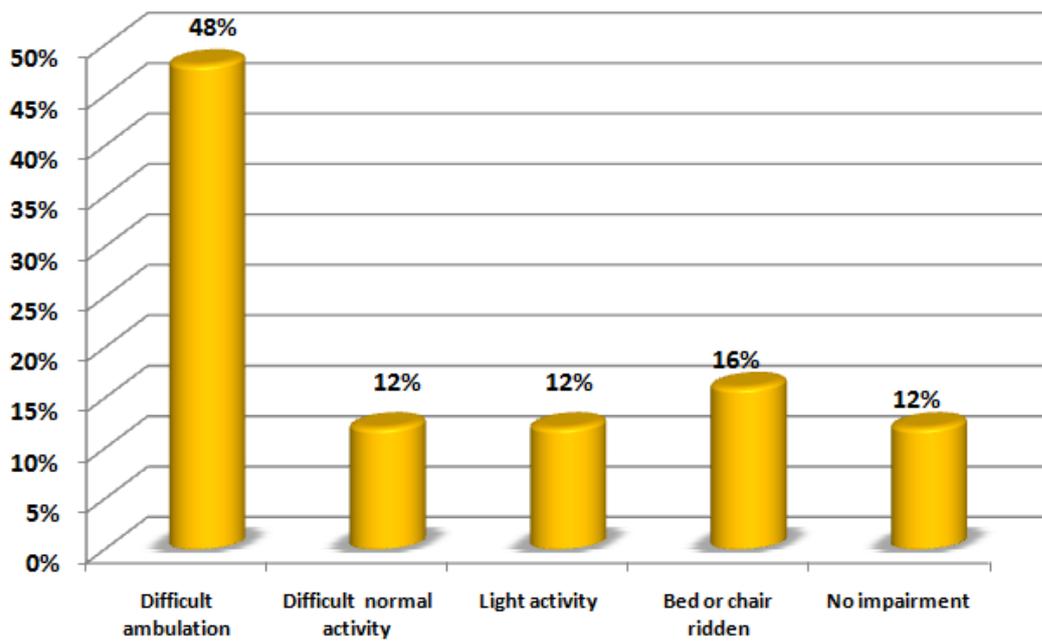


Figure 3 : Distribution of study population by type of functional impairment

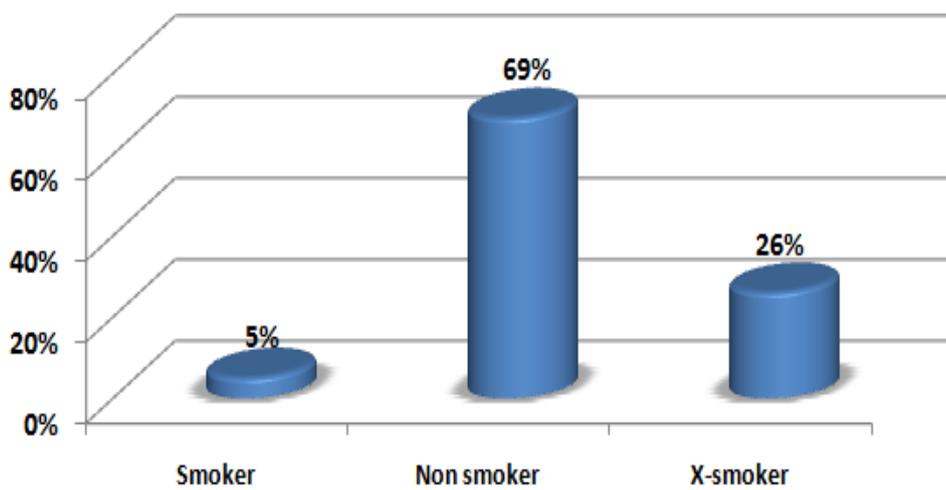


Figure 4 : Distribution of study population by smoking habit

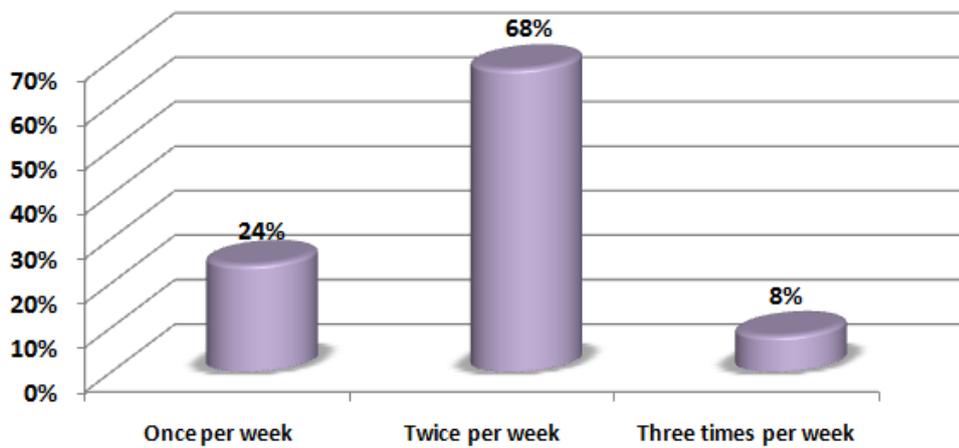
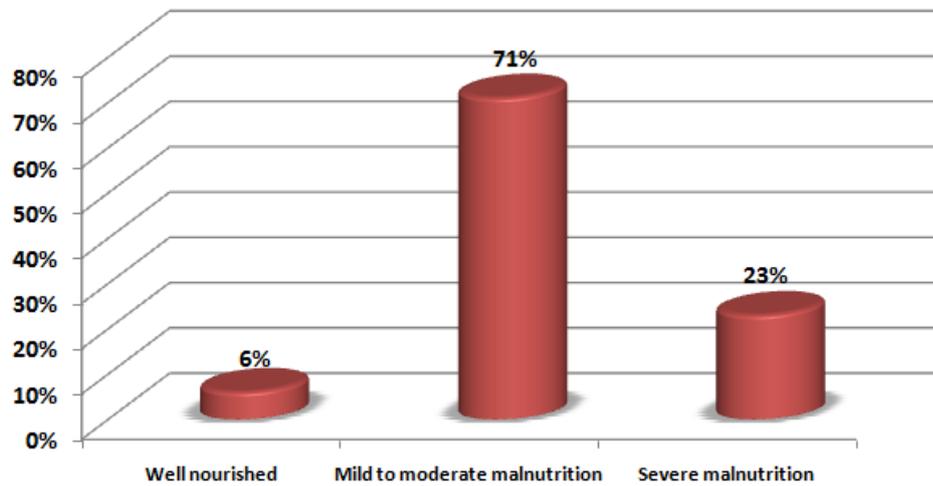


Figure 5 : Distribution of study population by frequency of dialys



**\*Modified subjective global assessment score : Well nourished (7-10) ,mild to moderate malnutrition (11-22) and severe malnutrition (23-35).**

Figure 6: Distribution of the study population by modified subjective global assessment

**Table (4): The association of nutritional status by study variables**

Variable	Well nourished	Mild to moderate	Severe	Total	P-value
<b>Age</b>					
(<20) years	0 (0%)	3 (6%)	0 (0%)	3 (4%)	0.817 <sup>a</sup>
(20-40)years	1 (20%)	10 (19%)	3 (18%)	14 (19%)	
(40-60)years	3 (60%)	21 (40%)	10 (59%)	34 (45%)	
(≥60)years	1 (20%)	19 (35%)	4 (23%)	24 (32%)	
<b>Sex</b>					
Male	3 (60%)	29 (55%)	9 (53%)	41 (55%)	1.000 <sup>a</sup>
Female	2 (40%)	24 (45%)	8 (47%)	34(45%)	
<b>Occupation</b>					
Employee	2 (40%)	12 (23%)	4 (24%)	18 (24%)	0.723 <sup>a</sup>
Not employed	3 (60%)	41 (77%)	13(76%)	57 (76%)	
<b>Residence</b>					
Urban	4 (80%)	33 (62%)	6 (35%)	43 (57%)	0.089 <sup>a</sup>
Rural	1 (20%)	20 (38%)	11 (65%)	32 (43%)	
<b>Smoking habit (smoker and x-smoker)</b>					
Present	1 (20%)	17 (32%)	5 (29%)	23 (31%)	1.000 <sup>a</sup>
Absent	4 (80%)	36 (68%)	12 (71%)	52 (69%)	
<b>Cause of renal failure</b>					
Diabetic nephropathy	5 (100%)	15 (28%)	4 (23%)	24 (32%)	0.006 <sup>**a</sup>
Other causes	0 (0%)	38 (72%)	13 (77%)	51 (68%)	
<b>Frequency of dialysis</b>					
Once/ week	0 (0%)	2 (4%)	16 (94%)	18 (24%)	<0.001 <sup>**a</sup>
Twice / week	0 (0%)	50 (94%)	1 (6%)	51 (68%)	
Three times / week	5 (100%)	1 (2%)	0 (0%)	6 (8%)	

\*\*p value ≤ 0.01 was significant , a : Fisher – exact test .

**Table (5): The association of nutritional status among study population by laboratory investigation**

Variable	Well nourished	Mild to moderate	Severe	Total	P-value
<b>Serum creatinine</b>					
High	5 (100%)	52 (98%)	17 (100%)	74 (99%)	1.000 <sup>a</sup>
Normal	0 (0%)	1 (2%)	0 (0%)	1 (1%)	
<b>Serum calcium</b>					
Hypocalcemia	2 (40%)	22 (42%)	9 (53%)	33 (44%)	0.791 <sup>a</sup>
Normal	3 (60%)	31 (58%)	8(47%)	42(56%)	
<b>Sodium</b>					
Hypematemia	0 (0%)	1 (2%)	0 (0%)	1 (2%)	0.769 <sup>a</sup>
Hyponatemia	5(100%)	48 (91%)	17 (100%)	70 (93%)	
Normal	0 (0%)	4 (7%)	0 (0%)	4 (5%)	
<b>Potassium</b>					
Hyperkalemia	0 (0%)	18 (34%)	5 (29%)	23 (31%)	0.564 <sup>a</sup>
Hypokalemia	0 (0%)	2 (4%)	1 (6%)	3 (4%)	
Normal	5 (100%)	33(62%)	11 (65%)	49 (65%)	
<b>Phosphate</b>					
High	3 (60%)	14 (26%)	11 (65%)	28 (37%)	0.009 <sup>***a</sup>
Normal	2 (40%)	39 (74%)	6 (35%)	47 (63%)	
<b>Albumin</b>					
Low	3 (60%)	33 (62%)	16 (94%)	52 (69%)	0.023 <sup>a</sup>
Normal	2 (40%)	20 (38%)	1 (6%)	23 (31%)	
<b>Packed cell volume</b>					
Anemia	5 (100%)	52 (98%)	17 (100%)	74 (99%)	1.000 <sup>a</sup>
Normal	0 (0%)	1 (2%)	0 (0%)	1 (1%)	

\*p value ≤ 0.05 was significant, \*\*p value ≤ 0.01 was significant : Fisher – exact test .

\***Normal value** : S.creatinine (53-97µmol/l in male ,44-80µmol/l in female),S. calcium (2-2.6 mmol/l),S.sodium (136-155mmol/l),S.potassium (3.5-5.3 mmol/l),S. phosphate (0.8-1.6 mmol/l) and S. albumin (35-52 g/l)

**Table (6): The association of nutritional status among study population by BMI and WHR**

Variable	Well nourished	Mild to moderate	Severe	Total	P-value
<b>Body mass index</b>					
Underweight (<18.5)	0 (0%)	3 (6%)	3 (18%)	6 (8%)	0.456 <sup>a</sup>
Normal (18.5-24.9)	4 (80%)	26 (49%)	8 (47%)	38 (51%)	
Pre-obese (25-29.9)	0 (0%)	14 (26%)	2 (12%)	16 (21%)	
Obese (30 and more)	1 (20%)	19 (10%)	4 (23%)	15 (20%)	
<b>Waist to hip ratio (WHR)</b>					
High risk (>1 in male and >0.85 in female)	3 (60%)	23 (43%)	4 (23%)	30 (40%)	0.262 <sup>a</sup>
Not high risk	2 (40%)	30 (57%)	13 (77%)	45 (60%)	

\*p value  $\leq 0.05$  was significant

a : Fisher – exact test .

**Table 7 : The mean differences of mid arm circumference by nutritional status**

Variable	Categories	N	%	Mean $\pm$ S.D	F	P value
MAC	Well nourished	5	6%	28.6 $\pm$ 3.04	3.205	<b>0.046*</b>
	Mild to moderate malnutrition	53	71%	27.3 $\pm$ 3.98		
	Severe malnutrition	17	23%	24.7 $\pm$ 4.41		

\*p value  $\leq 0.05$  was significant