Aim
We aimed to assess agreement between the Patient-Generated Subjective Global Assessment Short Form (PG-SGA SF) and the Short Nutritional Assessment Questionnaire (SNAQ), and their agreement with the full PG-SGA, in a selected clinical population.

Conclusion
Agreement between PG-SGA SF and SNAQ is poor. Agreement between SNAQ and full PG-SGA (reference) is also poor. PG-SGA SF categorizes 2.6 times more patients at risk of malnutrition than SNAQ, which facilitates triaging for proactive and interdisciplinary interventions to prevent or treat malnutrition.

Background
n the Dutch hospital Nij Smellinghe, the SNAQ is used to screen for risk of malnutrition. Since 2014, the PG-SGA including the PG-SGA Short Form, an interdisciplinary malnutrition tool that can be used to screen, monitor and assess malnutrition and its risk factors, is available in Dutch.

Methods
• Pre-surgery orthopedic patients, COPD outpatients, lung disease inpatients, cardiologic inpatients, colon/rectum cancer outpatients, and surgery inpatients from a regional hospital in The Netherlands participated in the study.
• Risk of malnutrition was assessed by SNAQ (usual care) and PG-SGA SF, and malnutrition by full PG-SGA.
• The SNAQ includes four (yes/no) questions about weight loss, appetite, and the use of nutritional supplements and/or tube feeding.
• The PG-SGA SF includes four boxes: Weight, Food intake, Nutrition impact symptoms (NIS), and Activities/function.
• Risk of malnutrition was categorized as: low (PG-SGA SF 0-3, SNAQ 0-1 points), moderate (resp. 4-8 and 2 points), and high risk (resp. ≥ 9 and ≥ 3 points). Malnutrition was defined as PG-SGA Stage B (moderate/suspected malnutrition) or Stage C (severely malnourished).
• Weighted kappa (κ) was used to analyze agreement between the PG-SGA SF and SNAQ, and agreement between respectively the PG-SGA SF and SNAQ and the full PG-SGA (reference).

Results
• 533 patients (65±14.0 yrs, 37 orthopedic, 20 COPD outpatients, 135 lung disease, 103 cardiologic, 21 colon/rectum cancer, and 217 surgery) were included
• 50% of the patients who were screened as low risk by the SNAQ were screened as medium/high risk by the PG-SGA SF.
• Agreement between PG-SGA SF and SNAQ was κ=0.30; 95% CI 0.24-0.36.
• Agreement between PG-SGA SF and SNAQ per patient group is shown in Table 1.

References