

Original Article

Prevalence of undernutrition in Japanese pediatric patients on admission: Comparison of tertiary, acute-care, and rehabilitation hospitals

Yukiko Maegawa MS¹, Yuma Konishi MS², Masaru Kubota MD, PhD^{2,3}, Yuka Kawate MS¹, Yoshihiro Wakazono MD, PhD⁴, Katsutsugu Umeda MD, PhD⁵, Chiharu Kawaguchi MD⁶

¹Department of Nutrition, Kyoto Katsura Hospital, Kyoto, Japan

²Department of Human Life and Environment, Nara Women's University, Nara, Japan

³Faculty of Agriculture, Department of Food and Nutrition, Ryukoku University, Shiga, Japan

⁴Department of Pediatrics, Kyoto Katsura Hospital, Kyoto, Japan

⁵Department of Pediatrics, Kyoto University Hospital, Kyoto, Japan

⁶Department of Pediatrics, Todaiji Medical and Educational Center, Nara, Japan

Background and Objectives: There exist many studies in Western countries dealing with pediatric nutritional assessment on admission, but those in Asian countries are comparatively limited. This study aimed at clarifying the prevalence of undernutrition in 3 Japanese pediatric hospitals, especially focusing on their different characteristics. **Methods and Study Design:** Study participants included 313 patients aged 1–17 years admitted to a tertiary hospital (175 patients), an acute-care hospital (99 patients), or a rehabilitation hospital (39 patients). On admission, body height, weight, and serum albumin were measured. BMI was calculated by dividing the weight (kg) by the square of height (m). Patients exhibited undernutrition on account of BMI z-score <−2, weight-for-height (W/H) <90%, height-for-age (H/A) <95%, or albumin <3.5 g/dL. **Results:** The overall prevalence of undernutrition was 53.0%. Among 4 nutritional measures, the prevalence was highest in H/A (33.9%), followed by W/H (26.8%), BMI z-score (17.6%) and albumin (12.8%). A rehabilitation hospital exhibited significantly higher prevalence than that in a tertiary- or acute-care hospital. By the classification of International Statistical Classification of Diseases and Related Health Problems-10, neurological diseases and congenital anomalies showed higher prevalence among the disease categories which had the number of enrolled patients more than twenty. **Conclusions:** This study indicates that hospital characteristics and inpatient disease categories are important in the admission evaluation of the likelihood of undernutrition. These observations require consideration by hospital physicians in paediatric nutritional diagnosis and management.

Key Words: undernutrition, hospitalized children, BMI, Waterlow classification, albumin

INTRODUCTION

Undernutrition is an important factor in predicting the prognosis of hospitalized children. It is thought to be associated with several clinical outcomes, including the length of hospital stay, infectious complications, and re-admission rates.¹⁻³ Since undernutrition can be observed on admission, during hospitalization, and after discharge, continuous monitoring of nutritional status and intervention are required. Based on this notion, the implementation of nutrition support teams in pediatric units has been recommended.⁴ At present, nutritional assessment based on anthropometry is the most acceptable method for evaluating a nutritional status in pediatric patients.^{5,6} Nutritional screening tools such as STAMP, STRONGkids, and PYMS are thought to be useful to predict a nutritional risk, particularly on admission.^{7,8} At some instances, biochemical biomarkers, such as albumin or prealbumin, have been included in screening procedures.⁹⁻¹⁰

Prevalence of undernutrition in pediatric patients on admission has been reported extensively in studies undertaken in Western countries. Using several anthropometric measures, these studies reported that the prevalence of undernutrition varied between 5.8 and 27.2%.^{1-3,11-16} On the other hand, the reports from the rest of the world, i.e. Brazil,¹⁷ Thailand,⁹ Iran,¹⁸ Vietnam¹⁹ and Turkey,²⁰ demonstrated slightly higher prevalence ranging from 10.0 to 55.0%. As for East Asia, we can find only one largescale study presented by Cao et al in China,²¹ but

Corresponding Author: Prof Masaru Kubota, Faculty of Agriculture, Department of Food and Nutrition, Ryukoku University, Shiga, Japan.

Tel: +81-77-599-5647; Fax: +81-77-599-5647

Email: masaru_kubota@chime.ocn.ne.jp

Manuscript received 22 July 2017. Initial review completed 06 November 2017. Revision accepted 04 December 2017.

doi: 10.6133/apjcn.042018.03

this investigation focused on the nutritional screening using STRONGkids rather than the anthropometric measures. Reasons for such a wide range of prevalence among different studies may be attributed to the differences in study years, patients' age, countries, anthropometric measures and hospital characteristics. Among these factors, in most previous studies, hospital characteristics were described simply as "tertiary" or "general" without descriptions of the patient details and distribution of the diagnosis. Although in adult inpatients, the disease category classified by the International Statistical Classification of Diseases and Related Health Problems (ICD)-codes, was demonstrated to play a pivotal role in the prevalence of malnutrition diagnosis.^{22,23} Therefore, precise description of the characteristics of participating hospitals, and patients' disease category is necessary for comparing the prevalence of undernutrition on admission among different studies.

Based on a review of the international literature, the present study aimed to delineate the prevalence of undernutrition on admission in Japanese pediatric patients. The study specifically pays attention to the difference of undernutrition recorded among 3 hospitals that have varying patients' characteristics.

METHODS

Study design and subjects

This study was conducted between July and December 2015 using data from patients admitted to the pediatric departments in 3 different hospitals: Kyoto University Hospital (a tertiary hospital), Kyoto Katsura Hospital (an acute-care hospital), and Todaiji Medical and Educational

Center (a rehabilitation hospital). These departments do not accept children admitted primarily for the purpose of surgical treatment. The pediatric department at Kyoto University Hospital accepts children mainly referred from primary or secondary clinics. Kyoto Katsura Hospital is a regional hospital in the southern part of Kyoto city. Its pediatric ward accepts patients with acute illnesses via outpatient or emergency clinics. The average length of hospital stay in 2014 was within 3 days. Todaiji Medical and Educational Center accepts pediatric patients with mental or physical disabilities mainly due to cerebral palsy or congenital anomalies. Cases from several patient typologies were excluded from this study based on 3 criteria: when patients were aged less than one year; when they lacked data concerning height, weight, or serum albumin on admission; or when they were critically ill and directly admitted to an intensive care unit. After exclusions, 313 patients were enrolled in the study, including 175 patients at Kyoto University Hospital, 99 at Kyoto Katsura Hospital, and 39 at Todaiji Medical and Educational Center. The details of patients, such as gender, age, and diagnosis are presented in Table 1. The diagnosis was made by a chief physician and was classified according to ICD-10 codes. This project was approved by the ethical and epidemiological committee at Nara Women's University (July 10, 2015).

Measurement of body height, weight, and serum albumin

Body height and weight on admission were measured by well-trained nurses at each hospital. Height was measured to the nearest 0.1 cm, and weight was measured to the

Table 1. Characteristics of patients at 3 different hospitals

Hospitals	Tertiary	Acute-care	Rehabilitation	Total
Number of patients	175	99	39	313
Gender				
Male	91 (52.0) [†]	54 (54.5)	21 (53.8)	166 (53.0)
Female	84 (48.0)	45 (45.5)	18 (46.2)	147 (47.0)
Age (years)				
1~	25 (14.3)	23 (23.2)	1 (2.6)	49 (15.7)
2~5	62 (35.4)	44 (44.4)	10 (25.6)	116 (37.1)
6~11	54 (30.9)	19 (19.2)	11 (28.2)	84 (26.8)
12~14	21 (12.0)	7 (7.1)	11 (28.2)	39 (12.5)
15~17	13 (7.4)	6 (6.1)	6 (15.4)	25 (7.9)
Disease category [‡]				
Infectious diseases (A)	5	21	0	26
Neoplasms (C)	33	0	0	33
Blood and immunologic diseases (D)	10	4	0	14
Endocrine and metabolic diseases (E)	5	1	1	7
Psychologic diseases	3	0	0	3
Neurological diseases (G)	16	1	31	48
Circulatory diseases (I)	2	0	0	2
Respiratory diseases (J)	4	51	0	55
Gastrointestinal diseases (K)	4	0	2	6
Skin diseases (L)	1	2	0	3
Muscle and bone diseases (M)	3	6	0	9
Genitourinary diseases (N)	1	2	0	3
Perinatal disorders (P)	10	0	0	10
Congenital anomalies (Q)	40	0	5	45
Unclassified diseases (R)	21	11	0	32
Food allergy (S)	17	0	0	17

[†]Numbers in parentheses indicate the percentages.

[‡]Classification of diseases is based on ICD-10.

nearest 0.1 kg. Since most patients in the rehabilitation hospital had severe spinal curvatures, their height was measured by the two-split method, in which the whole body was divided into 2 parts and measured. In such cases, measurements were taken from the top of the head to the greater trochanter and from the greater trochanter to the planta.²⁴ BMI was calculated by dividing the body weight (kg) by the square of height (m). Serum albumin was measured by an improved bromocresol purple (BCP) method using an automatic blood analyzer in venous blood drawn on admission.

Definition of undernutrition

Patients who fulfilled one of the following criteria were defined as exhibiting undernutrition: BMI z-score <-2, Waterlow classification: weight-for-height (W/H) <90% or height-for-age (H/A) <95%,²⁵ or albumin concentrations <3.5 g/dL. As the standard growth charts for evaluating BMI z-scores, W/H and H/A, we used the official Japanese children's anthropometric data for children age 5 and over published by the Ministry of Education, Culture, Sports, Science and Technology,²⁶ and for those age 4 and under published by the Ministry of Health, Labor and Welfare.²⁷

Statistical analysis

Differences in recorded variables were examined using the Chi-squared test. Correlations among nutritional

measures were evaluated by the Pearson analysis. All statistical analyses were performed using Excel Statistics (Version 2012). *p*-values less than 0.05 were considered significant.

RESULTS

Prevalence of undernutrition based on hospitals, gender, age, and disease category

In total, 166 patients (53.0%) were diagnosed with undernutrition since they had at least 1 abnormal nutritional measure (Table 2). Prevalence increased significantly with age (12~14 and 15~17 years) ($p < 0.001$), but there was not any sex difference ($p = 0.071$). Prevalence of undernutrition was significantly higher in the rehabilitation hospital than in the tertiary or acute-care hospitals ($p < 0.001$), while no statistical difference was found between the tertiary and acute-care hospitals ($p = 0.55$). In addition, prevalence of undernutrition was found to vary considerably among the ICD-10 disease category, from 83.3% in gastrointestinal diseases to 0% in skin diseases.

Prevalence of undernutrition in 4 nutritional measures

Among 4 nutritional measures in all patients, the prevalence of undernutrition was the highest in H/A (33.9%), followed by W/H (26.8%), BMI z-score (17.6%), and serum albumin (12.8%) (Table 3). As shown in Table 3, this trend was similar among 3 different hospitals. However, the prevalence of undernutrition on BMI z-score

Table 2. Prevalence of undernutrition according to gender, age, hospitals and disease category

Nutritional status	Normal nutrition	Undernutrition	Total	<i>p</i> values*
Number of patients	147 (47.0) [†]	166 (53.0)	313	
Gender				0.071
Male	70 (42.2)	96 (57.8)	166	
Female	77 (52.4)	70 (47.6)	147	
Age (years)				<0.001
1~	28 (57.1)	21 (42.9)	49	
2~5	52 (44.8)	64 (55.2)	116	
6~11	47 (56.0)	37 (44.0)	84	
12~14	11 (28.2)	28 (71.8)	39	
15~17	9 (36.0)	16 (64.0)	25	
Hospitals				<0.001
Tertiary	95 (54.3)	80 (45.7)	175	
Acute care	50 (50.5)	49 (49.5)	99	
Rehabilitation	2 (5.1)	37 (94.9)	39	
Disease category [‡]				
Infectious diseases (A)	16 (61.5)	10 (38.5)	26	
Neoplasms (C)	14 (42.4)	19 (57.6)	33	
Blood and immunologic diseases (D)	7 (50.0)	7 (50.0)	14	
Endocrine and metabolic diseases (E)	3 (42.9)	4 (57.1)	7	
Psychologic diseases	1 (33.3)	2 (66.7)	3	
Neurological diseases (G)	13 (27.1)	35 (72.9)	48	
Circulatory diseases (I)	1 (50.0)	1 (50.0)	2	
Respiratory diseases (J)	27 (49.1)	28 (50.9)	55	
Gastrointestinal diseases (K)	1 (16.7)	5 (83.3)	6	
Skin diseases (L)	3 (100)	0 (0)	3	
Muscle and Bone diseases (M)	8 (88.9)	1 (11.1)	9	
Genitourinary diseases (N)	2 (66.7)	1 (33.3)	3	
Perinatal disorders (P)	2 (20.0)	8 (80.0)	10	
Congenital anomalies (Q)	17 (37.8)	28 (62.2)	45	
Unclassified diseases (R)	18 (56.3)	14 (43.7)	32	
Food allergy (S)	14 (82.4)	3 (17.6)	17	

[†]Numbers in parentheses indicate the percentages.

[‡]Disease category was classified by ICD-10.

*The statistical difference was evaluated by the Chi-squared test.

Table 3. Prevalence of undernutrition as measured by 4 different nutritional measures at 3 different hospitals

Hospitals	Tertiary	Acute care	Rehabilitation	Total	<i>p</i> values*
Number of patients	175	99	39	313	
BMI z-score					<0.0001
undernutrition [†]	23 (13.1) [‡]	9 (9.1)	23 (59.0)	55 (17.6)	
normal nutrition	152 (86.9)	90 (90.9)	16 (41.0)	258 (82.4)	
H/A					<0.0001
undernutrition	49 (27.9)	29 (29.3)	28 (71.8)	106 (33.9)	
severe	9 (5.1)	3 (3.0)	16 (41.0)		
moderate	9 (5.1)	5 (5.1)	6 (15.4)		
mild	31 (17.7)	21 (21.2)	6 (15.4)		
normal nutrition	126 (72.1)	70 (70.7)	11 (28.2)	207 (66.1)	
W/H					0.0004
undernutrition	46 (26.3)	18 (18.2)	20 (51.3)	84 (26.8)	
severe	1 (0.6)	0 (0)	6 (15.5)		
moderate	16 (9.1)	5 (5.1)	7 (17.9)		
mild	29 (16.6)	13 (13.1)	7 (17.9)		
normal nutrition	129 (73.7)	81 (81.8)	19 (48.7)	229 (73.2)	
Albumin					0.30
undernutrition	21 (12.0)	11 (11.1)	8 (20.5)	40 (12.8)	
normal nutrition	154 (88.0)	88 (88.9)	31 (79.5)	273 (87.2)	

H/A: height-for-age; W/A: weight-for-age.

[†]Definitions of undernutrition for each measure is BMI z-score <-2, H/A <95%, W/H <90%, or albumin <3.5 g/dL.

[‡]Numbers in parentheses indicate the percentages.

*The statistical difference was evaluated by the Chi-squared test.

($p<0.0001$), H/A ($p<0.0001$) and W/H ($p=0.0004$) was statistically higher in the rehabilitation hospital compared to the tertiary or acute-care hospitals except for albumin ($p=0.30$). The difference in prevalence of undernutrition in 4 measures between the tertiary and acute-care hospital was not statistically significant (p values for BMI z-score, 0.42; H/A, 0.93; W/H, 0.17; albumin, 0.83).

Prevalence of undernutrition among different disease groups classified by ICD-10

The difference in prevalence of undernutrition among 6 representative disease categories was significant. The

highest level of undernutrition was found in the neurological diseases (72.9%) and the lowest level was recorded for the infectious diseases (38.5%) (Table 4). Among 4 nutritional measures, the prevalence of BMI z-score and H/A was highest in neurological diseases, whereas W/H was highest in neoplasms, and albumin was highest in respiratory diseases.

Correlation of 4 nutritional measures in all patients

As indicated in Table 5, a significant positive correlation was found between BMI z-score and W/H ($p<0.0001$). In addition, albumin levels were significantly correlated

Table 4. Prevalence of undernutrition by 4 nutritional measures in different disease category

ICD-10 Classification	Total patients	Positive patients [†]	BMI z-score	H/A	W/H
Infectious diseases (A)	26	10 (38.5) [‡]	2 (7.7)	6 (23.1)	7 (26.9)
Neoplasms (C)	33	19 (57.6)	7 (21.2)	12 (36.4)	13 (39.4)
Blood and immunologic diseases (D)	14	7 (50.0)	1 (7.1)	6 (42.9)	1 (7.1)
Neurological diseases (G)	48	35 (72.9)	21 (43.8)	27 (56.3)	19 (38.6)
Respiratory diseases (J)	55	28 (50.9)	6 (10.9)	19 (34.5)	10 (18.2)
Congenital anomalies (Q)	45	28 (62.2)	8 (17.8)	18 (40.0)	12 (26.7)

H/A: height-for-age; W/H: weight-for-height.

[†]Positive patients indicate those who showed at least one abnormal value in 4 nutritional measures. The statistical difference among diseases in different categories was evaluated by the Chi-squared test ($p=0.024$).

[‡]Numbers in parentheses indicate the percentages

Table 5. Correlation of nutritional measures in all patients (n=313)

	Correlation efficiency	<i>p</i> values*
BMI z-score vs H/A	0.036	0.53
BMI z-score vs W/H	0.75	<0.0001
BMI z-score vs Albumin	0.21	0.0004
H/A vs W/H	-0.01	0.86
H/A vs Albumin	0.24	0.009
W/H vs Albumin	0.32	<0.0001

H/A: height-for-age; W/H: weight-for-height.

*Correlation efficiency was evaluated by the Pearson analysis.

positively with BMI z-score ($p=0.0004$), H/A ($p=0.009$), and W/H ($p<0.0001$).

DISCUSSION

Hospitalized children may experience changes in their nutritional status from admission to discharge. An initial nutritional assessment is important since it comprises the basic data required for subsequent nutritional evaluation during hospitalization. The association of undernutrition on admission with length of hospital stay or other unfavorable outcomes suggests the importance of assessing a nutritional status on admission.^{1-3,28}

At present, there are not any commonly accepted anthropometric measures for evaluating the nutritional status in pediatric patients. Many investigators, especially those in Western countries, have recommended and used BMI z-scores <-2 based on the World Health Organization (WHO) reference growth chart.^{3,29} However, Joosten and Hulst warned that the use of WHO growth reference data had the possibility of overestimating or underestimating undernutrition compared with the use of country specific growth reference information.⁵ Considering that Japanese children tend to be shorter and thinner than children in Western countries, we used the Japanese growth chart for calculating BMI z-scores.^{26,27} In total, 55 patients (17.6%) exhibited BMI z-scores <-2 . Based on this measure, prevalence of undernutrition appears to be higher than in Western countries (5.8%–10.2%),^{3,13,16} but almost identical to the report by Cao et al. (14.5%).²¹ Other widely used anthropometric measures are H/A and W/H, expressed by either their z-scores^{12,14,18,19} or percentages of the standard values (Waterlow classification).^{9,11,20} In this study, we used Waterlow classification since we already had the data from a normal pediatric population.²⁵ Our overall findings concerning prevalence of undernutrition based on H/A (33.9%) and W/H (26.8%) were similar to those in the report by Hendricks et al.⁹ It is noteworthy that a rehabilitation hospital had higher prevalence on both measures and higher numbers of patients with moderate or severe undernutrition according to Waterlow classification.

There are arguments for and against using serum albumin as a biomarker for nutritional assessment.^{10,30} The present study indicates that the overall prevalence of undernutrition was 12.8% as judged by hypo-albuminemia (<3.5 g/dL). The order of undernutrition prevalence among different hospitals was as follows, rehabilitation, tertiary, and acute-care hospitals, but the difference in prevalence by a hospital type was not significant. It is notable that albumin concentrations correlated positively with 3 anthropometric measures. Agostoni et al demonstrated an inverse association between albumin levels and length of hospital stay.¹³ Therefore, although not sensitive enough to identify patients with undernutrition, we contend that albumin can still be a useful biomarker of nutritional status in pediatric patients.

The present study indicates that prevalence of undernutrition was significantly higher in a rehabilitation hospital than in tertiary and acute-care hospitals. The higher prevalence identified in a rehabilitation hospital is presumably associated with the different distribution of disease categories. Patients in a rehabilitation hospital mainly con-

sisted of those with neurological diseases (79.5%) and congenital anomalies (12.8%). The former disease category mainly consisted of cerebral palsy in the present study is considered to be a risk factor for malnutrition because of feeding difficulties, frequent gastrointestinal symptoms, and/or altered energy metabolism.^{24,31} On the other hand, overall prevalence of undernutrition was similar between the tertiary hospital and the acute-care hospital. This observation was unexpected, since patients at the tertiary hospital might have more underlying diseases than those in the acute-care hospital. However, Huysentruyt et al have reported that no significant difference was found between secondary and tertiary hospitals regarding the prevalence of chronic undernutrition as judged by H/A.¹ Whether there is the difference of prevalence of undernutrition between a tertiary hospital and an acute-care or secondary hospital waits for a further investigation by increasing enrolled hospitals and patients.

There are several limitations in the present study. First, the nutritional assessment was only undertaken at the time of admission. A concurrent study of patients' outcomes, such as length of hospital stay and infectious events, is desirable. Second, we selected only 3 hospitals as representatives of institutions with different characteristics. In future studies, the number of participating hospitals should be increased to avoid selection bias and to increase representation. Finally, since this a retrospective study, approximately 10%–15% of admitted patients were excluded due to the lack of at least one data parameter. In spite of these limitations, the present study has 2 major advantages. First, when nutritional assessment of hospitalized children in North-East Asian countries is still limited, we have identified important data on prevalence of undernutrition on admission using 3 anthropometric measures and albumin concentrations. Second, hospital characteristics, particularly the disease category of inpatients, were taken into consideration. We contend that the characteristics of hospitals should be taken into consideration when analyzing the nutritional status of pediatric inpatients and planning nutritional intervention. Since this is a retrospective observational study, we can't clarify the relative usefulness of each parameter. At present, however, we recommend to use one of anthropometric parameters, i.e. BMI-score or W/H, and albumin in combination for evaluating the nutritional status of pediatric patients.

ACKNOWLEDGEMENTS

The authors would like to thank Enago (www.enago.jp) for their pertinent advice on the present review.

AUTHOR DISCLOSURES

The authors declare no conflict of interest. This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

REFERENCES

1. Huysentruyt K, Alliet P, Muyschont L, Devreker T, Bontems P, Vandenplas. Hospital-related undernutrition in children: still an often unrecognized and untreated problem. *Acta Paediatr.* 2013;102:e460-6. doi: 10.1111/apa.12344.
2. Groleau V, BPharm MT, Doyon M, Brochu EE, Roy CC, Babakissa C. Malnutrition in hospitalized children:

- Prevalence, impact, and management. *Can J Diet Pract Res.* 2014;75:29-34. doi: 10.3148/75.1 2014.29.
3. Hecht C, Weber M, Grote V, Daskalou E, Dell'Era L, Gerasimidis K et al. Disease associated malnutrition correlates with length of hospital stay in children. *Clin Nutr.* 2015;34:53-9. doi: 10.1016/j.clnu.2014.01.003.
 4. Agostoni C, Axelson I, Colomb V, Goulet O, Koletzko B, Michaelsen KF et al. ESPGHAN Committee on Nutrition; European Society for Paediatric Gastroenterology. The need for nutrition support teams in pediatric units: a commentary by the ESPGHAN committee on nutrition. *J Pediatr Gastroenterol Nutr.* 2005;41:8-11. No doi
 5. Joosten KF, Hulst JM. Malnutrition in pediatric hospital patients: current issues. *Nutrition.* 2011;27:133-7. doi: 10.1016/j.nut.2010.06.001.
 6. Becker PJ, Nieman Carney L, Corkins MR, Monczka J, Smith E, Smith SE, Spear BA, White JV. Consensus statement of the Academy of Nutrition and Dietetics/American Society for Parenteral and Enteral Nutrition: indicators recommended for the identification and documentation of pediatric malnutrition (undernutrition). *J Acad Nutr Diet.* 2014;114:1988-2000. doi: 10.1016/j.jand.2014.08.026.
 7. Huysentruyt K, Devreker T, Dejonckheere J, De Schepper J, Vandenplas Y, Cools F. Accuracy of nutritional screening tools in assessing the risk of undernutrition in hospitalized children. *J Pediatr Gastroenterol Nutr.* 2015;61:159-66. doi: 10.1097/MPG.0000000000000810.
 8. Teixeira AF, Viana KD. Nutritional screening in hospitalized pediatric patients: a systemic review. *J Pediatr (Rio J).* 2016;92:343-52. doi: 10.1016/j.jpmed.2015.08.011.
 9. Tienboon P. Nutrition problems of hospitalized children in a developing country: Thailand. *Asia Pac J Clin Nutr.* 2002;11: 258-62.
 10. Ong C, Han WM, Wong JJ, Lee JH. Nutrition biomarkers and clinical outcomes in critically ill children: A critical appraisal of the literature. *Clin Nutr.* 2014;33:191-7. doi: 10.1016/j.clnu.2013.12.010.
 11. Hendricks KM, Duggan C, Gallagher L, Carlin AC, Richardson DS, Collier SB, Simpson W, Lo C. Malnutrition in hospitalized pediatric patients. Current prevalence. *Arch Pediatr Adolesc Med.* 1995;149:1118-22.
 12. Pawellek I, Dokoupil K, Koletzko. Prevalence of malnutrition in paediatric hospital patients. *Clin Nutr.* 2008; 27:72-6. doi:10.1016/j.clnu.2007.11.001.
 13. Agostoni C, Fossali E, Calderini E, Edefonti A, Colombo C, Battezzati A, et al. Nutritional assessment and risk of malnutrition in hospitalized children in northern Italy. *Acta Paediatr.* 2014;103:e416-7. doi: 10.1111/apa.12712.
 14. Baxter JA, Al-Madhaki FI, Zlotkin SH. Prevalence of malnutrition at the time of admission among patients admitted to a Canadian tertiary-care paediatric hospital. *Paediatr Child Health.* 2014;19:413-7.
 15. Pichler J, Hill SM, Shaw V, Lucas A. Prevalence of undernutrition during hospitalization in a children's hospital: what happens during admission? *Eur J Clin Nutr.* 2014;68: 730-5. doi: 10.1038/ejcn.2014.21.
 16. Thomas PC, Marino LV, Williams SA, Beattie RM. Outcome of nutritional screening in the acute paediatric setting. *Arch Dis Child.* 2016;101:1119-24. doi: 10.1136/archdischild-2016-310484.
 17. De Moraes Silveira CR, De Mello ED, Antonacci Carvalho PR. Evolution of nutritional status of pediatric inpatients of a tertiary care general hospital in Brazil. *Nutr Hosp.* 2008;23: 599-606.
 18. Moeeni V, Walls T, Day AS. Assessment of nutritional status and nutritional risk in hospitalized Iranian children. *Acta Paediatr.* 2012;101:e446-51. doi: 10.1111/j.1651-2227. 2012.02789.x.
 19. Huong PT, Lam NT, Thu NN, Quyen TC, Lien DT, Anh NQ, et al. Prevalence of malnutrition in patients admitted to a major urban tertiary care hospital in Hanoi, Vietnam. *Asia Pac J Clin Nutr.* 2014;23:437-44. doi: 10.6133/apjcn.2014. 23.3.19.
 20. Kapçı N, Akçam M, Koca T, Dereci S, Kapçı M. The nutritional status of hospitalized children: Has this subject been overlooked? *Turk J Gastroenterol.* 2015;26:351-5. doi: 10.5152/tjg.2015.0013.
 21. Cao J, Peng L, Li R, Chen Y, Li X, Mo B, Li X. Nutritional risk screening and its clinical significance in hospitalized children. *Clin Nutr.* 2014;33:432-6. doi: 10.1016/j.clnu.2013. 06.009.
 22. Corkins MR, Guenter P, DiMaria-Ghalili RA, Jensen GL, Malone A, Miller S, Patel V, Plogsted S, Resnick HE, American Society for Parenteral and Enteral Nutrition. Malnutrition diagnoses in hospitalized patients: United States, 2010. *JPEN J Parenter Enteral Nutr.* 2014;38:186-95. doi: 10.1177/0148607113512154.
 23. Tangvik RJ, Tell GS, Guttormsen AB, Eisman JA, Henriksen A, Nilsen RM, Ranhoff AH. Nutritional risk profile in a university hospital population. *Clin Nutr.* 2015; 34:705-11. doi: 10.1016/j.clnu.2014.08.001.
 24. Takeda Y, Kubota M, Sato H, Nagai A, Higashiyama Y, Kin H, Kawaguchi C, Tomiwa K. Carnitine in severely disabled patients: relation to anthropometric, biochemical variables, and nutritional intake. *Brain Dev* 2015;37:94-100. doi: 10. 1016/j.braindev.2014.03.012.
 25. Higashiyama Y, Kubota M, Oshima S, Mibu M, Yasui Y, Nagai A. Assessment of Japanese healthy children's nutritional status using Waterlow classification. *Health.* 2012;4:1036-40. doi: 10.4236/health.2012.411158
 26. The Ministry of Education, Culture, Sports, Science and Technology, Japan. Repts of health statistics in school children. (2001) (In Japanese) [cited 2016/10/01]; Available from: <http://e-stat.go.jp/SG1/estat/List.do?bid=000001016209&cycode=0>.
 27. The Ministry of Health, Labour and Welfare, Japan. Reports of growth investigation in infants and toddlers. (2001) (In Japanese) [2016/10/01]; Available from: <http://www.mhlw.go.jp/houdou/0110/h1024-4.html>.
 28. Aurangzeb B, Whitten KE, Harrison B, Mitchell M, Kepreotes H, Sidler M, Lemberg DA, Day AS. Prevalence of malnutrition and risk of under-nutrition in hospitalized children. *Clin Nutr.* 31;2012:35-40. doi: 10.1016/j.clnu.2011. 08.011.
 29. Daskalou E, Galli-Tsinopoulou A, Karagiozoglou-Lampoudi T, Augoustides-Savvopoulpu P. Malnutrition in hospitalized pediatric patients: assessment, prevalence, and association to adverse outcomes. *J Am Cull Nutr.* 2016;35:372-80. doi: 10.1080/07315724.2015.1056886.
 30. Leite HP, Rodrigues da Silva AV, de Oliveira Iglesias SB, Koch Nogueira PC. Serum albumin is an independent predictor of clinical outcomes in critically ill children. *Pediatr Crit Care Med.* 2016;17:e50-7. doi: 10.1097/PCC. 0000000000000596.
 31. Penagini F, Mameli C, Fabiano V, Brunetti D, Dilillo D, Zuccotti GV. Dietary intakes and nutritional issues in neurologically impaired children. *Nutrients* 2015;7:9400-15. doi: 10.3390/nu7115469.