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Letter to the Editor

Reply–Letter to the editor: "Reappraising diabetes prevalence and multimorbidity adjustment in geriatric nutrition research"

Dear Editor,

We would like to thank Chen and colleagues for their interest in our article. We think both of their points are relevant and are worth discussing [1].

Indeed, a prevalence of 34 % may be more than expected. However, there are similar studies to have such high prevalences [2,3]. A National Health and Nutrition Examination Survey study by Menke et al. evaluated the prevalence of diabetes mellitus from 1988 through 2012. In that study, a prevalence of 33 % among individuals ≥65 years of age was reported in 2012 [4]. Notably, around 11 % was undiagnosed diabetes mellitus. The National Diabetes Statistics Report of Centers for Disease Control reported a prevalence of 29.2 % for the same age group [5]. Our hospital is a referral center and may not perfectly represent the real-world population. Our population were outpatient older adults referred for comprehensive geriatric evaluation [6]. Older outpatients typically seek medical care for specific health concerns, such as falls, decreased appetite, or cognitive impairment. Consequently, they tend to present with greater frailty and a higher burden of comorbidities, such as DM, compared with community-dwelling older adults. Another reason for the high diabetes prevalence in our study may be related to the higher number of women [7]. There is a higher prevalence of diabetes in women. In Türkiye in 2021, the prevalence among older women was 38.6 % (22.9 % known, 15.8 % undiagnosed) [7]. Additionally, routine glucose measurements during follow-up as a part of geriatric assessment may have reduced the percentage of undiagnosed diabetes in our cohort.

While diabetes mellitus is expected to have significant impact on nutritional measures, we could not confirm that in our cohort. We think this may be due to characteristics of diabetes mellitus that are more common in older adults. A large subgroup is diagnosed in the 7th-8th decades. Perhaps our patients with DM had individualized HbA1c target levels based on their degree of dependency in activities of daily living. As a result, having diabetes might not have adversely affected their nutritional status [8]. However, since this issue was not the primary research question, we could not assess it. On the other hand, we agree that reporting the impact of comorbid conditions using indexes, such as the Charlson's comorbidity index, would better clarify the effects of overall comorbidities on health outcomes. Many recent studies demonstrate an association between the concept of multimorbidity and adverse outcomes, as emphasized by Chen et al. It would have been more appropriate to adjust for the severity, rather than the number, of comorbidities in the present study [9,10]. Nonetheless, our analyses accounted for major determinants of mortality and functional status in older adults, such as falls, reduced calf circumference, and scores on Basic and Instrumental Activities of Daily Living. This adds substantial rigor and value to our study [6].

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None declared.

Conflicts of interest

None declared.

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Pinar Soysal*
Bezmialem Vakıf University, Faculty of Medicine, Department of Geriatric Medicine, İstanbul, Turkey

Müberra Tanrıverdi
Bezmialem Vakıf University, Faculty of Health Sciences, Department of Physiotherapy and Rehabilitation, İstanbul, Turkey

Cihan Heybeli
Dokuz Eylül University, Faculty of Medicine, Department of Nephrology, İstanbul, Turkey

* Corresponding author. Adnan Menderes Vatan Bulvarı No:113 34093, Fatih, İstanbul, Turkey.
E-mail address: psoysal@bezmialem.edu.tr (P. Soysal).

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