9. -Mobility only inside the house with great help from one person (4.68 vs. 5.53%)
10. -Mobility with two people or non-mobility (4.87 vs. 8.7%)
11. –Unknown (1.06% vs. 1.98%)

One month after fracture the functional status evolution is 1. (1.42% vs. 0.5%), 2.(7.74% vs. 1.49%), 3.(12.88% vs. 2.48%), 4.(2.01% vs. 2.48%), 5.(5.54% vs. 5.45%), 6.(25.82% vs. 17.82%), 7.(3.57% vs. 4.46%), 8.(5.29 vs. 6.93%), 9.(8.20 vs. 12.87%), 10.(21.28% vs. 36.63%), 11.(6.25% 8.91%)

Conclusion: Centenaries present a worse prefracture functional status and also a worse postfracture functional status. These findings emphasize the need to improve care in very older patients and to prevent complications.

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DIAGNOSIS OF MALNUTRITION USING GLIM CRITERIA: VALIDITY OF 7 PRAGMATIC APPROACHES WHICH DO NOT REQUIRE THE MEASUREMENT OF MUSCLE MASS

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Objective: The GLIM criteria for malnutrition have been recently launched. Diagnosis requires at least one phenotypic criterion (weight loss, low BMI, and reduced muscle mass) AND at least one etiologic criterion (reduced food intake or assimilation and disease burden or inflammatory conditions). However, the measurement of muscle mass is not always feasible in clinical practice. Our objective was to calculate the prevalence, concordance, performance indicators, and feasibility of 7 pragmatic approaches of GLIM criteria which do not need the measurement of muscle mass, compared to the original GLIM criteria. Secondarily, we assessed the association between baseline malnutrition according to GLIM and 7 pragmatic approaches, with mortality in community-dwelling older adults from the SarcoPhAge (Sarcopenia and Physical Impairment with advancing Age) study during a 5-y follow-up.

Methods: This prospective population-based cohort was part of SarcoPhAge, which included 534 older adults in Belgium, followed up from 2013-2019. Community-dwelling healthy volunteers ≥65 years old were recruited. Baseline malnutrition was defined according to GLIM criteria and 7 pragmatic approaches: 1. Omission of muscle mass; 2. Substitution for hand-grip strength, 3. Calf-circumference, 4. Mid-arm circumference, 5. Goodman's grid, 6. Ishii's formula, and 7. Yu's formulas. Cohen-kappa coefficient, Sensitivity, Specificity, Positive (PPV), Negative (NPV) predictive values, Area under the curve (AUC), and TELOS-feasibility score were calculated. Cox-regressions (adjusted HRs, 95%CI) were used to measure the association between malnutrition (according to GLIM criteria and the 7 approaches) and the risk of mortality.

Results: Complete data to calculate GLIM were available for 373 subjects (73.07±5.96 y, 56% women). The prevalence of malnutrition with GLIM criteria was 24.4% and ranged from 13.9-20.9% in the 7 approaches. All showed high concordance (k≥0.7) with the original GLIM criteria, correct performance indicators (sensitivity≥65%, specificity≥95.4%, PPV≥85%, NPV≥88%, AUC≥0.7), and were feasible (TELOS≥3). Ishii's formula had the highest sensitivity (71.4%), NPV (91.19%), and AUC (0.735). The 7 approaches significantly predicted mortality during a 5-year follow-up [HR of 3.38 (1.89-6.09) using the original GLIM criteria and HRs ranging from 2.72 (1.51-4.91) to 3.94 (2.14-7.24) using the pragmatic approaches].

Conclusion: Our study bridged the gap between research and clinical practice and provided 7 pragmatic approaches of GLIM criteria which were highly concordant with the original ones, had correct performance indicators, predicted 3- to 4-fold mortality during a 5-y follow-up, and were feasible.

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TRABECULAR BONE SCORE AND BONE MARKERS AS PREDICTORS OF FRACTURE RISK IN OBESE MIDDLE-AGED DIABETIC AND NONDIABETIC PATIENTS

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Objective: To examine a correlation between bone markers and trabecular bone score (TBS) in obese and obese diabetic patients.

Methods: 79 obese patients of both sexes and aged between 30-50 y were divided into two groups according to a diagnosis of diabetes mellitus. TBS measured by Lunar Prodigy DF + 50247 17 Health Care apparatus was compared to the values of osteocalcin, β-CrossLaps, vitamin D, PTHs, as well total calcium and phosphorus.

Results: There was a positive correlation between TBS (L1-L4, L1-L3, L1-L2, L2-L3, L2-L4, L3-L4) and PTH values ($p<0.05$), between TBS (L3-L4) and osteocalcin ($p<0.05$) and between TBS (L3-L4) and β-CrossLaps ($p<0.05$), based on the Pearson's correlation coefficient. According to the Student's t-test, statistically significant differences between obese with and without diabetes were in PTH and TBS values. Obese diabetics have, on average lower PTH (p-0.032)and TBS (L2-L3, L2-L4 i L3-L4, with p=0.044, p=0.036 and p=0.030, respectively) compared to obese nondiabetics. ANOVA analysis showed significant differences in PTH (p -0.017), s-Osteocalcin (p -0.046) and β-CrossLaps (p-0.03) between patients without damage in the bone microarchitecture, and subjects with initial and established impairments. Patients with no impairment have, on average, higher PTH, osteocalcin, and β-CrossLaps values than subjects with initial or established impairments.

Conclusion: Preliminary results of this study showed that bone markers and TBS could be useful in marking obesity as a risk factor for fracture frequency, regardless of the sex and the age of the patients.

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SOCIAL MEDIA INFLUENCERS GIVE BAD ADVICE ABOUT OPTIMAL VITAMIN D LEVELS AND DOSES

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