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SCIENTIFIC LETTER

Bridging the nutritional gap between the intensive care unit and the ward: A plea for action to ensure continuity of care

Reduciendo la brecha nutricional entre la unidad de cuidados intensivos y la planta: una llamada a la acción para asegurar la continuidad asistencial

Dear Editor,

We read with great interest the article by Giménez-Esparza et al. on the impact of patient safety on clinical outcomes.[1] Nutrition is a cornerstone of recovery in critically ill patients, and timely, effective medical nutrition therapy (MNT) is essential not only for physical and functional restoration but also for preventing post-intensive care syndrome (PICS).[2] Yet, one crucial aspect of patient safety is frequently overlooked: the management of nutrition at key transition points in the Intensive Care Unit (ICU). Delaying the management of these issues until a post-ICU outpatient assessment, rather than addressing them at the time they arise, constitutes a missed therapeutic opportunity.

Too often, MNT is de-prioritized at key transition points, particularly during weaning from mechanical ventilation and ICU discharge. These moments are critical windows where patients are especially vulnerable to undernutrition and its consequences.

The first challenge arises when patients are expected to meet their full caloric and protein requirements through exclusive oral intake immediately after extubation or in the days that follow. However, common issues affecting critically ill patients —such as dysphagia, anorexia, dyspnea or depression— can limit oral intake to as little as 700 Kcal/day,[3] far below the 25—30 kcal/kg/day typically recommended in the post-acute and post-ICU phases.[4] This gap can be alleviated by actively monitoring oral intake and avoiding premature removal of the nasogastric tube.[4] Continued enteral feeding, used as a supplement rather than a replacement, can help patients in reaching their nutritional targets while reducing the psychological burden of forced oral feeding.

The second problem occurs at ICU discharge, where nutrition plans are rarely communicated or continued. The result is a nutritional gap: a breakdown in continuity of care. A recent study found that only 2% of ICU discharge reports included a complete MNT plan, resulting in only 10% of patients subsequently receiving more than 70% of their estimated energy and protein needs on the ward.[5] As some have aptly put it, ''patients are fed according to how hungry their physicians are''. To address this, we propose the development of multidisciplinary teams including intensivists, endocrinologists, and clinical nutrition specialists to identify high-risk patients at ICU discharge and initiate immediate follow-up. These teams must adapt to local resources but should share the same goal: to provide structured, proactive nutrition care beyond the ICU walls. Moreover, ICU discharge reports must routinely include clear nutritional goals and feeding plans. Candidates for follow-up by these teams may include patients who meet GLIM malnutrition criteria, those with obesity, those failing to meet 70% of nutritional targets, and those requiring ongoing artificial nutrition.

From our perspective, nutrition must be seen as a continuum of care. We call on intensivists to monitor oral intake as closely as they do with the other modalities of artificial nutrition, retain feeding tubes until nutritional goals are safely met, and, above all, bridge the gap between the ICU and the ward through collaborative protocols, and patient-centered nutritional strategies.

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No generative AI or AI-assisted technologies were used in the preparation of this Letter to the Editor.

Declaration of competing interest

The authors declare that they have no conflicts of interest relevant to the content of this Letter to the Editor.

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