

DAFTAR PUSTAKA

1. Shin J, Hwang SY, Jo IJ, Kim WY, Ryoo SM, Kang GH, et al. Prognostic value of the lactate/albumin ratio for predicting 28-day mortality in critically ill sepsis patients. *Shock.* 2018;50(5):545–50.
2. Bennett KA, Robertson LC, Al-Haddad M. Recognizing the critically ill patient. *Anaesth Intensive Care Med.* 2016;17(1):1–4.
3. Maslove DM, Tang B, Shankar-Hari M, Lawler PR, Angus DC, Baillie JK, et al. Redefining critical illness. *Nat Med.* 2022;28(6):1141–8.
4. Bukhari A, Taslim NA, As'ad S, Rasyid H, Aminuddin, Muchtar F, et al. Comparison of different early enteral feeding formulas on critically ill patients. *J Nutr Sci Vitaminol (Tokyo).* 2020;66:S2–10.
5. Wang B, Chen G, Cao Y, Xue J, Li J, Wu Y. Correlation of lactate/albumin ratio level to organ failure and mortality in severe sepsis and septic shock. *J Crit Care.* 2015;30(2):271–5.
6. Kushimoto S, Akaishi S, Sato T, Nomura R, Fujita M, Kudo D, et al. Lactate, a useful marker for disease mortality and severity but an unreliable marker of tissue hypoxia/hypoperfusion in critically ill patients. *Acute Med Surg.* 2016;3(4):293–7.
7. Ferrer R, Mateu X, Maseda E, Yébenes JC, Aldecoa C, De Haro C, et al. Non-oncotic properties of albumin. A multidisciplinary vision about the implications for critically ill patients. *Expert Rev Clin Pharmacol.* 2018;11(2):125–37.
8. Gharipour A, Razavi R, Gharipour M, Mukasa D. Lactate/albumin ratio: An early prognostic marker in critically ill patients. *Am J Emerg Med.* 2020;38(10):2088–95.
9. Yoon SH, Choi B, Eun S, Bae GE, Koo CM, Kim MK. Using the lactate-to-albumin ratio to predict mortality in patients with sepsis or septic shock: a systematic review and meta-analysis. *Eur Rev Med Pharmacol Sci.* 2022;26(5):1743–52.
10. Chebl RB, Jamali S, Sabra M, Safa R, Berbari I, Shami A, et al. Lactate/Albumin Ratio as a Predictor of In-Hospital Mortality in Septic Patients Presenting to the Emergency Department. *Front Med.* 2020;7(9):1–11.
11. Kayambankadzanga, RK, Schell CO, Wärnberg MG, Tamras T, Mollazadegan H, Holmberg M, et al. Towards definitions of critical illness and critical care

- using concept analysis. *BMJ Open*. 2022;12(9):1–11.
- 12. Sharma K, Mogensen KM, Robinson MK. Pathophysiology of Critical Illness and Role of Nutrition. *Nutr Clin Pract*. 2019;34(1):12–22.
 - 13. Manda-Taylor L, Mndolo S, Baker T. Critical care in Malawi: The ethics of beneficence and justice. *Malawi Med J*. 2017;29(3):268–71.
 - 14. Relja B, Land WG. Damage-associated molecular patterns in trauma. *Eur J Trauma Emerg Surg*. 2020;46(4):751–75.
 - 15. Simsek T, Şimşek HU, Cantürk NZ. Response to trauma and metabolic changes: Posttraumatic metabolism. *Turkish J Surg*. 2014;30(3):153–9.
 - 16. Dobson GP, Letson HL, Sharma R, Sheppard FR, Cap AP. Mechanisms of early trauma-induced coagulopathy: The clot thickens or not? *J Trauma Acute Care Surg*. 2015;79(2):301–9.
 - 17. Kirkman E, Watts S. Haemodynamic changes in trauma. *Br J Anaesth*. 2014;113(2):266–75.
 - 18. Mayr FB, Yende S, Angus DC. Epidemiology of severe sepsis. *Virulence*. 2014;5(1):4–11.
 - 19. Shashikumar SP, Stanley MD, Sadiq I, Li Q, Holder A, Clifford GD, et al. Early sepsis detection in critical care patients using multiscale blood pressure and heart rate dynamics. *J Electrocardiol*. 2017;50(6):739–43.
 - 20. Cho SY, Choi JH. Biomarkers of Sepsis. *Infect Chemother*. 2014;46(1):1–12.
 - 21. Van Lier D, Pickkers P. Circulating biomarkers to assess cardiovascular function in critically ill. *Curr Opin Crit Care*. 2021;27(3):261–8.
 - 22. Van Ierssel SH, Jorens PG, Van Craenenbroeck EM, Conraads VM. The endothelium, a protagonist in the pathophysiology of critical illness: Focus on cellular markers. *Biomed Res Int*. 2014;2014(985813):1–11.
 - 23. Preiser JC, van Zanten ARH, Berger MM, Biolo G, Casaer MP, Doig GS, et al. Metabolic and nutritional support of critically ill patients: Consensus and controversies. *Crit Care*. 2015;19(1):1–11.
 - 24. Casaer MP, Ziegler TR. Nutritional support in critical illness and recovery. *Lancet Diabetes Endocrinol*. 2015;3(9):734–45.
 - 25. Schuetz P, Seres D, Lobo DN, Gomes F, Kaegi-Braun N, Stanga Z. Management of disease-related malnutrition for patients being treated in hospital. *Lancet*. 2021;398(10314):1927–38.
 - 26. Pomara C, Riezzo I, Bello S, De Carlo D, Neri M, Turillazzi E. A Pathophysiological Insight into Sepsis and Its Correlation with Postmortem

- Diagnosis. *Mediators Inflamm.* 2016;2016(4062829):1–11.
- 27. Gourd NM, Nikitas N. Multiple Organ Dysfunction Syndrome. *J Intensive Care Med.* 2020;35(12):1564–75.
 - 28. Ni YN, Wang YM, Liang BM, Liang ZA. The effect of hyperoxia on mortality in critically ill patients: A systematic review and meta analysis. *BMC Pulm Med.* 2019;19(1):1–11.
 - 29. Rossaint J, Zarbock A. Pathogenesis of multiple organ failure in sepsis. *Crit Rev Immunol.* 2015;35(4):277–91.
 - 30. Johansen ME, Johansson PI, Ostrowski SR, Bestle MH, Hein L, Jensen ALG, et al. Profound endothelial damage predicts impending organ failure and death in sepsis. *Semin Thromb Hemost.* 2015;41(1):19–25.
 - 31. Marik PE, Hooper MH. Normocaloric versus hypocaloric feeding on the outcomes of ICU patients: a systematic review and meta-analysis. *Intensive Care Med.* 2016;42(3):316–23.
 - 32. Zhu JL, Liu H, Wang LL, Lu XH, Yin HY, Lyu J, et al. Association of lactate to albumin ratio and bicarbonate with short-term mortality risk in patients with acute myocardial infarction. *BMC Cardiovasc Disord.* 2022;22(1):1–12.
 - 33. Cakir E, Turan IO. Lactate/albumin ratio is more effective than lactate or albumin alone in predicting clinical outcomes in intensive care patients with sepsis. *Scand J Clin Lab Invest.* 2021;81(3):225–9.
 - 34. Ryoo SM, Kim WY. Clinical applications of lactate testing in patients with sepsis and septic shock. *J Emerg Crit Care Med.* 2018;2:14–14.
 - 35. Sun S, Li H, Chen J, Qian Q. Lactic acid: No longer an inert and end-product of glycolysis. *Physiology.* 2017;32(6):453–63.
 - 36. Legouis D, Faivre A, Cippà PE, De Seigneux S. Renal gluconeogenesis: an underestimated role of the kidney in systemic glucose metabolism. *Nephrol Dial Transplant.* 2020;37(8):1417–25.
 - 37. Li X, Yang Y, Zhang B, Lin X, Fu X, An Y, et al. Lactate metabolism in human health and disease. *Signal Transduct Target Ther.* 2022;7(1):1–22.
 - 38. Ferguson BS, Rogatzki MJ, Goodwin ML, Kane DA, Rightmire Z, Gladden LB. Lactate metabolism: historical context, prior misinterpretations, and current understanding. Vol. 118, *European Journal of Applied Physiology.* 2018. 691–728 p.
 - 39. Wang JX, Choi SYC, Niu X, Kang N, Xue H, Killam J, et al. Lactic acid and an acidic tumor microenvironment suppress anticancer immunity. *Int J Mol Sci.*

- 2020;21(21):1–14.
40. Proia P, di Liegro CM, Schiera G, Fricano A, Di Liegro I. Lactate as a metabolite and a regulator in the central nervous system. *Int J Mol Sci.* 2016;17(9):1–20.
 41. Hernandez G, Bellomo R, Bakker J. The ten pitfalls of lactate clearance in sepsis. *Intensive Care Med [Internet].* 2019;45(1):82–5. Available from: <https://doi.org/10.1007/s00134-018-5213-x>
 42. Bakker J, Postelnicu R, Mukherjee V. Lactate: Where Are We Now? *Crit Care Clin.* 2020;36(1):115–24.
 43. Nolt B, Tu F, Wang X, Ha T, Winter R, Williams DL, et al. Lactate and Immunosuppression in Sepsis. *Shock.* 2018;49(2):120–5.
 44. Alhazzani W, Møller MH, Arabi YM, et al. Surviving Sepsis Campaign: Guidelines on the Management of Critically Ill Adults with Coronavirus Disease 2019 (COVID-19). *Crit Care Med.* 2020;48(6):440–69.
 45. Innocenti F, Meo F, Giacomelli I, Tozzi C, Ralli ML, Donnini C, et al. Prognostic value of serial lactate levels in septic patients with and without shock. *Intern Emerg Med.* 2019;14(8):1321–30.
 46. Suetrong B, Walley KR. Lactic acidosis in sepsis: it's not all anaerobic: implications for diagnosis and management. *Chest.* 2016;149(1):252–61.
 47. Wardi G, Brice J, Correia M, Liu D, Self M, Tainter C. Demystifying Lactate in the Emergency Department. *Ann Emerg Med.* 2020;75(2):287–98.
 48. Kraut JA, Madias NE. Lactic Acidosis: Current Treatments and Future Directions. *Am J Kidney Dis.* 2016;68(3):473–82.
 49. Silva CM, Baptista JP, Mergulhão P, Froes F, Gonçalves-Pereira J, Pereira JM, et al. Prognostic value of hyperlactatemia in infected patients admitted to intensive care units: a multicenter study. *Rev Bras Ter intensiva.* 2022;34(1):154–62.
 50. Messina A, Bakker J, Chew M, De Backer D, Hamzaoui O, Hernandez G, et al. Pathophysiology of fluid administration in critically ill patients. *Intensive Care Med Exp.* 2022;10(1):1–15.
 51. Pan J, Peng M, Liao C, Hu X, Wang A, Li X. Relative efficacy and safety of early lactate clearance-guided therapy resuscitation in patients with sepsis; A meta-analysis. *Med (United States).* 2019;98(8):1–9.
 52. Boucaud-Maitre D, Ropers J, Porokhov B, et al. Lactic acidosis: relationship between metformin levels, lactate concentration and mortality. *Diabet Med.* 2016;33(11):1536–43.

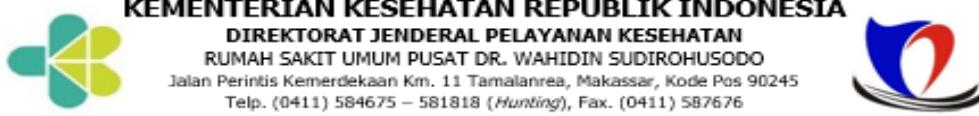
53. Villar J, Short JH, Lighthall G. Lactate Predicts Both Short- and Long-Term Mortality in Patients With and Without Sepsis. *Infrct Dis.* 2019;6(3):17–21.
54. Rabello F, Lima RL, Correa TG, et al. Blood Lactate Levels Cutoff and Mortality Prediction in Sepsis—Time for a Reappraisal? a Retrospective Cohort Study. *Shock.* 2016;46(5):480–5.
55. Haas SA, Lange T, Saugel B, Petzoldt M, Fuhrmann V, Metschke M, et al. Severe hyperlactatemia, lactate clearance and mortality in unselected critically ill patients. *Intensive Care Med.* 2016;42(2):202–10.
56. Belinskaia DA, Voronina PA, Batalova AA, Goncharov N V. Serum Albumin. *Encyclopedia.* 2020;1(1):65–75.
57. Levitt DG, Levitt MD. Human serum albumin homeostasis: A new look at the roles of synthesis, catabolism, renal and gastrointestinal excretion, and the clinical value of serum albumin measurements. *Int J Gen Med.* 2016;9:229–55.
58. Spinella R, Sawhney R, Jalan R. Albumin in chronic liver disease: structure, functions and therapeutic implications. *Hepatol Int.* 2016;10(1):124–32.
59. Hornok V. Serum albumin nanoparticles: Problems and prospects. *Polymers (Basel).* 2021;13(21):3759.
60. Bern M, Sand KMK, Nilsen J, Sandlie I, Andersen JT. The role of albumin receptors in regulation of albumin homeostasis: Implications for drug delivery. *J Control Release.* 2015;211:144–62.
61. Vincent JL, Russell JA, Jacob M, Martin G, Guidet B, Werner J, et al. Albumin administration in the acutely ill: What is new and where next? *Crit Care.* 2014;18(4):1061–7.
62. Kim S, McClave SA, Martindale RG, Miller KR, Hurt RT. Hypoalbuminemia and clinical outcomes: What is the mechanism behind the relationship? *Am Surg.* 2017;83(11):1220–7.
63. Yin M, Si L, Qin W, Li C, Zhang J, Yang H, et al. Predictive Value of Serum Albumin Level for the Prognosis of Severe Sepsis Without Exogenous Human Albumin Administration: A Prospective Cohort Study. *J Intensive Care Med.* 2018 Dec;33(12):687–94.
64. Liu Q, Zheng HL, Wu MM, Wang QZ, Yan SJ, Wang M, et al. Association between lactate-to-albumin ratio and 28-days all-cause mortality in patients with acute pancreatitis: A retrospective analysis of the MIMIC-IV database. *Front Immunol.* 2022;13(12):1–12.
65. Sheinenzon A, Shehadeh M, Michelis R, Shaoul E, Ronen O. Serum albumin

- levels and inflammation. *Int J Biol Macromol.* 2021;184:857–62.
66. Joannidis M, Wiedermann CJ, Ostermann M. Ten myths about albumin. *Intensive Care Med.* 2022;48(5):602–5.
67. Jagdish RK, Maras JS, Sarin SK. Albumin in Advanced Liver Diseases: The Good and Bad of a Drug! *Hepatology.* 2021;74(5):2848–62.
68. Whitman C. Fluid and Hyponatremia Management. *Crit Care Med.* 2017;45(3):486–552.
69. Kendall H, Abreu E, Cheng A-L. Serum Albumin Trend Is a Predictor of Mortality in ICU Patients With Sepsis. *Biol Res Nurs.* 2019;21(3):237–44.
70. Takegawa R, Kabata D, Shimizu K, et al. Serum albumin as a risk factor for death in patients with prolonged sepsis: An observational study. *J Crit Care.* 2019;51:139–44.
71. Rusli C, Bukhari A, Taslim NA, As'ad S, Rasyid H. Nutrition therapy in critically ill overweight elderly patient with heart failure, myocardial infarction, pneumonia, and chronic kidney disease. *J Nutr Sci Vitaminol (Tokyo).* 2020;66:S25–31.
72. Lichtenauer M, Wernly B, Ohnewein B, Franz M, Kabisch B, Muessig J, et al. The Lactate/Albumin Ratio: A Valuable Tool for Risk Stratification in Septic Patients Admitted to ICU. *Int J Mol Sci.* 2017 Sep;18(9).
73. Moustafa AA, Antonios MA, Abdellatif EM, Hussain AH. Association of lactate/albumin ratio level to organ failure and mortality in severe sepsis in a pediatric intensive care unit in Egypt. *Turk J Pediatr.* 2018;60(6):691–701.
74. Zhu X, Xue J, Liu Z, Dai W, Xu H, Zhou Q, et al. The Lactate/Albumin Ratio Predicts Mortality in Critically Ill Patients with Acute Kidney Injury: An Observational Multicenter Study on the eICU Database. *Int J Gen Med.* 2021;14:10511–25.
75. Al-Hamad D, Raman V. Metabolic syndrome in children and adolescents. *Transl Pediatr.* 2017;6(4):397–407.
76. Wischmeyer PE. Tailoring nutrition therapy to illness and recovery. *Crit Care.* 2017;21(3):1–11.
77. Akinosoglou K, Schinas G, Almyroudi MP, Gogos C, Dimopoulos G. The impact of age on intensive care. *Ageing Res Rev.* 2023;84(10):1–9.
78. Singer P, Blaser AR, Berger MM, Alhazzani W, Calder PC, Casaer MP, et al. ESPEN guideline on clinical nutrition in the intensive care unit. *Clin Nutr.* 2019;38(1):48–79.

79. Wu D, Shen S, Luo D. Association of lactate-to-albumin ratio with in-hospital and intensive care unit mortality in patients with intracerebral hemorrhage. *Front Neurol.* 2023;14(7):1–11.
80. Wang G, Liu J, Xu R, Fu Y, Liu X. Lactate/albumin ratio as a predictor of in-hospital mortality in critically ill children. *BMC Pediatr.* 2022;22(1):1–11.
81. Hu J, Jin Q, Fang H, Zhang W. Evaluating the predictive value of initial lactate/albumin ratios in determining prognosis of sepsis patients. *Medicine (Baltimore)*. 2024;103(12):1–5.
82. Lu Y, Guo H, Chen X, Zhang Q. Association between lactate/albumin ratio and all-cause mortality in patients with acute respiratory failure: A retrospective analysis. *PLoS One.* 2021;16(8):1–10.
83. Chen J, Gao C, Yang L, Yang L, He Y, Guo S, et al. The blood lactate/serum albumin ratio might represent a good prognostic indicator of 28-day mortality in patients with acute respiratory distress syndrome: a retrospective observational study. *Emerg Crit Care Med.* 2023;12(1):1–8.
84. Haschemi J, Müller CT, Haurand JM, Oehler D, Spieker M, Polzin A, et al. Lactate to Albumin Ratio for Predicting Clinical Outcomes after In-Hospital Cardiac Arrest. *J Clin Med.* 2023;12(12):1–14.
85. Yi X, Jin D, Huang S, Xie Z, Zheng M, Zhou F, et al. Association between lactate-to-albumin ratio and 28-days all-cause mortality in patients with sepsis-associated liver injury: a retrospective cohort study. *BMC Infect Dis [Internet]*. 2024;24(1):1–11. Available from: <https://doi.org/10.1186/s12879-024-08978-x>
86. Dudoignon E, Quennesson T, De Tymowski C, Moreno N, Coutrot M, Chaussard M, et al. Usefulness of lactate albumin ratio at admission to predict 28-day mortality in critically ill severely burned patients: A retrospective cohort study. *Burns.* 2022;48(8):1836–44.
87. Hill A, Elke G, Weimann A. Nutrition in the intensive care unit—a narrative review. *Nutrients.* 2021;13(8):1–26.
88. Huang T, Lin S. Usefulness of lactate to albumin ratio for predicting in-hospital mortality in atrial fibrillation patients admitted to the intensive care unit: a retrospective analysis from MIMIC-IV database. *BMC Anesthesiol.* 2024;24(1):1–9.
89. Abate SM, Basu B, Jemal B, Ahmed S, Mantefardo B, Taye T. Pattern of disease and determinants of mortality among ICU patients on mechanical ventilator in Sub-Saharan Africa: a multilevel analysis. *Crit Care.* 2023;27(1):1–

- 13.
90. Vickery N, Stephens T, du Toit L, van Straaten D, Pearse R, Torborg A, et al. Understanding the performance of a pan-African intervention to reduce postoperative mortality: a mixed-methods process evaluation of the ASOS-2 trial. *Br J Anaesth.* 2021;127(5):778–88.
 91. Weimann A, Braga M, Carli F, Higashiguchi T, Hübner M, Klek S, et al. ESPEN guideline: Clinical nutrition in surgery. *Clin Nutr.* 2017;36(3):623–50.
 92. Ren J, Kang Q, Wang F, Yu W. Association of lactate/albumin ratio with in-hospital mortality in ICU patients with acute respiratory failure: A retrospective analysis based on MIMIC-IV database. *Med (United States).* 2023;102(39):1–8.
 93. Rogobete AF, Grintescu IM, Bratu T, Bedreag OH, Papurica M, Crainiceanu ZP, et al. Assessment of metabolic and nutritional imbalance in mechanically ventilated multiple trauma patients: From molecular to clinical outcomes. *Diagnostics.* 2019;9(4).
 94. Jeong JH, Heo M, Lee SJ, Jeong YY, Lee JD, Yoo JW. Clinical usefulness of red cell distribution width/albumin ratio to discriminate 28-day mortality in critically ill patients with pneumonia receiving invasive mechanical ventilation, compared with lactate/albumin ratio: A retrospective cohort study. *Diagnostics.* 2021;11(12):1–9.

Lampiran 1.



Nomor : DP.04.03/D.XIX.2/17431/2023 18 September 2023
Hal : Izin Penelitian

Yth. Ketua Program Studi Ilmu Gizi Klinik
Fakultas Kedokteran Universitas Hasanuddin

Selubungan dengan surat saudara nomor 17217/UN4.6.8/PT.01.04/2023, tertanggal 21 Juli 2023, hal Permohonan Izin Penelitian, dapat kami fasilitasi dan memberikan izin pelaksanaan penelitian kepada:

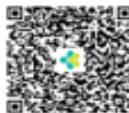
Nama : dr. Tien Muliawati Abadi
NIM : C175181006
Prog. Pend. : PPDS Ilmu Gizi Klinik
No. HP : 08114226172
Judul : Terapi Medik Gizi pada Pasien Kritis Kajian Terhadap Rasio Laktat Arteri dengan Albumin sebagai Prediktor Mortalitas di Ruang Intensive Care Unit RSUP Dr. Wahidin Sudirohusodo Makassar
Jangka Waktu : Tiga Bulan Setelah Surat ini di Keluarkan
Lokasi : Inst. Rekam Medik; Inst Sistem Informasi Rumah Sakit

dengan ketentuan sebagai berikut :

1. Sesuai dengan peraturan dan ketentuan penelitian yang berlaku di lingkup RSUP Dr Wahidin Sudirohusodo
2. Sebelum meneliti, peneliti wajib melapor kepada Pengawas Penelitian di masing-masing unit yang menjadi lokasi penelitian
3. Pelaksanaan penelitian tidak mengganggu proses pelayanan serta mendukung upaya peningkatan mutu pelayanan dan keselamatan pasien
4. Pemeriksaan penunjang, BHP dan lain-lain yang digunakan dalam penelitian, menjadi tanggung jawab peneliti, tidak dibebankan kepada pasien ataupun RS
5. Peneliti melaporkan proses penelitian secara periodik serta hasil penelitian di akhir waktu penelitian
6. Mencantumkan nama RSUP Dr Wahidin Sudirohusodo sebagai afiliasi institusi dalam naskah dan publikasi penelitian|
7. Surat Keterangan Selesai Penelitian menjadi salah satu syarat untuk mengikuti Seminar Hasil Penelitian
8. Bukti Penyerahan Skripsi/Thesis/Disertasi ke RSUP Dr Wahidin Sudirohusodo menjadi syarat penyelesaian studi

Mohon dapat dipastikan agar ketentuan tersebut dipenuhi peneliti sebelum menyelesaikan studi di institusi saudara. Atas perhatian dan Kerjasama yang baik, diucapkan terima kasih.

a.n. Direktur Utama
Direktur SDM, Pendidikan dan Penelitian,



Dr. dr. Nu'man A S Daud, Sp.PD, K-GEH, FINA SIM
NIP197112142000031004

Tembusan:

1. Kepala Instalasi Rekam Medik
2. Kepala Instalasi Sistem Informasi Rumah Sakit

Lampiran 2 Rekomendasi Persetujuan Etik UNHAS



KEMENTERIAN PENDIDIKAN, KEBUDAYAAN, RISET DAN TEKNOLOGI
 UNIVERSITAS HASANUDDIN FAKULTAS KEDOKTERAN
 KOMITE ETIK PENELITIAN UNIVERSITAS HASANUDDIN
 RSPTN UNIVERSITAS HASANUDDIN
 RSUP Dr. WAHIDIN SUDIROHUSODO MAKASSAR
 Sekretariat : Lantai 2 Gedung Laboratorium Terpadu
 JL PERINTIS KEMERDEKAAN KAMPUS TAMALANREA KM.10 MAKASSAR 90245.
 Contact Person: dr. Agusalim Bukhari.,MMed,PhD, SpGK TELP. 081241850858, 0411 5780103. Fax : 0411-581431



REKOMENDASI PERSETUJUAN ETIK

Nomor : 624/UN4.6.4.5.31/ PP36/ 2023

Tanggal: 5 September 2023

Dengan ini Menyatakan bahwa Protokol dan Dokumen yang Berhubungan Dengan Protokol berikut ini telah mendapatkan Persetujuan Etik :

No Protokol	UH23080625	No Sponsor	
Peneliti Utama	dr.Tien Muliawati Abadi	Sponsor	
Judul Peneliti	TERAPI MEDIK GIZI PADA PASIEN KRITIS KAJIAN TERHADAP RASIO LAKTAT ARTERI DENGAN ALBUMIN SEBAGAI PREDIKTOR MORTALITAS DI RUANG INTENSIVE CARE UNIT RSUP WAHIDIN SUDIROHUSODO		
No Versi Protokol	1	Tanggal Versi	24 Agustus 2023
No Versi PSP	1	Tanggal Versi	24 Agustus 2023
Tempat Penelitian	RSUP Dr. Wahidin Sudirohusodo Makassar		
Jenis Review	<input type="checkbox"/> Exempted <input checked="" type="checkbox"/> Expedited <input type="checkbox"/> Fullboard Tanggal	Masa Berlaku 5 September 2023 sampai 5 September 2024	Frekuensi review lanjutan
Ketua KEP Universitas Hasanuddin	Nama Prof.Dr.dr. Suryani As'ad, M.Sc.,Sp.GK (K)	Tanda tangan	
Sekretaris KEP Universitas Hasanuddin	Nama dr. Agussalim Bukhari, M.Med.,Ph.D.,Sp.GK (K)	Tanda tangan	

Kewajiban Peneliti Utama:

- Menyerahkan Amandemen Protokol untuk persetujuan sebelum di implementasikan
- Menyerahkan Laporan SAE ke Komisi Etik dalam 24 Jam dan dilengkapi dalam 7 hari dan Lapor SUSAR dalam 72 Jam setelah Peneliti Utama menerima laporan
- Menyerahkan Laporan Kemajuan (progress report) setiap 6 bulan untuk penelitian resiko tinggi dan setiap setahun untuk penelitian resiko rendah
- Menyerahkan laporan akhir setelah Penelitian berakhir
- Melaporkan penyimpangan dari protokol yang disetujui (protocol deviation / violation)
- Mematuhi semua peraturan yang ditentukan

Lampiran 3. Hasil SPSS

Case Processing Summary

			Cases		Total	
	Valid N	Percent	Missing N	Percent	N	Percent
RLAhighlow * Mortality	375	100.0%	0	0.0%	375	100.0%

RLAhighlow * Mortality Crosstabulation

			Mortality		Total	
			Ya	Tidak		
RLAhighlow	High (>0.71)	Count	95	70	165	
		% within RLAhighlow	57.6%	42.4%	100.0%	
	Low (≤0.71)	Count	70	140	210	
		% within RLAhighlow	33.3%	66.7%	100.0%	
Total		Count	165	210	375	
		% within RLAhighlow	44.0%	56.0%	100.0%	

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)	Point Probability
Pearson Chi-Square	22.039 ^a	1	.000	.000	.000	
Continuity Correction ^b	21.066	1	.000			
Likelihood Ratio	22.175	1	.000	.000	.000	
Fisher's Exact Test				.000	.000	
Linear-by-Linear Association	21.980 ^c	1	.000	.000	.000	.000
N of Valid Cases	375					

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 72.60.

b. Computed only for a 2x2 table

c. The standardized statistic is 4.688.

Risk Estimate

	Value	95% Confidence Interval	
		Lower	Upper
Odds Ratio for RLAhighlow (High (>0.71) / Low (≤0.71))	2.714	1.781	4.137
For cohort Mortality = Ya	1.727	1.370	2.178
For cohort Mortality = Tidak	.636	.520	.779
N of Valid Cases	375		

SGA_CB = C**Case Processing Summary^a**

			Cases		Total	
	Valid N	Percent	Missing N	Percent	N	Percent
RLAhighlow * Mortality	129	100.0%	0	0.0%	129	100.0%

a. SGA_CB = C

RLAhighlow * Mortality Crosstabulation^a

		Mortality		Total
		Ya	Tidak	
RLAhighlow	High (>0.71)	Count	36	56
		% within RLAhighlow	64.3%	35.7% 100.0%
	Low (≤0.71)	Count	23	50
		% within RLAhighlow	31.5%	68.5% 100.0%
Total		Count	59	70
		% within RLAhighlow	45.7%	54.3% 100.0%

a. SGA_CB = C

Chi-Square Tests^a

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)	Point Probability
Pearson Chi-Square	13.720 ^b	1	.000	.000	.000	
Continuity Correction ^c	12.431	1	.000			
Likelihood Ratio	13.924	1	.000	.000	.000	
Fisher's Exact Test				.000	.000	
Linear-by-Linear Association	13.613 ^d	1	.000	.000	.000	.000
N of Valid Cases	129					

a. SGA_CB = C

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 25.61.

c. Computed only for a 2x2 table

d. The standardized statistic is 3.690.

Risk Estimate^a

	Value	95% Confidence Interval	
		Lower	Upper
Odds Ratio for RLAhighlow (High (>0.71) / Low (≤0.71))	3.913	1.873	8.174
For cohort Mortality = Ya	2.040	1.381	3.015
For cohort Mortality = Tidak	.521	.355	.766
N of Valid Cases	129		

a. SGA_CB = C

AcidosisYN = Ya

Case Processing Summary ^a							
	Valid		Cases Missing		Total		Percent
	N	Percent	N	Percent	N		
RLAhighlow * Mortality	53	100.0%	0	0.0%	53	100.0%	

a. AcidosisYN = Ya

RLAhighlow * Mortality Crosstabulation^a

			Mortality			
			Ya	Tidak	Total	
RLAhighlow	High (>0.71)	Count	15	6	21	
		% within RLAhighlow	71.4%	28.6%	100.0%	
	Low (≤0.71)	Count	14	18	32	
		% within RLAhighlow	43.8%	56.3%	100.0%	
Total		Count	29	24	53	
		% within RLAhighlow	54.7%	45.3%	100.0%	

a. AcidosisYN = Ya

Chi-Square Tests^a

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)	Point Probability
Pearson Chi-Square	3.920 ^b	1	.048	.056	.044	
Continuity Correction ^c	2.883	1	.090			
Likelihood Ratio	4.014	1	.045	.056	.044	
Fisher's Exact Test				.056	.044	
Linear-by-Linear Association	3.846 ^d	1	.050	.056	.044	.033
N of Valid Cases	53					

a. AcidosisYN = Ya

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 9.51.

c. Computed only for a 2x2 table

d. The standardized statistic is 1.961.

Risk Estimate^a

	Value	95% Confidence Interval	
		Lower	Upper
Odds Ratio for RLAhighlow (High (>0.71) / Low (≤0.71))	3.214	.991	10.424
For cohort Mortality = Ya	1.633	1.013	2.631
For cohort Mortality = Tidak	.508	.242	1.067
N of Valid Cases	53		

a. AcidosisYN = Ya

AcidosisYN = Tidak**Case Processing Summary^a**

	Valid		Cases		Total	
	N	Percent	N	Percent	N	Percent
RLAhighlow * Mortality	322	100.0%	0	0.0%	322	100.0%

a. AcidosisYN = Tidak

RLAhighlow * Mortality Crosstabulation^a

RLAhighlow	High (>0.71)	Mortality		Total
		Ya	Tidak	
RLAhighlow	High (>0.71)	Count	80	64
	High (>0.71)	% within RLAhighlow	55.6%	44.4%
RLAhighlow	Low (<=0.71)	Count	56	122
	Low (<=0.71)	% within RLAhighlow	31.5%	68.5%
Total	High (>0.71)	Count	136	186
	High (>0.71)	% within RLAhighlow	42.2%	57.8%

a. AcidosisYN = Tidak

Chi-Square Tests^a

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)	Point Probability
Pearson Chi-Square	18.942 ^b	1	.000	.000	.000	
Continuity Correction ^c	17.968	1	.000			
Likelihood Ratio	19.052	1	.000	.000	.000	
Fisher's Exact Test				.000	.000	
Linear-by-Linear Association	18.884 ^d	1	.000	.000	.000	.000
N of Valid Cases	322					

a. AcidosisYN = Tidak

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 60.82.

c. Computed only for a 2x2 table

d. The standardized statistic is 4.346.

Risk Estimate^a

	Value	95% Confidence Interval	
		Lower	Upper
Odds Ratio for RLAhighlow (High (>0.71) / Low (<=0.71))	2.723	1.726	4.297
For cohort Mortality = Ya	1.766	1.360	2.294
For cohort Mortality = Tidak	.648	.527	.798
N of Valid Cases	322		

a. AcidosisYN = Tidak

Sex = Laki-laki

Case Processing Summary^a

			Cases			
	Valid N	Percent	Missing N	Percent	Total N	Percent
RLAhighlow * Mortality	197	100.0%	0	0.0%	197	100.0%

a. Sex = Laki-laki

RLAhighlow * Mortality Crosstabulation^a

		Mortality		Total
		Ya	Tidak	
RLAhighlow	High (>0.71)	Count	54	87
		% within RLAhighlow	62.1%	37.9% 100.0%
	Low (≤0.71)	Count	42	68 110
		% within RLAhighlow	38.2%	61.8% 100.0%
Total		Count	96	101 197
		% within RLAhighlow	48.7%	51.3% 100.0%

a. Sex = Laki-laki

Chi-Square Tests^a

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)	Point Probability
Pearson Chi-Square	11.095 ^b	1	.001	.001	.001	
Continuity Correction ^c	10.159	1	.001			
Likelihood Ratio	11.196	1	.001	.001	.001	
Fisher's Exact Test				.001	.001	
Linear-by-Linear Association	11.038 ^d	1	.001	.001	.001	.000
N of Valid Cases	197					

a. Sex = Laki-laki

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 42.40.

c. Computed only for a 2x2 table

d. The standardized statistic is 3.322.

Risk Estimate^a

	Value	95% Confidence Interval	
		Lower	Upper
Odds Ratio for RLAhighlow (High (>0.71) / Low (≤0.71))	2.649	1.485	4.728
For cohort Mortality = Ya	1.626	1.218	2.170
For cohort Mortality = Tidak	.614	.452	.833
N of Valid Cases	197		

a. Sex = Laki-laki

Sex = Perempuan

Case Processing Summary^a

			Cases			
	N	Percent	N	Percent	N	Percent
RLAhighlow * Mortality	178	100.0%	0	0.0%	178	100.0%

a. Sex = Perempuan

RLAhighlow * Mortality Crosstabulation^a

			Mortality		Total	
			Ya	Tidak		
RLAhighlow	High (>0.71)	Count	41	37	78	
		% within RLAhighlow	52.6%	47.4%	100.0%	
	Low (≤0.71)	Count	28	72	100	
		% within RLAhighlow	28.0%	72.0%	100.0%	
Total		Count	69	109	178	
		% within RLAhighlow	38.8%	61.2%	100.0%	

a. Sex = Perempuan

Chi-Square Tests^a

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)	Point Probability
Pearson Chi-Square	11.139 ^b	1	.001	.001	.001	
Continuity Correction ^c	10.128	1	.001			
Likelihood Ratio	11.178	1	.001	.001	.001	
Fisher's Exact Test				.001	.001	
Linear-by-Linear Association	11.076 ^d	1	.001	.001	.001	.000
N of Valid Cases	178					

a. Sex = Perempuan

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 30.24.

c. Computed only for a 2x2 table

d. The standardized statistic is 3.328.

Risk Estimate^a

	Value	95% Confidence Interval	
		Lower	Upper
Odds Ratio for RLAhighlow (High (>0.71) / Low (≤0.71))	2.849	1.528	5.313
For cohort Mortality = Ya	1.877	1.286	2.741
For cohort Mortality = Tidak	.659	.506	.858
N of Valid Cases	178		

a. Sex = Perempuan

VentilatorUsed = Ya

Case Processing Summary^a

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
RLAhighlow * Mortality	235	100.0%	0	0.0%	235	100.0%

a. VentilatorUsed = Ya

RLAhighlow * Mortality Crosstabulation^a

		Mortality			Total
		Ya	Tidak		
RLAhighlow	High (>0.71)	Count	82	18	100
		% within RLAhighlow	82.0%	18.0%	100.0%
	Low (≤0.71)	Count	54	81	135
		% within RLAhighlow	40.0%	60.0%	100.0%
Total		Count	136	99	235
		% within RLAhighlow	57.9%	42.1%	100.0%

a. VentilatorUsed = Ya

Chi-Square Tests^a

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)	Point Probability
Pearson Chi-Square	41.565 ^b	1	.000	.000	.000	
Continuity Correction ^c	39.860	1	.000			
Likelihood Ratio	43.937	1	.000	.000	.000	
Fisher's Exact Test				.000	.000	
Linear-by-Linear Association	41.388 ^d	1	.000	.000	.000	.000
N of Valid Cases	235					

a. VentilatorUsed = Ya

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 42.13.

c. Computed only for a 2x2 table

d. The standardized statistic is 6.433.

Risk Estimate^a

	Value	95% Confidence Interval		
		Lower	Upper	
Odds Ratio for RLAhighlow (High (>0.71) / Low (≤0.71))	6.833	3.693	12.645	
For cohort Mortality = Ya	2.050	1.635	2.570	
For cohort Mortality = Tidak	.300	.193	.466	
N of Valid Cases	235			

a. VentilatorUsed = Ya

VentilatorUsed = Tidak

Case Processing Summary^a

	Cases				N	Percent
	Valid		Missing			
	N	Percent	N	Percent	N	
RLAhighlow * Mortality	140	100.0%	0	0.0%	140	100.0%

a. VentilatorUsed = Tidak

RLAhighlow * Mortality Crosstabulation^a

		Mortality		Total
		Ya	Tidak	
RLAhighlow	High (>0.71)	Count	13	52
		% within RLAhighlow	20.0%	80.0%
	Low (<=0.71)	Count	16	59
		% within RLAhighlow	21.3%	78.7%
Total		Count	29	111
		% within RLAhighlow	20.7%	79.3%

a. VentilatorUsed = Tidak

Chi-Square Tests^a

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)	Point Probability
Pearson Chi-Square	.038 ^b	1	.846	1.000	.507	
Continuity Correction ^c	.000	1	1.000			
Likelihood Ratio	.038	1	.846	1.000	.507	
Fisher's Exact Test				1.000	.507	
Linear-by-Linear Association	.037 ^d	1	.847	1.000	.507	.163
N of Valid Cases	140					

a. VentilatorUsed = Tidak

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 13.46.

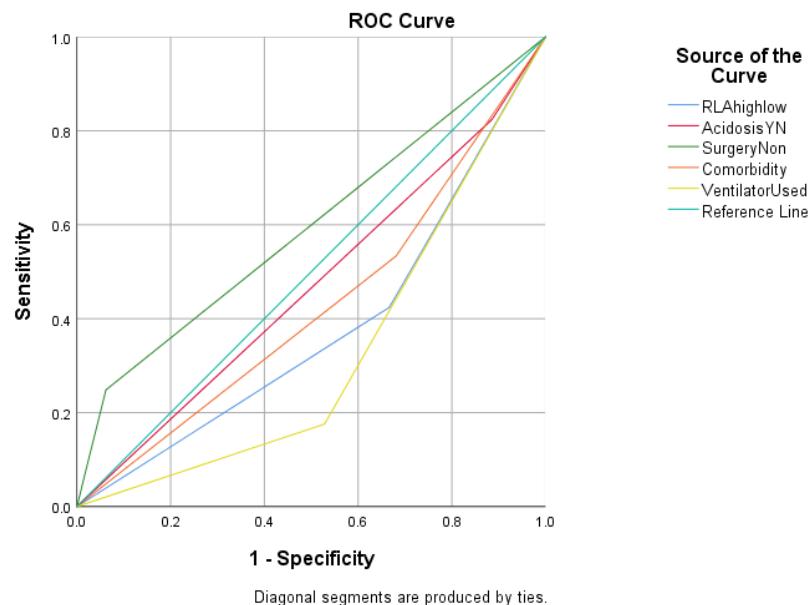
c. Computed only for a 2x2 table

d. The standardized statistic is -.193.

Risk Estimate^a

	Value	95% Confidence Interval	
		Lower	Upper
Odds Ratio for RLAhighlow (High (>0.71) / Low (<=0.71))	.922	.405	2.096
For cohort Mortality = Ya	.938	.488	1.800
For cohort Mortality = Tidak	1.017	.859	1.205
N of Valid Cases	140		

a. VentilatorUsed = Tidak



Area Under the Curve

Test Result Variable(s)	Area	Std. Error ^a	Asymptotic Sig. ^b	Asymptotic 95% Confidence Interval	
				Lower Bound	Upper Bound
RLAhighlow	.379	.029	.000	.321	.436
AcidosisYN	.469	.030	.307	.410	.528
SurgeryNon	.593	.030	.002	.534	.652
Comorbidity	.426	.030	.014	.368	.485
VentilatorUsed	.324	.028	.000	.269	.378

The test result variable(s): RLAhighlow, AcidosisYN, SurgeryNon, Comorbidity, VentilatorUsed has at least one tie between the positive actual state group and the negative actual state group. Statistics may be biased.

- a. Under the nonparametric assumption
- b. Null hypothesis: true area = 0.5

ROC Curve

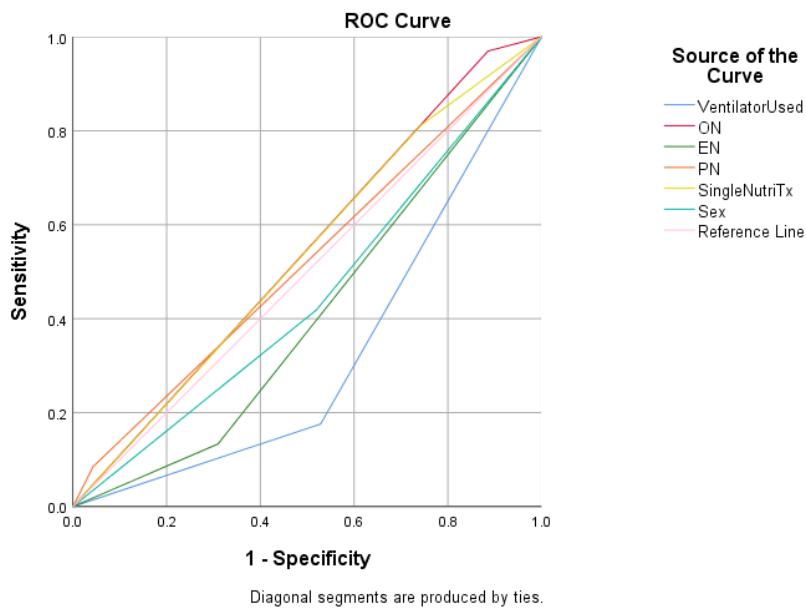
Notes		
Output Created		26-APR-2024 16:38:59
Comments		
Input	Data	D:\Lateral System\Karya Tulis\2023 laktat albumin\data RLA Final ve17.sav
	Active Dataset	DataSet1
	Filter	<none>
	Weight	<none>
	Split File	<none>
	N of Rows in Working Data File	375
Missing Value Handling	Definition of Missing	User-defined missing values are treated as missing.
	Cases Used	Statistics are based on all cases with valid data for all variables in the analysis.
Syntax	ROC VentilatorUsed ON EN PN SingleNutriTx Sex BY Mortality (1) /PLOT=CURVE(REFERENCE) /PRINT=SE /CRITERIA=CUTOFF(INCLUDE) TESTPOS(LARGE) DISTRIBUTION(FREE) CI(95) /MISSING=EXCLUDE.	
Resources	Processor Time	00:00:00.11
	Elapsed Time	00:00:00.10

Case Processing Summary

Mortality	Valid N (listwise)
Positive ^a	165
Negative	210

Larger values of the test result variable(s) indicate stronger evidence for a positive actual state.

a. The positive actual state is Ya.



Test Result Variable(s)	Area	Std. Error ^a	Asymptotic	Asymptotic 95% Confidence Interval		
				Sig. ^b	Lower Bound	Upper Bound
VentilatorUsed	.324	.028	.000		.269	.378
ON	.542	.030	.163		.484	.600
EN	.412	.029	.003		.355	.469
PN	.521	.030	.485		.462	.580
SingleNutriTx	.535	.030	.249		.476	.593
Sex	.450	.030	.094		.391	.508

The test result variable(s): VentilatorUsed, ON, EN, PN, SingleNutriTx, Sex has at least one tie between the positive actual state group and the negative actual state group. Statistics may be biased.

- a. Under the nonparametric assumption
- b. Null hypothesis: true area = 0.5