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## Editor's Note

### Nutrition in the Elderly: Food for Thought



Dr. Barry Goldlist, Editor in Chief, Geriatrics & Aging

Taking a 'stroll' through a geriatric unit, either in acute care or rehabilitation, one is struck by how many of the patients seem undernourished. This highlights the need for clinical dietitians as part of the multidisciplinary team required for effective geriatric care. Thankfully, most elderly people are not admitted to a geriatric unit, and their dietary issues are more similar to those facing the population at large.

Clearly, it is much better to eat in a healthy manner to prevent functional decline than it is to engage in heroic 'salvage' operations when catastrophic illness strikes (see the article 'Supporting seniors to age well with healthy eating' in this edition). However, the biggest issue facing most Western populations is not under nutrition, but rather excess weight. Should the same guidelines for overweight apply to those over 65 as have been developed in middle-aged populations? I am somewhat comforted, as I note my expanding waistline, by an article in last year's *Archives of Internal Medicine*<sup>1</sup> that suggests modest degrees of overweight (BMI 25–27) in the elderly do not increase cardiac and all cause mortality (although frank obesity does).

Even more interesting than total energy intake, is the content of the diet. Clearly elderly patients can suffer from specific nutritional deficiencies, such as Vitamin D or zinc (see article in this issue 'Zinc Deficiency in older adults' by AlAteequi and Allard). However, healthy people of all ages are thinking beyond simple dietary deficiency and wondering about the optimal dietary intake. In the current jargon, you are what you eat. This edition contains an article on diet and prostate disease and, of interest to both men and women, one on the relationship of Vitamin E to dementia (see article by Basran and Hogan in this edition). We usually think of vitamin E as a possible treatment of Alzheimer disease, but the antioxidant actions of vitamin E have long been postulated to be of benefit to the aging brain even before dementia occurs. Two recent studies in the *Journal of the American Medical Association* provide some evidence for the protective effects of vitamin E (and perhaps vitamin C).<sup>2,3</sup> Of course, epidemiological studies do not prove cause and effect; rather, they suggest appropriate directions for future treatment studies. What I found interesting is that while in both of these studies the relative risk of dementia was decreased by high dietary vitamin E (and in the first study, but not the second, high dietary vitamin C), supplements of vitamin E seemed to have no benefit.

Why might this be? The most obvious answer is that those who take Vitamin E supplements are different from those who do not; specifically, they might choose to take vitamin E when they detect early memory problems that predict future dementia. As well, vitamin E has only become popular as a supplement recently; thus, those who take their vitamin E as a supplement might not have had as long an exposure to its benefits as have those with a life-long, high dietary intake. It might also be that vitamin E is simply a surrogate for another dietary constituent that is actually of benefit. The fact that the two studies are discordant in their results with vitamin C is also cause for concern.

Regardless of the true relationship between vitamin E and dementia, there is no doubt that this edition of *Geriatrics and Aging* will provide a great deal of 'food for thought'. ♦

## References

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2. Englehart MJ, Geerlings MI, et al. JAMA 2002;287: 3223-9.
3. Morris MC, Evans DA, et al. JAMA 2002;287:3230-7.