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Editorial

Is There a Need for a Minimum Data Set for Nutritional Intervention Studies in Older Persons?

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THERE are now numerous studies that have demonstrated that weight loss in older persons is associated with poor outcomes (1–10). Protein energy malnutrition has been associated with immune dysfunction (11), infections (12), pressure ulcers (13), cognitive disturbance (14), frailty (15–19), hip fractures (20), anemia (21), falls (22), and alterations in anabolic hormones (23). Despite these epidemiological associations, there is limited data demonstrating that nutritional intervention in sick elderly patients can reverse these effects (24).

The best data for an improvement in outcome with a reversal of weight loss comes from the meta-analysis by the Cochrane collaboration that caloric supplements decrease mortality and length of hospitalization (25). Data by Yeh and colleagues (26) have suggested positive effects of megestrol acetate, and the GAIN (Geriatric Anorexia Nutrition) registry found that nursing home residents who gained weight had a significantly lower mortality than those who continued to lose weight (10).

The causes of weight loss in older persons are, as has been pointed out previously in the Journals, multifactorial (27,28). The most common cause of weight loss in older persons is depression (29,30). Other causes include inadequate feeding assistance (31,32), isolation (33), pain (34), poor environment (35), medications (36), and a variety of medical conditions (37). Weight loss from protein energy malnutrition needs to be distinguished from that due to dehydration (38).

The Council on Nutrition in Long Term Care has developed a useful algorithm for an approach to the management of weight loss in the long-term care situation (39). In many patients, weight loss can be reversed with the use of antidepressants with orexigenic properties such as mirtazapine (40). The place of anabolic steroids, such as testosterone, for pure weight loss has been poorly defined, and these agents should perhaps be limited to use in persons with sarcopenia (41–47). Orexigenics such as megestrol acetate or dronabinol are useful in persons where no obvious cause of weight loss is present (48).

Despite the evolving data and a strong belief that improving nutrition will enhance function (49), improve mobility (50), and reverse frailty (17,18), the interventional data proving this to be the case is miniscule. There is a major need to develop studies in older persons where the effects of nutritional interventions, both food and orexigenic drugs, as well as system-based interventions are studied in detail. This editorial represents a call for these studies to be done.

As a guideline for the methodological approaches to the data collection for nutritional intervention studies, with the *Journal of Nutrition, Health and Aging* we are jointly publishing the guidelines developed by the International Association of Gerontology/International Academy of Nutrition and Aging (IAG/IANA) Task Force (51). We are hopeful that this will stimulate carefully designed studies that will answer the role of nutrition in the management of older persons who are losing weight. As always, we strongly encourage letters either agreeing or disagreeing with aspects of this editorial and/or the Task Force's Report.

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