Plasma amino acid concentrations in healthy and cognitively impaired oldest-old individuals: associations with anthropometric parameters of body composition and functional disability

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Only a few reports exist of plasma amino acid profiles in the oldest-old, and none exist of the oldest-old with cognitive problems. Therefore, we measured fasting plasma amino acid concentrations in twenty-three healthy community-dwellers aged 90–103 years (group A); eighteen community-dwellers with mild cognitive impairment without dementia aged 91–104 years (group B); thirty-three patients with dementia aged 96–100 years (group C); and sixty healthy young controls aged 20–50 years. Biochemical and anthropometric parameters, and the basic activities of daily living (ADL) were also measured. Independent of cognitive status, in all oldest-old groups, essential:non essential amino acids (EAA:NEAA) was lower than in young controls and positively associated with body muscle mass. Patients with dementia were further characterized by a negative association between EAA:NEAA and the number of dependent ADL. All oldest-old groups had higher values of tyrosine:other large neutral amino acids (LNAA) than young controls. Groups B and C also had a higher phenylalanine:other LNAA. These data show that abnormalities in plasma amino acid profile are common in oldest-old individuals independent of their cognitive status, but that, in oldest-old patients with dementia, they are associated with functional disability. The abnormalities in phenylalanine and tyrosine plasma availability could contribute to the cause or aggravation of concurrent cognitive problems because these amino acids are neurotransmitter precursors and compete with other LNAA for transport into the brain.


Fasting plasma amino acids reflect recent protein intake and can be altered by a deficient intake of any essential amino acid (EAA), by an imbalance of the amino acids in the dietary proteins, or by a deficient protein–energy intake (Young, 1990). Plasma amino acids may also be affected by liver (Zoli et al. 1981) and kidney failure (Laidlaw et al. 1994; Fiorini & Cavatorta, 1997), alterations of glucose tolerance (Felg & Bergman, 1995), and hypermetabolic conditions associated with infections and other inflammatory disorders (Young, 1990).

According to experimental results, some amino acids (phenylalanine (Phe), tyrosine (Tyr), tryptophan, histidine, arginine (Arg), threonine, glycine (Gly)) act as neurotransmitter precursors, and their plasma concentrations might be a regulating factor in brain function (Lieberman, 1999).

The prevalence of nutritional (Schlienger et al. 1995) and cognitive disorders (Ritchie & Kildea, 1995) increases with age, but only a few studies have investigated the plasma amino acid pattern of elderly people (Rudman et al. 1989; Jeevanandam et al. 1990). Even fewer reports

Abbreviations: ADL, activities of daily living; Arg, arginine; BCAA, branched-chain amino acids; Cit, citrulline; DSM-IV, Diagnostic and Statistical Manual of Mental Disorders, 4th ed.; EAA, essential amino acid; Gly, glycine; IGF-1, insulin-like growth factor 1; LNAA, large neutral amino acids; NEAA, non-essential amino acids; Phe, phenylalanine; Tyr, tyrosine.

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(Bancel et al. 1994; Polge et al. 1997) exist of the amino acid profile in the age group known as the oldest-old (≥85 years of age), and no data are available about plasma amino acids of oldest-old individuals with cognitive problems.

An inadequate dietary intake leads not only to changes in fasting amino acid profile, but also to changes in body muscle and fat mass and in tissue biochemistry that may affect health status and functional performance of elderly people (Raynaud-Simon & Lesourd, 2000). Several techniques exist for the assessment of these changes in human subjects, but most of them are too invasive and complex for routine use in the elderly. Along with clinical data, simple and reliable, although somewhat gross, diagnostic parameters of protein–energy malnutrition generally used in geriatric practice are anthropometric measurements, which give information on the status of muscle and fat mass (World Health Organization, 1998), and biochemical tests aimed to evaluate body visceral transport proteins such as serum albumin (Constans et al. 2000).

In the present study we aimed to compare the fasting amino acid profile of healthy and cognitively impaired over-90-year-olds with the fasting amino acid profile of healthy young controls. We also investigated the relationships among plasma amino acid profile, anthropometric and biochemical markers of protein–energy malnutrition routinely used in geriatric practice, and physical disability.

**Subjects and methods**

**Subjects**

In order to create a bank of biomedical data and biological material available for studies of ageing, from January 1994 to January 1996 we recruited by several methods (advertisement, lists of medical practitioners, demographic lists from municipality registry offices) 160 over-90-year-olds resident in the provinces of Bologna and Ravenna (Emilia Romagna Region, Northern Italy) who were not institutionalized and were willing to undergo a standardized comprehensive geriatric assessment and venous blood draw. The procedure was performed with informed consent of the subjects or their next-of-kin, and with approval of the institutional review board of the Department of Internal Medicine, Cardioangiology, and Hepatology. Selected subgroups of these subjects have been described previously elsewhere (Ravaglia et al. 1996, 1997a,b, 1999). Due to the mixed recruitment procedure used, our database cannot be considered representative of the general Northern Italian oldest-old population.

Briefly, our assessment included for each subject: (1) a standardized interview for the collection of socio-demographic and medical data; (2) a thorough medical and neurological examination; (3) a performance-based assessment of the independence in the six basic activities of daily living (ADL) (Katz et al. 1970); (4) cognitive testing by the Italian version of the thirty-item Mini Mental State Examination (Valente et al. 1992); (5) drawing of an overnight fast venous blood sample for blood routine chemistry and, when available, surplus serum and plasma storage; (6) recumbent anthropometric measurements according to standardized procedures (Ravaglia et al. 1997b). BMI was calculated as weight (kg) divided by the square of the height (m) calculated from the knee-height measurement (Chumlea et al. 1985). Arm muscle area and arm fat area were calculated from mid-arm circumference and triceps skinfold thickness using standard formulas (Frisancho, 1981).

For the purposes of the present study, we selected seventy-four subjects (twenty-seven men and forty-seven women) who were assigned to group A, B or C.

Group A (n 23, age range 90–103 years) included community-dwelling healthy subjects who had Mini Mental State Examination scores in the normal range (20–30) according to Cummings’ (1993) education-specific cut-off points (19/30 for 0 to 4 years of education, 23/30 for 5 to 8 years, 27/30 for 9 to 12 years, 29/30 for 13 or more years), functioned well in their surroundings, and fulfilled the health admission criteria of the SENIEUR protocol for gerontological studies in man (Ligthart et al. 1984).

Briefly, SENIEUR exclusion criteria are: (1) clinical evidence of infective, inflammatory, neoplastic, and other acute or chronic disease including protein–energy malnutrition (as defined by clinical judgment and BMI <20 kg/m² for females and <22 kg/m² for males); (2) alteration of one or more of several laboratory indices, including erythrocyte sedimentation rate, haemoglobin, mean corpuscular volume, leucocyte count, urea, glucose, cholesterol and triacylglycerols, alkaline phosphatase, aspartate aminotransferase, alanine aminotransferase, serum protein electrophoresis, and urinalysis; (3) prescribed medication for treatment of acute or chronic disorders.

Group B (n 18, age range 91–104 years) included community-dwellers with Mini Mental State Examination scores below the education-adjusted cut-off points (range 19–22), but whose cognitive problems were not severe enough to meet the criteria for dementia stated by the American Psychiatric Association (1994) in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

Group C (n 33, age range 96–100 years) included subjects who had a clinical diagnosis of dementia according to DSM-IV criteria (Mini Mental State Examination range 0–22). Twenty-eight had Alzheimer’s disease (McKhann et al. 1984), four had vascular dementia (World Health Organization, 1992), and one suffered from Parkinson’s disease. Fifteen patients of this group were institutionalized.

In order to exclude underlying medical conditions affecting amino acid metabolism, exclusion criteria for group B and C included clinical and/or laboratory evidence of cancer and cardiovascular, pulmonary, hepatic, renal, or endocrine-metabolic diseases.

The remaining eighty-six over-90-year-olds listed in our database were not included in the present study because no plasma specimens were available for amino acid profile determination and/or because of concomitant acute or chronic diseases. These subjects did not differ significantly from the study subjects as to age, gender, cognitive status, and anthropometric measurements, but were more often institutionalized (46% compared with 20% of the study subjects; χ² = 11.006, P<0.001) and functionally...
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dependent (91% dependent in at least one of the six ADL compared with 70% of the study subjects; χ² = 9.595, P = 0.002).

As a young control group, we used sixty healthy functionally independent individuals aged 25–50 years, recruited among the hospital staff from January 1995 to January 1996. They had no known acute or chronic illness, were not taking any medication, and did not follow special diet regimens. Their BMI was in the normal range for adults (20–24.9 kg/m²) (Shenkin et al. 1996).

Laboratory procedures

A venous blood sample was taken from each participant between 6.00 and 9.00 hours, after an overnight fast. The blood samples of the oldest-old were collected at the subject’s place of residence on the same morning as the medical examination, whereas the samples from the young controls were collected at our laboratory. In both cases, samples were put on ice and processed within 1 h. Plasma samples were kept frozen at −70°C until analysis.

Concentrations of plasma amino acids were determined with a 3A30 Carlo Erba Amino Analysers (Carlo Erba, Fisons, Rodano, Milan, Italy) as described previously (Marchesini et al. 1987). In our laboratory, the intra-assay and inter-assay CV in the determination of plasma amino acids were ±5% and ±10%, respectively. According to storage studies at −70°C (Hubbard & Mejia, 1995), the amino acids measured in the present study are substantially stable in plasma except for the conversion of glutamine and asparagine into glutamic and aspartic acid respectively. For this reason, we calculated the sums of glutamine and glutamic acid and of asparagine and aspartic acid.

Additionally, serum creatinine, plasma total cholesterol, serum albumin, serum C-reactive protein, and serum insulin-like growth factor 1 (IGF-1) concentrations were assayed on frozen blood samples for all subjects as previously described (Ravaglia et al. 1996, 2000).

Calculations

Valine, leucine, and isoleucine were summed as branched-chain amino acids (BCAA). BCAA plus the aromatic amino acids Tyr and Phe were summed as large neutral amino acids (LNAA). BCAA along with Phe, methionine, threonine, lysine, and histidine were summed as EAA. Alanine, Gly, serine, glutamine, proline, Arg, taurine, glutamine + glutamic acid, asparagine + aspartic acid, ornithine, citrulline (Cit) and cystine were summed as non-essential amino acids (NEAA).

The following amino acid ratios were calculated: EAA: NEAA and Phe:Tyr, which are typically decreased in protein–energy malnutrition (Antener et al. 1981), and Cit:Arg and Gly:serine, which are typically increased in renal failure (Laidlaw et al. 1994). We also calculated Tyr: other LNAA and Phe:other LNAA because they are better predictors of Phe and Tyr availability to the brain than plasma concentrations (Lieberman, 1999).

<table>
<thead>
<tr>
<th>Study group...</th>
<th>Young controls (n 60)</th>
<th>Group A (n 23)</th>
<th>Group B (n 18)</th>
<th>Group C (n 33)</th>
<th>P value (one-way ANOVA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
</tr>
<tr>
<td></td>
<td>28·8</td>
<td>7·2</td>
<td>96·8*</td>
<td>4.9</td>
<td>96·4*</td>
</tr>
<tr>
<td>Sex: male</td>
<td>30</td>
<td>10</td>
<td>9</td>
<td>8</td>
<td>10</td>
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<tr>
<td>female</td>
<td>30</td>
<td>13</td>
<td>9</td>
<td>9</td>
<td>10</td>
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<tr>
<td>Dependency in ADL</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fully independent: n</td>
<td>60</td>
<td>9</td>
<td>4</td>
<td>2</td>
<td>&lt;0·001</td>
</tr>
<tr>
<td>%</td>
<td>100</td>
<td>40</td>
<td>22</td>
<td>6</td>
<td>0·001§</td>
</tr>
<tr>
<td>Dependent in 1–3 ADL: n</td>
<td>0</td>
<td>7</td>
<td>9</td>
<td>5</td>
<td>&lt;0·001</td>
</tr>
<tr>
<td>%</td>
<td>100</td>
<td>40</td>
<td>22</td>
<td>6</td>
<td>0·001§</td>
</tr>
<tr>
<td>Dependent in &gt;3 ADL: n</td>
<td>0</td>
<td>7</td>
<td>9</td>
<td>5</td>
<td>0·001</td>
</tr>
<tr>
<td>%</td>
<td>100</td>
<td>40</td>
<td>22</td>
<td>6</td>
<td>0·001§</td>
</tr>
<tr>
<td>Serum albumin (g/l)</td>
<td>41</td>
<td>2</td>
<td>40</td>
<td>5</td>
<td>37*</td>
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<tr>
<td>Plasma cholesterol (mmol/l)</td>
<td>4·7</td>
<td>1·5</td>
<td>5·4</td>
<td>1·3</td>
<td>5·1</td>
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<tr>
<td>Plasma triacylglycerols (mmol/l)</td>
<td>1·2</td>
<td>0·4</td>
<td>1·4</td>
<td>0·7</td>
<td>1·2</td>
</tr>
<tr>
<td>Serum reactive C-protein (mg/l)</td>
<td>3·7</td>
<td>1·2</td>
<td>3·1</td>
<td>1·5</td>
<td>4·6</td>
</tr>
<tr>
<td>Serum IGF-1 (µg/l)</td>
<td>229</td>
<td>50</td>
<td>96*</td>
<td>31</td>
<td>72*</td>
</tr>
<tr>
<td>Serum creatinine (µmol/l)</td>
<td>78</td>
<td>20</td>
<td>117*</td>
<td>33</td>
<td>124*</td>
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<tr>
<td>BMI (kg/m²)</td>
<td>23·9</td>
<td>2·1</td>
<td>24·5</td>
<td>3·9</td>
<td>23·6</td>
</tr>
<tr>
<td>Arm muscle area (cm²)</td>
<td>38·00</td>
<td>9·20</td>
<td>33·86*</td>
<td>8·71</td>
<td>29·36*</td>
</tr>
<tr>
<td>Arm fat area (cm²)</td>
<td>12·58</td>
<td>4·21</td>
<td>9·44*</td>
<td>5·77</td>
<td>7·61*</td>
</tr>
</tbody>
</table>

ADL, activities of daily living; IGF-1, insulin-like growth factor-1.

* P < 0·01 compared with young controls (after adjustment for all pair-wise comparisons by Bonferroni’s test).
† P < 0·01 compared with young controls, group A, and B (after adjustment for all pair-wise comparisons by Bonferroni’s test).
‡ P < 0·01 compared with young controls and group A (after adjustment for all pair-wise comparisons by Bonferroni’s test).
§ χ² test.
∥ For details of study groups and procedures, see p. 564.
Statistics

Data are reported as mean and standard deviations or number and percentage except for plasma amino acid concentrations, which had markedly skewed distributions. In order to avoid the variety of mathematical transformations that would otherwise be required in order to fulfill the assumptions of normality for each amino acid, their plasma concentrations are reported as medians (25th–75th percentiles).

Differences in anthropometric, biochemical, and functional characteristics among the study groups were evaluated by one-way parametric ANOVA (Bonferroni’s test for all pair-wise multiple comparisons) or \( \chi^2 \) test, as appropriate. Differences in plasma amino acid profile were evaluated by Kruskall–Wallis one-way ANOVA on ranks (Dunn’s test for all pair-wise multiple comparisons). Gender-related differences among each study group were tested by Student’s \( t \) test or Mann–Whitney non-parametric test, as appropriate.

In order to investigate the relationship of plasma amino acid profile with the other study variables, Spearman rank correlation coefficients were calculated separately for the four study groups. Correlation coefficients were tested for significance at \( P < 0.010 \). This conservative a level was chosen to reduce the risk of type 1 errors based on the small number of study subjects and the large number of tests of significance being made.

Statistical calculations were performed by SYSTAT10 (SPSS Inc, Chicago, IL, USA).

Results

Table 1 displays the characteristics of the study groups. Independent of cognitive status, all oldest-old groups had lower serum IGF-1, higher serum creatinine, and lower arm muscle area and arm fat area values than young controls. Both group B and C had lower serum albumin than young controls whereas no difference was found for group A. Group C was older and had lower serum IGF-1, BMI, arm muscle area and arm fat area values than group A and B. Group C also had the highest percentage of dependent ADL. Because of the reduced number of oldest-old subjects and the lack of gender-related statistically significant differences in any of the variables of interest except for arm muscle area values of young controls (men 41.53 (SD 9.10) cm\(^2\), women 33.61 (SD 6.42) cm\(^2\), \( P < 0.001 \)), men and women of each study group were pooled.

Tables 2 and 3 report the amino acid profile of young controls and oldest-old groups. No gender-related difference was found for any of the measured plasma amino acids. Independent of cognitive status, all the three oldest-old groups had higher Cit, cystine, asparagine + aspartate, glutamine + glutamic acid, and 3-methylhistidine plasma values, and lower EAA:NEAA and higher Tyr:other LNAA and Cit:Arg than young controls. Group A was further characterized by lower BCAA than young controls. Group B and group C had higher Gly plasma values and higher Phe:other LNAA and Gly:serine than young controls.

<table>
<thead>
<tr>
<th>Amino acid</th>
<th>Young controls</th>
<th>Group A</th>
<th>Group B</th>
<th>Group C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valine</td>
<td>240</td>
<td>187</td>
<td>168</td>
<td>120</td>
</tr>
<tr>
<td>Leucine</td>
<td>145</td>
<td>107</td>
<td>103</td>
<td>97</td>
</tr>
<tr>
<td>Isoleucine</td>
<td>69</td>
<td>49</td>
<td>41</td>
<td>40</td>
</tr>
<tr>
<td>Phenylalanine</td>
<td>34</td>
<td>34</td>
<td>34</td>
<td>34</td>
</tr>
<tr>
<td>Alanine</td>
<td>27</td>
<td>17</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>Histidine</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Lysine</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>11</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Study group</th>
<th>Amino acid (\mu mol/l)</th>
<th>Median</th>
<th>25th–75th percentiles</th>
<th>Median</th>
<th>25th–75th percentiles</th>
<th>Median</th>
<th>25th–75th percentiles</th>
<th>Median</th>
<th>25th–75th percentiles</th>
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<tr>
<td></td>
<td>Valine</td>
<td>240</td>
<td>187</td>
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<td>120</td>
<td>120</td>
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<td></td>
<td>Leucine</td>
<td>145</td>
<td>107</td>
<td>103</td>
<td>97</td>
<td>97</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Isoleucine</td>
<td>69</td>
<td>49</td>
<td>41</td>
<td>40</td>
<td>40</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Phenylalanine</td>
<td>34</td>
<td>34</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Alanine</td>
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<tr>
<td></td>
<td>Histidine</td>
<td>11</td>
<td>11</td>
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</tr>
<tr>
<td></td>
<td>Lysine</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

Table 2. Fasting plasma essential amino acid profile of the young controls and oldest-old groups‡

‡ For details of study groups and procedures, see p. 564.
### Table 3. Fasting plasma non-essential amino acid profile of the young controls and oldest-old groups†

(Median values and 25th–75th percentiles)

<table>
<thead>
<tr>
<th>Study group</th>
<th>Young controls (n 60)</th>
<th>Group A (n 23)</th>
<th>Group B (n 18)</th>
<th>Group C (n 35)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Median 25th–75th percentiles</td>
<td>Median 25th–75th percentiles</td>
<td>Median 25th–75th percentiles</td>
<td>Median 25th–75th percentiles</td>
<td></td>
</tr>
<tr>
<td>Glycine (μmol/l)</td>
<td>213 189–255</td>
<td>219 156–283</td>
<td>275 224–378</td>
<td>263 210–316</td>
<td>0·004</td>
</tr>
<tr>
<td>Serine (μmol/l)</td>
<td>104 85–124</td>
<td>96 81–111</td>
<td>97 87–129</td>
<td>103 85–124</td>
<td>0·254</td>
</tr>
<tr>
<td>Proline (μmol/l)</td>
<td>257 202–366</td>
<td>233 148–262</td>
<td>225 166–304</td>
<td>228 183–307</td>
<td>0·080</td>
</tr>
<tr>
<td>Taurine (μmol/l)</td>
<td>68 34–125</td>
<td>51 41–64</td>
<td>56 40–74</td>
<td>58 45–69</td>
<td>0·485</td>
</tr>
<tr>
<td>Tyrosine (μmol/l)</td>
<td>60 48–77</td>
<td>58 49–63</td>
<td>69 53–104</td>
<td>69 56–88</td>
<td>0·055</td>
</tr>
<tr>
<td>Ornithine (μmol/l)</td>
<td>102 72–127</td>
<td>89 70–110</td>
<td>92 68–109</td>
<td>90 73–124</td>
<td>0·626</td>
</tr>
<tr>
<td>3-Methylhistidine</td>
<td>249 256–159</td>
<td>6 4–7</td>
<td>5 0–7</td>
<td>6 4–9</td>
<td>0·001</td>
</tr>
<tr>
<td>Glutamine+glutamate</td>
<td>491 435–565</td>
<td>632 523–714</td>
<td>638 455–795</td>
<td>684 536–802</td>
<td>&lt;0·001</td>
</tr>
<tr>
<td>EAA:NEAA</td>
<td>0·47 0·44–0·53</td>
<td>0·39 0·33–0·45</td>
<td>0·39 0·35–0·46</td>
<td>0·39 0·35–0·43</td>
<td>&lt;0·001</td>
</tr>
<tr>
<td>Phenylalanine:tyrosine</td>
<td>0·9 0·8–1·1</td>
<td>0·9 0·7–1·0</td>
<td>0·9 0·7–1·0</td>
<td>0·9 0·7–1·0</td>
<td>&lt;0·001</td>
</tr>
<tr>
<td>Citrulline:arginine</td>
<td>0·3 0·1–0·8</td>
<td>0·9 0·6–1·0*</td>
<td>0·8 0·6–0·8*</td>
<td>0·8 0·7–1·0*</td>
<td>&lt;0·001</td>
</tr>
<tr>
<td>Glycine:serine</td>
<td>2·1 1·8–2·5</td>
<td>2·3 2·0–2·6</td>
<td>2·6 2·2–3·4*</td>
<td>2·4 2·1–2·7*</td>
<td>0·003</td>
</tr>
</tbody>
</table>

EAA, essential amino acids; NEAA, non-essential amino acids.

* P<0·05 compared with young controls (by Kruskall–Wallis ANOVA after adjustment for all pair-wise comparisons by Dunn’s test).
† For details of study groups and procedures, see p. 564.
A general linear multivariate model taking into account age, gender and institutionalization as possible confounding factors was performed (after appropriate normalization) for all the variables that were statistically different across groups at one-way ANOVA. All results were confirmed except for Gly values and Gly:serine of group B and C which were no longer statistically different from those of young controls.

No significant correlation between amino acid profile and any of the study variables was found in young controls. The most consistent association across the three oldest-old groups was between arm muscle area and EAA:NEAA (Fig. 1). In group A, arm muscle area was also positively associated with valine ($r = 0.556, P = 0.006$). In group C, arm fat area was positively associated with Phe, leucine, and histidine (Fig. 2), whereas the number of dependent ADL was negatively associated with EAA:NEAA (Fig. 3). A non-significant trend towards positive associations was found for both serum albumin and BMI with EAA:NAA across all the oldest-old groups ($P$ values between 0-10 and 0-05), and a marginally significant positive association ($r = 0.363, P = 0.032$) was found for BMI and Phe in group C. Serum creatinine was positively associated with cystine.
to the rather conservative choice for was found between plasma amino acid profile and the var-

in group B. No other statistically significant correlation

$r = 0.651, P = 0.001$ and leucine ($r = 0.556, P = 0.007$) in

group A, and with 3-methylhistidine ($r = 0.638, P = 0.006$) in

group B. No other statistically significant correlation

was found between plasma amino acid profile and the vari-
bles of interest. It must be remembered, however, that due
to the rather conservative choice for $\alpha$ level, the probability

of type 2 errors is large.

**Discussion**

The present study showed that the fasting plasma amino acid profile of oldest-old individuals with varying degree

cognitive impairment is different from that of the young adults, is associated with some anthropometric

parameters of body composition and, in oldest-old patients

with dementia, with functional dependency.

Our study has two major strengths. First, very few

studies have focused on fasting plasma amino acid profiles

of elderly people. Second, we adopted very strict selection

criteria in order to avoid the confounding effect of any

pathological conditions other than cognitive problems on

nutritional status and amino acid metabolism.

The present study also has several important limitations.

First, plasma amino acids represent only a small fraction of

the total body content, are subjects to many sources of vari-
ation other than diet, and are in constant state of exchange

with intracellular protein pools (Young, 1990). Therefore,
as also suggested by the lack of statistically significant

associations in functionally independent healthy young
controls, interpretation of any relationship between

plasma values of single amino acids and other variables

in older people requires extreme caution. Second, we did

not measure the essential amino acid tryptophan, although

tryptophan is an LNAA precursor of the neurotransmitter

serotonin. The brain tryptophan supply, however, is a func-
tion of the relative concentrations of free and albumin-
bound pool of tryptophan in blood (Partridge & Frier,
1990). Because the method we employed in order to

assess plasma amino acid profile did not allow a reliable

measurement of free tryptophan, we did not include trypt-

ophan among the study variables. Third, we pooled men and

women because of the reduced number of study subjects. Although from a biological point of view gender is very

likely to represent a confounding factor for several of our

study variable, no gender-related differences were found

in univariate analysis except for muscle mass in young
controls, and a multivariate analysis taking gender into

account was unable to add significant information to our

results, perhaps as a consequence of the small group
sizes. Noteworthy, gender-related differences have been

reported for some amino acids in young subjects but not

in aged subjects (Cubelli et al. 1991). Finally, for prac-
tical reasons related to the extreme age of our study sub-
jects, we could not measure dietary intake of energy and
protein. This information would have been very useful to

assess the adequacy of recent nutritional intake and to

understand better the cause of protein–energy malnutrition

in individuals exhibiting anthropometric and/or biochemi-
signs of this condition. Values of BMI ($<20\,kg/m^2$)

and/or serum albumin ($<35\,g/l$) consistent with a diagnosis

of mild protein–energy malnutrition (Shenkin et al. 1996)

were found in none of the SENIEUR oldest-old, 39% of

the oldest-old subjects who were cognitively impaired

without dementia and 42% of all patients with dementia.

As expected from previous studies, an age-related

reduction in muscle (sarcopenia) (Melton et al. 2000), fat

mass (Ravaglia et al. 1997b), and circulating levels of the

anabolic hormone IGF-1 (Flier & Underhill, 1997) were

also observed in all oldest-old individuals, independ-

ent of cognitive function. With respect to the SENIEUR

group, however, patients with dementia not only had a

reduced muscle mass (which could be due to both an

inadequate protein–energy intake and inactivity-induced

atrophy), but also a reduced fat mass, which is an index

of body energy stores (Frisancho, 1981), and reduced

values of serum IGF-1, which has been suggested to be a

far more sensitive marker of undernutrition than circulating

visceral proteins (Shenkin et al. 1996).

A first finding of the present study is that, independent of

cognitive function, EAA:NEAA of all oldest-old groups

was reduced with respect to young controls and positively

associated with muscle mass. A reduction in EAA:NEAA

has been already reported in elderly (Rudman et al.
1989; Jeevanandam et al. 1990) and oldest-old subjects

(Bancel et al. 1994), and might be suggestive of a diet

only marginally deficient in energy but containing an insuf-
ficient amount of proteins (Shenkin et al. 1996). The
replacement of dietary proteins with carbohydrates,

which are less expensive, more palatable, and more

easily chewable, is a common nutritional mistake even

among healthy elderly people because of dentition and

socio-economic problems (Thomas, 1998). Our finding of

low EAA:NEAA values and BCAA concentrations even

in the highly selected SENIEUR subjects is in agreement

with the view that dietary deficits may be very frequent

even among apparently healthy elderly subjects (Ravaglia
et al. 2000).

In the oldest-old with overt dementia, plasma avail-
ability of some EAA (Phe, leucine, histidine) was also

associated with fat mass. Preservation of fat mass requires

an adequate energy intake and, on their part, EAA cannot

be synthesized by the body but must be obtained from

Fig. 3. Relationship between the number of dependent activities of daily living and essential:non-essential amino acids (EAA:NEAA) in subjects with dementia aged $\geq 90$ years ($r = -0.470, P = 0.006$).
the diet. This, along with the great variability observed for these EAA plasma values in patients with dementia, suggests that these subjects might have a diet not only inadequate in its protein–energy content but also very unbalanced in its amino acid composition.

The fact that none of our study subjects exhibited clinical or biochemical signs of inflammation (serum C-reactive protein >8 mg/l) may explain why we did not find the general decrease of both EAA and NEAA reported by Polge et al. (1997) in hospitalized oldest-old patients with severe malnutrition (average BMI <17 kg/m², average serum albumin <30 g/l) and a large prevalence of hypermetabolic states (average serum C protein 30 g/l) and a large prevalence of hypermetabolic states (average serum C protein >5 mg/l).

BMI (Group A: \( r = 0.364, P=0.087 \); Group B: \( r = 0.355, P=0.146 \); Group C: \( r = 0.070, P=0.686 \)) and serum albumin (Group A: \( r = 0.223, P=0.301 \); Group B: \( r = 0.225, P=0.360 \); Group C: \( r = 0.060, P=0.732 \)) did not associate significantly with amino acid profile as we observed for arm fat area and arm muscle area. This agrees with previous suggestions that serum albumin by itself is unreliable as a nutritional marker because of the wide range of physiopathological conditions affecting its blood levels (Shenkin et al. 1996), and that upper arm anthropometry may provide better nutritional parameters than BMI in older subjects because of the high frequency of motor and spinal impairments affecting stature and weight measurement (World Health Organization, 1998).

Among oldest-old patients with dementia, we also found a striking positive association between EAA:NEAA and functional impairment. In particular, about 88% of the patients who had EAA:NEAA values below the 25th percentile for young controls (0.44) were dependent in three or more dependent ADL. This relationship may be easily explained by the fact that cognitive impairment affects the ability to independently select and eat food.

Kidneys play an important role in NEAA metabolism, and increases in cystine, aspartic and glutamic acid plasma concentrations and in Cit:Arg as those observed in our oldest-old subjects have been reported in renal failure (Fiorini & Cavatorta, 1997). Similarly, a loss of renal excretory capacity elevates the plasma concentrations of 3-methylhistidine, which is excreted by the kidney as a waste product of protein metabolism and whose plasma concentrations are highly reflective of renal function even at early stages of renal impairment (Laidlaw et al. 1994). Both ageing (Niederstadt & Steinhoff, 1997) and malnutrition (Benabe & Martinez-Maldonado, 1998) may be associated with a progressive deterioration of renal function, but alterations of the fasting amino acid profile clearly consistent with a reduced renal function have not been previously reported in the elderly (Rudman et al. 1989; Jeevanandam et al. 1990; Bancel et al. 1994; Polge et al. 1997). Only a few significant associations were found in the present study between plasma amino acids and serum creatinine of the oldest-old, but this could be a consequence of the small number of subjects in each group, of the very conservative \( \alpha \) level chosen, and of the fact that, in the elderly, changes in serum creatinine levels due to a reduced renal function may be masked by the concurrent reduction in muscle mass (Fasthomb et al. 1996).

Finally, the amino acid profile of the oldest-old subjects was characterized by a relative increase in plasma aromatic amino acids with respect to other LNAA. According to Rudman et al. (1991), elderly people may suffer from a limitation in the capacity of the homogentisic acid pathway, the common hepatic degradative pathway of Phe and Tyr, which could potentially reduce the dietary requirements and the tolerance to aromatic amino acids in elderly people. This limitation might be relevant to cognitive function because aromatic amino acids act as catecholaminergic precursors. Since all LNAA are actively transported across the blood–brain barrier by the same carrier mechanism, aromatic amino acids compete with other LNAA for transport into the brain (Lieberman, 1999).

Therefore, an increased influx of Phe or Tyr may alter the balance between catecholaminergic and serotoninergic function due to the competition of aromatic amino acids with the serotoninergic precursor tryptophan (Hargreaves & Pardridge, 1988). Moreover, Phe and its metabolites may have toxic effects on the brain (Hutenlocher, 2000). In normal adult human subjects, convincing experimental evidence of an association between cognitive performance and fasting plasma concentrations of specific LNAA has been reported for tryptophan only (Lieberman, 1999). Data about the possible association between dementia and plasma LNAA in the elderly are also scant and contrasting (Bonaccorso et al. 1998; Fekkes et al. 1998), but increases in Phe:LNAA have been recently reported in association with delirium (Flacker & Lipsitz, 2000).

In conclusion, we found several differences in plasma amino acid profile between young controls and oldest-old subjects with different degrees of cognitive impairment. Because some of these changes, in particular the abnormalities of aromatic amino acids availability, could contribute to the cause of or aggravate concurrent neurological and behavioural problems of oldest-old individuals with cognitive disorders, further research is needed about amino acid requirements in the extreme decades of human life.

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References


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