Dietary intake and nutritional status in cancer patients: comparing adults and older adults

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INGESTA DIETÉTICA Y ESTADO NUTRICIONAL EN PACIENTES CON CÁNCER: COMPARACIÓN ENTRE ADULTOS Y ADULTOS MAYORES

Resumen

Objetivo: Evaluar la ingesta de nutrientes y el estado nutricional de los alimentos en pacientes con cáncer ingresados en un hospital universitario, comparando por categoría de edad entre adulto y adulto mayor.


Resultados: Se evaluó a un total de 86 pacientes con una edad promedio de 56.5 años, con 55% varones y 42% adultos mayores. La categoría de adultos mayores tenía con mayor frecuencia peso bajo (24.4% frente a 16.3%, p < 0.01) y una menor frecuencia de sobrepeso (7% frente a 15.1%, p < 0.01) que los adultos. Ambos grupos tenían una frecuencia elevada de fumadores, consumo de alcohol e inactividad física. Los adultos mayores tenían un menor consumo de calorías, ingesta de hierro y ácido fólico. Se observó una ingesta inadecuada de vitaminas en ambos grupos; respectivamente, 52%, 43%, 95%, 76% y 88% para las vitaminas A, C, D, E y el ácido fólico. No hubo una asociación entre la ingesta de micronutrientes con el cáncer ni con el estado nutricional.

Conclusion: La ingesta de alimentos y de macro y micronutrientes es insuficiente en el grupo de adultos y un peor estado nutricional en la categoría de adultos mayores.

Key words: Diet. Cancer. Lifestyle habits. Nutritional status. Older adults.
Introduction

The etiology of cancer is multifactorial. Factors involved include the dietary habits and its composition, age and nutritional status. Diet can have both, positive or negative carcinogenic effects on some types of cancer.

Current evidence suggests that high consumption of red meat and protein are associated with increased colorectal cancer. Factors, associated with a lower cancer incidence, were high intake of fish, fruit, vegetables and whole grains. Factors regarding adequate consumption of vitamin D and dietary fiber are not as well established with lower risks of cancer.

Age is another risk factor. Average age of cancer is 65 years or older and median age of most common adult tumors is 70 years. The scientists are studying the basic molecular and cellular processes of aging on the mechanisms of tumor development and growth, but, currently, has not been completely defined.

Nutritional status is also an important factor in the cancer growth and development. Malnutrition and obesity have distinct implications, with the potential of a negative prognosis in cancer. In the older adults, this problem is aggravated since malnutrition is found to be a common problem at hospital admissions depending on the methods used and the disease, itself.

The objective of this study was to analyze the food intake and consumption of macro and micronutrients, as well as nutritional status, in an inpatient cancer group, comparing adults and older adults.

Methodology

This cross-sectional study included in patients with different cancer diagnosis, independent of disease length. Patients were admitted to a university hospital in Rio de Janeiro, Brazil, during the second semester of 2010. All patients were evaluated according to dietary habits and nutritional status, within the first 48 hours of admission. The inclusion criteria were patients >20 years of age, both genders, with a diagnosis of cancer. Age > 60 year was considered old adult. The exclusion criteria was pregnancy and lactation. The hospital’s Research Ethics Committee (Protocol 1754/08) approved this criteria.

Dietary Assessment

This assessment was based on a semi-quantitative, interviewer-administered food frequency questionnaire (FFQ) with 82 food items. The results were described according to qualitative and quantitative food groups, and intake of macro and micronutrients. The DIET PRO software version 4.011 was used for diet analysis.

This survey evaluated total energy intake, consumption of carbohydrates, proteins and lipids (saturated, polyunsaturated and monounsaturated fats). In addition to cholesterol, vitamins A, C, D, E, fiber, iron, calcium and folic acid were also analyzed.

The food groups were analyzed and compared with the Adapted Food Pyramid for the Brazilian population, dividing consumption by food groups and average quantities of consumption per group.

Consumption was also dichotomized into adequate/inadequate. Adequate groups were three to five servings’ fruit (400 g), four to five servings’ vegetables (150-200 g), three portions (400-600 g) of milk and dairy products, one to two servings (100-200 g) meat and eggs.

The Dietary Reference Intake was used to evaluate intake of micronutrients in relation to age and sex. In relation to vitamins, levels less than 625 or 500 mcg for Vitamin A, and 75 mg or 60 mg for Vitamin C, respectively, for men and women were considered low. Vitamin D, E and folic acid was considered low in both sexes if levels were lower than 10 mcg, 12 mcg and 320 mcg, respectively. Regarding minerals, calcium intake was defined as lower if levels were less than 1,000 mg to 1300 mg for adults and older adults;

Iron levels were considered low if level was less than 5 mg to 6 mg for men and women, respectively, and Selenium consumption level was less than 45 mcg.

Other data related to lifestyle risk, such as physical activity, smoking and alcohol consumption was also collected and analyzed. Patients were considered sedentary if they exercised less than 30 minutes a week. Regarding smoking, patients were classified as smokers or non-smokers; and alcoholism was characterized as frequent alcohol consumption or not at all, according to self-declaration.

Nutritional Assessment

Weight and height were determined with a mechanic scale (Fillizola®) with maximum capacity being 150 kg and accuracy of 0.1 kg. Based on this data calculated the Body Mass Index (BMI), dividing the weight by the square of the height (kg/m²) and nutritional status was classified according to the World Health Organization criteria (WHO, 1998). Adult criteria was as follows: BMI (kg/m²) < 18.5 = Underweight; 18.5 ≤ BMI ≤ 24.9 = Normal; 25 ≤ BMI ≤ 29.9 = Overweight; BMI ≥ 30 = Obesity. For older adult BMI Lipschitz was used BMI ≤ 22 = Under-nutrition; 22 < BMI < 27 = Normal; BMI ≥ 27 = Overweight.

Statistical Analysis

Descriptive analysis used average values, standard error and standard frequency. The Kolmogorov-Smirnov test used to assess normality. For variables with normal distribution, the Student t test was used. Variables without normal distribution used the Mann-
Whitney test to compare older adults and adults. Quantitative variables were transformed into dichotomous variables (normal or below the recommendation) and the chi-square test was used to assess differences in relation to inadequate micronutrient adults and older adults. The software used was SPSS13 version 21.0. p value < 0.05 considered significant.

Results

Inpatients evaluated equaled 86 (39 woman and 47 men), with the mean age of 56.5 y, 42% were older adults. Regarding gender, 55% (n = 47) were male. The most common type of cancer was hematologic (23.3%), followed by lung (22.1%), gastrointestinal tract (25.6%) and other types (i.e. prostate and breast). Table I shows the characteristics of cancer patients, stratified by age: adults and older adults.

Table II characterizes the lifestyle risk, gender and type of tumor in the older adults and the adults with cancer. Although, there was no difference between the two age groups, a high smoking frequency (41%), alcohol consumption (29%) and physical inactivity (41%) was found in, both, adult and older adult categories.

In relation to the recommendations of the food pyramid, 70% resulted in an insufficient intake of fruits (average intake: 345 ± 317 g) and 64% of vegetables (average intake of 160 ± 130.2 g). Regarding the consumption of milk and dairy products, 84% consumed lower than the recommended amount of 400-600 ml. No difference was found in food intake insufficiencies between adult and older adults.

Regarding the macronutrient and fiber, both age groups consumed normal carbohydrate proportion (55.6%), protein (18%) and fat (27%), but there was an important inadequacy of fat composition, especially monounsaturated (6.5%) and polyunsaturated (4%) (table III), was identified. The adult group consumed a higher caloric intake than the older adults did (p = 0.023). More than 50% consumed less fiber than the recommended 30 g/day, with the mean ingestion being 20 g/day. More severe cases were identified among the older adults. (p = 0.054)

A comparison of micronutrients and mineral ingestion between adults and older adults is identified in table IV. Iron was the only mineral significantly less consumed by older adults than by adults (13.8 ± 1.6 vs 19.1 ± 1.4, p = 0.014).

When evaluating the dietary recommendation, both categories consumed less than the suggested amount. A minimal number of patients attained the vitamin D recommendation. No significant difference between the two groups was noticed, with the exception being, the consumption of folate and calcium was less in the older adult group. Folate (91.5% older adults inadequacy × 72% adult inadequacy, p = 0.024) and calcium (88% older adults inadequacy × 72% adult inadequacy, p = 0.049).

The inadequacies of micronutrient intake was not associated with either cancer types or nutritional status (data not shown).

Regarding nutritional status, 32% have normal BMI, 40.7% underweight and 22.1% overweight. BMI did not differ from adults to older adult patients (table I), as indicated in figure 1, the older adults had a higher frequency of lower weight than in the adult group (58.3 % vs 28%, p = 0.018).

Nutrition and cancer: comparing adults and older adults

Table I

Characteristics of the cancer patients: differences between adults and older adults

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Adults Means ± SD</th>
<th>Older adults Means ± SD</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (year)</td>
<td>45.5 ± 1.6</td>
<td>71.9 ± 1.2</td>
<td>0.001</td>
</tr>
<tr>
<td>Weight (kg)</td>
<td>59.8 ± 12.2</td>
<td>58.2 ± 16.3</td>
<td>0.661</td>
</tr>
<tr>
<td>Height (m)</td>
<td>1.7 ± 0.1</td>
<td>1.6 ± 0.1</td>
<td>0.004</td>
</tr>
<tr>
<td>BMI (kg/m²)</td>
<td>21.5 ± 0.6</td>
<td>22.1 ± 0.8</td>
<td>0.538</td>
</tr>
</tbody>
</table>

BMI = Body mass index, SD = Standard Deviation, p = T test.

Table II

Differences in the prevalence of male gender, tumor type, physical inactivity, smoking and alcohol habits, according to age category

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Adults % (n)</th>
<th>Older adults % (n)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>58 (29)</td>
<td>50 (18)</td>
<td>0.303</td>
</tr>
<tr>
<td>Tumor type</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hematologic</td>
<td>30 (15)</td>
<td>14 (5)</td>
<td>0.333</td>
</tr>
<tr>
<td>Lung</td>
<td>18 (15)</td>
<td>28 (10)</td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>24 (12)</td>
<td>28 (10)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>28 (14)</td>
<td>30 (11)</td>
<td></td>
</tr>
<tr>
<td>Physical inactivity</td>
<td>21 (42)</td>
<td>14 (38)</td>
<td>0.772</td>
</tr>
<tr>
<td>Smoking</td>
<td>19 (38)</td>
<td>16 (44)</td>
<td>0.548</td>
</tr>
<tr>
<td>Alcohol habits</td>
<td>15 (30)</td>
<td>10 (28)</td>
<td>0.823</td>
</tr>
</tbody>
</table>

n = patient number. Chi-square test.

Table III

Macronutrient intake: differences between adult and older adults

<table>
<thead>
<tr>
<th>Macronutrients</th>
<th>Adults Means ± SD</th>
<th>Older adults Means ± SD</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Energy intake (kcal)</td>
<td>2379.7 ± 160.6</td>
<td>1855.1 ± 145.5</td>
<td>.023</td>
</tr>
<tr>
<td>Carbohydrate (% energy)</td>
<td>54.3 ± 1.4</td>
<td>53.2 ± 1.6</td>
<td>.603</td>
</tr>
<tr>
<td>Protein (% energy)</td>
<td>18 ± 0.7</td>
<td>20.6 ± 1.2</td>
<td>.070</td>
</tr>
<tr>
<td>Fat (% energy)</td>
<td>27.8 ± 1.1</td>
<td>26.3 ± 1.3</td>
<td>.393</td>
</tr>
<tr>
<td>Saturated Fat (g)</td>
<td>7.4 ± 0.5</td>
<td>6.5 ± 0.5</td>
<td>.202</td>
</tr>
<tr>
<td>Monounsaturated Fat (g)</td>
<td>6.5 ± 0.7</td>
<td>5.9 ± 0.6</td>
<td>.586</td>
</tr>
<tr>
<td>Polyunsaturated Fat (g)</td>
<td>4.1 ± 0.5</td>
<td>3.6 ± 0.4</td>
<td>.475</td>
</tr>
<tr>
<td>Cholesterol (mg)</td>
<td>273.9 ± 35.9</td>
<td>198.7 ± 18.8</td>
<td>.067</td>
</tr>
<tr>
<td>Fiber (g/d)</td>
<td>23.0 ± 2.6</td>
<td>16.9 ± 1.7</td>
<td>.054</td>
</tr>
</tbody>
</table>

SD = Standard Deviation. p = T test.
When stratifying the population, according to the types of cancer (hematologic, lung and gastrointestinal tract), there was no difference in nutritional status. However, in patients diagnosed with hematological cancer, a higher BMI (23.51 ± 4.3 kg/m²) was found than in those with lung cancer (19.78 ± 3.47 kg/m², p = 0.012).

Discussion

Food intake and nutrition have different meanings. The meal involves social, emotional and economics aspects. It is known that food intake has several errors, not only in Brazil, but worldwide. These errors lead to several chronic diseases, including cancer, with an increased prevalence in older adults.

Age is another concern. A transition from independence to disability, noticed in older adults, modified body composition and impaired physical activity resulted in weight loss, decrease in food intake and nutritional change. This study concluded there was a high male and older adult prevalence, as previously presented by Azevedo CD and Ulsenheimer A.

The most prevalent cancer was hematological, pulmonary and gastrointestinal, different from a Brazilian study conducted by INCA that defined skin, prostate and breast cancer as the most prevalent. This difference was justified by the source of patients, as it evaluated in a tertiary university hospital, involving serious cases.

Analysis of the food consumption indicated a low percentage of milk and dairy product intake, lower than the dietary recommendation (DRI). The association between low milk intake and colorectal, prostate and bladder cancer has already been demonstrated.

Vogtmann E et al studied 60,000 men, from ages 40 to 74, and identified an inverse relation between fruit intake and colon cancer. Epplein M et al confirmed the protective effect of fruit in cancer prevention, described the same association. Vegetable consumption seemed to reduce IGF-1 levels because they are richness in micronutrients, such as vitamins, therefore, reducing cancer risk. A low consumption of fruit and vegetable was identified.

Meat intake was elevated, while a lower consumption of fish was observed. Steffen A et al has already observed a higher intake of processed meat is positively associated with upper digestive tract, as well as Norat T et al, verifying this association in colon cancer. Other authors have made the same observation. All these statistics discount the Mediterranean diet, that has been known to establish protection against several diseases, including cancer. The diet of fruits, vegetables, olive oil and fishes emphasized in the Mediterranean diet. It is important to observe that what is chosen in our alimentation can define our life quality and health. The older adults made the same mistakes in selecting their diet intake as the adult category.

<table>
<thead>
<tr>
<th>Macronutrients</th>
<th>Adults Means ± SD</th>
<th>Older adults Means ± SD</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vitamin A (UI)</td>
<td>1076.6 ± 158.6</td>
<td>1021.0 ± 207.5</td>
<td>0.668</td>
</tr>
<tr>
<td>Vitamin C (mg)</td>
<td>392.1 ± 92.9</td>
<td>207.8 ± 43.3</td>
<td>0.840</td>
</tr>
<tr>
<td>Vitamin D (UI)</td>
<td>2.2 ± 0.42</td>
<td>11.6 ± 7.1</td>
<td>0.703</td>
</tr>
<tr>
<td>Vitamin E (UI)</td>
<td>13.0 ± 1.77</td>
<td>9.2 ± 1.4</td>
<td>0.122</td>
</tr>
<tr>
<td>Folic acid (mcg)</td>
<td>233.9 ± 27.9</td>
<td>164.0 ± 18.4</td>
<td>0.237</td>
</tr>
<tr>
<td>Selenium (mcg)</td>
<td>107.9 ± 13.6</td>
<td>80.5 ± 10.2</td>
<td>0.349</td>
</tr>
<tr>
<td>Iron (mg)</td>
<td>19.1 ± 1.6</td>
<td>13.8 ± 1.4</td>
<td>0.014</td>
</tr>
<tr>
<td>Calcium (mg)</td>
<td>741.9 ± 73.5</td>
<td>643.3 ± 72.9</td>
<td>0.381</td>
</tr>
</tbody>
</table>

SD = Standard Deviation, p = T test.
Dietary composition was also inadequate in both groups, with older adults being inferior to the adult category, consuming fewer calories, carbohydrates and lipids. The imbalance was observed in both macro and micronutrients. Carbohydrates and lipids were adequately consumed according to dietary recommendation, although, the lipids composition was not. A high consumption of saturated lipids and low level of polyunsaturated lipids was observed. The Mediterranean diet emphasizes olive oil, rich in monounsaturated lipids, as a tumor protectant factor regulating the oncogenesis.\(^{38,39}\)

There was a high protein intake based on DRI, justified by the high meat intake. Ali A et al.\(^{40}\), demonstrated that a high protein intake allied to higher consumption of carbohydrate are associated with increased risk of Non-Hodgkin’s Lymphoma, whereas a significantly reduced risk was observed with higher intake of vegetables.

Epidemiological and clinical studies demonstrate that a recommended intake of dietary fiber and whole grain is inversely related to obesity, type two diabetes, cardiovascular disease and cancer.\(^{41-47}\). Although most studies demonstrate this association, no evidence of an inverse association between fiber and cancer in any subgroup defined by age was found. Hutter CM et al.\(^ {44}\) found no association, either.

Additional studies did not confirm the link. A prospective study of 16,448 U.S. men found no association between the dietary intake of total cereal or vegetable fiber and colorectal adenomas, although, a slight reduction in risk was observed with increased fruit fiber intake.\(^{7}\) we attempted to justify this difference by the lower fiber consumption, according to DRI.

Some micronutrients were poorly consumed, specifically, vitamin A, C, D and E. Several studies exhibited a protective effect of some vitamins in the carcino genesis.\(^ {38,39}\). IN a review study, Welsh J et al.\(^ {48}\) confirmed the effect of high doses of dietary calcium and fiber on the carcinogenesis. Galas A et al.\(^ {49}\) established the wrong pattern, identifying a low calcium intake among cancer patients. Azevedo DC et al.\(^ {27}\) have demonstrated similar results. Other studies have shown different results, associating malnutrition with hematological disease.\(^ {51}\)

Limitations were found in our study since we had no verification of longevity of the disease or weight loss data, in addition to having a small convenience sample.

Conclusions

Food intake and consumption of macro and micronutrients was inadequate in this population. Comparing adults with older adults, the older adult category had a lower intake than the former, as well as, an inferior nutritional status.

In our study, association among diet and cancer types was not identified.

References

5. Vogtmann E et al. Fruit and vegetable intake and the risk of colorectal cancer: results from the Shanghai Men’s Health Study. Cancer Causes Control 2013. [Epub ahead of print]


