

Geriatric Nutrition and its Significance

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DESCRIPTION

Geriatric nutrition uses dietary concepts to help manage the physical, psychological, and emotional changes that come with old age, as well as to delay the consequences of ageing and disease. The term “elderly” used to refer to those aged individuals aged 65 and above, but with the expanding number of active and healthy seniors, the term has come to include “Young old” (65 to 75 years old), “old old” (75 to 85 years old), and “oldest old” (85 years and older) (85 and beyond). The fastest-growing demographic is those aged 85 and above.

A well-balanced diet is the basis of geriatric nutrition. This offers appropriate nutrition to help prevent heart disease, cancer, and stroke, which are the main causes of mortality. Furthermore, ongoing research suggests that some dietary behaviour, such as calorie restriction and antioxidant consumption, may help people live longer. Many bodily changes occur as people get older. The pace of degenerative change surpasses the rate of cell regeneration after the organism achieves physiologic maturity. Physiologic alterations that might impact nutritional status include the following:

Sarcopenia is a condition in which fat replaces muscle and causes a change in body composition. Exercise, particularly weight training, has been shown to slow down this process in research. During maturity, Basal Metabolic Rate (BMR) decreases by roughly 5% every decade due to a decrease in lean body mass. The body’s capacity to adapt to injury or surgery is slowed when total caloric demands decrease and protein stores are depleted. The loss of lean body mass causes a reduction in body water.

The decrease in digestion and absorption is one of the GI alterations. Digestive hormones and enzymes decrease, intestinal mucosa deteriorates, and gastric emptying time lengthens; as a result Pernicious anaemia and constipation are two disorders that are more probable in geriatrics. Hypochlorhydria, which reduces vitamin B₁₂ absorption and affects around one-third of elderly Americans, can cause pernicious

anaemia. Constipation in elderly individuals can be caused by reduced GI motility, insufficient fluid intake, or physical inactivity, despite the widespread use of laxatives.

Changes in the musculoskeletal system occur. When people are in their 30s or 40s, they begin to lose bone mass, which increases for women throughout menopause, making the skeleton more prone to fractures and osteoporosis. Bone retention is aided by adequate calcium and vitamin D consumption.

Sensory and oral alterations must be considered in geriatric feeding. Appetite may be affected by decrease in all senses, notably in the taste buds, which impair perception of salty and sweet tastes. More than 70% of the elderly suffer from xerostomia, or a lack of salivation. Denture users also eat less effectively than those who have natural teeth. Insulin secretion declines in the 40s, which can lead to glucose intolerance, and renal function declines in certain persons.

Changes in the cardiovascular system may occur. As blood pressure rises in women over the age of 80, lowering salt consumption becomes more significant (but, interestingly, it declines in older men). Men’s serum cholesterol levels peak around 60, whereas women’s levels continue to grow until 70.

Immuno-competence deteriorates as people become older. Lower immune function translates to a reduced ability to combat infections and cancer. Vitamin E, zinc, and a few other nutrients may help boost your immune system. A multitude of changes in a person’s social and psychological status may occur as they age, possibly impacting hunger and nutrition. Depression, the most prevalent cause of unexplained weight loss in older persons, affects around 15% of adults over 65, with a substantially greater prevalence among those in long-term care facilities.

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