



Nutritional Therapy on Resting Energy Expenditure in Malnourished Older

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ABOUT THE STUDY

Malnutrition is a general feature in elderly patients, and usually performs multiple factors. Malnutrition attention is related to the risk of infection, low life, long-term rehabilitation, and high risk, and higher mortality and morbidity and morbidity. Nutrition The prevalence of malnutrition is up to 50% at the elderly hospital, which is widely recognized and the relevance of the cause considered being a pathophysiological role is not yet well understood.

It is clear that the low energy inlet and the increased energy requirements are the main mechanism that causes malnutrition. However, malnutrition is often reversible and can be treated with an increase in energy and nutrient determination. It is very important to evaluate the resting energy expenditure (REE) to determine the accurate energy requirements and the prevention of negative energy balance. REE is responsible for more than two thirds of total energy consumption (T-piece) and represents personal energy requirements for maintaining an important organ at rest. REE can be measured by indirect heat measurement (IC) considered as a gold standard.

Reduced REE for malnutrition patients can be the result of metabolic adaptation to low energy intake. If this applies, the measured REE will decrease for malnutriability and is not the actual energy demand for the patient. It is known that energy deficiency and weight loss lead to metabolic regulation, resulting in reduced energy expenditure and improved metabolic efficiency. However, such indications can be reversed by nutrition therapy, which can lead to increased REE and promote weight recovery. Results from a 6-week refeeding study of 32

healthy young men followed by super feeding and calorie restriction showed that REE was significantly reduced during the 3-week calorie restriction due to metabolic adaptation and refeeding. It has been shown to normalize within 2 weeks. Longitudinal and longitudinal studies prior to reported a significant decrease in FFM with age.

REE decreases with age, primarily due to a decrease in FFM, as FFM is the main determinant of REE and explains 60-90% of its variance. However, this decrease in REE is widespread even after adjusting the body composition, so other causes are possible. Energy deficiency and weight loss can lead to metabolic regulation, resulting in reduced energy consumption and improved metabolic efficiency. Previous studies have shown that malnourished patients have lower REE than patients with normal nutritional status. In a cohort study of healthy subjects (ages 18-83), the mean REE measured by IC in the elderly over 70 years was higher than the mean REE measured in malnourished elderly patients. Therefore, low REE in malnourished patients may be the result of metabolic adaptation to low energy intake. As a result, the REE value may be biased by malnutrition and cannot represent actual energy requirements.

This is the first study of us as far as we know. In consideration of these findings, it is essential to consider the effects of malnutrition in the elderly hospital of malnutrition. If you have any questions, REE from Harrisendict Formula seems to better reproduce the actual energy demand of these patients as uncompressed data for indirect heat measurement. In addition, the increased REE for malnutrition elderly patients seems to be an indication of effective nutritional therapy.

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