Fish oil supplementation improves docosahexaenoic acid status of malnourished infants

Ella N Smit, Esther A Oelen, Ejaz Seerat, E Rudy Boersma, Frits A J Muskiet

Abstract

Aim—To investigate whether the low docosahexaenoic acid (DHA) status of malnourished, mostly breast fed, Pakistani children can be improved by fish oil (FO) supplementation.

Methods—Ten malnourished children (aged 8–30 months) received 500 mg FO daily for nine weeks. The supplement contained 62.8 mol% (314 mg) long chain polyunsaturated fatty acids of the ω3 series (LCPUFAo3) and 22.5 mol% (112 mg) DHA. Seven FO unsupplemented children served as controls. Red blood cell (RBC) fatty acids were analysed at baseline and at the study end.

Results—FO supplementation augmented mean (SD) RBC DHA from 2.27 (0.81) to 3.35 (0.76) mol%, without significantly affecting the concentrations of LCPUFAo6. Unsupplemented children showed no RBC fatty acid changes. One FO supplemented child with very low initial RBC arachidonic acid showed a remarkable increase from 4.04 to 13.84 mol%, whereas another with high RBC arachidonic acid showed a decrease from 15.64 to 10.46 mol%.

Conclusion—FO supplementation improves the DHA status of malnourished children. The supplement is apparently well absorbed and not exclusively used as a source of energy.

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Keywords: erythrocyte; fish oil; long chain polyunsaturated fatty acids; malnutrition

In a previous study we found very low erythrocyte (RBC) DHA concentrations in malnourished, mostly breast fed 4–6 month old Pakistani children. A low breast milk LCPUFAo3 content was identified as the major cause of their poor DHA status. Apart from low intake, poor PUFA status of malnourished children may also derive from malabsorption, impaired desaturation and elongation, peroxidation of PUFA, and the use of PUFA as an energy source via β-oxidation. Many studies have shown that fish oil (FO) supplementation increases DHA content of many blood compartments, including RBC and plasma lipid fractions. It is, however, unknown whether this also applies to malnourished children, as they may have poor fat absorption, or use the supplement as an energy source. In the present study we supplemented 10 malnourished Pakistani children with 500 mg FO daily for nine weeks and investigated whether it improved their DHA status, as derived from their RBC fatty acid composition. Seven unsupplemented counterparts served as controls.

Subjects and methods

SUBJECTS, SUPPLEMENT, AND STUDY DESIGN

Seventeen infants were recruited from the Nutrition Rehabilitation Center of the Pediatric Department, Federal Government Services Hospital, Islamabad (Pakistan). Anthropometric, demographic, socioeconomic, and clinical data were documented. They were classified according to local growth charts, provided by the WHO. Grades 2 and 3 malnutrition were defined as weight for age below the mean minus two standard deviations (SDs) and three SDs, respectively, using the data from the United States National Center for Health Statistics (NCHS) as a reference. The study conformed to local ethical standards and the Helsinki declaration of 1975 as revised in 1989.

The children were randomly assigned to receive one 500 mg capsule of FO (Pikasol, Hadsund, Norway) daily for approximately nine weeks (n = 10), or no oil (controls; n = 7). As the capsules proved too big to swallow, they were pierced and the oil was given by spoon. As stated by the manufacturer, each capsule contained 1.5 IU vitamin E. Table 1 provides details of the fatty acid composition, as established by us. The daily intakes corresponded with 190 mg eicosapentaenoic acid (EPA), 112 mg DHA, and 10 mg AA. EDTA anticoagulated blood (2.5 ml at most) was taken in an undefined metabolic state at base-
Significant differences between enrolment and study end. The controls did not exhibit RBC fatty acid differences between enrolment and study end. Compared with controls, FO supplemented children had at study end higher RBC 20:5ω3 (p = 0.010), 22:6ω3 (p = 0.007), sum of ω3 fatty acids (p = 0.007), ω3/ω6 (p = 0.010), LCPUFAω3/LCPUFAω6 (p = 0.002), and 24:1ω9 (p = 0.043). FO supplemented children showed increases of RBC 20:5ω3 (p = 0.005), 22:6ω3 (p = 0.007), 22:6ω3 (p = 0.009), sum of ω3 fatty acids (p = 0.005), LCPUFAω3/LCPUFAω6 (p = 0.005), ω3/ω6 (p = 0.005), LCPUFAω3/LCPUFAω6 (p = 0.005), 26:0 (p = 0.022, not shown) from baseline to study end. There were no changes in RBC ω6 fatty acids.

Discussion

We investigated whether the DHA status of malnourished Pakistani infants can be improved by FO supplementation. It was found that daily administration of 500 mg FO, containing 62.8 mol% LCPUFAω3, for nine weeks resulted in about 50% increases of RBC DHA and LCPUFAω3, without affecting the RBC LCPUFAω6 content. The unsupplemented control group did not exhibit RBC fatty acid changes. The results of this study were transferred to a 15 ml Teflon stopped tube, containing 1 mg butylated hydroxytoluene (antioxidant) and 50 μg maragric acid (17:0; internal quantification standard). The pre-

Table 1

<table>
<thead>
<tr>
<th>Fatty acids</th>
<th>Controls (n = 7)</th>
<th>Fish oil (n = 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>18:1ω9</td>
<td>0.37 ± 0.02</td>
<td>0.43 ± 0.05</td>
</tr>
<tr>
<td>20:4ω6</td>
<td>0.28 ± 0.02</td>
<td>0.32 ± 0.05</td>
</tr>
<tr>
<td>20:5ω3</td>
<td>0.35 ± 0.03</td>
<td>0.40 ± 0.06</td>
</tr>
<tr>
<td>22:3ω6</td>
<td>0.22 ± 0.02</td>
<td>0.27 ± 0.04</td>
</tr>
<tr>
<td>22:5ω3</td>
<td>0.33 ± 0.03</td>
<td>0.37 ± 0.06</td>
</tr>
<tr>
<td>22:6ω3</td>
<td>0.70 ± 0.07</td>
<td>0.75 ± 0.10</td>
</tr>
</tbody>
</table>

Data represent mean (SD) and are expressed as mol% (mol/100 mol). For abbreviations see Table 1. Controls received nutritional rehabilitation for 9.7 weeks (range 8−16); the fish oil group was additionally supplemented with 500 mg fish oil (see table 1) daily for 9.1 weeks (range 7−12).

Table 2

<table>
<thead>
<tr>
<th>Characteristics of the malnourished children</th>
<th>Controls (n = 7)</th>
<th>Fish oil (n = 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (mo)</td>
<td>24 (4−56)</td>
<td>17 (8−30)</td>
</tr>
<tr>
<td>Weight (kg)</td>
<td>6.0 (4.0−10.3)</td>
<td>5.9 (4.3−8.3)</td>
</tr>
<tr>
<td>Grade 2/3 grade</td>
<td>4/3</td>
<td>3/7</td>
</tr>
<tr>
<td>HD (g/100 ml)</td>
<td>(73−122)</td>
<td>(80−109)</td>
</tr>
<tr>
<td>Infections*</td>
<td>5/7</td>
<td>8/10</td>
</tr>
</tbody>
</table>

Breast fed 24/7

Data expressed as median (range), or fraction. *Significant differences between baseline and 9 weeks at p < 0.05.

Results

Table 2 presents the characteristics of the study groups. The mean FO supplementation period was 9.1 weeks (range 7−12). For the control group the mean time interval between enrolment and collection of the second blood sample was 9.7 weeks (range 8−16). Eight infants in the FO supplementation group and all controls had gained weight at the study end. When expressed as percentage of the reference average weight for age (NCHS) their median weights improved from 53.5% (range 47−68%) to 60% (46−69%) in the FO group and from 63% (57−68%) to 68% (60−70%) in the control group.

Table 3

<table>
<thead>
<tr>
<th>Fatty acids</th>
<th>Controls (n = 7)</th>
<th>Fish oil (n = 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>18:1ω9</td>
<td>0.16 (0.05)</td>
<td>0.18 (0.12)</td>
</tr>
<tr>
<td>20:4ω6</td>
<td>0.26 (0.08)</td>
<td>0.27 (0.07)</td>
</tr>
<tr>
<td>20:5ω3</td>
<td>1.62 (0.35)</td>
<td>1.51 (0.75)</td>
</tr>
<tr>
<td>22:4ω6</td>
<td>2.61 (0.29)</td>
<td>2.28 (0.73)</td>
</tr>
<tr>
<td>22:6ω3</td>
<td>9.94 (1.99)</td>
<td>7.43 (1.52)</td>
</tr>
<tr>
<td>22:5ω3</td>
<td>1.35 (0.17)</td>
<td>1.32 (0.39)</td>
</tr>
<tr>
<td>22:6ω3</td>
<td>14.03 (1.11)</td>
<td>13.01 (3.40)</td>
</tr>
<tr>
<td>22:5ω3</td>
<td>3.72 (0.37)</td>
<td>2.64 (0.71)</td>
</tr>
<tr>
<td>22:6ω3</td>
<td>0.95 (0.17)</td>
<td>0.92 (0.27)</td>
</tr>
</tbody>
</table>

Data represent mean (SD) and are expressed as mol% (mol/100 mol). For abbreviations see table 1. Controls received nutritional rehabilitation for 9.7 weeks (range 8−16); the fish oil group was additionally supplemented with 500 mg fish oil (see table 1) daily for 9.1 weeks (range 7−12).

Significant differences between baseline and 9 weeks at p < 0.05.

References
show that the FO supplement is apparently well absorbed in malnourished children and that the LCPUFAo3 are not exclusively used as a source of energy under these conditions. This is to our knowledge the first report to show the effects of LCPUFA supplementation on the RBC fatty acid composition of malnourished children. Koletzko et al.27 monitored the plasma fatty acid composition of eight recovering malnourished children during treatment with a high energy and high protein diet (including maize porridge, milk, eggs, beans, fish, meat, and vegetable oils). They found a slight improvement of the essential fatty acid status after 14 days treatment without additional LCPUFA supplements.

The most remarkable changes in the RBC fatty acid composition were recorded in a severely malnourished 21 month old, almost exclusively breast fed marasmic girl. Her weight was only 5.5 kg (47% of the reference average) at enrolment and a she had a “dry” skin. After nine weeks FO supplementation she had gained 1.8 kg (to reach 60% of the reference average). There was no clinical evidence that this weight gain was caused by water retention. Concomitantly she displayed an increase of both RBC o3 and o6 fatty acids, mainly at the expense of the sum of the saturated fatty acids (from 65.39 to 48.24 mol%). RBC DHA increased from 0.41 to 2.50 mol%. Surprisingly, a large increase was on account of RBC AA (from 4.04 to 13.84 mol%). It seems unlikely that this increase can be explained by the low AA intake from the supplement (10 mg per day). The RBC 18:2n6/20:4n6 ratio (a parameter of combined activities of Δ6-desaturase, chain elongation, and Δ5-desaturase) decreased from 1.60 to 0.71 mol/mol, while the RBC 20:3n6/20:4n6 ratio (a parameter of Δ5-desaturase activity) did not change. The data of this child suggest low activity of Δ6-desaturase at enrolment, which subsequently improved during the intervention period. A positive effect of o3 fatty acids on LCPUFAo6 fatty acids has previously been reported by Bjerve et al.28 They observed an increase of plasma and RBC LCPUFAo6 in patients with o3 fatty acid deficiency following FO supplementation. It was suggested that o6 fatty acids cannot accumulate normally in cell membranes at the condition of low o3 fatty acid supply. In contrast to the above case, a 30% decrease of RBC AA was observed in a 16 month old girl with a relatively high RBC AA level at baseline (from 15.64 to 10.46 mol%). Reduction of plasma and RBC AA concentrations after FO supplementation has previously been noticed in preterm21 22 and term21 infants and adults.20 The contradictory findings in the two cases may indicate that the effect of FO supplementation on RBC AA concentrations is dependent on baseline RBC AA contents, causing increases at low initial RBC AA status, and decreases at high initial RBC AA status.

We conclude that FO supplementation of malnourished Pakistani children improves their DHA status. Replacement of the presently employed purified FO by the much cheaper cod liver oil (approximately 10% DHA) may give similar results. Another factor in favour of cod liver oil as a supplement would be its high vitamin A and D contents. Malnourished children often have low vitamin A and D status.21 28 Further investigations are needed to clarify whether AA supplementation should be recommended in addition to DHA supplementation to prevent any adverse affects on the LCPUFAo6 status that are caused by augmentation of the LCPUFAo3 status.

We would like to thank the nurses at the Nutrition Rehabilitation Center for their help in weighing and selecting the children, Mrs IA Martini is acknowledged for her technical and practical contribution and Mr M Volmer for his statistical analyses.

References:

1. Innis SM. Essential fatty acids in growth and development. 