EXERCISE TRAINING AND NUTRITIONAL SUPPLEMENTATION FOR PHYSICAL FRAILTY IN VERY ELDERLY PEOPLE


Abstract Background. Although disuse of skeletal muscle and undernutrition are often cited as potentially reversible causes of frailty in elderly people, the efficacy of interventions targeted specifically at these deficits has not been carefully studied.

Methods. We conducted a randomized, placebo-controlled trial comparing progressive resistance exercise training, multinutrient supplementation, both interventions, and neither in 100 frail nursing home residents over a 10-week period.

Results. The mean (+SE) age of the 63 women and 37 men enrolled in the study was 87.1±0.6 years (range, 72 to 98); 94 percent of the subjects completed the study. Muscle strength increased by 113±8 percent in the subjects who underwent exercise training, as compared with 3±9 percent in the nonexercising subjects (P<0.001). Gait velocity increased by 11.8±3.8 percent in the exercisers but declined by 1.0±3.8 percent in the nonexercisers (P = 0.02). Stair-climbing power also improved in the exercisers as compared with the nonexercisers (by 28.4±6.6 percent vs. 3.6±6.7 percent, P = 0.01), as did the level of spontaneous physical activity. Cross-sectional thigh-muscle area increased by 2.7±1.8 percent in the exercisers but declined by 1.8±2.0 percent in the nonexercisers (P = 0.11). The multinutrient supplement had no effect on any primary outcome measure. Total energy intake was significantly increased only in the exercising subjects who also received nutritional supplementation.

Conclusions. High-intensity resistance exercise training is a feasible and effective means of counteracting muscle weakness and physical frailty in very elderly people. In contrast, multinutrient supplementation without concomitant exercise does not reduce muscle weakness or physical frailty. (N Engl J Med 1994;330:1769-75.)

The decline in muscle strength and mass during aging6,7 has been linked to physical frailty, falls, functional decline, and impaired mobility in very elderly people.5,8 Although many factors, including chronic illness, a sedentary lifestyle, nutritional deficiencies, and aging itself, may contribute to muscle weakness and loss of skeletal-muscle mass in people of advanced age, currently only skeletal-muscle disuse10 and undernutrition13-15 are potentially preventable or reversible with targeted interventions.

Muscle dysfunction associated with malnutrition may improve with nutritional supplementation in younger patients.16,17 Even in healthy elderly men, a multinutrient supplement augmented muscle hypertrophy, although not muscle strength, during a resistance training regimen similar to the one described here.18

We hypothesized that physical frailty is partially mediated by skeletal-muscle disuse and marginal nutritional intake, and should therefore be reduced by interventions designed to reverse these deficits.

Methods

Study Design

Detailed descriptions of the rationale and design of the Boston FICSIT (Frailty and Injuries: Cooperative Studies of Intervention Techniques) study19 and the entire FICSIT trial19 have been published elsewhere. Briefly, the Boston FICSIT study was a randomized, placebo-controlled, 10-week clinical trial in which the subjects were assigned to receive lower-extremity resistance training, a multinutrient supplement, both treatments, or a placebo activity and...
supplement. The study was approved by the human investigations review committees at New England Medical Center and the Hebrew Rehabilitation Center for Aged, and written informed consent was obtained from each subject.

Study Population
Volunteers were recruited from the residents of a 725-bed facility providing long-term care of the elderly. The criteria for inclusion were residential status, an age over 70 years, and the ability to walk 6 m. Subjects were excluded if they had severe cognitive impairment, rapidly progressive or terminal illness, acute illness or unstable chronic illness, myocardial infarction, fracture of a lower extremity within the six months before the study, or insulin-dependent diabetes mellitus; if they were on a weight-loss diet or undergoing resistance training at the time of enrollment; or if tests of muscle strength revealed a musculoskeletal or cardiovascular abnormality.

Interventions

Resistance Training
Subjects assigned to exercise training underwent a regimen of high-intensity progressive resistance training26 of the hip and knee extensors 3 days per week for 10 weeks. These muscle groups were chosen because of their importance in functional activities.27 For each muscle group, the resistance was set at 80 percent of the one-repetition maximum (the maximal load that could be lifted fully one time only).28 To maintain the intensity of the stimulus, the load was increased at each training session, as tolerated by the subject. Strength training was repeated every two weeks to establish a new base-line value.

Training sessions lasted 45 minutes and were separated by one day of rest. Each repetition lasted six to nine seconds, with a one- to two-second rest between repetitions and a two-minute rest between the three sets of eight lifts. All exercise sessions were supervised individually by a single exercise trainer, who was a certified therapeutic recreation specialist.

The knee extensors were trained with the use of the UNEX II chair (J.A. Preston, Clifton, N.J.). The hip extensors were trained in the first 53 subjects with the use of a wall-mounted cable-pulley system (G.E. Miller, New York). In the other 47 subjects, a double leg press (Keiser Sports Health Equipment, Fresno, Calif.) was used in place of the cable-pulley system, since it allowed for better positioning of the subject. There were no differences at base line or in treatment outcomes between subjects trained on these two machines.

Placebo Activities
All subjects not randomly assigned to resistance training engaged in three activities of their choice offered by the recreational-therapy service of the facility. No resistance training was allowed, but aerobic or flexibility exercises were permitted. Typical activities were walking, calisthenics while the subject was seated, board games, crafts, concerts, and group discussions.

Nutritional Supplement
The nutritional supplement (Exceed; Ross Laboratories, Columbus, Ohio) was given once each day in the evening for 10 weeks to minimize the effect of exercise training on habitual food intake. The supplement, a 240-ml liquid supplying 360 kcal in the form of carbohydrate (60 percent), fat (23 percent), and soy-based protein (17 percent), was designed to augment caloric intake by about 20 percent29 and provide one third of the recommended daily allowances of vitamins and minerals.30

Placebo Supplement
All subjects not receiving the experimental supplement were given an equal volume of a minimally nutritious (4 kcal), artificially sweetened, flavored liquid (Crystal Light; Kraft General Foods, White Plains, N.Y.). The supplements and placebos were administered in unmarked containers by the nursing staff, who were unaware of the contents of the containers and the group assignments.

Clinical Characteristics
Medical records were abstracted to obtain clinical information and ratings of functional status by the clinical nursing staff; scores on the Katz Activities of Daily Living Index were derived from these data. The Mini–Mental State Examination31 and the Geriatric Depression Scale32 were administered by the research staff.

Muscle Function
The maximal weight that could be lifted correctly for one repetition only was used as the measure of dynamic concentric muscle strength in the hip and knee extensors. To minimize imprecision related to repeated testing, the better of two measurements obtained one week apart was used as the base-line value. Strength measurements in this population are highly reliable (r = 0.85, P<0.001). The final test of muscle strength was performed during the week after the intervention. All measurements were made by a single observer (who was aware of group assignments but not involved in training). During the first session only, continuous electrocardiographic monitoring was used.

Physical Function
Gait velocity over a 6.1-m course was measured to the nearest 0.01 second and calculated as the average velocity in two trials, with a test–retest correlation coefficient of 0.99 (P<0.001). Stair-climbing power was calculated33 as the better value in two trials on a four-riser staircase with banisters. Repeated measures were reliable (r = 0.98, P<0.001).

Nutritional Intake
Habitual dietary intake, calculated to the nearest 0.1 g, was measured by weighing food over a three-day period during the week before and the 10th week of the intervention.34 Food records were analyzed by the Human Nutrition Division of Scientific Computing, with the Grand nutrient software system (Grand, release 9127190; Department of Agriculture Grand Forks Human Nutrition Research Center, Grand Forks, N.D.). The coefficient of variation for daily energy intake was 13.9 percent. The variables used in the analyses of energy intake included dietary energy intake, energy intake from diet and any clinically prescribed supplements) and total energy intake (dietary energy intake plus the energy content of the research supplement or placebo drink).

Body Composition

Anthropometric Measurements
Each subject’s weight (without clothing), calculated to the nearest 0.001 kg, was measured on a computerized force-transducer scale (Sartorius, Model F3305; Berlin, Germany) after a 12-to-14-hour fast. Standing height, calculated to the nearest 0.25 cm, was measured with a wall-mounted stadiometer. The body-mass index was calculated as the weight in kilograms divided by the square of the height in meters. Midthigh circumference, calculated to the nearest 0.1 cm, was measured with a fiberglass tape (Lafayette Instrument, Indianapolis) at the midpoint between the inguinal crease and the proximal pole of the patella.

Whole-Body Potassium
Whole-body potassium was measured as an index of body cell mass, which includes skeletal muscle.35 The coefficient of variation for weekly anthropomorphic phantom measurements was 5 percent.

Computed Tomographic Scans of the Midthigh
The muscle groups involved in the resistance training and mobility tests were scanned at the nondominant midthigh site.36 The scanner used for the first 85 subjects was a Siemens DR3 (Somatom-Siemens; Erlangen, Germany). For the other 15 subjects, the scanner was a Sytec 4000 (General Electric, Milwaukee). All computed
tomographic (CT) images were analyzed according to optical density on a computer (Macintosh IIci, Apple; Sunnyview, Calif.) by a single investigator in a blinded fashion, with Image software (Version 1.49, National Institutes of Health) modified for quantification of cross-sectional areas of muscle, bone, and fat to the nearest 0.01 cm². The coefficient of variation for repeated measurements of a single scan was less than 0.5 percent. CT data were complete for 61 of the subjects; incomplete data for the other 39 were due to technical difficulties with data extraction or artifacts on scans. There were no differences between the subgroups of subjects who had scans at either time and the entire sample.

**Physical Activity**

The level of physical activity was estimated with large-scale, integrated activity monitors (GMM; Verona, Pa.) worn around both ankles during the 72-hour period when food intake was being recorded. Habitual physical activity included all control and experimental activities, as well as all spontaneous leg movements. The average count per 24 hours (summing the values for both legs) was used in subsequent analyses. The manufacturer ceased production of the monitors in the middle of the study, after the activity level had been measured in 45 subjects. There were no differences between this subgroup and the entire study group. The coefficient of variation for sequential daily recordings was 24.7 percent.

**Statistical Analysis**

All data were analyzed with Systat statistical software (Systat; Evanston, Ill.) or Statview (Abacus; Berkeley, Calif.). Intention-to-treat analyses were used for the primary outcome variables. Linear regression was used to determine the appropriateness of the subsequent analyses of variance and covariance. Non-normally distributed data were subjected to log transformation before being analyzed for variance and covariance. A three-factor, repeated-measures analysis of variance was used to determine the effects of exercise and nutritional supplementation on the primary outcome variables, as well as to determine any interaction between exercise and nutritional supplementation. Analyses of covariance were used to adjust for clinically pertinent base-line characteristics (age, sex, muscle strength, and functional status) and any differences in other clinical characteristics. When F ratios were significant, post hoc comparisons of means were analyzed with Tukey's multiple-comparison test. Relations among variables of interest were analyzed pairwise with Pearson's correlation coefficients or Spearman's rank correlation coefficients, as appropriate, with the Bonferroni correction for multiple comparisons. Forward stepwise multiple-regression models were used to determine multivariate relations among variables that were significant in the univariate analyses. A two-sided P value less than or equal to 0.05 was considered to indicate statistical significance.

**RESULTS**

**Recruitment**

Of the 1306 residents of the Hebrew Rehabilitation Center for Aged who were available during the enrollment period, 349 were considered potentially eligible to participate in the study, none of whom were excluded during initial tests of muscle strength. One

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**Table 1. Base-Line Characteristics of the Subjects.***

<table>
<thead>
<tr>
<th>CHARACTERISTIC</th>
<th>EXERCISE (n = 25)</th>
<th>EXERCISE PLUS SUPPLEMENT (n = 25)</th>
<th>SUPPLEMENT (n = 24)</th>
<th>CONTROL (n = 26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographic and clinical characteristics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age (yr)</td>
<td>86.2±1.0 (72–95)</td>
<td>87.2±1.2 (76–98)</td>
<td>85.7±1.2 (75–97)</td>
<td>89.2±0.8 (78–98)</td>
</tr>
<tr>
<td>Female sex (% of subjects)</td>
<td>64</td>
<td>64</td>
<td>71</td>
<td>54</td>
</tr>
<tr>
<td>Level of dependence (% of subjects)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Independent</td>
<td>32.0</td>
<td>36.0</td>
<td>41.7</td>
<td>38.5</td>
</tr>
<tr>
<td>Semidependent</td>
<td>64.0</td>
<td>56.0</td>
<td>54.2</td>
<td>53.9</td>
</tr>
<tr>
<td>Dependent</td>
<td>4.0</td>
<td>8.0</td>
<td>4.2</td>
<td>7.7</td>
</tr>
<tr>
<td>Functional-status score</td>
<td>2.0±0.3</td>
<td>1.9±0.2</td>
<td>2.0±0.3</td>
<td>1.7±0.2</td>
</tr>
<tr>
<td>Length of stay (mo)</td>
<td>9.0 (2–83)</td>
<td>10.0 (1–115)</td>
<td>9.0 (1–98)</td>
<td>7.5 (1–85)</td>
</tr>
<tr>
<td>Regular medications (no.)</td>
<td>4.5±0.5</td>
<td>5.3±0.5</td>
<td>6.4±0.6</td>
<td>5.1±0.5</td>
</tr>
<tr>
<td>Diagnosed (no.)</td>
<td>5.6±0.4</td>
<td>4.9±0.5</td>
<td>5.0±0.4</td>
<td>4.7±0.3</td>
</tr>
<tr>
<td>Mini–Mental State score</td>
<td>20.9±1.2</td>
<td>23.1±1.0</td>
<td>22.7±1.3</td>
<td>22.2±1.0</td>
</tr>
<tr>
<td>Depression score</td>
<td>8.2±5.3</td>
<td>9.9±7.2</td>
<td>9.5±6.1</td>
<td>12.7±8.7</td>
</tr>
<tr>
<td>Muscle strength and mobility</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leg strength (kg)</td>
<td>34.3±2.9</td>
<td>24.8±1.8</td>
<td>29.6±2.6</td>
<td>30.8±2.3</td>
</tr>
<tr>
<td>Ambulatory assistance (% of subjects)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>26</td>
<td>8</td>
<td>17</td>
<td>15</td>
</tr>
<tr>
<td>Cane</td>
<td>44</td>
<td>25</td>
<td>35</td>
<td>42</td>
</tr>
<tr>
<td>Walker</td>
<td>22</td>
<td>54</td>
<td>39</td>
<td>35</td>
</tr>
<tr>
<td>Wheelchair</td>
<td>9</td>
<td>13</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>Falls in past year</td>
<td>72</td>
<td>68</td>
<td>57</td>
<td>65</td>
</tr>
<tr>
<td>% of subjects</td>
<td>(1–0–21)</td>
<td>(1–0–93)</td>
<td>(1–0–14)</td>
<td>(1–0–6)</td>
</tr>
<tr>
<td>Activity level (counts/day)</td>
<td>16,416±2759</td>
<td>15,440±3847</td>
<td>12,614±1859</td>
<td>17,728±3713</td>
</tr>
<tr>
<td>Gait velocity (m/sec)</td>
<td>0.51±0.04</td>
<td>0.44±0.04</td>
<td>0.45±0.05</td>
<td>0.47±0.04</td>
</tr>
<tr>
<td>Stair-climbing power (W)</td>
<td>39.1±3.4</td>
<td>36.7±3.6</td>
<td>34.3±4.2</td>
<td>38.9±3.5</td>
</tr>
<tr>
<td>Nutritional status and body composition</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Body-mass index</td>
<td>24.9±0.7</td>
<td>24.5±0.8</td>
<td>25.4±0.7</td>
<td>25.8±0.5</td>
</tr>
<tr>
<td>Energy intake (kcal/day)</td>
<td>1,439±63</td>
<td>1,425±66</td>
<td>1,558±53</td>
<td>1,485±58</td>
</tr>
<tr>
<td>Whole-body potassium (g)</td>
<td>78.1±6.3</td>
<td>79.6±6.3</td>
<td>79.6±6.3</td>
<td>79.8±6.3</td>
</tr>
<tr>
<td>Thigh-muscle area (cm²)</td>
<td>62.0±3.48</td>
<td>61.05±3.92</td>
<td>56.90±3.70</td>
<td>60.17±3.36</td>
</tr>
<tr>
<td>Muscle cross-sectional area (% of total leg cross-sectional area)</td>
<td>48±2</td>
<td>46±3</td>
<td>44±2</td>
<td>44±3</td>
</tr>
</tbody>
</table>

*Normally distributed data are presented as means ± SE; skewed data are presented as medians. Values in parentheses are ranges. Level of dependence was determined according to the level of care received. Functional status was determined according to the Katz Activities of Daily Living Index; a score of 0 signifies independent functioning, and a score of 6 dependent functioning. The Mini–Mental State Examination has a scale of 0 to 30; a score under 24 denotes cognition impairment. On the Geriatric Depression Scale (0 to 30), a score over 10 denotes depressive symptoms. Leg strength was determined by summing the values of the one-repetition maximum for the right and left hip and knee extensors. The activity level was determined in 45 subjects by summing the values on the right- and left-side activity monitors; the mean three-day value was used. The muscle cross-sectional area was determined by CT in 85 subjects.

**P** = 0.05 for the comparison with the exercise group.
hundred residents consented to participate in the study. The reasons given for not consenting to participate included the perceived time commitment and the inconvenience of the study.

Characteristics of the Subjects

The base-line characteristics of the subjects are summarized in Table 1. Their mean (±SE) age was 87.1±0.6 years, and 38 percent were 90 years old or older. Eighty-three percent of the subjects required a cane, walker, or wheelchair, and 66 percent had fallen during the previous year; their physical activity counts were about 25 percent of the levels we have recorded in sedentary young adults. The most prevalent chronic conditions included arthritis (in 50 percent of the subjects), pulmonary disease (in 44 percent), osteoporotic fracture (in 44 percent), hypertension (in 35 percent), and cancer (in 24 percent). The control group had a higher prevalence of hypertension than the treatment groups (63 percent vs. 20 to 28 percent, P<0.01), and this factor was accounted for in the analyses of covariance. Fifty-one percent of the subjects met the screening criteria for cognitive impairment, and 38 percent met the criteria for depression. The base-line nutritional intake was 25.8±0.5 kcal per kilogram of body weight per day, less than the level shown to be adequate for short-term weight maintenance (30 to 33 kcal per kilogram per day).33,34

The muscle-strength values (the one-repetition maximum) for the four muscle groups (right and left hip and knee extensors) were summed in order to derive a unitary variable representing lower-body strength. For the entire study sample, lower-body strength was 29.9±1.2 kg (range, 7.7 to 61.8). There was a difference in strength at base line (F = 2.71, P = 0.05), with the subjects assigned to exercise training and nutritional supplementation weaker than those assigned to exercise training alone (24.8±1.8 vs. 34.3±2.9 kg, respectively). Base-line strength was included as a covariate in all analyses.

Base-Line Relation between Muscle Strength and Body Composition

Whole-body potassium (Fig. 1) was significantly related to muscle strength (r = 0.54, P<0.001), as was regional muscle area determined by CT scanning (r = 0.57, P<0.001). However, age, medical diagnoses or medications, functional status, length of stay in the facility, cognition, or depressive symptoms did not explain the base-line variance in strength or body composition.

Compliance with the Protocol and Adverse Events

Ninety-four percent of the randomized subjects completed the trial. There were two unrelated deaths (one in the supplement group and one in the control group) the first week of the study, and two subjects (one in the exercise group and one in the supplement group) dropped out before the start of the study because of lack of interest. Two subjects in the exercise group dropped out during training: one after the first training session because of generalized musculoskeletal pain, and the other in the seventh week of the study because of pneumonia.

The values for median compliance with exercise sessions (97 percent), control activities (100 percent), and use of the nutritional (99 percent) or placebo (100 percent) supplement were high. The mean training load was 84.5±0.0 percent of the most recent one-repetition maximum.

Diarrhea occurred in two subjects receiving the nutritional supplement. Two subjects in the exercise group reported joint pain (one in a prosthetic hip joint and the other in an osteoarthritic knee), necessitating an alteration of the training regimen. No cardiovascular complications occurred during any testing or training sessions.

Primary Outcomes

Muscle Strength and Size

Exercise significantly improved the results of all muscle-strength tests and increased the muscle cross-sectional area (Table 2 and Fig. 2). The changes in muscle strength after exercise were unrelated to age, sex, medical diagnosis, or functional level. A forward multiple-regression model of the variables that showed significant univariate associations with the relative change in strength after exercise training included assignment to the exercise group, base-line strength, and whole-body potassium (all P<0.001); this model explained 66.3 percent of the variance in increased strength. The subjects in the exercise group who had initially weaker muscles but larger reserves of whole-body potassium (an index of mus-
Table 2. Primary Outcome Variables.*

<table>
<thead>
<tr>
<th>Outcome Variable</th>
<th>No. of Subjects</th>
<th>Study Group</th>
<th>P Value</th>
<th>Effect of Exercise</th>
<th>Effect of Supplement Interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Muscle strength and mobility</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Right knee (kg)</td>
<td>89</td>
<td>EXERCISE</td>
<td>4.9±0.6</td>
<td>0.1±0.6</td>
<td>(&lt;0.001)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>EXERCISE PLUS SUPPLEMENT</td>
<td>5.0±0.5</td>
<td>-0.8±0.6</td>
<td>(&lt;0.001)</td>
</tr>
<tr>
<td>Left knee (kg)</td>
<td>87</td>
<td>SUPPLEMENT</td>
<td>5.2±0.6</td>
<td>-1.1±0.6</td>
<td>(&lt;0.001)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CONTROL</td>
<td>5.0±0.6</td>
<td>-1.3±0.6</td>
<td>(&lt;0.001)</td>
</tr>
<tr>
<td>Right hip (kg)</td>
<td>48</td>
<td>EXERCISE</td>
<td>8.8±1.2</td>
<td>0.7±1.0</td>
<td>(&lt;0.001)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>EXERCISE PLUS SUPPLEMENT</td>
<td>6.3±1.0</td>
<td>1.3±1.0</td>
<td>(&lt;0.001)</td>
</tr>
<tr>
<td>Left hip (kg)</td>
<td>48</td>
<td>SUPPLEMENT</td>
<td>8.1±1.0</td>
<td>0.6±0.9</td>
<td>(&lt;0.001)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CONTROL</td>
<td>6.8±0.9</td>
<td>0.7±0.8</td>
<td>(&lt;0.001)</td>
</tr>
<tr>
<td>Right leg press (kg)</td>
<td>38</td>
<td>EXERCISE</td>
<td>8.3±2.9</td>
<td>0.6±3.7</td>
<td>0.007</td>
</tr>
<tr>
<td></td>
<td></td>
<td>EXERCISE PLUS SUPPLEMENT</td>
<td>14.9±3.0</td>
<td>1.8±3.3</td>
<td>0.007</td>
</tr>
<tr>
<td>Left leg press (kg)</td>
<td>39</td>
<td>SUPPLEMENT</td>
<td>26.1±14.4</td>
<td>6.3±18.5</td>
<td>(0.012)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CONTROL</td>
<td>12.9±2.4</td>
<td>1.4±2.9</td>
<td>(&lt;0.001)</td>
</tr>
<tr>
<td>Gait (m/sec)</td>
<td>90</td>
<td>EXERCISE</td>
<td>3.3±9.2</td>
<td>7.2±12.5</td>
<td>(&lt;0.001)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>EXERCISE PLUS SUPPLEMENT</td>
<td>67.6±10.3</td>
<td>13.5±11.2</td>
<td>(&lt;0.001)</td>
</tr>
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<td>Stair-climbing power (W)</td>
<td>83</td>
<td>SUPPLEMENT</td>
<td>11.1±2.5</td>
<td>1.1±2.6</td>
<td>(&lt;0.001)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CONTROL</td>
<td>7.9±2.7</td>
<td>2.5±2.7</td>
<td>(&lt;0.001)</td>
</tr>
<tr>
<td>Physical activity (counts/day)</td>
<td>45</td>
<td>EXERCISE</td>
<td>3412±1700</td>
<td>142±1600</td>
<td>0.12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>EXERCISE PLUS SUPPLEMENT</td>
<td>553±1751</td>
<td>1230±1670</td>
<td>0.12</td>
</tr>
<tr>
<td>Body composition</td>
<td></td>
<td>SUPPLEMENT</td>
<td>51.0±18.4</td>
<td>17.6±18.9</td>
<td>(0.03)</td>
</tr>
<tr>
<td>Weight (kg)</td>
<td>88</td>
<td>CONTROL</td>
<td>0.2±0.4</td>
<td>0.8±0.4</td>
<td>0.19</td>
</tr>
<tr>
<td>Whole-body potassium (g)</td>
<td>75</td>
<td>EXERCISE</td>
<td>0.4±1.5</td>
<td>0.8±0.4</td>
<td>0.19</td>
</tr>
<tr>
<td></td>
<td></td>
<td>EXERCISE PLUS SUPPLEMENT</td>
<td>1.5±0.6</td>
<td>-0.5±0.4</td>
<td>0.19</td>
</tr>
<tr>
<td>Thigh-muscle area (cm²)</td>
<td>61</td>
<td>SUPPLEMENT</td>
<td>0.4±1.9</td>
<td>0.8±0.6</td>
<td>0.21</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CONTROL</td>
<td>2.2±1.9</td>
<td>1.5±0.7</td>
<td>(0.08)</td>
</tr>
</tbody>
</table>

*Data are means ±SE. All means and analyses have been adjusted for baseline age, sex, functional status, lower-body strength, and hypertension.

†A total of 94 subjects completed the trial. Smaller numbers of subjects are shown here because of technical problems (see text) or illness at the time of testing.

The supplement significantly increased body weight, although much less than had been anticipated with a total of 25,200 kcal added to the diet over a period of 10 weeks (360 kcal per day for 70 days). The supplement did not have a significant effect on whole-body fat-free mass.

Mobility

Use of a cane, walker, or wheelchair at base line was associated with lower values of strength, gait velocity, and stair-climbing power. Four subjects in the exercise group who had previously used a walker required only a cane after the study, whereas one non-exercising subject who had used a cane required a walker after the study. The exercise intervention significantly improved habitual gait velocity, stair-climbing ability, and the overall level of physical activity (Table 2 and Fig. 3). The nutritional supplement had no effect on mobility.

Dietary Intake

The median energy intake from the supplement was 335 kcal per day in the subjects receiving only the supplement and 358 kcal per day in those receiving both the supplement and exercise training (98 and 99 percent of the planned intake, respectively). Exercise significantly blunted the decrease in ad libitum energy intake during the trial (P = 0.04); the decrease was largest in the group of patients receiving only nutritional supplementation (Fig. 4). Total energy intake was significantly increased only in the group receiving the supplement.
ceiving both exercise training and nutritional supple-
mentation, because of the primary effect of exercise
(P<0.01), with a trend toward an interaction between
the two treatments (P = 0.08).

**DISCUSSION**

This trial demonstrates that a high-intensity, pro-
geSSive regimen of resistance exercise training im-
proves muscle strength and size in frail elderly people.
These changes are accompanied by improvement in
mobility and an increased level of spontaneous phys-
ical activity. Multinutrient supplementation has nei-
ther an independent nor an additive effect on these
outcomes, despite a marginal nutritional intake at
base line. The subjects who were initially the weakest
but did not have severe muscle atrophy had the largest
benefit from weight-lifting exercise. This pattern, as
well as the large gain in strength as compared with the

![Graph showing changes in energy intake](image)

**Figure 4. Mean (±SE) Changes in Energy Intake in the Four
Study Groups.**

Dietary energy intake included the energy content of meals,
snacks, and nutritional supplements other than the supple-
ment or placebo drink used in the study. Total energy intake included
dietary energy intake plus the energy content of the nutritional
supplement or placebo drink used in the study. Values are adjust-
ed for age, sex, functional status, base-line muscle strength, and
hypertension. Exercise significantly blunted the decline in dietary
energy intake after the trial (P = 0.04), a decline that was most
pronounced in the supplement-only group (trend for interaction
between exercise and supplement, P = 0.09). There was a signif-
icanl augmentation of total energy intake that was attributable to
exercise (P<0.01), particularly in the subjects receiving both ex-
ercise training and nutritional supplementation (trend for interac-
tion between exercise and supplement, P = 0.08).

![Graph showing changes in physical activity](image)

**Figure 3. Mean (±SE) Changes in the Level of Spontaneous
Physical Activity, According to the Presence or Absence of
Exercise.**

Bars indicate the percentage of change in the physical-activity
count after adjustment for age, sex, functional status, base-line
muscle strength, and hypertension. Nutritional supplementation
had no effect on the mean daily physical-activity level, which was
calculated from measurements over a 72-hour period. Exercise
training was associated with a significant increase in the mean
daily level of physical activity.

modest change in muscle area, suggests that improved
neural recruitment of existing but underused skeletal
muscle may have accounted for most of the functional
improvement.

Only two other studies (both uncontrolled) have
specifically addressed adaptation to resistance train-
ing in institutionalized elderly people. The first also
also demonstrated a large gain in strength (174 percent),
as well as improvements in muscle area and tandem
...
EXERCISE AND NUTRITIONAL SUPPLEMENTATION FOR FRAILTY IN THE ELDERLY


REFERENCES


This article is dedicated to the memory of Dr. Abraham Daich (1892 to 1993), whose intellectual curiosity and indomitable spirit led him to join our research study at the age of 98 years and whose vision of healthful aging continues to inspire our efforts. We are indebted to Ross Laboratories for the nutritional supplement, and to Keiser Sports Health Equipment for the resistance training equipment.