

## METABOLIC RESPONSE TO A KETOGENIC BREAKFAST IN THE HEALTHY ELDERLY

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**Abstract:** *Objective:* To determine whether the metabolism of glucose or ketones differs in the healthy elderly compared to young or middle-aged adults during mild, short-term ketosis induced by a ketogenic breakfast. *Design and participants:* Healthy subjects in three age groups (23±1, 50±1 and 76±2 y old) were given a ketogenic meal and plasma  $\beta$ -hydroxybutyrate, glucose, insulin, triacylglycerols, total cholesterol, non-esterified fatty acids and breath acetone were measured over the subsequent 6 h. Each subject completed the protocol twice in order to determine the oxidation of a tracer dose of both carbon-13 ( $^{13}\text{C}$ ) glucose and  $^{13}\text{C}$ - $\beta$ -hydroxybutyrate. The tracers were given separately in random order. Apolipoprotein E genotype was also determined in all subjects. *Results:* Plasma glucose decreased and  $\beta$ -hydroxybutyrate, acetone and insulin increased similarly over 6 h in all three groups after the ketogenic meal. There was no significant change in cholesterol, triacylglycerols or non-esterified fatty acids over the 6 h.  $^{13}\text{C}$ -glucose and  $^{13}\text{C}$ - $\beta$ -hydroxybutyrate oxidation peaked at 2-3 h post-dose for all age groups. Cumulative  $^{13}\text{C}$ -glucose oxidation over 24 h was significantly higher in the elderly but only versus the middle-aged group. There was no difference in cumulative  $^{13}\text{C}$ - $\beta$ -hydroxybutyrate oxidation between the three groups. Apolipoprotein E (E4) was associated with elevated fasting cholesterol but was unrelated to the other plasma metabolites. *Conclusion:* Elderly people in relatively good health have a similar capacity to produce ketones and to oxidize  $^{13}\text{C}$ - $\beta$ -hydroxybutyrate as middle-aged or young adults, but oxidize  $^{13}\text{C}$ -glucose a little more rapidly than healthy middle-aged adults.

**Key words:** Ketones, glucose, healthy elderly,  $^{13}\text{C}$  stable isotope tracers.

### Introduction

In humans, glucose is the brain's primary energy substrate and ketone bodies (ketones) are its primary replacement fuel during fasting or low carbohydrate intake (1). Ketones refers collectively to three molecules: acetoacetate (AcAc),  $\beta$ -hydroxybutyrate ( $\beta$ -OHB), and acetone (2). During ketogenesis, AcAc is formed first and is the only ketone metabolized by the tricarboxylic acid cycle as an energy substrate. After being converted back to AcAc by  $\beta$ -OHB dehydrogenase,  $\beta$ -OHB can also serve as an energy substrate (3). Acetone is produced by decarboxylation of AcAc and is exhaled in the breath in proportion to plasma ketone concentrations (2).

Impaired availability of energy substrates to the brain may be implicated in the progression towards Alzheimer's disease (4, 5). Raising blood ketones with a ketogenic meal shows preliminary potential to alleviate some features of the cognitive deficit in Alzheimer's disease (6). Given this potentially important clinical application, but the relative scarcity of information about how energy substrates are utilized during healthy aging, i.e. during aging minimally confounded by symptomatic degenerative disease, our primary objective was to evaluate glucose and ketone utilization in the healthy elderly compared to young and middle-aged adults.

Insulin inhibits ketone production so to achieve short-term

ketogenesis subjects were given a very low carbohydrate breakfast composed of medium chain triacylglycerol (MCT), heavy cream, protein powder and water. MCT efficiently induce mild to moderate ketosis in humans (7) because they are rapidly absorbed and pass directly via the hepatic portal venous circulation to the liver where they are  $\beta$ -oxidized with some of the resulting acetyl CoA being captured in ketones. MCT do not require a carnitine-dependent transport system to enter the inner mitochondrial space, and are thus more readily available for oxidation and at a lower energetic cost than long chain triacylglycerol (LCT) (8). Although the present study was not designed or powered for analysis of the effect of genotype, apolipoprotein E genotype of our subjects was determined since it affects both post-prandial fat metabolism (9) and risk of Alzheimer's disease (10, 11).

### Materials and Methods

#### Subjects

Subjects were recruited in three age groups: 18-25 y old (young: Y), 40-55 y old (middle-aged: M), and 70-85 y old (elderly: E). This distribution maintained a minimum 15 y gap between age groups and also avoided the increasing impact of frailty beyond 85 y old (12). All subjects were non-smokers and determined to be in relatively good health by a medical evaluation and blood screening done after a 12 h overnight fast.

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Fasting glucose and hemoglobin HbA1c were used to rule out the presence of overt diabetes. A complete blood cell count was used for blood disorders; electrolyte profile, AST and ALT for renal and liver function; HDL and LDL cholesterol, triglycerides; albumin for nutritional status; C-reactive protein as a marker of inflammatory processes; and TSH for thyroid function. Anthropometric parameters such as height, weight, body mass index (BMI), and fasting plasma metabolites did not differ significantly between age groups (Table 1). Approval for the study was obtained from the Research Ethics Committee of the Health and Social Services Center – Sherbrooke University Geriatrics Institute, which oversees all human research done at the Research Center on Aging.

**Table 1**

Anthropometric characteristics and fasting plasma constituents

	Young (n = 11)	Middle-aged (n = 12)	Elderly (n = 9)
<b>Anthropometry:</b>			
Age (y)	23 ± 1	50 ± 1	76 ± 2
Height (m)	1.74 ± 0.03	1.65 ± 0.03	1.67 ± 0.08
Weight (kg)	77.4 ± 4.9	74.2 ± 4.6	72.3 ± 3.7
BMI (kg/m <sup>2</sup> )	25.3 ± 1.1	27.2 ± 1.6	25.7 ± 1.3
<b>Fasting plasma measures:</b>			
-Hydroxybutyrate (mmol/L)	0.07 ± 0.10	0.09 ± 0.13	0.07 ± 0.04
Glucose (mmol/L)	5.4 ± 0.6	5.3 ± 0.4	5.7 ± 0.7
Insulin (mU/L)	6.8 ± 4.4	4.5 ± 3.9	4.0 ± 2.6
Triacylglycerol (mmol/L)	0.9 ± 0.3	1.1 ± 0.5	1.5 ± 0.5
Non-esterified fatty acids (mmol/L)	0.6 ± 0.3	0.5 ± 0.1	0.6 ± 0.2
Cholesterol (mmol/L)	4.2 ± 0.4	5.3 ± 1.1	5.3 ± 0.7

Mean ± SEM. No significant difference in any parameter except age (P<0.0001).

**Tracer protocol and sample collection**

Subjects arrived at 7:30 a.m. after having fasted overnight for 12 h. An intravenous forearm catheter was installed and baseline blood samples taken. The catheter was kept patent by flushing hourly with non-heparinized saline. The stable isotope tracer was then consumed (<sup>13</sup>C-glucose or <sup>13</sup>C- -OHB), followed immediately by the ketogenic breakfast drink, which was consumed within approximately 30 mins. After consuming the ketogenic breakfast, blood samples were taken hourly over 6 h using a 5 ml latex-free syringe (Becton Dickinson, Franklin Lakes, NJ) and transferred immediately to a 5 mL K<sub>2</sub>-EDTA-coated tube (Becton Dickinson, Franklin Lakes, NJ). Tubes were stored on ice at 4°C until the conclusion of the study period at which point they were all centrifuged at 3500 rpm for 18 min at 4°C. The separated plasma was stored at -20°C until further analyzed. During the 6 h study period, water was available ad libitum and subjects were asked to remain in a resting position with short walks.

Each subject participated in two identical metabolic study days, one to test <sup>13</sup>C-glucose metabolism and the other to test <sup>13</sup>C- -OHB metabolism. The tracers were U-<sup>13</sup>C<sub>6</sub> D-glucose or 2,4-<sup>13</sup>C<sub>2</sub> sodium D-3-hydroxybutyrate (50 mg each; Cambridge Isotope Laboratories, Andover, MA) each consumed in 15 mL

nanopure water and in randomized order. The two study days were separated by at least one but not more than three weeks. Breath samples for <sup>13</sup>CO<sub>2</sub> and acetone analysis were collected in triplicate at baseline and every 30 min afterwards using a breath collection device (Easysampler, Quintron Instrument Company, Milwaukee, WI) and 10 mL evacuated glass tubes (Exetainer, Labco Ltd, Buckinghamshire, UK). The first ~150 mL of exhaled air is dead space (13), so to collect a true alveolar breath sample, the subjects exhaled for 3 sec before breath sample collection. For acetone analysis, 1 mL of breath was transferred from one of the three Exetainer tubes to a glass gas-tight syringe (Hamilton Company, Reno, NV).

**Ketogenic breakfast drink**

The ketogenic breakfast drink consisted of a blend of MCT (Mead Johnson, Ottawa, ONT, CA), 35% heavy cream (Québon Ultra Crème, Longueuil, QC, CA), raspberry-flavored milk protein powder (Davisco Foods International, Inc., Eden Prairie, MN, courtesy of Agropur Cooperative, Granby, QC, CA) and water (Table 2). The fatty acid composition of the ketogenic breakfast is shown in Table 3. This ketogenic breakfast was designed to give a ratio of total fat to protein plus carbohydrate of 4.5:1, which is sufficient to induce mild, short-term ketosis in young adults (2). The total carbohydrate content of the drink was limited to the carbohydrate already in the cream (3.2%). Total protein content was calculated to be 1/3 of the subject's daily protein requirement as determined by the Harris-Benedict equation and the Canada Food Guide (Health Canada, Ottawa, ON, CA). Total fat was then adjusted to be equivalent to 4.5 times the protein plus carbohydrate content. Subjects received an average of 1104 kCal, 90% of which was fat. In the breakfast drink, the amount of total fat (g), MCT (g), fat/body weight (g/kg), or fat/BMI (g/kg/m<sup>2</sup>) did not differ significantly across the three study groups.

**Table 2**

Ketogenic breakfast meal composition<sup>1</sup>

	(g)	(%)
<b>Components:</b>		
protein powder	25 ± 1	10
cream	100 ± 0	41
medium chain triacylglycerol	71 ± 4	29
water	46 ± 2	20
<b>Macronutrients:</b>		
protein	25 ± 1	18
carbohydrate	3 ± 0	2
fat	110 ± 4	80

1. Calculated to give a ratio of 4.5:1 parts fat to protein plus carbohydrates based on 1/3 of the subject's daily protein requirements according to basal energy expenditure. Meal components and macronutrients are given as mean ± SEM (n = 32). Meal content did not differ significantly between age groups.

**Table 3**  
Fatty acid composition (%) of the ketogenic breakfast and its fat components<sup>1</sup>

	Breakfast n = 32	MCT n = 3	Cream n = 3
8:0	14.4 ± 1.5	39.8 ± 0.4	N/D
10:0	31.3 ± 0.8	58.6 ± 0.3	5.9 ± 0.1
12:0	4.0 ± 0.1	1.6 ± 0.1	8.9 ± 0.1
14:0	9.8 ± 0.4	N/D	21.9 ± 0.2
16:0	20.4 ± 0.7	N/D	31.9 ± 0.1
18:0	4.9 ± 0.3	N/D	6.5 ± 0.2
Total Saturates	84.7 ± 1.3	100.0 ± 0	75.0 ± 0.2
14:1n-5	1.3 ± 0.6	N/D	2.3 ± 0.0
16:1n-7	1.0 ± 0.1	N/D	2.4 ± 0.1
18:1n-9	11.0 ± 0.6	N/D	18.1 ± 0.2
Total Monounsaturates	14.0 ± 0.6	N/D	22.8 ± 0.2
18:2n-6	1.1 ± 0.2	N/D	2.3 ± 0.1
Total Polyunsaturates	1.1 ± 0.2	N/D	2.3 ± 0.1

1. Meal composition, given as mean ± SEM. Meal energy content did not differ significantly between age groups. N/D = not detected.

#### Isotope ratio mass spectrometry

Enrichment of <sup>13</sup>C in breath CO<sub>2</sub> following the ingestion of the <sup>13</sup>C tracer was analyzed by isotope ratio mass spectrometry (Europa 20-20, Sercon Ltd, Crewe, Cheshire, UK) as previously described (14). 5% CO<sub>2</sub>/N<sub>2</sub> was the reference gas and He was the carrier gas (Praxair Canada Inc. Mississauga, ON, Canada). Atom percent (AP) is the relative abundance of <sup>13</sup>C in the sample calculated by the following equation:

$$(1) \quad AP = \frac{100}{1/[(\delta/1000 + 1) {}^{13}C_{ref} + 1]}$$

<sup>13</sup>C data in delta notation (δ) is the ratio of <sup>13</sup>C to <sup>12</sup>C calibrated against the reference gas and the international standard, Pee Dee Belemnite (15). The percent dose recovered (PDR) of the tracer administered to the subjects was calculated as in equation (2),

$$(2) \quad PDR = \frac{APE \times VCO_2}{\text{mmol } {}^{13}C\text{-tracer administered}} \times 100\%$$

in which atom percent excess (APE) is calculated using of the value obtained in equation (1) for time t minus the value obtained at time 0. Taking into account the chemical purity, the isotopic enrichment of the tracer, and the natural abundance of <sup>13</sup>C, the quantity of <sup>13</sup>C excreted on breath (mmol) was calculated as shown in equation (3):

$$(3) \quad \text{mmol } {}^{13}C = \frac{\text{mg tracer}}{\text{molecular weight}} \times \text{chemical purity} \times ([99\% \# {}^{13}C] + [1\% \text{ total } \# C])$$

The chemical purity of both tracers was 98% and their isotopic purity was 99%. The CO<sub>2</sub> production constant of 300 mmol/h was used as determined by Schofield (16) and previously validated for healthy adults (17). VCO<sub>2</sub> was then calculated by multiplying the CO<sub>2</sub> production constant (300 mmol/h) by body surface area, calculated according to Gehan

and George (18).

#### Gas chromatographic analysis of acetone

Triplicate 0.3 ml samples of breath collected into gastight syringes were injected directly on to a capillary gas chromatograph equipped with a flame ionization detector (Agilent model 6890, Palo Alto, CA) and 30 m DB-WAX column (0.25 mm i.d.; Agilent J&W Scientific Santa Clara, CA). The temperature of the oven was set at 30°C and held for one minute and then increased at a rate of 5°C/min to 60°C where it was held for 2 min. The carrier gas was He and the flow rate was 7 mL/min. The injector temperature was 150°C and the detector temperature was 250°C. Acetone peak areas were calibrated against an aqueous acetone standard. A 0.2 mL of the aqueous standard was then injected into the gas chromatograph.

#### Other analyses

Plasma glucose, -OHB, cholesterol, triacylglycerols (TG), and non-esterified fatty acids (NEFA) were measured by colorimetric assay using an automated clinical chemistry analyzer (Dimension XPand Plus, Dade Behring Inc., Newark, DE) and commercially available reagent kits from the same company, except for -OHB (RX Daytona kit; Randox Laboratories Ltd., Antrim, UK), and NEFA (Wako Diagnostics, Richmond, VA). Insulin was analyzed by ELISA (Mercodia, Upssala, Sweden) and a microplate reader (model 3550, BioRad, Hercules, CA). ApoE genotype was analyzed at the McGill University Center for Studies in Aging (19).

Fatty acid composition of the ketogenic breakfast, MCT, and cream was analyzed by extraction of the total lipids into 2:1 chloroform/methanol with 0.02% BHT, using triheptadecanoin as the internal standard (20). The total lipids were then saponified with 1 M methanolic KOH followed by derivitization of the fatty acids to fatty acid methyl esters using 14% BF<sub>3</sub> methanol. Fatty acid methyl esters were analyzed using a gas chromatograph (Agilent model 6890) equipped with a 50 m BPX-70 fused capillary column (0.25 mm i.d. x 0.25 μm film thickness; J&W Scientific, Folsom, CA). Splitless injection and flame ionization detection were performed at 250°C. The oven temperature program was 50°C for 2 min, increasing to 170°C at a rate of 20°C/min, held for 15 min, increased to 210°C at a rate of 5°C/min and held there for 7 min. The inlet pressure of the carrier gas (He) was 233 kPa at 50°C. The identity of individual fatty acids was determined by comparing retention times with standard mixtures of fatty acids (NuChek 68A, 411, 455; NuChek Prep, Inc., Elysian, MN) and a custom mixture of saturated fatty acid standards.

#### Statistical analysis

Results are given as mean ± SEM. Comparisons during the metabolic study period are shown from baseline (time 0 h; T<sub>0</sub>) up to 6 h later (T<sub>6</sub>), and again 24 h later (T<sub>24</sub>) for tracer oxidation. To determine if tracer oxidation differed over time or between age groups, a repeated measures two-way ANOVA

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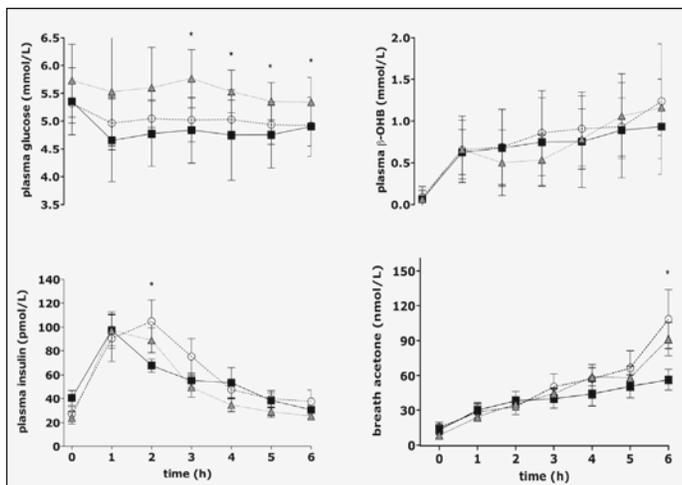
was performed followed by a Bonferroni post-hoc test to determine where significant differences existed. The Pearson test was used to test the significance of correlations between plasma and breath metabolites. Ketogenic breakfast composition was analyzed by one-way ANOVA. Statistical analysis of tracer oxidation data, differences in ketogenic meals composition and fatty acid profile between groups, and correlations were performed with Prism software (version 4.0, GraphPad Prism, San Diego, CA). An independent variables ANOVA test for time and age was performed to determine if any of the plasma metabolites differed between age groups or by ApoE 4 genotype. Statistical analysis of plasma metabolites was performed with SPSS software (version 12.0, SPSS Inc, Chicago, IL). Significance was set at  $p < 0.05$ .

**Results**

**Plasma and breath metabolites:** From baseline ( $T_0$ ) to 6 h after taking the ketogenic breakfast drink and tracer ( $T_6$ ), plasma glucose was mostly stable in all three groups but between  $T_3$  and  $T_6$ , glucose was 12% higher in the E compared to the Y group ( $p < 0.05$ ; Figure 1). In all three groups, plasma insulin peaked at 90-105 pmol/L at  $T_1$  to  $T_2$ . Except at  $T_2$  in the M group, the M and E groups had a similar post-prandial insulin response to the Y group. Between  $T_0$  and  $T_6$  and in all three groups, plasma  $\beta$ -OHB rose from  $\sim 0.1$  to  $\sim 1.3$  mmol/L and breath acetone rose from  $\sim 13$  to  $\sim 87$  nmol/L (Figure 1). Breath acetone was higher at  $T_6$  in the M and E groups versus the Y group. For all subjects, there was a significant positive correlation between plasma  $\beta$ -OHB and breath acetone at  $T_0$  and  $T_6$  (Figure 2).

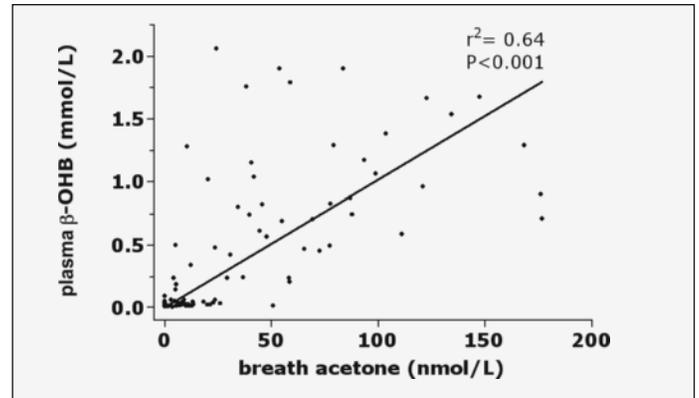
**Figure 1**

Plasma glucose (upper left), insulin (lower left),  $\beta$ -hydroxybutyrate (upper right), and breath acetone (lower right) over 6 h following consumption of a ketogenic breakfast at time 0 (mean  $\pm$  SEM; \* $P < 0.05$ ). Symbols represent young (■), middle-aged (○) and elderly (▲) subjects



**Figure 2**

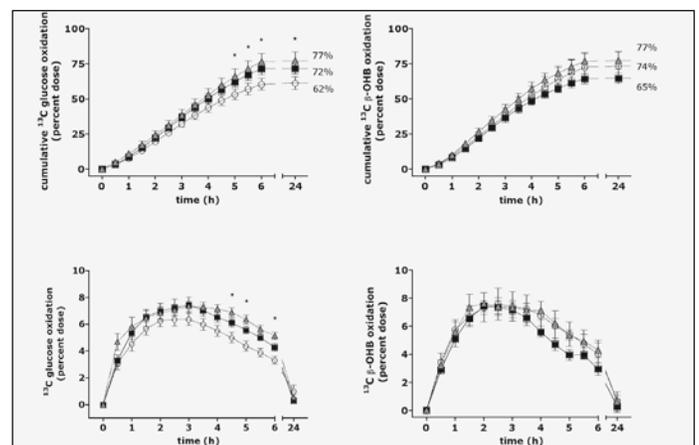
Correlation between breath acetone and plasma  $\beta$ -hydroxybutyrate before and 6 h after consuming a ketogenic breakfast



**$^{13}C$  Tracer oxidation:** In all subjects and with both tracers,  $^{13}CO_2$  excretion on breath peaked at 2-4 h post-dose and returned close to baseline within 24 h of tracer administration. In all three age groups,  $^{13}C$ -glucose oxidation peaked at 6.4 to 7.4 % dose/h between  $T_{2.5}$  and  $T_3$  (Figure 3). At  $T_{4.5}$ ,  $T_5$  and  $T_6$ ,  $^{13}C$  glucose oxidation was significantly higher in the E compared to the M group. Cumulative  $^{13}C$  glucose oxidation 24 h after dosing was 72%, 62%, and 77% of dose for Y, M and E subjects, respectively (Figure 3). From  $T_5$  to  $T_{24}$ , cumulative oxidation of  $^{13}C$  glucose was significantly higher in the E versus M group ( $P < 0.05$ ), but not compared to the Y group. In all three groups,  $^{13}C$   $\beta$ -OHB oxidation peaked at  $\sim 7.5$  % dose/h at  $T_2$ . Cumulative 24 h  $^{13}C$   $\beta$ -OHB oxidation was 65%, 74%, and 77% of the dose administered in Y, M and E subjects, respectively, with no significant differences between groups (Figure 3).

**Figure 3**

Oxidation of  $^{13}C$  glucose (lower left - % dose/h; upper left - cumulative oxidation/24 h) and  $^{13}C$   $\beta$ -hydroxybutyrate (lower right - % dose/h; upper right - cumulative oxidation/24 h) following consumption of a ketogenic breakfast and the respective tracer at time 0 (mean  $\pm$  SEM; \* $P < 0.05$ ). Symbols represent young (■), middle-aged (○) and elderly (▲) subjects

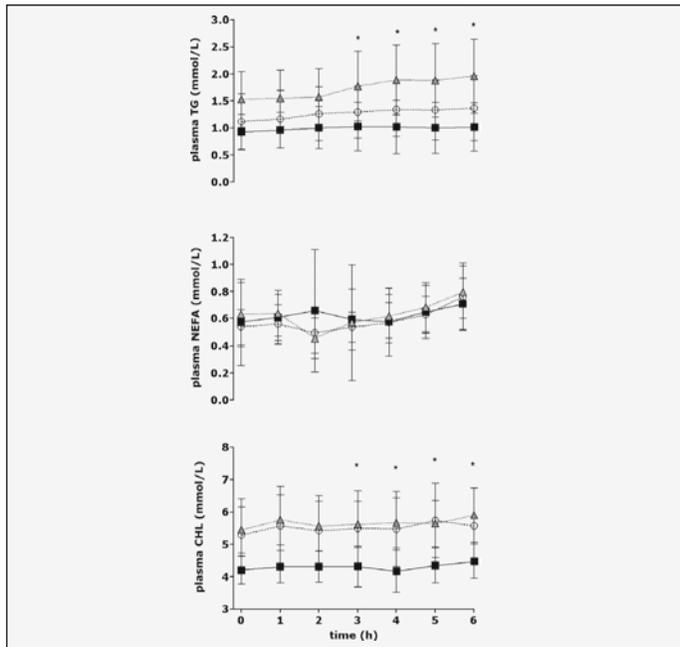


**Other measurements**

There was no significant effect of the ketogenic breakfast on plasma TG, NEFA, or total cholesterol over the 6 h study period (Figure 4). However, from T3 to T6, plasma TG and total cholesterol were significantly elevated in the E group compared to the Y group.

**Figure 4**

Plasma triacylglycerols (TG), non-esterified fatty acids (NEFA), and cholesterol (CHL) over 6 h following consumption of a ketogenic breakfast at time 0. Symbols represent young (■), middle-aged (○) and elderly (▲) subjects (mean ± SEM; \*P<0.05)



Genotype distribution could only be determined for 27 of the 31 subjects (Table 4). For statistical comparisons, genotypes were grouped according to presence or not of the ApoE 4 allele. As expected, 4 carriers had significantly elevated plasma cholesterol, but had no significant differences in other metabolites (data not shown).

**Table 4**

Apolipoprotein E genotype of the subjects

	2/2	3/2	3/3	4/3	4/4	4/2	total
Young	0	4	5	0	0	0	9
Middle-aged	1	3	3	3	0	1	11
Elderly	0	0	6	1	0	0	7
% Frequency	4	26	51	15	0	4	100

Apolipoprotein E genotype is shown as the combinations of Apolipoprotein E 2, 3, or 4 variant alleles.

**Discussion**

Overall, we found that for 6 h after consuming a ketogenic breakfast drink, elderly, middle-aged and young adults in good

health had a comparable changes in plasma -OHB and breath acetone. To our knowledge, previously published studies of ketone levels in the elderly have not reported their production after a ketogenic meal. For instance, higher plasma -OHB was reported for the elderly, but only after an 18 h fast (21). Our study confirms the previously reported short term ketogenic effect of a very low carbohydrate breakfast (2), and shows that the healthy elderly achieve a level of ketosis (plasma -OHB and breath acetone) and 24 h oxidation of -OHB that is equivalent to or slightly above what is observed in healthy young and middle-aged subjects. In the absence of differences in plasma -OHB or -OHB oxidation, whether the doubling of breath acetone at the end of the 6 h metabolic study day is physiologically meaningful remains to be determined.

Our elderly group had statistically significant but very modest differences in glucose metabolism compared to the middle-aged our young adults. Although fasting glucose was not statistically different between the three groups, plasma glucose (but not insulin) was statistically higher in the elderly towards the end of the metabolic study period. Cumulative glucose oxidation over 24 h was 24% higher in the elderly but only versus the middle-aged group; the glucose oxidation did not differ significantly between the elderly and young groups. Without further experimentation, these data are difficult to interpret because although higher plasma glucose could be due to various mechanisms related to emerging insulin resistance, one would not expect a concomitant rise in glucose oxidation (Figure 3) if, in fact, glucose metabolism was impaired.

Statistically significant differences between age groups in cholesterol and TG also emerged 3-6 h after taking the breakfast meal. Issa et al. have also reported somewhat slower TG clearance after consuming a meal containing 40 g of fat (22). Several studies have suggested that slower post-prandial clearance of an oral fat load may contribute to aging-associated pathology such as coronary heart disease (23, 24) and may be influenced by declining insulin sensitivity (25-27). Post-prandially, the plasma cholesterol response of both the M and the E groups was elevated compared to the Y group. This could be attributed to the presence of four subjects in the M group who were ApoE 4 carriers, as this polymorphism is known to elevate cholesterol levels (28). In fact, when the 4 carriers were removed, cholesterol data for the M group fell between the Y and E groups (data not shown).

Although baseline plasma TG was non-significantly higher in the elderly, none of the subjects showed a significant post-prandial TG response between T<sub>0</sub> - T<sub>6</sub>. Given that the ketogenic breakfast contained approximately 50% LCT (Table 3), a post-prandial increase in plasma TG would have been anticipated. Seaton et al. found that in comparison with LCT, there was no significant change in plasma TG and even a slight decrease during the first hour after a single dose of 48 g of MCT (29). Hill et al. observed an increase in fasting TG but no change over 6 h after giving a single dose of MCT following a 6 day diet in which MCT represented 40% of daily energy requirements (30). MCT are clearly absorbed differently from

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LCT but, in our study, it is still not clear whether MCT or the low carbohydrate content of the meal could have suppressed the plasma TG response to the LCT in the cream.

By design, the ketogenic breakfast given to our subjects was not strictly isoenergetic across groups. Rather, using the Harris-Benedict equation, the energy content of the ketogenic breakfast was calculated in terms of percentage of basal energy needs, which takes into account several parameters including gender, age, and anthropometric parameters. Other methods to match meals across groups with different anthropometry include normalizing to only one parameter such as fat in the meal to body weight, BMI, or hip-to-waist ratio. Recent studies suggest a stronger relation of parameters such as insulin resistance to body fat mass rather than to age itself (31, 32). As such, determining % body fat distribution might have helped us more accurately compare subjects. Regardless, neither the calculated values for basal energy expenditure nor the total fat content (g), MCT content (g), fat content/body weight (g/kg), or fat content/BMI (g/kg/m<sup>2</sup>) differed significantly between the three age groups ( $P>0.05$ ).

Our main objective was to assess the short-term ketone response to a ketogenic breakfast during healthy aging and we conclude that the ability to produce ketones appears to be fully functional during healthy aging. Hence, these results support emerging strategies aiming to use physiological levels of ketones to correct or bypass deteriorating brain glucose uptake in the elderly.

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### References

1. Sokoloff L. Measurement of local cerebral glucose utilization and its relation to local functional activity in the brain. *Adv Exp Med Biol* 1991;291:21-42.
2. Musa-Veloso K, Likhodii SS, Cunnane SC. Breath acetone is a reliable indicator of ketosis in adults consuming ketogenic meals. *Am J Clin Nutr* 2002;76:65-70.
3. Mitchell GA, Kassovska-Bratinova S, Boukaftane Y, et al. Medical aspects of ketone body metabolism. *Clin Invest Med* 1995;18:193-216.
4. Petersen KF, Befroy D, Dufour S, et al. Mitochondrial dysfunction in the elderly: possible role in insulin resistance. *Science* 2003;300:1140-2.
5. Freemantle E, Vandal M, Tremblay-Mercier J, et al. Omega-3 fatty acids, energy substrates, and brain function during aging. *Prostaglandins Leukot Essent Fatty Acids* 2006;75:213-20.
6. Reger MA, Henderson ST, Hale C, et al. Effects of beta-hydroxybutyrate on cognition in memory-impaired adults. *Neurobiol Aging* 2004;25:311-4.
7. Freund G, Weinsier RL. Standardized ketosis in man following medium chain triglyceride ingestion. *Metabolism* 1966;15:980-91.
8. Bach AC, Babayan VK. Medium-chain triglycerides: an update. *Am J Clin Nutr* 1982;36:950-62.
9. Weintraub MS, Eisenberg S, Breslow JL. Dietary fat clearance in normal subjects is regulated by genetic variation in apolipoprotein E. *J Clin Invest* 1987;80:1571-7.
10. Reiman EM, Chen K, Alexander GE, et al. Functional brain abnormalities in young adults at genetic risk for late-onset Alzheimer's dementia. *Proc Natl Acad Sci USA* 2004;101:284-9.
11. Poirier J. Apolipoprotein E in the brain and its role in Alzheimer's disease. *J Psychiatry Neurosci* 1996;21:128-34.
12. Chevalier S, Gougeon R, Nayar K, Morais JA. Frailty amplifies the effects of aging on protein metabolism: role of protein intake. *Am J Clin Nutr* 2003;78:422-9.
13. Turner DL, Martin PA, Mitchell GS. Hypoxic exercise does not elicit long-term modulation of the normoxic exercise ventilatory response in Goats. *Adv Exp Med Biol* 1995;393:245-8.
14. McCloy U, Ryan MA, Pencharz PB, Ross RJ, Cunnane SC. A comparison of the metabolism of eighteen-carbon 13C-unsaturated fatty acids in healthy women. *J Lipid Res* 2004;45:474-85.
15. Whitehead R. *New techniques in nutritional research*. San Diego: Academic Press, 1991.
16. Schofield WN. Predicting basal metabolic rate, new standards and review of previous work. *Hum Nutr Clin Nutr* 1985;39 Suppl 1:5-41.
17. Slater C, Preston T, Weaver LT. Comparison of accuracy and precision of heart rate calibration methods to estimate total carbon dioxide production during 13C-breath tests. *Europ J Clin Nutr* 2006;60:69-76.
18. Gehan EA, George SL. Estimation of human body surface area from height and weight. *Cancer Chemother Rep* 1970;54:225-35.
19. Nalbantoglu J, Gilfix BM, Bertrand P, et al. Predictive value of apolipoprotein E genotyping in Alzheimer's disease: results of an autopsy series and an analysis of several combined studies. *Ann Neurol* 1994;36:889-95.
20. Folch J, Lees M, Sloane Stanley GH. A simple method for the isolation and purification of total lipids from animal tissues. *J Biol Chem* 1957;226:497-509.
21. London ED, Margolin RA, Duara R, et al. Effects of fasting on ketone body concentrations in healthy men of different ages. *J Gerontol* 1986;41:599-604.
22. Issa JS, Diamant J, Forti N. Postprandial lipemia: influence of aging. *Arq Bras Cardiol* 2005;85:15-9.
23. Zilvermit DB. Atherogenesis: a postprandial phenomenon. *Circulation* 1979;60:473-85.
24. Lewis GF, Carpentier A, Adeli K, Giacca A. Disordered fat storage and mobilization in the pathogenesis of insulin resistance and type 2 diabetes. *Endocrine Rev* 2002;23:201-29.
25. Boquist S, Hamsten A, Karpe F, Ruotolo G. Insulin and non-esterified fatty acid relations to alimentary lipaemia and plasma concentrations of postprandial triglyceride-rich lipoproteins in healthy middle-aged men. *Diabetologia* 2000;43:185-93.
26. Fulop T, Tessier D, Carpentier A. The metabolic syndrome. *Pathol Biol (Paris)* 2006;54:375-86.
27. Carpentier AC, Frisch F, Brassard P, et al. Mechanism of insulin-stimulated clearance of plasma nonesterified fatty acids in humans. *Am J Physiol Endocrinol Metab* 2007;292:E693-701.
28. Dallongeville J, Lussier-Cacan S, Davignon J. Modulation of plasma triglyceride levels by apoE phenotype: a meta-analysis. *J Lipid Res* 1992;33:447-54.
29. Seaton TB, Welle SL, Wardenko MK, Campbell RG. Thermic effect of medium-chain and long-chain triglycerides in man. *Am J Clin Nutr* 1986;44:630-4.
30. Hill JO, Peters JC, Swift LL, et al. Changes in blood lipids during six days of overfeeding with medium or long chain triglycerides. *J Lipid Res* 1990;31:407-16.
31. Boden G, Chen X, DeSantis RA, Kendrick Z. Effects of age and body fat on insulin resistance in healthy men. *Diabetes Care* 1993;16:728-33.
32. Boden G, Chen X, Desantis RA, Kendrick Z. Effects of insulin on fatty acid reesterification in healthy subjects. *Diabetes* 1993;42:1588-93.