Abstracts

P10 DIET QUALITY, SARCOPENIA AND FRAILTY IN OLDER MEN: CROSS SECTIONAL ANALYSIS FROM THE BRITISH REGIONAL HEART STUDY

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Background Frailty, a vulnerability to adverse health outcomes, and sarcopenia, a decline in muscle mass and strength or performance are associated with ageing. Frailty and sarcopenia predict increased mortality and hospitalisation, and sarcopenia often occurs with an increase in body fat known as sarcopenic obesity which elevates these risks further. Diet quality is well established as a predictor of mortality, but few studies have investigated diet quality in relation to frailty or sarcopenia, and findings are inconclusive. We have therefore examined the associations between diet quality, frailty and sarcopenic obesity categories.

Methods We used cross sectional data from community-dwelling men aged 71–91 years (British Regional Heart Study) in 2010–2012 recruited from 24 primary care practices. Men completed a food frequency questionnaire, from which the Healthy Dietary Index (HDI) and Elderly Dietary Index (EDI) were derived, and attended a physical examination. Frailty was based on the 5 components of the Fried frailty phenotype and we used a sarcopenic obesity classification which defines 4 groups; optimal, sarcopenic, obese or sarcopenic obese based on waist circumference and mid-arm muscle circumference.

We used logistic regression models to investigate whether diet quality was associated with frailty and sarcopenic obesity or obesity.

Results 1331/3137 men (42%) had data for sarcopenia/obesity, all covariates and diet quality and 1119 men (36%) for frailty, covariates and diet quality. After adjusting for age, social class, region of residence, smoking, alcohol consumption, cardiovascular disease and energy intake, men in the top quartile of the HDI score had a lower odds of being frail (0.58 95% CI 0.34, 0.96) compared with men in the bottom quartile, and men in the top quartile of either HDI or EDI had a lower odds of being obese compared with men in the bottom quartile (0.52 95% CI 0.33, 0.84% and 0.57 95% CI 0.38, 0.86 respectively). Neither the HDI or EDI was associated with sarcopenia or sarcopenic obesity, and the EDI was not associated with frailty.

Conclusion Higher diet quality based on both the HDI and EDI is associated with obesity but we found no evidence that diet quality is associated with sarcopenia in these elderly British men. However, our findings suggest that a higher diet quality as indicated by the HDI, a measure of adherence to WHO nutrient intake guidelines, might be relevant for the prevention or reversal of frailty.

P11 THE ENDURING INFLUENCE OF CONTROLLING PARENTING ON PERSONAL MASTERY IN OLDER AGE


Background Personal mastery is the subjective feeling of control over the events in one’s own life. It is associated with healthy ageing, including better cardio-metabolic health, immune function and physical functioning. As an adult mastery is strongly associated with achievements of education, income and social class. However, within-group differences indicate that there could be other ways to feel in control. Mastery is theorised to be a self-concept first learnt in adolescence, and as such family may play a role in shaping it. Those whose parents support them psychologically and allow them appropriate freedom as an adolescent may grow up perceiving themselves to be in control, over and above tangible socio-economic resources.

Data The Medical Research Council National Survey of Health and Development (NSHD) is a representative sample of births in mainland Britain that occurred during a week in March 1946. Participants were (n=1,037) study members who had provided data at ages 4, 26, 43 and 68. Controlling parenting was measured using the Parental Bonding Instrument (PBI). This measures perceived parental levels of psychological control (e.g. Invasiveness, overprotection).

The outcome was personal mastery assessed at age 68 using Pearlin’s 7 item scale. An example item is, “I have little control over the things that happen to me.” Multivariable regression analysis was used to test the association between psychologically controlling parenting and personal mastery at age 68, controlling for childhood and adult socio-economic markers.

Results Higher perceived parental psychological control was associated with lower mean mastery –0.12 (95% 0.20,−0.04)
Background In 2007, heads of government in the Caribbean Community (CARICOM) committed to concerted policy action to address non-communicable diseases, whose burden was recognised as a threat to regional development. In 2015, a large mixed-method evaluation study investigated the progress made in developing and implementing relevant policies. As part of this, a qualitative study in seven Caribbean countries aimed to identify, assess and compare existing policies, gaps in policy responses, and the factors influencing successful policy development and implementation.

Methods Policy document analysis was complemented by 76 semi-structured interviews with 80 relevant stakeholders in government, civil society and the private sector. Data collection and analysis protocols were developed iteratively. Interviews were audio-recorded and analysed pragmatically framed by the WHO NCD Action Plan, a Multiple Streams policy approach and realist evaluation principles. An analysis team coded using Dedoose software, after which two lead researchers synthesised the analyses.

Results Policy gaps existed regarding alcohol, diet and physical activity. Most widely reported successes across countries were policies and health promotion initiatives to support healthy eating in communities and in schools, including the development of dietary guidelines. Physical activity was targeted primarily in schools, with public participation in public sports events. Successful initiatives were often marked by collaboration between government ministries such as health, education and agriculture. There were very few existing policies around alcohol harm. The impact of these initiatives was reported as limited by adverse upstream determinants, including reliance on food imports and existing trade agreements as well as development and implementing policies to reduce alcohol related harm necessitates regional cooperation for a unified response.

Conclusion The least well developed policy responses concern upstream determinants of unhealthy diets, physical inactivity and alcohol harm. Local and regional political support is essential to accelerate action to support environments conducive to healthy eating and active living. Addressing reliance on food imports and existing trade agreements as well as developing and implementing policies to reduce alcohol related harm necessitates regional cooperation for a unified response.