DIET FOR THE CONVALESCENT AND THE AGED.*

By CECIL BULL, M.R.C.P.

(Physician and Hon. Radiologist, Royal Waterloo Hospital; Physician, Ear, Nose and Throat Hospital, Golden Square; Hon. Radiologist, New General Hospital, Southend.)

There is a human tendency to associate names, often indeed for no better reason than euphony, but mostly it is intended that by associating words we also associate ideas and so help the jaded memory in its difficult task. Strawberries and cream, whisky and soda, colocynth and hyoscyamus, Anthony and Cleopatra—our language is rich in examples. Infants and the aged is another; but convalescent and the aged—no—we may throw them together for the sake of an evening's discussion but in the matter of the discussion we must divorce them, for we are going to speak of the diet which is appropriate to the convalescent, and to the aged, and there is little that is common to both.

A.—Diet for the Convalescent.

"Convalescent" is a wide term with a different significance to the lay and the medical minds. To the lay person he is convalescent when recovering from any illness; to the doctor he is convalescent from a specific illness, and the duration of his convalescence, the treatment and the prognosis depend upon the nature of the illness. It is not possible to say that there is any diet, any treatment or any prognosis for a convalescent patient except in terms of the disease from which he has been suffering.

We must therefore tabulate a little:—

1. Convalescence from accidents and general febrile illnesses.
2. ,, ,, illness and disease affecting the alimentary tract.
3. ,, ,, diseases affecting other systems.

1. Convalescence from accidents and general febrile illnesses.

Here we are legislating for the most part for the young and hearty who in moments of their usual robust health can eat without regret and drink synthetic whisky, who are in short passing through that brief phase of life in which we have perfect health and do our best to ruin it. That they should have come under our care is merely a misfortune; their natural resistance has collapsed before an overwhelming blast of virulent infection or the foot has slipped over pitfall or gin.

In this list we include all the exanthemata, common colds, influenza, tonsillitis and the like. When the fury of the infection has spent itself, the patient has elected to live and the exhausted cells of the body are beginning to resume their normal functions, we have to direct how to nourish the returning strength without overloading or poisoning the still weakened system.

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This is the easiest of the group of convalescents to diet, and treatment demands little more than common sense. In the earliest phase of convalescence *milk* still forms the basis and should be kept in the diet by using coffee and milk, cereals and milk and milk puddings with cream, since many patients look with disfavour on milk in a glass when they are convalescent.

Protein. Eggs, fish and meat are introduced gradually and in small quantities at first. It is customary to introduce them in the above order but once it is decided to give protein this is not so important. It is important that whatever protein is used shall be fresh; it is also better that the simple proteins of white fish, chicken, mutton and beef be given before the less digestible "fatty" proteins of pork, duck, goose, game and salmon. The reaction of the patient to the diet should be watched but there is, as a rule, little difficulty in working this group rapidly up to a full protein diet.

Carbohydrates. Simple cereals form the principal carbohydrate element of the diet. Flour, oatmeal and rice are given as toast, bread, milk puddings and plain cakes but not mixed with large quantities of fat, fruit and sugar as rich puddings, cakes or pastry.

Vegetables. Well cooked vegetables of all kinds are permitted to patients convalescent from accidents and general febrile illnesses not directly affecting the alimentary tract.

Fruit is one of the last of the foods to appear on the menu of the convalescent—and then sparingly. It is fortunate for the patient's visitors that the least harmful is the time-honoured grape: a little orange juice may be given occasionally to those who like it but not fruit drinks heavily loaded with sugar.

Sugar—except that required for flavouring—should not be encouraged.

The amount of fluid a patient takes may be left to his own discretion and need neither be encouraged nor suppressed, but the quality must be under the physician's direction. Water, milk, tea, coffee, meat extracts and barley water are fluids for the convalescent. Alcohol is a promise for when he is cured.

Smoking is so closely associated with meals as almost to belong to a dietary. Smoking satisfies a desire to be restless and therefore has a psychological value which offsets any theoretical harm it may do to the gastric juices.

2. Convalescence from diseases of the alimentary tract.

For the purposes of diet regulation these diseases may be divided into two groups—non-specific diseases and specific infections.

(a) The principal members of the group of *non-specific* diseases are:—

- Gastric and duodenal ulcer;
- Cholecystitis and jaundice;
- Appendicitis;
- Diverticulitis;

and the same diet is suitable to them all.

(b) The commoner *specific* infections are:—

Gastro-enteritis;

Typhoid fever;

Ulcerative colitis;

Dysentery.

The less common and tropical diseases which require special dietetic treatment are not included in this list.

(a) *Diet for the group of non-specific diseases:—*

As in the diet of convalescence from general febrile illnesses, *milk* forms the basis in the early stage and should be given as coffee and milk, cereals and milk and milk puddings. It is our object to keep at least a pint in the daily diet up to the end of convalescence, and by introducing it in various ways in a mixed diet the patient is hardly aware of the quantity he is taking.

Protein. In the early stage of convalescence the protein should consist of eggs and fish; poultry and meat come in to the diet towards the end when convalescence is almost complete. In all cases the patient should be on the full diet he is to follow before leaving the hospital or nursing home.

The protein which these patients take should be fresh and once-cooked and should not be combined or served with fat in high proportion. This means, in practice, that the proteins of the ox, sheep, fowl and the simple fishes are better than those of the pig and salmon and that they should be boiled, grilled or roasted and not served with additional fat.

It is repetition, but nevertheless necessary, in giving dietary directions to add that the patient is not to be given done-up dishes of twice-cooked meat, or any tinned or potted foods, spiced meats, sausages or galantines. It is also wise to discourage shell-fish until fully convalescent.

Fats. Butter, cream, cheese and olive oil are given in the diet and the quantity of fat which occurs with meat is included, but no large quantities of animal fat should be added and meats fried in fat should not be given.

Cereals. All plain cereals are included in this dietary but the term "plain cereals" is defined as the well-cooked starch of wheat, rice and oatmeal. Certain additions in the cooking and serving of these starches are also permitted for variation; these additions are:—milk, and small quantities of butter and sugar for flavouring. Thus the range of cereals extends from bread and biscuit to simple cakes and puddings but excludes pastries, fruit cakes and puddings rich in fat, sugar and fruit.

Vegetables are given in very small quantities very well cooked: they should be used to garnish the meal and may be said to supply variety and colour rather than food value.

The manner of serving should always be "well-cooked." No raw vegetables or salads, and no vegetables which contain large quantities of cellulose are included in the diet until the end of convalescence.

Fruit. Like vegetables, fruit also is to be used sparingly and to provide variety. It may be used raw or cooked and the nature of the fruit is of singularly small importance compared with the quantity. The giving of fruit in quantity with the intention of promoting action of the bowels is as unprofitable as it is—in my view—unwise.

Sugar may be used as flavouring but no concentrated sugar in the form of sweets and ice-creams, or heavily sweetened puddings or drinks should be allowed. Gifts of chocolates and sweets by the patient's friends are forbidden.

Drinks. Water is the best drink, and after water:—tea, coffee, meat extracts, milk and soda-water and barley water. These are drinks for convalescent patients. Others belong to the post-convalescent period.

(b) *Diet for convalescence after specific infections of the alimentary tract.*

These are diseases due to bacterial poison introduced with the food; the exception is ulcerative colitis for which no definite organism has been isolated, but since it behaves like these diseases and the dietary treatment is similar it is included in the list.

In the dietary treatment of these diseases animal protein is excluded and in the diet of convalescence our chief concern is to re-introduce protein with such care and watchfulness that we do not start a relapse.

The diet in this group of convalescents is therefore mainly *carbohydrate* and the first care is that the patients can and do successfully take all forms of carbohydrates:—cereals, vegetables and salads, fruits and fruit-juices. Sugar is good for them; alcohol in any form may be taken. They have a wonderful appetite but however varied and interesting you make the carbohydrate dishes they inevitably crave the flesh pots. In the matter of adding protein we must be guided by the patient's reactions: it must be a process of trial and error. Begin with an egg; add two eggs and then three, watching the patient's chart the while. When there seems to be no danger from the eggs add fish, and so on, gradually to meat—bringing the patient up to a full normal diet before he goes from under your care. This last caution is especially significant in ulcerative colitis, a disease in which permanent cure comes only after a long convalescence and in which relapse is gradual and insidious and may begin from the day on which the patient returns to normal life.

3. Convalescence from diseases affecting other systems.

This is a large and somewhat diverse group which cannot be classified under one heading as regards diet, and for which the diet is really a continuance of that prescribed during the acute stages of the illness. Such a statement covers diabetes mellitus and diseases of the blood. Somewhat similar are the diseases of the renal and cardiovascular systems.

In the treatment of *acute nephritis* protein is withdrawn and in convalescence animal protein is slowly reintroduced into the diet while a careful watch is kept on the urine. Certain cases of nephritis pass on from an acute to a chronic phase and the albumin in the urine never completely clears up: in such patients there is no

object in withholding protein indefinitely and their period of convalescence may be reckoned to begin from the time when it is decided that no further reduction in the output of albumin is to be expected.

In *cardiovascular disease* it is customary to reduce the proportion of protein in the diet during any acute phase and while the patient is still confined to bed, but it is irrational to maintain that restriction during convalescence. While the patient is still under observation is therefore the time to bring gradually into his menu all forms of protein—without discrimination as to its colour.

In cardiovascular diseases alcohol is of greatest importance and on strict dietary principles should be withdrawn totally except in so far as it may be required as an emergency stimulant. That is the principle but one which should be interpreted with the freest common sense and worldly wisdom. Sufferers from cardiovascular diseases are frequently fond of and connoisseurs of alcohol, and to deprive them forever of alcohol removes something essential to their physical and psychical well-being; they no longer have the same interest in life or the same community of interest with or for their own particular friends—

“but fill me with the old familiar juice
methinks I will recover bye-and-bye.”

Harsh measures and alarming words make their joyful spirits miserable and our commendable efforts may actually shorten the life we are trying to prolong. “Uplift” is all very well, if you catch your victim young, but in these cases we are about 40 years late and dealing with the battered wreck of heart and arteries supporting the frame of established habits. Take care lest in our solicitude for the arteries we destroy the frame. It is better to insist on moderation than to force a fellow creature to embrace the fiery cross of abstinence.

B.—Diet for the Aged.

With advancing age there is a reversion to simplicity and a dependence upon others: physically there is general weakness and a prolonged latent period: mentally there is contraction of the orbit of interests and a tendency to revolve in a smaller circle with self as an ever increasing centre.

There is a superficial resemblance in this to the state of infancy, and from time to time the idea of reverting to the natural diet of the infant has occurred to men in their old age. In most instances their admirable motives have been misunderstood and such researches have achieved publicity and harsh criticism; yet it is significant that the recorded examples have been men.

One has only to look at the aged with a medical eye to appreciate that they are living more by good luck than anything; their arteries are calcified, their bones brittle, their joints arthritic, and jaws edentulous—witnessing to the truth of the words of the psalmist:—

“The days of our age are three-score years and ten: and though men be so strong that they come to four-score years yet is their strength then but labour and sorrow . . .”

Longevity is hereditary, good stock is the best assurance of old age and diet is not especially a factor in long life. Indeed, I can think of several old men who—in the language of their friends—began to drink themselves to death at fifty: but did not fulfil the prophecy until ninety.

When we are called upon for any reason whatsoever to advise old people there is one most important principle to keep in mind—*do not interfere with the diet of the aged*. And there is a great deal more than that. In fact the treatment of old patients is rather a list of “don’ts” than of active measures.

They react very badly to any change in their habits or environment. They are better treated at home than moved to new surroundings. They should not be kept in bed if they can possibly be kept out of it. Their clothing, their exercise and finally their eating and drinking should not be lightly interfered with. Any changes in their diet which are considered essential should be made gradually and with the patient’s acquiescence. Old people stand starvation badly; they are the first to go under in a famine and the same is true if an artificial famine is created in the home.

With such words of caution let us proceed briefly to outline what is theoretically the best diet for the aged:—

Breakfast in bed and consisting of cereal and cream, roll and butter with marmalade and occasionally an egg. Tea or coffee to drink.

Lunch—the principal meal of the day—a little fish or meat with well-cooked vegetables, milk pudding or boiled pudding, cheese and butter. Water, beer or wine to drink.

Tea—Bread and butter. Plain cakes. Tea.

Supper—In the evening, a glass of hot milk with biscuits.

This diet has an adequate caloric value in simple foods and is suitable for most old people. As a rule they do not require and cannot digest large quantities of food, and any disturbance of digestion, whether from excessive quantity or unsuitable quality, has a greater effect on the old than on younger subjects. Many old people have reached such a diet gradually and of their own choice, and in those cases in which it is considered wise—for reasons of dyspepsia reacting on the general health of the patient—to interfere with the diet, such changes as outlined should be approached gradually and made over a long period.

Convalescent and the aged. The convalescent gathering strength to overcome new worlds; the aged living in the past and mutely asking to be left alone without the disturbance of dyspepsia. Two problems for which we can lay down only general principles, since diet is but one important link in the practice of therapeutics. Every case is an individual problem and the solution of the problem is the art of medicine.