RESEARCH ARTICLE

Nutritional status, survival and mortality in Alzheimer patients - a cross-sectional study [version 1; peer review: 1 approved with reservations, 1 not approved]

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Abstract

Introduction: Dementia is a common health problem in elderly people, Alzheimer disease (AD) being the most prevalent. AD can be considered as a cause of death and must be registered on the death certificate of the patients. However, most of the time, the main cause of death registered is not related to AD, but as an underlying or contributing cause. For example, individuals who have AD and die from myocardium infarction. This study aimed to analyze if nutritional status was associated with survival and mortality for AD, and if AD was reported as actual cause of death on the death certificate.

Methods: The study was carried out as a cross-sectional study with elderly citizens of the community registered in the National Health System (SUS), with cognitive, nutritional, biochemical and hematological evaluations of 30 AD patients in Guarapuava, Paraná state, Brazil.

Results: Significant differences were not observed between live and dead patients when evaluated considering the methods applied. Only 22% of the death certificates stated death due to AD. The patient's cause of death showed a strong relation to respiratory issues; potential explanations based on immunological, biochemical and comorbidity were not confirmed on this study.

Conclusions: AD was not declared as the cause of death in the
The majority of certificates, contributing to the underreporting and reducing the information of death due to AD in the country.

**Keywords**
Dementia, Alzheimer disease, mortality, nutritional value, survivorship

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**Introduction**

The dementias are classified among the most frequent health problems in elderly people. Alzheimer disease (AD) stands out as the most prevalent, occurring in more than 50% of the cases. Alzheimer disease facilitates the advent of opportunistic diseases, which combined to the fragility of the person, deglutition disturbances, and malnutrition can increase the death risks. People with AD live on average 8.3 years from diagnosis among 65 years old, and 3.4 with diagnosis after 90 years.

According to the World Health Organization (WHO), AD can be considered as a cause of death and must be registered on the death certificate of the patients. Nevertheless, in the majority of cases, the main death cause is not related to AD, but other issues are usually listed as immediate causes. According to Ministry of Health the immediate cause of death is the disease, injury or last complication that occurred immediately prior to the moment of death, having a direct correlation with the basic cause of death.

The lack of national data still constitutes a gap in the knowledge of the mortality due to AD, although it has a known impact on the patient, family and caregiver.

It is known that at the present time there is no medical intervention capable of preventing or curing AD, but a protective effect can come from a good diet and quality of life, therefore, nutrition is shown to play an essential role. In this context, the present study aimed to investigate whether nutritional status was associated with AD survival and mortality, and if AD was recorded as the underlying cause of death in the death certificate.

**Method**

The present study was conducted in the city of Guarapuava, central-west region of Paraná state, Brazil. We performed a cross sectional study with elderly citizens of the community registered in the National Health System (SUS), through which they receive, at no charge, specific drugs for AD.

The patients of this study had their diagnosis of AD performed by SUS doctors, according to the “Neurological and Communicative Disorders and Cerebral Vascular Accident National Institute and the Association of Alzheimer Disease and Related Disturbs (NINCDS – ADRDA)”.

**Recruitment**

Data were accessed in CELEPAR System (Information and Communication Technology Company of Paraná) after research project approval. After the identification (name and address) of the 66 patients with AD, provided by a computerized system (CELEPAR System), visits were made to patients’ homes. Patients / caregivers were invited to take part in the study, and a written informed consent form was signed by a person responsible/patient caregiver who agreed voluntarily to participate in the study.

**Data collection**

Data collection was carried out in two phases: the first between August and October 2011, for the anthropometric, nutritional measures, and hematologic exams. “Exclusions from the study were as follows: 7 patient due to death, 11 patient because they had moved from the city, 2 were not found at the address registered in the system, and 16 the caregivers did not accept to participate due to the patient status of weakness”. This left 30 patients remaining in the study.

Research was done in two phases, between August 2011 and June 2013. The first stage was based on collecting nutritional and anthropometric measurements, as well as hematological tests. One and a half years later (June 2013), the researchers contacted the patients or caregivers, verifying that 30% (n=9) of the patients died since the first stage, in 2011. Death certificates (Dc) were evaluated in accordance with International Disease Classification (CID-10). It was defined as death due to AD in cases which had AD as the main cause of the death on the death certificate. Death with AD was recorded when it was mentioned in any part of the medical report of the death certificate. It was considered as codes CID G30.0 to G30.9.

With the intention of evaluating the anthropometrical measures of the patients, we performed a body mass index (BMI). The weight and the height were collected according to the methods advocated in the feed and nutritional surveillance system (SISVAN). BMI measurements were taken using a digital precision scale with kilograms scale from Plenna®. To obtain the height values, a stadiometer was used with a centimeter scale. When it was not possible to obtain the weight and height, as some patients could not stay in the orthostatic position since the patients were bedridden, estimated values were used from the formula proposed for Chumlea (1985). BMI was calculated using the correlation between the square of total corporal weight (kilograms) and the height (meters), using the cut points for elderly people proposed for Lipschitz (1994).

The nutritional state of the participants was evaluated using the mini nutritional assessment (MAN) (13). The MAN is an instrument composed of measures and practical questions that comprise anthropometric evaluations (weight, arm and calf circumferences, height and loss of weight record), global evaluation (life style, drugs, mobility and diseases), dietary evaluation (qualitative and quantitative) and self-evaluation (nutrition perception). The sum of MAN scores allows discrimination between patients, where values below 17 characterize the patient as undernourished, between 17 and 23.5 at malnutrition risk and between 23.5 and 30 as normal. The MAN was applied to the patients classified with Clinical Dementia Rating (CDR) 2 or 3. The food consumption was evaluated through the patient or caregiver report of consumed food through memory of 24 hour estimated in home measurements converted to grams. This data was analysed on Avanutri 4.0® software. Each nutrient was compared to the Dietary Reference Intake (DRI)” according to gender and age, due to the lack of specific recommendations for AD patients.
Also, for the staging of the demential process the Clinical Dementia Rating (CDR) was used. The clinical evaluation of dementia classifies the development stage of AD, where zero rating represents normal, 0.5 dementia questionable (CDR 0.5), 1 mild dementia (CDR 1), 2 moderate dementia (CDR 2) and 3 severe dementia (CDR 3)\(^8\).

The blood collection was performed at patients’ home according to the recommendations for venous blood collection from the Brazilian Society of Clinical Pathology and Laboratory Medicine (2010)\(^16\).

The samples of serum were analysed in biochemistry semi-automated equipment CA 2006 (SHEL – B4B Group, Brazil), and commercial kits (Labtest® - Minas Gerais, Brazil). The total cholesterol, high-density lipoprotein (HDL) cholesterol, low-density lipoprotein (LDL) cholesterol, very low-density lipoprotein (VLDL) cholesterol and triglycerides were evaluated according to the parameters from the Brazilian Cardiology Society, 2013\(^17,18\). The glucose levels were classified according to parameters from the Brazilian Diabetes Society, 2014\(^18,19\). The albumin was dosed through colorimetric methodology, using bromocresol green on the biochemistry semi-automated equipment CA 2006 (SHEL – B4B Group, Brazil), and ALBUMINA PP (Cat# 419, Gold Analisa Diagnostica SA, Brazil) and evaluated following Painter, Cope and Smith parameters\(^19\).

The complete blood count (CBC) was carried out in a hematological analyser Cell-dyn Ruby (Abbott, Illinois, USA) with 33 parameters that use flow cytemetry for the white cells, erythrocytes and platelets analysis and the spectrophotometric methodology for the determination of hemoglobin. The hematological parameters were taken from the WHO\(^20\).

**Statistical analysis**

The statistical analysis was completed using SPSS package version 20.0. Initially, it was carried out using non-parametric analysis due to the large number of variables that do not fall in a normal distribution when evaluated for Shapiro-Wilk test. The first step of the analysis consisted of the comparison of the initial evaluation (base line) between the subjects who have died during the study, and those revaluated in a later phase according to the test proposed by Mann-Whitney. This step also analyzed the survival according to the tests proposed by Kaplan-Maier and considering CDR, IMC, clinical variables, such as age and, diagnosis data as time variable. This step was also analyzed by Qui-Square test with corrections to verify associations between death and sociodemographic and clinical variables.

**Ethics and consent**

The study was approved by the Research Education Committee of the State University of the Center-West - COMEP / UNICENTRO through process 026/2011. Written informed consent was obtained from a person responsible/patient caregiver for all participants.

**Results**

Respiratory issues accounted for the majority of deaths (Table 1). Alzheimer disease was specified in 22% of cases \((n=2)\) and the patients without a specific cause of death on the death certificate was 22% \((n=2)\). No patient had ICD G30.0, early-onset Alzheimer’s disease (Table 1)\(^9\).

As shown in Table 2, the anthropometric variables and macronutrients ingestion are compared between live and patients who died up until two years after the study evaluation. None of the subjects showed values greater than zero on basophils, atypical lymphocytes, blasts, myelocytes and metamyelocytes variables; values greater than zero indicate pathologies.

Table 3 shows the differences on micronutrients consumption between the two groups investigated. The only significant difference found between live and deceased patients, was the phosphorus consumption. Figure 1 shows that the phosphorus consumption was lower those who died compared to the live

| Gender | N | %  | CID* | Cause of Death in DO*                  |
|--------|---|----|------|----------------------------------------|
| Female | 2 | 22%| J 31.1 | Chronic nasopharyngitis               |
| Male   | 0 |    |      |                                        |
| Female | 0 | 11%| J 44.9 | Chronic obstructive lungs disease not specified. |
| Male   | 1 |    |      |                                        |
| Female | 0 | 11%| J 15.9 | Pneumonia bacterial not specified      |
| Male   | 1 |    |      |                                        |
| Female | 1 | 11%| K 57.9 | Diverticular intestine disease, location not specified |
| Male   | 0 |    |      |                                        |
| Female | 2 | 22%| G 30.9 | Alzheimer disease not specified        |
| Male   | 1 | 22%| R 99  | Other not well defined or not specified causes of death |

*CID, codes according to the International Disease Classification review (CID -10), DO, death certificate.

**Table 1. Death causes according to gender and CID registered on the death certificate.**

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Table 2. Comparison between nutritional, hematological and biochemistry parameters among live and deceased patients with AD.

|                          | Living MD | P75-P25 | Deceased MD | P75-P25 | P*  |
|--------------------------|-----------|---------|-------------|---------|-----|
| Weight                   | 64.8      | 15.30   | 54.9        | 29.80   | 0.894 |
| BMI†                     | 24.8      | 4.20    | 22.6        | 7.30    | 0.594 |
| CC‡                      | 33.0      | 3.00    | 31.0        | 3.00    | 0.689 |
| Total MNA§ score         | 21.50     | 5.00    | 21.0        | 8.00    | 0.283 |
| R24 Kcal Hours           | 1487      | 1014    | 1633        | 857     | 0.790 |
| Adequacy % Kcal R24     | 86.1      | 29.60   | 87.9        | 75.40   | 0.657 |
| PTN/KG                   | 1.1       | 0.70    | 0.7         | 0.40    | 0.077 |
| CHO¶ %                   | 52.1      | 12.50   | 58.9        | 13.80   | 0.137 |
| PTN|| %                  | 19.0      | 3.60    | 15.3        | 3.40    | 0.086 |
| LIP** %                  | 28.7      | 7.50    | 27.6        | 10.80   | 0.894 |
| Hematological Parameters |           |         |             |         |     |
| Erythrocytes             | 4.7       | 0.42    | 4.3         | 0.58    | 0.124 |
| Hemoglobin               | 13.9      | 1.70    | 12.3        | 2.65    | 0.097 |
| Volglob                  | 42.3      | 2.80    | 38.6        | 5.55    | 0.066 |
| Vgm                      | 89.9      | 5.10    | 90.9        | 10.08   | 0.881 |
| Hgm                      | 29.5      | 1.42    | 29.9        | 3.44    | 0.754 |
| Chgm                     | 32.9      | 1.57    | 32.5        | 1.46    | 0.669 |
| Rwd                      | 13.1      | 0.60    | 13.2        | 0.85    | 0.711 |
| Leukocytes               | 7310      | 2650    | 6635        | 3615    | 0.549 |
| Eosinophils              | 140.6     | 418.5   | 227.7       | 164     | 0.798 |
| Lymphocytes              | 2152.5    | 783.6   | 2133.6      | 908.7   | 0.977 |
| Monocytes                | 703.0     | 288.3   | 551.3       | 123.8   | 0.374 |
| Rods                     | 79.1      | 36.0    | 66.3        | 63.6    | 0.344 |
| Segmented                | 4508.7    | 1662.4  | 4106.6      | 2676.4  | 0.842 |
| Neutrophils              | 4587.8    | 1689.4  | 4172.8      | 2800.7  | 0.798 |
| Platelets                | 223000    | 65000   | 217000      | 78500   | 0.842 |
| Biochemical Parameters   |           |         |             |         |     |
| HDL (mg/dL)              | 41.0      | 15.0    | 42.0        | 17.0    | 0.475 |
| LDL (mg/dL)              | 103.0     | 47.0    | 93.0        | 28.0    | 0.798 |
| CT†† (mg/dL)             | 170.0     | 52.0    | 161.0       | 22.0    | 0.887 |
| VLDL (mg/dL)             | 22.0      | 17.0    | 24.0        | 16.0    | 0.842 |
| Glucose (mg/dL)          | 86.0      | 22.0    | 83.0        | 25.0    | 0.344 |
| TRIG§§ (mg/dL)           | 112.0     | 86.0    | 118.0       | 81.0    | 0.842 |
| Albumin (g/dL)           | 3.0       | 1.0     | 3.0         | 1.0     | 0.671 |

*P<0.05  †BMI: Body Mass Index; ‡CC: Calf circumference; §MNA: Mini Nutritional Assessment; ||PTN: Protein; ¶CHO: Carbohydrate; **LIP: Lipids; ††CT: Total Cholesterol; §§TRIG: Triglycerides. Mann-Whitney U test.
Table 3. Nutritional ingestion values comparison between live and deceased AD patients*.

|          | Living MD | Living P75-25 | Deceased MD | Deceased P75-P25 | P  |
|----------|-----------|---------------|-------------|------------------|----|
| Vit. A (RE): | 234.8 (26.1%) | 787 (89.0%) | 321.3 (37.9%) | 235.4 (20.3%) | 0.894 |
| Vit. D (mcg): | 2.8 (18.7%) | 2.30 (15.40%) | 1.7 (11.3%) | 1.20 (15.3%) | 0.104 |
| Vit. B1 (mg): | 1.4 (120.9%) | 0.90 (79%) | 1.4 (118.3%) | 0.8 (70.2%) | 0.244 |
| Vit. B2 (mg): | 1.5 (113.6%) | 0.7 (65.4%) | 1.3 (109.2%) | 0.8 (77.4%) | 0.226 |
| Vit. B3 (mg): | 20.6 (128.4%) | 22.0 (136.2) | 15.5 (96.6%) | 8.4 (55.8%) | 0.283 |
| Vit. B5 (mg): | 3.0 (59.8%) | 1.9 (38.0%) | 2.6 (51.4%) | 1.1 (22.2%) | 0.226 |
| Vit. B6 (mg): | 1.1 (70.0%) | 1.1 (74.0%) | 0.8 (50.6%) | 0.6 (39.8%) | 0.077 |
| Vit. B12 (mcg): | 3.0 (125.4%) | 4.5 (188.3%) | 2.2 (92.9%) | 2.7 (113.7%) | 0.372 |
| Vit. C (mg): | 53.8 (62.8%) | 88.4 (116.90%) | 42.9 (57.2%) | 57.8 (75.3%) | 0.929 |
| Vit. E (mg): | 9.6 (64.0%) | 8.4 (56.00%) | 14.8 (98.7%) | 6.7 (44.7%) | 0.397 |
| Fol. (mcg): | 109.9 (27.5%) | 95.2 (23.80%) | 119.3 (29.8%) | 71.3 (17.8%) | 0.594 |
| Ca (mg): | 482.1 (40.2%) | 300.9 (25.10%) | 403.0 (33.6%) | 278.8 (23.2%) | 0.625 |
| P (mg): | 962.9 (137.6%) | 439.7 (62.80%) | 731.5 (104.5%) | 197.6 (28.2%) | 0.011 |
| Mg (mg): | 176.6 (47.0%) | 67.1 (19.10%) | 136.6 (35.4%) | 85.1 (32.3%) | 0.209 |
| Fe (mg): | 12.5 (156.3%) | 8.1 (101.30%) | 8.9 (111.3%) | 6.3 (78.8%) | 0.137 |
| Zn (mg): | 8.9 (87.5%) | 7.0 (67.50%) | 8.5 (77.3%) | 6.7 (98.1%) | 0.533 |
| Cu (mcg): | 0.9 (0.1%) | 0.3 (0.00%) | 0.8 (0.1%) | 0.5 (0.0%) | 0.226 |
| I (mcg): | 46.5 (31.0%) | 41.8 (27.90%) | 45.7 (30.5%) | 17.4 (11.6%) | 0.790 |
| Se (mcg): | 50.9 (92.5%) | 64.2 (116.70%) | 43.0 (78.2%) | 23.5 (42.7%) | 0.086 |
| Mn (mg): | 1.3 (72.2%) | 1.7 (94.40%) | 1.6 (69.6%) | 0.5 (21.8%) | 0.894 |
| K (mg): | 1848.3 (39.3%) | 846.4 (18.00%) | 1451.4 (30.9%) | 667.8 (14.2%) | 0.137 |
| Na (mg): | 2002.0 (166.8%) | 1822.9 (141.34%) | 2018.0 (168.2%) | 1376.1 (122.6%) | 0.859 |

*Gross value (% adequacy). Mann-Whitney U test.

Figure 1. Phosphorus ingestion (P) and adequacy (%) in AD patients distributed by health condition. *Mann-Whitney U test.
group, although the phosphorus consumption was sufficient for both groups.

In addition, Table 4 shows that there were no deaths in patients classified as eutrophic (MAN specification), while all the undernourished patients and at risk of it had died.

According to the CDR classification of the patients who died, 55% were in mild cognitive failure. Of these, 44% were male, which represents half of the male group of the sample. The health conditions showed that 23% (n=7) of the patients had some type of cancer, and from them, 42% (n=3) have died.

Figure 2 shows the AD patient survival curve as a function of age. The survival rate is modified for the disease stage and the results demonstrate a lower survival rate for the patients in the early stages of the disease.

**Discussion**
This study has observed that the respiratory issues may appear as one of the main death cause in AD patients, which may be related to age, due to the advanced age of the majority of the patients. The limitation of the respiratory functional system on AD, due to the depletion of the cough reflex and the accumulation of discharge, reduce the pulmonary ventilation and the elderly immunological system is more affected, facilitating the occurrence of infection, especially respiratory ones.

The elderly with dementia can exhibit dysphagia, making necessary the use of enteral probes for feeding and the elimination of the discharge from upper airways, increasing the respiratory infections. Pneumonia is one of the most common causes of hospitalization of AD patients and its pathology is directly related to its mortality.

Furthermore, seniors are more likely to present with secondary drug effects, increasing the death risks. The elevated chance of pneumonia in AD patients has to be remembered when treating these people. A study in Finland compared the risk of pneumonia associated with acetylcholinesterase inhibitors (AChEls) (donepezil, Transdermal rivastigmine, galantamine and memantine) in people with AD diagnosis and concluded that people who used rivastigmine and memantine in comparison with donepezil had an increased risk of pneumonia. This risk occurred, not only from

**Table 4. AD patients according to health conditions and gender.**

| Health Condition                  | Living | Deceased |
|----------------------------------|--------|----------|
| Gender                           |        |          |
| Female                           | 13     | 05       |
| Male                             | 08     | 04       |
| High Cholesterol                 |        |          |
| No                               | 14     | 06       |
| Yes                              | 07     | 03       |
| Diabetes                         |        |          |
| No                               | 15     | 05       |
| Yes                              | 06     | 04       |
| High Blood Pressure              |        |          |
| No                               | 07     | 03       |
| Yes                              | 14     | 06       |
| Cancer                           |        |          |
| No                               | 17     | 06       |
| Yes                              | 04     | 03       |
| BMI§                             |        |          |
| Low weight                       | 07     | 04       |
| Euthrophic                       | 11     | 02       |
| Over weight                      | 03     | 03       |
| MNA§ Classification              |        |          |
| Normal                           | 05     | 00       |
| Risk of malnutrition             | 11     | 05       |
| Malnourished                     | 05     | 04       |
| CDR* Value                       |        |          |
| Mild Dementia                    | 05     | 05       |
| Moderate Dementia                | 07     | 01       |
| Serious Dementia                 | 09     | 03       |

*CDR: Clinical Dementia Rating; †MMSE: Mini Mental State; § MNA Examination Mini nutritional Assessment, # Body Mass Index (BMI).
the drug characteristics, but also for the severity of the AD. The same study considered the use of pneumococcal vaccination for elevated risk of pneumonia with great efficiency. In Brazil, memantine is used only in moderate and severe stages of the disease.

Other medicines that deserve special attention are the neuroleptics, or tranquilizers, used in AD patients to control the agitation, hostility, delusions and hallucinations. These medicines are antagonists of dopamine, decreasing its transmission and compromising the deglutition function, facilitating aspiration pneumonia. The effects of the neuroleptics on the dopaminergic system usually occurs in severe AD, so it is used in lower doses.

On the other hand, the benzodiazepines that can also be used as tranquilizers in AD have slight effects on the dysphagia, decreasing aspiration pneumonia.

For cause of death analysis, the death certificates must be filled in a correct form. The death certificate is the only source of mortality data and depends directly on the quality of the information provided by the doctor. The underlying death cause was defined by the World Health Organization as a disease or lesion that had initiated the pathological events chain and brought the patient directly to death. In line with the methodology proposed for this study, it was recorded as AD with the codes CID G30.0 to G30.9. Underlying cause of death being AD, the code G30.0 did not appear in any certificate, reinforcing the idea that the death certificates frequently register the immediate death causes instead of to register AD as a cause.

AD generally causes undernourishment to the elderly and it can be associated with physiological alterations, dental issues, physical limitations, and diseases that decrease the appetite, food absorption and, drug interactions.

Although there is no difference between the groups in this study, it could be observed that values are below those recommended by the Dietary Reference Intakes - DRIS (15) for almost all micronutrients. Figure 1 shows that phosphorus was the only micronutrient with significant differences found between the live and dead group. However, this difference cannot explain the observed mortality rates, since the percentage of this micronutrient adequacy was inside the normal values in those who died and above the recommended level in the live group. In addition, the most significant symptoms of phosphorus deficiency include bone weaknesses, discomfort in many joints, weakness, dental decay and rickets. In this study, there was no biochemical analysis of phosphorus dosage in the study groups due to the methodology limitations.

Therefore, the early diagnosis of malnutrition is important due the association with the greater mortality in AD. The data from this study supports this, since all the patients who have died were undernourished according to MAN classification.

The consequences of the weight loss and malnutrition in people with dementia occurs due to the dependency of care, difficulties in mobility, food preparation, chewing and deglutition. Moreover,
the nutritional status of the elderly AD patients has a significant impact on the disease course, affecting cognitive parameters and functional symptoms. Additionally, the malnutrition causes a decrease in white blood cells, leading to alterations in antibodies production and immune resistance, decreasing the survival rate in undernourished patients. Thus, to reduce or at least delay the AD prevalence, maintaining a proper diet from childhood is crucial and reinforced due the fact that the cardiovascular risks are directly related with the development of dementia.

In relation to the AD associated factor, our study reveals that 33% of those who died had higher levels of cholesterol and 44% had diabetes. An epidemiological study has demonstrated the direct relation between high cholesterol levels and the increased risk of cognitive issues, vascular alterations and AD. In terms of diabetes, in this study its presence was not associated with the mortality rates; the survival curve did not show differences between subjects with and without diabetes (p=0.572), although diabetes mellitus is a disease which has risk factors common to AD.

A prospective study from 2010 has evaluated the associated factors of evolutionary differences and mortality due to AD between males and females. The males had more comorbidities due the differences in exposure, work, alcohol consumption, tobacco consumption and differences on the attitudes related to the disease, increasing the chance of death, reinforcing our study, where 44% of the those who died during the study were males. In some cases, the male mortality occurs due to external causes, given that females have higher chances of developing AD in advanced ages, correlating with our sample composition. On the other hand, a study conducted by Teixeira et al. (2015) shows a higher mortality in AD females, which may be explained by the prevalence of cases in this gender in Brazil and other countries.

Among the possible comorbidities occurring in this population, cancer stands out, decreasing survival in the elderly. This effect was not completely observed in this study, where 76.7% of the patients were not cancer patients. From the 23.3% that were cancer patients, 57% have died since the beginning of the study. Still according to Teixeira et al. (2015), the neoplasms were more frequent in patients without AD.

In the study performed by Mussico et al. (2013), elderly patients with cancer have a reduced risk of dementia due to AD and vice-versa. Although demonstrating common pathophysiological mechanisms such as mitochondrial dysfunction, oxidative stress and DNA damage that are propitious to the genetic and metabolic connections between cancer and neurodegeneration, there is an inverse association between the pathologies. Romero (2014), in a prospective study, analyzed the cancer notification proportion on death certificates of dementia patients and concluded that AD patients have a lower risk of mortality due to malignant neoplasia. In our study, the survival curve has not shown significant differences when the subjects with and without cancer were compared (p=0.998).

A decrease in the survival rate was observed in Figure 2 showed a difference between the distinct disease stages. However, the lower survival values were observed in patients who were classified in the mild dementia stage, an unexpected result that is not in line with the literature. Nevertheless, the death of patients of the study is strongly related to respiratory issues and to the progression of the disease. The risk factors for pneumonia on initial AD stage are not sufficiently understood, but one possibility is that a silent aspiration of saliva or bolus without causing cough, respiratory difficulty or other external sign can cause pneumonia due to aspiration. Also, because the symptoms and effects caused by the AD are less evident in mild disease stage patients, the preoccupation with immunological care may be reduced.

Furthermore, while several studies use the diagnostic time as the survival time, this study has not used it; first due to the difficulties, such as lack of specialized doctor in SUS to assist the great demand and the lack of information about AD, confusing its symptoms with simple senility or not searching for an appropriate diagnostic. Second, the correlation with age is associated with the disease and the survival.

The obtained results were discussed and interpreted considering the limitation of a cross-sectional study with a limited number of patients. In addition, the information was not collected before the patient’s death due to the improbability of each case. Nonetheless, the longest past period since the evaluation and the death was 18 months. Thus, the number and quality of the information fortify the results with social relevance, since they were obtained from a non-institutionalized dementia, where caregivers are relatives, a common situation among people with dementia in Brazil.

The nutritional status, biochemical and basic comorbidities were not confirmed in this study to explain this relation. Therefore, the AD patients profile characterization in the study and the observed reduction on the survival probability may indicate the absence of proper attention, suggesting new searches for its confirmation. At the same time, the quality of the information in the death certificates that frequently do not register dementia as an implicit cause generates underreporting of the long-term chronic degenerative diseases.

Other limitation is the quality of information given in the death certificate, which does not record AD as an implied reason, giving no notice of chronic degenerative diseases and hiding results. This suggests there is a need for more research in this area, because there is still a shortage of studies on this subject.
Data availability
All raw data was freely available on the Open Science Framework site: Doi: 10.17605/OSF.IO/PE38C.

Competing interests
No competing interests were disclosed

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The authors addressed two important aspects related to Alzheimer's disease: 1) accuracy of mortality rates, and 2) nutrition as a risk factor. However, the experimental design presented in the current version of the manuscript fall short in addressing both issues. Several important shortcomings in the experimental design and interpretation of the results render this manuscript unacceptable. For example:

1. The authors compare or use different variables in the study but does not present a power analysis to support that the number of participant is sufficient to draw any conclusion.

2. It is unclear how nutritional status relate to the death certificate. The introduction is confusing as to what is the gap in knowledge and the relationship of the proposed questions.

3. The main limitation of death certificate is that, in the case of AD, the diagnosis is not confirmed (i.e. neuropathology). The authors did not address this major limitation.

4. Who completed the MAN? A caregiver? How this data was collected?

5. Cancer patients need to be segregated from the data since may have contributed to the only difference observed; phosphorus level.

6. The participants are not segregated based on stage of AD (i.e. mild, moderate, severe). It is expected that the stage of the disease will affect their nutritional level.

7. The discussion section addressed issues not supported by the data or even related to it. For example: There is no data on the use of any of the drugs mentioned by the research participants. How is this information relevant to the study?

In summary, in the present form, the authors do not have any supporting data for the
interpretations and conclusion presented in the manuscript.

Is the work clearly and accurately presented and does it cite the current literature?
No

Is the study design appropriate and is the work technically sound?
No

Are sufficient details of methods and analysis provided to allow replication by others?
No

If applicable, is the statistical analysis and its interpretation appropriate?
No

Are all the source data underlying the results available to ensure full reproducibility?
Partly

Are the conclusions drawn adequately supported by the results?
No

Competing Interests: No competing interests were disclosed.

I confirm that I have read this submission and believe that I have an appropriate level of expertise to state that I do not consider it to be of an acceptable scientific standard, for reasons outlined above.

Reviewer Report 12 March 2018

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The report is of a small study of 30 people with Alzheimer’s disease, 9 of whom died within 1.5 years of baseline assessment. Information is provided on recorded cause of death and participants who died are compared to the remainder on a range of anthropometric, haematological, biochemical and nutritional indices recorded at baseline.

I'm all in favour of data being in the public domain; however, the discussion section needs to be fundamentally revised before the paper can be viewed as accepted. The conclusions which can be drawn are very limited by the sample size and do not adequately support the extensive material presented in the discussion, so this should be substantially abbreviated as described below. There
are also aspects of the methodology which need to be clearer.

1. While it is reasonable to display a breakdown of causes of death, and reasonable to comment on the relatively low proportion of death certificates mentioning AD (which has been described in other samples), it is not appropriate to draw conclusions about dementia-related factors contributing to causes of death. Conditions such as respiratory disease are common causes of death in any older population and the study does not evaluate whether they are any higher in people with dementia than the general population, so it is misleading to be discussing, for example, elevated risks of pneumonia or cancer or whatever.

2. Although I don’t object to the authors displaying descriptive data on their baseline covariates stratified according to subsequent death, a study of this size would only be able to identify very large differences at statistical significance; therefore I don’t feel that it is appropriate to be discussing the findings in any more detail than a simple presentation of descriptive data. The difference in phosphorus levels is highly likely to represent type 1 statistical error because of the very large number of comparisons made, so it is reasonable not to draw any inferences from this. The rest of the discussion about risk factors for mortality is not justified because the study does not have statistical power to detect these associations and, indeed, no significant associations are identified.

3. It is reasonable to comment on levels of survival in the sample, but I don’t think that anything can be concluded about stage of dementia and survival because the numbers are simply not large enough.

4. The repeated description of the study as cross-sectional is misleading. The study took a group of 30 people and followed them up for mortality. It is therefore surely a cohort study? Similarly, I don’t understand the sentence in the third-to-last paragraph: “In addition, the information was not collected before the patient’s death due to the improbability of each case.” Surely all the information was collected before death (apart from the death certification)?

5. As far as I can tell, the participants were people who were recorded as receiving medications for AD and who were then approached and visited at home. There does not appear to have been any formal evaluation of the diagnosis, apart from the completion of a CDR. Is this correct? It would be helpful if the sample identification and recruitment process was a little more clear.

Is the work clearly and accurately presented and does it cite the current literature?
Partly

Is the study design appropriate and is the work technically sound?
Partly

Are sufficient details of methods and analysis provided to allow replication by others?
Partly

If applicable, is the statistical analysis and its interpretation appropriate?
Partly
Are all the source data underlying the results available to ensure full reproducibility?
Yes

Are the conclusions drawn adequately supported by the results?
No

**Competing Interests:** No competing interests were disclosed.

**Reviewer Expertise:** Dementia epidemiology

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.

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