From mitochondria to healthy aging: The role of branched-chain amino acids treatment: MATeR a randomized study

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Title: From Mitochondria To Healthy Aging: The Role Of Branched-chain Amino Acids Treatment: MATeR A Randomized Study

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Abstract

Rationale: Malnutrition often affects elderly patients and significantly contributes to the reduction in healthy life expectancy, causing high morbidity and mortality. In particular, protein malnutrition is one of the determinants of frailty and sarcopenia in elderly people.

Methods: To investigate the role of amino acid supplementation in senior patients we performed an open-label randomized trial and administered a peculiar branched-chain amino acid enriched mixture (BCAAem) or provided diet advice in 155 elderly malnourished patients. They were followed for 2 months, assessing cognitive performance by Mini Mental State Examination (MMSE), muscle mass measured by anthropometry, strength measure by hand grip and performance measured by the Timed Up and Go (TUG) test, the 30 seconds Chair Sit to Stand (30-s CST) test and the 4 meters gait speed test. Moreover we measured oxidative stress in plasma and mitochondrial production of ATP and electron flux in peripheral blood mononuclear cells.

Results: Both groups improved in nutritional status, general health and muscle mass, strength and performance; treatment with BCAAem supplementation was more effective than simple diet advice in increasing MMSE (1.2 increase versus 0.2, p=0.0171), ATP production (0.43 increase versus -0.1, p=0.0001), electron flux (0.50 increase versus 0.01, p<0.0001) and in maintaining low oxidative stress. The amelioration of clinical parameters as MMSE, balance, four meter walking test were associated to increased mitochondrial function.

Conclusions: Overall, our findings show that sustaining nutritional support might be clinically relevant in increasing physical performance in elderly malnourished patients and that the use of specific BCAAem might ameliorate also cognitive performance thanks to an amelioration of mitochondria bioenergetics.

Keywords

Malnutrition, elderly patients, branched-chain amino acids, muscle mass and strength, mitochondrial activity and biogenesis, oxidative stress.

Abbreviations

30-s CST, 30 seconds chair sit to stand test; ADL, activity of daily living; BCAAem, branched chain amino acid enriched mixture; BCAAs, branched chain amino acids; BMI, body mass index; CIRS, cumulative index rating scale; COX-1 and 4, cytochrome C oxidase 1 and 4; FOXO, forkhead box O; GAPDH, glyceraldehyde 3-phosphate dehydrogenase; GDS, geriatric depression scale; GLM, linear regression models; MFN-1 and 2, mitofusin-1 and 2; MMSE, mini-mental state examination; MNA, mini nutritional assessment test; mTOR, mechanistic target of rapamycin; NRF-1, nuclear respiratory factor-1; NO, nitric oxide; OECD, organisation for economic co-operation and development; PBMCs, peripheral blood mononuclear cells; ROS, reactive oxygen species; RT-PCR, real time PCR; TBARs, thiobarbituric acid reactive substances; TFAM, mitochondrial transcription factor A; TUG, timed up and go test.

Introduction

Thanks to an increased life expectancy, an improvement in health status and medical services, the older population is constantly increasing. In 2015, 617 million (8.5%) people in the world were aged 65 and over (older adults) and these numbers are estimated to rise to 1.6 billion by 2050 (1). Despite the increase in life expectancy, there is no corresponding increase in healthy life expectancy: recent findings in 2015 show that, despite a life expectancy at the age of 65 of 21.2 years for women and 17.9 years for men, only 9.4 years are healthy years (2). Concomitantly, health maintenance in older age will be one of the most relevant societal challenges in the future years. Lifestyle changes appear to be fundamental in increasing healthy life expectancy, and adequate nutrition is enormously important, given that malnutrition (i.e., undernutrition), particularly as protein-energy deficit is very common amongst the elderly population. This is due to the effects of aging *per se* that causes decreased salivation, difficulty swallowing, and delayed emptying of the stomach and oesophagus, as well as slower gastrointestinal movement (3). Other conditions associated with aging, such as drug use, loneliness, depression, lack of oral health, low quality of life, in addition to chronic non-communicable diseases, markedly increase the undernutrition risk (4). It has been estimated that undernutrition affects between 20 and 50% of hospitalised patients (5) and 5 and 10% of patients living at home in the community (6), the great variations reported in different studies depends

not only to differences in the population analysed, but also on the adopted definition. Recently a large study (7), that applies harmonized criteria to define malnutrition in different clinical settings and population, shows a great underestimation of the problem and confirms higher prevalence of malnutrition in residents of nursing homes and hospitalized patients evaluated by Mini Nutritional Assessment test (MNA). Malnutrition is more prevalent in patients affected by acute and chronic disorders with reduced functional status (7) and is associated with poor clinical outcomes and prognosis. Malnutrition is associated with reduced immune function, anaemia, impaired cognitive function, and higher hospitalisation rate and is a strong independent predictor of mortality [for a review, see A. Granic et al, 2018 (8)]. Malnutrition causes body weight loss and muscle atrophy, decreased muscle strength and function, impaired balance, and increased fall and fall-related injuries. The malnutrition-linked muscle atrophy accelerates transition to frailty (9) and has been considered as one of the determinants of sarcopenia (10,11). Importantly, sarcopenia is defined as low muscle mass, with defective muscle strength (also named dynapenia) and decline of physical performance (12) and is, *per se*, associated with increased morbidity and mortality (13). Although several guidelines and consensus documents on nutritional care of malnourished elderly subjects have been proposed (14), and protein needs established in the range from 0.8 g/kg/day (healthy adults) and up to 1.5 g/kg/day (in some cases even higher) according to age, disease and degree of protein depletion (15), the daily protein consumption in older subjects is often inadequate and undernutrition and sarcopenia are underestimated and considered as one of the factors of aging (4, 7).

It has been suggested that the aging process significantly affects protein metabolism and enhances the muscle wastage that accompanies undernutrition and sarcopenia. Some studies show lower plasma concentrations of branched-chain amino acids (BCAAs) in elderly subjects (16,17), whereas others do not (18,19). This may be due to the increased first-pass splanchnic extraction of amino acids in older people, with a consequent decrease in delivery to the skeletal muscle tissue and availability for muscle tissue anabolism (20). Most kinetics studies show no difference in the ability of older subjects to retain and metabolise BCAAs (21–24).

These observations suggest that the dietary requirement of proteins and essential amino acids is higher in the elderly than in young adults (25) and that an increased intake of a mixture of amino acids or essential amino acids can increase amino acid availability and result in the stimulation of muscle protein anabolism (26).

A number of reports, including a recent well conducted meta-analysis concludes that dietary supplement of essential amino acids is more effective than non-essential amino acid or whole protein supplementations in malnourished patients (27).

Notably, amino acid mixtures enriched in BCAAs have been shown to promote mitochondrial biogenesis and function, in addition to decrease oxidative stress via nitric oxide (NO) and mechanistic target of rapamycin (mTOR) signalling pathways in middle-aged mice (28). A more recent study has shown the stimulatory effect of leucine on mitochondrial respiration and ATP production in human macrophages (29). These results are important because mitochondrial dysfunction is a hallmark of the aging processes and age-related disorders, including sarcopenia and cognitive decline, are characterized by reduced mitochondrial mass and function [for a comprehensive review, see N. Sun et al, 2016 (30)]. Dietary supplementation of BCAA-enriched mixtures (BCAAem) may contribute to slow-down mitochondrial decline and to ameliorate clinical status of malnourished elderly patients (31).

The MATeR study thus aimed to evaluate the efficacy of a specific BCAAem compared to diet advice to promote mitochondrial function and improve clinical outcomes, particularly muscle and cognitive performance, in malnourished elderly community-dwelling subjects.

Materials and methods

Study design.

We conducted a parallel, randomized, controlled, open-label trial to determine the efficacy of dietary BCAAem supplementation, as compared with diet advice, in the slow-down of both muscle and cognitive deficit in malnourished community-dwelling men and women aged 80 years or older. Randomisation was performed by computer generated tables to allocate treatments, with a simple randomization method; the

patients received a consecutive number after enrolment and were subsequently allocated to randomization list, according with Kim et al (32). The randomisation was carried out by the principal investigator, scientists performing lab measurement and statistical analyses were blind to treatment.

The inclusion criterion was malnutrition defined as MNA lower than 17. The MNA test is composed of 18 items that can be completed in less than 10 minutes. It provides a multidimensional assessment of senior patients nutritional status taking into account four domains: anthropometry, general status, dietary habits, and self-perceived health and nutrition states. Anthropometry includes the measurement of calf and arm circumferences, Body Mass Index (BMI), calculated after the measurement of weight and height, and questions about weight loss (4 items); general status comprehends 7 questions related to general health, medication and mobility; the assessment of dietary habits comprehends 5 questions on the number of meals, food and fluid intake and autonomy of feeding; 2 questions evaluate self-perceived health and nutrition states (33,34).

Exclusion criteria were known malignancy, life expectancy of less than two months, heart failure (NYHA IV), end stage renal disease, liver cirrhosis (Child B-C), tube/percutaneous endoscopic gastrostomy feeding or parenteral nutrition, Mini-Mental State Examination (MMSE)≤18 and MNA>17. MMSE ≥ 18 identifies patients with mild form of cognitive impairment, those patients generally do not have problems in swallowing and are able to take drugs. We evaluated for inclusion 336 malnourished patients presenting to our out-patients service for a geriatric evaluation, the evaluation was done by expert geriatricians, of the evaluated patients 181 were excluded for presence of exclusion criteria; one hundred and fifty-five malnourished elderly patients living at home in the community and who were admitted to the outpatients' department of our Unit were enrolled. Patients were evaluated at baseline and randomised to receive diet advice, summarised in an easy-to-use brochure for lay persons (77 patients) or to BCAAem supplements (78 patients, Aminotrofic®, kindly supplied by Errekappa Euroterapici S.p.A. and Professional Dietetics S.p.A, 2 sachets/day). Aminotrofic® is a BCAA enriched mixture, it contains Leucine (1,250 mg), Lysine (650 mg), Isoleucine (625 mg), Valine (625 mg), Threonine (350 mg), Cystine (150 mg), Histidine (150 mg), Phenylalanine (10 mg), Methionine (50 mg), Tyrosine (30 mg), Tryptophan (20 mg), Vitamin B 6 (0.1 mg),

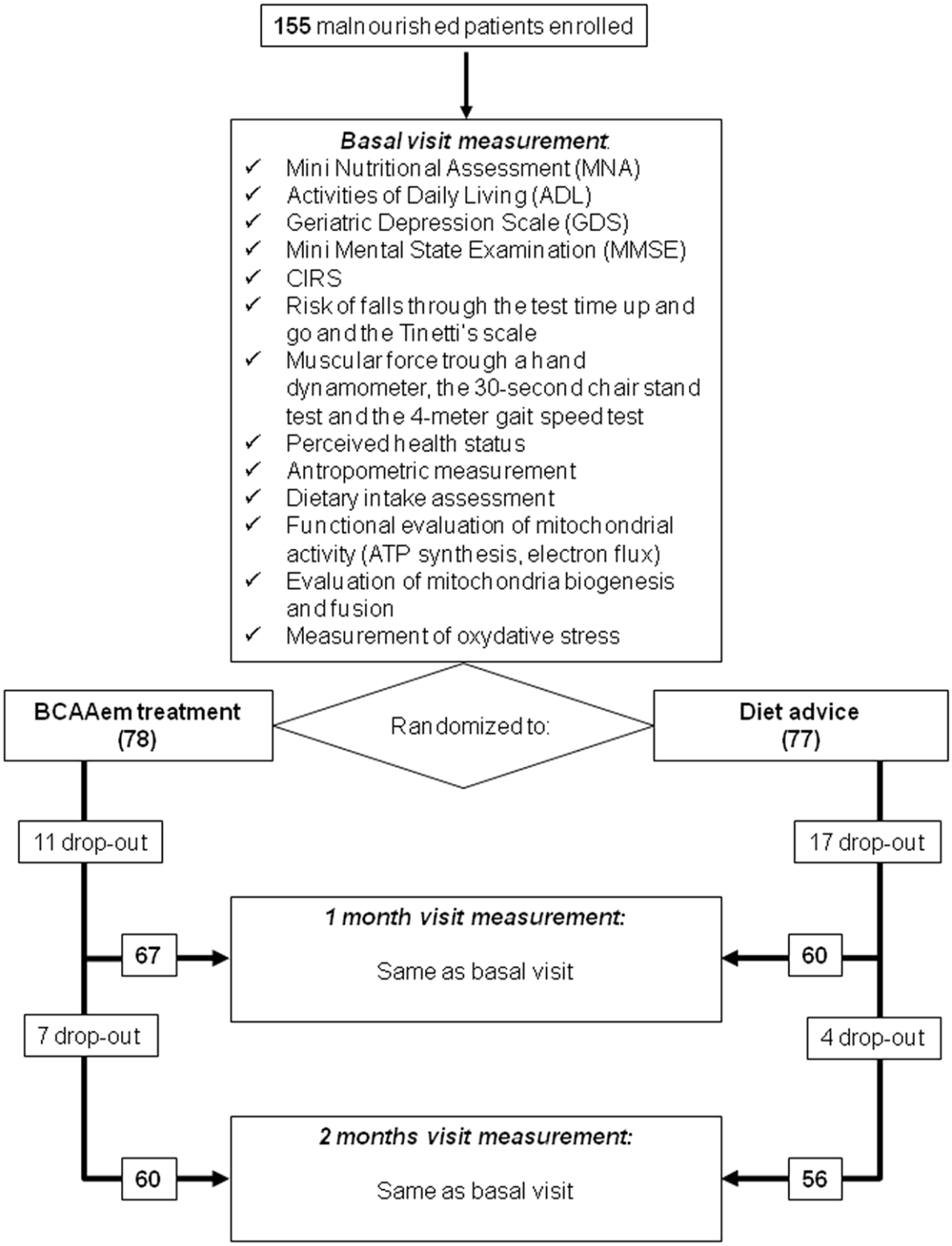
Vitamin B1 (0.15 mg). We suggested the patients to take the BCAAem in the mid-morning and afternoon, regardless of food ingestion. In order to check the compliance we asked the patients to bring back at center the empty sachets at follow-up visit.

Diet advice comprised general advice on the meaning and consequences of malnutrition and dietary recommendation based on the principle of "Food First" to maximize the patient nutritional intake from regular food and drink according with the ESPEN Guidelines on Enteral Nutrition for geriatric patients (35). According to the "Food First" approach we suggested the patients to increase the frequency of eating, maximize the nutrient and energy density of food and drink and fortify food with the addition of fats and sugars, suggested recommendations were given to the patients both orally by the physician and by the use of a brochure; provided dietary recommendations are summarized in the **Supplementary Table 1**.

Period of patient enrolment: February 2013-September 2017. Patients were called back to the centre and all the measurements were performed after 1 and 2 months. 116 patients completed the study (60 treated with BCAAem and 56 with diet advice). In the BCAAem group, 2 patients died after the first month, 1 was admitted to hospital within the first month, 10 patients did not return for the month-1 visit and 5 patients did not return for the month-2 visit for personal reasons. In the diet advice group, 1 patient died during the first month, 2 patients did not return for the month-1 visit since they were hospitalised, 14 patients did not return for the month-1 visit and 4 patients for the month-2 visit for personal reasons, there were no collateral effects. Only data from patients with complete follow up were included in the statistical analyses (**Fig. 1**).

Fig.1. Diagram of the study design.

The diagram shows the study design and the number of patients at each visit in bold. The tests performed at each visit are specified.



188

189 The main outcome measures were muscle mass, strength and performance and mitochondrial ATP

190 production; secondary measurements were cognitive performance, nutritional status, health perceived

191 status, mitochondrial biogenesis and activity in peripheral blood mononuclear cells (PBMCs). The

192 measurements were carried out at baseline and after 1 and 2 months of treatment.

193 *Clinical assessment.*

194 *Global clinical assessment:* Self-sufficiency was measured by assessing the Katz Index of Activity of Daily
195 Living (ADL), which evaluates overall performance in six functions: bathing, dressing, going to toilet,
196 transferring, continence and feeding; cognitive performance was evaluated by MMSE that is a brief test
197 used to routinely track cognitive changes in an individual both cognitively intact or with severe cognitive
198 impairment over time. Patients' mood was evaluated by the short form of Geriatric Depression Scale (GDS),
199 the scale consists of 15 questions related to the patient's mood answered "yes" or "no". The cut-off point
200 adopted to define a patient as depressed is a GDS higher than 7 (36). Perceived health status was measured
201 by asking the patients to answer the question "How is your health in general?". The patients' answers:
202 "very good", "good", "fair", "bad" or "very bad" were rated from 5 (Very good) to 1 (Very bad), although
203 there is not yet full standardisation of the measurement of perceived health status across Organisation for
204 Economic Co-operation and Development (OECD) Countries, here we used a standard health interview
205 survey instrument used in the OECD Health Statistics 2007 (37), confirmed in OECD Health Statistics 2018
206 (available on line at http://www.oecd.org/els/health-systems/health-data.htm) and accepted in Italy. The
207 Cumulative Index Rating Scale (CIRS) was also recorded, this scale accounts for both the presence and the
208 severity of co-morbidities (38).

209 *Nutritional status assessment:* We assessed patients' dietary intake using the PROGEO software (Progeo
210 S.r.l., Italy), it provides an extensive food database and allows to record and to accurately estimate
211 patients' average nutritional intake. The Photo Intake tool helps patients to recognize the amount of food
212 by the visual weight method, ingested showing pictures of food in 3 portions, food quantities can also be
213 recorded as conventional standard units (spoon, glass, cup, etc.). The software provides a large food
214 database and automatically displays patients' average daily calories and nutrients intake. The interview was
215 based on the recall method on 7 days making reference to the "standard week" as suggested by the
216 manufacturer. The interview was done by geriatricians trained by a nutritionist.

217 BMI was assessed by weighing patients by a precision scale and measuring their height using an altimeter
218 wall, BMI was calculated as weight in kg/height in meters squared. Percentage of fat mass was measured

using a plicometer (Mahr GMBH Esslingen), the Pollock, Schmidt and Jackson's formula on three sites (triceps, subscapular and abdomen) was applied (39,40). Skinfold thickness measurements were performed by trained staff according to standard technique: the skinfold thickness was measured by lifting a fold of skin and subcutaneous fat away from the underlying muscle and bone, the skinfold thickness was measured in duplicate with the plicometer. When a difference between the first and the second measurement exceeded 6 mm, a third measurement was taken. The plicometer is applied 1cm from the ridge of skin; take reading 3 seconds after application, to standardise any effects produced by deformation of tissues. The triceps skinfold was measured at the back of the left arm, midway between the acromial process of the scapula and the olecranon process of the ulna. The subscapular skinfold is picked up just under the lower angle of the scapular lifted horizontally below the tip of right scapula. The abdominal skinfold was lifted diagonal midway between umbilicus and right anterior superior iliac spine.

Muscle mass, strength and performance: Appendicular muscle mass was measured using arm and calf circumference. Arm circumference was measured in duplicate to the nearest 0.001 m at a point midway between the lateral projection of the acromion process of the scapula and the inferior margin of the olecranon process of the ulna. The mean of the two measurements was used in the analyses. The calf circumference was measured to the nearest 0.001 m on the left leg with the participant standing straight, feet 20 cm apart, body weight equally distributed on both feet and at the level of the widest circumference of the calf; measurements were taken according to the Longitudinal Aging Study Amsterdam (LASA - http://www.lasa-vu.nl/themes/physical/anthropometry.htm).

Muscle strength was measured via the hand grip test, using a hydraulic hand dynamometer (MSD, Europe) (41) to assess muscle performance and mobility the Timed Up and Go (TUG) test, 30 seconds Chair Sit to Stand (30-s CST) test and the 4 meters gait speed test were performed.

TUG is a simple test used to assess a person's mobility and requires both static and dynamic balance. TUG is performed by measuring the time that the patient takes to rise from a chair, walk three meters, turn around, walk back to the chair and sit down. TUG performed in ten seconds or less indicate normal mobility; 11–20 seconds are within normal limits for frail, elderly and disabled patients and greater than 20

seconds means that the person needs assistance outside and indicates further examination and intervention. A score of 30 seconds or more suggests that the person may be prone to falls (42). The 30-s CST allows the evaluation of lower body strength and to assess the fatigue effect due to the number of sit-to-stand repetitions. It is performed with a chair without arms, the patient seated in the middle of the chair with the arms crossed over his/her chest, then is instructed to stand up as quickly as possible safely without using his/her arms. The number of stands the patients completed in 30 seconds is manually recorded (43).

The 4-meter gait speed test was performed using a stopwatch and measures the time, in seconds, the patients take to complete a 4-meter walk.

The risk of falls further was evaluated using the Tinetti Gait and Balance Instrument as follows: to test the patient's balance, the patient has to sit in a hard, armless chair and is asked to rise and stay standing, then turn 360° and sit back down. Next, the patient walks a few meters at a normal speed, turns, walks back and sits down. The evaluator observes several features and scores the patient's performance: the higher the score, the better the performance. The maximum score for Gait is 12 points, while the maximum for Balance is 16 points, with a total maximum for the overall Tinetti Instrument of 28 points. Score Interpretation: <19 high risk of falls, 19-28 low risk of falls.

Laboratory tests.

Functional evaluation of mitochondrial activity: In order to isolate mitochondrial fractions, blood cells were washed twice in ice-cold PBS, then lysed in 0.5 mL buffer A (50 mMTris, 100 mMKCl, 5 mM MgCl2, 1.8 mM ATP, 1 mM EDTA, pH 7.2), supplemented with protease inhibitor cocktail III (Calbiochem), 1 mM PMSF and 250 mMNaF. Samples were clarified by centrifuging at 650×g for 3 min at 4°C, and the supernatant was collected and centrifuged at 13000×g for 5 min at 4°C. This supernatant was discarded and the pellet containing mitochondria was washed in 0.5 mL buffer A and suspended in 0.25 mL buffer B (250 mM sucrose, 15 mM K2HPO4, 2 mM MgCl2, 0.5 mM EDTA, 5% w/v BSA). A 50 µL aliquot was sonicated and used for the measurement of protein content, as reported in Campia et al, 2009 (44); the remaining part was diluted to a protein concentration of 10 µg/µL and stored at −80°C until the use. The activity of Complex I–III was measured on 10 µL of non-sonicated mitochondrial samples (44), suspended in 0.59 mL buffer C (5

mM KH2PO4, 5 mM MgCl2, 5% w/v BSA). Then 0.38 mL buffer D (25% w/v saponin, 50 mM KH2PO4, 5 mM MgCl2, 5% w/v BSA, 0.12 mM cytochrome c-oxidized form, 0.2 mM NaN3) was added for 5 min at room temperature. The reaction was started with 0.15 mM NADH and was followed for 5 min. The absorbance was read using a Synergy HT Multi-Mode Microplate Reader (Bio-Tek Instruments, Winooski, VT). Results were expressed as nmol reduced cytochrome C/min/mg mitochondrial proteins. In each experimental set, the complex I inhibitor rotenone (100 μM) was added as an internal negative control. In the presence of rotenone, the electron flux was reduced to below 5%.

The amount of ATP was measured on 20 μg of mitochondrial extracts using the ATP Bioluminescent Assay Kit (FL-AA, Sigma Aldrich Co., St. Louis, MO). Data were converted into nmol/mg mitochondrial proteins, using a previously set calibration curve.

Under these experimental conditions, the rate of cytochrome C reduction, expressed as nmol cytochrome C reduced/min/mg cell protein, was dependent on the activity of both Complex I and Complex III.

Real time PCR and assessment of mitochondria biogenesis and fusion: Real time PCR (RT-PCR) was used to evaluate the mRNA levels of Cytochrome C Oxidase 1 and 4 (COX-1 and COX-4), Mitofusin-1 and 2 (MFN-1 and MFN-2), Nuclear Respiratory Factor-1 (NRF-1) and Mitochondrial Transcription Factor A (TFAM) from whole blood nucleated cells.

Red cells were lysed in all peripheral blood samples, total nucleated cells were collected and dissolved in TRIzol reagent (TRISure, Bioline Reagents Ltd, UK) and frozen at -80 °C until RNA extraction. RNA was isolated using chloroform extraction and subsequent isopropanol precipitation according to the manufacturer's protocol. 1 μg of RNA was reverse-transcribed to single-stranded cDNA using the SensiFAST cDNA Synthesis Kit (Bioline Reagents Ltd, UK). RT-PCR was performed using the SensiFAST SYBR Hi-ROX Kit (Bioline Reagents Ltd, UK). The housekeeping control gene was β-actin, and gene expression was quantified using the $2^{-\Delta\Delta Ct}$ method. The primers used (Invitrogen, California, USA) are shown in **Supplementary Table 2**.

All the lab experiments were performed in duplicate, data presented are averages of the duplicates. The coefficient of variation intra-operator ranges between 0.03 and 1.00 for all the measurements.

297 *Oxidative stress:* To determine the oxidative stress level, we measured plasma thiobarbituric acid reactive
298 substances (TBARs), as indicators of lipid peroxidation, using ELISA (TBARS Assay Kit, Cayman Chemical, MI,
299 USA), according to the manufacturer's protocol.
300 *Statistical analyses:* The sample size was calculated on both clinical and lab outcomes; amongst clinical
301 outcome muscle mass was used; in particular sample size provide an 85% power ($p<0.05$), 50 patients per
302 group have to be enrolled to detect a difference (alpha error = 0.05) of at least 2% variation in muscle mass,
303 based on a study on the effect of BCAAs administration on muscle mass and performance in humans (45).
304 As the patients were old and frail we assumed a possible 35% of drop out at the follow-up. In order to
305 calculate sample size for lab tests we considered as significant an increase of 1.5 fold in ATP production as
306 shown by D'Antona et al with BCAAem in aged mice (28), data on ATP production in humans by PBMCs
307 derives from Avis et al (46) based on this analyses sample size was calculated to provide 95% power
308 ($p<0.05$) to detect a 1.5-fold difference in ATP production was 13 patients per group .
309 All the analysed variables were tested for normality by the kurtosis test, TUG, 30-s CST, 4 meters walking
310 test, TBARs, electron flux were non-Gaussian.

311 To evaluate possible differences between patients treated with BCAAem or diet advice at baseline the
312 patients were compare by one-way ANOVA for Gaussian variables and by the Mann-Whitney U test for
313 non-Gaussian ones. Gender was compared amongst patients treated with BCAAem or diet adviceby $\chi 2$ test.

314 The effect of treatment was evaluated per protocol using the two-way ANOVA for repeated measurements
315 for Gaussian variables, non-Gaussian variables were evaluated after logarithmic transformation. To
316 evaluate possible influences of mitochondrial function on muscle and cognitive performance six linear
317 regression models (GLM) were fitted, between ATP and electron flux and TUG, 30-s CST, Tinetti and 4
318 meters walking test, hand grip and MMSE, non-Gaussian variables were logarithmically transformed.

319 SPSS 24.0 were used for the analyses and $p<0.05$ was considered statistically significant. Graphs were
320 drawn using GraphPad 7.0 for Windows.

321 *Ethics Committee approval and consent to participate.*

The study was approved by the Ethics Committee of our Hospital ("Comitato Etico Interaziendale A.O.U. Città della Salute e della Scienza di Torino - A.O. Ordine Mauriziano - A.S.L. TO1", protocol number 0002637), in accordance with the ethical standards of the Declaration of Helsinki and its subsequent amendments. Informed consent was obtained from all individual participants included in the study. The full protocol is available upon request to the corresponding author.

Results

Patients treated with BCAAem or diet advice were comparable for all the clinical variables analysed, this excludes possible selection bias that could influence our results (**Supplementary Table 3**). Compliance to BCAAem was good, none of the patients have a compliance lower than 75%, the compliance ranges between 75% and 90%.

Treatment significantly improves general health and cognitive performance.

Patients' general health measured by perceived health status equally improved in both treatment groups and significantly correlated with nutritional status (MNA: $R=0.50$, $p<0.0001$; fat percentage: $R=0.26$, $p=0.005$) at the end of the follow-up period. Also, the mood measured by GDS significantly improved. The level of independence was not significantly influenced by treatment.

Patients' overall cognitive performance measured by MMSE significantly improved in patients treated with BCAAem, not in patients treated with diet advice; MMSE significantly correlated with MNA ($R=0.28$, $p=0.002$) as well as GDS ($R=-0.32$, $p<0.0001$) at the end of the follow-up period (**Table 1**).

Treatment significantly improves nutritional status.

Patients adhered to the dietary recommendation as shown by the increased caloric intake. Caloric intake increased in both groups and was particularly consistent in the group treated with diet advice, where dietary recommendations were reinforced by the use of an easy-to-use illustrated brochure, in this group

345 also protein intake was significantly higher. During treatment, we observed a significant improvement in
346 nutritional status measured by MNA, fat mass and BMI in both groups (**Table 2**).

347 *BCAAem treatment increases muscle mass, strength and performance.*

348 Muscle mass measured by calf and arm circumferences significantly increased in both groups as well as
349 muscular strength measured by hand grip strength (**Table 3**).

350 To evaluate whether muscular performance was influenced by treatment, we performed the TUG, the 30-s
351 CST test to evaluate both performance and resistance to fatigue. Muscular performance improved with
352 treatment as did muscle mass. Risk of falls was measured using the Tinetti scale and the TUG, mobility was
353 measured using the 4-meter gait speed test, these tests improved equally in the two groups (**Table 3**).

354 *BCAAem improve bioenergetic capacity of PBMCs.*

355 Here we show that ATP production and electron flux significantly increased over time only in mitochondria
356 from patients treated with BCAAem, and that BCAAem maintain oxidative stress at baseline values,
357 whereas, in patients treated with diet advice, oxidative stress increased over time (**Table 4**).

358 To model the relationship between mitochondria stimulation on PBMCs and effects of BCAAem or diet
359 advice on muscular and cognitive performance we applied a linear regression approach.

360 Our data showed that mitochondrial ATP production significantly predicts balance measured by Tinetti
361 after 2 months of treatment and 4 meters walking test after 1 month of treatment (**Table 5**). MMSE is
362 significantly predicted by ATP after 1 month and by electron flux after 2 months of treatment (**Table 6**).

363 We also evaluated the effect of BCAAem treatment on some of the main mitochondrial biogenesis and
364 fusion markers. Our data showed that treatment increases the expression of COX-1 and COX-4 and TFAM,
365 whereas NRF-1 shows only a non-significant trend towards the increase, significant differences versus
366 baseline levels were measured only in patients treated with BCAAem. The expression of MFN-1 and MFN-2

was increased although not significantly by treatment; in the BCAAem treated patients we observed an increased expression of these two molecules after one month of therapy (**Table 7**).

Discussion

As life expectancy increases, adequate nutrition is fundamental for successful aging, here, we confirm that amelioration of nutritional status is associated with improvement in general health status, muscle and cognitive performance in old malnourished patients, and show that this may be due to an improvement of their mitochondrial bioenergetics profile and decreasing oxidative stress.

Here we show that the diagnosis of malnutrition and its treatment, albeit using different approaches, is fundamental in improving patients' general health and nutritional status. Indeed, in both our treatment groups, there was an improvement in MNA, and weight gain, however the increase in caloric and protein intake was higher in patients treated only with diet advice; the use of this approach instead of the use of an isonitrogenous mix of non-essential aminoacids with a double blind design may be considered as a limitation of the study, however the use of the "food first" approach underlines the role of the physician's counselling in patients' adherence to diet. Another possible limitation of the study is the use of a "non-standard" recall method for diet evaluation, here we use a recall on the 7 days before the interview as our old patients usually follow a standard diet with little variation day by day, the evaluation of 7 days allow us to make a more comprehensive evaluation asking the patients "what is your usual meal (breakfast, lunch, dinner and snacks)? Do you change your meal during one week? If yes when and how during the previous week?". The improvement in cognitive performance, measured by MMSE, was significant in patients taking BCAAem supplements: indeed, patients treated with BCAAem gain, on average, 1.2 points of MMSE. This result is in accordance with a previous study in a cohort of patients with severe chronic obstructive pulmonary disease. However, in this study, the increase in cognitive performance was associated with improved pulmonary gas exchange and there was no mechanistic explanation (47). The effect of the administration of BCAAs in cognitive function was also previously assessed in severely brain damaged

patients with hepatic encephalopathy or traumatic brain injuries: in these patients, intravenous BCAAs improve consciousness, assessed using the Glasgow Coma Scale and performance, assessed using the Disability Rating Scale. However, no cognitive tests were performed in these studies and the underlying mechanism was not investigated (48–52). A mechanistic explanation has been provided by the study of animal models of brain injury, demonstrating the efficacy of dietary supplementation with BCAAs in promoting cognitive performance, by restoring hippocampal function, given that BCAAs act as glutamate and GABA precursors (53). In humans, a recent, very large retrospective study showed an association between serum level of isoleucine, leucine and valine with a lower risk of dementia. This study does not report any causal mechanism (54).

Poor nutrition and, in particular, protein-energy deficit further accelerate the loss of muscle mass and function associated with age: sarcopenia (55,56). Sarcopenia increases the risk of falls, disability, frailty, loss of independence and death increasing healthcare costs (57,58). Here, we show that intervention on malnutrition can improve muscle mass and performance. In particular, we show an improvement in balance by the Tinetti balance test and the TUG test, with a consequent reduction of the risk of falls and fall-related injuries in a population with increased risk of falls (average TUG higher than 14 seconds). Treatment increases muscle performance, increasing mobility, and resistance to fatigue; the improved performance in the 4-meter gait speed test observed during treatment demonstrates an overall increase in health and the performance status of the patients according to previous study (62). Also, muscle strength measured using hand dynamometer increased in both treatment groups.

Taken together, these data demonstrate that dietary intervention can counteract the decrease in physical and cognitive performance in old malnourished patients and that loss of muscle mass and function can be countered using an appropriate treatment strategy in a rapidly aging population.

Several studies suggest a major role of mitochondrial dysfunction as a major contributor to aging and age-related diseases [for a review, see Cedikova et al, 2016 (63)]. Mitochondrial biogenesis, ATP production and oxidative phosphorylation capacity decrease with aging and production of reactive oxygen species,

damaged mitochondrial DNA and protein increase [for a review, see Cedikova et al, 2016 (63)]. In this study, we further investigate the mechanisms underlying the better clinical effects obtained with the administration of BCAAem, besides diet advice, by evaluating the treatment effects on mitochondrial function, biogenesis and fusion, as well as oxidative stress. In animal models, the administration of BCAAs has been shown to be effective in increasing the number and the function of mitochondria (28). In a small cohort of young healthy obese and non-obese subjects, the infusion of a mixture of aminoacids increased ATP production rates of muscular mitochondria in lean, but not in obese subjects (64). The increase in size, number and energy production of mitochondria that follows the administration of BCAAem was associated with better muscle performance, on both at skeletal and cardiac muscle level in mice (28). Here we evaluated mitochondria from PBMCs, it has been previously shown that mitochondria isolated from skeletal muscle and from PBMCs have a similar bioenergetics profile and are associated with gait speed in older adults (65), as regards neurological tissues other authors measured mitochondrial function in PBMCs and correlates its reduction with neurodegeneration (66). According with these observations we show that mitochondrial activity measured using ATP production and electron flux increase is associated with both cognitive and muscular performance amelioration in elderly patients; these data are particularly interesting as they suggest a possible non-invasive and reliable measure to follow up treatment outcomes. We show that the increase of TFAM, mitochondrial respiratory chain (COX-1 and COX-4) and mitofusin gene expressions correlate with an increase in ATP production and electron flux, and suggest that BCAAem treatment induces biogenesis, activity and fusion of mitochondria, stimulating at the end the bioenergetic capacity of PBMCs.

Mitochondrial biogenesis and fusion are particularly increased after the first month of treatment. Afterwards, there is a plateau with no further increase, whereas mitochondrial activity increases during the entire follow-up period. This suggests that, after an increase in the number and fusion of mitochondria, the organelles maintain an increased function without any further increase in their number.

Other than the effect on muscle mass and function, treatment of malnutrition is associated with improved general health. This may be due to better energy production associated with an increase in respiratory

chain activity and a decrease in oxidative stress, in an experimental model of progeroid aging characterised by increased DNA damage, boosting mitochondrial preserves mammalian health and increases longevity (67).

It is well known that oxidative damage is one of the components of aging: the increase in free radical production and the decrease in the defence against oxidative stress cause molecular alteration and functional decay; the free radical theory of aging suggests that oxidative stress is an important factor in age-associated diseases (68). Here, we show that BCAAem supplementation lowers the levels of oxidative stress in elderly patients.

In conclusion, this study, for the first time, suggests that BCAAem treatment in old malnourished patients could be a good strategy able to ameliorate the bioenergetic capacity of PBMCs, this effect may partially explain the positive trend on muscle and cognitive performance in these patients.

Conflict of interest statement and funding

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Statement of authorship

FS and IB performed the lab experiments, acquired and analysed the lab data, and participated in drafting and critically revising the manuscript. CRavetta, GC, FD, CF, FGP and PP performed the clinical evaluation of patients and managed the dataset. MM, EN, CRiganti, CRuocco and GCI participated in the study design and were major contributors in writing the manuscript. PD designed the study, performed the statistical analyses and wrote the paper. All authors read and approved the final manuscript.

Availability of data and materials

The datasets generated and/or analysed during the current study are not publicly available but are available from the corresponding author upon reasonable request.

REFERENCES

1. He W, Goodkind D, Kowal P. An aging world: 2015-International Population Reports. US Census Bureau, Washington, DC. 2016;

2. Healthy life years and life expectancy at age 65 by sex. Eurostat, European Commission, Luxemburg. 2016;

3. Nieuwenhuizen WF, Weenen H, Rigby P, Hetherington MM. Older adults and patients in need of nutritional support: review of current treatment options and factors influencing nutritional intake. Clin Nutr. 2010 Apr;29(2):160–9.

4. Appleton KM. Increases in energy, protein and fat intake following the addition of sauce to an older person's meal. Appetite. 2009 Feb;52(1):161–5.

5. Gaskill D, Black LJ, Isenring EA, Hassall S, Sanders F, Bauer JD. Malnutrition prevalence and nutrition issues in residential aged care facilities. Australas J Ageing. 2008 Dec;27(4):189–94.

6. McCormack P. Undernutrition in the elderly population living at home in the community: a review of the literature. J Adv Nurs. 1997 Nov;26(5):856–63.

7. Wolters M, Volkert D, Streicher M, Kiesswetter E, Torbahn G, O'Connor EM, et al. Prevalence of malnutrition using harmonized definitions in older adults from different settings - A MaNuEL study. Clin Nutr. 2018 Nov 3;

8. Granic A, Mendonça N, Hill TR, Jagger C, Stevenson EJ, Mathers JC, et al. Nutrition in the Very Old. Nutrients. 2018 Feb 27;10(3).

9. Vanitallie TB. Frailty in the elderly: contributions of sarcopenia and visceral protein depletion. Metab Clin Exp. 2003 Oct;52(10 Suppl 2):22–6.

10. Artaza-Artabe I, Sáez-López P, Sánchez-Hernández N, Fernández-Gutierrez N, Malafarina V. The relationship between nutrition and frailty: Effects of protein intake, nutritional supplementation, vitamin D and exercise on muscle metabolism in the elderly. A systematic review. Maturitas. 2016 Nov;93:89–99.

11. Shen Y, Chen J, Chen X, Hou L, Lin X, Yang M. Prevalence and Associated Factors of Sarcopenia in Nursing Home Residents: A Systematic Review and Meta-analysis. J Am Med Dir Assoc. 2018 Nov 5;

12. Cruz-Jentoft AJ, Baeyens JP, Bauer JM, Boirie Y, Cederholm T, Landi F, et al. Sarcopenia: European consensus on definition and diagnosis: Report of the European Working Group on Sarcopenia in Older People. Age Ageing. 2010 Jul;39(4):412–23.

13. Beaudart C, Zaaria M, Pasleau F, Reginster J-Y, Bruyère O. Health Outcomes of Sarcopenia: A Systematic Review and Meta-Analysis. PLoS ONE. 2017;12(1):e0169548.

14. Cederholm T, Barazzoni R, Austin P, Ballmer P, Biolo G, Bischoff SC, et al. ESPEN guidelines on definitions and terminology of clinical nutrition. Clin Nutr. 2017;36(1):49–64.

15. Deutz NEP, Bauer JM, Barazzoni R, Biolo G, Boirie Y, Bosy-Westphal A, et al. Protein intake and exercise for optimal muscle function with aging: recommendations from the ESPEN Expert Group. Clin Nutr. 2014 Dec;33(6):929–36.

16. Van Eijk HM, Dejong CH, Deutz NE, Soeters PB. Influence of storage conditions on normal plasma amino-acid concentrations. Clin Nutr. 1994 Dec;13(6):374–80.

17. Katsanos CS, Kobayashi H, Sheffield-Moore M, Aarsland A, Wolfe RR. Aging is associated with diminished accretion of muscle proteins after the ingestion of a small bolus of essential amino acids. Am J Clin Nutr. 2005 Nov;82(5):1065–73.

517 18. Walrand S, Short KR, Bigelow ML, Sweatt AJ, Hutson SM, Nair KS. Functional impact of high
518 protein intake on healthy elderly people. Am J Physiol Endocrinol Metab. 2008
519 Oct;295(4):E921-928.

520 19. Engelen MPKJ, De Castro CLN, Rutten EPA, Wouters EFM, Schols AMWJ, Deutz NEP.
521 Enhanced anabolic response to milk protein sip feeding in elderly subjects with COPD is
522 associated with a reduced splanchnic extraction of multiple amino acids. Clin Nutr. 2012
523 Oct;31(5):616–24.

524 20. Short KR, Nair KS. The effect of age on protein metabolism. Curr Opin Clin Nutr Metab Care.
525 2000 Jan;3(1):39–44.

526 21. Boirie Y, Gachon P, Beaufrère B. Splanchnic and whole-body leucine kinetics in young and
527 elderly men. Am J Clin Nutr. 1997 Feb;65(2):489–95.

528 22. Kullman EL, Campbell WW, Krishnan RK, Yarasheski KE, Evans WJ, Kirwan JP. Age
529 attenuates leucine oxidation after eccentric exercise. Int J Sports Med. 2013 Aug;34(8):695–9.

530 23. Moreau K, Walrand S, Boirie Y. Protein redistribution from skeletal muscle to splanchnic tissue
531 on fasting and refeeding in young and older healthy individuals. J Am Med Dir Assoc. 2013
532 Sep;14(9):696–704.

533 24. Deutz NEP, Thaden JJ, Ten Have GAM, Walker DK, Engelen MPKJ. Metabolic phenotyping
534 using kinetic measurements in young and older healthy adults. Metab Clin Exp. 2018;78:167–
535 78.

536 25. Walrand S, Boirie Y. Optimizing protein intake in aging. Curr Opin Clin Nutr Metab Care.
537 2005 Jan;8(1):89–94.

538 26. Rolland Y, Dupuy C, Abellan van Kan G, Gillette S, Vellas B. Treatment strategies for
539 sarcopenia and frailty. Med Clin North Am. 2011 May;95(3):427–38, ix.

540 27. Cheng H, Kong J, Underwood C, Petocz P, Hirani V, Dawson B, et al. Systematic review and
541 meta-analysis of the effect of protein and amino acid supplements in older adults with acute or
542 chronic conditions. Br J Nutr. 2018 Mar;119(5):527–42.

543 28. D'Antona G, Ragni M, Cardile A, Tedesco L, Dossena M, Bruttini F, et al. Branched-chain
544 amino acid supplementation promotes survival and supports cardiac and skeletal muscle
545 mitochondrial biogenesis in middle-aged mice. Cell Metab. 2010 Oct 6;12(4):362–72.

546 29. Grajeda-Iglesias C, Rom O, Hamoud S, Volkova N, Hayek T, Abu-Saleh N, et al. Leucine
547 supplementation attenuates macrophage foam-cell formation: Studies in humans, mice, and
548 cultured macrophages. Biofactors. 2018 May;44(3):245–62.

549 30. Sun N, Youle RJ, Finkel T. The Mitochondrial Basis of Aging. Mol Cell. 2016 Mar
550 3;61(5):654–66.

551 31. Valerio A, D'Antona G, Nisoli E. Branched-chain amino acids, mitochondrial biogenesis, and
552 healthspan: an evolutionary perspective. Aging (Albany NY). 2011 May;3(5):464–78.

553 32. Kim J, Shin W. How to do random allocation (randomization). Clin Orthop Surg. 2014
554 Mar;6(1):103–9.

555 33. Guigoz Y, Vellas B, Garry PJ. Assessing the nutritional status of the elderly: The Mini
556 Nutritional Assessment as part of the geriatric evaluation. Nutr Rev. 1996 Jan;54(1 Pt 2):S59-
557 65.

558 34. Guigoz Y. The Mini Nutritional Assessment (MNA) review of the literature--What does it tell
559 us? J Nutr Health Aging. 2006 Dec;10(6):466–85; discussion 485-487.

560 35. Volkert D, Berner YN, Berry E, Cederholm T, Coti Bertrand P, Milne A, et al. ESPEN
561 Guidelines on Enteral Nutrition: Geriatrics. Clin Nutr. 2006 Apr;25(2):330–60.

562 36. Rinaldi P, Mecocci P, Benedetti C, Ercolani S, Bregnocchi M, Menculini G, et al. Validation of
563 the five-item geriatric depression scale in elderly subjects in three different settings. J Am
564 Geriatr Soc. 2003 May;51(5):694–8.

565 37. OECD Health Data 2007: Statistics and Indicators for 30 Countries. OECD, Paris. 2007;

566 38. Parmelee PA, Thuras PD, Katz IR, Lawton MP. Validation of the Cumulative Illness Rating
567 Scale in a geriatric residential population. J Am Geriatr Soc. 1995 Feb;43(2):130–7.

568 39. Durnin JV, Womersley J. Body fat assessed from total body density and its estimation from
569 skinfold thickness: measurements on 481 men and women aged from 16 to 72 years. Br J Nutr.
570 1974 Jul;32(1):77–97.

571 40. Jackson AS, Pollock ML, Ward A. Generalized equations for predicting body density of
572 women. Med Sci Sports Exerc. 1980;12(3):175–81.

573 41. Norman K, Stobäus N, Gonzalez MC, Schulzke J-D, Pirlich M. Hand grip strength: outcome
574 predictor and marker of nutritional status. Clin Nutr. 2011 Apr;30(2):135–42.

575 42. Podsiadlo D, Richardson S. The timed 'Up & Go': a test of basic functional mobility for frail
576 elderly persons. J Am Geriatr Soc. 1991 Feb;39(2):142–8.

577 43. Millor N, Lecumberri P, Gómez M, Martínez-Ramírez A, Izquierdo M. An evaluation of the
578 30-s chair stand test in older adults: frailty detection based on kinematic parameters from a
579 single inertial unit. J Neuroeng Rehabil. 2013 Aug 1;10:86.

580 44. Campia I, Lussiana C, Pescarmona G, Ghigo D, Bosia A, Riganti C. Geranylgeraniol prevents
581 the cytotoxic effects of mevastatin in THP-1 cells, without decreasing the beneficial effects on
582 cholesterol synthesis. Br J Pharmacol. 2009 Dec;158(7):1777–86.

583 45. Hiraoka A, Michitaka K, Kiguchi D, Izumoto H, Ueki H, Kaneto M, et al. Efficacy of
584 branched-chain amino acid supplementation and walking exercise for preventing sarcopenia in
585 patients with liver cirrhosis. Eur J Gastroenterol Hepatol. 2017 Dec;29(12):1416–23.

586 46. Avis HJ, Hargreaves IP, Ruiter JPN, Land JM, Wanders RJ, Wijburg FA. Rosuvastatin lowers
587 coenzyme Q10 levels, but not mitochondrial adenosine triphosphate synthesis, in children with
588 familial hypercholesterolemia. J Pediatr. 2011 Mar;158(3):458–62.

589 47. Dal Negro RW, Aquilani R, Bertacco S, Boschi F, Micheletto C, Tognella S. Comprehensive
590 effects of supplemented essential amino acids in patients with severe COPD and sarcopenia.
591 Monaldi Arch Chest Dis. 2010 Mar;73(1):25–33.

592 48. Rossi Fanelli F, Cangiano C, Capocaccia L, Cascino A, Ceci F, Muscaritoli M, et al. Use of
593 branched chain amino acids for treating hepatic encephalopathy: clinical experiences. Gut. 1986
594 Nov;27 Suppl 1:111–5.

595 49. Sato S, Watanabe A, Muto Y, Suzuki K, Kato A, Moriwaki H, et al. Clinical comparison of
596 branched-chain amino acid (l-Leucine, l-Isoleucine, l-Valine) granules and oral nutrition for
597 hepatic insufficiency in patients with decompensated liver cirrhosis (LIV-EN study). Hepatol
598 Res. 2005 Apr;31(4):232–40.

599 50. Walser M. Therapeutic aspects of branched-chain amino and keto acids. Clin Sci. 1984
600 Jan;66(1):1–15.

601 51. Yee BK, Hauser J, Dolgov VV, Keist R, Möhler H, Rudolph U, et al. GABA receptors
602 containing the alpha5 subunit mediate the trace effect in aversive and appetitive conditioning
603 and extinction of conditioned fear. Eur J Neurosci. 2004 Oct;20(7):1928–36.

604 52. Aquilani R, Boselli M, Boschi F, Viglio S, Iadarola P, Dossena M, et al. Branched-chain amino
605 acids may improve recovery from a vegetative or minimally conscious state in patients with
606 traumatic brain injury: a pilot study. Arch Phys Med Rehabil. 2008 Sep;89(9):1642–7.

607 53. Cole JT, Mitala CM, Kundu S, Verma A, Elkind JA, Nissim I, et al. Dietary branched chain
608 amino acids ameliorate injury-induced cognitive impairment. Proc Natl Acad Sci USA. 2010
609 Jan 5;107(1):366–71.

610 54. Tynkkynen J, Chouraki V, van der Lee SJ, Hernesniemi J, Yang Q, Li S, et al. Association of
611 branched-chain amino acids and other circulating metabolites with risk of incident dementia and
612 Alzheimer's disease: A prospective study in eight cohorts. Alzheimers Dement. 2018
613 Jun;14(6):723–33.

614 55. Moore DR. Keeping older muscle "young" through dietary protein and physical activity. Adv
615 Nutr. 2014 Sep;5(5):599S-607S.

616 56. Granic A, Mendonça N, Sayer AA, Hill TR, Davies K, Adamson A, et al. Low protein intake,
617 muscle strength and physical performance in the very old: The Newcastle 85+ Study. Clin Nutr.
618 2018 Dec;37(6 Pt A):2260–70.

619 57. Rantanen T, Avlund K, Suominen H, Schroll M, Frändin K, Pertti E. Muscle strength as a
620 predictor of onset of ADL dependence in people aged 75 years. Aging Clin Exp Res. 2002
621 Jun;14(3 Suppl):10–5.

58. Granic A, Davies K, Jagger C, M Dodds R, Kirkwood TBL, Sayer AA. Initial level and rate of change in grip strength predict all-cause mortality in very old adults. Age Ageing. 2017 01;46(6):970–6.

59. WHO Global Report on Falls Prevention in Older Age. World Health Organization, Geneva, Switzerland. 2008;

60. Carty CP, Cronin NJ, Nicholson D, Lichtwark GA, Mills PM, Kerr G, et al. Reactive stepping behaviour in response to forward loss of balance predicts future falls in community-dwelling older adults. Age Ageing. 2015 Jan;44(1):109–15.

61. Chang VC, Do MT. Risk factors for falls among seniors: implications of gender. Am J Epidemiol. 2015 Apr 1;181(7):521–31.

62. Rydwik E, Bergland A, Forsén L, Frändin K. Investigation into the reliability and validity of the measurement of elderly people's clinical walking speed: a systematic review. Physiother Theory Pract. 2012 Apr;28(3):238–56.

63. Cedikova M, Pitule P, Kripnerova M, Markova M, Kuncova J. Multiple roles of mitochondria in aging processes. Physiol Res. 2016 Dec 22;65(Supplementum 5):S519–31.

64. Kras KA, Hoffman N, Roust LR, Patel SH, Carroll CC, Katsanos CS. Plasma Amino Acids Stimulate Uncoupled Respiration of Muscle Subsarcolemmal Mitochondria in Lean but Not Obese Humans. J Clin Endocrinol Metab. 2017 01;102(12):4515–25.

65. Tyrrell DJ, Bharadwaj MS, Van Horn CG, Kritchevsky SB, Nicklas BJ, Molina AJA. Respirometric Profiling of Muscle Mitochondria and Blood Cells Are Associated With Differences in Gait Speed Among Community-Dwelling Older Adults. J Gerontol A Biol Sci Med Sci. 2015 Nov;70(11):1394–9.

644 66. Michalak S, Florczak-Wyspiańska J, Rybacka-Mossakowska J, Ambrosius W, Osztynowicz K,
645 Baszczuk A, et al. Mitochondrial Respiration in Intact Peripheral Blood Mononuclear Cells and
646 Sirtuin 3 Activity in Patients with Movement Disorders [Internet]. Oxidative Medicine and
647 Cellular Longevity. 2017 [cited 2019 Jan 8]. Available from:
648 https://www.hindawi.com/journals/omcl/2017/9703574/

649 67. Safdar A, Bourgeois JM, Ogborn DI, Little JP, Hettinga BP, Akhtar M, et al. Endurance
650 exercise rescues progeroid aging and induces systemic mitochondrial rejuvenation in mtDNA
651 mutator mice. Proc Natl Acad Sci USA. 2011 08;108(10):4135–40.

652 68. Meng J, Lv Z, Qiao X, Li X, Li Y, Zhang Y, et al. The decay of Redox-stress Response
653 Capacity is a substantive characteristic of aging: Revising the redox theory of aging. Redox
654 Biol. 2017;11:365–74.

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Table 1. Global clinical assessment at baseline and follow-up according to treatment.

The table shows multiple T-test and Two-way ANOVA for multiple measure results. Values are shown as mean ± SE and 95% CI of the difference between basal, 1 and 2 months of treatment.

* Denotes differences between baseline and 1 month; ** Denotes differences between baseline and 2 months; $ Denotes differences between 1 and 2 months; Significant values are in bold.

	Perceived health status					
	BCAAem[1]		**Diet advice**		**Two-way ANOVA**	
	Mean±SE	*95% CI of difference*	*Mean±SE*	*95% CI of difference*	*Effect of*	*p*
baseline	3±0.1	**-0.56 to -0.02***	2.9±0.1	**-0.56 to -0.02***	**Time**	**< 0.0001**
1 month	3.3±0.1	-0.5 to 0.02$	3.2±0.1	-0.6 to -0.04$	**Treatment**	0.8437
2 months	3.5±0.1	**-0.8 to -0.3****	3.5±0.2	**-0.8 to -0.3****	**Interaction**	0.9300
	MMSE[2]					
	BCAAem[1]		**Diet advice**		**Two-way ANOVA**	
	Mean±SE	*95% CI of difference*	*Mean±SE*	*95% CI of difference*	*Effect of*	*p*
baseline	25.1±0.4	**-1.1 to -0.04***	25.6±0.4	-0.2 to 0.8*	**Time**	**0.0139**
1 month	25.7±0.4	-0.8 to 0.2$	25.3±0.5	-1.0 to 0.06$	**Treatment**	0.9422
2 months	26±0.4	**-1.4 to -0.3****	25.8±0.4	-0.7 to 0.4**	**Interaction**	**0.0171**

	GDS[3]					
	BCAAem[1]		Diet advice		Two-way ANOVA	
	Mean±SE	*95% CI of difference*	*Mean±SE*	*95% CI of difference*	*Effect of*	*p*
baseline	6.1±0.3	-0.4 to 0.8*	6.0±0.4	-0.2 to 0.9*	**Time**	**0.0084**
1 month	5.9±0.4	-0.3 to 0.9$	5.7±0.4	-0.3 to 0.8$	**Treatment**	0.7448
2 months	5.6±0.4	-0.1 to 1.1**	5.4±0.3	**0.01 to 1.2****	**Interaction**	0.9184
	ADL[4]					
	BCAAem[1]		**Diet advice**		**Two-way ANOVA**	
	Mean±SE	*95% CI of difference*	*Mean±SE*	*95% CI of difference*	*Effect of*	*p*
baseline	10.2±0.3	-0.2 to 0.4*	9.7±0.3	-0.2 to 0.5*	**Time**	0.3569
1 month	10.1±0.3	-0.2 to 0.5$	9.5±0.3	-0.5 to 0.1$	**Treatment**	01130
2 months	10.0±0.3	-0.1 to 0.6**	9.7±0.3	-0.3 to 0.30**	**Interaction**	0.2294

663 [1]Branched Chain Amino Acid Enriched Mixture; [2]Mini-Mental State Examination; [3]Geriatric Depression Scale;

664 [4]Activity of Daily Living.

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Table 2. Patients' nutritional status at baseline and follow-up according to treatment.

The table shows multiple T-test and Two-way ANOVA for multiple measure results. Values are shown as mean ± SE and 95% CI of the difference between basal, 1 and 2 months of treatment.

* Denotes differences between baseline and 1 month; ** Denotes differences between baseline and 2 months; $ Denotes differences between 1 and 2 months; Significant values are in bold.

	Caloric Intake (Kcal/day)					
	BCAAem[1]		**Diet advice**		**Two-way ANOVA**	
	Mean±SE	*95% CI of difference*	*Mean±SE*	*95% CI of difference*	*Effect of*	*p*
baseline	1095±36	**-137 to -15.8***	1042±29	**-169 to -48***	**Time**	**<0.0001**
1 month	1172±36	-80 to 42.4$	1151±31	**-168 to -47$**	**Treatment**	0.9740
2 months	1189±36	**-156 to -34.1****	1259±38	**-277 to -156****	**Interaction**	**0.0031**
	Daily protein Intake (g/Kg weight)					
	BCAAem[1]		**Diet advice**		**Two-way ANOVA**	
	Mean±SE	*95% CI of difference*	*Mean±SE*	*95% CI of difference*	*Effect of*	*p*
baseline	0.85±0.02	-0.03 to 0.09*	0.87±0.02	**-0.20 to -0.04***	**Time**	0.0874
1 month	0.83±0.02	-0.06 to 0.06$	0.97±0.02	-0.04 to 0.08$	**Treatment**	**0.0001**

2 months	0.83±0.02	-0.03 to 0.09**	0.96±0.02	**-0.14 to -0.02****	**Interaction**	**0.0007**
	MNA[2]					
	BCAAem[1]		**Diet advice**		**Two-way ANOVA**	
	Mean±SE	*95% CI of difference*	*Mean±SE*	*95% CI of difference*	*Effect of*	*p*
baseline	14.8±0.26	-0.03 to 0.09*	14.9±0.28	**-0.16 to -0.04***	**Time**	**<0.0001**
1 month	18.0±0.43	-0.06 to 0.06$	17.8±0.38	-0.04 to 0.08$	**Treatment**	0.9057
2 months	18.9±0.5	-0.03 to 0.09**	18.8±0.47	**-0.14 to -0.02****	**Interaction**	0.8366
	Fat mass (%)					
	BCAAem[1]		**Diet advice**		**Two-way ANOVA**	
	Mean±SE	*95% CI of difference*	*Mean±SE*	*95% CI of difference*	*Effect of*	*p*
baseline	18.8±0.94	-1.68 to 0.61*	20.2±0.88	-1.7 to 0.6*	**Time**	**0.0009**
1 month	19.3±0.92	-2.16 to 0.13$	20.8±0.88	-1.6 to 0.7$	**Treatment**	0.1708
2 months	20.3±0.94	**-2.70 to -0.41****	21.2±0.88	-2.2 to 0.1**	**Interaction**	0.6438
	BMI[3]					
	BCAAem[1]		**Diet advice**		**Two-way ANOVA**	
	Mean±SE	*95% CI of difference*	*Mean±SE*	*95% CI of difference*	*Effect of*	*p*

baseline	20.5±0.42	-1.42 to 0.10*	20.8±0.41	-1.38 to 0.14*	**Time**	**0.0010**
1 month	21.2±0.68	-0.92 to 0.60$	21.5±0.42	-0.81 to 0.71$	**Treatment**	0.7239
2 months	21.3±0.66	**-1.57 to -0.05****	21.5±0.41	-1.43 to 0.09**	**Interaction**	0.9482

673 [1]Branched Chain Amino Acid Enriched Mixture; [2]Mini Nutritional Assesment test; [3]Body Mass Index.

674

675

676 **Table 3. Muscle mass, strength and performance at baseline and follow-up according to treatment.**

677 The table shows multiple T-test and Two-way ANOVA for multiple measure results. Values are shown as
678 mean ± SE and 95% CI of the difference between basal, 1 and 2 months of treatment.

679 * Denotes differences between baseline and 1 month; ** Denotes differences between baseline and 2
680 months; $ Denotes differences between 1 and 2 months; Significant values are in bold.

	Muscle mass					
	Calf circumference (cm)					
	BCAAem[1]		**Diet advice**		**Two-way ANOVA**	
	Mean±SE	*95% CI of difference*	*Mean±SE*	*95% CI of difference*	*Effect of*	*p*
baseline	30.4±0.35	**-1.14 to -0.04***	30.7±0.43	-1.08 to 0.02*	**Time**	**0.0004**
1 month	31.0±0.38	-0.87 to 0.23$	31.2±0.40	-0.54 to 0.56$	**Treatment**	0.8560
2 months	31.3±0.39	**-1.45 to -0.36****	31.19±0.39	-1.07 to 0.03**	**Interaction**	0.4521
	Arm circumference (cm)					
	BCAAem[1]		**Diet advice**		**Two-way ANOVA**	
	Mean±SE	*95% CI of difference*	*Mean±SE*	*95% CI of difference*	*Effect of*	*p*
baseline	22.7±0.36	-0.75 to 0.23*	23.0±0.40	-0.83 to 0.15*	**Time**	**0.0045**
1 month	23.0±0.37	-0.77 to 0.21$	23.3±0.40	-0.54 to 0.44$	**Treatment**	0.6754

2 months	23.3±0.38	**-1.03 to -0.04****	23.4±0.44	-0.88 to 0.10**	**Interaction**	0.7351
			Muscle strength			
			Hand grip (Kg)			
	BCAAem[1]		**Diet advice**		**Two-way ANOVA**	
	Mean±SE	*95% CI of difference*	*Mean±SE*	*95% CI of difference*	*Effect of*	*p*
baseline	17.9±1.0	-2.01 to 0.47*	17.9±1.0	-1.84 to 0.65*	**Time**	**0.0474**
1 month	18.5±1.0	-1.6 to 0.87$	18.7±0.9	-1.0 to 1.50$	**Treatment**	0.7796
2 months	18.3±1.0	-2.40 to 0.10**	19.1±1.0	-1.59 to 0.90**	**Interaction**	0.5231
			TUG (sec)[2]			
	BCAAem[1]		**Diet advice**		**Two-way ANOVA**	
	Mean±SE	*95% CI of difference*	*Mean±SE*	*95% CI of difference*	*Effect of*	*p*
baseline	19.8±2.14	**1.5 to 7.6***	20.5±1.5	-1.2 to 4.9*	**Time**	**0.0001**
1 month	15.2±1.0	-2.9 to 3.2$	18.7±1.6	-2.1 to 4.0$	**Treatment**	0.2780
2 months	15.1±1.1	**1.6 to 7.8****	17.7±1.7	-0.3 to 5.9**	**Interaction**	0.3215
			30-s CST[3]			
	BCAAem[1]		**Diet advice**		**Two-way ANOVA**	
	Mean±SE	*95% CI of*	*Mean±SE*	*95% CI of*	*Effect of*	*p*

		difference		*difference*		
baseline	6.8±0.5	**-2.6 to -0.7***	6.0±0.5	**-2.4 to -0.5***	**Time**	**<0.0001**
1 month	8.4±0.6	-1.0 to 0.88$	7.4±0.5	-1.6 to 0.3$	**Treatment**	0.3328
2 months	8.5±0.7	**-2.7 to -0.7****	8.1±0.6	**-3.0 to -1.1****	**Interaction**	0.5810
	Tinetti					
	BCAAem[1]		**Diet advice**		**Two-way ANOVA**	
	Mean±SE	*95% CI of difference*	*Mean±SE*	*95% CI of difference*	*Effect of*	*p*
baseline	20.4±0.8	**-2.1 to -0.1***	18.3±0.8	**-3.2 to -1.1***	**Time**	**< 0.0001**
1 month	21.5±0.7	-1.7 to 0.3$	20.4±0.8	-1.3 to 0.7$	**Treatment**	0.1503
2 months	22.2±0.7	**-2.8 to -0.8****	20.7±0.9	**-3.4 to -1.4****	**Interaction**	0.2076
	4 meters walking test (sec)					
	BCAAem[1]		**Diet advice**		**Two-way ANOVA**	
	Mean±SE	*95% CI of difference*	*Mean±SE*	*95% CI of difference*	*Effect of*	*p*
baseline	8.2±0.6	-0.3 to 1.7*	9.8±0.7	**0.4 to 2.3***	**Time**	**<0.0001**
1 month	7.5±0.6	-0.7 to 1.3$	8.4±0.7	-0.6 to 1.4$	**Treatment**	0.1684
2 months	7.2±0.6	**0.04 to 2.0****	8.0±0.7	**0.8 to 2.8****	**Interaction**	0.3955

681 [1]Branched Chain Amino Acid Enriched Mixture; [2]Timed Up and Go test; [3]30 seconds Chair Sit to Stand test.

682

683 **Table 4. Mitochondrial activity and oxidative stress at baseline and follow-up according to treatment.**

684 The table shows multiple T-test and Two-way ANOVA for multiple measure results. Values are shown as
685 mean ± SE and 95% CI of the difference between basal, 1 and 2 months of treatment.

686 * Denotes differences between baseline and 1 month; ** Denotes differences between baseline and 2
687 months; $ Denotes differences between 1 and 2 months; Significant values are in bold.

688

	ATP (changes vs baseline)					
	BCAAem[1]		**Diet advice**		**Two-way ANOVA**	
	Mean±SE	*95% CI of difference*	*Mean±SE*	*95% CI of difference*	*Effect of*	*p*
baseline	1.00±0.00	**-0.45 to -0.15***	1.00±0.00	-0.13 to 0.17*	**Time**	**0.0001**
1 month	1.30±0.09	-0.28 to 0.016$	0.98±0.01	-0.16 to 0.14$	**Treatment**	**0.0005**
2 months	1.43±0.10	**-0.58 to -0.28****	0.99±0.02	-0.14 to 0.16**	**Interaction**	**0.0001**
	Electron flux (changes vs baseline)					
	BCAAem[1]		**Diet advice**		**Two-way ANOVA**	
	Mean±SE	*95% CI of difference*	*Mean±SE*	*95% CI of difference*	*Effect of*	*p*
baseline	1.00±0.00	**-0.38 to -0.13***	1.00±0.00	-0.13 to 0.13*	**Time**	**< 0.0001**
1 month	1.26±0.05	**-0.37 to -0.12$**	1.00±0.01	-0.14 to 0.12$	**Treatment**	**< 0.0001**

2 months	1.50±0.09	**-0.62 to -0.38****	1.01±0.04	-0.14 to 0.12**	**Interaction**	**< 0.0001**

	TBARs[2] (µg/M)					
	BCAAem[1]		**Diet advice**		**Two-way ANOVA**	
	Mean±SE	*95% CI of difference*	*Mean±SE*	*95% CI of difference*	*Effect of*	*p*
baseline	2.3±0.4	-2.8 to 1.2*	4.1±0.7	-3.02 to 0.97*	**Time**	**0.0007**
1 month	3.0±0.57	-2.4 to 1.6$	4.5±0.9	**-4.61 to -0.61$**	**Treatment**	**0.0289**
2 months	3.2±0.70	-3.1 to 0.85**	6.7±1.3	**-5.64 to -1.64****	**Interaction**	**0.0332**

689 [1]Branched Chain Amino Acid Enriched Mixture; [2]Thiobarbituric Acid Reactive Substances.

690

691

692 **Table 5. Muscle performance and balance.**

693 The table shows the results for linear regression models (GLM), non-Gaussian variables indicated by * were

694 logarithmically transformed. Significant values are in bold.

695

Dependent variable	Co-variate	β±SE	t	p	95% CI
Tinetti baseline	*Slope*	18.9±2.7	7.0	**0.000**	**13.5 to 24.4**
	Electronflux baseline	-0.02±0.01	-1.4	0.179	-0.05 to 0.009
	ATP baseline	0.05±0.03	1.5	0.134	-0.016 to 0.119
Tinetti 1 month	*Slope*	20.0±2.9	6.8	**0.000**	**14.1 to 25.8**
	*Electronflux 1 month**	0.000±0.013	0.02	0.984	-0.03 to 0.26
	ATP 1 month	0.011±0.04	0.32	0.752	-0.06 to 0.08
Tinetti 2 months	*Slope*	48.9±13.5	3.6	**0.001**	**21.8 to 75.9**
	*Electronflux 2 months**	0.05±0.04	1.5	0.131	-0.02 to 0.122
	ATP 2 months	-13.5±6.2	-2.2	**0.033**	**-25.9 to -1.1**
Dependent variable	**Co-variate**	**β±SE**	**t**	**p**	**95% CI**
4 meters walking test baseline*	*Slope*	0.89±0.08	11.2	**0.000**	**0.7 to 1.0**
	Electronflux baseline	0.000±0.000	0.8	0.394	0.000 to 0.001
	ATP baseline	-0.001±0.001	-1.4	0.175	-0.003 to 0.001

4 meters walking test 1 month*	*Slope*	0.96±0.10	9.6	**0.000**	**0.76 to 1.16**
	*Electronflux 1 month**	0.000±0.000	0.40	0.691	-0.001 to 0.001
	ATP 1 month	-0.002±0.001	-2.0	**0.045**	**-0.005 to -6.1E^{-5}**
4 meters walking test 2 months*	*Slope*	0.42±0.46	0.92	0.361	-0.49 to 1.33
	*Electronflux 2 months**	-0.002±0.001	-1.73	0.089	-0.004 to 0.000
	ATP 2 months	0.23±0.21	1.08	0.283	-0.19 to 0.644

696

697 **Table 6. Cognitive performance.**

698 The table shows the results for linear regression models (GLM), non-Gaussian variables indicated by * were

699 logarithmically transformed. Significant values are in bold.

Dependent variable	Co-variate	β±SE	t	p	95% CI
MMSE[1] baseline	*Slope*	24.3±1.4	17.2	**0.000**	**21.5 to 27.2**
	Electronflux baseline	0.002±0.007	0.22	0.829	-0.01 to 0.02
	ATP baseline	0.02±0.018	0.99	0.327	-0.02 to 0.05
MMSE[1] 1 month	*Slope*	22.7±0.17	12.9	**0.000**	**19.2 to 26.20**
	*Electronflux 1 month**	-0.002±0.08	-0.27	0.790	-0.02 to 0.013
	ATP 1 month	0.048±0.02	2.29	**0.026**	**0.006 to 0.09**
MMSE[1] 2 months	*Slope*	29.9±7.9	3.8	**0.000**	**14.01 to 45.7**
	*Electronflux 2 months**	0.05±0.02	2.5	**0.014**	**0.01 to 0.09**

	ATP 2 months	-3.31±3.6	-0.9	0.366	-10.6 to 3.9

[1]Mini-Mental State Examination.

Table 7. Mitochondria biogenesis and fusion at baseline and follow-up according to treatment. The table shows multiple T-test and Two-way ANOVA for multiple measure results. Values are shown as mean ± SE and 95% CI of the difference between basal, 1 and 2 months of treatment.

* Denotes differences between baseline and 1 month; ** Denotes differences between baseline and 2 months; $ Denotes differences between 1 and 2 months; Significant values are in bold.

	COX-1[1] (changes vs baseline)					
	BCAAem[2]		**Diet advice**		**Two-way ANOVA**	
	Mean±SE	*95% CI of difference*	*Mean±SE*	*95% CI of difference*	*Effect of*	*p*
baseline	1.0±0.0	**-23.8 to -1.9***	1.0±0.0	-11.4 to 10.6*	**Time**	0.1155
1 month	13.9±8.5	-4.4 to 17.5$	1.4±0.3	-13.2 to 8.7$	**Treatment**	0.1967
2 months	7.3±3.6	-17.3 to 4.7**	3.7±1.2	-13.6 to 8.3**	**Interaction**	0.1409
	COX-4[3] (changes vs baseline)					
	BCAAem[2]		**Diet advice**		**Two-way ANOVA**	
	Mean±SE	*95% CI of difference*	*Mean±SE*	*95% CI of difference*	*Effect of*	*p*
baseline	1.0±0.0	**-2.3 to -0.10***	1.0±0.0	-1.39 to 0.76*	**Time**	**0.0459**
1 month	2.2±0.7	-0.7 to 1.47$	1.3±0.09	-1.1 to 1.04$	**Treatment**	0.2373

2 months	1.8±0.5	-1.9 to 0.3**	1.3±0.19	-1.4 to 0.73**	**Interaction**	0.3786
	TFAM[4] (changes vs baseline)					
	BCAAem[2]		**Diet advice**		**Two-way ANOVA**	
	Mean±SE	*95% CI of difference*	*Mean±SE*	*95% CI of difference*	*Effect of*	*p*
baseline	1.0±0.0	**-6.9 to -0.6***	1.0±0.0	-3.8 to 2.5*	**Time**	**0.0178**
1 month	4.8±1.0	-2.4 to 3.9$	1.7±0.5	-4.5 to 1.8$	**Treatment**	0.0932
2 months	4.2±1.15	-6.2 to 0.1**	3.0±1.5	-5.1 to 1.2**	**Interaction**	0.2235
	NRF-1[5] (changes vs baseline)					
	BCAAem[2]		**Diet advice**		**Two-way ANOVA**	
	Mean±SE	*95% CI of difference*	*Mean±SE*	*95% CI of difference*	*Effect of*	*p*
baseline	1.0±0.0	-20.2 to 3.5*	1.0±0.0	-13.5 to 10.2*	**Time**	0.6599
1 month	9.4±6.4	-14.1 to 9.6$	2.6±0.7	-12.8 to 10.9$	**Treatment**	0.3507
2 months	11.6±9.5	-22.4 to 1.3**	3.6±1.2	-14.4 to 9.3**	**Interaction**	0.2055

	MFN-1[6] (changes vs baseline)					
	BCAAem[2]		Diet advice		Two-way ANOVA	
	Mean±SE	*95% CI of difference*	*Mean±SE*	*95% CI of difference*	*Effect of*	*p*
baseline	1.0±0.0	**-22.4 to -2.1***	1.0±0.0	-10.8 to 9.4*	**Time**	0.0746
1 month	13.2±7.7	-7.0 to 13.3$	1.7±0.3	-10.3 to 10.0$	**Treatment**	0.1648
2 months	10.1±6.1	-19.3 to 1.0**	1.8±0.3	-11.0 to 9.3**	**Interaction**	0.1320

	MFN-2[7] (changes vs baseline)					
	BCAAem[2]		Diet advice		Two-way ANOVA	
	Mean±SE	*95% CI of difference*	*Mean±SE*	*95% CI of difference*	*Effect of*	*p*
baseline	1.0±0.0	**-11.6 to -1.1***	1.0±0.0	-6.0 to 4.5*	**Time**	0.0772
1 month	7.3±4.1	-1.9 to 8.6$	1.7±0.3	-5.9 to 4.6$	**Treatment**	0.2046
2 months	3.9±1.6	-8.2 to 2.3**	2.4±0.5	-6.6 to 3.9**	**Interaction**	0.1810

[1]Cytochrome C Oxidase-1; [2]Branched Chain Amino Acid Enriched Mixture; [3]Cytochrome C Oxidase- 4;

[4]Mitochondrial Transcription Factor A; [5]Nuclear Respiratory Factor-1; [6]Mitofusin-1; [7]Mitofusin-2.