Essential fatty acid requirements of vegetarians in pregnancy, lactation, and infancy¹,²

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ABSTRACT  Long-chain polyunsaturated fatty acids (LCPUFAs) derived from linoleic (18:2n−6) and α-linolenic (18:3n−3) acids are required for the normal development of the retina and central nervous system, but the extent to which they can be synthesized from the parent fatty acids is debated. Consuming LCPUFAs markedly increases their proportions in tissue lipids compared with their parent fatty acids. Thus, it has been argued that LCPUFAs must be supplied in the diet. LCPUFAs are generally absent from plant foods, thus it is important find out how essential fatty acid requirements are met by vegetarians. A developing fetus obtains LCPUFAs via selective uptake from its mother’s plasma and LCPUFAs are present in the breast milk of vegetarians. There is no evidence that the capacity to synthesize LCPUFAs is limited in vegetarians. However, there are greater proportions of n−6 LCPUFAs and lower proportions of n−3 LCPUFAs in vegetarians compared with omnivores. This difference is probably a consequence of the selection of foods by vegetarians with high amounts of linoleic acid. Although lower concentrations of docosahexaenoic acid (22:6n−3; DHA) have been observed in blood and artery phospholipids of infants of vegetarians, it is uncertain whether their brain lipids contain lower proportions of DHA than those of infants of omnivores. On the basis of experiments in primates that showed altered visual function with a high ratio of linoleic acid to α-linolenic acid, it would be prudent to recommend diets with a ratio between 4:1 and 10:1 in vegetarians and that excessive intakes of linoleic acid be avoided. Am J Clin Nutr 1999;70(suppl):555S–9S.

KEY WORDS  Docosahexaenoic acid, vegetarians, lipids, pregnancy, lactation, essential fatty acids, retinal development, central nervous system development

INTRODUCTION

There are 2 series of essential fatty acids derived from linoleic acid (18:2n−6) and α-linolenic acid (18:3n−3). Both fatty acids are supplied primarily by foods of plant origin but they undergo further desaturation and chain elongation in animal tissues, giving rise to long-chain polyunsaturated fatty acids (LCPUFAs; Figure 1). Linoleic acid deficiency results in the failure of several physiologic systems but is characterized particularly by scaly dermatitis, increased susceptibility to infection, and poor growth (1). Linoleic acid itself plays a role in maintaining the barrier to permeability of the skin, and its long-chain metabolite, arachidonic acid (20:4n−6; AA), is the major precursor of physiologically active eicosanoids, which regulate a variety of physiologic systems. Dietary deficiency of linoleic acid is rare because even the most meager diet is likely to provide sufficient linoleic acid to meet the requirement, which is estimated to be 1−2% of dietary energy. On the other hand, iatrogenic deficiency of linoleic acid can arise in infants fed breast-milk substitutes that contain insufficient quantities of linoleic acid, during enteral and total parenteral nutrition, and in conditions that cause fat malabsorption (1). It is now recognized that α-linolenic acid is a dietary essential (2) because its metabolite, docosahexaenoic acid (22:6n−3; DHA), plays important roles in brain and retinal function (1, 3). The final metabolic step in the conversion of α-linolenic acid to DHA is peroxisomal β-oxidation, which shortens 24:6n−3 to 22:6n−3.

The preterm human infant probably needs DHA, and possibly AA, in the diet because they may not be synthesized from their precursors at a rate commensurate with needs (4, 5). DHA and AA are found in breast milk and it has been proposed that breast-milk substitutes should have LCPUFA concentrations comparable with those found in breast milk (2). However, the essential fatty acid requirements of preterm infants are complex owing to their immaturity and rapid rate of brain growth. The controversy over whether term infants require a dietary source of LCPUFAs has not been resolved (6). Some studies showed improvement in visual function (7, 8) in term infants fed formula fortified with DHA, but others found no differences between the visual function between term infants fed formula with or without DHA and AA and those fed breastmilk (9, 10). Furthermore, Jensen et al (11) were unable to show differences in the latency or amplitude component of the visual evoked response between groups of term infants fed formulas with 0.4%, 1.0%, 1.8% and 3.24% α-linolenic acid from birth to 4 mo compared with breast-fed infants. Heird et al (6) concluded that visual function is unlikely to be compromised in term infants who receive no exogenous DHA if exogenous AA, in the diet because they may not be synthesized from their precursors at a rate commensurate with needs (4, 5). DHA and AA are found in breast milk and it has been proposed that breast-milk substitutes should have LCPUFA concentrations comparable with those found in breast milk (2). However, the essential fatty acid requirements of preterm infants are complex owing to their immaturity and rapid rate of brain growth. The controversy over whether term infants require a dietary source of LCPUFAs has not been resolved (6). Some studies showed improvement in visual function (7, 8) in term infants fed formula fortified with DHA, but others found no differences between the visual function between term infants fed formula with or without DHA and AA and those fed breastmilk (9, 10). Furthermore, Jensen et al (11) were unable to show differences in the latency or amplitude component of the visual evoked response between groups of term infants fed formulas with 0.4%, 1.0%, 1.8% and 3.24% α-linolenic acid from birth to 4 mo compared with breast-fed infants. Heird et al (6) concluded that visual function is unlikely to be compromised in term infants who receive no exogenous DHA if exogenous α-linolenic acid comprises ≈1% of energy intake.

It has also been suggested that pregnant and lactating women may need to supplement their diets with DHA to meet the needs

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TABLE 1
Polyunsaturated fatty acid intakes of vegan, vegetarian, and omnivorous women

<table>
<thead>
<tr>
<th>Subjects</th>
<th>18:2n−6</th>
<th>18:3n−3</th>
<th>18:4n−6</th>
<th>18:5n−6</th>
<th>18:6n−3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vegans</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nonlactating2 (n = 10)</td>
<td>21.4 ± 3.23</td>
<td>1.2 ± 0.22</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Lactating2 (n = 19)</td>
<td>20.4 ± 2.49</td>
<td>1.2 ± 0.28</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Vegetarians</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nonlactating UK whites2 (n = 18)</td>
<td>14.6 ± 1.69</td>
<td>1.5 ± 0.17</td>
<td>Trace</td>
<td>Trace</td>
<td>Trace</td>
</tr>
<tr>
<td>Nonlactating UK Indians2 (n = 21)</td>
<td>14.2 ± 1.25</td>
<td>0.9 ± 0.10</td>
<td>Trace</td>
<td>Trace</td>
<td>Trace</td>
</tr>
<tr>
<td><strong>Omnivores</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nonlactating2 (n = 10)</td>
<td>9.1 ± 1.07</td>
<td>1.1 ± 0.15</td>
<td>0.15 ± 0.02</td>
<td>0.09 ± 0.02</td>
<td>0.04 ± 0.02</td>
</tr>
<tr>
<td>Nonlactating2 (n = 22)</td>
<td>11.8 ± 1.22</td>
<td>1.0 ± 0.08</td>
<td>0.13 ± 0.04</td>
<td>0.08 ± 0.02</td>
<td>0.10 ± 0.02</td>
</tr>
</tbody>
</table>

1,2 ± SEM. Data from reference 14.
2,4 Measurements were taken in: 21988, 41980.

MATERIAL AND FETAL SUPPLY OF ESSENTIAL FATTY ACIDS

There is little evidence to suggest that fat intake changes during pregnancy, but fat storage does increase in early pregnancy, probably because of increased energy metabolism efficiency. A typical pregnancy results in the accumulation of 4 kg body fat; the composition of the body fat stored tends to reflect that of the diet because there is little de novo synthesis of fatty acids from carbohydrates when the diet is relatively high in fat. The mother is able to convert both linoleic and α-linolenic acid to AA and DHA, respectively. These LCPUFAs appear to be taken up preferentially by the placenta and undergo further chain elongation and desaturation in fetal tissues, including the brain. This is evident from the relatively higher amounts of AA and DHA and lower amounts of parent fatty acids in fetal plasma phospholipids compared with the maternal circulation.

Analyses of the fetal plasma and cord artery phospholipids show similar proportions of total LCPUFAs in infants of vegetarian mothers and in infants of omnivorous mothers (Figure 2:15). However, the proportion of DHA was lower and the proportions of n−6 LCPUFAs such as AA and docosapentaenoic acid (22:5n−6) were higher in vegetarians than in those of omnivorous control subjects. The consumption of n−3 LCPUFAs in
pregnancy results in an increase in the proportion of DHA (12) but this may also be accompanied by a reduction in the proportion of LCPUFAs derived from n-6 fatty acids.

**RELATION BETWEEN ESSENTIAL FATTY ACIDS STATUS AND PREGNANCY OUTCOME**

It has been hypothesized that essential fatty acid intake affects the duration of pregnancy. It is well known that linoleic acid deficiency in rats leads to impaired parturition due to insufficient synthesis of AA, which is needed for the formation of biologically active prostaglandins that are required for normal uterine contraction. Prolonged gestation has been observed in women in the Faeroe Islands who consume whale oil during pregnancy, and a controlled trial found that fish oil consumption during pregnancy increased its duration by 2–3 d (16). Birth weight, on the other hand, was not affected. However, concerns were raised over the increased risk of maternal hemorrhage. A slightly shorter duration of pregnancy in vegetarian than in omnivorous women has been reported (15, 17). Birth weights adjusted for gestational age have also been reported to be lower in British vegetarians of Indian origin than in omnivores (15). However, there is little evidence from animal studies to suggest that high intakes of linoleic acid or an altered ratio of linoleic acid to α-linolenic acid affects birth weight (3).

**COMPARISON OF THE BREAST-MILK COMPOSITIONS OF VEGETARIANS AND OMNIVORES**

As a rule, the proportion of linoleic acid in breast milk tends to be greater in vegetarians, especially vegans, than in omnivores (Table 2; 14, 18, 19). The UK studies (14) have consistently found lower proportions of DHA in the breast milk of vegetarians, especially in vegans compared with omnivores. Studies of vegetarians in the United States (18, 19) have not found lower proportions of DHA in breast-milk lipids. This may be related to higher intakes of α-linolenic acid from soybean oil or preformed DHA in the case of macrobiotic vegetarians. However, the proportion of AA in breast milk is similar among vegetarians, vegans, and omnivores. The proportion of α-linolenic acid is more variable. The proportion of DHA in breast milk can be increased by consuming preformed DHA (20). To date, no studies have investigated the influence of increased intake of α-linolenic acid on breast-milk DHA concentrations.

**COMPARISON OF THE ESSENTIAL FATTY ACID STATUS AMONG BREAST-FED INFANTS OF VEGETARIAN AND OMNIVOROUS MOTHERS AND FORMULA-FED INFANTS**

To date, only 1 study has compared the essential fatty acid status of infants of vegans and infants of omnivores who were breast-fed exclusively (21). This study reported lower proportions of DHA in erythrocyte lipids and slightly higher proportions of docosatetraenoic acid (22:4n-6) and AA in vegans and omnivores, respectively.

The same authors performed similar analyses in infants who had been fed modified cow-milk formula exclusively for the same amount of time (22). The infants fed cow-milk formula had a lower proportion of AA than did both groups of breast-fed infants (Figure 3). Furthermore, their proportion of DHA was higher than that of the breast-fed infants of vegans but lower than that of the breast-fed infants of omnivores. The cow-milk formula used provided ≈0.5% of energy as linoleic acid and 0.5% energy as α-linolenic acid as well as small amounts of longer-chain n-3 fatty acids, and was typical of the fatty acid composition of breast-milk substitutes that were in use up to about the mid-1970s. Manufacturers of infant formulas subsequently increased the amount of linoleic acid substantially to such an extent that linoleic acid typically provides ≈10% of energy in modern formulas.
CONCLUSIONS

There are differences in the essential fatty acid status of vegetarians and omnivores, the most notable being the higher intakes of linoleic acid by vegetarians and, to a lesser degree, the differences in intake of LCPUFAs. Because the proportion of AA in the blood and tissue lipids of vegetarians and vegans is similar to or greater than that of omnivores, the implication is that vegans and vegetarians do not require AA in their diets because they can synthesize adequate amounts from linoleic acid. It has been suggested that the capacity to synthesize AA from linoleic acid may be limited in neonates. However, the breast milk of vegetarian mothers supplies additional AA to neonates.

The lower proportion of DHA in the blood and tissue lipids of vegans and vegetarians is of some concern because it may adversely affect brain and cardiac function (1). Evidence that the enzymes necessary for the conversion of α-linolenic acid to DHA are functional in term infants (23) suggests that LCPUFAs are not absolutely required in the diet. However, if the intake of linoleic acid is excessive or the rate of synthesis of DHA is not commensurate with needs, as is the case with preterm infants, consumption of DHA may be necessary. Vegetarians who breast-feed their infants will supply them with both α-linolenic acid and DHA. Vegetarian and vegan diets are unlikely to be lacking in α-linolenic acid because it is derived mainly from plant sources. Whether there would be any benefit from the mother consuming preformed DHA is uncertain. Animals studies suggest that the ratio of linoleic acid to α-linolenic acid in the maternal diet is important in determining the proportion of DHA in brain lipids. For example, in rats fed adequate intakes of α-linolenic acid, it is possible to decrease the proportion of DHA in fetal brain with high intakes of linoleic acid (24). This is probably because linoleic acid competitively inhibits the Δ6 desaturation of 24:5n–3 to 24:6n–3. It has been shown that altering the ratio of linoleic acid to α-linolenic acid in infant milks can change the proportion of DHA in the erythrocyte lipids of term infants (25). Furthermore, lower proportions of DHA and higher proportions of 22:5n–6 have been observed in the brain lipids of formula-fed infants compared with control subjects (26, 27). Although no studies have examined the brain lipids of infants of vegetarians, it is likely that they will reflect the balance of n–6 to n–3 in the maternal diet. Because visual and cognitive function might be influenced by differences in the balance of n–6 and n–3 fatty acids, there is a case for conducting a randomized, controlled trial in vegetarians of supplementation with an acceptable source of DHA or an altered ratio of linoleic acid to α-linolenic acid with pregnancy outcome (maternal and fetal) and measurements of the visual and cognitive function of infants as the measured endpoints.

It is of some concern that the amount of n–6 fatty acids has been increased and that of n–3 fatty acids has been reduced in the food supply by modern agricultural and food processing practices. Vegetable oils, such as sunflower and corn oil, with high ratios of linoleic acid to α-linolenic acid are now widely used. Feeding cattle with feed concentrates rather than grass leads to lower concentrations of α-linolenic acid in dairy products. The process of partial hydrogenation of soybean and canola oils leads to the selective destruction of α-linolenic acid. There has been emphasis on increasing the intake of linoleic acid in the diet because of its putative cholesterol-lowering properties. The consequence of these changes in the food supply is an increase in the proportion of linoleic acid in breast-milk lipids in both the United Kingdom and the United States and probably a decline in the proportion of DHA. For example, in the late 1970s, linoleic acid typically accounted for 8–10% of the total fatty acids consumed; typical values observed in omnivores in the mid-1990s were ≈15% (10, 28), which is similar to or greater than that of omnivores, the implication is that vegans and omnivores, the most notable being the higher intakes of linoleic acid by vegetarians and, to a lesser degree, the differences in intake of LCPUFAs. Because the proportion of AA in the blood and tissue lipids of vegetarians and vegans is similar to or greater than that of omnivores, the implication is that vegans and vegetarians do not require AA in their diets because they can synthesize adequate amounts from linoleic acid. It has been suggested that the capacity to synthesize AA from linoleic acid may be limited in neonates. However, the breast milk of vegetarian mothers supplies additional AA to neonates.

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to the proportions found in vegetarians. There is no apparent advantage of consuming >6% of energy from linoleic acid; a high intake has the disadvantage of inhibiting the synthesis of DHA from α-linolenic acid. Whereas further research is needed to quantify the optimum ratio of n-6 to n-3 fatty acids in the diet, it would be prudent to ensure that vegetarian diets do not contain excessive amounts of linoleic acid and that the ratio of linoleic acid to α-linolenic acid is between 4:1 and 10:1, as suggested by Food and Agriculture Organization/World Health Organization (2).

REFERENCES