Effects of randomized supplementation of methionine or alanine on cysteine and glutathione production during the early phase of treatment of children with edematous malnutrition

Curtis O Green, Asha V Badaloo, Jean W Hsu, Carolyn Taylor-Bryan, Marvin Reid, Terrence Forrester, and Farook Jahoor

ABSTRACT

Background: We have shown that a low glutathione concentration and synthesis rate in erythrocytes are associated with a shortage of protein-derived cysteine in children with edematous severe acute malnutrition (SAM).

Objective: We tested the hypothesis that methionine supplementation may increase protein-derived cysteine and upregulate cysteine synthesis, thereby improving glutathione synthesis during the early treatment of edematous SAM.

Design: The cysteine flux, its de novo synthesis and release from protein breakdown, and erythrocyte glutathione synthesis rate were measured in 12 children with edematous SAM in the fed state by using stable isotope tracers at 3 clinical phases as follows: 3 ± 1 d (±SE) [clinical phase 1 (CP1)], 8 ± 1 d [clinical phase 2 (CP2)], and 14 ± 2 d (clinical phase 3) after admission. Subjects were randomly assigned to receive equimolar supplements (0.5 mmol · kg⁻¹ · d⁻¹) of methionine or alanine (control) immediately after CP1.

Results: In the methionine compared with the alanine group, cysteine flux derived from protein breakdown was faster at CP2 than CP1 (P < 0.05), and the change in plasma cysteine concentration from CP1 to CP2 was greater (P < 0.05). However, there was no evidence of a difference in cysteine de novo synthesis and its total flux or erythrocyte glutathione synthesis rate and concentration between groups.

Conclusions: Methionine supplementation increased cysteine flux from body protein but had no significant effect on glutathione synthesis rates. Although cysteine is made from methionine, increased dietary cysteine may be necessary to partially fulfill its demand in edematous SAM because glutathione synthesis rates and concentrations were less than previous values shown at full recovery. This study was registered at clinicaltrials.gov as NCT00473031.

INTRODUCTION

A low concentration of blood reduced glutathione is one contributor to increased morbidity in children with edematous severe acute malnutrition (SAM) than with nonedematous SAM (1–3). Glutathione has many important functions including a central role in the regulation of numerous enzymatic pathways and, most importantly, the body’s antioxidant and detoxification systems (2, 4, 5). We have shown that a reduced rate of red cell glutathione synthesis in children with edematous SAM was restored after ~11 d supplementation with N-acetylcysteine (NAC) (6, 7). This result suggested that a low glutathione synthesis rate and concentration are associated with a shortage of cysteine, which is the rate-limiting precursor for glutathione synthesis.

Cysteine in the body is derived from the diet, de novo synthesis from methionine and serine, and protein breakdown. Therefore, we explored factors that underlie the shortage of cysteine by comparing cysteine and methionine kinetics in edematous and nonedematous SAM while children consumed the same standard treatment diet. Results showed that, in the acute, infected state, children with edematous SAM had a slower production of cysteine (8) and its precursor methionine (9) than did nonedematous children because of a slower rate of release from protein breakdown. However, there was no difference in methionine transsulfuration to cysteine between edematous and nonedematous children. Nevertheless, de novo cysteine synthesis in children with edematous SAM was faster when children were acutely ill than after recovery ~6 wk later. These results suggested an upregulation of methionine transsulfuration to cysteine possibly to meet an increased demand for cysteine during early nutritional rehabilitation. In addition, because methionine is a precursor for the synthesis of methionyl-transfer RNA, which is the cofactor for the initiation of synthesis of all body proteins, methionine deficiency may be related to the overall suppression of protein turnover in SAM (10). Therefore, we hypothesized that methionine supplementation during the early phase of treatment would increase the cysteine availability through enhanced protein turnover and de novo synthesis, which, in turn, would enhance glutathione synthesis, thereby quickly restoring the antioxidant capacity.

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3 Address correspondence to AV Badaloo, Tropical Metabolism Research Unit, University of the West Indies, Mona, Kingston 7, Jamaica. E-mail: asha.badaloo@uwimona.edu.jm.
4 Abbreviations used: CP1, clinical phase 1; CP2, clinical phase 2; CP3, clinical phase 3; NAC, N-acetylcysteine; SAM, severe acute malnutrition.

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SUBJECTS AND METHODS

Subjects

Children, who were admitted to the ward at the Tropical Metabolism Research Unit of the University of the West Indies, Jamaica, for treatment of primary SAM were eligible for the study if they were diagnosed with edematous SAM (kwashiorkor or marasmic-kwashiorkor) according to the Wellcome Classification of malnutrition (11). Participants were studied as 2 groups supplemented with either methionine or isonitrogenous alanine as a control. A sample size of 7 children/group was based on the detection of a 1-SD difference between alanine and methionine groups in the main outcome, the glutathione synthesis rate, with the assumption of a moderate correlation between baseline and repeat measurements of 0.8 at 5% significance and 80% power. The treatment followed a standard protocol as described previously (12). This study was conducted in accordance with the Helsinki Declaration of 1975 as revised in 1983 for human experimentation. The proposal was approved by the Medical Ethics Committee of the University Hospital of the West Indies and the Baylor Affiliates Review Board for Human Subject Research of Baylor College of Medicine. Written informed consent was obtained from at least one parent of each child enrolled.

Study design

With the use of a stable-isotope tracer methodology, rates of production of reduced glutathione (glutathione) and cysteine were measured before and at 2 time points after subjects received supplements of methionine or isonitrogenous alanine as a control. Subjects were randomly assigned in parallel to receive supplements for ~12 d starting immediately after the first experimental measurement. Subjects were allocated to receive supplements on a 1:1 ratio on the basis of a sequence generated by the ralloc command in STATA 12 software (StataCorp LP). The randomization sequence was performed by MR who retained sole custody of the sequence. Eligible subjects were assigned to supplement by AVB after consultation with MR. Participants and care providers were blinded to the treatment allocation. Measurements were carried out in the following 3 phases: clinical phase 1 (CP1) took place at 3 ± 1 d (±SE) postadmission when subjects were both infected and malnourished but clinically stable as indicated by blood pressure, pulse, and respiration rates; clinical phase 2 (CP2) took place at 8 ± 1 d postadmission; and clinical phase 3 (CP3) took place at 14 ± 2 d postadmission when the children were still severely malnourished but after treatment of infection and loss of edema and had an improved effect and appetite. All children received an antibiotic treatment for 10 d.

Diet

All 3 measurements were conducted during the clinical stabilization period when a diet that provided maintenance quantities of energy and protein (417 kJ · kg⁻¹ · d⁻¹ and 1.2 g protein · kg⁻¹ · d⁻¹) was fed according to a standard treatment protocol as previously described (6–9). Thus, subjects had been receiving the therapeutic diet for ~2 d before CP1, ~7 d before CP2, and ~13 d before CP3 measurements. Each child received 2 mL vitamin solution/d, which contained 6000 IU vitamin A (palmitate), 1600 IU vitamin D (calciferol), 2 mg thiamine HCl, 3.2 mg riboflavin, 120 mg vitamin C (ascorbic acid), 4 mg vitamin B-6 (vitamin B-6 HCL), and 28 mg nicotinamide (Trovipite; Federated Pharmaceuticals) and a mineral mix of potassium, magnesium, and zinc salts [37.28 g KCl + 50.84 g MgCl₂·6H₂O + 3.36 g Zn(CH₃COO)₂·2H₂O per liter H₂O; Sigma].

To ensure that the same amount of energy and protein was given during the course of the isotope infusions, 33% of the child’s daily intake was given by continuous intragastric infusion over an 8-h period starting 2 h before the isotope infusions. This method provided 17.4 kJ · kg⁻¹ · h⁻¹ and 0.05 g protein · kg⁻¹ · h⁻¹. Weight and length were monitored throughout hospitalization, the former was measured daily with an electronic balance (model F150S; Sartorius), and the latter was measured weekly with a horizontally mounted stadiometer (Holtain Ltd).

Supplement

Immediately after CP1, subjects began receiving either l-methionine (0.5 mmol · kg⁻¹ · d⁻¹) or an equimolar quantity of l-alanine as a control made up in sterile water. Supplements were of Sigma United State Pharmacopoeia grade (methionine M5308 and alanine A7469). The total daily supplement was given orally in equal aliquots just before each feed. Because 1 mol methionine yields 1 mol cysteine, the dose of methionine supplement was equimolar to the NAC supplement that had a beneficial effect in our previous study (4). An additional supporting reason was that the dose was equivalent to intake during catch-up growth when protein intake is ~3 g · kg⁻¹ · d⁻¹, which has 74.1 (ie, 24.7 · 3) mg methionine · kg⁻¹ · d⁻¹ or 0.5 mmol · kg⁻¹ · d⁻¹.

Isotope infusion protocol

Isotopic tracers were administered by a constant intravenous infusion. Total cysteine production was measured by using [²H₃]-cysteine, and the conversion of [U-¹³C₃]-serine to cysteine was used to measure its de novo synthesis rate. The glutathione synthesis rate in erythrocytes was determined from the rate of incorporation of erythrocyte-free [²H₂]-glycine (precursor) into erythrocyte glutathione (product).

Intravenous access sites were established in opposite arms by the insertion of 22G or 24G catheters after preparation of access sites with a topical anesthetic (EMLA cream; Astra Pharmaceuticals Ltd). One intravenous catheter was used for the infusion of labeled serine, cysteine, and glycine, and the other intravenous catheter was used for blood sampling. A nasogastric tube was inserted into the child’s stomach, and a Flexiflo Magna-Port Y-Port connector (Ross Products Division, Abbott Laboratories) was attached to the proximal end. Approximately 33% of the child’s daily dietary intake was given over the next 8 h by a continuous intragastric infusion into one limb of the Y port by using an enteral infusion pump (Flexiflo companion enteral nutrition pump; Ross Laboratories). Sterile solutions of [²H₃]-cysteine, U-¹⁵C₃-serine, and [²H₂]-glycine (each 98% enriched; Cambridge Isotope Laboratories) were prepared in 9 g NaCl/L. Approximately a 2.2-mL blood sample was drawn after 2 h continuous intragastric feeding, which was followed immediately
by simultaneous primed-continuous intravenous infusions of 2H2-cysteine (prime: 1.5 μmol/kg; infusion rate: 1.5 μmol · kg$^{-1} · h^{-1}$), 2H2-glycine (prime: 30 μmol/kg; infusion rate: 30 μmol · kg$^{-1} · h^{-1}$), and U13C3-serine (prime: 8.0 μmol/kg; infusion rate: 8.0 μmol · kg$^{-1} · h^{-1}$). Four additional ~2.2-mL blood samples were drawn every 0.5 h during the last 1.5 h of infusions. Infusion rates and blood sampling protocols were the same for the 2 subsequent experiments performed in subjects at CP2 and CP3.

Sample analyses

Previously described analytic procedures were used in the measurement of glutathione and cysteine kinetics (13). Immediately after each timed blood sample was taken, a 1-mL aliquot was processed for subsequent measurements of the plasma free cysteine concentrations and red cell glutathione concentration and enrichment. The same 1-mL aliquot was processed for these 3 measurements. The 1-mL aliquot was quickly placed in a tube that contained an equal volume of isotonic ice-cold monobromobimane buffer (pH 7.4) solution (5 mmol monobromobimane/L, 17.5 mmol Na2 EDTA/L, 50 mmol potassium phosphate/L, 50 mmol serine/L, 50 mmol boric acid/L) and for plasma free cysteine derivatization. The whole blood monobromobimane buffer mixture was centrifuged at 1000 × g for 10 min at 4°C. The plasma monobromobimane supernatant fluid was removed and placed in the dark at room temperature for 20 min for the development of the plasma free cysteine-monobromobimane derivative. Erythrocytes were immediately lysed by a rapid freeze and thaw after the addition of 1 mL of the 5-mmol monobromobimane/L buffer, and the mixture was left in the dark at room temperature for 20 min for the development of the erythrocyte reduced glutathione-monobromobimane derivative. Proteins were precipitated from both the plasma and erythrocyte mixtures with ice-cold 1-mol perchloric acid/L, and the supernatant fluid was stored at −70°C for later analysis of glutathione and cysteine concentrations and for isotopic enrichment of glutathione.

With the use of the remaining blood, hematocrit was first determined by using ~80 μL blood with a Micro Hematocrit Centrifuge (Damon/IEC Division). A 1-mL aliquot of each of the remaining timed blood samples was processed for later analysis of the enrichment of red cell free glycine and of plasma cysteine and serine. The same 1-mL aliquot of blood was processed for enrichment analyses of all 3 amino acids. The 1-mL aliquot of blood was centrifuged at 1000 × g for 10 min at 4°C, and erythrocytes were removed and washed 3 times with an ice-cold 9-g NaCl/L solution followed by the precipitation of proteins with an ice-cold 1-mol perchloric acid/L solution. The supernatant fluid from this mixture that contained erythrocyte free amino acids was stored at −70°C for the later isolation of free glycine (glutathione precursor) and measurement of its isotopic enrichment. The plasma was stored −70°C for the later isolation of serine and cysteine and measurement of their isotopic enrichments.

Concentration of erythrocyte glutathione

The glutathione concentration in the stored erythrocyte glutathione-monobromobimane supernatant fluid was measured by using reverse-phase HPLC as previously described (13) on a Hewlett-Packard 1090 HPLC equipped with a Model HP 1046A fluorescence detector (Hewlett-Packard). A fraction collector was used to collect the erythrocyte glutathione-containing eluant for hydrolysis of glutathione to its constituent amino acids and isolation of glycine for isotopic enrichment.

Concentration of plasma cysteine

The cysteine concentration in the stored plasma cysteine-monobromobimane supernatant fluid was measured by using reverse-phase HPLC as previously described (13) on a Hewlett-Packard 1090 HPLC equipped with a Model HP 1046A fluorescence detector (Hewlett-Packard).

Isotopic-enrichment analysis

Enrichment of erythrocyte glutathione. Glutathione enrichment was determined from the enrichment of glycine incorporated into the glutathione peptide. Glycine was isolated from the erythrocyte glutathione fraction, which was collected during the HPLC determination of the glutathione concentration. The erythrocyte glutathione fraction was dried, and the peptide was hydrolyzed for 4 h in 6 mol HC1/L at 110°C to yield its constituent amino acids. The hydrolysate was dried, and released amino acids were converted to their n-propyl ester heptafluorobutyramide derivatives for mass spectrometric analysis. The tracer-to-tracer ratio of the glycine derivative was measured by using negative chemical ionization gas chromatography–mass spectrometry with the selective monitoring of ions at an m/z of 293–295.

Enrichment of erythrocyte-free glycine and plasma cysteine and serine. The enrichment of glycine in the stored supernatant fluid that contained erythrocyte-free amino acids and cysteine and serine in plasma were also measured by using negative chemical ionization gas chromatography–mass spectrometry. Amino acids in each of these samples were first isolated by using cation-exchange chromatography before conversion to their n-propyl ester heptafluorobutyramide derivatives for mass spectrometric analysis. For the plasma cysteine dithiothreitol, 0.075 mL of a 10-mmol/L solution was added to the derivatization mixture to convert cystine to cysteine. The tracer-to-tracer ratio of n-propyl ester heptafluorobutyramide derivatives were monitored at a selective m/z of 293–295 for those of erythrocyte-free glycine, 535–538 for plasma cysteine, and 519–522 for plasma serine.

Calculations

Total cysteine flux (Q) was calculated by using plasma plateau tracer:tracer ratios in the following steady state equation:

\[ Q (\mu\text{mol} \cdot \text{kg}^{-1} \cdot \text{h}^{-1}) = I(E_{\text{Inf}} + E_{\text{pl}}) \]

where \( E_{\text{Inf}} \) is the tracer:tracer ratio of the infusate, \( E_{\text{pl}} \) is the tracer:tracer ratio of plasma cysteine (M+2 isotopomer), and \( I \) is the rate of infusion of the \(^2\text{H}_2\)-cysteine tracer.

Because \( Q \) represents the sum of all inputs (and outputs) of an amino acid through the body pool,

\[ Q_{\text{Cys}} = B_{\text{Cys}} + I_{\text{Cys}} + S_{\text{Cys}} \]

where \( B_{\text{Cys}} \) is cysteine released from body protein breakdown, \( I_{\text{Cys}} \) is cysteine intake from the diet and tracer infusion, and \( S_{\text{Cys}} \) is cysteine intake from the diet and tracer infusion.
is cysteine synthesized de novo. Hence, endogenous cysteine flux [ie, cysteine derived from protein breakdown plus de novo synthesis ($B_{\text{CYS}} + S_{\text{CYS}}$)] was calculated by subtracting $I_{\text{CYS}}$ from $Q_{\text{CYS}}$.

Similarly, cysteine derived from protein breakdown $B$ can be calculated as

$$B_{\text{CYS}} = Q_{\text{CYS}} - (I_{\text{CYS}} + S_{\text{CYS}}) \quad (3)$$

Cysteine produced by de novo synthesis, which receives its carbon atoms from serine and its sulfur from methionine, can be obtained from the rate of conversion of serine to cysteine by using the equation

$$\text{Cysteine synthesis} = Q_{\text{CYS}} \times (E_{\text{CYS}} + E_{\text{SER}}) \quad (4)$$

where $Q_{\text{CYS}}$ is cysteine flux obtained with the $^3$H$_2$-cysteine tracer, $E_{\text{CYS}}$ is the tracer:tracee ratio of cysteine (M+3 isotope) derived from the U-$^{13}$C$_2$-serine, and $E_{\text{SER}}$ is the plasma tracer:tracee ratio of serine at an isotopic steady state.

The fractional synthesis rate (FSR) of erythrocyte-glutathione was calculated according to the precursor-product equation (13):

$$\text{FSR}_GSH(\%/d) = \frac{|E_{t6} - E_{t4.5}|}{E_{\text{rbc}}} \times \frac{[2400/(t_6 - t_{4.5})]}{(5)}$$

where $E_{t6} - E_{t4.5}$ is the increase in the tracer:tracee ratio of erythrocyte glutathione-bound glycine between the 4.5th and 6th hours of infusion, when the tracer:tracee ratio of erythrocyte-free glycine ($E_{\text{rbc}}$) had reached a steady state. The absolute synthesis rate of erythrocyte glutathione was calculated as the product of the erythrocyte glutathione concentration and the fractional synthesis rate. Units of the absolute synthesis rate are ex.

d.g.

**RESULTS**

Eight children in each group were randomly assigned to receive methionine or alanine, but measurements were completed and analyzed in 12 of these children. Two children recruited in the alanine group were dropped from the study because the hemoglobin concentration (4.9 g/L) in one patient was considered too low by the pediatrician in charge for taking experimental blood samples, and the other child was diagnosed with sickle cell disease. No measurements were carried out in 2 patients assigned to the methionine group because of difficulty in establishing intravenous lines. No adverse effect of supplements was observed during the experimental period or during the rehabilitation of participants. Age and physical characteristics of the 12 patients in whom measurements were completed are shown in Table 1. Ages, lengths, and weights were not significantly different between alanine- and methionine-supplemented groups. There was no significant gain in weight or in height over the period of measurements. Clinical characteristics of children at admission are shown in Table 2. Eleven of the 12 children studied had between 1 and 4 different infections at admission. Hemoglobin and albumin concentrations ranged between 5.5 and 10.4 g/L and between 15 and 28 g/L, respectively. The white blood cell count ranged between 6.4 and 27.6 $\times 10^3$ cells/L, and body temperatures of the children were between 36°C and 38°C.

Total methionine intake from feeds and the supplement was 0.77 mmol · kg$^{-1}$ · d$^{-1}$, Cysteine and kinetics data are shown in Table 3. De novo cysteine synthesis at CP1 was higher than at CP3 ($P = 0.04$), but there was no effect of the methionine

![Image](https://example.com/image.jpg)

**TABLE 1**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Clinical phase 1</th>
<th>Clinical phase 2</th>
<th>Clinical phase 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Alanine ($n = 6$)</td>
<td>Methionine ($n = 6$)</td>
<td>Alanine ($n = 6$)</td>
</tr>
<tr>
<td>Age (mo)$^2$</td>
<td>11.5 ± 4.1</td>
<td>8.5 ± 1.8</td>
<td>11.7 ± 4.1</td>
</tr>
<tr>
<td>Weight (kg)</td>
<td>5.8 ± 1.0</td>
<td>5.9 ± 0.6</td>
<td>5.7 ± 1.1</td>
</tr>
<tr>
<td>Length (cm)</td>
<td>63.1 ± 4.7</td>
<td>64.3 ± 3.3</td>
<td>63.2 ± 4.7</td>
</tr>
<tr>
<td>Weight-for-age (%)$^2$</td>
<td>63.5 ± 6.2</td>
<td>70.5 ± 3.7</td>
<td>61.4 ± 5.8</td>
</tr>
<tr>
<td>Weight-for-length (%)$^2$</td>
<td>91.5 ± 3.3</td>
<td>88.8 ± 5.8</td>
<td>88.8 ± 3.5</td>
</tr>
<tr>
<td>Length-for-age (%)$^2$</td>
<td>86.1 ± 3.2</td>
<td>91.8 ± 1.7</td>
<td>86.0 ± 3.1</td>
</tr>
</tbody>
</table>

$^1$All values are means ± SEs. Clinical phase 1 took place at 3 ± 1 d (±SE) after admission when subjects were both infected and malnourished but clinically stable; clinical phase 2 took place at 8 ± 1 d after admission; and clinical phase 3 took place at 14 ± 2 d after admission when subjects were still severely malnourished but no longer infected, had lost edema, and had improved affect and appetite. Weight-for-age, weight-for-length, and length-for-age are expressed as the percentage of the median for a reference child of the same age or height.

$^2$Main effect of clinical phase, $P < 0.05$ (repeated-measures ANOVA).
supplementation. However, the total cysteine flux increased from CP1 to CP3 ($P = 0.02$). Also, cysteine derived from protein breakdown increased in both methionine and control groups from CP1 to CP3, but the rise from CP1 to CP2 was greater in the methionine group than alanine group (clinical phase by supplement interaction: $P = 0.05$). Similarly, the plasma cysteine concentration increased from CP1 to CP3 in both groups. When the change in cysteine concentration was analyzed, the change from CP1 to CP2 was greater with methionine supplementation ($P = 0.01$; unpaired $t$ test). The glutathione absolute synthesis rate and concentration were higher at CP3 than CP1 and CP2 ($P = 0.00$), but there was no significant effect of methionine supplementation (Table 4).

**DISCUSSION**

Data showed that supplementation with 0.5 mmol methionine/d did not elicit an improvement in the cysteine concentration and glutathione synthesis and concentration as reported for an equimolar amount of NAC supplementation in our previous study with the same treatment diet. Also, there was not a faster rate of loss of edema. Similar to our previous findings (8, 9), the de novo cysteine synthesis was upregulated at CP1 before supplementation but was not significantly different between the 2 groups. Although, after about 5 d of methionine supplementation, the plasma cysteine concentration increased in association with an increase in cysteine derived from protein, there was no significant effect on glutathione kinetics. Moreover, at the end of the supplementation period, the glutathione absolute rate of synthesis and concentration were less than values shown at full nutritional recovery in our previous study (7), which suggested that the total cysteine availability was not sufficient to have a significant effect on glutathione kinetics. There is a strong possibility that the difference in outcome between the NAC and methionine supplements in our studies was because NAC is more potent at facilitating an increase in cysteine

**TABLE 3**

Cysteine kinetics in children with edematous severe acute malnutrition

<table>
<thead>
<tr>
<th>Child</th>
<th>Diagnosis</th>
<th>Supplement group</th>
<th>Infection</th>
<th>Hemoglobin</th>
<th>Leukocyte</th>
<th>Albumin</th>
<th>Temperature</th>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>g/L</td>
<td>$\times 10^6$ cells/L</td>
<td>g/L</td>
<td>°C</td>
</tr>
<tr>
<td>1</td>
<td>k</td>
<td>Met</td>
<td>B, SC, URTI, OM</td>
<td>8.4</td>
<td>10.0</td>
<td>28</td>
<td>37.8</td>
</tr>
<tr>
<td>2</td>
<td>mk</td>
<td>Ala</td>
<td>URTI, D, SC</td>
<td>6.7</td>
<td>27.6</td>
<td>18</td>
<td>36.0</td>
</tr>
<tr>
<td>3</td>
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<td>Met</td>
<td>B, OM, SC</td>
<td>6.4</td>
<td>18.9</td>
<td>22</td>
<td>37.0</td>
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<tr>
<td>4</td>
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<td>Ala</td>
<td>D</td>
<td>6.7</td>
<td>7.9</td>
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<td>36.8</td>
</tr>
<tr>
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<td>k</td>
<td>Met</td>
<td>None</td>
<td>6.4</td>
<td>12.7</td>
<td>27</td>
<td>36.6</td>
</tr>
<tr>
<td>6</td>
<td>k</td>
<td>Ala</td>
<td>B, URTI, UTI, SC</td>
<td>5.3</td>
<td>8.1</td>
<td>20</td>
<td>37.0</td>
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<tr>
<td>7</td>
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<td>Met</td>
<td>SC</td>
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<td>17.3</td>
<td>24</td>
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<td>Ala</td>
<td>B, OM, SC</td>
<td>7.4</td>
<td>22.4</td>
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<tr>
<td>9</td>
<td>k</td>
<td>Met</td>
<td>URTI, SC</td>
<td>5.5</td>
<td>8.8</td>
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<td>36.0</td>
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<tr>
<td>10</td>
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<td>D, SC</td>
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<tr>
<td>11</td>
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<tr>
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<td>Ala</td>
<td>OM</td>
<td>8.1</td>
<td>8.6</td>
<td>22</td>
<td>38.0</td>
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</table>

$^1$ Ala, alanine; B, bacteremia; D, infective diarrhea; k, kwashiorkor; mk, marasmic kwashiorkor; Met, methionine; OM, otitis media; URTI, upper respiratory tract infection; UTI, urinary tract infection; SC, skin candidiasis.

$^2$ Clinical phase 1 took place at 3 ± 1 d (±SE) after admission when subjects were both infected and malnourished but clinically stable; clinical phase 2 took place at 8 ± 1 d after admission; and clinical phase 3 took place at 14 ± 2 d after admission when subjects were still severely malnourished but no longer infected, had lost edema, and had improved affect and appetite. Analyses were conducted by using repeated-measures ANOVA.

$^3$ Mean ± SEM (all such values).

$^4$ Compared with alanine at the same stage [95% CIs: 7.4, 29.3 (Tukey) and 6.7, 30.0 (Bonferroni)].
availability to enhance glutathione synthesis. Iminocyclase 1, which is the enzyme that catalyzes the deacetylation of NAC, has a low affinity for NAC and low activity in red blood cells (15). Therefore, a limited intracellular deacetylation of NAC to provide cysteine does not account for the full effect of NAC in supporting erythrocyte glutathione production such as after the administration of paracetamol (14). As a substrate for cysteine, an NAC extracellular concentration 20 times that of cysteine is required to optimally produce total free glutathione (15). Therefore, the positive effect of NAC on glutathione synthesis in our previous study could have been associated with the effect of NAC on releasing free cysteine from plasma cystine (14, 16), which is the form in which >90% of soluble cysteine is present in plasma (17). Whillier et al (16), by using a proton nuclear magnetic resonance technique, have shown that redox exchange reactions between NAC and cysteine result in the formation of mixed disulphides including NAC cysteine, NAC-NAC, and free cysteine that can readily enter red blood cells to sustain glutathione synthesis.

Despite an early increase in the amount of cysteine derived from protein breakdown in the methionine-supplemented group, the inability to meet the total cysteine demand may in part have been related to the high demand for cysteine in edematous SAM. Recently, we have shown that the total cysteine requirement to meet the body’s demands was higher in edematous SAM than non-edematous SAM (18). This effect may be associated with a higher demand to synthesize cysteine-rich proteins such as acute phase proteins as a consequence of infection and to make gut mucosal proteins and cysteine-rich mucins for repair of the markedly atrophic gut mucosa that accompanies edematous SAM. Glycine is a methyl-group acceptor that forms succinyl (N-methylglycine) and may contribute substantially to the transmethylaidation flux (23). In addition, serine which is used in the transsulfuration pathway, can be synthesized in part from glycine. However, methionine intake in excess of the demand was not supported by the lack of an increase in the conversion of methionine to cysteine in the face of a shortage of cysteine (6, 7) and the increased demand for cysteine in edematous SAM (18). Moreover, production rates of glycine (24) and serine (9) are not reduced in SAM.

In conclusion, methionine supplementation in children with edematous SAM increases the plasma cysteine concentration and cysteine derived from protein breakdown but not de novo cysteine or glutathione synthesis. Dietary methionine might not be able to satisfy the total demand for cysteine in these children. Therefore, cysteine might be conditionally essential in edematous SAM, and consequently, dietary cysteine might be needed to partially fulfill the total requirement for cysteine.

**TABLE 4**
Reduced glutathione kinetics in erythrocytes of children with edematous severe acute malnutrition

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>ASR</th>
<th>FSR</th>
<th>Concentration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>mmol · L⁻¹ · d⁻¹</td>
<td>%/d</td>
<td>mmol/L</td>
<td></td>
</tr>
<tr>
<td>Clinical phase 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alanine</td>
<td>6</td>
<td>0.3 ± 0.1²</td>
<td>38.9 ± 6.2</td>
<td>0.6 ± 0.2</td>
</tr>
<tr>
<td>Methionine</td>
<td>6</td>
<td>0.2 ± 0.04</td>
<td>58.5 ± 9.3</td>
<td>0.4 ± 0.05</td>
</tr>
<tr>
<td>Clinical phase 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alanine</td>
<td>6</td>
<td>0.6 ± 0.08</td>
<td>57.2 ± 5.4</td>
<td>1.1 ± 0.2</td>
</tr>
<tr>
<td>Methionine</td>
<td>6</td>
<td>0.6 ± 0.2</td>
<td>76.1 ± 17.4</td>
<td>0.7 ± 0.1</td>
</tr>
<tr>
<td>Clinical phase 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alanine</td>
<td>6</td>
<td>0.9 ± 0.6</td>
<td>61.0 ± 5.2</td>
<td>1.5 ± 0.2</td>
</tr>
<tr>
<td>Methionine</td>
<td>6</td>
<td>0.9 ± 0.1</td>
<td>52.2 ± 6.3</td>
<td>1.7 ± 0.2</td>
</tr>
<tr>
<td>P</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supplement × clinical phase</td>
<td>—</td>
<td>0.86</td>
<td>0.13</td>
<td>0.06</td>
</tr>
<tr>
<td>Supplement</td>
<td>—</td>
<td>0.86</td>
<td>0.33</td>
<td>0.57</td>
</tr>
<tr>
<td>Clinical phase</td>
<td>—</td>
<td>0.001</td>
<td>0.10</td>
<td>0.001</td>
</tr>
</tbody>
</table>

¹Clinical phase 1 took place at 3 ± 1 d (±SE) after admission when subjects were both infected and malnourished but clinically stable; clinical phase 2 took place at 8 ± 1 d after admission; and clinical phase 3 took place at 14 ± 2 d after admission when subjects were still severely malnourished but no longer infected, had lost edema, and had improved appetite. Analyses were conducted by using repeated-measures ANOVA. ASR, absolute synthesis rate; FSR, fractional synthesis rate.

²Mean ± SEM (all such values).
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The authors’ responsibilities were as follows—FJ, TF, AVB, and MR: designed the research; CT-B: was the study pediatrician; AVB, CT-B, and COG: conducted the research; JWH, AVB, and MR: analyzed data or performed the statistical analysis; COG, AVB, TF, and FJ: wrote the manuscript; and all authors: read and approved the final manuscript. None of the authors had a conflict of interest.

REFERENCES