

In addition, AHA urges the Committee to make specific recommendations for consumption of 250 to 500mg of EPA and DHA per day. Two servings of fish per week would make an average intake of 250mg to 500mg of EPA and DHA per day.

Although we acknowledge that this goes beyond current dietary reference intakes established by the Institute of Medicine (IOM), it has been over six years since the IOM updated its reports examining these essential fatty acids. An updated report examining current science would be extremely useful in establishing recommended levels for omega-3 fatty acids, but available data already shows that consumption of food-based sources of EPA and DHA has a cardiovascular benefit. Therefore, the Committee should recommend weekly consumption of EPA and DHA, especially through consumption of oily fish. The recommendation would keep EPA and DHA combined, since scientific evidence on how the fatty acids function separately is lacking.

The Committee should also address alpha-linolenic acid (ALA). ALA serves as a precursor for synthesis of EPA and DHA so it is required by the body; however, the body cannot synthesize ALA, so a dietary source is required. The Guidelines should provide examples of major sources of ALA such as flaxseed, canola, and soybean oil.

Unsaturated Fatty Acids

The AHA is currently in the process of publishing a science advisory on omega-6 fatty acids and the risk for cardiovascular disease. We believe this paper may be of interest to the Committee. The paper will be available online after January 26th at <http://circ.ahajournals.org/cgi/reprint/CIRCULATIONAHA.108.191627>.

Fluid and Electrolytes

Sodium

The current Dietary Guidelines recommendation that individuals consume less than 2,300mg of sodium per day is too high. The amount should be changed to the amount recommended in the 2005 Guidelines for salt sensitive populations, or no more than 1,500mg of sodium per day. According to the Centers for Disease Control and Prevention, the special populations described above – individuals with hypertension, African-Americans, middle-age, and older adults – now account for 68% of the American population.¹ Because these specific population groups now constitute a majority of the total population, the 1,500mg should apply to all populations.

A reduced sodium intake can have significant health benefits. Studies have shown that a reduced sodium intake can lower blood pressure, prevent hypertension, can help control hypertension, and can prevent cardiovascular disease. And although sodium is an essential nutrient, there is no biologic requirement for 2,300mg a day. Very little sodium is needed. Under conditions of maximal adaptation and without sweating, the minimum amount of sodium required to replace losses is estimated to be no more than 180 mg per day. However, it is unlikely that a diet providing this level of sodium intake is sufficient to meet dietary requirements for other

¹ Darwin Labarthe, Division for Heart Disease and Stroke Prevention, Centers for Disease Control and Prevention. Presentation at the Institute of Medicine Committee on Strategies to Reduce Sodium Intake. January 13, 2009.

nutrients. Therefore, to ensure nutrient adequacy and replace sweat losses, healthy adults generally need about 1,500 mg a day.²

To accommodate a more realistic approach for reducing the sodium intake to 1,500mg in the 2010 Dietary Guidelines, the Committee may want to consider making a recommendation for reducing sodium in two phases. In recent comments to the Food and Drug Administration and the Institute of Medicine, AHA recommended that the daily value for sodium be lowered to 1,500mg by 2020 with an intermediate goal of 2,000mg by 2013. This two-step phase down should provide manufacturers with time to reformulate products and identify acceptable salt substitutes, as well as allow consumers to adapt their taste sensitivities to the lower sodium content in foods.

To meet a science-based recommendation of 1,500mg per day, the scientific report and the policy document must strongly encourage consumers to reduce sodium intake by choosing foods with little or no salt and limiting the amount of salt added to food. However, we acknowledge that it will be difficult for consumers to lower their sodium intake to 1,500mg on their own. With processed foods accounting for 77% of all sodium consumed, it will require the cooperation of food manufacturers and restaurants to reduce the sodium content of the foods they make available to the public. AHA would like to see food manufacturers and restaurants reduce the salt added to foods by 50% over the next 10 years.

Beverages

The current Guidelines recommend that consumers select beverages with little added sugars or caloric sweeteners. AHA agrees with this recommendation; the 2006 AHA Diet and Lifestyle Recommendations suggest limiting beverages that are high in added sugars.

In recent years the consumption of beverages with added sugars has risen markedly. High calorie energy drinks and caffeinated beverages have become the leading source of added sugar in the diet. This is concerning because high consumption of beverages with added sugars has been associated with consumption of greater calories and weight gain. Consumers tend not to compensate as well for calories consumed in liquid form when compared to calories consumed as solid foods. Because calories consumed as beverages may not be as satiating, we tend to overconsume beverages and other foods.

The Committee should address and emphasize high calorie energy drinks and caffeinated beverages in the updated Guidelines.

Vitamins

The Dietary Guidelines recommend consumption of a number of vitamins including vitamins A, C, D, E, and B₁₂. Individuals are instructed to obtain these vitamins through vitamin-rich sources of food, fortified foods, and/or supplements.

² Institute of Medicine. *Dietary Reference Intakes: Water, Potassium, Sodium Chloride, and Sulfate*. 1st ed. Washington, DC: National Academy Press; 2004.