PACIFIC JOURNAL OF MEDICAL SCIENCES
{Formerly: Medical Sciences Bulletin}
ISSN: 2072 – 1625

Pac. J. Med. Sci. (PJMS)
www.pacjmedsci1625.com. Email: managingeditorpjms1625@gmail.com.

COMMENTARY:

CLINICAL INTERPRETATION OF THE UNITED STATES DIETARY GUIDELINES FOR AMERICANS 2025-2030: IMPLICATIONS FOR OLDER ADULTS

SHYH POH TEO

PAPRSB Institute of Health Sciences, Universiti Brunei Darussalam,
Jalan Tungku Link, Gadong, Brunei Darussalam

Email: shyhpoh.teo@ubd.edu.bn

Submitted: March 2026, Accepted: March 2026

COMMENTARY:

CLINICAL INTERPRETATION OF THE UNITED STATES DIETARY GUIDELINES FOR AMERICANS 2025-2030: IMPLICATIONS FOR OLDER ADULTS

SHYH POH TEO

PAPRSB Institute of Health Sciences, Universiti Brunei Darussalam,
Jalan Tungku Link, Gadong, Brunei Darussalam

Email: shyhpoh.teo@ubd.edu.bn

Submitted: March 2026, Accepted: March 2026

INTRODUCTION:

The United States Dietary Guidelines for Americans (DGA) are among the most influential national nutrition guidelines globally and are frequently referenced in clinical practice, education, and research outside the United States [1]. Although designed as population-level guidance, they often inform individual dietary advice. This Clinical Note provides a brief overview of key recommendations in the updated DGA, highlights aspects particularly relevant to older adults, and discusses practical and methodological considerations relevant to geriatric practice.

Overview of key dietary guideline recommendations:

The 2025–2030 DGA maintains a life-course approach to nutrition and emphasizes overall dietary patterns rather than isolated nutrients. Core recommendations include consumption of nutrient-dense foods such as vegetables, fruits, whole grains, protein foods, dairy or fortified alternatives; limitation of sodium intake to less than 2,300 mg per day for most adults; limitation of saturated fat to less than 10% of total energy intake; and reduction of added sugars [1].

Protein intake is highlighted more explicitly, with recommended targets of approximately 1.2 – 1.6 g/kg/day. The guidelines also strongly discourage consumption of highly processed

foods, particularly those high in salt and added sugars and low in nutrient density. Full-fat dairy products are considered acceptable when unsweetened, reflecting a shift from earlier guidance that preferentially promoted low-fat or fat-free options. In practice, this requires distinguishing between occasional inclusion of saturated-fat-containing foods within a balanced diet and routine consumption that may increase cardiovascular risk.

Clinical relevance for older adults:

Although the DGA is not specifically designed for older populations, several recommendations are directly relevant to ageing and geriatric care.

Protein intake and muscle health:

Sarcopenia and frailty are prevalent among older adults and associated with increased risk of falls, disability, hospitalization, and mortality [2]. Previous editions of the DGA acknowledged the importance of adequate protein intake but did not specify higher targets for older adults. This current emphasis aligns with evidence suggesting that older adults may require greater protein intake than younger adults to preserve muscle mass and physical function, particularly in the context of chronic disease, acute illness, or reduced physical activity [3].

Achieving higher protein targets may be challenging due to reduced appetite, comorbidity, functional limitations, socioeconomic factors, and dietary preferences [4]. In clinical settings, this requires a pragmatic food-based approach, prioritizing the inclusion of protein at each meal using familiar and acceptable foods (e.g. eggs, dairy, legumes, fish, and soft-textured options). Protein advice should therefore be individualized and integrated into usual eating patterns.

Energy intake and nutritional adequacy:

Age-related changes in appetite, taste, dentition, gastrointestinal function, and functional ability may compromise dietary intake in older adults [4]. Acceptance of full-fat dairy products when unsweetened may support adequate energy and protein intake in individuals at risk of undernutrition, particularly where appetite or meal volume is limited.

There is increasing recognition that the health effects of foods, particularly dairy products, depend not only on nutrient composition but also on the overall food matrix and processing methods such as fermentation. These factors influence digestion and metabolic responses and may explain why whole or fermented foods differ in their health effects from isolated nutrients with similar fat content [5]. This supports emphasising

whole, minimally processed foods rather than focusing solely on individual nutrients.

Carbohydrate-rich foods, including whole grains and starchy vegetables, remain important sources of energy and are associated with positive health status in older adults [6]. Thus, protein-focused recommendations should not displace carbohydrate foods that contribute substantially to total energy intake and dietary fiber.

Diet quality and food processing:

Diets high in ultra-processed foods are often energy-dense but nutrient-poor. In older adults, reliance on such foods may worsen malnutrition risk and contribute to poorer functional outcomes [7]. Accordingly, the recommendation to limit highly processed foods aligns with geriatric nutrition principles that prioritize nutrient density, adequacy, and simplicity of meals.

Sodium intake:

Sodium restriction remains a consistent feature of successive DGAs and is clinically relevant given the high prevalence of hypertension and cardiovascular disease in older adults [8]. In geriatric practice, sodium reduction must be balanced against risks of reduced appetite, poor palatability, and inadequate intake. For frail or institutionalised individuals, maintaining food enjoyment and sufficient intake may take priority over strict sodium targets.

Clinical caveats and methodological considerations:

Despite their relevance, DGA recommendations should be applied cautiously to older adults. The guidelines are population-level tools intended to inform public health policy rather than individualized clinical care [9]. Higher protein targets may not be appropriate for all individuals, particularly those with advanced chronic kidney disease or specific metabolic conditions. Guidance permitting inclusion of saturated-fat–containing foods requires careful interpretation. Clinicians should clarify that such foods may be included occasionally and in small amounts within an otherwise balanced diet, rather than consumed regularly or in place of unsaturated fat sources.

Cost, access, and food insecurity may also limit the dietary approaches that emphasize increased protein intake for some older adults, reinforcing the need for flexible advice that incorporates affordable, nutrient-dense foods. Communicating these recommendations to the public may also present challenges, as concepts such as food matrix effects and context-dependent dietary risk require clinical interpretation to prevent oversimplification or misapplication.

Concerns regarding potential bias are best understood as methodological rather than ideological. The DGA relies heavily on observational evidence and intermediate cardiometabolic outcomes, reflecting the challenges of long-term nutrition trials. Outcomes of particular relevance to ageing populations, such as physical function, cognitive decline, and disability-free survival, also remain underrepresented in the evidence base [10].

CONCLUSIONS:

The 2025–2030 United States Dietary Guidelines incorporate several updates that may be clinically meaningful for older adults, particularly in relation to protein adequacy, dietary quality, and prevention of undernutrition. However, the population-wide framing requires careful, individualized application in geriatric practice. Clinicians should interpret the guidelines as a flexible framework rather than a prescriptive standard, adapting recommendations to individual functional status and nutritional risk.

REFERENCE:

1. U.S. Department of Agriculture, U.S. Department of Health and Human Services. Dietary guidelines for Americans, 2025-2030 [Internet]. Washington, DC, United States of America; 2026 [cited 2026 Mar 15]. Available from: https://cdn.realfood.gov/DGA.pdf
2. Cruz-Jentoft AJ, Bahat G, Bauer J, Boirie Y, Bruyère O, Cederholm T, Cooper C, Landi F, Rolland Y, Sayer AA, Schneider SM, Sieber CC, Topinkova E, Vandewoude M, Visser M, Zamboni M. Sarcopenia: revised European consensus on definition and diagnosis. Age Ageing 2019;48(1):16–31.
3. Olaniyan ET, O'Halloran F, McCarthy AL. Dietary protein considerations for muscle protein synthesis and muscle mass preservation in older adults. Nutr Res Rev 2021;34(1):147-157.
4. Van der Meij BS, Wijnhoven HA, Lee JS, Houston DK, Hue T, Harris TB, Kritchevsky SB, Newman AB, Visser M. Poor appetite and dietary intake in community-dwelling older adults. J Am Geriatr Soc 2017;65(10):2190-2197.
5. Thorning TK, Bertram HC, Bonjour JP, De Groot L, Dupont D, Feeney E, Ipsen R, Lecerf JM, Mackie A, McKinley MC, Michalski MC, Remond D, Riserus U, Soedamah-Muthu SS, Tholstrup T, Weaver C, Astrup A, Givens I. Whole dairy matrix or single nutrients in assessment of health effects: current evidence and knowledge gaps. Am J Clin Nutr 2017;105(5):1033–45.
6. Korat AVA, Duscova E, Shea MK, Jacques PF, Sebastiani P, Wang M, Mahdavi S, Eliassen AH, Willett WC, Sun Q. Dietary carbohydrate intake, carbohydrate quality, and healthy aging in women. JAMA Network Open 2025;8(5): e2511056.
7. Srour B, Fezeu LK, Kesse-Guyot E, Allès B, Méjean C, Andrianasolo RM, Deschasaux M, Hercberg S, Galan P, Monteiro CA, Julia C, Touvier M. Ultra-processed food intake and risk of cardiovascular disease: prospective cohort study (NutriNet-Santé). BMJ 2019; 365: l1451.
8. Rust P, Ekmekcioglu C. Impact of salt intake on the pathogenesis and treatment of hypertension. Adv Exp Med Biol 2016; 956:61–84.
9. Volkert D, Beck AM, Cederholm T, Cruz-Jentoft A, Goisser S, Hooper L, Kiesswetter E, Maggio M, Raynaud-Simon A, Sieber CC, Sobotka L, Van Asselt D, Wirth R, Bischoff SC. ESPEN guideline on clinical nutrition and hydration in geriatrics. Clin Nutr 2018;38(1):10–47.
10. Ioannidis JPA. The challenge of reforming nutritional epidemiologic research. JAMA. 2018;320(10):969-970.