

One More Day — General Protocol

Lifetime · One Year · Week · Day

Version 1.0 · Evidence reviewed through October 14, 2026

Purpose: Preserve the health, capacity, freedom, and relationships that let you keep living a life you choose, while supporting the long-term mission of overcoming aging.

This is a practical starting protocol for generally healthy adults, not an individualized treatment plan. Pregnancy, frailty, significant illness, an eating-disorder history, or medications that affect exercise or nutrition require adaptation with an appropriate clinician. Screening recommendations must also fit your country and personal risk.

The protocol has three kinds of recommendations:

Label	Meaning	How to use it
Foundation	Human evidence and professional guidance support health, function, or disease prevention. Not every item has a randomized mortality trial.	Build a sustainable version into ordinary life.
Conditional	Useful for a particular risk, deficiency, symptom, preference, or training goal.	Use when the reason applies to you.
Research	Early human studies, surrogate outcomes, animal experiments, or mechanistic plausibility.	Follow the evidence; do not assume a consumer longevity benefit.

The exact calendar below is an OMD implementation proposal. The whole package has not been tested as one intervention, and no credible number of “extra years” can be promised from following it.

Lifetime — Protect your future capacity

1. Avoid preventable losses. Stay tobacco-free. If you smoke, use evidence-based cessation support; quitting is valuable at any age. Make no alcohol the default, and do not start drinking for supposed cardiovascular benefits. Alcohol increases cancer risk, including at low intake. If you are physically dependent on alcohol, arrange medical support before stopping abruptly. Use seat belts and appropriate helmets, avoid impaired or drowsy driving, and make injury prevention part of your sport. These actions belong in a longevity strategy alongside disease prevention. [1, 2]

2. Keep building physical reserve. Maintain the ability to walk briskly, climb stairs, carry groceries, get up from a chair or the floor, and participate in activities you enjoy. Train aerobic fitness, strength, and the balance or mobility your life requires. Early adulthood is a good time to establish technique and habits; later life places increasing importance on preventing falls, preserving muscle and bone, and recovering after illness. There is no single VO_2max , body-fat percentage, or lifting record that everyone must achieve. [3, 4]

3. Manage cumulative cardiovascular and metabolic risk. Keep a personal record of blood pressure, relevant lipid results, medical conditions, medications, and family history. Discuss early heart attacks, strokes, diabetes, and relevant cancers in your family with a clinician. The 2026 ACC/AHA guideline recommends measuring lipoprotein(a), or Lp(a), at least once in adulthood. ApoB and coronary calcium scans have more selective roles. Use risk-appropriate treatment when needed; lifestyle and appropriate medication can work together. [5]

4. Maintain access to care. Keep vaccination records and a simple medical summary. Know where to obtain primary, dental, and urgent care. Complete screening when it becomes appropriate for your age, anatomy, family history, and country. Investigate persistent symptoms instead of

explaining everything as stress or aging. Routine screening and evaluating a new symptom are different decisions. [6–8]

5. Protect a life you want to continue. Maintain close relationships, community, meaningful work or learning, and enjoyable activities. Treat persistent loneliness, depression, anxiety, or burnout as problems worth addressing. Social connection has value in itself; its associations with survival do not mean a particular number of conversations guarantees longer life. Build a schedule and environment that protect sleep, food access, movement, recovery, and time with people. [9]

6. Spend on the largest actionable gap. Prioritize useful care, food, a workable sleep environment, and sustainable exercise before optional supplements or testing. Ask of every purchase: What problem will this solve? What decision will the result change? What does it cost in money, time, side effects, and attention? A useful protocol should make daily life easier to sustain.

7. Stay open to better interventions. OMD's mission is to overcome aging. Today's practical responsibility is to preserve function and reduce known risks while evaluating new therapies honestly. Require evidence in the relevant human population, an outcome that matters, acceptable harms, and feasible ongoing care. Do not equate a younger-looking methylation clock with rejuvenation of the whole person.

Healthy older adults can generate useful hypotheses. Their habits alone cannot establish causality: genes, wealth, environment, and survivorship also shape who remains healthy. Likewise, animal lifespan extension and cellular reprogramming results do not establish a safe human regimen.

One Year — Build, review, and improve the system

The yearly goal is to make a few important behaviors dependable and close meaningful prevention gaps.

First 30 days

1. **Make a one-page baseline.** For seven ordinary days, note approximate sleep, exercise, meals, energy, and any persistent symptoms. Record existing medical results and the dates of your last relevant preventive care. Devices are optional.
2. **Choose no more than three priorities.** Examples: a consistent sleep opportunity, two weekly strength sessions, or replacing a daily sugary drink. If you smoke, have an untreated condition, or have concerning symptoms, addressing that can outrank optimization habits.
3. **Schedule the behaviors.** Choose realistic days, locations, and a smaller fallback version. Buy or prepare the foods that make your chosen eating pattern easy.
4. **Resolve overdue care.** Arrange a clinical review if you have symptoms, unmanaged risk factors, missing preventive care, or no clear screening plan. An annual planning exercise does not mean everyone needs an annual examination or blood panel.
5. **Choose one functional measure.** For example, use the same comfortable walking route and record time and effort, or track repetitions and load for a familiar exercise. Older adults or people with limitations may use a clinician-selected chair-rise, gait, or balance assessment. Avoid turning the baseline into an exhausting maximum-effort test.

Months 2–3

Repeat the routine long enough to learn whether it fits. Increase exercise gradually. If you repeatedly miss a habit, reduce the time requirement or change the environment.

At around three months, compare the same functional measure and your daily energy, pain, sleep, and enjoyment. Repeat laboratory tests only when a clinician recommends them to answer a specific question or monitor treatment.

Months 4–12

Use a 20–30 minute review every three months. Keep what helps, remove low-value complexity, and change one main behavior at a time. Recheck your functional measure under similar conditions. Adjust for travel, exams, illness, injury, pregnancy, or changing work demands.

At the end of the year, review:

- Which activities became easier, and which became harder?
- Are sleep, energy, relationships, and enjoyment acceptable?
- Are any medical or preventive-care actions overdue?
- Which expenses or measurements changed a useful decision?
- What is the single most valuable improvement for the next year?

These review intervals are practical defaults, not experimentally established longevity doses.

The prevention review: what is actually due?

Area	Practical decision
Blood pressure	Know a reliable baseline. U.S. USPSTF guidance suggests annual screening from age 40 or with increased risk; low-risk adults aged 18–39 with previous normal readings may be screened every 3–5 years. Elevated readings need confirmation and a follow-up plan, often including home or ambulatory measurement. [6]
Lipids and inherited risk	Review the need for a standard lipid profile and discuss one adult Lp(a) measurement. Repeat frequency and treatment depend on results and risk. ApoB is selective, not a mandatory recurring test for everyone. [5]
Diabetes screening	Use age, weight, family history, ancestry, pregnancy history, symptoms, and local guidance. As one U.S. example, USPSTF recommends screening adults aged 35–70 with overweight or

Area	Practical decision
	obesity; earlier screening or lower BMI thresholds may be appropriate for some groups. [7]
Vaccinations and infections	Check the current national schedule and your records. Review seasonal vaccines, incomplete series, and age-, exposure-, travel-, or risk-specific vaccines. Discuss sexual-health testing when relevant. [8]
Cancer and bone screening	Determine which specific tests you are due for. Family history or a known inherited condition may change the schedule. Screening should have an appropriate indication and a clear response to an abnormal result.
Teeth, vision, and hearing	Arrange dental follow-up at the interval recommended for your risk. Seek assessment for changes in vision or hearing and for persistent oral symptoms. [10]
Additional laboratory tests	CBC, ferritin, B12, thyroid, kidney, liver, or other tests should answer a clinical question or monitor a condition or medication. Routine vitamin D testing is not recommended for otherwise healthy adults without an indication. [11]
Optional "longevity" testing	CGM, repeated epigenetic clocks, broad hormone panels, and whole-genome sequencing are not required by this protocol. Routine whole-body CT or MRI screening is also excluded for asymptomatic, average-risk adults because demonstrated net benefit is lacking and follow-up harms are possible. [12, 13]

Blood pressure and lipid goals belong in an individual care plan. A value inside a laboratory's reference range does not necessarily establish low lifetime risk, and one mildly abnormal result does not automatically establish disease.

Week — Schedule the work and the recovery

Movement

Aerobic activity — Foundation. Build toward **150–300 minutes of moderate activity per week, 75–150 minutes of vigorous activity**, or a combination. About one vigorous minute counts as two moderate minutes for this guideline. A moderate effort allows conversation but makes singing difficult. Count active transport and sports when they genuinely reach the relevant intensity. The entire time spent at a class is not automatically vigorous exercise. [3, 4]

Strength — Foundation. Train the major muscle groups on **at least two days per week**. A practical session can include a squat or chair-rise, a hip hinge, a push, a pull, and a carry or trunk exercise. Start with movements and loads you can control; add repetitions or load gradually. A qualified coach or physiotherapist can adapt technique and restrictions. The particular exercises and session length are implementation choices.

Balance and mobility — Conditional. Use short sessions for limitations relevant to your sport or daily activities. Older adults should include multicomponent activity emphasizing balance and strength on at least three days weekly, adjusted to their ability. [3]

Recovery — Foundation in principle; schedule individualized. Leave room for easier activity and adequate food and sleep. You do not need to add HIIT to a week already containing demanding sport. Recurrent pain, persistent fatigue, or deteriorating sleep is a reason to change the load and, when appropriate, seek assessment.

A repeatable example week

Day	Main activity
Monday	Full-body strength; 20-minute brisk walk
Tuesday	30-minute brisk walk, cycling, swimming, or comparable activity
Wednesday	20-minute brisk walk; optional mobility
Thursday	Full-body strength; 20-minute brisk walk

Day	Main activity
Friday	30-minute moderate aerobic session
Saturday	30-minute active outing with someone you enjoy
Sunday	Easy movement or rest; prepare for the next week

The example supplies **150 moderate aerobic minutes plus two strength sessions**. Substitute activities you enjoy. If you already practice a demanding sport several times weekly, count its actual active minutes and fill remaining gaps instead of automatically adding this entire schedule.

A difficult week: Protect sleep, keep some movement, eat regularly, and use brief strength sessions if feasible. Even small amounts of activity are useful. A reduced week does not need to be “repaid” with exhausting workouts. [4]

Food, people, and a short review

- Shop or prepare food once or twice so protein, vegetables, fruit, legumes, and whole grains are readily available.
- Put a meaningful social activity and an enjoyable activity in the calendar. They may be the same activity.
- Spend **10 minutes** reviewing sleep, movement, pain or fatigue, and the next week’s schedule.
- Choose one adjustment. The review should lead to an action, not another large tracking system.

Day — Repeat a small set of defaults

Sleep and light

Protect enough sleep opportunity to obtain adequate sleep. Most adults can start with a 7–9-hour sleep target and adjust to their needs; the

AASM/SRS consensus recommends at least seven hours regularly, with some people needing more. Keep wake time reasonably consistent. A wearable's estimate is secondary to the broader pattern and how you function. [14]

Get outside in daylight when practical, and make the bedroom dark, quiet, and comfortable. A morning walk can combine light, movement, and a pleasant start to the day. There is no universal mandatory number of sunlight minutes. Reduce late-evening activities that repeatedly delay sleep.

If loud snoring, witnessed breathing pauses, persistent insomnia, or sleepiness despite adequate opportunity is present, seek assessment. Increasing time in bed alone may not address the cause.

Meals

Use a plant-rich, nutritionally adequate pattern — Foundation. Build meals around vegetables, fruit, legumes, whole grains, nuts, seeds, and appropriate protein sources. Fish, soy foods, beans, eggs, and dairy or fortified alternatives can fit different preferences. Favor unsaturated fats. Frozen and canned foods can be practical options; packaging itself is not a measure of nutritional harm.

Aim for **at least 400 g of fruit and vegetables and at least 25 g of naturally occurring fiber daily**, increasing fiber gradually if needed. Reduce sugary drinks, processed meat, and foods that repeatedly crowd out adequate nutrition. Mediterranean-style dietary patterns have human cardiovascular outcome evidence, including trials in older adults at elevated risk. [15, 16]

Match protein and energy to your needs — Conditional. Include a protein source in each main meal. For healthy adults who train regularly, roughly **1.2–1.6 g/kg/day** is a practical starting range within sports-nutrition guidance; greater needs can apply to particular training or dietary situations. This is a training-support target, not a proven longevity

optimum. Kidney disease and other clinical conditions require individual advice. Eat enough to support training and recovery. [17]

Meal timing — Optional. Regular meals and avoiding very large meals immediately before sleep may make the routine easier. A roughly 12-hour overnight break can be convenient, but it is not a mandatory anti-aging intervention. Do not sacrifice adequate intake or post-training recovery to obey a clock. In a 12-month obesity trial, adding an eight-hour eating window to calorie restriction did not provide a statistically significant additional weight-loss benefit. [18]

Drink water regularly and replace additional fluid losses during heat or prolonged exercise. Fluid targets need adjustment for activity and medical conditions.

Movement, care, and enjoyment

Move at several points during the day. Break up long periods of sitting when practical; a brief walk between tasks or after a meal is an easy implementation. Follow the day's planned exercise rather than forcing a hard workout every day. [4]

Brush twice daily for two minutes with fluoride toothpaste, and clean between the teeth once daily. For sun exposure, use shade, clothing, and broad-spectrum, water-resistant **SPF 30+** sunscreen on exposed skin, following reapplication instructions. Protect your hearing in loud environments and use the safety equipment your activity requires. [10, 19]

Take prescribed medicines as directed. Keep supplements limited to a defined purpose. A clinician or dietitian can help address a deficiency or intake gap. **Creatine monohydrate, commonly 3–5 g/day, is an optional training-support tool for suitable adults**, not an established lifespan-extension treatment. Consider health conditions, interactions, product quality, and cost. [17]

Make room for a meaningful conversation, learning, play, or something you simply enjoy. A short breathing, prayer, meditation, or quiet-time practice

can be used if it helps you unwind; no exact duration is a proven longevity dose.

The daily checklist

- ☐ I protected adequate sleep opportunity.
- ☐ I moved and followed the training or recovery plan that fit today.
- ☐ I ate enough, with protein and plant foods.
- ☐ I completed oral care, prescribed care, and relevant exposure protection.
- ☐ I made room for connection or enjoyment.

Use the checklist as a reminder, not a score of personal worth. On an unusually difficult day, the minimum is regular food, basic care, whatever gentle movement is feasible, and a reasonable bedtime.

Research update — What changes the protocol in October 2026?

This is a targeted update of decision-relevant findings, not a systematic review of all geroscience. A treatment may work for one disease without being useful for healthy people.

Development	What the evidence actually shows	OMD decision now
Earlier cardiovascular prevention: 2026 guideline	The updated ACC/AHA dyslipidemia guideline emphasizes lifetime lipid exposure, an adult Lp(a) measurement, and selective additional risk assessment. [5]	Add the Lp(a) discussion to the prevention review. Individualize treatment; avoid universal drug targets or scans.

Development	What the evidence actually shows	OMD decision now
Structured lifestyle support and cognition: US POINTER, 2025	In 2,111 adults aged 60–79 at elevated cognitive risk, a structured multidomain program produced a small additional improvement in cognitive test performance over two years compared with a self-guided program. The difference was 0.029 standard deviations per year. This was not proof of dementia prevention or the effect of any single component. [20]	Make exercise, food, social engagement, and follow-up easier to repeat. A sustainable support structure is worth including.
GLP-1 therapies and clinical outcomes	SELECT randomized 17,604 people with established cardiovascular disease and overweight or obesity, without diabetes. Major cardiovascular events occurred in 6.5% with semaglutide versus 8.0% with placebo over approximately 40 months. Benefits apply to the studied clinical context; gastrointestinal effects and discontinuation also matter. [21]	Discuss appropriate treatment when a medical indication exists. These results do not establish an anti-aging prescription for healthy, normal-weight people.
Senolytics: an encouraging disease-specific result, October 1, 2026	A double-blind randomized proof-of-principle trial in 31 people with fibrotic MASH reported liver fibrosis improvement without worsening MASH in 47% receiving dasatinib plus quercetin versus 7% receiving placebo. Adverse events were more frequent with treatment. This is a small trial using a histological endpoint. An earlier trial in 60 postmenopausal	Follow confirmatory trials and longer-term outcomes. The field has a human disease signal worth studying, but this does not justify self-treatment for general longevity.

Development	What the evidence actually shows	OMD decision now
	women did not meet its primary bone-resorption endpoint. [22, 23]	
Rapamycin: mixed, limited human findings	PEARL reported exploratory benefits in some measures but no significant improvement in its primary visceral-fat endpoint; 114 participants completed the study. In a separate 2026 trial of 40 older adults exercising for 13 weeks, rapamycin did not improve the primary functional outcome. The primary between-group result was not statistically significant; some sensitivity analyses suggested worse gains, with more minor adverse events. [24, 25]	Keep rapamycin outside the general self-care protocol. Human longevity benefit and an acceptable long-term preventive regimen remain unestablished.
Partial reprogramming: initial human observations, October 8, 2026	Life Biosciences reported interim ER-100 observations in three glaucoma participants through day 56, including preliminary visual-field improvement in two. This is a sponsor announcement from an open-label phase 1 study, not controlled proof of efficacy. Short follow-up in three people cannot establish long-term safety. [26]	Update the old statement "no human data." There are now early observations; reliable evidence of general human rejuvenation is still absent. Track registered trials, not a promised consumer-treatment date.
Biological-age clocks and supplements	A post hoc DO-HEALTH analysis in 777 older adults found small changes in several methylation measures with omega-3 over three years. CALERIE found a small change in a pace-of-aging measure with calorie restriction.	Do not purchase supplements or restrict calories solely to improve an age score. Treat clocks as research measurements rather

Development	What the evidence actually shows	OMD decision now
	These measured biomarker effects are not equivalent to demonstrated extra lifespan. [27, 28]	than a personal health verdict.
NAD⁺ boosters, including NMN	A September 25, 2026 randomized trial in adults aged 65+ found that 24 weeks of NMN raised blood NAD ⁺ metabolites but did not significantly improve its primary hearing endpoint or physical performance. Other nominal findings did not survive correction for multiple testing. The study had commercial funding. [29]	NMN and related “longevity stacks” are not required. Consider the opportunity cost compared with an unresolved health or training need.

Fasting and calorie restriction: Weight reduction can be appropriate when excess adiposity is harming health. The aim is a sustainable improvement while maintaining adequate nutrition and muscle. For a healthy-weight, active person, chronic restriction or multi-day fasting is not a default longevity recommendation. A biomarker result does not override worsening strength, fatigue, menstrual function, mood, or recovery. [18, 28]

Other marketed options: This general protocol does not require sauna, cold plunges, red-light devices, unapproved peptides, exosome products, or commercial “rejuvenation” procedures. An optional experience can have value for enjoyment or a specific supported indication; buying it is not a prerequisite for following OMD.

When to change the protocol: Upgrade an intervention when relevant human studies show a meaningful benefit with acceptable harms, and the result is sufficiently credible and applicable to change a decision. Preserve the distinction between a peer-reviewed trial, a trial registration, a preprint,

and a company announcement. Recheck the research periodically; daily news consumption is not necessary for a good daily protocol.

A small feedback system

Track only what helps you decide. A useful weekly record can fit on one line:

Sleep pattern | aerobic minutes | strength sessions | energy or function | pain or fatigue | next adjustment

If you track weight or waist size for a specific reason, interpret trends rather than daily fluctuations. Stop or simplify tracking that creates anxiety without improving decisions. A wearable is optional; recovery scores and sleep-stage estimates are not diagnoses.

For a small behavior experiment, write one question, one change, an observable outcome, and a review date. Example: "For two weeks, I will take a short walk after lunch on weekdays and note whether afternoon energy improves." An individual response is useful personal feedback, but it is not proof of an anti-aging mechanism.

Persistent worsening fatigue, recurrent injury, unexplained weight loss, or symptoms despite adequate rest call for clinical evaluation. Sudden chest pain, severe shortness of breath, or stroke-like symptoms require urgent care rather than a protocol adjustment.

Changes from the existing OMD notes

This protocol carries forward the mission, attention to physiological reserve, evidence honesty, accessible habits, and the importance of freedom and happiness.

It makes four substantive updates:

1. **Testing is driven by decisions.** The earlier equipment and blood-panel lists are not treated as universal minimum requirements.
2. **The 12-hour eating window is optional.** Adequate nutrition, recovery, and adherence determine whether it is useful.
3. **The geroscience update includes both encouraging and negative findings.** Senolytic evidence varies by population and endpoint; early reprogramming observations are now available.
4. **No treatment timeline is promised.** Entry into human trials does not establish when an effective, affordable, broadly applicable therapy will exist.

The source pages were used as a philosophy and knowledge map. Their full 159-paper corpus was not independently re-audited for this document. Actionable recommendations and selected current developments were checked against the sources below. Existing source pages have not been rewritten.

Confidence: Approximately **90% subjective confidence** in the overall recommendation to prioritize these foundations over optional longevity interventions for generally healthy adults. This is an editorial judgment, not a calibrated probability, a clinical evidence grade, or an estimate of personal lifespan benefit. Confidence in the exact schedule is lower because preferences, baseline health, and constraints differ.

Sources

OMD source documents

- One More Day、ワンモアデイ
- Biology of Aging (Geroscience) — Knowledge Notes
- One More Day — Healthspan Full Guide

Human evidence and official guidance

1. **CDC.** Benefits of Quitting Smoking. [Official guidance](#).
2. **WHO Europe.** Alcohol and cancer, 2025. [Official fact sheet](#).
3. **WHO.** Physical activity; 2020 guidelines and current fact sheet. [Official guidance](#).
4. **CDC.** Adult Activity: An Overview. [Official implementation guidance](#).
5. **ACC/AHA and partner societies.** 2026 Guideline on the Management of Dyslipidemia. [Official guideline announcement](#); [guideline](#).
6. **USPSTF.** Hypertension in Adults: Screening, 2021. [Recommendation](#).
7. **USPSTF.** Prediabetes and Type 2 Diabetes: Screening, 2021. [Recommendation](#).
8. **CDC.** Adult Immunization Schedule by Age. Use the live schedule and local clinical advice. [Official schedule](#).
9. **WHO Commission on Social Connection.** From loneliness to social connection, 2025. [Report](#). Social connection has broad health relevance; mortality evidence is substantially observational.
10. **American Dental Association.** [Home Oral Care](#) and [Dental Floss/Interdental Cleaners](#).
11. **Endocrine Society.** Vitamin D for the Prevention of Disease, 2024. [Clinical practice guideline](#).
12. **FDA.** Full-Body CT Scans: What You Need to Know. [Official guidance](#).
13. **American College of Radiology.** Statement on Screening Total Body MRI, 2023. [Professional guidance](#).
14. **AASM/Sleep Research Society consensus panel.** Recommended Amount of Sleep for a Healthy Adult, 2015. [Consensus statement](#). See also [NIH/NHLBI adult sleep-duration guidance](#).
15. **WHO.** Healthy diet, updated January 26, 2026. [Official guidance](#).
16. **Estruch et al.** Primary Prevention of Cardiovascular Disease with a Mediterranean Diet Supplemented with Extra-Virgin Olive Oil or Nuts.

NEJM, 2018. Corrected/re-published PREDIMED report. Human trial in older adults at high cardiovascular risk; randomization irregularities led to reanalysis.

17. **NIH Office of Dietary Supplements**. Dietary Supplements for Exercise and Athletic Performance. Professional fact sheet. Training and nutrition guidance, not proof of lifespan extension.
18. **Liu et al**. Calorie Restriction with or without Time-Restricted Eating in Weight Loss. NEJM, 2022. Randomized trial.
19. **American Academy of Dermatology**. Sunscreen FAQs. Official guidance.
20. **Baker et al**. Structured vs Self-Guided Multidomain Lifestyle Interventions for Global Cognitive Function: The US POINTER Randomized Clinical Trial. JAMA, 2025. Human RCT.
21. **Lincoff et al**. Semaglutide and Cardiovascular Outcomes in Obesity without Diabetes. NEJM, 2023. SELECT human RCT.
22. **Koning et al**. Senolytics dasatinib and quercetin in metabolic dysfunction-associated steatohepatitis: a proof-of-principle randomized, controlled trial. Nature Metabolism, October 1, 2026. Paper record; author-institution abstract.
23. **Farr et al**. Effects of intermittent senolytic therapy on bone metabolism in postmenopausal women: a phase 2 randomized controlled trial. Nature Medicine, 2024. Human RCT.
24. **Moel et al**. Influence of rapamycin on safety and healthspan metrics after one year: PEARL trial results. Aging, 2025. Human randomized trial. Exploratory outcomes and industry relationships warrant attention.
25. **Stanfield et al**. Exercise and Weekly Sirolimus (Rapamycin) in Older Adults: RAPA-EX-01 Randomised, Double-Blind, Placebo-Controlled Trial. Journal of Cachexia, Sarcopenia and Muscle, 2026. Human RCT.
26. **Life Biosciences**. First-in-human ER-100 interim data, October 8, 2026. Sponsor announcement; trial registration NCT07290244. Preliminary, uncontrolled, sponsor-reported observations.

27. **Bischoff-Ferrari et al.** Individual and additive effects of vitamin D, omega-3 and exercise on DNA methylation clocks of biological aging in older adults from the DO-HEALTH trial. Nature Aging, 2025. Post hoc biomarker analysis of an RCT.
28. **Waziry et al.** Effect of long-term caloric restriction on DNA methylation measures of biological aging in healthy adults from the CALERIE trial. Nature Aging, 2023. RCT biomarker analysis.
29. **Igarashi et al.** Sustained NAD⁺ augmentation by high-dose nicotinamide mononucleotide supplementation in older adults: a 24-week randomized, double-blind, placebo-controlled trial. npj Aging, September 25, 2026. Human trial. Included to identify the research direction; no dose recommendation is inferred from it.