Insulin Dependent Diabetes Trust

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Weight and Diet

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A National Opinion Poll survey in 1999 showed that one third of us believe that margarine is a high fat food, so proving the misconception still persists that margarines and soft spreads are lower in fat than butter. The survey also showed that the British public is still confused about healthy eating. It is IDDT's experience that for many people this confusion still exists.

There are many differing views on diet and on weight loss particularly in the treatment of both Type 1 and Type 2 diabetes.

There is increasing evidence that reducing or controlling carbohydrate intake is better for people with both types of diabetes which was the recommended diet twenty years ago.

Carbohydrate counting is returning to the treatment of diabetes but this requires greater education of people with diabetes.

Dietary information

The 1997 World Health Organisation Report declared that obesity and diabetes has reached epidemic levels. Obesity is now overtaking smoking as the most important avoidable cause of ill health. It is associated with high blood pressure, Type 2 diabetes and many other problems such as arthritis, breathing difficulties and depression. Almost 80% of people with Type 2 diabetes are obese at diagnosis although many people are unaware that obesity is a risk factor for diabetes.

In 1994 almost 13% of British men and 16% of women were obese – a doubling since 1980. Being overweight affects one in three of the British adult population. It is thought that populations are generally eating less but exercise levels are lower than they have ever been suggesting that obesity is really caused by inactivity – we eat more food than we use up in energy.

What is the difference between obesity and being overweight?

- Obesity is having a body mass index (BMI) greater than 30
- Over weight is having a BMI of between 25 and 30.
- Acceptable weight is having a BMI between 20 and 25
- Underweight is having a BMI of less than 20

BMI is your weight in kilograms divided by your height in metres squared (7kg = 14pounds). A much simpler definition of obesity is a waistline over 40 inches in men and over 35 inches in women!

Fats

Fats are a very important part of healthy eating in reducing the risks of heart disease and keeping blood cholesterol levels down. As people with diabetes have an increased risk of heart disease, it is particularly important to understand about the fats in our diet.

Fats provide some of the energy our bodies need. The healthy eating guidelines recommend that we should eat less fat, especially saturated fat in order to reduce this risk of heart disease. This can best be achieved by eating a varied diet with plenty of fruit, vegetables, whole grain cereals, pasta, rice and potatoes.

What is fat?

- Fats come in both solid and liquid forms – solid fats include butter, lard and the fat visible on meat. Liquid fats include sunflower, corn and olive oils.
- Fats can also be divided into visible and invisible fats. Visible fats, such as butter and the fat on meat are easy to spot and cut out but invisible fats, such as those in cakes, biscuits, dairy foods like cheese and fried foods are more difficult to see and we may not even be aware that they are present in some foods.
- Fats can also be divided into four types – polyunsaturated fats, saturated and trans and monounsaturated fats.

Polyunsaturated fat – comes mainly from vegetable sources such as sunflower oil or seeds and is also found in oily fish such as mackerel or sardines. There are two different groups of polyunsaturates containing fatty acids that are essential to our health and they must be obtained through the diet we eat because the body cannot make them. One type of polyunsaturates found in the oils can reduce blood cholesterol levels. The second type found in oily fish appears to have no effect on blood cholesterol although they do make the blood less ‘sticky’ which in turn, makes the blood less likely to clot and block the blood flow to the heart.

Saturated fat – is found in foods from animals such as meat, cheese, butter and cream. Many baked goods such as cakes, biscuits and pastries are also high in saturated fats. Excessive intake of these fats can increase the ‘bad’ cholesterol levels [LDL] and heart disease.

Trans fats – also called ‘hidden fats’ or ‘trans fatty acids’, behave in

a very similar way to saturated fats and they too have been linked to raised ‘bad’ cholesterol levels [LDL] and heart disease. They are made from vegetable oil and found in nearly all convenience foods but also occur naturally in some dairy products and in beef and lamb. Just one gram of trans fats a day can increase the risk of heart disease. It is not difficult to eat one gram a day - a KFC of crispy strips of chicken and fries contains 4.4.gms of trans fat, McDonalds McNuggets and fries 3gms and a Burger King Whopper with fries 2.3gms.

Trans fats are being cut from many well known food brands such as Horlicks, Mars and Weetabix but beware because it is not compulsory for manufacturers to list trans fats on their food labels.

Monounsaturated fat – this is found in significant amounts in most types of nuts, oily fish, avocados and olive oil. It does not raise blood cholesterol and there is some evidence to show that it may also help to reduce cholesterol levels.

More facts about facts

Food manufacturers alter foods to produce lower fat versions of standard foods that are high in fats, such as cheese, mayonnaise, biscuits and crisps. It is often the fats in foods that make them taste so nice, smell nice and give a creaminess to the texture so manufacturers use a ‘fat replacer’ to make them taste better and attractive enough for us to want to eat them. Other low fat products such as skimmed milk, do not have fat replacers as the fat content is reduced by simply removing the fat eg in low fat crisps the fat content is lowered by reducing the amount of fat left on the crisps, leaving the actual contents of potatoes, vegetable oils and salt the same. Needless to say, the food manufacturers have spent years finding fat replacers that satisfy our taste buds and there are different ways of doing this.

Mimicking the effect - these fat replacers are designed to mimic the texture and effect of fat. They are usually based on carbohydrates and proteins and may be extracts of fruits, oats or seaweed. They are listed on the food labels as whey powder, gelatin, lecithin, starches, carrageenan, cellulose, guar gum, locust bean gum and maltodextrins. These additives are also used in standard foods but they have a more critical role to play in low fat foods. These types of fat replacers cannot usually be used in frying or baking because the heat affects them.
In some foods water and fats are mixed into an emulsion to give the impression of creaminess but when the fat is reduced the consistency is not the same so emulsifiers are used [eg lecithin] in spreads sauces and salad dressings.

Fats also have a slippery feeling in the mouth and protein replacers, such as milk protein whey, are used for this purpose. The small particles of protein in the whey act like ball bearings and slide over each other to feel like fat on the tongue. These are used in yogurts, ice creams and mayonnaise.

Modifying the fat - new technology has focussed on developing fat-based fat replacers that work in the same way as fats. They have the same texture as fats but can be used for frying and baking. They have been chemically modified to give fewer calories than standard fats. These sound promising but there are some problems yet to be solved because one product, Olestra approved in the US but not used in the UK, is not absorbed into the blood stream and passes out of the body unchanged. This can cause unpleasant side effects.

Hopefully this will help you to know a little bit more about the products you are buying to try to reduce your fat intake.

Obesity and weight loss drugs

Is there uncertainty?

There are constant warnings that obesity and overweight will shorten our lives unless we take action and this is almost unquestioned. However research [Journal of the American Medical Association, June 2005] suggests that the obesity epidemic and its dangers may not be quite as it has been painted.

The research showed that if you are classed as overweight, you may have a lower risk of premature death than those classed as having a healthy weight and it also showed that in the long term, not dieting may be better for your health than trying to lose weight. In other words, people who had tried dieting tended to die younger than those who had not!

The researcher suggests that it is far from certain that obesity and overweight take any measurable toll on mortality and even severe obesity failed to show up as a statistically significant mortality risk. In fact, the statistic that obesity has been responsible for 400,000 extra deaths a year has been radically revised downwards and this is not what we expect!

A possible explanation is that there are more than a hundred risk factors for heart disease eg poor diet, lack of physical fitness, stress and some gene variations but most studies linking heart disease to obesity lump all these risk factors in with obesity. However, this recent study separated out the various risk factors which then gave a very different picture showing that the number of deaths linked to moderate and severe obesity ranged between 22,000 more to 7,000 fewer deaths. There is obviously a wide margin of error and these results are controversial but what this does imply is that there is uncertainty.

Clearly if you are overweight, smoke, eat poor food and don't exercise, then you are more at risk of illness but if you are overweight, or even obese with a healthy lifestyle, then this risk becomes less certain. It remains to be seen what effect, if any, this research will have.

Weight loss / anti-obesity drugs

There has been a rise in the number of anti-obesity pills being prescribed. For example, the number of NHS prescriptions for overweight people in Scotland has increased fivefold in the last 5 years - doctors gave almost 90,000 prescriptions for anti-obesity drugs last year at a cost to NHS Scotland of £4.1million. In 2001 there were just 18,000 prescriptions costing £765,732. Despite this huge increase, there are questions about whether drugs alone can combat obesity and that these drugs are given to appease people when what they really need is support to make long-term lifestyle and eating behaviour changes.

All these drugs have some side-effects, as listed below, and people who have come off the drugs after losing weight have found that the weight quickly goes back on.

The Scottish Executive has said that these drugs should only be used as part of a weight management programme and only be given to people who have made serious attempts to lose weight by diet, exercise and other changes in behaviour. Dr Andrew Walker of Glasgow University, is quoted as saying that while these drugs play an important role in treating obesity, they are fairly drastic and were really designed for people who are very obese.

The National Institute for Clinical Excellence states that drug therapy for weight loss should be considered for patients who have not reached their target weight loss, or have reached a plateau with dietary, activity and behavioural changes alone.

The anti-obesity drugs are:

Xenical [orlistat]- was given marketing authorisation in 1998 and costs the NHS around £40 a month. It blocks the enzyme that digests fat so stopping a third of the fat eaten from being digested. It can cause flatulence and frequent bowel movements and if a high fat meal is eaten while on the pills it can lead to incontinence.

Reductil [sibutramine] – was given marketing authorisation in 2004 and costs around £50 a month. It works by boosting serotonin levels so making slimmers feel satisfied with less food. Side effects can include raised blood pressure and heart rate, headaches, dry mouth, constipation and sleeplessness.

Acomplia [rimonabant] - the most recent drug, costs about £55 a month. It targets the endocannabinoid system which governs the body's appetite. It taps into the same brain system as cannabis and critics say that it may alter moods. A recently published Cochrane Review of Acomplia found that after one year it produces modest

weight loss of about 5% of body weight and only the higher dose of 20milligrams produced significant weight loss - 1.5 inches on the waistline - and slightly reduced blood pressure. However the higher dose brought on more, and more serious, side effects than both the lower dose and a placebo. The side effects included nausea, dizziness, headache, joint pain and diarrhoea but more serious side effects included psychiatric and nervous system disorders. All the studies were funded by the manufacturers, Sanofi-Aventis, so this is possibly the drug in its best light!

Acomplia has not been compared to other less expensive drug treatments for obesity. The Drugs and Therapeutics Bulletin has previously concluded that Xenical [orlistat] is a reasonable option for obese people where diet, exercise and/or behavioural methods alone have failed. When re-looking at Acomplia it still maintains that Zenical is a better choice because it has the most evidence for safety and efficacy.

Acomplia went on sale in July 2006 in Europe and in the UK was approved for use in the NHS. However, health insurers in Germany refused to fund it, in Denmark cost reimbursement is only in overweight patients with life-threatening obesity-related conditions and in the US the drug regulatory authority, the FDA, refused to licence Acomplia [Zimulti in the US] because of adverse effects. In some people it prompted suicidal behaviour and caused other psychological side effects such as depression, anxiety, irritability and insomnia. In a study of 120 people using Acomplia, two committed suicide, one was considering it and another attempted to strangle his daughter. The manufacturers, Sanofi-Aventis, has withdrawn its application to sell Acomplia in the US.

Latest news on Acomplia in Europe and the UK

In July 2007 the European Medicines Agency [EMEA] issued a warning that Acomplia heightens the risk of suicide among those also taking anti-depressants but stopped short of suspending the drug. Finally, in 2008 the EMEA suspended Acomplia at last acknowledging the serious side effects it may cause.

Just follow the rules, not easy

By Jenny Hirst

One report maintains that most of the benefits from weight loss achieved through dieting come with the first 5-10kg lost, but because dieting is stressful, 90% of people fail to achieve this, or if they do, they usually put the weight back on within a year. People with diabetes are no different to the rest of 90% of the population who fail. Or are the incentives of the long-term complications sufficient to keep us on the straight and narrow year in and year out, especially for those who not only have to adhere to the healthy diet but also to a weight reducing diet too?

For some of us, looking to the future is sufficient to enable us to stick to the diet, but not for everyone nor is it sufficient to just hand out a diet sheet and an explanation of what we should do. If you are 15 years old ‘the future’ looks a long way off when all your friends are eating burgers at 3 o’clock in the afternoon. If you are 45 years old when diagnosed, you have a lifetime of eating habits, and possibly drinking habits, that have to change. A diet sheet alone does not bring about these changes.

For me, as the mother of a child, now grown up, diet always produced conflicts and guilt.

Conflicts and guilt

My memory of meeting a dietitian for the first time was when my daughter was in hospital 33 years ago at diagnosis. I couldn’t believe my eyes – she was very pleasant with an attractive face and she kindly went through the diet with me which, in those days, was much more restricted. But she was, to put it bluntly, fat. I realise that Mum’s are sensitive at diagnosis but I could hardly contain my anger! How dare she tell me about the need for a strict diet for my little girl, which as she pointed out, would be healthy for the whole family, when she was fat?

She then told me to cut out all sweet stuff, cakes, puddings and

above all thickening in the gravy. I know this sounds ridiculous now but she said it! It caused me real problems because I was brought up in Yorkshire and was taught from very early days that the way to a man's heart was through his stomach and what could be better than roast beef, Yorkshire pudding and good thick gravy? Remember I had a husband and a son to think of as well as my daughter, so I really had great conflicts going on in those first few months.

What was I to do?

- I couldn't give my daughter thickened gravy.
- I couldn't give her different gravy from the rest of the family and make her 'different'. I couldn't give the men thin gravy as it was against all my Northern teachings – I might lose a husband and my son would never learn the value of good thick gravy!
- I couldn't disobey the dietitian.
- In the end I resolved the conflict and we all had good thick gravy but this then left me with a huge sense of guilt because I was disobeying the dietitian's orders. I always felt that I should confess at the clinic, but I never did.

So diet and dietitians have always made me feel pretty bad. The dietary advice conflicted with my cultural background and I had difficulty resolving this. Whichever way I had resolved it within the family, I would have felt guilty. The fact that I did not confess my disobedience at the clinic just added to this guilt.

Feeling inadequate, confused and a bit dim!
To add to this, dietary information always makes me feel pretty inadequate, confused and a bit dim. They keep changing the goal posts! I realise that knowledge has improved over the years and research has shown the benefits of the present healthy eating recommendations. I don't have a problem with that but we do seem to be getting mixed messages.

- If we are supposed to eat the healthy diet recommended for the rest of the population, why do diabetes magazines have pages of recipes in glorious technicolour?
- Why did we stop counting carbohydrates? Well some of us never did and it is interesting that carbohydrate counting appears to be coming back!
- How are the newly diagnosed supposed to balance their insulin and their carbohydrates if they don't know what is in it?
- Now we have the glycaemic index and I have to admit that the title alone is a total seems complicated for many of us.
- What is wrong with talking about simple things like fast acting or long acting carbohydrates, fats and proteins?

So if you are feeling the pressures of the diet for your diabetes, you are not alone!
Here are just a few of the things I have learnt over the years:

- The dietary information needs to be simple. We need to know the basic food information about carbohydrates, fats and proteins in a language that we, the patients or carers, can understand.
- If you are a man with diabetes and your partner does the cooking, she needs to know what you should and should not eat to avoid undue anxiety on her part from lack of dietary knowledge. If you are a woman with diabetes, then you probably feel the pressures to cook 'ordinary' food for the rest of the family and this may make diet more difficult for you.

To our advisers I say:

- Don't expect too much of us. Set targets that we can achieve so that we don't always feel to be failing. Recognise that if we know what we should do, and don't do it, we probably feel bad about ourselves anyway, so don't be judgmental.
- Recognise that changing eating habits may cause confusion, conflict and guilt for all sorts of reasons – cultural, social or working circumstances. That bingeing on sweet stuff can be a compensation for frustration, sadness or boredom in people with diabetes just as much as those people without it.
- Recognise that some rules do actually make it easier for people

than to just have a system of 'healthy eating'. Too much freedom can cause confusion and anxiety, whereas rules can give a sense of security.

- Remember that just because healthy eating is good for everyone, does not make it easier for people with diabetes. We do not really have a choice, unlike the general population, so this does make it different and more difficult. We HAVE to eat a healthy diet.

Planning to lose weight

By Katharine Morrison - a GP with a son who has Type 1 diabetes
Becoming and keeping slim is of even greater benefit to people who have diabetes than the general population. Abdominal obesity promotes insulin resistance and insulin resistance promotes abdominal obesity. Worsening of blood sugar control and the insidious death of overworked pancreatic beta cells results.

Most people know what to eat and what not to eat to stay thin. They just don't follow their plan consistently enough says weight loss doctor Stephen Gullo. He asks his patients, "Do you really love this food so much that you want to wear it?"

He has many tips and strategies to help people succeed and these are published in his best selling book, "The Thin Commandments."

Keeping a written record of all the food you consume is a good starting point. Instead of grazing throughout the day or alternatively delaying and missing meals he recommends planned eating about every four hours. The food of course cannot be any old thing that is around. You must plan ahead. A simple and obvious thing to do, isn't it?

Yet, many things seem to get in the way of such a straightforward action plan - emotional eating, food cravings, distractions, huge portions, just plain boredom. Every meal is a weight losing, gaining or maintaining opportunity. You have the choice.
It can be difficult to deal with carbohydrate and other cravings especially if you are sleep deprived or stressed. A high protein or high fibre breakfast can help. Protein shakes are portable and can blunt that sweet tooth. It is much easier not to buy food that you overeat rather than attempt to resist it once it is in your cupboard. High sugar or fructose plus fat seems to be the worst combinations for craving which stimulates fat storage. This combination is widely available in processed and fast foods.

Many people are quite frugal eaters till they get home at night. By then they are starving and then there is no holding back. An afternoon snack around 4 pm can help especially if it is of the filling high protein/ high fibre type. Following this with an evening meal with high fibre vegetables, salad, and an adequate amount of protein will keep you going till morning without over doing the calories.
Hunger outside with meal times usually means you have underdone the protein or overdone the rapidly acting carbohydrate at the previous meal. Your daily protein requirement can be worked out by dividing your ideal weight in kilograms by six. If a woman weighs 60kg for instance she will need 10 oz of lean protein a day split between meals and snacks as a minimum. One egg is around one ounce of protein if this makes size estimation more meaningful.

When you shop for food go on a full stomach and don't buy naughty things for "someone else". Make a list and stick to it. For many people internet grocery shopping can help. What things do you find difficult to resist?

Apart from not actually buying and eating the stuff what else can you do to take your focus away from food? Social activities, exercise, self soothing activities and house and garden work are all possibilities. "Why are they so unattractive compared to eating a tube of Pringles in front of the telly?" I can't help but ask myself.
Dr Gullo insists that your lifelong success at weight control depends on how well you handle the foods that tempt you the most. For each

food that causes you a problem, you need to decide whether you can truly limit your consumption to special occasions or whether you need to eliminate that food entirely. This may seem rather harsh, but for virtually everyone a complete ban is actually easier than a plan to moderate consumption.

Here are three tips to control cravings.

- Is it hunger? Eat cold meat or a boiled egg.
- Desperate for something sweet? Rinse your mouth out with dry wine, lemon juice or vinegar.
- Desperate for something salty? Eat something sweet like a square of high cocoa chocolate or suck an artificial sweetener tablet.

If you do go ahead and guiltily get tucked into your personal equivalent of my Pringles problem, what do you do next? Many people will do the manana, manana thing. I've done it now, so I may as well have toasted cheese, the kids' smarties, the leftover quiche and start again tomorrow. No. No. No. Says Dr Gullo. You must get back on the wagon right away. This is not your last meal. There are lifetime consequences on your health you know. You need to eat foods that you like and are nutritious and that fill you up. And you must do this consistently.

The best foods to fill you up are white meat, fish and seafood, high fibre low starch vegetables and eggs. High calcium dairy foods, grapefruit and cinnamon can also enhance weight loss. Removing unnecessary fat from you meals by attention to cooking methods. Removing dressings and sauces also helps. Be careful to avoid alternatives such as "lite" dressings that are bulked out with sugar. Just cut them down.

Drinking water, eating meals that contain a fixed amount of calories and exercise are all strategies that help weight loss.

Once you are a weight you are happy with it can be just as hard to keep it off. To do this you need to keep to your good habits and not go back to your self defeating ways. Remember that it will be the same old stuff that is likely to trip you up. You may have lost a lot of weight but you will never lose your vulnerability to the old habits.
As a society we do tend to reward ourselves with food as we celebrate life events and relieve our misery over daily events. How can you reward yourself differently? How can you promote healthy eating habits to get the best out of your life?

Warning – skipping injections to lose weight

Diabetes UK estimate that 1 in 3 women with diabetes under the age of 30 in the UK are missing insulin injections at any one time, to help them lose weight with a high proportion of these are teenage girls. These figures are based on a small study carried out in Oxford in 1999. Nowadays it is referred to as 'diabulimia' and it is an eating disorder that can have serious health consequences. The reason for the weight loss is that missing insulin injections results in very high blood glucose levels and ketoacidosis, similar to the state before diagnosis so there is quite a large weight loss quite quickly. Although 'diabulimia' is not recognised as a medical and psychiatric condition, in the US doctors have issued warnings about this misuse of insulin.
With today's pressures to be thin, teenage girls and young women easily discover that not carrying out some or all their injections results in swift weight loss but those that have done it, admit that they feel ill a lot of the time, also tired and thirsty. One of the problems is that people who are doing this are unlikely to own up to it at the time but there will be many who admit that they have done it at some time in their lives. For parents who are wondering why their daughter's blood glucose levels are erratic, this could be one possible explanation.

Eating disorders

Eating disorders are bad news for anyone but an eating disorder with diabetes is particularly serious.

Basically eating disorders are serious preoccupations with food, weight and/or body image.

Clinically there are 3 types:

- **Anorexia** – self starvation triggered by an extreme fear of gaining weight
- **Bulimia** - a binge/purge cycle stemming from a fear of gaining weight.
- **Compulsive eating** – bingeing thought to be caused by a need to numb negative emotions and negative self-image.

However there is a range of eating disorders that happen to people with diabetes that do not fit into the 'clinical' definitions but need recognition.

A study published in the BMJ [June 9, 2000] showed that teenage girls with diabetes are twice as likely to suffer from eating disorders as non-diabetic girls of the same age. Experts warn that intensive treatment, which can cause weight increase, may be a contributory factor in the higher rates of eating disorders amongst young women with diabetes. They also warn that girls with diabetes and eating disorders are at greater risk of the early complications of diabetes with a threefold risk of permanent eye damage.

1545 Canadian girls between the ages of 12 and 19 were studied and they found that girls with diabetes were 2.4 times more likely to have an eating disorder. 10% met the medical criteria for diagnosis of an eating disorder compared with 4% of young women without diabetes. Even more worrying is that a third of the girls admitted to binge eating and 11% said they had either under dosed or stopped taking their insulin at some stage.

Michelle Tichy who has had diabetes since she was 7 years old, talks to IDDT about her experiences and eating disorders. We hope this will be of interest to many but especially parents of children and young people with diabetes and to those affected by one of the eating disorders and we are grateful to Michelle for sharing her experiences with us. The views are those of Michelle and are not necessarily those of IDDT, but we welcome this first-hand experience:

The first couple of years were OK aside from adjustments to the new routine and my parents increased fighting. I guess I blamed myself for their fights, I was always putting myself in the midst of these fights and often I tried to deflect their anger at each other on to myself. By the time I was 11 it was clear that they were headed to separation and divorce.

My response to the pain that this caused me was self-inflicted pain and a warped perfectionism. I developed an eating disorder that can best be classified as 'borderline anorexia' in that my symptoms were: rigid food rituals, strict rules about the amount of food eaten, purging, excessive exercising and extreme fear of gaining any weight. At the same time I developed a fanatical fear of ever getting high blood sugar, so I ran normal to low. My eating disorder continued for the next 7or 8 years, made worse by puberty and I actually delayed menses until 6 months after I turned 15 and this can be considered a symptom of anorexia. Since my weight never went below normal the only clinical diagnosis I ever received was 'borderline anorexia' and this was inaccurate because of the purging bulimia. This is one reason that I choose not to use clinical definitions for eating disorders that do not take into account the realities of all sorts of eating and body image problems.

My eating disorder was never caught by any of my doctors, in fact I was their star diabetic patient because I kept my blood sugars so close to normal! Even the dietitians missed the fact that I was barely eating enough to continue functioning. I never lied to any of them but I never offered any information to them about my Eating Disorder.

I cannot pin point the cause of my eating disorder to one thing specifically, the following are the main causes I see:

- Indoctrination by doctors on the importance of diabetics being thin.
- Society's standards of beauty.
- Stress/ perfectionism.
- My family falling apart.

I have been in recovery now for 3 years – it is rough at times.

My view of the connections between diabetes and eating disorders.
People with Type 1 diabetes have eating restrictions placed upon them by doctors generally from diagnosis. From my experience as a 7year old, it felt like I had been locked into a cage and was only allowed to eat certain things, none of which was 'fun stuff'.

More common eating disorders related to diabetes:

- Running high blood sugars [hyperglycaemia] so that your body produces ketones and in doing so there is weight loss.
- Reduction of insulin dosage so that you run high blood sugars and so that you don't have to eat very much.

My views on being healthy with diabetes and avoiding or overcoming body image problems and eating disorders

- Know yourself and what it feels like to be high or low.
- Respect yourself, neither an eating disorder nor ignoring diabetes is healthy.
- Doctors are resources to keep you healthy. If you don't trust yours enough to be able to talk to them, maybe you need a different one.
- Try to be the best you can – not some societal ideal.
- Remember to try to get something from each food group at each meal.
- Do everything in moderation from food to exercise. Find activities you enjoy to both 'de-stress' and be active [walking tennis etc]. Try meditation or yoga for stress relief and getting to know your body.
- Find people to talk with about your insecurities. Join a support group.

Alcohol and diabetes

Did you know that alcohol lowers the blood sugars?
Well, it does and naturally this can result in hypoglycaemia. The tendency to hypo after alcohol can be within 4-6 hours but blood glucose levels can remain low for 24-36 hours after significant alcohol consumption. The carbohydrates that the drink may contain do not offset the blood sugar lowering effect of the alcohol, so do not count these as part of your carbohydrate consumption and assume you will be OK.

In addition to the risk of hypos, alcohol impairs your judgement and so if you have diabetes, this means that you may not realise that you are having a hypo and so you will not treat it with sugary food. Furthermore, your friends may not realise that you are hypo and may simply assume that your 'odd' behaviour is because you are drunk. This is a dangerous situation and can result in a severe hypoglycaemic attack, unconsciousness, seizure and hospitalisation.

Having diabetes does not mean that you cannot or should not drink alcohol because this can affect your social life. However, it does mean that you should:

- Only drink in moderation, sensible advice whether you have diabetes or not.
- Learn by experience how alcohol affects you – everyone is different.
- Take the appropriate steps to prevent a hypo and if necessary lower your insulin dose at the meal prior to going out for a drink.
- The best time to drink is with a meal.

- If you are not having a meal with your alcohol, then it is a good idea to nibble carbohydrate [eg crisps] throughout the evening.
- Never drink alcohol before a meal.
- Have an extra bedtime snack before going to bed. Remember the alcohol could lower your blood glucose during the night while you are asleep, resulting in a night hypo. The alcohol may also make you sleep more soundly and so the hypo warnings may not wake you.

Interesting research about alcohol and diabetes
The Lancet [July 24,1999] reports on a study looking at the effects of alcohol in relation to coronary heart disease in people with late onset diabetes.

It has been recognised for some time that moderate alcohol consumption reduces the risk of death from coronary heart disease in the general population by 20-60%. Research from the US finds that a similar but stronger association exists in people with late onset diabetes. In 1984 -1986 983 people with late onset diabetes with an average age of 68 years were asked about their alcohol consumption during the previous year. They were then followed up for the next 12 years.

People who had never drunk alcohol and those who had drunk but now abstained had the highest death rate from coronary heart disease. The death rate in moderate drinkers [one to six drinks per week] was significantly lower and even lower in those who had seven or more drinks per week.

Before you get excited, the authors say that they do not recommend that people with diabetes take up drinking for health reasons because the study needs confirming by further research. They also warn that alcohol increases the frequency and severity of hypoglycaemia and impairs the warning symptoms of an impending hypo. Sorry to disappoint you!

Useful Research

LOW GLYCEMIC INDEX DIETS BETTER FOR WEIGHT LOSS
A new Cochrane systematic review from Australia found that the low glycaemic index diet [GI] is satisfying and has proven benefits. The glycemic index ranks foods rich in carbohydrate based on their effect on blood sugar levels.

Low GI foods, such as lentils, sweet potatoes and apples produce more consistent blood glucose levels compared to high GI foods such as white rice and French fries. Previous studies suggest that keeping blood sugar levels steady throughout the day may stimulate more weight loss so the reviewers evaluated randomized controlled trials that compared weight loss in people eating foods low GI foods to weight loss in people on higher GI diets or other types of weight loss plans. The conclusions were:

- Those eating low GI foods dropped significantly more weight - about 2.2 pounds more than those on other diets.
- Low GI dieters also experienced greater decreases in body fat measurements
- None of the studies reported adverse effects associated with consuming a low glycemic index diet.
- The low GI diet is more satisfying than other diets so people are less inclined to feel hungry and therefore are more likely to maintain this diet than other strict diets on which they feel hungry.
- Low GI diets appear to be effective even in obese people – obese low GI dieters lost about 9.2 pounds, compared with about 2.2 pounds by other dieters.
- People eating low GI foods experienced greater improvements in total blood cholesterol and LDL [bad] cholesterol.
- The message really is that the success of low glycaemic diets lies with the person's willingness to comply with its nutritional principles.
- Ref 1. Low glycaemic index or low glycaemic load diets for overweight and obesity. (Review) Thomas, DE, Elliott EJ, Baur L. Cochrane Database of Systematic Reviews 2007, Issue 3.

WEIGHT CHANGE AND DURATION OF OVERWEIGHT AND OBESITY IN THE INCIDENCE OF TYPE 2 DIABETES

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This study was carried out looking at Body Mass Index [BMI] in men between the ages of 40 and 59 drawn from one general practice in 24 British towns. 5 years after entering the study they filled in a questionnaire and the main outcome measure was the development of Type 2 during a follow up period of 12 years. The results showed that in the 6,916 men with no history or evidence of diabetes at the beginning, 237 of them developed Type 2 diabetes. Substantial weight gain [>10%] was associated with a significant increase in the risk of Type 2 diabetes compared with the men with stable weight. After the exclusion of men who developed diabetes early in the follow up, weight loss [4% or greater] was associated with a reduction in the risk of Type 2 diabetes compared with the stable group. The lower risk associated with weight loss was seen on obese and non-obese men and in men with normal and high non-fasting blood glucose levels. The risk of Type 2 diabetes increased progressively and significantly with increasing levels of initial BMI and also with the duration of overweight and obesity.

Insulin Dependent Diabetes Trust
PO Box 294
Northampton
NN1 4XS

tel: 01604 622837
fax: 01604 622838
e-mail: support@iddtinternational.org
website: www.iddtinternational.org