

NSA

Disease-Related Malnutrition

Diabetes – the best diet?

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“Diet is the cornerstone of management of diabetes”. Yet this area produces more heated controversy in management than any other in diabetes therapy. An enthusiasm for unnaturally high carbohydrate diets, together with dogma regarding beneficial effects of complex versus simple carbohydrates, has been gradually eroded by the demonstration that larger glycaemic loads elevate blood glucose levels more in the presence of the insulin deficiency, which characterises diabetes. With modern insulin therapy, in type 1 diabetes mellitus, the patient can now eat sucrose and adjust the insulin dosage to the carbohydrate load of the incoming meal as desired. Currently (despite much debate) there is no strong scientific evidence of long-term benefit from avoidance of carbohydrate foods labelled “high” glycaemic index, or even of short term harm from their ingestion, in diabetes. While large amounts of dietary fibre (>50gm) have been shown to benefit glycaemic control and lipids, studies have not yet shown patients undertaking long-term consumption at such levels.

Monounsaturated fats can be utilised to replace saturated fat. Reduction of the latter to <10% of energy intake remains a dietary instruction which hasn’t changed. N-3 fatty acids are best ingested through increased fish and plant sources rather than supplements.

Protein restriction is usually unnecessary and at an average 15-20% of energy intake should not be altered, except in renal failure, as people with diabetes may use more protein than normal. Weight management is of major importance in type 2 diabetes but is now a consideration in some patients with type 1 diabetes, partly reflecting the population incidence of obesity. Despite possible short-term effectiveness of various diet compositional changes to achieve greater weight loss, long-term studies (>1yr) show similar regain without use of medication or bariatric surgery. Diabetic subjects are less able to lose weight on a similar reducing diet than their non-diabetic spouses. Their genetic predisposition and the appetite-promoting diabetic medications are possible contributors to this phenomenon.

Finally, a commitment to a full assessment of the patient as a whole and genuine tailoring of the dietary prescription to the patient may be able to prevent the 50% noncompliance often reported with diabetic diet.