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DIETARY INTERVENTION IN LIPID CLINICS: A NATIONAL SURVEY OF DIETITIANS AND PHYSICIANS

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Management of hyperlipidaemia, especially if severe, is best initiated in a Lipid Clinic where a physician with special interest in these metabolic conditions, and a dietitian work as a team. Dietary intervention is generally said to be the mainstay in treating the majority of people with hyperlipidaemia (Consensus Panel 1992; the Expert Panel 1988; Study Group, European Atherosclerosis Society 1988). Dietary modification offers other advantages such as a reduction in sodium intake, an increase in dietary fibre intake and if necessary, a decrease in caloric intake. However, with the introduction of highly effective drugs for lipid lowering, the value of diet and of the dietitian's contribution may now be questioned, although diet and drugs can act synergistically (Clifton et al 1992).

Two self administered questionnaires, one for the physician and one for the dietitian were designed and sent to 24 Lipid Clinics across Australia. The dietitian's questionnaire had 25 questions about dietary assessment, dietary education, evaluation of dietary intervention at the clinic and a section for personal opinion(s). The physician's questionnaire had 12 questions that the dietitian was asked and another 7, including some on drug therapy. The response rate from physicians was 74% (n=14) and from dietitians 59% (n=10).

A major finding of the survey was that the recommended first line of therapy, 6 months of diet, was not practical in a high proportion of cases. The reasons include: (i) the type of hyperlipidaemia is considered resistant to diet, (ii) patients have been given dietary advice before coming to the clinic and are reluctant to have other treatment and (iii) because dietetic work is time consuming, patients are not seen by a dietitian at every visit and their dietary compliance is then assessed by another staff member.

Another finding was that techniques commonly used in dietetics, such as the diet history, were stated by respondents to be unsatisfactory tools for dietary assessment and intervention. Thirdly, estimates of compliance with the prescribed diet were not taking place, hence its success could not be determined.

Dietary intervention in Lipid Clinics could be enhanced by: (1) developing and testing protocols and management plans which are considered the most effective diets for different types of hyperlipidaemia, (2) maintaining an up to date list of food products, (3) improving techniques for monitoring dietary compliance, for instance by use of biochemical markers such as fatty acid content of blood lipids and (4) accumulating records about responses to diets so that dietetic work can be focussed where it is most likely to have a worthwhile effect.

For 1990s a number of issues must be considered with regards to defining which lipids are most useful for gauging compliance, how can the effect of diet be distinguished from the effect of drugs, how often should patients be seen at the different stages of dietary treatment and how long should diet alone be persisted with?

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