Best Tx Unclear for Disordered Eating in Type 1

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KEYSTONE, COLO. — Identifying adolescent type 1 diabetes patients with eating disorders is a lot easier than figuring out how to help them, according to several experts.

"It's a very difficult problem to treat, and none of us knows exactly how to do it," Dr. Denis Daneman said at a conference on the management of diabetes in youth.

Published reports of treatment success consist of a single case report of a positive outcome with fluoxetine, and a nearly 2-decade-old favorable result with cognitive-behavioral therapy in a small group of patients at the University of Oxford (England).

On the other hand, Dr. Daneman, chair of the department of pediatrics at the University of Toronto, and his colleagues saw no benefit at 6 months' follow-up in terms of glycosylated hemoglobin levels or rates of purging by insulin omission in a study in which 85 girls in a pediatric diabetes clinic who had signs of eating disturbance were randomized to a six-session intensive psychoeducation program or treatment as usual (Int. J. Eat. Disord. 2002;32:230-9).

Rita Temple-Trujillo said helping these young diabetes patients regain control typically involves a one-step-forward/two-steps-back journey. A major frustration, she added, is that traditional eating-disorder treatment programs are seldom helpful. The therapists simply don't understand that the etiology of disturbed eating behaviors in patients with insulin-dependent diabetes is very different from similar behaviors in their usual clientele.

She shared a recent discouraging experience in which, with some difficulty, she got a 20-year-old type 1 diabetes patient and her parents enrolled in an eating-disorders program, only to suffer a major setback.

"When they did the routine lab work and discovered [that her hemoglobin A_{1c} was high], they told us, 'She can't come into our program until she's metabolically stable,' " recalled Ms. Temple-Trujillo, a clinical social worker at the Barbara Davis Center for Childhood Diabetes, which cosponsored the conference along with the University of Colorado and the Children's Diabetes Foundation at Denver.

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The irony is that the eating disorder is the reason these young diabetes patients are metabolically unstable.

Dr. Daneman, who is also pediatrician-in-chief at the Hospital for Sick Children, Toronto, discussed the etiologic model of disordered eating in patients with type 1 diabetes that he and Dr. Gary Rodin developed more than 15 years ago. That model holds that the high rate of these pathological behaviors is driven in part by what he termed diabetes-specific vulnerabilities.

These include the insulin-related weight gain that typically occurs just after diabetes is diagnosed. Also, the shift from moderate control of blood glucose to intensive insulin therapy often results in weight gain, which exacerbates feelings of body dissatisfaction and promotes a drive for thinness. The diminished self-esteem accompanying any chronic disease is another factor.

"Nutritional counseling, I believe, is another core feature of diabetes care that lowers the bar," he said. For example, patients with diabetes are often taught about food differently than are people without diabetes. "And even though we try to demystify the diet and make it less rigid, we're still telling patients to count every gram of carbohydrate they eat. If that isn't dietary restraint, I don't know what is," the pediatric endocrinologist said.

He predicted that the much-anticipated development of the artificial pancreas will be "a magic bullet," which will make many of the problems related to disturbed eating behaviors in diabetes patients go away because they will no longer be able to manipulate insulin dosing to control their weight.

When the loop between the continuous glucose monitor and the insulin pump finally gets closed, insulin dosing will be governed by the meter readings without external interference. ■