Approaches at Odds in Eating Disorders, Diabetes

BY BRUCE JANCIN
Denver Bureau

KEYSTONE, COLO. — The disparate and often conflicting management philosophies for type 1 diabetes and eating disorders are evident in the contrasting meal plans traditionally advocated for individuals with one disease or the other, Stephanie H. Gerken said at a conference on the management of diabetes in youth.

Diabetes management focuses on numbers. Diabetic patients are taught to count and record calorie consumption, grams of carbohydrate, and minutes of exercise—not to mention blood glucose levels, glycosylated hemoglobin, and body weight.

In contrast, eating disorder (ED) clinics stay away from numbers altogether. In fact, at some ED clinics food labels are covered up so patients won't fret about them. In the diabetes world, however, reading food labels is taught as a core skill, noted Ms. Gerken, a diabetes educator and registered dietician at the International Diabetes Center, Park Nicollet Clinics, Minneapolis.

Diabetes patients are taught to count numbers; ED patients are encouraged not to worry about them.

MS. GERKEN

She is part of a joint team from the Park Nicollet diabetes and ED centers. Their goal is to improve outcomes in these challenging patients. A collaborative approach such as this is optimal, she said, because psychiatrists know little about contemporary diabetes care, while few pediatric endocrinologists are comfortable treating EDs.

Snacks are another huge issue for dual-diagnosis patients. The ED clinic view is snacks are essential for weight restoration and to reduce bingeing and purging. The meal plan for ED patients typically calls for three meals and three snacks daily. But the diabetes philosophy is snacks aren't necessary and require additional insulin injections.

Diabetic patients are taught to focus on one food group: carbohydrates. The ED treatment philosophy is that all seven food groups are important. Fat is an important dietary component for ED patients because it promotes satiety and weight restoration. Fat isn't encouraged in diabetic patients because of their increased risk of cardiovascular disease, she said at the conference sponsored by the University of Colorado and the Children's Diabetes Foundation, Denver.

Outpatient eating disorder meal plans are very big on desserts. They have to be, because they're aimed at bulking patients up and making eating more enjoyable. But one serving of a dessert can contain anywhere from 15 g to 80 g of carbohydrate. That's a real problem for a diabetic patient who's been withholding insulin for weight control and whose carbohydrate-counting skills have grown rusty.

Which of the dueling meal plan philosophies takes precedence depends upon how an individual's treatment is going. During the inpatient stay for an eating disorder—and the Park Nicollet recommendation is that all diabetic patients with an eating disorder should start treatment on an inpatient basis—the patient follows the eating disorders institute rules and meal plan; the diabetes team's goals at that point are mainly just to stabilize blood glucose and establish insulin doses.

Outpatient therapy in the Park Nicollet program entails weekly visits with a psychiatrist, a physician with a special interest in the medical side of eating disorders, and Ms. Gerken or someone else from the diabetes care team.

These disparate specialists communicate closely. As the patient's eating disorder behavior and body self-image improve, diabetes management can become more aggressive and the diabetes meal plan assumes a greater role.

The treatment outcome literature on dual-diagnosis patients is quite limited and shows only modest success. Progress, Ms. Gerken has learned, comes at a snail's pace.

"We have to do a lot of case management with these patients. You have to be patient and take your little successes as big successes. That might mean a patient is self-testing blood glucose one more time per day than last week, or taking one more insulin shot than a month ago. That's progress," she said. ■