

Carbohydrate intake in T2DM

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For people with type 2 diabetes (T2DM), knowing which dietary pattern to follow can be confusing. Given the complexity of the condition and the diversity of people affected, guidelines have increasingly focussed on a personalised approach to dietary recommendations. In this issue of the journal Hawkins and Zinn¹ argue for the active endorsement of low carbohydrate diets for those with T2DM in New Zealand and express their surprise that this is not currently occurring.

We wish to clarify and correct their concerns. The authors appear to be confusing ‘carbohydrate reduction’ with ‘very low carbohydrate’ or ‘ketogenic’ diets. The latter are not recommended as a long-term dietary strategy for T2DM; while the former (a focus on carbohydrate quantity and quality) forms the basis of guidelines from Dietitians NZ² and the NZ Ministry of Health,³ and have been incorporated into the New Zealand Society for the Study of Diabetes (NZSSD)’s Type 2 Diabetes Management guidance,⁴ to maintain consistency as evidenced based best practice.

We agree that very low carbohydrate diets improve glucose metabolism and insulin sensitivity in the short term in people with T2DM,⁵ but a long term condition requires a long-term strategy. A recent systematic review and meta-analysis has demonstrated that robust randomised-controlled trials designed to identify a change in HbA1c in those with T2DM are sparse, and comparisons are limited by different approaches to statistical analysis.⁶ The study referenced by Hawkins and Zinn¹, offering a low carbohydrate programme to people with T2DM, is certainly promising.⁷ However, only 39% of the cohort chose a low carbohydrate approach and of these 51% achieved diabetes remission. These outcomes are not unique to a low carbohydrate programme; similar results were seen in the robust cluster-randomised DiRECT trial, with a very different dietary approach.⁸

The critical factor is the same for almost any dietary intervention – those with T2DM must follow a dietary pattern they can maintain^{9,10} – a personalised diet approach that incorporates patient preference, income, co-morbidities, cultural suitability and nutritional needs, alongside regular professional contact and supportive behavioural change programmes.¹⁰ What is abundantly clear in these successful intervention studies is the degree of support required for optimal outcomes. Primary care is in crisis and dietitians are critically short across the country. Our most important advocacy for those with T2DM must be to address the underlying drivers of inequity, move the narrative from an individual blame to societal responsibility, and importantly address the workforce crisis.

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