

# Lifestyle Modification Urged for ‘Diabesity’

BY BETSY BATES  
Los Angeles Bureau

SAN DIEGO, CALIF. — “Diabesity,” as Dr. David Heber calls type 2 diabetes, is a lifestyle disease, not a diagnosis that necessarily requires heavy lifting of the prescription pad.

Too many physicians begin and end the conversation by saying, “You have diabetes and I have a drug for you,” he said at the Perspectives in Women’s Health meeting.

Obesity, which packs proinflammatory adipocytes around the heart, liver, and intestines, stands as the greatest threat to women’s health in the modern world, said Dr. Heber, professor of medicine and director of the University of California at Los Angeles Center for Human Nutrition.

It costs \$130 billion in the United States each year, impacting nearly every organ system in the body, including the reproductive system (Dr. Heber calls polycystic ovary syndrome “diabetes of the ovary”), musculoskeletal system, and the hepatic system, rapidly becoming a leading cause of liver transplantation.

Dr. Heber emphasized that judging patients by appearance alone, or even body mass index, will miss many women at in-

creased risk for cardiovascular disease and diabetes because of abdominal fat.

“Women have higher body fat than men at every BMI,” he said, quoting one study that found that 45% of women with normal BMIs had excess internal fat.

In his office, he uses a bioelectrical impedance meter to measure skeletal muscle versus fat tissue mass, from which calculations can be made for the number of calories per day required to reduce weight in a certain period of time.

The next step is to discuss with patients the need for lifestyle modification to preserve health in a way that they can envision.

Unfortunately, both emotions and nature work in opposition to weight loss, since “psychology trumps physiology every time. You eat when you are not hungry. Nature wants you to hold on to calories.”

Diabetes, he said, “is great genes in the wrong century.”

For many people, then, a whole restructuring of views about food must counteract impulses and a food industry that has conditioned us to crave foods that are sweet, bland, oily, and creamy “so that you can consume a large amount of food without realizing it,” Dr. Heber said.

## Brighten Mealtimes for Weight Loss

Dr. Heber encourages his diabetes patients to eat from the following color groups of fruits and vegetables:

- ▶ **Red.** Tomato products, soups, sauces, juices (contain lycopene).
- ▶ **Red/purple.** Red wine, grapes, berries, plums (contain anthocyanins, ellagitannins).
- ▶ **Orange.** Carrots, mango, apricot, sweet potato (contain  $\beta$ -carotene/ $\alpha$ -carotene).
- ▶ **Orange/yellow.** Citrus fruits, papaya, peaches (contain citrus

flavonoids).

▶ **Yellow/green.** Spinach, corn, avocado, green beans (contain lutein/zeaxanthin).

▶ **Green.** Broccoli, Brussels sprouts, cabbage (contain glucosinolates, indoles).

▶ **White/green.** Garlic, onions, chives, asparagus (contain allyl sulfides).

Dr. Heber tells his patients to avoid white and beige foods, such as white bread.

Focusing on fruits and vegetables, whole grains, fish, spices, and nuts in a color-coordinated diet (see box) can provide fewer calories and fewer proinflammatory foods, as described in Dr. Heber’s book for lay audiences, “What Color Is Your Diet?” (New York: HarperCollins Publishers, 2001.)

Replacing two meals a day (one per day for weight maintenance after weight loss) with high protein, low-calorie, meal replacement shakes makes the transition even easier.

Drinking thick shakes for two meals makes people want chewy, crunchy, colorful foods for snacks and the third meal of the day, he explained. Fruits and vegetables fit that bill.

The strategy also helps patients learn to self-monitor their eating and to better gauge portion sizes and estimate calories.

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## Apathy Found Common Among Diabetes Patients

BY TIMOTHY F. KIRN  
Sacramento Bureau

A study of 81 male veterans with diabetes showed that 61% of them exhibited clinically significant apathy, a psychological condition that might predict adherence to diabetic self-care.

“Clinicians and educators may want to screen for apathy routinely in clinical care of patients with diabetes, especially in patients with poor [glycemic] control,” Dr. Prasad R. Padala, of the Veterans Affairs Medical Center, Omaha, Neb., and colleagues wrote in the January issue of Diabetes Research and Clinical Practice.

The study was conducted by recruiting 100 patients from a diabetes clinic at the medical center. Each person was tested for evidence of depression and took three psychological tests—the Apathy Evaluation Scale (clinician version), the Hamilton Rating Scale for Depression, and the Self-Care Inventory, which rates adherence to diabetes management recommendations (Diabetes Res. Clin. Pract. 2008;79:37-41). Data from those tests were then correlated with patient demographic and laboratory data.

The average age of the 81 patients analyzed for the study was 59 years. Ninety-four percent were male, 88% were white, 11% were African American, and 1 patient was Hispanic; 19 patients found to be depressed were excluded from the study.

The cross-sectional study recorded a mean score on the Apathy Evaluation Scale of 36, and 50 of the 81 patients had a score above 30, which is the cutoff for clinically significant apathy.

Apathy was associated with a higher body mass index (34 kg/m<sup>2</sup>, compared with 30 kg/m<sup>2</sup> among those without apathy), a lower adherence to an exercise plan, and a lower adherence to administering the correct dose of insulin, Dr. Padala and colleagues said.

A statistically significant association between apathy and hemoglobin A<sub>1c</sub> level was not found, though there was a trend (8.3% in those with apathy vs. 7.64% in those without), Dr. Padala added.

Studies of other conditions, such as multiple sclerosis and parkinsonism, have suggested that apathy is a common feature of several chronic illnesses.

Apathy is characterized by a lack of initiative and motivation, emotional indifference, and decreased social engagement, the study said.

For clinicians who might want to screen patients with diabetes for apathy, the test that the study used takes too long to administer in a busy office. However, there is a short set of basic screening questions from an inventory developed for neuropsychiatric evaluation that clinicians can use (Neurology 1994;44:2308-14), Dr. Padala wrote.

The questions, which can be asked of either the patient or a caregiver, are: Has the patient lost interest in the world around him/her? Has he/she lost interest in doing things or does he/she lack motivation for starting new activities? Is he/she more difficult to engage in conversation or in doing chores? Is the patient apathetic or indifferent? A yes answer to any of those questions would call for more detailed testing. ■

