

Eating Disorder Risk Elevated in Type 1 Diabetes

BY BRUCE JANCIN
Denver Bureau

KEYSTONE, COLO. — A high index of suspicion for eating disorders is warranted in adolescents and young adults with type 1 diabetes, Stephanie H. Gerken said at a conference on the management of diabetes in youth.

The largest studies suggest the prevalence of eating disorders (EDs) meeting Diagnostic and Statistical Manual, Fourth Edition, criteria is about 10% in adolescent girls with type 1 diabetes. Another 14% have subthreshold variants. Both rates are roughly twice those found in nondiabetic adolescent girls.

The most common unhealthy weight-control practice among diabetic teens is intentional omission of insulin to lose weight. Many diabetic patients with weight concerns quickly figure out that skipping insulin injections is an easier way to drop pounds than restricting food intake or bingeing and purging, explained Ms. Gerken, a diabetes educator and registered dietician at the International Diabetes Center, Park Nicollet Clinics, Minneapolis.

The elevated risk of eating disorders in association with type 1 diabetes is not limited to adolescents.

"We've been surprised at how many adults we see in their 30s and 40s who've been struggling for over 10 years with this and are finally wanting and accepting help," Ms. Gerken said at the conference sponsored by the University of Colorado and the Children's Diabetes Foundation, Denver.

She is part of a joint team composed of staff at the diabetes center and at the Park Nicollet Eating Disorders Institute—Minnesota's sole inpatient ED treatment facility. The unusual multidisciplinary program was created in recognition that this is a particularly challenging group of patients adept at exploiting the often conflicting management goals for the two diseases.

Patients with combined ED and type 1 diabetes experience poor metabolic con-

trol, with serious long-term consequences. British investigators who followed 87 type 1 diabetic females aged 11-25 years for 8-12 years found 26% had a clinical ED or evidence of bingeing and purging at baseline and/or follow-up. Thirty-six percent admitted to misusing insulin for weight control. The group with disordered eating had a high rate of microvascular complications at follow-up in addition to two deaths because of renal disease, one from cardiovascular disease, and one suicide (Diabetes Care 2005; 28:84-8).

Personality characteristics that have been associated with eating disorders in adolescent girls with type 1 diabetes include perfectionism, negative and avoidant coping skills such as self-blame and wishful thinking, and borderline personality characteristics.

Family factors also figure prominently in girls with type 1 diabetes and an ED.

These patients tend to come from families who seldom eat together. The parents have a high level of weight-related concerns, are often dieting, and make negative comments about eating or weight.

"Every patient I work with has some kind of issues with the family," Ms. Gerken observed.

Eating disorders are notoriously tough to diagnose. Affected individuals will hide the evidence because of shame, denial, and a powerful desire to keep losing weight.

Red flags that a diabetic patient may have an ED include frequent low blood sugar levels, anxiety about getting on the scale, an increase in glycosylated hemoglobin together with weight loss, repeated hospitalizations for diabetic ketoacidosis, a drop in self-monitoring of blood glucose, and frequent "forgetting" to bring the blood glucose monitor or records to office visits.

Other warning signs include withdrawal from friends and family, irritability, bodily dissatisfaction, delayed puberty, unexplained menstrual or fertility problems, deteriorating school performance, compulsive exercise, and food stealing. ■



Diabetic patients with weight concerns will intentionally skip insulin injections to drop pounds.

DR. GERKEN

Diabetes Patients' Psychological Needs Not Being Addressed

BY CHRISTINE KILGORE
Contributing Writer

WASHINGTON — A significant number of patients with diabetes say they need help coping with the disease, but too few have such psychological needs addressed during initial diabetes education sessions, Mark Peyrot, Ph.D., reported at the annual scientific sessions of the American Diabetes Association.

"Most of patients' basic care needs are addressed" in diabetes self-management training, said Dr. Peyrot of the department of medicine at Johns Hopkins University, Baltimore. "But very little of their psychosocial needs are being addressed."

Dr. Peyrot reported that 44% of 178 patients in this study, which was based at the University of Pittsburgh Medical Center, chose "healthy coping" as one of the areas in which they wanted help.

Patients were asked to review the American Association of Diabetes Educators' seven "self-care behaviors"—which it uses in its patient assessment instrument and in its system for evaluating outcomes in diabetes education—and choose areas in which they wanted to set goals and learn skills. Patients could choose as many behaviors as they wished.

The interest in "healthy cop-

ing" was unexpectedly similar to the interest in "reducing risks" (49%), "being active" (46%), and "problem-solving" (41%).

Dr. Peyrot said that he expected interest in coping would be more modest. On the other hand, some areas—such as "monitoring" (chosen by 39%) and "taking medications" (chosen by 34%)—were rated "lower than what we'd expect," he said.

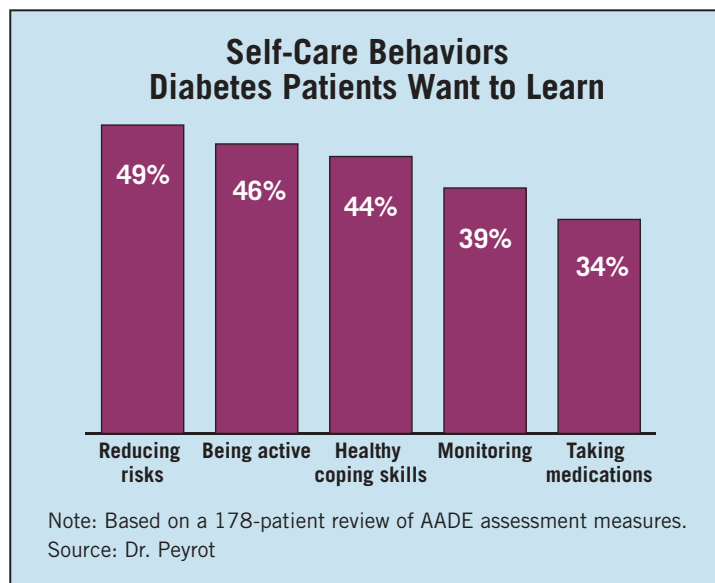
Diabetes educators' responses to patients' needs varied widely. In 94% of initial visits, educators addressed monitoring issues, for instance, and in 88% and 87% of initial visits they addressed exercise and eating, respectively. Medications were addressed in 75% of visits, problem solving in

44%, and risk reduction in 56%, said Dr. Peyrot, who is also director of the center for social and community research at Loyola College, Baltimore.

Although almost half of patients expressed psychological needs, coping was addressed in only 18% of patients' initial visits, he said.

"To a large extent, there was a standardized package being delivered to patients," he noted.

They were seen at four of the University of Pittsburgh Medical Center's diabetes self-management training programs, each of which uses the AADE's National Diabetes Education Outcomes System to track and assess diabetes education. ■



Topiramate Seems to Improve Sleep-Related Eating Disorder

BY SHARON WORCESTER
Southeast Bureau

SALT LAKE CITY — Patients with sleep-related eating disorder may benefit from topiramate treatment, a small study suggests.

Of 17 patients with chronic sleep-related eating disorder (SRED) who were treated with the anticonvulsant, 4 discontinued treatment due to lack of efficacy and 2 others stopped taking the drug because of side effects, including pruritus and weight gain.

The remaining 11 patients remained on therapy for a mean follow-up of 2 years, with all 11 achieving full or substantial control of SRED episodes. Ten of these 11 patients lost a substantial amount of weight (mean of 9.4 kg), Dr. Carlos H. Schenck reported in a poster at the annual meeting of the Associated Professional Sleep Societies.

Topiramate has been shown in previous studies to promote weight loss and control binge eating, and at least two case reports have suggested that it is helpful for controlling SRED. In the current study, the 17 patients presented with weight gain and non-restorative sleep as a result of SRED; 9 had failed prior therapies for the condition; and the other 8 received topiramate as first-line therapy, noted Dr. Schenck of the Minnesota Regional Sleep Disorders Center

and the University of Minnesota, both in Minneapolis.

Patients were initially treated with 25 mg topiramate at bedtime, with weekly increases of 25 mg as needed and as tolerated. The maximum dosage was 400 mg, with a mean dosage of 104.5 mg in the 11 patients who remained on therapy. Those patients had a mean age of 45 years, and nine were women. The duration of SRED ranged from 3 to 45 years, and 10 patients experienced nightly SRED episodes.

In 5 of the 11 patients, SRED was idiopathic, and in 6, the SRED was presumed symptomatic; eight other sleep disorders were present in these patients. These disorders included restless legs syndrome/periodic limb movement disorder in five patients and sleepwalking, narcolepsy, and primary insomnia in one patient each.

In addition, five patients had one or more Axis I psychiatric disorders, including four patients with a mood disorder, one with chemical dependency in remission, two with anxiety disorder, and one with a paranoid disorder.

Eight patients were using other medications at the time topiramate was initiated; these included benzodiazepines/agonists (five patients), dopaminergics (three patients), trazodone (three patients), antipsychotics (two patients), and daytime psychotropics (four patients). ■