



Richard Bernstein MD, FACE, FACN, CWS

Richard Bernstein, MD, FACE, FACN, CWS, says probably because of a 'rigid adherence to tradition,' the American Diabetes Association still feels that long-term diabetes complications could be avoided by reducing fat and substituting large amounts of carbohydrate which could be covered by taking 'industrial' doses of insulin.

Low-Carb Guru Weighs In On Controversy

I struggle to understand why you are publishing information recommending low-or no-carb meals for people with diabetes.

As someone who has taken insulin for 29 years, I would expect you most of all to understand the relationship between carbohydrate and insulin. I have to fight this confusion with my patients on a regular basis. Do you not agree that people with type 1 diabetes who take insulin are at high risk of hypoglycemia and ketoacidosis when they deplete carbohydrate from their meals? What happened to the knowledge that carbohydrate is our body's primary fuel source as well as B vitamins and fiber?

I truly wish that we would stop confusing our diabetes population by giving them so much conflicting information. Many of my patients are advised

to avoid carbohydrate to promote "weight loss" by most of our primary care and family practitioner physicians. Unfortunately, many of them are also on long acting insulin or sulfonylureas. These patients will be causing hypoglycemia and possible ketosis by following their physicians advise.

Also, many dietitians who read your publication will not agree with Joy Pape's "point of view." My request to you is to stop publishing articles that contain controversial, unproven, and possibly harmful advice. Let's give people clear, concise, proven, and recommended guidelines from health organizations with credibility, shall we?

Diane Schafer, LDN, RD, CDE

P.S. I thought we all knew by now that diets don't work.

We asked Richard Bernstein, MD, FACE, FACN, CWS, of the New York Diabetes Center in Mamaroneck, New York, to respond to Diane Schafer's letter:

I was present in the late 1940s when the American Diabetes Association (ADA) first recommended a high-carbohydrate diet. At that time, it was believed that the long-term complications of diabetes were due to the high cholesterol levels so common to people with diabetes. It was assumed that this was a consequence of dietary fat and that by dramatically reducing fat and substituting large amounts of carbohy-

drate, these complications would be avoided.

There never were, and still have never been, any studies supporting this hypothesis. So if anything is "un-proven," it is the ADA hypothesis. Except for a brief change of mind in 1975-76, it wasn't until the Diabetes Control and Complications Trial terminated that the ADA acknowledged that the real culprit might be high blood sugars.

More recently, studies comparing high- and low-carbohydrate diets have finally been performed and show that low-carbohydrate diets reduce both blood sugars (HbA1c) and conventional

cardiac risk factors. A number of these studies were actually published in ADA research journals such as *Diabetes Care*.

In spite of this, probably because of a rigid adherence to tradition, the ADA continued to raise carbohydrate guidelines and even now recommends the use of rapid-acting carbohydrate such table sugar, bread, potatoes, pasta, etc.. The new but unproven ADA hypothesis is that people with diabetes can keep blood sugars normal by covering large amounts of carbohydrate with “industrial” doses of insulin.

This never worked for me (I’ve had diabetes for 58 years) or for my thousands of patients. The reasons for this include the following:

1) We can never know the exact carbohydrate content of a meal. In the United States, labeling laws permit an error of +/- 20 percent of the carbohydrate content of a serving. For a typical ADA meal containing 150 grams of carbohydrate, the uncertainty is +/- 30 grams. One gram of carbohydrate will typically raise the blood sugar of a type 1 person by 5 mg/dl for a net uncertainty of +/- 150 mg/dl. Carbohydrate estimates in books are even more uncertain.

2) John P. Bantle, MD, professor of medicine, division of diabetes, endocrinology and metabolism at the University of Minnesota Medical School, demonstrated that for a given individual from day to day, the uncertainty of insulin absorption from typical ADA megadoses varies from +/-29 percent to +/- 39 percent. He further showed that the timing of action of these large doses is likewise highly variable.

Thus, it is the high-carbohydrate diets covered by megadoses of insulin that increase the likelihood of hypoglycemia. In the 20 plus years that I have been in practice, only five of my patients have had severe hypoglycemia causing loss of consciousness. Two of these people were eating excessive amounts of carbohydrate and three made major mistakes such as taking the wrong type of insulin. I’m sure this is a far cry from the incidence of severe hypoglycemia among patients of high-carbohydrate practitioners.

The ADA’s designation of high blood sugar—an A1C of 7% (corresponding to an average blood glucose of 170 mg/dl) when non-diabetics whom I have tested show about 4.2-4.8%—attests to its lack of interest in blood-sugar normalization.

This may further explain the ADA failure to give up on its high-carbohydrate diet. This likelihood is also supported by ADA opposition to blood glucose self monitoring (BGS) for 14 years—from 1969 when I first demonstrated it to their president until 1983 when pressure from patients became overwhelming. To this day, the ADA opposes BGS for the 90 percent of people with diabetes who don’t take insulin. As a result, Medicare will not pay for BGS for this 90 percent.

Doesn’t this suggest that all of us with diabetes have an “orphan” disease without strong organized support for our well being?

If some readers still consider this subject “controversial,” they should log on to the Internet (www.amazon.com and www.amazon.co.uk) and search at

these sites for my book “Diabetes Solution” to read what hundreds of Amazon readers over the years have been saying about the lifesaving effects of their new low-carb diets.

Remember, however, that lowering dietary carbohydrate without drastically lowering insulin doses and doses of other blood-sugar lowering medications can cause severe hypoglycemia.

Diabetes Interview asked Joy Pape to write a low-carbohydrate column for an obvious reason—it is essential to the best thing that can be offered to us short of a cure—normal blood sugars. ■

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