



**A Program for Managing Your Treatment: The Joslin Guide to Diabetes**

*Revised Fireside edition—2nd ed.; Richard S. Beaser, MD and Amy P. Campbell, RD, MS, CDE; 2005; ISBN-13 978-0-7432-5784-8; 431 pages; \$16.95*

I am delighted and honored to have been afforded the opportunity of reading and reviewing this valued text both from my perspective of my being a type-2 diabetic and my serving as a healthcare provider. This text is coauthored by a physician (MD) and a certified diabetes educator (CDE).

All due proper efforts and attempts have been made to provide detailed written and illustrated aspects of the self-care of type-1 and type-2 diabetes disorders in adults and children, and with pregnancy-, sexuality- and travel-related issues, such as:

- proper diet, including both carbohydrate and portion control (that is, weighing and measuring food-before eating both at home and in restaurants)
- proper care on sick days
- proper testing of blood glucose self-testing—both fasting and postprandial (after eating)
- proper exercise
- reasonably tight control of both blood glucose level and hemoglobin-A1C (%)

Clearly, the authors recognize that “The U.K. Prospective Diabetic Study (UKPDS) group established our need for tight glycemic control, showing that for every 1% drop in A1C there was a decrease in all diabetes-related endpoints including the risk of myocardial infarction, stroke and microvascular disease.”

I am looking forward to the third edition of this text in which it is to be hoped that the authors—rather than endorsing “if you smoke try to stop”—will consider the feasibility of endorsing “if you smoke cigarettes you must stop smoking cigarettes and you must abstain from all forms of tobacco including:

- no pipe smoking
- no cigar smoking
- no chewing tobacco
- no dipping snuff

Further—in the hoped-for third edition—I would like to see the authors consider the feasibility of moving toward our American College of Endocrinology (ACE) tight control goals for:

- fasting blood glucose levels as listed in the table below
- postprandial blood glucose as listed in the table below
- hemoglobin-A1C as listed in the table below.

I plan to keep this valued text close at hand for the education of my patients, challenged as I am with our diabetes disorders.

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This excellent companion to the diabetic patient is made up of 410 pages divided into 28 beautifully structured and well-written chapters, which are divided into six parts comprising of similar and related chapters.

The first three chapters are contained in part 1 of the book; chapter 1 deals with the team approach, emphasizing that the most important member of the team (i.e., the diabetic patient) should be an active team player as this has been shown to promote metabolic control. The second chapter, on the other hand, discusses the etiology, classification and pathogenesis of diabetes in simple language and a logical sequence without sacrificing the important messages. The relative roles of obesity, genetic factors, aging and other risk factors for type-2 diabetes have been presented in the normal day-to-day language without the usual medical jargon. Also, similarly discussed are insulin resistance, glucotoxicity and mechanism of insulin action. In the third chapter, the goals and tools for treatment are presented in simple language with a beautiful summary of the landmark studies in diabetes (i.e., the UKPDS and DCCT trials).

Part 2 contains the next eight elaborate chapters (chapters 4–11) summarizing the essentials of non-pharmacologic treatment of diabetes. In chapter 4, the fundamentals of nutrition and meal planning, and the central role nutrition plays in any diabetes treatment program are discussed in simple language. Emphasis is placed on such concepts as “free foods,” “carbohydrate counting” and the effects on foods on metabolic control. The concept of glycemic index, glycemic load and sensitivity, and correction factor are discussed in the fifth chapter. Chap-

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ter six, on the other hand, discusses the links between diabetes and heart disease and the role of lifestyle change in modifying this risk. The extra demands imposed by dining out and holiday eating and how to overcome them are highlighted in chapter 7.

Causes, effects and measurements of obesity and rational approaches to manage it are discussed in chapter 8, while the beneficial effects of physical activity on blood glucose control as well as cardiovascular well-being are convincingly presented in simple language in chapters 9 and 10.

The third part is made up of five chapters and deals with methods of treatment and monitoring of control of diabetes. The benefits and methods used in monitoring are discussed in chapter 12. The types, mechanisms of action and side effects of oral antidiabetic drugs are discussed in chapter 13, while the history, types, strengths and techniques of insulin injection are presented in chapter 14. Chapters 15 and 16, respectively, address the concept of “intensive” or physiologic insulin therapy and insulin pumps.

Part four deals with adjustment of treatment programs when targets are not met or complications result from or during therapy and is contained in five chapters. The symptoms, causes, home management and adjustments for hypoglycemia and hyperglycemia are presented in chapters 17 and 18, respectively.

The pathophysiology and roles of counterregulatory hormones during acute illness and their effects on diabetic metabolic control as well as “sick-day” rules are presented in a simple language in chapter 19.

Chapter 20 takes an extensive look at chronic complications of diabetes, reviewing evidence from the UKPDS and the DCCT trials and emphasizes risk factor control by regular blood pressure checks, good glycemic control, lipid management, eye and foot examination on a regular basis and proper manage-

ment of any anomaly detected.

The fact that the diabetic is more vulnerable to preventable foot sepsis and amputations, and how to prevent this are discussed in chapter 21.

The fifth part of the book deals with special challenges in diabetes in three chapters. The challenge posed by diabetes in childhood, pregnancy, and such issues as erectile dysfunction in males and women’s health issues are discussed in chapters 22, 23 and 24.

The last—but by the no means the least—part of the book deals with diabetes in the elderly in chapter 25, coping with diabetes in chapter 26, travelling with diabetes in chapter 27 and good diabetes care in chapter 28.

The book has a rich appendix and has defined some words and phrases used in the day-to-day care of diabetes.

The main weakness of the book is in the use of units presumably because it is meant for the American public where units of mg/dl instead of mmol/L are used for blood glucose levels. This may be confusing for the non-U.S. resident. In future editions, both units may be used to cater to all diabetics. The other weakness is the absence of practical advice for the fasting diabetic. Muslims make up more than a billion people today, and a significant number of them reside in the United States. Many are diabetic, and there is a need to include evidence-based advise for them as well.

Apart from these, this book is an excellent masterpiece—not only for the lay public but for doctors, nurses, nutritionist and health educators who render service to diabetic individuals and their families.

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## Death to Diabetes

*DeWayne McCulley, BS, EE;  
North Charleston, SC: Book  
Surge LLC, 2005; Library of  
Congress control #2005909270;  
ISBN 0-9773607-4-1; 384 pages;  
\$24.95*

This is a text, which I wish I had available for me to read when I was diagnosed myself with my type-2 diabetes disorder 20 years ago. Individuals diagnosed with type-2 diabetes probably need to read this text. Healthcare providers who choose to provide care for individuals diagnosed with type-2 diabetes need to read this text. Concisely written and precisely referenced, this book is a true cornucopia of healthy information—as reasonably expected from and by the author who holds his degree in electrical engineering from Pennsylvania State University. A few carefully selected examples follow:

- “Foods that caused my blood glucose to remain high include pancakes, bagels, orange juice, salad dressing, toast, and French fries.”
- “A diabetic’s immune system is weakened.”
- “Type 2 diabetes is a complex, insidious disease that slowly and silently destroys your body one day at a time.”
- “Ask your doctor for a local support group that can help you.”
- “Use an exercise tracking worksheet to record your progress and provide motivation.”

A reasonable and prudent provider might well consider obtaining a radioisotopic treadmill stress electrocardiogram, heart stress test or equivalent for virtually any previously inactive and/or sedentary individual diagnosed with so-called

type-2 diabetes (the very same diabetes disorder that I share with the author of this text) prior to the commencement of any exercise program, so that a prescription for exercise may well be obtained from a focused allied healthcare provider.

The author clearly endorsed and firmly recommended both the value of frequent testing and recording the results of both fasting glucose testing and perhaps two hours after meal glucose testing—home blood glucose monitoring (blood sugar self-testing) by the identified patient diagnosed with type-2 diabetes and the prompt and timely recognition of a diabetic emergency with the need for immediate, timely and prompt medical treatment and care as follows:

- “If your blood glucose is greater than 300, do not exercise, contact your doctor—immediately—and dial 911.”
- “If your blood glucose is less than 90, eat a snack before your exercise.”
- “Know the signs of low blood sugar (hypoglycemia). For example, if you feel weak, dizzy or have the shakes, you may be having a hypoglycemic episode (low blood sugar), eat something immediately to raise your blood glucose level. Do not attempt to exercise. Call your doctor immediately—and dial 911.”
- “Bring all of your medications including over-the-counter drugs, vitamins and other supplements to your next appointment. To avoid drug interactions and over-medication, make sure that your doctor knows about every drug, vitamin and other supplements that you are taking.”

The author presents a discussion of pharmaceuticals that may well be provided and/or recommended for those diagnosed with their type-2 diabetes disorder.

For the future, I would appreciate

electrical engineer DeWayne McCulley, BS, EE, the author of this text, providing us—his fellow patients afflicted with their diagnoses of their type-2 diabetes disorder—with follow-up editions of this valued text, say, every five years. I am interested in knowing if he will eventually need daily insulin, as I, myself, some years ago, had been on insulin injections during my own medical crisis. I expect that eventually I may require daily insulin injections more likely than not—once again for the reasonably tight control of my diabetes disorder.

I plan to keep this book handy in my office.

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### **Needles Herbs Gods and Ghosts: China Healing and the West to 1848**

*Linda L. Barnes*

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Physicians share their care of patients with the individual being cared for, their family, spiritual advisors, the community and other providers. Other providers may or may not be licensed, and may be self-taught or schooled in specific types of alternative care.

Alternative care is sought after

by three different types of patients: 1) those aged 35–50 who want to do something to slow the aging process; 2) people with diseases that cannot be cured by science-based medicine, are treated poorly or with modalities, and those disease side effects that alter a patient’s life in a way different from the disease; and 3) contrarians and others whose philosophy is incongruent with science or people who are just angry toward and alienated from mainstream medicine.

In evaluating which alternative systems we feel comfortable with our patients using, it is important to know the worldview of the system being used. It is important to ask what is the explanatory model of health and illness of the therapeutic intervention. Without a therapy having a philosophy, we feel less secure with our patients being treated by those providers. Cultural, historical or other systems of care outside of science may not fit into our belief system but are often still complete, respected and able to interact with conventional medical providers in the treatment of patients.

Acupuncture is a system of medical treatment with a philosophy outside of science and is widely accepted by the American public. Medical providers wanting to become more conversant with eastern medical providers or acupuncturists, or patients who have an interest in using these kind of therapies need reputable sources who don’t have financial incentives to sell a system of thought.

Linda L. Barnes has written a textbook about eastern medicine that is an excellent resource for practicing physicians. Her book is incredibly well written and comes across more as a story than a textbook, despite the heavy load of facts and research that are packed into it. The book will indirectly answer many of the questions that practitioners have about oriental medicine by providing history and context for the practices of these providers and

how they came to occupy the role they have as alternative therapy.

In describing the worldview of eastern medicine, Barnes clearly states the philosophy:

*The theory of humors presumed that all things consisted of core principles, called elements—fire, air, earth and water. Elements themselves were not matter. Rather, they joined with matter to constitute four qualities—heat, cold, dryness and moisture. Everything one consumed consisted of these elements. When digested, they become fluids called “humors”—blood, phlegm, yellow bile, or black bile, corresponding to fire, air, earth and water. The veins contained a combination of humors, but, because the humor “blood” predominated, its name was given to the mix as a whole.*

Each of the main organs had a humoral complexion, as did a person's general system. Each complexion corresponded to a temperament—blood to “sanguine,” phlegm to “phlegmatic,” yellow bile to “choleric,” and black bile to “melancholic.” One's complexion and temperament simultaneously described a physiological type and a psychological profile. Health involved the equilibrium of the humors appropriate to a given person's complexion: disease lay in their imbalance or improper mixture.

After introducing us to Chinese healing, the history starts with Chaucer's description of Chinese medicine as brought to the western world, and stories on the slave trade where Chinese and Mongolian slaves brought their own medical traditions with them when they were sold in different parts of the world. This started in the early 1400s.

Barnes provides us with a thorough and fair portrait of a very complex medical system and how it

evolved. She reviews when different herbs or traditional treatments were added to the system and became accepted. She provides the good and the bad in the system and talks about what people thought they could accomplish with “needle” therapy, as well as reviewing the claims that they had the ability to stop aging completely or take the heat out of a pulse, both of which would help keep a person healthy. She also explains the role of spirituality in Chinese medicine, talking about neglected ancestors becoming angry ghosts.

Chinese medicine did present contradictory ideas to those accepted in the west. Christian doctrine required a single soul, and Chinese medicine posited a yin and yang to the soul. In the 1500s, Chinese practitioners started to be labeled “philosophers” and not “doctors” or “priests.” That way, it was a philosophy—not a religion or school of thought—for medical care alone. Therefore, it could not be considered a competitor to Christianity.

While the worldview remained pretty consistent throughout history, new herbs, such as ginseng, and treatments were introduced into the armamentarium of the Chinese medical providers. Ginseng was first used by these healers in the mid-1600s. Vegetarianism is listed as a treatment because vegetables were considered medicines. At the same time, animal-based medicines crossed over from oriental medicine to western medicine, with the feeling that the odder the medicine the more potent the properties. So elephant skin, rhinoceros horn or bat gallbladder was ascribed properties that were not easily traceable to any specific experience. The power of many of the Chinese treatments and thoughts had an impact on the thinking of the time, and therapies were accepted or discarded differently in different cultures.

Throughout its history, Chinese medicine gave us a way to reflect on our own treatments and its effectiveness. This school of thought became

accepted as a clear alternative but never established a foothold in our society as a competing school of thought. The book does a great job of informing the reader on the history of Chinese medicine. It is a very welcome addition to the library of physicians as well as historians.

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## The Golden Gate Diet

Adam Brook, MD

In the *Golden Gate Diet*, Dr. Adam Brook claims to have discovered a new science-based approach to weight loss that will reduce heart disease risk by 50% and cancer risk by 40%, and will lead to a 1–2-lb weight loss per week. The diet is based on eating foods with low “caloric density”—that is, foods that have fewer calories per gram. Brook suggests, “the lower the caloric density, in general, the more a food will promote weight loss” (p. 103). Foods with a high caloric density (calories / food weight in grams >3) are discouraged and considered bad foods that promote weight gain. Foods with a caloric density of <2 are considered to have low caloric density, and Brook contends that these foods will lead to greater feelings of satiety and will consequently promote weight loss.

The idea of caloric density is not new at all. It is more often referred to in nutrition texts and diet planning literature as “nutrient density.” The principle of nutrient density suggests that in order to meet nutritional needs without consuming excess calories, individuals should select foods with more nutrients and fewer calories per unit of weight. Although choosing

nutrient-dense foods is an important part of planning a healthy diet, the oversimplified idea that eating low-caloric-density foods (with little regard for portion control), is not the magic bullet to losing weight, as the *Golden Gate Diet* asserts.

When one looks closely at the diet plans included in the appendix of this book, they are actually just a series of 1,200-calorie meal plans. For most healthy individuals, consuming 1,200 calories per day will indeed lead to weight loss because it is far below most individuals' basal energy needs. However, recommending 1,200 calories per day to all readers, regardless of their baseline body mass index, activity level, gender, age or lifestyle is not prudent. Nonetheless, the meal plans provided are generally well balanced, tasty and reasonable menus. Unfortunately, the menus did not always include recommended portion sizes, making them difficult to accurately follow, and no recipes are included for readers who wish to reproduce the meals. Still, for an individual looking for a structured, low-calorie meal plan, these menus could be quite helpful and serve as nice examples of healthy, nutrient-dense meals and snacks.

Though eating calorie-dense foods is advisable for weight loss, it was not always clear why some foods in the *Golden Gate Diet* are strongly recommended and others admonished. For example, Kellogg's™ Raisin Bran® cereal is recommended (even though it has a caloric density above the recommended level of 2), while General Mills's Raisin Bran is prohibited. Whole-wheat bread is to be eaten "in moderation," while toasted whole-wheat bread is to be "limited," but reduced-calorie white bread is recommended. It is helpful for readers to have guidelines for the types of foods that should be consumed regularly (and seldom) on a calorie-reduced diet; however, Brook's food lists fail to fully capture many of the important dietary recommendations

described elsewhere in the book.

In the book's second chapter entitled "The Weight Problem in America and the Popular Diets that Don't Work," Brook harshly critiques the Atkins, Ornish and South Beach diets. While Brook repeatedly claims that his plan is an easy, delicious way to "lose weight and ... keep it off in the long run" (p. 30), he concludes with chapters on the weight loss drugs and bariatric surgery methods that are recommended for readers who fail to lose weight after following the diet for six months. As with all restrictive diet plans, long-term planning and support are necessary for maintained success, and Brook notes the importance of incorporating a multifaceted approach to weight loss that includes dietary changes, physical activity and emotional support.

While the idea of caloric density is in itself an important tenet of diet planning for weight control, the major flaw of the *Golden Gate Diet* is that it largely ignores the importance of portion control. Eating excess calories (even if they are calorie dense) will eventually lead to weight gain. As obesity prevalence rates continue to rise, it will be increasingly important for physicians to possess a strong set of skills and resources to work with patients around issues of nutrition and weight control. Practitioners would be better served to refer patients to [www.mypyramid.gov](http://www.mypyramid.gov), where they can get individualized dietary recommendations from the USDA. Better yet, health professionals should refer patients to a registered dietitian, an important member of the healthcare team with the training and expertise to address issues related to nutrition and weight loss.

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## C A R E E R O P P O R T U N I T Y



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