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THE EPIDEMIC OF DIABETES

Family Focus

VOLUME 12 NUMBER 2

SPRING 2003



THE KIDNEY
COMMUNITY'S NEWSPAPER

Fighting A Growing Epidemic

Dear *Family Focus* Reader:



William F. Keane, MD

I would like to take this opportunity to wish all of you a healthy 2003. I also wish to talk to you about the growing concern that we, the National Kidney Foundation (NKF), have with regard to a growing epidemic of Type 2 diabetes mellitus* in the United States and worldwide.

It has been estimated that about 16 million people in the U.S. have diabetes and up to one third of them do not know that their blood sugars are high. This has been confirmed by the NKF's efforts through the KEEP (Kidney Early Evaluation Program) screening program, which tests people who are at risk for developing kidney disease. KEEP results showed similar numbers of people who were unaware of the fact that they had increased blood sugars or high blood pressure.

CHRONIC KIDNEY DISEASE (CKD) is one of the most important complications of Type 2 diabetes. High blood pressure is also common in patients with diabetes and is another important factor that can lead to the development of CKD. An increased serum creatinine, a measure of kidney function, and the presence of protein in the urine are markers that show those individuals who are at highest risk for progression of CKD and the development of kidney failure. Diabetes is a risk for heart and blood vessel disease, and that risk is higher for diabetics with CKD. The same laboratory tests

that identify those who have the greatest risk for CKD also predict those people with the highest risk for cardiovascular disease (like heart attacks and strokes).

Currently, diabetes is the most common cause of kidney failure in the U.S., causing nearly 50 percent of all new cases. By the year 2010, over one half of all patients with chronic kidney disease will have kidney failure because of diabetes. This growing epidemic of Type 2 diabetes is particularly common in Hispanic, Asian, Native American and African American people, but it is also increasingly common in Caucasian people. Obesity and physically inactive lifestyles have contributed to the growth of this condition in both children and adults.

Today, people are becoming overweight at earlier and earlier ages. Those who are overweight often have other problems that in addition to increasing their chance of having diabetes, also puts them at risk for heart disease. High blood pressure, high levels of "bad" cholesterol, and low levels of "good" cholesterol are all common in people who are overweight, and all of these increase the chance of developing kidney and heart disease. The combination of being overweight, having abnormal blood lipids (fats), and often, having high blood pressure has been called the Metabolic Syndrome.

THE GOOD NEWS is that medical research has provided new and groundbreaking treatments to lower the chance of developing kidney and heart disease and their problems. The NKF has helped pioneer the way by advocating detection (screening) programs and developing treatment

approaches for your doctor to use. Good control of blood pressure with drugs that lower protein in the urine (this frequently requires two to three medications), treatment of cholesterol, stopping smoking, diet, and increased exercise all will decrease the risk of someone with diabetes eventually developing kidney and heart failure. It is also important to know that early recognition and treatment of the Metabolic Syndrome is extremely important for the future health of the nation.

In conclusion, I want to stress that it is necessary for you and your family to take control of your health and recognize the importance of the conditions that can put you at high risk for diabetes and its complications.

Best regards for a kidney healthy year,
William F. Keane, MD

Immediate Past President, NKF

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* Articles in this issue refer to both Type 1 and Type 2 diabetes. See page 2 for definitions of these.



Karren King

from the editor

I began working in a dialysis unit in 1979. Until that time I had never realized the seriousness of having diabetes. I had naïvely thought it was simply a matter of having a daily shot and following a special diet. After being in the dialysis unit for a short time, I quickly realized how very little I knew about diabetes. Indeed, diabetes was quite serious. Not only did I see many people who were on dialysis strictly because they had diabetes, but I also saw firsthand the other medical problems affecting limbs and vision that it could cause. Now, 24 years later, diabetes among those with kidney failure is rampant, with approximately one-half of all people on dialysis in the United States because of it.

You may be thinking that you do not need to read this issue of *Family Focus* because you do not have diabetes. Before you take it to the recycle bin, you need to realize that you or those close to you may be at risk for getting diabetes. This issue is full of facts not only for those who currently have diabetes but it also provides valuable information on how you may prevent it.

We have two issues of *Family Focus* remaining for this year. The theme for the next issue will be bone disease and lipids (fats in your blood), both very important for people with kidney disease. The last issue of the year will focus on how those on dialysis and staff in the unit can improve their communication. We have randomly selected 5,000 of the approximately 32,000 patient readers who receive *Family Focus* at

their home to complete a survey on the topic of communication in the dialysis unit. We are very interested to see what you have to tell us, and we, in turn, will share the results with you, our readers. Our hope is that this information will shed light on how you and your health care team members in the unit communicate, with the ultimate goal being to improve overall care.

In the early Fall, our Editorial Board will be meeting to select the four topics for 2004's issues. Are there topics that you would like us to cover? We want to be responsive to your needs and concerns but to do that we need you to tell us what they are. So...how about it; what do you want YOUR newspaper to address? 

For the Editorial Board
Karren King

DEFINITIONS

DIABETES MELLITUS (also known simply as diabetes) is a condition in which the body cannot properly use the sugar in food for energy. There are two major types of diabetes.

TYPE 1 DIABETES is a disease, usually appearing during childhood, in which an organ called the pancreas is damaged. The pancreas normally produces insulin to help us get energy from food. With Type 1 diabetes, the body has a problem making insulin. People with Type 1 diabetes need to take insulin shots in order to live.

TYPE 2 DIABETES is a problem using the insulin that is made by the pancreas. This problem can be caused, or made worse, by lifestyle, especially by obesity and inactivity. Type 2 diabetes used to be a problem mainly for people over 40, but now it is also affecting younger people.



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Insulin and Your Health

By Karen Zoller, RN, BSN, CDE

Today in the world of diabetes care it is very possible for those with diabetes to control blood sugar levels by living a healthy lifestyle and receiving proper insulin therapy. The goal of diabetes control is normal blood sugars. Research has shown that a diabetic person with near normal blood sugars (150 mg/dl or less) is less likely to have complications of diabetes, such as kidney and heart disease.

The key to blood sugar control is to know how insulin works in diabetes care and to choose a treatment that is right for your lifestyle. Since diabetes is caused when the body cannot produce enough insulin, it is important to learn what is going on inside your body. Insulin is made by an organ called the pancreas, which is located near the stomach. Insulin is a hormone that is needed for life; your body cannot live without it. Basically, insulin helps to keep the body in balance. Insulin helps you grow, heal sores and get the energy from the food you eat into your muscles so that you can be active and function normally.

FOOD + INSULIN = ENERGY

A simple formula to remember is **Food + Insulin = Energy**. This is how the formula works. The food you eat goes into your stomach where it is digested. Then your pancreas makes insulin to bind with the food, which allows the food to get into the muscles for energy. Insulin is the key to the door of the muscles. However, in diabetes, the pancreas cannot make enough insulin. If your body does not have enough insulin, the food cannot get into the muscles; it stays in the blood stream and results in a high blood sugar test. A high blood sugar test is the body's way of saying, "Help, I need more insulin to get the food into the muscles."

No matter how you do it, either by a combination of diet, exercise, pills or insulin, your body just wants the right amount of insulin to keep it healthy. It is a balancing game that takes work for good health. You have a choice—if you want control, you can have it.

Blood sugar monitors are valuable tools that help you get to know your body and how the foods you eat and the medicines you take affect it. The monitor allows you to control your blood sugar and gives you the flexibility and freedom to make self-changes at home regarding your diet and exercise. The monitor can also provide very important information to your physician to aid in adjusting your insulin therapy.



There are three categories of insulin available for treatment. They are fast-acting, intermediate-acting, and long-acting. The fast-acting insulins include Lispro, Aspart and Regular. Fast-acting insulin works within 5 to 30 minutes and lasts around two to four hours. The intermediate-acting insulins include NPH, Lente, and 70/30 mix; these work within two to four hours and last around 12 to 18 hours. The long-acting insulins include Ultralente and Glargine, which work within 6 to 10 hours and last for 20 to 24 hours.

Glargine, also known as Lantus, is the newest insulin on the market. Glargine works for 24 hours, which only requires one shot a day. Glargine acts as basal insulin, which gives a constant, low amount of insulin throughout the whole day and has no peak (no highs or lows). It can be used alone or in combination with Lispro shots or insulin pills.

The goal of insulin therapy is to mimic a normal insulin pattern in the body. To do this, it usually takes a combination of long-acting or intermediate-acting insulin combined with fast-acting insulin. Long-acting insulin gives the body a constant source of

insulin over 24 hours, but it needs help in covering meal times because food at mealtimes needs more insulin for energy: **Food + Insulin = Energy**. Therefore, the use of faster-acting insulin is needed to provide meal-time insulin coverage. As you can see, there is a lot of variety and opportunity in the insulin treatment of diabetes.



“It is very possible to control your blood sugar and live a healthy and productive life.”

It is very possible to control your blood sugar and live a healthy and productive life. You have many choices to make diabetes treatment fit into your lifestyle. A lot depends on the amount of effort you want to put into it. Whether you have diabetes or not, a healthy lifestyle takes work. You are the “star,” and your health care team members are the coaches. Staying healthy is a partnership between you and your health care team. Work with your team, monitor your blood sugar and find a plan that is good for you. Even though there is not yet a cure for diabetes, you can control it by learning as much as you can about the disease and choosing the right medical therapy. You can do it! **FF**

**FOOD
+
~~INSULIN~~
=
TOO
MUCH
BLOOD
SUGAR**

**FOOD
+
INSULIN
=
ENERGY**

About the Author

Karen Zoller, RN, BSN, CDE is a clinical nurse and diabetes educator at Mescalero Hospital on Mescalero Apache Indian Reservation in Southern New Mexico.

Should You Believe Everything You Read on the Internet?

By Bobbie Knotek, RN, BSN, CNN

The answer to that question is NO! If you've used the Internet, you know medical and health information is everywhere. But information on the Internet is often out of date and may even be wrong. To guard against problem Web sites and reassure yourself that information you read is up-to-date and correct, use these checks to "test" medical and health Web sites.

► REASON FOR WEB SITE:

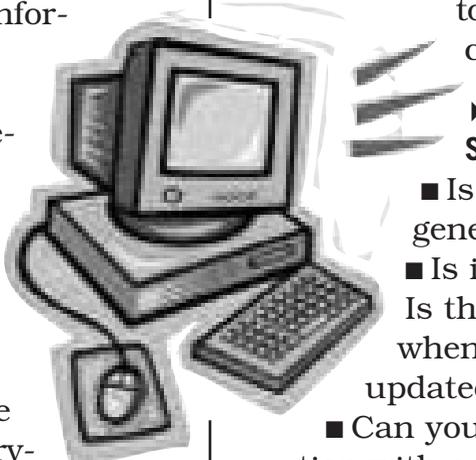
- Can you tell why the site was written?
- Is the site giving you information, trying to talk you into something or trying to sell you something?
- Is the author writing for the public? Was the site written in a way that is easy to understand?
- Does the Web site have ads for products or services?
- Does the information support what your doctor has told you or does it try to take the place of a doctor's visit or advice?

► PERSON(S) WHO WROTE INFORMATION:

- Can you tell who wrote the information?
- What are his/her credentials – is the author a doctor, nurse, lawyer, etc.?
- Is the author an expert on the topic?
- Is he/she trying to sell a product or service?
- Is the author's address, e-mail address or phone number provided?

► WHO PAYS FOR WEB SITE:

- Does it say who pays for the Web site?
- Whose Web site is it? The last two to three letters of a Web site's address or URL tells what type of organization or business is paying for the Web site.
 - .org = usually a non-profit organization
 - .edu = a school, college or other educational organization
 - .gov = a U.S. government Web site
 - .com = a Web site written by a business
- What do you know about this organization or business?
- Is this organization or business an expert in the topic?
- If advertising helps pay for cost of



the Web site, does it state this on the site?

- Does the Web site tell you how to contact the person in charge of the site?

► INFORMATION ON WEB SITE:

- Is information detailed or general?
- Is information up to date? Is there a date to show when information was last updated or changed?
- Can you double-check information with a reliable person, like your doctor, nurse, social worker or dietitian?
- For research Web sites, is the data explained?
- Does the Web site tell you where data or information came from in a reference?
- If there is advertising on the site, can you tell the difference between ads and education?
- Does the information in one part of the site agree with the information in other parts?
- Is there an HONcode seal on the Web site? The HONcode is an approval seal that Web sites can get from Health on the Net Foundation. This organization approves the use of their seal for medical and health Web sites that meet their Code of Conduct and agree to give dependable and correct information.

► "WARNING SIGNS" THAT INFORMATION COULD BE OUT OF DATE OR WRONG:

- Name of person who wrote information is not given.
- Bad grammar and spelling.
- Angry, critical or "hateful" information.
- No dates on Web site for when information was published, last reviewed or changed.
- Web sites on rapidly changing subjects with "old" review or change dates.
- Web sites that tell "one side of the story" and never discuss "other side."

- Claims that other products or services are not as good as products or services offered on this Web site.
- Advertisements for non-prescription herbs or supplements (always check with your doctor, nurse or dietitian before buying or taking any herbs or supplements).
- Statistics with no references.
- Exaggerated sentences – "hundreds of people use this medicine every day."
- Statements that a medicine or treatment is really important or special.
- Information that is always true or that applies to everyone – "a medicine, product or treatment works for everyone."
- Conflict of interest – for example, a Web site stating that research on cigarette smoking and tobacco related illnesses is a lie is paid for by a cigarette company.
- Information that is "too good to be true."

Finally, ALWAYS double-check information you find on the Internet with your health care team!

Speaking of Web sites – check out these Web sites on diabetes! If you do not have a computer or Internet service, many senior centers, community centers and libraries offer free or low cost Internet service. ☺

*American Diabetes Association:
www.diabetes.org*

*Diabetic Retinopathy Foundation:
www.retinopathy.org/index.html*

*Juvenile Diabetes Research Foundation:
www.jdf.com*

*Lower Extremity Amputation Program (LEAP):
www.bphc.hrsa.gov/leap*

*National Institute of Diabetes & Digestive & Kidney Diseases:
www.niddk.nih.gov/health/diabetes/diabetes.htm*

Diabetes and Dialysis: Tips For Living Well

By Dale Ester

My kidneys failed because of my diabetes. I had to take ownership of the disease when it lured me into dialysis many years ago. But I have learned a lot since then. You have probably heard the saying, "hindsight is 20/20." Hopefully, these tips will make your management of diabetes and dialysis much easier. I used to think there was not much I could do to slow down the hurtful effects of diabetes, especially its effect on my dialysis treatment, but I was mistaken! Here are my insights for living well with diabetes while on dialysis.

CONTROL DIABETES OR IT WILL CONTROL YOU!

There is not much you can do now to change your history of chronic kidney disease (CKD), regardless of its cause. But you do have many choices about taking control of your diabetes and its effect on your dialysis treatment. Surviving with diabetes and CKD involves a strong commitment to doing as much as you can to control how both diseases are affecting not only your body, but your mind, spirit, quality-of-life and well-being!

IN LAYMAN'S TERMS, WHAT IS DIABETES?

Diabetes is a condition with more than one cause. The effect of this condition is that the body is unable to use the sugar in the blood. In some cases, an organ called the pancreas does not create enough insulin. In other cases, the body is unable to use the insulin. Basically, insulin helps convert food in the stomach into energy.

There are two known types of diabetes. Type 1 diabetics depend upon insulin injected under the skin because the pancreas is no longer producing insulin. Type 2 diabetics may not need insulin; they may be able to take pills to help the pancreas produce more insulin. Physical exercise is typically helpful with managing both Types 1 and 2.

Both types of diabetes require close personal attention by the patient for effective control of blood sugar levels. Diabetics should be aware of how much medication they use daily and its effects, as well as the effects of exercise and the types of food they eat. Blood sugar testing is needed several times daily, too! Close control can lead to fewer complications. Good diabetes blood sugar management can help decrease long-term problems.

Some tips for managing your diabetes while on any form of dialysis:

1 TAKE PERSONAL CONTROL of your blood sugar and test it more than once or twice daily. Those people with Type 1 diabetes should ask their doctor about using a more fast-acting insulin when their blood sugar is high or above their normal. Individuals who have Type 2 diabetes should check with a doctor about adjusting their daily oral medications if blood sugar is above normal.

2 EAT SOME FOOD AT LEAST TWO HOURS or more before starting your dialysis treatment. Since hemodialysis treatment is often three to four hours long, your body must have a reserve energy source to manage the insulin or diabetes pills you have taken.

3 ALWAYS HAVE SOME FORM OF "GLUCOSE" on hand to end any low blood sugar episode. Glucose can be bought at most drug store chains or supermarkets and is often sold as a tablet or in a jelly-like tube. Keep the glucose with you and be ready to use it at times when your blood sugar gets too low. Most people know when their blood sugar is too low because they feel one or more of these physical signs: cold sweats, nervousness, shakiness, sweating or forgetfulness. If untreated, low blood sugar can cause unconsciousness and a coma.

4 IF YOU ARE ON PERITONEAL DIALYSIS, ask your physician about injecting your insulin directly into the dialysis solution. This method of giving insulin works for some people on peritoneal dialysis and decreases the number of shots they have to give themselves.

5 MANY DIALYSIS UNITS DO NOT ALLOW EATING while on dialysis. If you feel it is necessary to eat, talk with your dietitian about having a snack right before or right after dialysis in the waiting room.

Before trying any new changes, be sure to discuss them with your health care team.



Good blood sugar control happens by making good choices, not by accident. These tips for living well on dialysis with diabetes will help you to take control of your diabetes. Since diabetes and kidney failure are a full-time job of sorts, give close attention to the effects some simple adjustments can make toward improving your long-term outcome. Life and longevity will become sweeter when your blood sugar level is as close to a non-diabetic normal as possible. Take control of the diabetes or it will control you!

FF

Don't Forget the Fitness Facts!

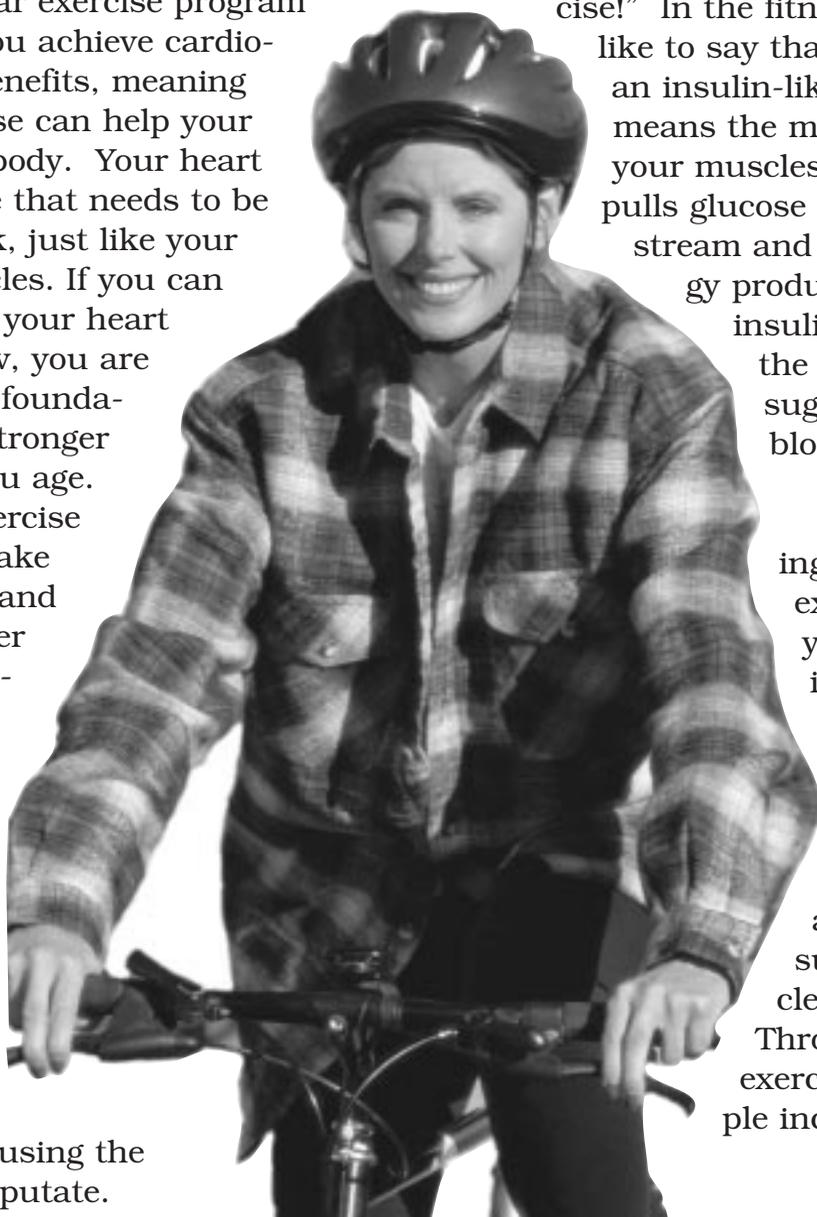
By Pedro Recalde, MS, ACSM

In past issues of *Family Focus* we have talked about how exercise can fit into your dialysis schedule, how to make it fun, and how to do it safely. But some may wonder, "This may be O.K. for the average person on dialysis, but what about me with diabetes?" Well, my friends, not only are you not to be left out, we have some special reasons why exercise can work just for you.

WHAT IF I HAVE TYPE 1 DIABETES?

In order to have a safe and beneficial exercise session, you always need to make sure that your body is ready for action. You are encouraged to check your blood glucose before an exercise session to make sure your level is below 250 mg/dL, with no ketones. This will help ensure that your blood sugar is neither too low nor too high for a healthy exercise session.

A regular exercise program can help you achieve cardiovascular benefits, meaning that exercise can help your heart and body. Your heart is a muscle that needs to be put to work, just like your other muscles. If you can strengthen your heart muscle now, you are setting the foundation for a stronger heart as you age. Regular exercise can also make your arms and legs stronger while lowering your body fat. Also, one of the greatest fears of a diabetic is lessening circulation to hands and feet, possibly causing the need to amputate.



“Through regular exercise, many people increase their sensitivity to the point that they can cut down on the amount of insulin medications used for glucose control.”

Keeping your muscles strong and your heart healthy is the best way to keep your arteries clean and circulation open.

WHAT IF I HAVE TYPE 2 DIABETES?

Ah, yes, so many reasons to exercise and so little space to write about them. Let us just start with the statement, "You have every reason to exercise!" In the fitness world, we like to say that exercise has an insulin-like effect. This means the motion of moving your muscles during exercise pulls glucose from your blood stream and uses it for energy production. Just like insulin, it stimulates the clearance of sugar from your blood.

By participating in a regular exercise program, you can also increase your sensitivity to insulin.

Insulin is the key that opens the windows and lets blood sugar enter muscle and fat stores. Through regular exercise, many people increase their

sensitivity to the point that they can cut down on the amount of insulin medications used for glucose control. Remember, on the way there, try to avoid exercising during your peak insulin time or your blood sugar might drop too low. If you exercise by yourself, it's a good idea to let someone know where you are going. It is also recommended that you keep a snack handy, just in case you run into some unexpected blood sugar "lows."

WHY ELSE SHOULD I EXERCISE?

Although stress can be from "good" things (like planning a wedding or party) or from "bad" things (like dealing with taxes or parking tickets), both good and bad stresses have a few things in common. Continuous stress can cause your muscles to be tense, your arteries to tighten, your heart workload to go up, and your blood level of fatty acids and blood sugar to rise. These responses help you deal with your current stress, but they can be harmful if they happen on a daily basis. Many people use exercise as a way to clear their minds and physically drain stress from their bodies.

Eating healthy and exercising often can keep you energized for anything the day can throw at you. You might need extra energy to stay focused at work, with your homework, or to set records in your gym. If you start making time for fun activities like sports and exercise now, it will be easier for you to keep them up when you are older.

WHAT IF I DO NOT HAVE DIABETES, BUT MY PARENTS DO?

If someone in your family has diabetes, this is a sign that you should really start thinking about how much exercise can help you. The best way to control diabetes is to not have it at all, and the perfect medicine is your daily dose of playing in the sun. So go out and find some friends to play with. That is an order! **FF**

Beating Blood Sugar Blues

By Patricia Weber, RD

Have you looked at your thumbprint lately? It is unique, as you are, and should tell you that it is rare to have a “one size fits all” for anything in life, including the diabetes diet. Often people think about limiting “sugar” when they think about the diabetes diet, but in truth, it is about balance and lifestyle. Although it is also important to exercise and control your blood pressure, in this article we will focus on how diet can help adults with Type 2 diabetes control their blood sugar.

All foods are made up of carbohydrate, protein, and fat. Carbohydrate in foods is sugar, starch or fiber. Some examples are cakes and desserts, grains and milk and fruits and vegetables. Carbohydrate has the biggest effect on after-meal blood sugar because nearly all of the carbohydrate we eat breaks down to glucose and enters the blood stream. Things that effect the body’s conversion of carbohydrate to glucose (sugar) are the amount of food eaten, the type of sugar or starch (carbohydrate) eaten, the cooking method, or the combination of carbohydrates with other foods, like fats. Among these, the most important factor is the amount of food eaten. Two words that should be avoided are, “Supersize it!” The same is true for the amount of sugar in your diet. Sugar can be included in the diet, but too much sugar can cause high blood sugar and lead to weight gain and poor nutrition. Work with your dietitian or diabetes educator to figure out the right amount of carbohydrate you should eat at meals and snacks. This is called “carbohydrate counting.”

Protein and fat are important parts of your diet, too, and also should be individualized to your needs. The best protein choices are found in lean beef, pork, poultry, fish, skim milk, eggs, and soy. The best fat choices are canola or olive oil. If you eat margarine, it should be soft tub and trans-fat free. Trans-fats have been artificially hardened by adding hydrogen, and are not heart-healthy. Fat may also slow digestion, which could have an affect on the after-meal glucose, by causing the blood sugar to peak at a later time. This might require a change in the timing of your medication.

If you have had a transplant you are at risk for developing diabetes from the anti-rejection drugs. Ask your dietitian about the Food and Drug Administration Dietary Guidelines for Americans, keep your blood pressure controlled, and ask your physician to monitor your blood sugar regularly.



Type 2 diabetes usually starts out as a disease that causes high blood sugars after eating, so even if one’s fasting blood sugar is normal, damage might be happening. Because of this, sometimes you should check your blood sugar one or two hours after

eating. Remember that your blood sugar may be high one hour after a meal, but ideally should return to normal by two hours. The blood sugar readings can help you figure out if the type or amount of carbohydrate you have eaten is right to keep your blood sugar in control. The readings can also help you know when your medication is the most active and be a guide for you and your diabetes caregiver in determining if changes are needed in the amount or timing of insulin or pills you take. Work with your doctor to set a blood sugar goal that is right for you.

In the coming year, make it a goal to learn how food, especially carbohydrate, can affect your blood sugar. By knowing and choosing the right amounts of carbohydrates for your meals and snacks, you can improve your blood sugar and feel better. **FF**

About the Author

Patricia Weber is a renal dietitian at Vanderbilt Dialysis Clinic in Nashville, Tenn. She is board-certified in both renal nutrition and diabetes education.

THE MORE YOU KNOW

The following brochures, available from the National Kidney Foundation, offer more information about diabetes and chronic kidney disease. To receive a brochure, call the NKF’s toll-free number, 1-800-622-9010 or send an e-mail to info@kidney.org

Diabetes and Chronic Kidney Disease (also in Spanish)
“Because diabetes may injure the blood vessels in the body, it can cause permanent kidney damage. The earliest sign of kidney damage is an increase in albumin in the urine.”

Diabetes and Chronic Kidney Disease: A Guide for American Indians and Alaska Natives

“One out of five American Indians and Alaska Natives has diabetes, compared with one of 20 adults in the total U.S. population.”

Winning the Fight Against Silent Killers: A Guide for African Americans

“It is possible to have diabetes and have few or no symptoms. Yet, even this mild form of diabetes, if untreated, can cause damage to your kidneys, eyes, brain and heart.”

Nutrition and Chronic Kidney Disease

“You may need to make only a few changes in your diabetic diet to fit your needs as a kidney patient.”



MAILBOX



Dear Editor,

I have been on dialysis since December 1999, and am currently waiting for a transplant.

I received my issue of *Family Focus* today. After reading the article "Ideal Dialysis Care in the Next 10 Years" (Fall, 2002) and especially your excellent letter, "The Future: What Does It Hold?", I felt a compulsion to write to you.

Regarding the progress that has been made and perhaps potential in the future, I am enclosing a letter (reprinted, right) that may be of significant interest to your readers.

Little did I know that in 1965, then age 35, that I would some day be on dialysis. It was at that time, after seeing an NBC presentation entitled, "Who Shall Live," that I wrote to then President Lyndon Johnson. I urged him to do something about the necessity of committees to decide who would have access to our dialysis centers that existed at that time.

Mrs. King, I thank you and your staff for an excellent publication.

Sincerely,

Frank Joel Gironda
Eastham, Mass.



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
WASHINGTON, D.C. 20201

REFER TO DCD/XDB

Bureau of State Services

December 10, 1965

Mr. Frank J. Gironda
92 Shady Knoll Drive
Longmeadow, Massachusetts

Dear Mr. Gironda:

The President has received your letter about artificial kidney treatment and asked this office to reply for him. The President appreciates your taking the time to express your concern because he and we of the Kidney Disease Branch share that concern with you.

The Public Health Service helped support the research at the University of Washington which proved that it is possible to maintain life in patients with kidney failure and uremia through periodic treatments with the artificial kidney. The success of this research, and the success of the community Artificial Kidney Center in Seattle, led the President to request additional funds for kidney disease programs in his budget for the current fiscal year. Congress responded by appropriating \$6,400,000 for research and service programs for patients with kidney diseases.

These funds are being used to conduct further kidney research and to provide community services for patients with these disorders. Ten new artificial kidney centers will be created, which will bring the total number of such centers receiving partial Federal support to 14 by July 1, 1966. These centers are intended to serve as regional demonstration and training centers, and receive partial Federal support through three year grants. At the end of the grant period, the community must provide resources to continue the program.

Artificial kidney center treatment is only one method of approaching the problem posed by kidney disease. Additional Federally-supported programs are being developed to aid in the prevention of kidney disease and to insure adequate treatment of the diseases before they progress to kidney failure. In the long run, these preventive approaches may lead to a reduction in the number of patients who need the expensive artificial kidney center treatment.

Rest assured that we share your concern over the health problem posed by diseases of the kidney, and that we will continue to seek answers to the perplexing problems - both medical and social - that these diseases pose.

Sincerely yours,

James R. Kimmey, M.D.
Chief, Kidney Disease Branch
Division of Chronic Diseases

Dear Friends,

My husband, Michael, passed away December 27, 2002, six months to the day after receiving his second kidney transplant. He was 37 years old, the father of our three sons and an ordained minister, and had kidney problems since he was three.

At the funeral home I was asked if I'd like the obituary to read that his passing followed a long illness. I said no. Michael's death followed a long life.

Over the years we had read articles on the right diet, exercise, types of dialysis, frequency of dialysis, medications, physicians, involvement in medical care, insurance, the newest procedures and advances, the psychological-spiritual-physiological impact of kidney disease... The amount of information available is perpetual. But above all this coping, Michael lived.

Our story is awesome, but each of you has one, too. For those facing or coping with dialysis, transplantation or any challenge—my message, Michael's message, is:

Don't be afraid. Don't wait. Don't let the coping bury you. Live, however long it lasts.

Sincerely,
Lisa M. Johnston
Hannibal, Mo.

Government Launches Program to Prevent Type 2 Diabetes

By Dolph Chianchiano, JD, MPA



Dolph
Chianchiano,
JD, MPA

The National Diabetes Education Program (NDEP), a joint project of the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention, has been producing public and professional education materials since 1997.

NDEP's newest initiative, the first of its kind, is designed to spread the word that Type 2 diabetes can be prevented or delayed in people who are at risk for the disease. The initiative is called "Small Steps, Big Rewards" and is part of "Steps to a Healthier US: Putting Prevention First," for which Tommy Thompson, the Secretary of the US Department of Health and Human Services, has committed a budget of \$125 million. "We are asking Americans to find out if they are at risk for diabetes and we are showing them how to take action to prevent it,"

Secretary Thompson said. "With the support of business and industry leaders, this critical prevention message will be delivered where Americans live, work and play and through their health care providers."



"Small Steps, Big Rewards" has a goal of preventing 75,000 new cases of diabetes in the next year.

NDEP's message is that Type 2 diabetes can be delayed or prevented by modest weight loss through diet modification ("if you are over 45 and overweight, lose five to seven percent of your body weight") and moderate exercise, such as walking 30 minutes a day, five days a week. (Walking is described

as "A Step in the Right Direction.") Check with your doctor before beginning your own exercise program. Those who are younger than 45, overweight, and who have one or more other risk factors (family history or high blood pressure) for diabetes are told that they should consult their health care providers about testing. The "Small Steps, Big Rewards" approach is based upon the results of research supported by the NIH, known as the Diabetes Prevention Program. That study showed that simple lifestyle changes resulted in a 58 percent lower chance of getting diabetes for people who are at increased risk for the disease. Moreover, these impressive results were true for all ethnic and age groups and especially in those over age 60.

NDEP has published a Toolkit for Health Care Providers and booklets for

the public, including: "Am I at risk for Type 2 Diabetes?" and "Your GAME PLAN for Preventing Type 2 Diabetes." The Toolkit explains how to translate research on diabetes prevention into clinical practice. Some of the topics covered in the public booklets include: "Should I be tested for diabetes?" "What can I do about my risk?" "Why walk?" "Is it okay for me to walk?" "How do I start a walking program?" These booklets are available from the National Diabetes Information Clearinghouse (800-860-8747 or at www.niddk.nih.gov/health/diabetes/ndic.htm) and, since they are government publications, the public is encouraged to copy and distribute as many of them as desired. **F**

About the Author

Dolph Chianchiano is the National Kidney Foundation's Vice President of Health Policy and Research.

Dear Editor,

I am a 59-year-old black male from Atlanta. I've been in ESRD since July 1998, and have been on the kidney transplant list for almost three years. In May 2000, I filed charges with the Equal Employment Opportunities Commission (EEOC) against my employer for refusal to grant reasonable accommodation due to my kidney failure and dialysis treatments.

Following an eight-month investigation, EEOC found them in violation of title VII of the Americans with Disabilities Act. My employer contested this, and my case was sent to the Department of Justice civil rights divisional employment litigation section in Washington, DC. I am preparing a lawsuit for wages, consortium and pain and suffering, and I will prevail.

There are probably others in the renal community suffering the same, or have suffered the same, not knowing what steps to take to defend against this type of injustice.

I hope that my sharing this information with them will assist and motivate them to take action.

Sincerely,
Mr. Ceridwen Williamson
Atlanta, Ga.



MORE MAILBOX

Non-Kidney Complications of Diabetes

By Janet McGill, MD

Almost half of all people who are on dialysis have diabetes. In many cases, diabetes is the cause of kidney disease. Sometimes people have diabetes in addition to hypertension or other diseases that may cause kidney failure, such as polycystic kidney disease or glomerulonephritis. Many people have had diabetes for years and have complications of long time diabetes such as difficulty seeing or nerve damage. If you were only recently told by your doctor that you have diabetes there is a lot to learn about the disease. There are many problems that can be caused by diabetes and all people with diabetes need to know how to recognize and manage them.

Eye problems are common in those with kidney failure from diabetes. One of these problems is cataracts, which cause blurred vision that cannot be fixed with glasses. When cataracts occur, you may have problems seeing at night or reading before you have trouble seeing during the day. These changes may happen slowly. If you have cataracts you will eventually need surgery, and possibly even a special contact lens, to see well. Cataracts can even happen in young people with or without diabetes who need to take steroids such as prednisone for lupus or for a kidney transplant.



Retinopathy is the eye disease caused by high sugars. This problem affects the back of the eye. There is no pain or change in sight when the early signs of retinopathy appear in the eye. The eye doctor uses eye drops to get a good look at this part of the eye, which is very difficult to see if the pupil is not dilated

(widened). When the pupil is dilated, the eye doctor looks for signs of damage to tiny blood vessels, such as leaking or small areas of bleeding. As the eye disease gets worse, the damage to the small blood vessels is seen more easily. New, easily broken vessels grow in some areas of the retina (back of the eye). This is called proliferative retinopathy. A sudden loss of sight in one eye can be caused when the new, delicate blood vessels bleed. This is frightening, and calls for specialized help from a retina specialist eye doctor. The eye doctor may recommend laser treatments to prevent these small vessels from growing or to treat them. Doctors have also learned that earlier treatment with laser therapy saves eyesight. This advice may come as a surprise to people who can see well and have no symptoms.

Nerve damage is also very common in diabetes. Like kidney and eye disease, it is related to high sugars. In the beginning, you may have increased feeling in your hands or feet, or a loss of feeling. Often, but not always, there is severe pain as nerve damage gets worse. There is an easy way to check for lost feeling. Take a metal spoon and hold it against your cheek. It should feel cool. Immediately, touch the bottom of your feet with the spoon. If

it does not feel as cool on your foot as it does on your cheek, you may have nerve damage. Now warm the spoon by holding it under warm (not hot!) water. Repeat the test. Does it feel as warm to your foot as it does to your cheek? If not, you may have lost the ability to notice temperature changes, an early sign of nerve damage. Loss of feeling puts you at risk for injuries or infections that can end up as serious infections, ulcerations or gangrene (dead tissue).

If you have neuropathy (nerve damage)—even if you do not have diabetes—you may have been told to “Take care of your feet!” First, make sure that a doctor looks at your feet at every visit by taking off your shoes and socks before he or she enters the room. Ask the doctor if there are any problems that may require immediate attention. If possible, see a podiatrist (foot doctor), who will examine your feet and take care of toenails, corns, calluses and other problems. Both the medical doctor and the foot doctor should check for pulses in your feet, signs of infection and problems such

About the Author

Janet McGill, MD, is an associate professor of medicine at Washington University School of Medicine, and an active clinical researcher in diabetes. Dr. McGill is co-director of the Prevention and Control Core of the DRTC at Washington University.



as tight heel cords, bunions or hammertoes. Look at your feet twice each day and keep a mirror handy to check the soles of your feet. Dry your feet carefully, especially between the toes, and treat athlete's foot right away with over-the-counter medicine. If it does not get better immediately, call your doctor or foot doctor. If you get calluses on your feet, ask about a shoe support to help prevent them.

Speaking of shoes, when is the last time that you had your feet measured? Adults often need shoes that are wider and longer than they think they need because the arch of their foot may flatten as they get older. Ask for help when buying shoes, make certain that they fit right and wear shoes with cushioned, rubber soles. Never, ever go barefoot! Many people with severe nerve damage do not develop serious foot problems because they are watchful and careful. With daily care and help from your doctors, you can be one of those people. **FF**

Healthy Living with Diabetes

By Mary Beth Callahan, ACSW/LMSW-ACP

Living with diabetes can be challenging; however, you can have a big influence on your blood sugar and your overall health by watching your diet, exercising, lowering your stress and making small lifestyle changes. It is also important to know what benefits are available to help you manage diabetes. Even little steps can make a big difference. The American Diabetes Association Web site (www.diabetes.org) provides several ideas to help you get started. Managing stress levels and finding ways to pay for tools that help with diabetes control are two steps toward healthy living.

▶ TAKING CARE OF BUSINESS — TAKING CARE OF STRESS

All of us experience stress. When stress occurs, the body prepares to take action. This preparation is called the “fight-or-flight” response. This response makes a lot of our stored energy—glucose (sugar) and fat—ready to go to work in the cells in our body. These cells are then ready to help the body get away from danger. If you have diabetes, the “fight-or-flight” response does not work well. The insulin is not always able to let the extra energy into the cells, so the glucose piles up in the blood.



When stress lasts a long time—because of surgery, chronic illness or juggling work with dialysis—hormones that are designed to deal with a short-term stressful event stay turned on for a long time. As a result, long-term

stress can cause long-term high blood sugar levels.

Stress can also cause higher blood sugar because people under stress may not take good care of themselves. They may drink more alcohol or exercise less. They may forget to check their blood sugar levels or plan good meals.

You can find out if mental stress affects your sugar control. Before you check your blood sugar level, write down a number rating your mental stress level on a scale of 1 to 10. Then write down your glucose level next to it. After doing this for a week or two, look for a pattern. Do high stress levels often occur with high sugar levels and low stress levels with low sugar levels? If so, stress may affect your glucose control. There are many ways that managing the stress in your life can help you manage your diabetes. Some of these ideas can be found in the Winter 2002 issue of *Family Focus* “Life is Like a Rubber Band,” page 8. (To view on-line, go to www.kidney.org/patients/backissues.cfm and select this issue.)

▶ INSURANCE FOR PEOPLE WITH DIABETES

Medicare covers a portion of diabetes education. This may include a Medicare-approved diabetes education program under a plan of care prepared by your doctor, medical nutrition therapy (three hours of one-on-one medical nutrition therapy the first year you receive the service and two hours each year after that), blood sugar monitoring supplies, insulin pumps and supplies for using the pump. Medicare covers the same type of blood sugar testing supplies for people with diabetes whether or not they use insulin.

Try to find a pharmacy or supplier that accepts assignment for Medicare-covered supplies. If the pharmacy or supplier accepts assignment, Medicare will reimburse the pharmacy or supplier directly. You should only pay your co-insurance amount when you get your supplies. If no suppliers or pharmacies in your area accept Medicare assignment, you may want to order

your supplies through the mail. Talk with your nephrology social worker to explore mail order pharmacy options.

If you have Medicare Part B, have diabetes and meet certain conditions, Medicare will cover therapeutic shoes if you need them. Medicare requires that a podiatrist, podorthist or other qualified doctor prescribe the shoes and fit or give you the shoes. Finally, if you have Medicare and diabetes, Medicare will pay for part of an eye exam to check for diabetic eye disease and glaucoma. Again, financially, it is best to use a provider that accepts Medicare assignment.

The national “Participating Physician Directory” contains names, addresses and specialties of Medicare participating physicians who accept assignment on Medicare claims. You can get the free “Participating Physician Directory” at www.medicare.gov or by calling 1-800-MEDICARE (633-4227); (TTY users should call 1-877-486-2048). 

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It is Not Just the Sugar: Preventing or Delaying Type 2 Diabetes

By Kelly Evarts Chambers, MS, RD, CDE

The increase in the number of people in the United States diagnosed with Type 2 diabetes is alarming. Since 1991, diabetes has increased by 60 percent in the U.S. Type 2 diabetes, once thought to be an adult disease, is now also being diagnosed in children. On the positive side, Type 2 diabetes is caused by specific health conditions, and there are steps you can take to lower your chances of developing it.

There are a number of health conditions that are grouped together and referred to as Syndrome X. This syndrome, or group of health conditions, was defined in 1988 by Dr. Gerald Raven. If you have Syndrome X, you may be at risk for developing Type 2 diabetes and/or having a heart attack. The following are the health conditions that make up Syndrome X:

- ▶ Prediabetes, which is a fasting blood sugar level between 110-125 mg/dL
- ▶ High insulin levels in your blood due to insulin resistance. Insulin resistance means that your cells are resistant or insensitive to the insulin, so your body has to make even more insulin in order to keep your blood sugar normal.
- ▶ Being overweight, especially around the midsection.
- ▶ Low level of good cholesterol or HDL (high density lipoprotein)
- ▶ High triglyceride level (triglycerides are the most common form of fat in your diet and body)
- ▶ High blood pressure (greater than 140/90)

So how do you lower your risk for getting Type 2 diabetes? The two most important things you can do are to increase your physical activity and lose weight if you are overweight. A recent study showed that people who do moderate exercise (such as walking) 30 minutes a day and lower their body weight by 9 percent had a 58 percent lower chance of developing Type 2 diabetes. So if you weigh 200 pounds and have been told you are overweight, you

should try to lose 10 to 20 pounds. Exercise will also help increase your good cholesterol (HDL) and lower your triglyceride level, blood pressure and blood sugar. Little changes, like parking farther away from the store or doctor's office and taking the stairs instead of the elevator, are a good start to increasing physical activity. Be sure to talk with your doctor before starting an exercise program.

Since obesity and high triglyceride levels are risk factors for Syndrome X, it helps to lower the amount of fat in your diet. There are different types of dietary fat: saturated, polyunsaturated and monounsaturated. Saturated fat (found in whole milk, butter, fatty red meats, poultry with skin and products made with shortening, lard, palm, palm kernel or coconut oils) will raise your cholesterol level more than anything else in your diet. The healthier types of fat, called polyunsaturated and monounsaturated fat, can help lower your bad cholesterol. Polyunsaturated fat is found in tub margarine and most vegetable oils (corn, safflower or soybean). Monounsaturated fat is found in olive, canola and peanut oils. Other healthy food choices include lean ground meat, skinless poultry breast, low fat condiments such as salad dressings and mayonnaise, and low fat dairy products (i.e., nonfat or one percent milk, low fat cottage cheese, low fat sour cream).

Carbohydrates can also affect your blood sugar and triglyceride level. Our body needs carbohydrates, but some carbohydrate choices are better than others. Avoid foods that are high in simple sugar and low in nutritional value, such as table sugar, regular soda, maple syrup, cakes, cookies and pies. Healthier choices are foods high in complex carbohydrates and fiber, such as whole grain breads, dried beans, brown rice, bran cereals and fresh fruits and vegetables. These foods generally do not raise your blood sugar as quickly as those high in simple sugars.

Adults are not the only ones affect-

ed by high cholesterol, Type 2 diabetes or obesity. The number of obese children has gone up a lot in the past 10 years. About 30 percent of all adolescents and teenagers are thought to be overweight and about 15 percent are obese. This extra body weight is now causing chronic diseases that were once mostly found in adults. Many of the healthy eating hints mentioned above such as lowering simple sugar and fat are appropriate for children, too. Daily physical activity is also important; try to find an activity that your children enjoy, such as riding a bike, playing sports or swimming and, if you are able, join them.



It is often hard to make lifestyle changes. Focus on one or two areas that you feel need improvement. It is often easier to fix one or two problems rather than changing all of your eating habits at one time. For example, you may find that you eat out five or six times a week, so your goal may be to limit dining out to three times a week. I encourage you to work with your dietitian as you chart your way to a healthier lifestyle.



About the Author

Kelly Evarts Chambers, MS, RD, CDE has been a practicing dietitian for over 12 years. She currently specializes in diabetes and kidney disease. Kelly is a Certified Diabetes Educator and works at Providence Hood River Memorial Hospital and Ray Yasui Dialysis Unit in Hood River, Oregon.

Transplant Options with Diabetes

By Linda Harte, RN, BSN, MA, CNN, CCT

Diabetes is the number one cause of kidney failure in this country. Transplantation, which is one form of treatment for chronic kidney failure, can be performed in people with Type 1 or Type 2 diabetes. The complications of diabetes can make transplantation of any type more risky than for someone without diabetes; however, studies have shown that long-term survival for diabetic transplant recipients is greater than the survival of those with diabetes who are on dialysis.

Not all people with diabetes are candidates for transplantation. This is because of the high risk of heart attack, stroke, infection and poor wound healing for diabetics. It is very important for the transplant team to evaluate each diabetic person carefully before considering transplantation. In particular, the blood vessels around the heart, and those leading to the brain and legs must be checked for narrowing and disease. High blood pressure must be brought under control. For candidates to receive a pancreas transplant, bladder function must be tested. A kidney transplant is a wonderful gift and it is very important to put a new kidney into a body that is as "healthy" as possible. Whenever possible, problems detected by these tests will be corrected prior to any transplant.

The types of transplants available for a person with diabetes are kidney transplant alone, combined kidney-

pancreas transplant, pancreas transplant alone or pancreatic islet cell transplant. Some larger transplant programs offer all of these types of transplant. Smaller programs may only offer kidney transplantation. If you are interested in a transplant option that is not available at your transplant center ask to be referred to another program for more information.



- A kidney transplant alone means a life without dialysis as long as the transplanted kidney survives. Even though you may feel much better and can usually enjoy an improved diet, diabetes with its treatment and other complications still exists. Close, regular follow-up with the transplant team is absolutely necessary to monitor kidney function and blood sugar control. Poor blood pressure and blood sugar control after a successful transplant will damage the new kidney.

- Type 2 diabetes can often be managed with diet, weight loss and oral medication. Therefore, kidney-pancreas transplantation together is generally done with those who have Type 1 diabetes. If this type of transplant is successful there is no longer the need for dialysis or for insulin. Blood sugars can be close to normal as soon as 12 hours after surgery. Recipients will no longer need a diabetic diet if the transplant is successful. If the transplant is done early in the diagnosis of kidney problems, some of the complications such as neuropathy (nerve damage) and retinopathy (disease in the blood vessels in the eyes) can be stopped, slowed down or reversed. The risks for complications with a kidney-pan-

creas transplant such as leaking from the bladder and infection are higher than for a kidney alone because the pancreas is more technically difficult to transplant because of its placement. A combined kidney-pancreas transplant is usually recommended for patients without a history of heart problems. It is typically better if the transplant surgery is done when kidney disease is first found and before too many complications develop from the diabetes.

- Pancreatic islet cell transplantation involves taking the cells that are needed to produce insulin from a donor's pancreas and infusing them (similar to a blood transfusion) into a large vein in the person receiving the transplant. Preparing and keeping these cells alive for transplantation is difficult. While it is a minor surgical procedure, rejection is seen more often with this type of transplantation. Much research is being done to make this a more successful choice for people with diabetes.
- Pancreas transplantation alone can be done in people with severe complications of diabetes but with fairly good kidney function. The aim of this type of transplantation is to prevent or delay kidney failure and other complications. More often, pancreas transplantation is done in people who already have a good functioning kidney transplant and are doing well with few complications.

After any type of transplant, very close follow-up with your doctor and other health care team members is important. In someone with diabetes who has received a kidney transplant alone, heart and blood vessel disease, infections, retinopathy, neuropathy and even kidney disease can occur if blood sugars and blood pressures are not strictly controlled. However, it is still the opinion of most kidney doctors that transplantation is a good treatment for many people with diabetes. If you have diabetes, discuss all of the options of transplantation with your doctor and health care team.



Transplantation Medications and Type 2 Diabetes Mellitus

By William M. Bennett, MD

Kidney transplantation is now the treatment of choice for kidney failure. Even with conditions such as heart disease or diabetes mellitus, people with kidney transplants still live longer than those on dialysis, and generally have a better quality of life.

However, health problems can still happen, even after transplantation. The leading cause of death after kidney transplantation is cardiovascular disease, especially among transplant recipients with diabetes mellitus. This is due to the damage to blood vessels in the heart and other parts of the body from years of diabetes. Therefore, it is extremely important for diabetics to try to prevent conditions that cause heart disease. It is generally agreed that keeping an ideal body weight, quitting smoking, good nutrition and exercise are important for staying healthy after transplantation.



Even though the results of transplantation can be very good, you can develop diabetes after transplantation. One cause is medications. Some of the common medications responsible for causing diabetes are corticosteroids (Prednisone and Solumedrol) and calcineurin inhibitors (Prograf and cyclosporine). Weight gain and smoking also contribute.

Corticosteroids are well known to cause insulin resistance and hyperglycemia (high blood sugar) following transplantation. Post-transplant diabetes occurs in over 20 percent of people with a family history of diabetes, African Americans and those who are overweight. The major challenge for those on steroid therapy is control of blood sugar. This can be done by pay-

ing close attention to diet, keeping normal body weight and carefully controlling lipids (fats) in the blood. It is very important for the health care team to lower the steroid dose to the lowest level while still keeping the kidney rejection-free. This can best be done when steroids are used together with the newer anti-rejection medications such as mycophenolate mofetil (CellCept) and sirolimus (Rapamune). With transplant recipients who have little or no rejection during their first post-transplant year, steroid withdrawal has been done safely in many transplant centers. There is a slightly increased risk of rejection with steroid withdrawal, so it is important for the health care team to closely watch kidney function by measuring the levels of serum creatinine (a waste product in the blood) every two weeks. Studies have shown that African Americans may have more risk for rejection. Therefore, steroid withdrawal may not be advisable for African Americans.

The other medications associated with development of Type 2 diabetes are calcineurin inhibitors (cyclosporine and Prograf). In studies, tacrolimus (Prograf) has been associated with a greater chance of getting diabetes mellitus after the transplant, especially when it is used by those with other risk factors, including obesity, family history of diabetes, and steroid use. The tendency to develop diabetes can be related to the dose and blood levels of these medications. Even with the "ideal" blood levels and doses of cyclosporine or tacrolimus to prevent rejection, diabetes can occur. In some patients, cyclosporine may be used instead of tacrolimus if there is a high risk of developing diabetes after transplantation.

In order to keep people with transplants as healthy as possible with good, working kidneys, it should be emphasized before transplantation and then often after the transplant, that keeping an ideal body weight, controlling blood pressure and controlling blood sugar by oral hypoglycemic agents (such as glyburide and metformin), diet or even insulin are extremely important. In people who

are at risk for getting diabetes, different combinations of medications can lower this possibility. Discuss the various options for medications to treat rejection with your health care team so the best therapy can be selected for you. **FF**

About the Author

William M. Bennett, MD, of the Northwest Renal Clinic, is the Medical Director, Solid Organ and Cellular Transplantation at Legacy Good Samaritan Hospital in Portland, Oregon.



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Both Sides of the Coin

By Kathleen Collins

Throughout my 30 years as a registered nurse I must admit that I categorized my patients. Sometimes it was because of their condition and other times it was because of their behavior. I would label a patient as cooperative, uncooperative or unmanageable: good, bad or ugly. I, along with many other staff members, felt that patients should look to the doctors and nurses for guidance in their care and trust our judgment. After all, did we not have their best interest at heart?



Kathleen Collins, shown here with her husband and children, worked as a registered nurse for 30 years.

As time passed, I discovered that some doctors and nurses were not always right and did not always have the patient's best interest at heart. This is when I became a patient advocate, someone who speaks up for the patient to ensure they receive appropriate care and are treated with respect. I began to fight for patient rights long before they became required in hospitals, nursing homes and dialysis centers.

Even though I was at times unable not to categorize patients, I tried not to let my feelings affect the quality and quantity of care I provided. I encouraged my patients to express their true

feelings and complaints. I did what I could to correct any problems and explained things to patients that were causing them concern. I felt that if a patient understood more about the tests, treatments and other care they were receiving, they would be more able to cooperate. I believed that lack of knowledge made a patient feel out of control or afraid and that this could be the root of much of what was known as uncooperative or even "bad" behavior. But it took my experiences as a patient to fully appreciate how important patient rights are to promoting understanding and cooperation from the patient.

In March of 1999 I went on disability due to blindness as a result of long years of diabetes. I loved being a nurse and found this drastic change of lifestyle very depressing. Then in December of that year I was diagnosed with chronic kidney failure. I was placed on a very restrictive renal diet and a whole bag full of medications. I had a shunt placed in my arm in August of 2000 in preparation for dialysis. I started dialysis in June of 2001. This is when the nurse became the patient and found that the other side of the coin was a whole new ball game.

Experiencing chronic and long-term illness up front and personal caused a lot of emotional as well as physical turmoil in my life. It was sometimes difficult to be a good, cooperative patient. I found that there were times when I felt out of control and these feelings would spill over at the oddest times. I sometimes cried while on dialysis. I would give short and even rude answers to the dialysis center staff. Then I would feel guilty later and feel that I was one of those patients I had labeled as "bad" or maybe even "ugly." This was a very disturbing feeling to me, and I wanted to get my feelings and actions back under control.

"I began to take control of the situation by being more in control and not allowing myself to feel overwhelmed by circumstances."

Through much prayer and meditation I began to realize that I was in a state of denial and rejection of my situation. I thought of what I would tell my patients when I was a practicing nurse. I would encourage them to become part of the care team and to express their thoughts and ask questions. I started talking to the staff at every opportunity. I learned about the process of dialysis and the treatment routine. I then was able to gently remind the staff if they forgot something in their rush to get patients on and off the machines. I talked with other patients and shared my thoughts and feelings. I started writing articles about my experiences and sent them to newspapers, newsletters and magazines. I shared these articles with the staff at the dialysis center and with some of the patients. I began to take control of the situation by being more in control and not allowing myself to feel overwhelmed by circumstances.

I then reviewed the patient rights policies and this also made me feel more in control and more a part of the care team. I may not always be a "good" patient when my treatments do not go as well as they should some days, but I no longer revert to being a "bad" or even "ugly" patient. I am taking my rights and responsibilities seriously and this has made all the difference. **FF**

About the Author

Kathleen Collins is a wife, mother and grandmother who lives in Hampton, South Carolina.

Guidelines for Diabetes Underway

By Jennifer Martin, National Kidney Foundation

Over 60 recognized experts were brought together on May 7-8, 2003 in Chicago, Illinois for the National Kidney Foundation's (NKF) Consensus Conference on Diabetes and Transplantation. The purpose of the meeting was to develop guidelines to improve the care provided to people with diabetes who have chronic kidney disease (CKD) both before and after they receive a transplant, as well as to work to lower the rate of post-transplant diabetes.

The Consensus Conference is part of a major NKF project on diabetes, which is being developed to help diabetic transplant recipients keep their transplant and remain in the best possible health after a transplant and to improve the outcomes of kidney transplantation for people with diabetes. The conference Co-chairs were Robert Gaston, MD, and Francis Delmonico, MD.

Conference participants met in four work groups to discuss different aspects of the topic: 1) Pre-transplant evaluation of the person with diabetes and their management on the wait list; 2) therapeutic alternatives for the individual who has diabetes and CKD; 3) minimizing occurrence of post-transplant diabetes; and 4) optimizing long-term kidney transplant outcomes of those with diabetes.

Recommended guidelines are being developed for publication and will include special precautions for treating and preventing diabetes, the risks and benefits of different treatment options, and protocols for immunosuppression and treatment. They may also include recommendations for follow-up activities to be undertaken by the NKF and other groups, such as the development of tools for health care workers, educational offerings, patient information materials or ideas for changing practice and procedures at the transplant

center or doctor's office. The conference participants may also suggest the development of formal K/DOQI Clinical Practice Guidelines on diabetes and CKD.

The NKF will develop programs to help make possible widespread adoption of the recommendations to improve the care provided to people with diabetes who have CKD as well as the outcome of their care.

Novartis and United Resource Networks provided funding for this conference.

If you want to be on the NKF's e-mail list for follow-up information from the Diabetes and Transplantation Consensus Conference, please send your request to jenm@kidney.org 

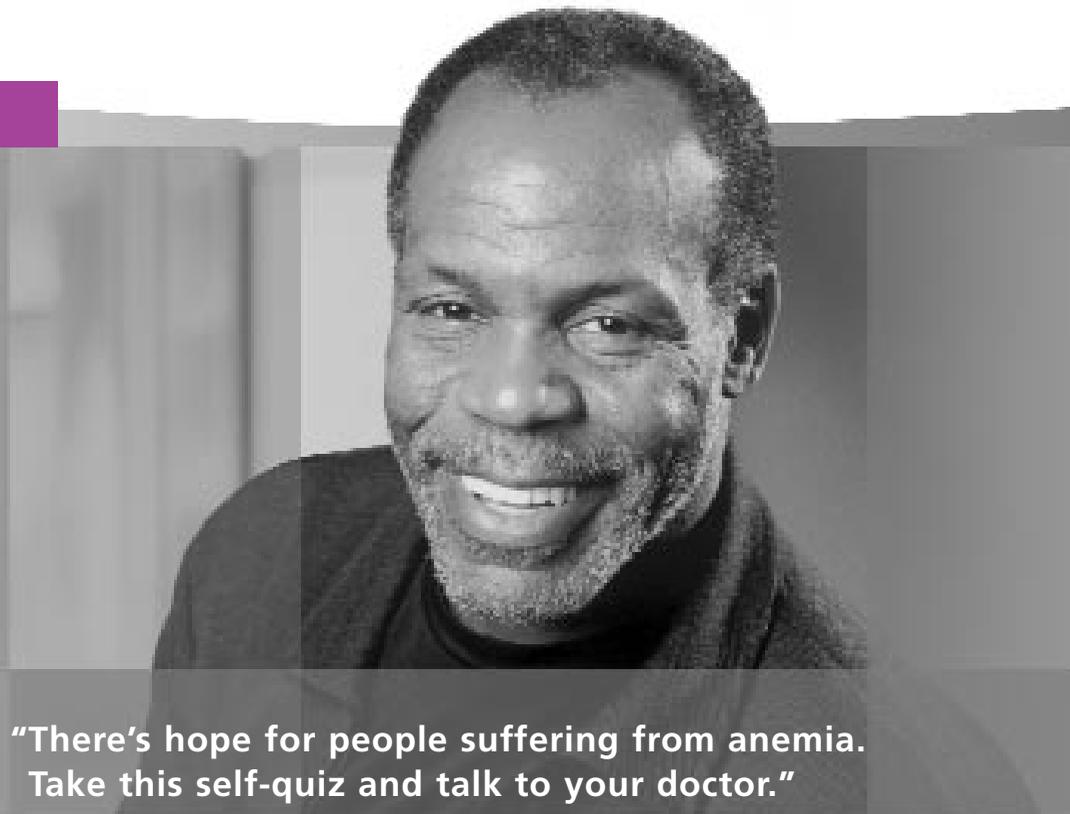
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