



Parents' Bulletin

February 2010

Happy Easter

As Christmas decorations come down, the shops start to stock up on the next chocolate frenzy known as Easter. Chocolate is everywhere and as a parent it is a daunting time of year as we think about balancing diabetes and making sure our children don't miss out on all the Easter fun.

In my experience of having diabetes for over 30 years, dealing with times like Easter becomes easier with knowledge but mainly experience. With the best will in the world, people can tell you carbohydrate values in treats such as sweets and chocolate and while this is helpful information, it but does not always help to explain the fluctuations in blood sugar readings that can occur after indulging in treats.

We have put together some practical information and I have also roped in my mum and brother so they can give their experience of how they dealt with the dreaded chocolate treats.



Easter And Counting Carbs

Different types of carbohydrate

Quick-acting carbohydrates

Some carbohydrates are quick-acting eg sweet foods such as cakes, puddings, chocolate. Sugary foods will raise blood sugars more quickly and higher in people with diabetes and more injected insulin or medications may be necessary. Sugary carbohydrates tend not to last as long in the body so blood sugars may drop before the next

meal. Sugary carbohydrates tend to make blood glucose levels peak and trough.

Slow-acting carbohydrates

Some carbohydrates are slower acting and last longer eg bread, potatoes and high fibre cereals. These carbohydrates do not raise the blood sugars as quickly or as high after eating. They last longer and therefore tend to give more even blood glucose levels. The amount of insulin, or in Type 2 diabetes medication, needed may be less if sugary foods are avoided and the diet is made up of slower and longer-acting carbohydrates.

For people with diabetes, the slow-acting carbohydrates are better because they last longer to balance the amount of insulin or medication that has been given.

Table 1

	Weight	Carbs	Fat
Milk Chocolate	25g	14.9g	7.6g
White Chocolate	25g	14.6g	7.7g
Plain Chocolate	25g	16.2g	7.3g
Crunchie	25g	18g	4.5g
Cream Egg	25g	17.9g	4g
Boost	25g	15.5 g	7.3g
Buttons	25g	14.5g	7.4g
Chocolate Eclairs	25g	18g	0.7g
Chocolate Orange	25g	14.5g	7.4g
Kit Kat	25g/4 fingers	14.4g	6.6g
Flake	25g	13.9g	5.2g
Double Decker	25g	16.2g	1.3g
Fruit Gums	25g	20g	1.2g
Fruit Pastillies	25g	20.9g	0g
Fudge	25g	18g	4.1g

For more information about carbohydrate please email
bev@iddtinternational.org or give IDDT a call on 01604 622837

If you have any bright ideas of how to raise awareness of childhood diabetes, contact Bev on 01604 622837 or e-mail bev@iddtinternational.org

Puzzles of Easter

I have diabetes and I would like to explain how my family and I dealt with Easter after my diagnosis.

My memories of Easter are all pleasant and I have no hang ups when Easter comes along so I guess my mum got it right for me and my brother at Easter. It is true there were never massive amounts of chocolate at Easter but we had some. I really could not tell you what type of eggs we got or how big they were. The thing I do remember clearly from Easter is two wonderful presents I received from my Grandma. One year she bought me a hand painted china egg which took pride of place in my bedroom and showing it to all my over. Another Easter me that really sticks in my memory was a decorated card board egg but this slid apart in the middle and inside was a whole host of little fluffy chicks. I played with these for hours and as my mum reminds me, I left the Easter egg that she had worried over on the side and it was still there the next day.



I was lucky I never had a particularly sweet tooth as a child and do not remember having any huge cravings for chocolates and sweets. I also do not remember feeling I had been denied chocolate and sweets either because my mum did a very brave and clever thing, she allowed me and my brother to have treats. She lovingly made us believe that chocolate and sweets were treats and that treats could not happen every day or they would not be special. To me this made Easter even better as it was not just another Easter Egg but a special

Egg especially for me. Well Done Mum -wish I still had the same self control today.

Mum Dealing with Easter

The first year that Bev had diabetes, I dreaded the whole chocolate Easter thing. Over 30 years ago, sweets were a definite no, no for someone with diabetes but we bucked the system and decided that it would be unfair to deny Bev, and therefore her brother, at least one Easter egg. So I weighed a fairly standard-sized Easter egg and realised that they don't contain much chocolate because they are actually very thin. (See Table 1 on page 2, this shows a carbohydrate count of chocolate and other treats). So Bev ate her egg in pieces, usually after a meal so the chocolate did not raise her blood sugars as much as if she just ate it at any other time of day. Yes, I did know that chocolate also contained fat but for one day, I didn't and don't think it matters too much.

One of the real problems though was that family and friends also usually gave the children Easter eggs, so before diabetes hit our family they used to get at least half a dozen eggs each. We decided to bring back an old family tradition which was that children left a basket behind the bathroom door for Easter Bunny to visit during the night – rather like Father Christmas. Don't ask me why it was behind the bathroom door, it was something my brother and I did as children many years earlier!

So with diabetes in the family, instead of just leaving chocolate eggs in the basket, in our house Easter Bunny left one egg and a lot of little parcels – new colouring books, crayons and those sorts of things. They lasted much longer, were just as enjoyable and the children liked having surprises!

We explained the situation to friends and family and they were more

than happy to give little parcels instead of eggs. Family and friends often worry about doing the right thing, so it also helped them to know how to handle this new situation for our family.

I now have grandchildren, who thankfully don't have diabetes, and they get several Easter eggs but I notice that they hardly ever manage to eat them all and they end up being left in a cupboard! So I now wonder if I worried too much about getting it right at Easter?

My Brother Dealing with Easter

To be perfectly honest, I don't really remember Easter before Bev was diagnosed as I would only have been about 5. However, one thing that I do remember is that there were not lots of eggs around. That does not mean that Easter was not something to look forward to, certainly there were a couple of eggs but the little presents that came along with them were far more fun. Unwrapping them on Easter morning meant that Easter became more like a miniature version of Christmas! In hindsight, I can also see that it taught us to enjoy the chocolate eggs that we did get and that we should not eat it all at once but make it last.

I suppose Easter in our house was just a bit different. Another thing I do recall is going to school the next day and everybody competing to see who had got the most eggs. I was certainly not in the running for that competition but wasn't bothered because I was perfectly happy with what I had been given. I can also remember thinking how silly some of them sounded when they claimed that they been given ridiculous amounts of eggs. I suppose another thing we never had in our house was the stomach ache that went along with gorging on too much chocolate!

Now I have a daughter of my own and although she does not have diabetes I still do not like the thought of her getting lots and lots of

eggs. She gets several eggs from friends and family but I have stuck to the principal of only buying her one from me, along with several other little presents (or as she has got older one larger, and usually more expensive, present!). I have always done this and would like to think that she has never been disappointed at Easter, so I suppose while the first Easter after diagnosis will be the hardest, if you start as you mean to go on Easter can be just as enjoyable as ever.

Changes In The Reporting Of HbA1c

Just to remind you, HbA1cs will be reported in units of 'mmols/mol' and not the percentage figure we are used to. If this looks a little familiar it is because our home blood glucose test results are measured in 'mmols/l' which is not the same.

From June 2009, HbA1c results in the UK will be given in both percentage and mmol/mol to give everyone time to get used to the new units. From April 1st 2011, the results will be reported only in mmol/mol.

The relationship between the old and the new measurements

Old HbA1c [%]	New HbA1c [mmol/mol]
6.0	42
6.5	48
7.0	53
7.5	59
8.0	64
9.0	75

* So if you are aiming for HbA1c targets of 6.5% and 7.5%, the new units will be 48mmol/mol and 59mmol/mol.

* Normal blood glucose [in someone without diabetes] is 4 - 6% but in the new units it will be 20 - 42mmol/mol.

Ask Dr Laurence – Your Questions Answered

Question: My daughter was diagnosed 6 years ago with Type 1 diabetes and she is now 13 years old. We have struggled very hard to control her blood sugars but everything that has been suggested does not appear to work. Mainly her blood sugars will drop even after she has eaten. My daughter is very under developed for a 13 year old and she struggles to gain weight, she is constantly tired and sometimes complains of feeling sick.

After some research I realised that these symptoms could mean she has coeliac disease but when suggesting this to my GP he was very reluctant to do any tests and I really don't know where to go from here. Do you think my fears are worth pursuing?

Answer: Diabetes and coeliac disease share common genetic origins and in children with diabetes up to 10% may also have coeliac disease. The figure for the non-diabetic population is 1%. Going on to a gluten free diet will control coeliac disease but clearly this is an added stress when added to the dietary challenges of diabetes. There are a wide range of gluten free products available for coeliac disease.

The symptoms of poor growth and development may well indicate coeliac disease and I would certainly wish to pursue this with blood and stool tests. In addition, a full endocrine assessment including the pituitary gland would be a good idea to rule out other possible causes of these symptoms.

For more information on coeliac disease and diabetes contact IDDT for our Free leaflet on 01604 622837 or bev@iddtinternational.org

or

Coeliac UK, PO Box 220, High Wycombe. Bucks HP11 2HY Tel 01494 437278 Helpline 0870 44448804 www.coeliac.co.uk

Introduction To IDDT Trustee – John Birbeck



My involvement with IDDT stems from my wife Sue having Type 1 diabetes. She was diagnosed 36 years ago, shortly after we got married. She has never really understood why she became a diabetic, perhaps the shock of getting married! No, more probably it followed on from a short

course of steroids prescribed to treat a lung condition. At this time the only insulin available, was animal and she was prescribed animal Lente, being a combination of both short and long-acting, which was injected once a day. This is a long way from today – Sue now injects four times a day with a pen instead of a glass syringe that needed sterilising each time. Glucose monitors were not available then either.

Sue lived with diabetes quite successfully for a number of years, although the birth of our second son was difficult. Happily our son, although born prematurely, has not appeared to suffer from these early complications. Apart from the occasional ‘hypos’, nothing significant occurred until December 1987, when, whilst driving with the two boys, without warning Sue had ‘hypo’, which caused a serious car accident. Fortunately, no-one was seriously injured, although the car was a write-off. It sounds incredulous but animal Actrapid had been replaced by the new synthetic GM insulin, Human Actrapid, but Sue only knew about this change when she picked up her medication from the pharmacy and began using it just three days prior to the accident! It transpired that Sue needed several units less of human insulin than she had of animal. It seemed that the medical professionals had accepted the pharmaceutical company’s assurances that this new GM insulin was superior to the animal insulin which had been successfully used for over sixty years.

Whilst this new GM insulin suited many people, for others it had side-

effects, one of the most significant being ‘loss of hypo warnings’ – warnings are so vital to living successfully with diabetes, and clearly a major factor in the car accident. Sue’s consultant recommended a reduction in the dose of short-acting insulin but she remained on human insulin. Living without warning signs of impending hypos became a grave concern, and unfortunately in the mid 90’s, Sue had yet another serious head-on car accident. She was completely oblivious to having driven for five miles in the opposite direction to that planned. Again there were no serious injuries, but managing diabetes with no ‘warnings’ made life very stressful – there appeared no obvious solution.

A few years later an article appeared in the Daily Mail highlighting that many people with Type 1 diabetes experienced major side-effects following their use of human insulins. Unfortunately, in some cases these side effects resulted in deaths. This article clearly highlighted that a number of people with diabetes were more suited to animal insulin. The contact referred to in the article was IDDT, and as they say, the rest is history. Convincing Sue’s consultant to revert to animal insulin was a real challenge, as she was made to feel foolish in making the suggestion but she stood her ground and reverted back to animal.

IDDT has campaigned long and hard for people with diabetes to have a choice of insulin available and after lobbying for many years, the Minister of State for Health issued the following statement:-

“The Department of Health fully accepts that some people are better suited to animal insulin, and that animal insulin should continue to be made available.”

On the face of it, success but the fight to guarantee supplies of animal insulin continues. I was really honoured to be asked to become an IDDT Trustee in 2008. Although now retired, my professional background was in Information Technology for nearly 40 years working for a major pharmaceutical company, where I held a number of senior roles.

With my knowledge of the industry, it is clear that the driving force of

all the major pharmaceutical companies is primarily to ensure their share-holders get a return on their investment. However, in trying to achieve this objective, the long-term wellbeing of the patient is often compromised, with the rush to get the product launched!

Finally, it is worth re-iterating that IDDT is funded by its members and is therefore not influenced in any way by the pharmaceutical industry, thereby enabling the organisation to tackle any issue raised by members.



Adjusting Insulin Doses

Adjusting your child's insulin dose is not easy, learning and gaining confidence can take time. To try to point you in the right direction here is some information that may help. When adjusting your child's insulin dose it is essential to check their blood glucose levels before a meal, 2 hours after the meal and if you can during the night. This will help to see the results of the adjustments you are making. (See table 1)

Writing this part of the article feels like I am asking for the impossible but it is a good idea to have a blood glucose target in mind when you start to adjust insulin doses.

The ideal targets are not below 4mmol/l and not above 10mmol/l but don't set yourself an impossible task. You can bring glucose readings down in stages. For example, if your child is waking in the morning at 15mmol/l aiming for blood glucose readings of 4mmol/l would be very difficult, so aim for 10mmol/l then when you reach that target have a little break and start again to try to get the readings lower.

24 Hour Profile Test
Blood tests:
1. Before each meal.
2. 11/2 – 2 hours after a meal.
3. One test during the hours of 2 – 6 am.

Basic Rules

- A blood glucose profile cannot be interpreted correctly if a hypo has occurred in the previous 24 hours – a high blood glucose level could be the result of a rebound following a hypo.
- Begin by decreasing the dose to avoid hypos before attempting long – term adjustments. If a hypo occurs without an apparent reason (such as not as a result of extra exercise or lack of food) you should reduce the existing insulin dose the following day. (See table 2 below)
- It is a good idea to try and keep the carbohydrate content of meals and the amount physical exercise as constant as you can when adjusting insulin doses. Knowing the total carbohydrate intake for meals and nacks is more important when adjusting the pre-meal insulin dose.
- Do not change more than one dose at a time. It is easy to end up in a vicious circle when you don't know which adjustment has caused what.
- Don't make large changes in a dose all at once. (See table 2)
- Wait a couple of days between changes in insulin doses so that you can see clearly what the outcome of the changes are. There will always be a deposit of insulin in the body and it will take a couple of days before this has sorted itself out.

Table 2

By how much at a time should the dose be changed	
If you need to change the rapid or short – acting insulin dose, for instance when someone is running a temperature, while they are exercising or when they are eating more or less food than usual, Ragnar Hanas (author of Type 1 Diabetes) recommends the following changes to start out with:	
If the usual insulin dose is	Change the dose by
1 – 3 units	1/2 unit
4 – 9 units	1 unit
>10 units	2 units

Year Six Lesson Plan To Teach Children And Schools More About Type 1 Diabetes

We know that some parents have trouble getting their children's schools to understand diabetes and nationally there is still a long way to go in educating people about diabetes, so we have come up with a Year Six Lesson Plan that is designed to help.

Personal Social Health & Economic Education (PSHE) is currently a non-statutory part of the curriculum. Many schools choose to teach it because they find their pupils benefit from learning through presentations, creating posters and role play enabling them to manage their feelings and build positive relationships with others. PSHE promotes positive behaviour, mutual respect and self-awareness.

We felt PSHE classes would be an ideal place to raise awareness and understanding of diabetes. Our Year Six Lesson Plan will be launched at the Birmingham Education Show in March and will be free to all Primary School teachers. If you would like a Lesson Plan to take into your child's school then e mail me at: bev@iddtinternational.org or give me a ring on 01604 622837.

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Hall of Fame



Ben is 3 years old and was diagnosed with Type 1 at 13 months old and copes really well with all aspects of his condition. Ben has been extremely brave and has just started injecting into his tummy. He keeps everyone smiling and is a real livewire. Ben's Mum, little brother Aaron and all of us at IDDT are extremely proud of Ben as

he lets nothing stand in his way. We also wish Ben good luck when he starts nursery.



Here is a fab picture of Emily, her mum Helen, and her twin sisters Hollie and Maisie taken by a York Newspaper.

Emily has been using an insulin pump for a year and it is amazing how well she has coped. Her Mum suggested going to a meeting at Emily's Diabetes Unit and she decided to give the pump a try. Emily was a bit wary at first, worrying about how it would all work and what it would look like. The little machine she uses for her blood tests sends a message to the pump which in turn regulates her insulin. Emily has nominated her Mum for 'parent of the year' for being so caring and understanding. IDDT and Emily's Grandma feel that Emily also deserves a great big pat on the back for the way she 'just gets on with it' without a moan. Well done Emily we are all really proud of you.

How to get on to the Hall of Fame

It's easy, simply email a photo of your kids to bev@iddtinternational.org and let us know why you think they should be up on the Hall of Fame.

If you would like to join IDDT, or know of someone who would, please fill in the form (block letters) and return it to:

IDDT

PO Box 294
Northampton
NN1 4XS

Name: _____

Address: _____

Postcode: _____

Tel No: _____

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From Your Editor – Bev Freeman

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