

population, but ideally they should not give any mention to diabetes (or obesity) but only objective characteristics (i.e., salt content, calories, glycemic index, or merely effect on blood glucose), and it should be the duty of well-informed individuals to decide, with the help of a dietitian and/or doctor, to choose the sort and amount of food to be consumed.

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Reply

Dr. Slama discusses two general concepts with reference to our study concerning the metabolic response to an oral challenge of hydrogenated starch hydrolysate (HSH) versus glucose in diabetes (1).

The first concept concerns foods being designated as “good” or “bad” for people with diabetes. We have no quarrel with this and agree with the American Diabetes Association’s position statement on food labeling, which states that “no food should be designated or promoted as ‘good’ or ‘bad’, ‘healthful,’ or ‘unhealthful’ ” (2). In fact, such words are meaningful only when considered in the context of an individual’s overall food consumption, life-style, location in the continuum of education (survival through fine tuning), clinical goals (e.g., weight loss and glycemic control), diabetes medication, and degree of risk for other complications (hypertension, cardiovascular disease, nephropathy).

The primary reason we performed our study was to provide further information to practitioners about an ingredient that we found on packages marketed to people with diabetes, but about which little information was available concerning “suitability.” Our study provided this “suitability” information: HSHs do not cause deterioration in glycemic control and do not cause undesirable side effects for people with diabetes compared with glucose and to nondiabetic individuals. Therefore, we find HSHs suitable for inclusion in the diet of individuals with diabetes, rather than classifying it as “good” or “bad” for people with diabetes.

The second concept addressed by Dr. Slama is an appeal for universal reporting of glycemic indexing figures for all foods studied. Although we did not provide specific glycemic index figures for the HSHs studied, the glycemia relative to glucose is stated clearly in our article (1). The specific glycemic index numbers were not indicated for the following reasons: there is no consensus about a method for calculating area under the curve (3,4) or the standard to be used (e.g., glucose [5] or bread [6]); in addition, there is no general agreement among health practitioners concerning the use of glycemic indexing as an educational tool. In fact, the National Institutes of Health Consensus Development Conference on Diet and Exercise in Non-Insulin-Dependent Diabetes Mellitus indicated that “many factors contribute to a different glycemic response from the same food. These include processing, cooking, and food storage time. Other considerations include the variable degree of mastication in the elderly with dental problems, the diurnal variation in absorption, and racial and ethnic differences. Some studies have shown diminution of glycemic effects when foods are combined in a mixed meal. For these reasons, at this time the panel does not recommend the use of specific glycemic indices in the dietary therapy of patients with NIDDM” (7).

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