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The detection of disordered eating risk in patients with type 2 diabetes mellitus

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Background and aims
Type 2 diabetes is strongly associated with obesity as the major potentially modifiable risk factor. Apart from total caloric intake, certain eating patterns have been associated with the risk of diabetes and insulinoresistance. Researchers have found that specific groups in the community may be at increased risk of eating disorders, including people with diabetes and those who are obese. The aim of the study was to detect the risk of disordered eating in patients with T2DM using EAT-26 questionnaire.

Materials and methods
We studied 107 patients with type 2 diabetes mellitus (20 men and 87 women) recruited from clinical and community settings. The mean age of the participants was $61.75 + 9.32$ years; the mean BMI was $34.39 + 6.72$ kg/m^2. The most widely used standardized measure of eating disorders symptoms the Eating Attitudes Test (EAT-26) was used for the purposes of the present study. Questions are scored on a Likert scale from 0 (never, seldom, or sometimes) to 3 (always). A score greater than 20 represents a risk for developing a eating disorder, and participants are categorised as being at risk of disordered eating.

Results
The analysis showed that 49 patients with T2DM (45,7%) have score more than 20 on EAT-26; 58 patients (54, 37%) scored less than 20. Among the subgroup of men the value 20 and more was revealed in 7 questionnaires (35%), the score less 20 – in 13 ones (65%). In the subgroup of women 42 females (48,7%) were 'positive' on their cut-offs, 45 females (51,3%) account less 20. The significantly higher mean value (2,01) was received on the question 'I avoid foods with sugar in them': 52 persons (48,6%) answered 'always', 26 persons – 'usually', 9 persons (8.4%) – 'often', 20 persons (18.7%) – 'never, seldom, or sometimes'. The higher rate on this question maybe associated with the specifity of diabetes and could influence the total score rate on the scale. Future research efforts are required to strengthen the present findings.

Conclusion
Our findings showed a high risk of disordered eating among patients with T2DM according to EAT-26 questionnaire. More research is needed to understand the role of eating disorders in T2DM.

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Gestational diabetes and weight gain in outpatient practice

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Hyperglycaemia is one of the most common medical conditions women encounter during pregnancy. The occurrence of gestational diabetes mellitus (GDM) is rising and it represents an important modifiable risk factor for adverse pregnancy outcomes. Similar to GDM, excessive weight gain is associated with a number of undesirable consequences for both the mother and neonate. The aim of this study was to evaluate prevalence of GDM in outpatient practice and investigate associations between glucose metabolism and gestational weight gain (GWG) during pregnancy.

Methods
We analysed retrospective data of all adult pregnant women who were followed up in Vilnius Karoliniskiu clinic, Lithuania and gave birth in 2016. GDM was diagnosed using the UK National Institute for Health Care Excellence (NICE) criteria. GWG was categorized as low, appropriate and excessive according to Institute of Medicine Guidelines.

Results
Data of 415 women were analysed. Mean age at delivery was 30.14 ± 5.13 years. The first antenatal visit was at 11.64 ± 4.47 gestational week. Oral glucose tolerance test was performed at 26.62 ± 4.14 gestational week. A total of 86 women (21%) were diagnosed with GDM and 4 (1%) had overt diabetes in pregnancy. 15.1% of women having GDM were normal weight, 33.3% – overweight, 51.6% – obese. Overweight and obese women had 3.68 (95% CI 2.21–6.11) times higher odds ratio for developing GDM comparing with underweight or normal weight women ($P < 0.0001$). Mean total GWG was higher in underweight and normal weight women group than that in overweight and obese women group (13.87 ± 4.85 vs 11.59 ± 5.88 kg ($P = 0.001$)). Mean total GWG was higher in normal glucose tolerance group compared to GDM group (13.73 ± 4.84 vs 12.15 ± 6.09 kg ($P = 0.03$)). Excessive GWG have had one-third (33.1%) of all women. Excessive GWG was more frequent in GDM group than in healthy women (45.9% vs 30.1%, $P = 0.009$).

Conclusions
This audit presents a relatively high prevalence of GDM in everyday outpatient practice. Overweight and obesity significantly increases risk of GDM. Compliance with lifestyle guidelines helps women with GDM to control weight gain during pregnancy, nevertheless excessive gestational weight gain is still more frequent in women with GDM.

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Oral glucose tolerance test in reclassification of gestational diabetes after delivery – results from portuguese national registry

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Introduction
Gestational diabetes (DG) is associated with higher risk of diabetes mellitus (DM), and it's recommended to perform an oral glucose tolerance test (OGTT) with 75 g after delivery to its reclassification. However, not all scientific societies recommend it.

Aim
To evaluate glucose tolerance with OGTT after delivery in women with DG and the risk factors to glucose intolerance in glycaemia at $120'$.

Methods
Retrospective cohort study that included women with DG who performed OGTT after deliver between 2012 and 2015, from national register of diabetes and pregnancy of Portuguese Society of Diabetes. The WHO diagnostic criteria were considered.

Results
7435 women were included: 92.2% ($n = 6857$) had a normal response; 0.8% ($n = 60$) presented DM criteria (43% ($n = 26$) at 0' and 57% ($n = 34$) at $120'$), 1.1% ($n = 84$) had impaired fasting glucose (IFG) and 5.9% ($n = 434$) had impaired glucose tolerance (IGT). Women with DM criteria at reclassification presented higher values at fasting glycaemia (FG) in 1st trimester (119.7 ± 35.0 vs 97.3 ± 7.1 mg/dl; $P < 0.001$), at glycaemia at $60'$ at OGTT in 2nd trimester (211.3 ± 42.3 vs 175.5 ± 30.1 mg/dl; $P < 0.001$), daily dose of insulin (31.4 ± 20.5 vs 21.7 ± 16.9 U; $P < 0.001$) and $n°$ of injections (2.9 ± 1.6 vs 2.2 ± 1.3; $P < 0.001$), and earlier diagnosis (16.4 ± 8.4 vs 19.7 ± 8.5weeks; $P = 0.004$) and delivery (37.5 ± 2.2 vs 38.4 ± 1.6; $P < 0.001$). Of 32 women with FG in 1st trimester ≥ 126 mg/dl, 34.4% had DM criteria, 18.8% IFG and 12.5% IGT at reclassification. At reclassification, women with DM criteria at $120'$, were associated with IFG after delivery (OR $= 24.17$; IC95% 11.32–51.60), insulin therapy (OR $= 7.40$; IC95% 3.14–17.44), DG diagnosis at $60'$ in 2nd trimester OGTT (OR $= 3.85$; IC 95% 1.30–11.40), newborn large for gestational age (LGA) (OR $= 3.20$; IC95% 1.59–6.46) and DG in previous pregnancy (OR $= 2.59$; IC95% 1.36–4.95). Women with IGT were associated with these risk factors and also age ≥ 35years (OR $= 1.54$; IC 95% 1.27–1.87).

Conclusion
The prevalence of glucose intolerance after delivery was 7.8%, with the majority of women (5.9%) being diagnosed with IGT, a condition with increased cardiovascular risk. DM was diagnosed in 0.8% of women, exclusively by glycaemia at $120'$ in 57%. DM diagnosis at $120'$ was associated with DG in previous pregnancy, DG diagnosis at $60'$ in 2nd trimester OGTT, insulin therapy during pregnancy, newborn LGA and IFG after delivery. These data reinforces the importance of OGTT for correct reclassification of DG, with increased relevance in women with risk factors.

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