# Letters to the Editor

## Tips for Facilitating Lifestyle Changes in Low-Income Communities

**Original Article:** Diabetes Self-Management: Facilitating Lifestyle Change

**Issue Date:** September 15, 2017

**See additional** reader comments at: https://www.aafp.org/afp/2017/0915/p362.html

**To The Editor:** We were elated to read your article on lifestyle changes to promote weight loss and improve glycemic control in persons with diabetes mellitus. The program outlined includes measurable tools not only to assess the patient's readiness for behavioral changes but also to create short, realistic goals, which is a model we would want to implement with our patients and residents.

The article acknowledges that the Look AHEAD (Action for Health in Diabetes) study[1] was conducted with a carefully selected population with an abundance of resources, and it briefly mentions that psychosocial factors can be barriers to the interventions. As such, adapting these tools in practice can have some challenges in a resource-poor community. Therefore, when teaching and practicing in a low-income area, which makes up the largest portion of patients with diabetes and chronic diseases, we recommend some small changes to the protocol to address the social determinants of health.

Many of our patients reside in communities with high obesity rates, comparable with studies showing that counties with poverty rates exceeding 35% have obesity rates 145% greater than in wealthy counties.[2] This patient population is afflicted with safety concerns prohibiting them from walking in their neighborhoods and is often unable to afford gym memberships or sometimes even proper clothing for exercise. Thus, meal replacement or phone tracking models are luxuries that patients in the greatest need cannot afford. Although case management can help with basic needs, we also suggest alternative methods for implementing the programs discussed in the article, such as physician- or police-guided safe walking groups, paper logs for tracking food consumption and physical activity, instructions on how to count and chart heart rate, and a review of fresh items available through the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that can be cooked in bulk.

It is often patients with the greatest need who realistically cannot benefit from new treatment models simply because of the lack of resources. As physicians, we must challenge ourselves to make the needs of these patients a priority if we are to adequately address the epidemics of obesity, prediabetes, and diabetes.

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**Editor's Note:** This letter was sent to the authors of "Diabetes Self-Management: Facilitating Lifestyle Change," who declined to reply.

## Ketogenic Diet an Option for Treating Uncontrolled Epilepsy

**Original Article:** Epilepsy: Treatment Options

**Issue Date:** July 15, 2017

**See additional** reader comments at: https://www.aafp.org/afp/2017/0715/p87.html

**To The Editor:** Thank you for your summary of treatment options for epilepsy. However, we wanted to clarify the evidence regarding the ketogenic diet. As many as one-third of patients

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have refractory epilepsy that is not easily controlled with medication. Studies have shown that patients who are not seizure-free with adequate dosing of an initial drug will only have their epilepsy controlled 10% of the time by adding a second medication.[1,2] Also, antiepileptic medications have considerable cognitive, mood, oral health, and dermatologic adverse effects.

The ketogenic diet has been used in patients with drug-resistant epilepsy since the 1920s. Most major hospital centers offer multidisciplinary ketogenic programs. Randomized controlled trials demonstrate that these diets result in more than 50% reduction in seizures with small populations becoming seizure free.[3] In 2008, the International Ketogenic Diet Study Group published clinical management guidelines for effective nonpharmacologic treatment of intractable childhood epilepsy.[4] Adverse effects from the ketogenic diet, including constipation and kidney stones, are preventable, and a survey of patients found 96% would recommend it to others.[5]

When two or three antiepileptic medications have been ineffective, the ketogenic diet should be considered as a treatment option. It is especially useful in Dravet syndrome, infantile spasms, myoclonic-astatic epilepsy, and tuberous sclerosis complex. The ketogenic diet is the treatment of choice for seizures from glucose transporter type 1 deficiency and pyruvate dehydrogenase deficiency syndromes.[4] It is important for family physicians to understand the limitations of medications for these patients, and the effective alternatives.

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**In Reply:** We agree that the ketogenic diet may be tried if seizures are not well-controlled after attempting pharmacologic management. The literature suggests that the ketogenic diet might be helpful in certain types of seizures, but this is based on limited evidence.[1] Limitations include variability of inclusion criteria and small cohorts. We appreciate the work of the Charlie Foundation and the International Ketogenic Diet Study Group to identify areas where the ketogenic diet could be utilized.[2] However, these guidelines are strongly grounded in expert opinion due to the lack of robust trials.

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