Diabetic Neuropathy

Abstract: A relatively early and alas one of the most distressing end results of the Diabetic pathogenesis is the affection of nerves. Its extent and intensity depends upon the duration of the disease and the status of glycemic control.

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Pathogenesis

Segmental degeneration of axon in all fibers
Thickening of the basement membrane of intraneural capillaries

Categories- Depending upon the number and type of nerves involved, it is categorized into the following:

1. Number– Single or multiple nerve(s) involvement
2. Type– Cranial, peripheral (sensory / motor) or autonomic

Clinical Manifestations: Common symptoms of nerve involvement are-

1. Cranial Nerves– The 3rd and 6th nerves are more frequently involved leading either to paresis of the muscle that is supplied or pain in the area enervated.

2. Peripheral Nerves– Either sensory, motor or both may be involved.

- Sensory nerve involvement causes abnormal sensations (hyperesthesia or anasthesia), burning, numbness, tingling, cotton-wool feeling, pain – sensation of lightening, fleeting, pin-pricking, stabbing, etc in the area supplied.
- Motor nerves involvement causes weakness, easy fatigue, decreased endurance, muscle wasting and rarely atrophy of the muscles supplied.
- Gait abnormalities, loss of arch of feet, multiple fractures, Charcot joints, etc are caused due to both nerve (motor and sensory) affection.

3. Autonomic Nerves– Commonly the patients experience bouts of dizziness (postural hypotension), gustatory perspiration, anhydriosis, diarrhea, constipation, nausea, vomiting, difficulty in micturition, retrograde ejaculation and palpitation.

Often it is the admixture of multiple types of nerve involvement in a single patient at a single point of time. Hence the patient complains of a variety of symptoms which may go on changing according to the exciting factors and other external influences.

Management- The role of mind and mental state of disposition are very important factors which must be considered while handling such a case for management.

Constitutional homoeopathic remedies must be selected on the basis of state of disposition and the totality of symptoms. Monitoring of blood glucose levels, dietary control, exercises, auxiliary measures like– fomentations, short wave diathermy, massages, etc, should be used in conjunction with medicines. Even stockings, appliances like shoes, splints, casts, etc. have to be recommended in advanced peripheral neuropathy cases. Those still not responding to the above measures may undergo acupressure or acupuncture sittings too.

1. Palliative: *Hyper, Led-pal, Spig, Gnaphalium, Sang, Ars-alb, Phytolocca* and few others have been quite effective and are more frequently used at our centre.

2. Curative: In our experience, polycrest remedies like *Sulph, Lyco, Phos, Kali-iod, Aur-met, Sil, Nat-mura* and few others are more commonly

indicated than others in such patients. Of course the curative remedy is highly individualized and has to be given in settled patients (Case Type V) with good number of mental and/or physical generals and particulars, even if more in number, complete or incomplete demand palliative treatment.

Diabetic Nephropathy

ABSTRACT: Kidneys are the commonest target organs affected with DM as a result of end stage pathology of DM. At least 35-50% diabetics suffer from minor or major renal pathology which is psoro-sycotic in nature.

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DIABETIC NEPHROPATHY, THE PATHOGENESIS

THERE ARE 2 PATTERNS

1. DIFFUSE
2. SEGMENTAL (NODULAR- KIMMELSTEIL WILSON LESION)

On exposure to an exciting factor in an already established diabetic, an initial psoric inflammation of the glomeruli occurs and subsides in sometime. When the maintaining factor continues, the psoro-sycotic-tubercular miasm is sensitized more and more. This leads to recurrence of the inflammatory process – glomerulo-nephritis. Now, when the inflammation subsides, it is followed by healing by fibrosis. Thus the glomerular basement membrane becomes hyper-permeable first to albumin and later to molecules of glucose, urea, sodium and other vital substances. As the pathology progresses, the nephrons become dysfunctional. After a few years, the kidneys undergo compensatory hypertrophy and become totally non-functional, ie, renal failure or renal shut down occurs.

CLINICAL MANIFESTATIONS

1. May remain functionally silent for 10-15 yrs
2. Profuse urine that is watery, transparent with albumin < night
3. Edema: Initially below the eyes, face, feet and then generalized dropsy
4. Anaemia: Normochromic
5. Dullness, lethargy, easy fatigue
6. Irritability, hypersensitive to external impressions
7. Hypertension
8. When renal failure sets in then – oliguria and anuria
9. Micro-albuminaria is the 1st sign of DM nephropathy

MANAGEMENT: Close monitoring of Blood glucose levels, dietary control – salt restriction

MEDICINE: In homoeopathy we have a herd of effective medicines for this condition, namely

A] ACUTE STAGE: *Apis-mel, Ars-alb, Cantharis, Apocynum-can, Berberis-vulg, Sarsaparilla, Solidago, Terebinth* and few others.

B] CHRONIC STAGE: Drugs like *Lyco, Lach, MS, NM, Sepia, NA* and few others

C] LAST STAGE: *Eel's-serum, Apis, Ars, Benz-acid* in LM potency must be used.

AUXILIARY MEASURES: Dialysis (peritoneal, haemodialysis), Renal transplant

The Diabetic Diet - A Review

Abstract: For many years, dietary prescriptions for patients with DM were rigid and difficult to follow. Lists of major foods were provided, listing calories and composition, and diets were constructed. Today there is no ONE 'Diabetic Diet'- rather it is tailor made to suit the patient.

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The recommended diet can only be defined as a dietary prescription based on nutrition assessment and treatment goals. Medical nutrition therapy for people with DM should be individualized, with consideration given to eating habits, culture and lifestyle factors. Nutrition recommendations are then developed to meet treatment goals and desired outcomes. Monitoring metabolic parameters, including blood glucose, glycosylated hemoglobin, lipids, blood pressure and body weight, as well as quality of life, is crucial to ensure successful outcomes. Flexibility in use of ordinary foods is important for patients and their families. The first decision is the caloric content of the diet, based on the need to gain, lose or maintain the current weight. Caloric recommendations for adults carrying out "average" activity decrease with age and range from 42 kcal/kg of body weight in 18 year old men to 33 kcal/kg for 75 year old women.

The minimal protein requirement for good nutrition is about 0.9 g/kg of body weight per day, and the acceptable range is 1.0 to 1.5 g/kg per day. Since very low protein diets may slow the progression of nephropathy, protein content should probably be limited to 0.8 g/kg per day or about 10% of daily calories when this complication develops.

The distribution of calories between carbohydrate and fat must be individually determined. Restriction of fat is usually prudent if weight loss is desired because of its high energy content. After protein and fat content is chosen, the remaining calories are assigned to carbohydrates. Sucrose can be allowed in moderation as part of the carbohydrate component. Increasing the fiber content of the diet may be helpful. In a dietary regimen, it is the long term overall dietary pattern that counts; deviation for one or two meals does not matter much. In adults, the "treat" technique often ensures better dietary cooperation than more rigid demands. In persons who have recently opted for homoeopathic management but are still on insulin, the distribution of calories is important if hypoglycemia is to be avoided. A typical pattern includes 20% calories of total for breakfast, 35% for lunch, 30% for dinner and 15% as a late evening meal. Often a mid-morning and mid-afternoon snack is necessary.

The dietary management in diabetics varies with the type of constitution of the individual, his mental (sanguine, nervous, melancholic, etc temperament) and physical generals (cravings, desires, aversions, foods that disagree), prominent presenting symptoms and whether or not one is already on insulin. For diabetics who are dependent on insulin, particularly those on intensive insulin regimens, the composition of the diet is not of critical importance, since adjustment of insulin can cover wide variations in food indigestion. In non insulin dependent patients not treated with exogenous insulin, more rigorous adherence to diet is required, since the endogenous insulin reserve is limited.

At the Department of Medicine of NAHI, we recommend the following dietary regimen for our Indian patients-

A] Diet For Associated Obesity + Hyperlipidemia + Ischemic Heart Disease: The aim is to reduce weight @ 1Kg/week and serum Cholesterol @ 10mg/dl / week. Omit red meat (mutton), dairy products – cream, butter, cheese, refined sugar, chocolates, pastries, dalda, dry fruits, bananas, sauce, maida and groundnut /coconut/ linseed (jawas) oil. An increased intake of green leafy vegetables (preferably raw), fruits (apple, pomergranate, papaya, lichi) and pulses- dal, sunflower/ safflower- kardi oil is recommended. For Non Vegetarians, egg white, chicken (white meat) and sea fish while in vegetarians sprouted beans, spinach (palak), fenugreek (methi), oats/ porridge should be encouraged. Rice, noodles, potatoes, idli, dosa, pickles, chawanprash, corn, jaggery- instead of sugar, milk, biscuits (Marie), mushrooms and honey can be used in moderation. People with constipation should be advised carbon after each meal- burnt rice or chappati (khakra). Fluids should be restricted to 1-1.5 L/ day.

B] Diet For Associated Hypertension- Poor Sodium diet (less than 2 gm), no baking soda, and no salt permitted at the table. Foods that can be taken- Milk, sugar, bread, chappati, honey, jam, oranges, grapes, almonds, cashew-nuts, rice, mixed vegetable soup, sour lime, potato, dal, french beans, apple (baked), boiled peas, cornflakes, eggs and tomatoes.

C] Diet For Sudden Weight Loss: Initially give more liquids and less solids, high energy and protein content foods/drinks - soya milk, mixed vegetable soup (tomato, gourd - lauki, palak, whole egg (white+yolk), boiled dal water, turai and rice water. Gradually cow's milk and milk products- cream (malai) butter, paneer may be started. Body massage with ghee and cream (malai) if the patient cannot take per orally.

D] Diet for Nephropathy: Fluid restriction- 1-1.5 L/day only. Absolute restriction of protein - all (non-veg food, milk, palak, methi), fruits, common and rock salt, pickles, papad, dal, soyabean oil. Relative restrictions include ghee. Free usage of gourd (lauki), pumpkin (kaddu) brinjal, lady's finger (bhindi), rice, idli, noodles, curd, paneer, Lo-Salt, cauliflower, cabbage, jaggery (gur), honey, poha, sago (sabudana) and potatoes. Vitamin/ minerals in the form of carrots, beetroot can be taken.

Dietary Prescription in Diabetics

Abstract: Diabetes is a commonest disorder encountered by most of us in present days. The incidence is seen more common in younger age group. It might be due to inheritance or high stress conditions at work place or early frustrations or easy disappointments. Whatever may be the causative factors, Homeopathic science has the answer in understanding them as well as curing them. Dietary prescription is as important as selecting the right simillimum as Diabetes is a disorder of metabolism. Many times our medicine is correct but if we don't advice proper diet and auxiliary methods then we will surely fail. This article is written keeping in view the latest updates.

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