

Medical Diets - Standardized, New and Obsolete Terminologies



By Barbara Wakeen, MA, RD, LD, CCFP, CCHP

I often speak about Standardized Medical Diet programs and Diet Terminologies to ensure what diets are ordered, are those modifications expected and served. A Standardized Medical Diet program links Food Service and Medical Departments in meeting the nutrition therapy needs of our populations. We all know the importance of good communications with the Medical Department, and we know the number of medical diets can snowball if there isn't good communication with the medical department, along with a continual monitoring system.

As dietitians, we are responsible to ensure the therapeutic diet needs of our populations are met. I recently reviewed a list of diets for a prison with more than 30% diets. The orders were for all types of restrictions including 'no this' and 'no that', i.e., beans, soy, processed meat, salad, fish, onions, mushrooms, eggs, apple, cabbage, nuts, vinegar, oatmeal, and more in one or multiples of these limitations. Typically these are preferences, but not always, sometimes they are allergies or intolerances, but should be listed as such. In addition, the terms used were not always consistent with recognized therapeutic diet

terminology fitting a specific diet such as:

- Splenda each meal
- Diabetic-ADA-Snack x 2 - Reduced Carb – double entrée, peanut butter 1 x daily, 2-3 oz – no beans – no soy – no chicken – 4 pcs fruit daily
- Bland - Diabetic/ADA snack – gluten free – no meat – restricted fiber
- No nuts – low sodium – cereal w/ milk X 3 - bland – no peanut butter – Splenda each week – no seeds

There were several diets such as these combinations on the 18 page list. Trying to narrow some of these down to a therapeutic diet w/modifications is challenging, time consuming and costly overall for Medical, Food Service and other disciplines. Needless to say, my recommendation was to set up a Standardized Medical Program with diets ordered based on a medical need, not on food preferences. In addition, I requested to meet with Medical to discuss setting up a standardized program.

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I use the *Nutrition Care Manual (NCM)* from the Academy of Nutrition and Dietetics as a diet manual resource as it is evidence based and is updated frequently. One of the areas I discovered a couple years ago in the manual was the information on 'obsolete diets'. I was gathering reference information for a Low Residue diet, only to find that the terminology was considered 'obsolete' and the Low Fiber diet had replaced it. (Note: In looking for it to reference in this article 'low residue' was not even listed.) There are several diet terms that the NCM has deemed as 'obsolete.'

The following are some disease states with associated obsolete diet terms we use in our facilities:

GERD – Gastro esophageal Reflux Disease

The "bland diet" and the use of milk to treat heartburn are considered to be obsolete.

Recommendations that may reduce the symptoms of GERD are a trial of limiting or eliminating the following foods:

- Peppermint and spearmint
- Chocolate
- Alcohol
- Caffeinated beverages (regular tea, coffee, colas, energy drinks, other caffeinated soft drinks)
- Decaffeinated coffee and decaffeinated regular tea (herbal teas, except those with peppermint or spearmint, are allowed)
- Pepper
- High-fat foods, including:
 - Reduced-fat (2%) milk, whole milk, cream, high-fat cheeses, high-fat yogurt, chocolate milk, cocoa
 - Fried meats, bacon, sausage, pepperoni, salami, bologna, frankfurters/hot dogs
 - Fried foods

- Nuts and nut butters
- Pastries and other high-fat desserts
- More than 8 teaspoons of oil, butter, shortening per day

- Any fruits or vegetables not tolerated

Diarrhea

Clear liquid diets are now considered obsolete because of the often high sugar content and resulting hyperosmolality that may exacerbate diarrhea.

Gallbladder

The use of very-low-fat or fat-free diets are no longer required for treatment of gallbladder disease.

Peptic Ulcers

- Sippy diet
- Bland diet
- Increased amounts of milk

Hypertension

Nutrition therapy used for the treatment of hypertension was previously called:

- Low sodium diet
- Low salt diet
- No added salt diet
- Mild salt restricted diet

Hypertension Nutrition Therapy now references the DASH (Dietary Approaches to Stop Hypertension) plan which reduces sodium. In general, if a food has more than 300 mg per serving, it's likely not a good choice in the hypertension nutrition therapy plan. Dietary goals for persons with hypertension are 1,500 milligrams (mg) and 2,400 mg sodium per day.

Renal Diagnoses

Acute Renal Failure

- Renal diet (a single diet for all renal diseases)
- Low-protein diet

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Nephritic Syndrome

- Renal diet (a single diet for all renal diseases)
- High-protein diet

Chronic Kidney Disease

- Renal diet (nonspecific for stage of kidney disease)
- 60 g protein
- 60 g protein, 2 g sodium, 2 g potassium
- Giovanetti diet

Chronic Kidney Disease is addressed in stages of 1 – 4 with diabetes and stage 5 for those on dialysis and not on dialysis. There are other kidney related nutrition therapies for various states which reflect back to why one ‘renal’ diet doesn’t fit all.

Heart Failure

Diets often prescribed for populations with heart failure include:

- Low-sodium diet
- Low-salt diet
- No-added-salt diet
- Mild-salt-restricted diet

Heart Failure Nutrition Therapy is the new terminology replacing the diets as listed above. The focus of the diet is still low sodium along with monitoring of fluid and weight changes.

Hypercholesterolemia (hyperlipidemia)

Multiple nutrition therapies for hyperlipidemia:

- Low-cholesterol diet
- Low-fat diet
- American Heart Association I or American Heart Association II diet
- National Cholesterol Education Program Step I or National Cholesterol Education Program Step II diet

- Heart-healthy diet
- **High Cholesterol Nutrition Therapy** now references the Therapeutic Lifestyle Changes (TLC) diet plan designed by the National Cholesterol Education Program (NCEP) for those with elevated cholesterol levels. This diet limits the amount (25% - 30%) and types of fat in the diet and encourages omega – 3 fats (fish twice a week), emphasizing daily fiber intake (20 – 30 grams), whole grains (3 oz) and cups of fruits and vegetables per day and exercise.

Type 1 and Type 2 Diabetes

- No concentrated sweets
- No sugar added
- Low sugar
- Liberal diabetic

Per the NCM, none of these approaches to food and meal planning is considered appropriate as each unnecessarily restricts sucrose.

In addition, the term “ADA diet” has never been clearly defined, but has historically meant a physician-determined energy level (calorie) with a specified percentage of carbohydrate, protein, and fat based on exchange lists, e.g. 1800 cal ADA Diet w/PM Snack. **This term should no longer be used because neither the Academy of Nutrition and Dietetics nor American Diabetes Association endorse any single meal plan or specified percentages of macronutrients.**

Terminology now references Type 1 and Type 2 Diabetes Nutrition Therapy and emphasizes carbohydrate counting noting typical patterns of 3 – 5 carb choices per meal and 1 – 2 for snacks. In our populations, these ranges are often higher given the higher calorie ranges we offer.

Reactive Hypoglycemia (non-diabetic)

Traditional practice to avoid foods containing sugars

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and to eat protein- and fat-containing foods is no longer appropriate.

Per the NCM, “Recent research on the glycemic index and sugar raises questions about the appropriateness of restricting only sugars, as many of these foods have a lower glycemic response than many of the starches that were recommended in the past. Furthermore, protein is also a stimulant of insulin and a high-fat intake, especially saturated fats, may interfere with the body’s use of insulin.” I see these diets associated with bariatric patients which may incorporate yet other diet modifications.

Diverticular Diagnoses

Historical diet recommendations have been to avoid nuts, seeds and hulls.

Per the NCM, recent literature questions this recommendation based on the lack of published research supporting these common nutrition recommendations ([Sheth, 2008](#); [Strate, 2008](#); [Egash, 2006](#)).

Current Trends in Corrections

The trend in corrections is to offer simplified diet plans that may combine more than one dietary restriction, such as Cardiovascular (low fat-cholesterol-sodium), Cardiac/Diabetic or even have a ‘Heart-Healthy’ main population menu with or without consistent carbohydrates which reduces medical diet needs even further. Of course, some of these ‘self-defined’ terms to standardize diets in our facilities are based on some subjective items such as state/agency standards, practice approved by the Medical Department, availability of special foods, i.e. reduced sodium meats, sugar free beverages.

The term many of us reference as ‘Heart Healthy’ is most often consistent with the 2010 Dietary Guidelines “general, healthful” diet (depending on our definitions). In general, it is typically lower in sodium, fat (amounts and types, i.e. saturated and *trans* fat) and cholesterol, higher in fiber w/ whole grains, fruit and vegetables, has limited protein w/emphasis on lean meats, and incorporates fish and legumes as well as low fat dairy products. Sweets, desserts and sugary drinks may also be limited or eliminated.

The general, healthful diet is also consistent with Therapeutic Lifestyle Changes (TLC) and the American Heart Association’s diet recommendations which also reference the Dietary Approaches to Stop Hypertension (DASH) diet. In essence, for many who incorporate the restrictions of these diets in our main population (or Heart-Healthy) menus, we can eliminate many medical diets e.g. cardiac, cardiovascular, low sodium, etc. promoting health across the board. If the menus are further modified to include consistent carbohydrates, the general, healthful diet can replace those diets listed above deemed as ‘obsolete’ such as no concentrated sweets, American Diabetes Association (ADA) diet, diabetic diet, or diabetic diet with a specific kilocalorie level (e.g., 1,800-kcal ADA diet). As dietitians we should consider the new terminologies and diet modifications in our specialized niche that may replace current practices and some of the obsolete terms noted above.

ACFSA Networking Discussion Group Information

If you would like to be added to the Dietitians in Corrections networking listserv, please email me directly at bwakeen@neo.rr.com. This is an informal discussion group and your name/email address will be listed in each email sent to the group. You do not have to be a dietitian to be on the list.

DHCC EML

Dietetics in Health Care Communities (DHCC) has an EML for the Corrections Sub-Unit. To participate, one must be a DHCC member, which means being a member of the Academy of Nutrition and Dietetics as well. Emails communicated through this group are sent through a private email address for DHCC members only. To join, visit www.DHCCdpg.org or contacts Marlene Tutt at lenetutt@yahoo.com. There are many member benefits including networking, publications and continuing education credits.

