

Dear Colleague,

Your help in providing support and monitoring is very much appreciated whilst your patient makes dietary and lifestyle changes.

The Fast 800 is based on research by Professor Roy Taylor of Newcastle University showing that by cutting down to 800 calories a day, almost 50% of overweight Type 2 Diabetics lost significant amounts of weight, returned their blood glucose levels to the normal range and were able to stop all diabetes medication (see this information <https://thefast800.com/the-science/>).

The Fast 800 diet has been developed by Dr Michael Mosley in his books The Fast 800 and The Blood Sugar Diet. Dr Clare Bailey, who writes the accompanying recipe books, is a GP in the UK and has helped many patients lose weight, improve their blood sugars and reverse their diabetes. She is currently involved in research into this approach with Oxford University.

The Fast 800 Online Programme is a step-by-step guide, based on a low-carb Mediterranean-style diet, and combining this with options for 800 Calorie 'Fasting', which can be done daily for up to 3 months, intermittently by following the 5:2 approach or just by reducing portions.

With practical support and lifestyle advice throughout the course via individual weekly meal plans, calorie counted recipes, shopping lists, exercise, mindfulness and – crucially – through peer and professionally supported forums, patients are able to make significant and sustainable diet and lifestyle changes.

From experience, it is often necessary to consider reducing or stopping insulin, SGLT-2 Inhibitors ('flosins') and sulphonylureas as well as reducing anti-hypertensive medication early on for those making significant dietary changes. To provide pointers for medical professionals we have attached a summary below.

Your help with arranging standard blood testing, such as monitoring HbA1c and the patient's home blood sugars is very much appreciated.

We hope you will find this helpful.

All the best,

Dr Clare Bailey, GP Buckinghamshire, UK    Dr Patrick Garratt, GP Perth, Western Australia

## Supporting Patients to Improve their Blood Sugars

*We include some general information about this here and on the website, but **as with the information below**, it is not a substitute for proper, individual medical advice.*

All options are based on a moderately low carb Mediterranean style diet. Options to choose a more intensive 800 calorie 'fasting' approach to intermittent fasting or simply portion control.

- **The 800 Plan:** Very Low-Calorie Diet: Fast, intensive and effective, the 800 involves eating just over 800 calories a day for 8 weeks. It is based on Professor Taylor's research into diabetes reversal. Requires motivation and commitment.
- **The 5:2 Plan:** Intermittent Fasting, more flexible and less intensive. Cut down to 800 calories on some days, also known as 'fasting'. Usually means 5 days eating a Mediterranean style diet with some portion control and 2 days 'fasting' on about 800 calories. Not suitable for those on certain medications such as insulin, gliclazide or warfarin.
- **The Way of Life Plan:** Slower & gentler, no fasting (although TRE recommended), just portion control, suitable for most people including; those who don't need to lose weight, are less motivated, the elderly, and those requiring medical supervision.

**TIPS for patients:** On a low-calorie day, increase water intake by 1-1.5 litres (to about 2.5L depending on activity and circumstances), plan ahead, tell other people and try to avoid snacking (if you must, a small portion of nuts is best).

## How long?

The 800-calorie rapid weight loss phase is safe, for most individuals, up to 12 weeks, as long the patient sticks to our recommendations, drink plenty of water and take a high-quality multivitamin. We would also recommend that after 3 months, the patient moves to an intermittent fasting regime and starts introducing non-fasting days each week using the Mediterranean-style diet.

If the patient has been following an 800-calorie plan for the last 3 months and wants to continue on the plan, we recommend that you, the doctor, first gives the all-clear. As the patient continues on the plan it is important that they touch base with you, the doctor, on a regular basis, particularly if the patient has a medical condition or are on medication.

## Considerations

1. **Consider a different variant of diabetes or type 1;** If the patient is atypical or not responding as expected.
2. **The diet may involve significant restriction of food intake (800 calories);** for up to 8-12 weeks.
3. **Diabetic medication:** Consider reducing medication that could cause hypos first. Otherwise on a last in, first out basis. Consider reducing evening hypoglycaemic medication first. Reassure the patient that there may be a temporary increase in blood sugar, but if they stick to the diet it is likely to continue to improve.

- **Insulin;** If making a significant change to a low carb diet & particularly if reducing to 800 calories, consider reducing insulin by half (if on >20 Units). Advise patient regarding risk of hypos and management.
- You may reduce by half again, depending on fasting blood sugars and should consider reducing or discontinuing if fasting blood sugars are around 8 or below. If insulin <20 Units consider stopping it altogether. Ask patient to check FBS regularly during the day (about 4 times a day initially). Review at 1 week or sooner as required.
- **Sulphonylureas;** Consider stopping or reducing by half on commencement of the diet.
- **Most other oral hypoglycaemic agents;** Can be decreased or stopped according to degree of control achieved. Advise re hypo risk & management (very low blood sugar can be extremely dangerous).
- **SGLT-2 Inhibitors ('flozins');** generally consider stopping (risk of Euglycaemic DKA)
- **Antihypertensives:** Unless poor control or on 2 or more medications, consider halving or stopped on commencement of the BSD. BP likely to reduce within days as insulin resistance improves, so advise patient to watch out for feeling light headed and/or check BP at home – may require further reduction or discontinuation.

**Agree a plan** for the patient to contact appropriate healthcare professional if blood glucose levels become very high (fasting >14mmol per litre), they are getting hypos or if the BP is too high or too low. *More details in table on final page.*

#### 4. Tests - baseline bloods;

- **HbA1C;** although advised to do only 3monthly, significant improvements usually seen within 6 wks.
- **Fasting glucose;** may return to normal within a few weeks.
- **Lipid profile;** usually improves alongside reduced blood sugars, despite increase in fat intake.
- **ALT/GGT;** Improves as liver recovers.
- **Hb & Iron status;** should be assessed prior to starting, especially for the elderly or vegetarians.
- **U&Es; TFTs;**
- **Measurements;** BP, weight, height, BMI, waist circumference (via umbilicus)

5. **Goal:** Depending on starting weight. Aim to lose 10-15% of body weight. If original BMI > 40, goal may need to be 15-20%. South Asians may need to aim for BMI closer to 22 or 23.
6. **Encourage patient to choose which approach to follow.** Check lifestyle, individual suitability, motivation & clinical needs. Consider the 5:2 BSD or the easier Mediterranean style way of life. They can move from one approach to another.
7. **Extra retinal screening should be considered if moderate or more severe retinopathy is present.** Re-screen within six months of achieving a substantial improvement in blood glucose. Sudden normalisation in retinal blood flow can disadvantage damaged areas of the retina, resulting in deterioration in retinopathy.
8. **Side effects;** Commonest are probably headache, constipation and tiredness, usually due to dehydration. Normally settles with extra water (1-1.5L). Sometimes helped by a little extra salt in the diet. Consider vitamin supplementation on 800 calorie days.
9. **Although a low calorie Mediterranean style diet is normally suitable for most people, AVOID** reduced calorie diet if the patient is;

- Underweight and/or has a history of an eating disorder
- Under 18 years of age
- Breastfeeding or pregnant (can do Mediterranean style diet with monitoring)
- Diagnosed with a significant psychiatric disorder or substance abuse
- Frail or recovering from surgery, uncontrolled BP, cardiac arrhythmia or other abnormalities.
- Under active investigation or treatment or has a significant medical condition affecting ability to comply with diet, a history of intermittent porphyria
- Unwell, has a fever, renal failure (stage 4 or 5), recent cardiac event, stroke or heart failure.
- Some medications such as Warfarin and Lithium need adjusting and are not suitable for intermittent fasting due to dose fluctuations.
- Careful monitoring for patients with history of seizure is also recommended.

**10. Recommended Reviews;** Review adherence, hypos, side effects, blood sugars, medication, BP, weight & waist at 2 weeks, then monthly for 2-3 months, then as required. Monitor HbA1C. Maintain routine diabetic reviews, even if blood sugar returns to normal.

**11. Resources;**

- Information of Prof Roy Taylor’s research:  
<http://www.ncl.ac.uk/magres/research/diabetes/reversal/#publicinformation>
- Patient advice, useful resources, recipes and online community at <http://www.thebloodsugardiet.com> and [www.thefast800.com](http://www.thefast800.com).
- See The 8 Week Blood Sugar Diet Recipe Book, by Dr Clare Bailey for program and recipes and The 8 Week Blood Sugar diet by Michael Mosley for scientific studies, stories and more information.
- Feel free to contact us at [info@fast800.com](mailto:info@fast800.com).

**Type 2 Diabetes: Diabetic Medications on a Low Carbohydrate Diet – Suggestions**

If a patient is on the diet and is on type 2 diabetes medication, there are three main areas worth considering:

1. Is there a risk of hypoglycaemia?
2. What is the degree of carbohydrate restriction?
3. Does the medication provide benefit, and if so, do any potential side effects outweigh the benefit?

Drug Group	Action	Hypo risk?	Considerations (to continue/stop)
Sulfonylureas (e.g. Gliclazide)	Increase pancreatic insulin secretion	YES	STOP (or if gradual carbohydrate restriction then wean by e.g. halving dose successively)
Insulins*	Exogenous insulin	YES	REDUCE/STOP (Convert to all basal and wean appropriately, e.g. successive 30-50% reductions, towards elimination) *see below

<b>Meglitinides</b> (e.g. Repaglinide)	Increase pancreatic insulin secretion	<b>YES</b>	<b>STOP</b> (or if gradual carbohydrate restriction then wean by e.g. halving dose successively)
<b>SGLT-2 inhibitors</b> (e.g. Empagliflozin)	Increase renal glucose secretion	No	<b>STOP</b> . Risk of Euglycaemic DKA with normal/near normal sugars (especially if LADA that has been misdiagnosed as T2DM).
<b>GLP-1 agonists</b> (e.g. Liraglutide)	Slow gastric emptying. Glucose dependent pancreatic insulin secretion.	No	Optional, consider clinical pros/cons (expensive).
<b>Biguanides</b> (e.g. Metformin)	Reduces insulin resistance	No	Optional, consider clinical pros/cons.
<b>Thiazolidinediones</b> (e.g. Pioglitazone)	Reduce peripheral insulin resistance	No	Usually stop. Concern over risks usually outweigh benefits.
<b>DPP-4 inhibitors</b> (e.g. Sitagliptin)	Inhibit DPP-4 enzyme	No	Stop. No significant risk, but no benefit in most cases.
<b>Alpha-glucosidase inhibitors</b> (e.g. Acarbose)	Delay digestion of starch and sucrose	No	Stop. No benefit on a low carbohydrate diet.
<b>Blood glucose testing strips</b>	Provide feedback on blood glucose response to food	N/A	A period of measuring blood glucose helpful for informing them about the effect of various foods on blood glucose. Measurement may also be useful if HbA1c is not improving as expected.
<p><b>*Insulin reduction suggestion</b> -Tailor to individual. Usually requires close supervision with healthcare professional, and if in doubt seek expert input.</p> <p><b>T2DM without 'beta cell failure'</b>: If using basal-bolus regime consider converting to long-acting insulin only, BD in equal doses (OD may suit some people). On commencing low carb diet consider reducing total insulin by 30-50%. Monitor QDS initially for hypoglycaemia (rescue glucose if required). Consider continued down-titration of insulin as insulin resistance improves (can take months).</p> <p><b>Caution: Some T2DM may have significant 'beta cell failure'; or other forms of pancreatic insufficiency (e.g. LADA or T3c) misdiagnosed as T2DM. Consider this if rapidly increasing HbA1c, thirst, polydipsia, weight loss, low C-peptide. Insulin should not be eliminated in this cohort, although basal and bolus dose adjustment needed for carbohydrate restriction.</b></p>			