A Review of the Relationship between Dietary Glycemic Index and Glycemic Load and Type 2 Diabetes

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Introduction

In recent decades, the pattern of diseases has been changed due to enhanced quality of health services and vaccination. This pattern proceeds towards the reduction in communicable diseases and increase in chronic diseases, particularly type 2 diabetes (T2D). T2D is a disease, associated with obesity, insulin...
resistance, hypertension, and high concentration levels of triglycerides (Ebrahimi et al., 2008). Diabetes mellitus is diagnosed with hyperglycemia, impaired metabolism of carbohydrates, fats and proteins, and absolute lack of insulin. The disease is one of the most common and costly chronic diseases worldwide, the prevalence of which is increasing due to the lifestyle changes and improvement of the health status of communities, which results in the increased survival rate. The disease affects all races differently. The prevalence and incidences of this disease has increased in many societies, especially in developing countries. Currently, diabetes is the fourth leading cause of death in most countries. In recent decades, epidemiologic studies have been conducted on T2D in Iran, based on which the population of patients with diabetes was estimated to be more than 1.5 million (Larejani and Zahedi, 2001). The recent studies indicated high prevalence rate of diabetes in the Iranian population (Ebrahimi et al., 2008, Larejani and Zahedi, 2001). The epidemiologic studies showed that the lifestyle and specially eating habits play a major role in the incidence of T2D. It is expected to reduce the prevalence rate of the disease and its complications by changing the eating habits. Since carbohydrates make up the bulk of food in our country and most Asian countries, it is recommended to consider the type and amount of carbohydrate intake carefully, which is helpful in preventing diabetes risk factors. High carbohydrate diets have negative effects on blood lipid levels as indicators of triglycerides, low-density cholesterol (LDL-c), high-density cholesterol (HDL-c) and glycated hemoglobin (HbA1c), the metabolism of glucose and they also increase insulin levels and thus resistance to insulin. Therefore, the diets also increase the risk of diabetes as well as cardiovascular diseases (Niknam and Esmailzadeh, 2012, Saneei and Esmailzadeh, 2013, Shirani et al., 2015).

Dietary carbohydrates are broken into simple and complex sugars, moreover; postprandial metabolic and hormonal responses are often different in complex and simple sugars. Therefore, carbohydrates are classified according to glucose postprandial responses, which are commonly classified in terms of glycemic index (GI) and glycemic load (GL). Moreover, GL and GI reflect the dietary carbohydrates and value of the eaten carbohydrates. The postprandial blood glucose levels and the insulin response are dependent on the quality as well as the quantity of carbohydrates intake (Atkinson et al., 2008, Foster-Powell et al., 2002). It has been reported during the past two decades that a low GI diet can improve the blood glucose control, lipid profile, and weight increase insulin sensitivity and reduce the effects of insulin resistance; while high GI diet increases the levels of blood glucose, insulin response, food intake, and risk of obesity. In general, most of foods with a low GI contain high amount of fiber, which protects the person against diabetes and cardiovascular diseases (Shirani et al., 2015, Tsihlias et al., 2000). A limited number of recent observational studies have shown that low GI or GL diet has a beneficial effect on metabolic risk factors of cardiovascular disease and T2D, including body mass index (BMI), cholesterol, HDL, HbA1c (Chiavaroli et al., 2016, Min et al., 2016, Niknam and Esmailzadeh, 2012, Shirani et al., 2015).

It has been recommended in an epidemiological cohort study that dietary GI and GL are associated with diseases associated with insulin resistance. Furthermore, there is a positive association between the GI and GL and the development of the T2D (Mirmiran et al., 2009, Thorup et al., 2013).

**Materials and Methods**

Our article is a traditional review article. This review article was extracted by searching the creditable scientific databanks, including: PubMed, Embase, Science Direct, and Scopus using keywords such as GI, GL, diabetes and carbohydrate from the published literature. In this paper, a variety of studies, including
prospective cohort, retrospective, case-control, and cross studies were studied from 2000 to 2016. The thematic relevance of the studies was assessed by investigating the title and summary of the article. The studies with the target group of animals, were not reviewed in this article. Finally, 25 articles with appropriate design, reliable and relevant information were selected and analyzed for this review article.

Results

In studies investigating the effect of dietary fiber and glycemic profile in diabetic patients, positive effects of high-fiber and low GI diets on blood glucose were observed. In a previous study in Canada which was similarly conducted on the evaluation of the effects of low GI and high fiber diets in patients with T2D, it was observed that the level of HbA1c was reduced by 18% in individuals who were under the influence of low GI and high fiber diet for 6 months (Jenkins et al., 2008). In a study, conducted on 36787 Australian women aged from 40 to 69 years old with no history of diabetes, the relationship between the dietary GI and fiber-rich foods and risk of T2D were studied. The results of this study showed a reduction in GI diet to maintain the carbohydrate intake, which reduces the risk of T2D. To reduce the risk of diabetes, researchers recommended the use of bread with a low GI, instead of white bread and promotion of whole grain intake (Hodge et al., 2004, Psaltopoulou et al., 2010, Yanni et al., 2016). Moreover, a review study in this respect states that following a low GI diet in patients with T2D and type 1 diabetes has short-term and long-term beneficial effects on controlling blood sugar. Since, high-fiber carbohydrate diets have necessarily low GI insulin shows lower responses and improves the lipid profiles after eating these types of diets (Riccardi et al., 2008). The postprandial blood sugar levels determine the demand for insulin which depend on the quantity and quality of the ingested carbohydrate (Brand-Miller, 2004). In a prospective cohort study, an investigation was made on the consumption of dietary fiber from whole grains, fruits, vegetables and GI diet and the incidence of gestational diabetes (GDM) in a period of 8 years. The results showed that a 10 g/day increase in the dietary fiber reduces the risk of developing GDM by 26% and there is a positive relationship between the GI diet and the risk of GDM (Zhang et al., 2006). The GI diet was also investigated in some studies, in which it was found that following this type of diet has positive effects on the prevention and treatment of diabetes. In a prospective study investigating the relationship between GI and diet and the GL of diet and risk of T2D, a total of 3075 elderly individuals were studied for 4 years, it was observed that the elderly with low GI diet are less likely to develop diabetes (Sahyoun et al., 2008).

The results of a review study on the use of diets with a low GI in the management of diabetes control, showed that a low GI diet, in comparison with a normal or a high GI diet, improves blood sugar in people with diabetes by reducing HbA1c to the 0.43%. The study stated that foods with a low GI compared with conventional foods or high GI, have a small but clinically useful effect on medium-term control of blood glucose in patients with diabetes (Brand-Miller et al., 2003). Moreover, another study showed that a low GI diet improves the insulin sensitivity and the blood glucose status by 60%. The results of this study over a period of 6 months showed that there is a significant positive relationship between dietary GI with the risk of diabetes in men and young women and those who had low physical activity and history of diabetes has been observed (Brand-Miller, 2004).

Furthermore, a prospective study was conducted in Iran to investigate the relationship between the GI and GL with the metabolic syndrome and its indicators. In this study, GL and GI were determined in people who were diagnosed with metabolic syndrome during the follow-up and were compared with people with no metabolic syndrome. The prevalence of metabolic syndrome was significantly higher in
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the highest GL and GI quintile compared with the lowest quintile after adjustment for lifestyle and dietary risk factors. On the other hand, the GI in the highest quintile was associated with an increase in the BMI, total cholesterol, low density lipoprotein cholesterol (LDL-c) and lower high density lipoprotein cholesterol (HDL-c) and the GL in the highest quintile were associated with an increase in the LDL-c and lower HDL-c. The results of this study show that the GI and GL can have adverse effects on the metabolic syndrome including diabetes (Mirmiran et al., 2009). Moreover, in a prospective study in Europe, which investigated the relationship between a low GI diet and the effect of the traditional Mediterranean diet and the incidence of T2D on 22295 people, it was observed that the traditional Mediterranean diet decreased the incidence of T2D by 20% (Rossi et al., 2013). Main results of these are presented in Table 1.

<table>
<thead>
<tr>
<th>Author Year</th>
<th>No. of participants</th>
<th>Age (years)</th>
<th>Main results</th>
<th>Study duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rossi et al. 2013</td>
<td>22259</td>
<td>40-63</td>
<td>Low GI diet decreases the incidence of type 2 diabetes by 20%</td>
<td>11.34 years</td>
</tr>
<tr>
<td>Mirmiran et al. 2010</td>
<td>120</td>
<td>&gt;40</td>
<td>GI and GL have adverse effects on the metabolic syndrome</td>
<td>6.4 years</td>
</tr>
<tr>
<td>Jenkins et al. 2008</td>
<td>210</td>
<td>&lt;60</td>
<td>low GI diet and high fiber diet reduces HbA1C by 18%</td>
<td>6 months</td>
</tr>
<tr>
<td>Sahyaun. et al. 2008</td>
<td>3075</td>
<td>70-79</td>
<td>low glycemic index die is related to low prevalence of diabetes in 4 years</td>
<td>4 years</td>
</tr>
<tr>
<td>Zhang et al. 2006</td>
<td>758</td>
<td>31</td>
<td>- 10 g/day increase in the dietary fiber reduces the risk of developing GDM by 26% - positive relationship between the GI and the risk of GDM</td>
<td>8 years</td>
</tr>
<tr>
<td>Allison et al. 2004</td>
<td>36787</td>
<td>40-69</td>
<td>low GI diet and high fiber diet reduces the risk of type 2 diabetes</td>
<td>4 years</td>
</tr>
<tr>
<td>Brand miller 2004</td>
<td>44</td>
<td>30-45</td>
<td>low GI diet improves the insulin sensitivity and the blood glucose status by 60%</td>
<td>6 months</td>
</tr>
</tbody>
</table>

**Discussion**

Many studies showed the inverse association between GI, GL, HDL-c level, and the direct relationship between the GI and GL of the dietary intake and reduced blood sugar (Niknam and Esmailzadeh, 2012, Saneei and Esmaillzadeh, 2013, Shirani et al., 2015). Consumption of carbohydrates creates a range of different blood glucose levels and the insulin responses in people. The differences are affected by the quality and quantity of carbohydrates. Based on the previous studies, some types of carbohydrates increase both the risk of diabetes, cardiovascular diseases through fluctuations in blood glucose after meals, increasing insulin levels and levels of blood lipids (Niknam and Esmailzadeh, 2012, Saneei and Esmaillzadeh, 2013, Shirani et al., 2015). The fluctuation in...
blood sugar levels, especially blood sugars 2 hours after eating is the risk factor, which increases the risk of cardiovascular diseases in non-diabetic persons. This problem also exists in people with diabetes. Moreover, high blood sugar and failure to control hyperglycemia and its resulting fluctuations play important role in the increased prevalence of cardiovascular diseases among people with diabetes. Since the high-fiber carbohydrate diet necessarily contains low GI, insulin shows lower responses and also improves lipid profiles after eating this type of diet (Krishnan et al., 2007, Riccardi et al., 2008, Salas-Salvadó et al., 2011). Diets containing carbohydrate sources and high GI can lead to an increase in postprandial blood sugar and insulin. The hyper insulinemia can increase the risk of cardiovascular diseases by affecting the serum lipids, coagulation factors, inflammatory agents, endothelial function, and blood pressure (Ebrahimi et al., 2008, Makino et al., 2016, Shirani et al., 2015).

The results of both studies are not consistent. The results of several randomized clinical trials have shown that there is no significant difference between a diet high in GI/GL and a low GI/GL diet in terms of their effect on glucose and insulin concentration and the insulin resistance (Brand-Miller et al., 2003, Riccardi et al., 2008). The results of the current studies on the effect of the type and amount of carbohydrate intake and GI, GI of the diet on the risk of T2D still remain controversial. But it is worth mentioning that the high-carbohydrate diet with a high GI and GL has negative effects on lipid metabolism and glucose in the body and can increase the risk of cardiovascular diseases and T2D.

Additionally, a diet with moderate fat, low saturated fats and carbohydrates low in GI and GL is another factor which plays a major role in the management and prevention of cardiovascular diseases and T2D. A simple and cost-effective way to reduce the disease complications and its related mortality is to investigate the effects of diet on the causes of T2D. In this way, nutrition expert and physicians can easily control the serum glucose and HbA1c levels that are strong predictors of diabetes by adopting appropriate nutritional and dietary decisions and consulting on the proper dietary pattern and nutritional intervention. Considering the fact that the forms and glycemic nature of carbohydrates can increase the risk of diabetes and exacerbate its complications, it is necessary to conduct study and research in this area (Atkinson et al., 2008, Shirani et al., 2015).

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Author contributions
Zeinali F, Asadi Samani H, Toupchian O, Abdollahi S, Samadi M wrote the paper. Samadi M is responsible for all parts of the manuscript. All authors read and approved the final manuscript.

Conflicts of Interest
The authors of this paper have no conflicts of interest to disclose.

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Tsilihas EB, Gibbs AL, McBurney MI & Wolever TM 2000. Comparison of high-and

