

Moving to a Whole-Food Plant-Based Diet

What changes in your body, what happens to your medication needs, and what to watch for — especially if you take insulin.

Read this first. Changing how you eat can change how much medication you need — sometimes within days. That is a good thing, but it is not something to manage alone. **Do not stop, skip or lower any medication on your own.** Take this sheet to the clinician who prescribes your medicines and make a plan with them *before* you change your diet. Keep taking everything you have been prescribed until they tell you otherwise.

WHAT ACTUALLY CHANGES

When dietary fat drops and whole plant foods go up, cells respond to insulin more readily. The same plate of carbohydrate produces a smaller rise in blood sugar than it did before. People are often surprised by the direction of this: **carbohydrate intake usually goes up, and insulin need often goes down.**

- **Timing.** The shift can begin within a few days and is often clear inside two weeks.
- **Carbohydrate.** Expect more of it — beans, lentils, whole grains, fruit, starchy vegetables. What matters is that it arrives wrapped in fiber and intact structure, not that there is less of it.
- **Fiber.** Typically two to three times what you were eating. This slows glucose absorption and is a large part of why the numbers move.
- **Blood pressure and weight** frequently fall too, which is why those medications may also need review.

THE MAIN HAZARD: LOW BLOOD SUGAR

If you take insulin, a sulfonylurea (glipizide, glyburide, glimepiride) or a meglitinide (repaglinide, nateglinide), your dose was set for how your body behaved on the old diet. On the new one, the same dose can be too much. **This is the single most important conversation to have before you start.**

Know the numbers. Below 70 mg/dL (3.9 mmol/L) is low. Below 54 mg/dL (3.0 mmol/L) is clinically significant and needs prompt treatment. Any episode where you need someone else's help is severe — tell your prescriber the same day.

Signs: shakiness, sweating, racing heart, sudden hunger, irritability, confusion, blurred vision, headache, trouble concentrating.

Treat it: 15 g of fast carbohydrate (4 oz juice, 3–4 glucose tablets), wait 15 minutes, recheck. Repeat if still under 70. Then eat something with fiber and protein. *If you take acarbose or miglitol, treat with glucose tablets or gel specifically — table sugar and juice will not work fast enough.*

Test more often for the first few weeks

Fasting, before meals and two hours after meals — more frequently than usual for at least the first two to four weeks, and especially on any day you are more active than normal. If you use a continuous monitor, this is the time to watch it closely. **Write the numbers down and bring them to your appointments** — that record is what your prescriber will use to adjust doses safely.

TYPE 1 AND TYPE 2 ARE NOT THE SAME CONVERSATION

- **Type 1.** Insulin is never stopped. Total daily dose often falls, and the balance may shift — many people find they need relatively *more* bolus insulin and *less* basal, and that their insulin-to-carbohydrate ratios and correction factors need reworking. This is a job for your endocrinologist or diabetes educator, not for trial and error.
- **Type 2.** Oral medication and insulin doses often come down, and some people are eventually able to come off certain medicines entirely. That decision belongs to your prescriber, based on your numbers.

GIVE YOUR GUT TWO TO FOUR WEEKS

Going from low fiber to high fiber overnight causes gas and bloating. Build up over two to four weeks rather than all at once, drink more water, rinse canned beans well, and start with the gentler legumes (lentils, split peas) before the heavier ones. This settles. It is not a sign the food is wrong for you.

Medications, Interactions and Monitoring

Hand this side to your physician, pharmacist or diabetes educator. It lists the specific things that commonly need attention when a patient moves to a whole-food plant-based pattern.

HYPOGLYCEMIA RISK BY DRUG CLASS

Class	Hypo risk alone	Note during the dietary transition
Insulin (basal & bolus)	High	Total daily dose commonly falls. Basal/bolus split and carb ratios often need rework.
Sulfonylureas glipizide, glyburide, glimepiride	High	Frequently the first agent considered for reduction. Long-acting agents carry prolonged risk.
Meglitinides repaglinide, nateglinide	Moderate	Meal-linked; risk rises if a meal is smaller or delayed.
Metformin	Low	Safe alone, but raises risk in combination. Also lowers B ₁₂ — check the level.
DPP-4 inhibitors	Low	Risk arises mainly in combination with insulin or a sulfonylurea.
GLP-1 / dual agonists	Low	Same. Appetite suppression plus high-volume, high-fiber meals can reduce intake sharply.
SGLT2 inhibitors	Low	See the DKA note below — this is the one to read.
Pioglitazone, acarbose	Low	Acarbose: treat any hypoglycemia with glucose, not sucrose.

SGLT2 inhibitors and euglycemic DKA. Ketoacidosis can occur on these agents with a glucose reading that looks normal, so it is easily missed. Risk rises with a sharp drop in carbohydrate intake, illness, dehydration, alcohol or surgery. A well-built plant-based diet is *higher* in carbohydrate, which works in the patient's favour — but people often cut carbohydrate at the same time as they cut animal foods, and that is where trouble starts. **Seek urgent care for nausea, vomiting, abdominal pain, deep or rapid breathing, fruity breath or unusual fatigue, even if the glucose reading is normal.**

THREE INTERACTIONS THAT GET MISSED

- **Warfarin and vitamin K.** A large increase in leafy greens will move the INR. The guidance is *consistency, not avoidance* — a steady intake around 90–120 mcg daily, or steadily higher, is manageable; erratic intake is not. Notify the anticoagulation clinic *before* the change and check INR more often through the transition.
- **Levothyroxine.** Soy, high-fiber meals, calcium and iron all reduce absorption. Empty stomach, 30–60 minutes before food, same time daily, with soy and high-fiber meals separated by several hours. Recheck TSH 6–8 weeks after a substantial dietary change.
- **Antihypertensives and potassium.** Blood pressure often falls — watch for orthostatic dizziness on ACE inhibitors, ARBs, diuretics or beta-blockers. Plant-heavy eating also raises potassium intake substantially, which matters on an ACE inhibitor, ARB or spironolactone, and in reduced kidney function.

NUTRIENTS TO COVER

- **Vitamin B₁₂ — non-negotiable.** Supplement or reliably fortified foods, lifelong. Check the level, and MMA if the result is borderline.
- **Vitamin D** — per level and latitude, as for anyone.
- **Iodine** — iodized salt or a supplement if dairy and iodized salt are both out.
- **Omega-3** — ground flax, chia or walnuts daily; algae-based EPA/DHA if indicated.
- **Iron and zinc** — less well absorbed from plants. Vitamin C at meals helps; tea and coffee with meals hinder.
- **Calcium** — fortified soy milk, calcium-set tofu, low-oxalate greens.

WORTH CHECKING

- Glucose logs or CGM data — the first 2–4 weeks are the decisive window
- A1C at 3 months (it lags; the daily numbers move first)
- Fasting lipids at 6–12 weeks
- B₁₂, vitamin D, TSH if on levothyroxine
- Basic metabolic panel — potassium and renal function
- INR more frequently if on warfarin
- Blood pressure at home, sitting and standing

QUESTIONS TO ASK AT YOUR APPOINTMENT

- ☐ Which of my medications can cause low blood sugar, and which one would we reduce first?
- ☐ At what glucose reading should I call you rather than wait for the next visit?
- ☐ How often should I be testing over the next month, and what should I be writing down?
- ☐ Do my insulin-to-carbohydrate ratio or correction factor need to be recalculated?
- ☐ Do my blood pressure medications need reviewing at the same time?
- ☐ Which labs do you want, and when should I come back?