



Meta-analyses

Effect of vegetarian dietary patterns on cardiometabolic risk factors in diabetes: A systematic review and meta-analysis of randomized controlled trials



Effie Vigiouliouk ^{a, b}, Cyril WC. Kendall ^{a, b, c}, Hana Kahleová ^{d, e}, Dario Rahelić ^f,
 Jordi Salas-Salvadó ^{g, h}, Vivian L. Choo ^{a, b, i}, Sonia Blanco Mejia ^{a, b}, Sarah E. Stewart ^{a, b},
 Lawrence A. Leiter ^{a, b, j, k, l}, David JA. Jenkins ^{a, b, j, k, l}, John L. Sievenpiper ^{a, b, k, l, *}

^a Toronto 3D (Diet, Digestive Tract and Disease) Knowledge Synthesis and Clinical Trials Unit, Clinical Nutrition and Risk Factor Modification Center, St. Michael's Hospital, Toronto, Canada

^b Department of Nutritional Sciences, Faculty of Medicine, University of Toronto, Toronto, Canada

^c College of Pharmacy and Nutrition, University of Saskatchewan, Saskatoon, Canada

^d Institute for Clinical and Experimental Medicine, Diabetes Centre, Prague, Czech Republic

^e Physicians Committee for Responsible Medicine, Washington, DC, USA

^f Department of Endocrinology, Diabetes and Metabolic Diseases, Dubrava University Hospital, Zagreb, Croatia

^g CIBER Fisiopatología de la Obesidad y Nutrición (CIBEROBn), Instituto de Salud Carlos III, Madrid, Spain

^h Human Nutrition Department, IISPV, Universitat Rovira i Virgili, Reus, Spain

ⁱ Cumming School of Medicine, University of Calgary, Calgary, Canada

^j Department of Medicine, University of Toronto, Toronto, Canada

^k Division of Endocrinology & Metabolism, St. Michael's Hospital, Toronto, Canada

^l Li Ka Shing Knowledge Institute, St. Michael's Hospital, Toronto, Canada

ARTICLE INFO

Article history:

Received 7 December 2017

Accepted 31 May 2018

Keywords:

Vegetarian

Cardiometabolic risk

Diabetes

Systematic review

Meta-analysis

GRADE

SUMMARY

Background & aims: To update the European Association for the Study of Diabetes (EASD) clinical practice guidelines for nutrition therapy, we conducted a systematic review and meta-analysis of randomized controlled trials to summarize the evidence for the effect of vegetarian dietary patterns on glycemic control and other established cardiometabolic risk factors in individuals with diabetes.

Methods: We searched MEDLINE, EMBASE, and Cochrane databases through February 26, 2018 for randomized controlled trials ≥ 3 weeks assessing the effect of vegetarian dietary patterns in individuals with diabetes. The primary outcome was HbA_{1c}. Secondary outcomes included other markers of glycemic control, blood lipids, body weight/adiposity, and blood pressure. Two independent reviewers extracted data and assessed risk of bias. Data were pooled by the generic inverse variance method and expressed as mean differences (MD) with 95% CIs. Heterogeneity was assessed (Cochran Q statistic) and quantified (I² statistic). The overall certainty of the evidence was assessed using the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) approach.

Results: Nine trials (n = 664 participants) met the eligibility criteria. Vegetarian dietary patterns significantly lowered HbA_{1c} (MD = -0.29% [95% CI: -0.45, -0.12%]), fasting glucose (MD = -0.56 mmol/L [95% CI: -0.99, -0.13 mmol/L]), LDL-C (MD = -0.12 mmol/L [95% CI: -0.20, -0.04 mmol/L]), non-HDL-C (MD = -0.13 mmol/L [95% CI: -0.26, -0.01 mmol/L]), body weight (MD = -2.15 kg [95% CI: -2.95, -1.34 kg]), BMI (MD = -0.74 kg/m² [95% CI: -1.09, -0.39 kg/m²]) and waist circumference (MD = -2.86 cm [95% CI: -3.76, -1.96 cm]). There was no significant effect on fasting insulin, HDL-C, triglycerides or blood pressure. The overall certainty of evidence was moderate but was low for fasting insulin, triglycerides and waist circumference.

Abbreviations: ESM, electronic supplementary material; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; MD, mean difference.

* Corresponding author. St. Michael's Hospital, #6137-61 Queen Street East, Toronto, ON, M5C 2T2, Canada. Fax: +1 416 867 7495.

E-mail address: john.sievenpiper@utoronto.ca (J.L. Sievenpiper).

Conclusion: Vegetarian dietary patterns improve glycemic control, LDL-C, non-HDL-C, and body weight/adiposity in individuals with diabetes, supporting their inclusion for diabetes management. More research is needed to improve our confidence in the estimates.

ClinicalTrials.gov identifier: NCT02600377.

© 2018 Published by Elsevier Ltd.

1. Introduction

Diet and lifestyle are the cornerstone of diabetes management [1–3]. Vegetarian dietary patterns, which are characterized by the omission of some or all animal products, have shown a wide range of health benefits. Several prospective cohort studies, many of which were conducted in Adventist populations, show that consuming a vegetarian dietary pattern is associated with a lower risk of type 2 diabetes [4–6], coronary heart disease [7–9], obesity [8,10], hypertension [11–13], cardiovascular mortality [14,15] and all-cause mortality [14]. These findings are consistent with several systematic reviews and meta-analyses of controlled trials which show vegetarian dietary patterns improve glycemic control [16], blood lipids [17], body weight [18,19] and blood pressure [20] in individuals with different metabolic phenotypes. Furthermore, systematic reviews and meta-analyses of prospective cohort studies show that increased consumption of red or processed meat is associated with an increased risk of type 2 diabetes [21–23], coronary heart disease [24], hypertension [25], stroke [24,26,27], cardiovascular mortality [28], and all-cause mortality [28,29].

Despite this evidence for benefit, diabetes guidelines vary in their recommendations for the use of vegetarian dietary patterns in diabetes management. Although the American Diabetes Association (ADA) and Diabetes Canada guidelines include recommendations for vegetarian dietary patterns for diabetes management [3,30], the evidence ratings for these recommendations indicate that further research is required [3,30], whereas the European Association for the Study of Diabetes (EASD) guidelines have not made any specific recommendations for vegetarian dietary patterns [31].

To update the recommendations for the role of vegetarian dietary patterns among other dietary patterns in the management of diabetes, the Diabetes and Nutrition Study Group (DNSG) of the EASD commissioned a series of systematic reviews and meta-analyses using the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) approach. The present systematic review and meta-analysis using GRADE was conducted to address the question of whether the available evidence from randomized controlled trials of vegetarian dietary patterns in comparison with non-vegetarian dietary patterns shows advantages for glycemic control and other established cardiometabolic risk factors in individuals with diabetes.

2. Methods

We followed the Cochrane Handbook for Systematic Reviews of Interventions (version 5.1.0) for the planning and conduct of this systematic review and meta-analysis [32]. Reporting followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines [33] (ESM Table 1). The study protocol was registered at [ClinicalTrials.gov](https://www.clinicaltrials.gov) (identifier, NCT02600377).

2.1. Data sources

We searched MEDLINE, EMBASE, and the Cochrane Central Register of Controlled Trials through February 26, 2018 using a search strategy based on the PICO framework [34] (ESM Table 2).

Manual searches of reference lists from included trials supplemented the electronic database searches.

2.2. Study selection

We included randomized controlled trials of ≥ 3 weeks follow-up duration comparing the effect of vegetarian dietary patterns (including vegan to lacto-ovo-vegetarian) with non-vegetarian dietary patterns on glycemic control and other established cardiometabolic risk factors in individuals with diabetes. No restrictions were placed on language. Studies were excluded if they were non-randomized, < 3 weeks follow-up duration, no vegetarian intervention, no non-vegetarian control, no suitable outcome data, or not conducted in individuals with diabetes.

2.3. Data extraction

Two investigators (EV and VLC, SBM or SES) independently reviewed and extracted relevant data from each included report. A standardized form was used to extract data on sample size, participant characteristics, study setting and design, level of feeding control, intervention and control arm, macronutrient composition of diets, energy balance, follow-up duration, funding source and outcome data. Authors were contacted for missing outcome data [35]. All discrepancies and disagreements were resolved through consensus.

2.4. Risk of bias assessment

Included trials were independently assessed by two investigators (EV and VLC, SBM or SES) for risk of bias using the Cochrane Risk of Bias Tool [32]. Assessment was done across 5 domains of bias (sequence generation, allocation concealment, blinding, incomplete outcome data and selective reporting). The risk of bias was assessed as either low (proper methods taken to reduce bias), high (improper methods creating bias) or unclear (insufficient information provided to determine the bias level). All discrepancies and disagreements were resolved through consensus or where necessary by a third author.

2.5. Outcomes

The primary outcome was HbA_{1c}. Secondary outcomes included other markers of glycemic control (fasting glucose and insulin), blood lipids (LDL-C, non-HDL-C, HDL-C, triglycerides), body weight/adiposity (body weight, BMI, waist circumference), and blood pressure (systolic and diastolic blood pressure). When non-HDL-C values were not reported, they were derived by subtracting HDL-C from total cholesterol values with SDs derived from HDL-C and total cholesterol variance data using the variance sum law [36]. Mean differences (MDs) between the intervention and control arm and respective standard errors were extracted for each trial. If these were not provided they were derived from available data using published formulas [32]. MDs for change-from-baseline values were preferred over end values. If median data was provided they were converted to mean data using methods developed by Luo et al. [37].

2.6. Data syntheses

Primary analyses were conducted using Review Manager (Rev-Man), version 5.3 (Nordic Cochrane Centre, Cochrane Collaboration, Copenhagen, Denmark). Subgroup and publication bias analyses were conducted using STATA software, version 13.0 (StataCorp, College Station, TX, USA). Data were expressed as MDs with 95% CIs and pooled using the generic inverse variance method with random effects models. Fixed effects model was used when data from <5 trials were available. Paired analyses were conducted for crossover trials [38] using a correlation coefficient of 0.5. To mitigate a unit-of-analysis error, the arms of trials with multiple intervention or control arms were combined to create a single pairwise comparison. Heterogeneity was assessed using the Cochran Q statistic and quantified using the I^2 statistic. Significance for heterogeneity was set at $P < 0.10$ with an $I^2 > 50\%$ considered to be evidence of substantial heterogeneity [32]. Sources of heterogeneity were explored using sensitivity and subgroup analyses. Sensitivity analyses were performed in which each individual trial was removed from the meta-analysis and the effect size recalculated to determine whether a single trial exerted an undue influence. Sensitivity analyses were also performed using correlation coefficients of 0.25 and 0.75 to determine whether the overall results were robust to the use of different correlation coefficients in crossover trials. A post-hoc sensitivity analysis for HDL-C was conducted in which analyses were restricted to trials with <5% energy (E) difference in total fat between the intervention and control arms. If ≥ 10 trials were available, then *a priori* subgroup analyses were conducted using meta-regression by baseline values, study design, follow-up, comparator arm, risk of bias and diabetes duration [39,40]. If ≥ 10 trials were available, then we also assessed publication bias by visual inspection of funnel plots and formal testing by the Egger and Begg tests [32,41].

2.7. Grading of the evidence

The GRADE approach was used to assess the certainty of the evidence [42–54]. The certainty of the evidence was graded as high, moderate, low, or very low. Randomized controlled trials receive an initial grade of high by default and are downgraded based on the following pre-specified criteria: risk of bias (weight of trials showing risk of bias by the Cochrane Risk of Bias Tool), inconsistency (substantial unexplained inter-study heterogeneity, $I^2 > 50\%$ and $P < 0.10$), indirectness (presence of factors that limit the generalizability of the results), imprecision (the 95% CI for effect estimates were wide or cross minimally important differences [MIDs] for benefit or harm), and publication bias (significant evidence of small-study effects).

3. Results

3.1. Search results

Figure 1 shows the literature search and selection process. We identified a total of 6498 reports, 6395 of which were excluded based on review of titles and/or abstracts. The remaining 103 reports were retrieved and reviewed in full, of which 94 were excluded. A total of 9 reports containing data for 9 trial comparisons involving 664 participants with diabetes met the eligibility criteria and were included in the final analyses [35,55–62].

3.2. Trial characteristics

Table 1 shows the characteristics of the 9 included trials. All trials were conducted in outpatient settings, with more than half

conducted in the United States [56,57,59,60,62] and one each in Greece [55], Brazil [58], Czech Republic [35], and Korea [61]. Trials had a median follow-up duration of 12 weeks (range: 4–74 weeks), an approximately equal distribution of men and women (median % women: 53%, range: 18–83%), and more than half used a parallel design (6 trials). Most participants had type 2 diabetes (99%), were middle-aged (median age: 56 years, range: 32–61 years), overweight or obese (median BMI: 34 kg/m², range: 23–35 kg/m²) and some or most were taking oral antihyperglycemic agents [35,56–62], insulin [55,56,58,59,61], lipid-lowering agents [35,56,57,59–62], and/or anti-hypertensive agents [35,56–61]. Mean diabetes duration varied from 7 to 9.5 years [57,59,61] for those with type 2 diabetes and before the onset of 30 years of age for those with type 1 diabetes [55], otherwise it was unspecified [35,56,58,60,62]. Median baseline (range) values for each outcome were as follow: HbA_{1c}, 7.6% (6.7–8.2%); fasting glucose, 8.5 mmol/L (7.0–10.3 mmol/L); fasting insulin, 105 pmol/L (not applicable); LDL-C, 2.7 mmol/L (1.9–3.4 mmol/L); HDL-C, 1.2 mmol/L (0.9–1.5 mmol/L); non-HDL-C, 3.7 mmol/L (2.6–4.3 mmol/L); triglycerides, 1.7 mmol/L (1.4–2.2 mmol/L); body weight, 97.5 kg (96.5–102.3 kg); BMI, 34.4 kg/m² (23.5–35.1 kg/m²); waist circumference, 111.6 cm (83.7–113.8 cm); systolic blood pressure, 130.1 mmHg (123.4–145 mmHg); and diastolic blood pressure, 82.0 mmHg (76.9–85 mmHg).

Macronutrient composition of the intervention and control arms varied across trials. Across intervention arms, the median (range) intake values reported were: carbohydrate, 60% E (49–77.5% E); protein, 15% E (12–17% E); fat, 25% E (10–34% E); saturated fat, 5.1% E (1.6–8.8% E); and fiber, 28.3 g/d (12.6–39 g/d), and across control arms they were: carbohydrate, 50% E (41–65% E), protein, 19% E (16–21.5% E), fat, 30% E (19–37% E), saturated fat, 8.5% E (4.4–11.6% E); and fiber, 20 g/d (7.7–39 g/d). For the purpose of dietary recommendations, we rescaled the macronutrient composition for those trials whose macronutrients did not sum to 100%, which resulted in the following mean macronutrient compositions across intervention arms – 62:14:23 and across control arms – 50:19:31 (carbohydrate:protein:fat, %). Feeding control varied across trials: metabolic control (2 trials), supplemental control (2 trials) and dietary advice (4 trials); otherwise it was unspecified (1 trial). Four trials had a neutral energy balance [55,57,58,60], 1 trial had a negative energy balance [35] and the remainder of the trials were not designed to be isocaloric [56,59,61,62]. The majority of trials were funded by some form of agency or agency alone (8 trials) or it was unspecified (1 trial).

3.3. Risk of bias

ESM Figs. 1–5 show the summary and individual Cochrane Risk of Bias assessments of the included trials. The majority of trials were judged as having unclear or low risk of bias across domains.

3.4. Effect of vegetarian dietary patterns on glycemic control

3.4.1. HbA_{1c}

Figure 2 and ESM Fig. 2a show the effect of vegetarian dietary patterns on HbA_{1c}. In 8 trials involving 378 participants with type 1 diabetes ($n = 9$) and type 2 diabetes ($n = 369$), a significant reduction in HbA_{1c} was observed compared to control diets (MD = -0.29% [95% CI: -0.45 , -0.12%], $P = 0.0006$) with no evidence of inter-study heterogeneity ($I^2 = 14\%$, $P = 0.32$).

3.4.2. Fasting glucose

Figure 2 and ESM Fig. 2b show the effect of vegetarian dietary patterns on fasting glucose. In 6 trials involving 313 participants with type 2 diabetes, a significant reduction in fasting glucose was observed compared to control diets (MD = -0.56 mmol/L [95%

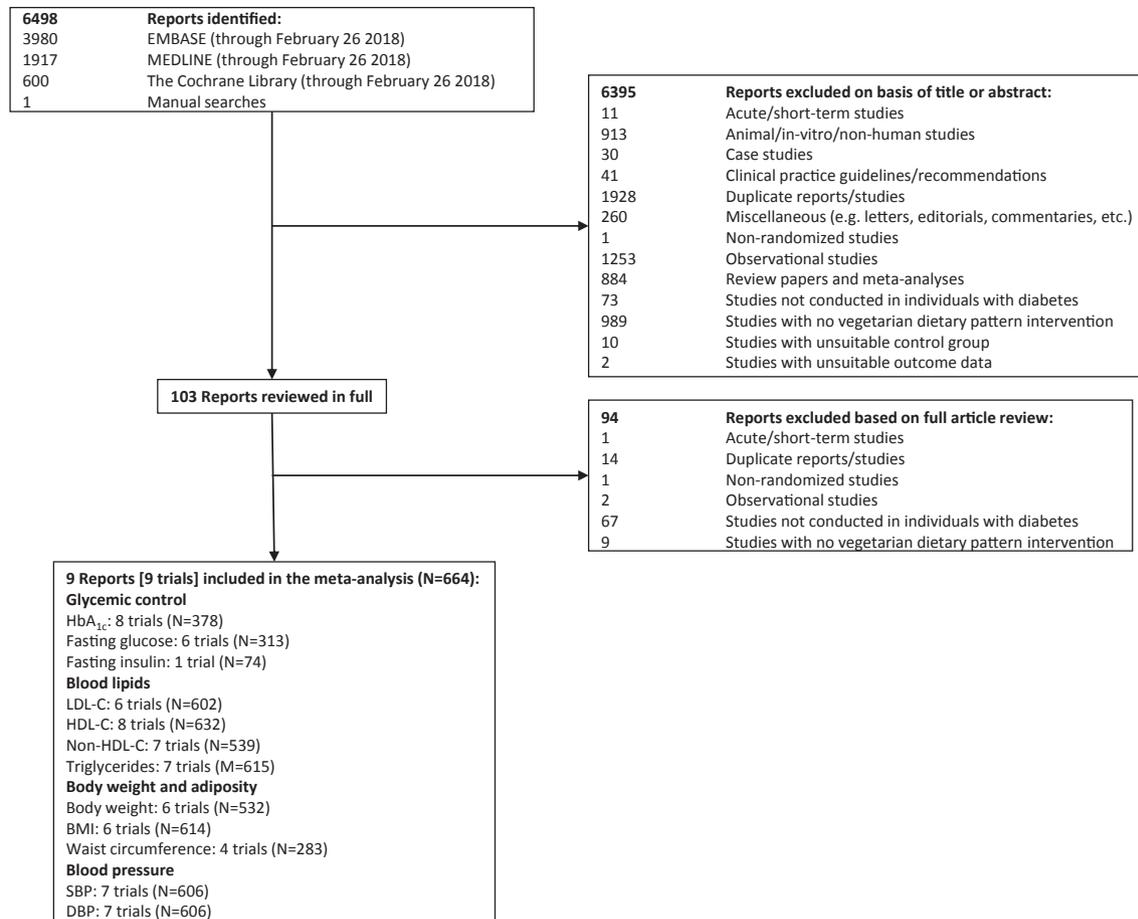


Fig. 1. Flow of the literature for the effect of vegetarian dietary patterns on cardiometabolic risk factors in diabetes. DBP = diastolic blood pressure; SBP = systolic blood pressure.

CI: $-0.99, -0.13$ mmol/L, $P = 0.01$) with no evidence of inter-study heterogeneity ($I^2 = 0\%$, $P = 0.56$). The trial by Kontessis et al. [55], which met the inclusion criteria, was not included in the primary analysis due to implausible variance data that could not be verified with the study authors. Omission of this trial did not alter the direction or significance of the pooled effect estimate or the evidence of inter-study heterogeneity.

3.4.3. Fasting insulin

Only one trial reported data for fasting insulin, which showed vegetarian dietary patterns did not significantly alter fasting insulin compared to the control diet (MD = -7.92 pmol/L [95% CI: $-27.92, 12.08$ pmol/L], $P = 0.44$) in 74 participants with type 2 diabetes [35].

3.5. Effect of vegetarian dietary patterns on blood lipids

3.5.1. LDL-C

Figure 2 and ESM Fig. 3a show the effect of vegetarian dietary patterns on LDL-C. In 6 trials involving 602 participants with type 2 diabetes, a significant reduction in LDL-C was observed compared to control diets (MD = -0.12 mmol/L [95% CI: $-0.20, -0.04$ mmol/L], $P = 0.002$) with no evidence of inter-study heterogeneity ($I^2 = 0\%$, $P = 0.54$).

3.5.2. HDL-C

Figure 2 and ESM Fig. 3b show the effect of vegetarian dietary patterns on HDL-C. In 8 trials involving 632 participants with type 2 diabetes, vegetarian dietary patterns did not significantly alter

HDL-C compared to control diets (MD = -0.03 mmol/L [95% CI: $-0.08, 0.02$ mmol/L], $P = 0.19$) with evidence of substantial inter-study heterogeneity ($I^2 = 66\%$, $P = 0.004$).

3.5.3. Non-HDL-C

Figure 2 and ESM Fig. 3c show the effect of vegetarian dietary patterns on non-HDL-C. In 7 trials involving 539 participants with type 2 diabetes, a significant reduction in non-HDL-C was observed compared to control diets (MD = -0.13 mmol/L [95% CI: $-0.26, -0.01$ mmol/L], $P = 0.03$) with no evidence of inter-study heterogeneity ($I^2 = 0\%$, $P = 0.44$).

3.5.4. Triglycerides

Figure 2 and ESM Fig. 3d show the effect of vegetarian dietary patterns on triglycerides. In 7 trials involving 615 participants with type 2 diabetes, vegetarian dietary patterns did not significantly alter triglycerides compared to control diets (MD = 0.14 mmol/L [95% CI: $-0.10, 0.38$ mmol/L], $P = 0.26$) with evidence of substantial inter-study heterogeneity ($I^2 = 71\%$, $P = 0.002$).

3.6. Effect of vegetarian dietary patterns on body weight and adiposity

3.6.1. Body weight

Figure 2 and ESM Fig. 4a show the effect of vegetarian dietary patterns on body weight. In 6 trials involving 532 participants with type 2 diabetes, a significant reduction in body weight was observed compared to control diets (MD = -2.15 kg [95%

Table 1
Trial characteristics.

Study, year [Reference]	Participants	Age, ^a y	Baseline BMI or body weight ^{a,b}	Setting ^c	Design	Feeding control ^d	Intervention diet	Control diet	Macronutrient composition (CHO:PRO:FAT) ^e , %E	Energy balance ^f	Follow-up duration, wks	Funding sources ^g
Kontessis et al. 1995 [55]	9 T1DM (7W, 2M)	32 (20–48) ^h	23.8 (20.6–27.8) kg/m ^{2h}	OP, GRC	C	NR				Neutral	4	NR
Intervention							Vegetable protein diet		~49:17:34			
Control								Animal protein diet	~41:19:37			
Nicholson et al. 1999 [56]	11 T2DM (5W, 6M)	51 (34–62)	96.7 (13.3) kg	OP, USA	P	Supp				Neutral ⁱ	12	Agency
Intervention	7 (3W, 4M)						Low-fat vegan diet		75:14:11			
Control	4 (2W, 2M)	60 (51–74)	97.0 (22.9) kg					Conventional low-fat diet	51:18:31			
Wheeler et al. 2002 [57]	17 T2DM (3W, 14M)	56 (12.4)	33.1 (5.8) kg/m ²	OP, USA	C	Met				Neutral	6	Agency-Industry
Intervention							Plant-based protein diet		53:17:30			
Control								Animal-based protein diet	53:17:30			
de Mello et al. 2006 [58]	17 T2DM (3W, 14M)	59 (11)	26.2 (2.6) kg/m ²	OP, BRA	C	DA				Neutral	4	Agency
Intervention							Lacto-vegetarian low-protein diet		59:12:30			
Control								Usual diet	47:22:31			
Control								Usual diet + all meat replaced with chicken	50:21:29			
Barnard et al. 2009 [59]	99 T2DM (60W, 39M)	56.7 (9.8)	33.9 (7.8) kg/m ²	OP, USA	P	DA				Neutral ^j	74	Agency
Intervention	49 (27W, 22M)						Low-fat vegan diet		66:15:22			
Control	50 (33W, 17M)	54.6 (10.2)	35.9 (7.0) kg/m ²					Conventional diabetes diet (2003 ADA)	47:21:34			
Kahleova et al. 2011 [35]	74 T2DM (39W, 25M)	54.6 (7.8)	35.1 (6.1) kg/m ²	OP, CZE	P	Met				Negative	24	Agency
Intervention	37 (20W, 17M)						Vegetarian diet		60:15:25			
Control	37 (19W, 18M)	57.7 (4.9)	35.0 (4.6) kg/m ²					Conventional diabetes diet (DNSG of the EASD)	50:20:30			
Mishra et al. 2013 [60]	291 T2DM (242W, 50M)	44.3 (15.3)	34.7 (7.1) kg/m ²	OP, USA	P	Supp				Neutral ^k	18	Agency
Intervention	142 (110W, 32M)						Low-fat vegan diet		57:15:31			
Control	149 (132W, 18M)	46.1 (13.6)	35.3 (8.5) kg/m ²					Usual diet	48:17:37			
Lee et al. 2016 [61]^l	106 T2DM	57.5 (7.7)	23.9 (3.4) kg/m ²	OP, KOR	P	DA				Neutral ^m	12	Agency
Intervention	53						Vegan diet		72:14:19			
Control	53	58.3 (7.0)	23.1 (2.4) kg/m ²					Conventional diabetes diet (2011 KDA)	65:16:19			

(continued on next page)

Table 1 (continued)

Study, year [Reference]	Participants	Age, ^a y	Baseline BMI or body weight ^{a,b}	Setting ^c	Design	Feeding control ^d	Intervention diet	Control diet	Macronutrient composition (CHO:PRO:FAT) ^e , %E	Energy balance ^f	Follow-up duration, wks	Funding sources ^g
Barnard et al. 2018 [62]	40 T2DM	61 (41–79) ^o	34.9 (6.54) kg/m ²	OP, USA	P	DA	Low-fat, low glycemic index vegan diet		78:13:10	Neutral ^h	20	Agency
Intervention	19											
Control	21	61 (30–75) ^o	33.0 (5.96) kg/m ²					Portion-controlled diet	50:21:30			

ADA = American Diabetes Association; C = crossover; CHO = carbohydrate; DA = dietary advice; DNSG = Diabetes and Nutrition Study Group; EASD = European Association for the Study of Diabetes; KDA = Korean Diabetes Association; M = men; Met = metabolic feeding control; OP = outpatient; NR = not reported; P = parallel; PRO = protein; Supp = supplemental feeding control; T1DM = type 1 diabetes mellitus; T2DM = type 2 diabetes mellitus; W = women; wks = weeks; y = years; %E = percent energy.

^a Values reported as mean (SD or range).

^b Baseline body weight values are only reported when no data on BMI were available.

^c Countries are abbreviated using ISO 3166-1 alpha-3 codes (three letter country codes defined in ISO 3166-1).

^d Metabolic feeding control (Met) is the provision of all meals and foods consumed during the study under controlled conditions. Supplemental feeding control (Supp) is the provision of some meals and foods consumed during the study. Dietary advice (DA) is the provision of counseling on the appropriate intervention and control diets.

^e Planned macronutrient composition of intervention and control diets. End of study values measuring energy from carbohydrates, fat and protein are reported only if the study did not report or design diets to have a planned macronutrient composition. Numbers preceded by “~” were calculated using relevant data provided by the study.

^f Negative energy balance refers to a deficit in normal energy intake and/or intake below energy requirements. Neutral energy balance refers to the maintenance of usual energy intake and/or meeting energy requirements. Positive energy balance refers to consuming additional energy (kcal) above what is normally consumed and/or intake above energy requirements.

^g Agency funding is that from government, university, or not-for-profit sources. Industry funding is that from trade organizations that obtain revenue from the sale of products.

^h Reported as median (range).

ⁱ Study explicitly stated that the intervention and control diet were not designed to be isocaloric given that the vegan diet was much lower in fat.

^j Participants in the intervention arm had no restriction on energy intake. Participants in the control arm with a BMI > 25 kg/m² were prescribed energy deficits of 500–1000 kcal.

^k Participants in the intervention arm had no restriction on energy intake. Participants in the control arm made no dietary changes and were given no dietary guidance.

^l All data reported in this table are based on n = 93 (completers).

^m Participants in the intervention arm had no restriction on energy intake. Participants in the control arm were asked to restrict their individualized daily energy intake based on body weight, physical activity, need for weight control, and compliance.

ⁿ Participants in the intervention arm had no restriction on energy intake. Participants in the control arm were prescribed energy limits needed for weight loss (typically a deficit of 500 calories/day).

^o Values reported as median.

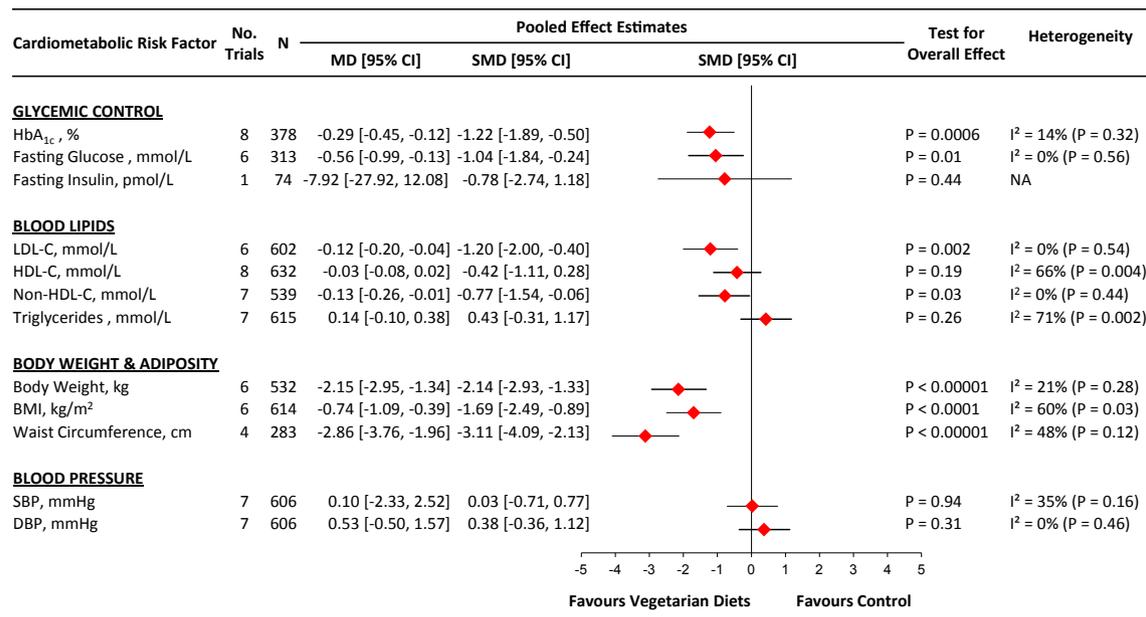


Fig. 2. Forest plot of pooled effect estimates of the effect of vegetarian dietary patterns on cardiometabolic risk factors in diabetes in randomized controlled trials. Data are expressed as weighted mean differences with 95% CIs using the generic inverse-variance method modeled by random effects (≥ 5 trials available) or fixed effects (< 5 trials available). To allow the pooled effect estimates for each end point to be displayed on the same axis, mean differences were transformed to standardized mean differences (SMDs). Pseudo-95% CIs for each transformed SMD were derived directly from the original mean difference and 95% CI. Paired analyses were applied to all crossover trials. Inter-study heterogeneity was tested by the Cochran Q-statistic and quantified by I^2 at a significance level of $P < 0.10$. DBP = diastolic blood pressure; MD = mean difference; N = number of participants; NA = not applicable; SBP = systolic blood pressure; SMD = standardized mean difference.

CI: $-2.95, -1.34$ kg], $P < 0.00001$) with no evidence of inter-study heterogeneity ($I^2 = 21\%$, $P = 0.28$).

3.6.2. BMI

Figure 2 and ESM Fig. 4b show the effect of vegetarian dietary patterns on BMI. In 6 trials involving 614 participants with type 2 diabetes, a significant reduction in BMI was observed compared to control diets (MD = -0.74 kg/m² [95% CI: $-1.09, -0.39$ kg/m²], $P < 0.0001$) with evidence of substantial inter-study heterogeneity ($I^2 = 60\%$, $P = 0.03$).

3.6.3. Waist circumference

Figure 2 and ESM Fig. 4c show the effect of vegetarian dietary patterns on waist circumference. In 4 trials involving 283 participants with type 2 diabetes, a significant reduction in waist circumference was observed compared to control diets (MD = -2.86 cm [95% CI: $-3.76, -1.96$ cm], $P < 0.00001$) with no evidence of inter-study heterogeneity ($I^2 = 48\%$, $P = 0.12$).

3.7. Effect of vegetarian dietary patterns on blood pressure

3.7.1. Systolic blood pressure

Figure 2 and ESM Fig. 5a show the effect of vegetarian dietary patterns on systolic blood pressure. In 7 trials involving 606 participants with type 2 diabetes, vegetarian dietary patterns did not significantly alter systolic blood pressure compared to control diets (MD = 0.10 mmHg [95% CI: $-2.33, 2.52$ mmHg], $P = 0.94$) with no evidence of inter-study heterogeneity ($I^2 = 35\%$, $P = 0.16$).

3.7.2. Diastolic blood pressure

Figure 2 and ESM Fig. 5b show the effect of vegetarian dietary patterns on diastolic blood pressure. In 7 trials involving 606 participants with type 2 diabetes, vegetarian dietary patterns did

not significantly alter diastolic blood pressure compared to control diets (MD = 0.53 mmHg [95% CI: $-0.50, 1.57$ mmHg], $P = 0.31$) with no evidence of inter-study heterogeneity ($I^2 = 0\%$, $P = 0.46$).

3.8. Sensitivity and subgroup analyses

ESM Table 3 shows select sensitivity analyses in which systematic removal of individual trials altered the results. The significance was lost for fasting glucose by the removal of Lee et al. [61], LDL-C by the removal of Mishra et al. [60], and non-HDL by the removal of several trials [35,57–60], although the pooled effect estimates still favored vegetarian dietary patterns in all cases. The pooled effect estimate changed from non-significant to a significant decrease for HDL-C by the removal of Lee et al. and a significant increase [61] for triglycerides by the removal of Kahleova et al. [35]. The evidence of substantial heterogeneity for BMI was partially explained by the removal of Mishra et al. [60] and fully explained by the removal of Lee et al. [61]. For waist circumference removal of Barnard et al. [59] changed the heterogeneity from non-significant to significant.

ESM Table 4 shows sensitivity analyses in which we used different correlation coefficients (0.25 and 0.75) for paired analyses of crossover trials. Neither of the correlation coefficients altered the significance of the pooled effect estimates or the evidence for heterogeneity for any outcome, with the exception of waist circumference, where a 0.75 correlation coefficient changed the heterogeneity from non-significant to significant.

Post hoc sensitivity analyses for HDL-C in which analyses were restricted to trials with $< 5\%$ energy difference in total fat between the intervention and control arms [57,58,61] decreased the evidence for heterogeneity (residual $I^2 = 0\%$, $P = 0.54$) without altering the results (MD = 0.04 mmol/L [95% CI: $-0.01, 0.00$ mmol/L], $P = 0.15$).

Subgroup analyses were not conducted for any outcome as < 10 trials were available.

Table 2
GRADE assessments.

Certainty assessment*							Effect	Certainty
Nº of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations**	MD [95% CIs]	
Glycemic control								
<i>HbA_{1c}</i> , %								
8	Randomized trials	Not serious ^a	Not serious	Not serious	Serious ^b	None	−0.29 [−0.45, −0.12]	⊕⊕⊕○ Moderate
<i>Fasting glucose</i> , mmol/L								
6	Randomized trials	Not serious	Not serious	Not serious	Serious ^c	None	−0.56 [−0.99, −0.13]	⊕⊕⊕○ Moderate
<i>Fasting insulin</i> , pmol/L								
1	Randomized trials	Not serious	Not serious ^d	Serious ^e	Serious ^f	None	−7.92 [−27.92, 12.08]	⊕⊕○○ Low
Blood lipids								
<i>LDL-C</i> , mmol/L								
6	Randomized trials	Not serious	Not serious	Not serious	Serious ^g	None	−0.12 [−0.20, −0.04]	⊕⊕⊕○ Moderate
<i>HDL-C</i> , mmol/L								
8	Randomized trials	Not serious	Serious ^h	Not serious	Not serious	None	−0.03 [−0.08, 0.03]	⊕⊕⊕○ Moderate
<i>Non-HDL-C</i> , mmol/L								
7	Randomized trials	Not serious	Not serious	Not serious	Serious ⁱ	None	−0.13 [−0.26, −0.01]	⊕⊕⊕○ Moderate
<i>Triglycerides</i> , mmol/L								
7	Randomized trials	Not serious	Serious ^j	Not serious	Serious ^k	None	0.14 [−0.10, 0.38]	⊕⊕○○ Low
Body weight & adiposity								
<i>Body weight</i> , kg								
6	Randomized trials	Not serious	Not serious	Serious ^l	Not serious	None	−2.15 [−2.95, −1.34]	⊕⊕⊕○ Moderate
<i>BMI</i> , kg/m ²								
6	Randomized trials	Not serious	Not serious ^m	Serious ^l	Not serious	None	−0.74 [−1.09, −0.39]	⊕⊕⊕○ Moderate
<i>Waist circumference</i> , cm								
4	Randomized trials	Not serious	Not serious	Serious ^l	Serious ⁿ	None	−2.86 [−3.76, −1.96]	⊕⊕○○ Low
Blood pressure								
<i>SBP and DBP</i> , mmHg ^o								
7	Randomized trials	Not serious	Not serious	Not serious	Serious ^p	None	SBP: 0.10 [−2.33, 2.52] DBP: 0.53 [−0.50, 1.57]	⊕⊕⊕○ Moderate

DBP = diastolic blood pressure; MD = mean difference; SBP = systolic blood pressure.

*Since all included studies were randomized controlled trials, the certainty of the evidence was graded as high for all outcomes by default and then downgraded based on pre-specified criteria. Risk of Bias – Downgraded if the majority of studies were considered to be at high risk of bias. Inconsistency – Downgraded if there was substantial unexplained heterogeneity ($I^2 > 50\%$, $P < 0.10$) that was unexplained by any *a priori* sensitivity or subgroup analyses. Indirectness – Downgraded if there were factors present relating to the participants, interventions, or outcomes that limited the generalizability of the results. Imprecision – Downgraded if the 95% confidence interval (95% CI) crossed the minimally important difference (MID) for benefit or harm. MID used for each outcome were: 0.3% for HbA_{1c} [70], 0.5 mmol/L for fasting glucose, 5 pmol/L for fasting insulin, 0.1 mmol/L for blood lipids, 0.5 kg for body weight [81], 0.2 kg/m² for BMI, 2 cm for waist circumference, and 2 mmHg for blood pressure.

**Not able to assess publication bias for any of the outcomes as <10 trials were available.

^a No serious risk of bias for the effect of vegetarian dietary patterns on HbA_{1c} even though two trials [56,59] contributing 25% weight were high risk for attrition bias (incomplete outcome data) and one trial [61] contributing 37% weight was high risk for selection (allocation concealment) and performance bias (blinding of participants and personnel).

^b Serious imprecision for the effect of vegetarian dietary patterns on HbA_{1c}, as the 95% CIs (−0.45, −0.12%) overlap with the minimally important difference for clinical benefit (−0.3%).

^c Serious imprecision for the effect of vegetarian dietary patterns on fasting glucose, as the 95% CIs (−0.99, −0.13 mmol/L) overlap with the minimally important difference for clinical benefit (−0.5 mmol/L).

^d Not able to assess inconsistency for fasting insulin as only 1 trial was available for inclusion.

^e Serious indirectness for the effect of vegetarian dietary patterns on fasting insulin, as only 1 trial in 74 participants with type 2 diabetes was available for analysis (Kahleova et al., 2011).

^f Serious imprecision for the effect of vegetarian dietary patterns on fasting insulin, as the 95% CIs (−27.92, 12.08 pmol/L) include the minimally important difference for both clinically important benefit (−5 pmol/L) and harm (5 pmol/L).

^g Serious imprecision for the effect of vegetarian dietary patterns on LDL-C, as the 95% CIs (−0.20, −0.04 mmol/L) overlap with the minimally important difference for clinical benefit (−0.1 mmol/L).

^h Serious inconsistency for the effect of vegetarian dietary patterns on HDL-C, as $I^2 = 66\%$ and $P = 0.004$.

ⁱ Serious imprecision for the effect of vegetarian dietary patterns on non-HDL-C, as the 95% CIs (−0.26, −0.01 mmol/L) overlap with the minimally important difference for clinical benefit (−0.1 mmol/L).

^j Serious inconsistency for vegetarian diets and triglycerides, as $I^2 = 71\%$ and $P = 0.002$.

^k Serious imprecision for the effect of vegetarian dietary patterns on triglycerides, as the 95% CIs (−0.10, 0.38 mmol/L) overlap with the minimally important difference for clinical harm (0.1 mmol/L).

^l Serious indirectness for the effect of vegetarian dietary patterns on body weight and adiposity, as majority of the trials (5/6 trials for body weight and BMI and 3/4 trials for waist circumference) had a follow-up duration <1 year.

^m Although there is evidence of substantial heterogeneity for the effect of vegetarian dietary patterns on BMI ($I^2 = 60\%$, $P = 0.03$), removal of 2 trials (Mishra et al., 2013 and Lee et al., 2016) explained some or all of the heterogeneity ($I^2 = 40\%$, $P = 0.15$ and $I^2 = 0\%$, $P = 0.60$, respectively).

ⁿ Serious imprecision for the effect of vegetarian dietary patterns on waist circumference, as the 95% CIs (−4.06, −1.34 cm) overlap with the minimally important difference for clinical benefit (−2 cm).

^o Systolic and diastolic blood pressure were combined into one quality assessment for blood pressure.

^p Serious imprecision for the effect of vegetarian dietary patterns on systolic blood pressure, as the 95% CIs (−2.33, 2.52 mmHg) include the minimally important difference for both clinically important benefit (−2 mmHg) and harm (2 mmHg).

3.9. Publication bias

Publication bias was not assessed for any outcome as <10 trials were available.

3.10. GRADE assessment

Table 2 shows a summary of the GRADE assessments of the overall certainty of the evidence for the effect of vegetarian dietary

patterns on cardiometabolic risk factors. The evidence was graded as moderate for HbA_{1c}, fasting glucose, LDL-C, non-HDL-C, and blood pressure owing to a downgrade for imprecision; moderate for HDL-C owing to a downgrade for inconsistency; moderate for body weight and BMI owing to a downgrade for indirectness; low for fasting insulin and waist circumference owing to downgrades for imprecision and indirectness; and low for triglycerides owing to downgrades for inconsistency and imprecision.

4. Discussion

The present systematic review and meta-analysis of 9 randomized controlled trials including 664 predominantly middle-aged, overweight or obese participants with type 2 diabetes controlled by medications (including oral antihyperglycemic agents, insulin, lipid-lowering agents and/or anti-hypertensive agents) showed that vegetarian dietary patterns in comparison with non-vegetarian dietary patterns have benefits for glycemic control and other established cardiometabolic risk factors over a median follow-up of 12 weeks. An improvement was observed in the primary outcome HbA_{1c} of 0.29%. Further improvements were observed in glycemic control as assessed by fasting glucose; blood lipids as assessed by LDL-C and non-HDL-C; and body weight/adiposity as assessed by body weight, BMI and waist circumference. No significant effects were observed on fasting insulin, HDL-C, triglycerides and blood pressure.

4.1. Results in relation to other studies

Our findings extend those of previous systematic reviews and meta-analyses. The improvements in glycemic control seen in our systematic review and meta-analysis are in agreement with a previous systematic review and meta-analysis in individuals with type 2 diabetes, which showed vegetarian dietary patterns lowered HbA_{1c} and non-significantly lowered fasting glucose [16]. Although we found a significant lowering-effect on fasting glucose, this discrepancy can be explained by our inclusion of a new trial [61], confirmed by sensitivity analyses. Our findings for lipids were consistent with a previous systematic review and meta-analysis conducted in individuals with and without diabetes, which showed vegetarian dietary patterns lowered LDL-C and non-HDL-C, without significantly altering triglycerides [17]. A significant HDL-C decreasing-effect was also found. Although we did not find a significant HDL-C lowering-effect of vegetarian dietary patterns, the result was complicated by substantial heterogeneity. This inconsistency was explained in sensitivity analyses by differences in total fat intake between the intervention and control arms of trials. Our findings for body weight were comparable with 2 previous systematic reviews and meta-analyses [18,19] conducted in individuals with and without type 2 diabetes, both of which showed that vegetarian dietary patterns significantly lowered body weight. Lastly, our findings for blood pressure were inconsistent with a previous systematic review and meta-analysis of randomized controlled trials in people with and without diabetes, which showed significant reductions in systolic and diastolic blood pressure [20]. Although our findings showed no effect on blood pressure, this may be attributable to the entry criteria in the trials. The majority of the trials in the previous systematic review and meta-analysis included individuals who were pre-hypertensive or had stage 1 hypertension not on anti-hypertensive medications [20], whereas most of the trials in our systematic review and meta-analysis included individuals with type 2 diabetes who had well-controlled blood pressure (median blood pressure was 130.1/82 mmHg) on antihypertensive medications.

4.2. Potential mechanisms

Several potential mechanisms may explain the observed benefits of vegetarian dietary patterns on different cardiometabolic risk factors. Vegetarian dietary patterns are inherently lower in energy, which was observed in several included trials that placed no restriction on calorie intake [56,58–61]. This is mainly attributed to their lower fat and higher fiber content [63,64], which promotes weight loss and, in turn, improvements in glycemic control [2,3]. Vegetarian dietary patterns also consist of lower intakes of saturated fat and higher intakes of unsaturated fat, phytochemicals (e.g. phytosterols, phenolics, etc.), plant protein in place of animal protein, and low glycemic index foods. All of these components have individually shown beneficial effects on a wide range of cardiometabolic risk factors and their respective mechanisms have been described in greater detail in previously published reviews [66,67] and systematic reviews and meta-analyses [16–20,68].

4.3. Strengths and limitations

Our systematic review and meta-analysis had several strengths. These included a rigorous search and selection strategy that identified all available randomized controlled trials examining the effect of vegetarian dietary patterns on cardiometabolic risk factors in individuals with diabetes; inclusion of predominantly high quality randomized controlled trials, which give the greatest protection against bias; use of intention-to-treat data when available [59–61,66], which tend to provide more conservative pooled estimates [69]; and assessment of the overall certainty of the evidence using the GRADE approach.

There were also several limitations of our systematic review and meta-analysis. First, there was evidence of serious imprecision in the pooled estimates across several outcomes. The 95% CIs were wide such that they could not rule out clinically important harm in the case of triglycerides and blood pressure and clinically trivial effects in the case of HbA_{1c}, fasting glucose, LDL-C, non-HDL-C, and waist circumference. There was also instability in the significance of the pooled effect estimates with the removal of single trials during sensitivity analyses resulting in the loss of significance for fasting glucose, LDL-C and non-HDL-C and gain in significance for HDL-C (decrease) and triglycerides (increase). Second, serious indirectness complicated the pooled estimates for body weight outcomes. Although Barnard et al. [59] was over 1 year, the median follow-up among the trials was just 3-months with all other trials ≤6-months. This duration is considered of modest practical value to assess a sustained weight-loss benefit, although we did consider it sufficient for assessing a meaningful effect on other cardiometabolic outcomes. Third, there was evidence of inconsistency in HDL-C. Sensitivity analyses showed that the lack of effect of vegetarian dietary patterns on HDL-C appears to depend on the level of fat intake, suggesting that the lack of effect on HDL-C may not apply to different macronutrient distribution ranges. Fourth, only 1 trial was conducted in individuals with type 1 diabetes. Although the glycemic and cardiometabolic benefits would not be expected to differ in this population, our findings remain most relevant to people with type 2 diabetes. Finally, the small number of available trials (<10 trials) meant that we were unable to conduct subgroup and publication bias analyses for any outcome.

Weighing these strengths and limitations, our GRADE assessments graded the overall evidence as low for fasting insulin, triglycerides and waist circumference and moderate quality for the remaining glycemic control (HbA_{1c}, fasting glucose), lipid (LDL-C, HDL-C, non-HDL-C), body weight (body weight, BMI), and blood pressure outcomes.

4.4. Implications

Despite imprecision in the pooled estimate for HbA_{1c}, the observed reduction of 0.29%, although modest, meets the threshold of $\geq 0.3\%$ proposed by the U.S. Food and Drug Administration for the development of new antihyperglycemic medications for diabetes [70]. This clinically meaningful reduction was observed in the presence of oral antihyperglycemic agents, the use of which was reduced by individuals in several of the included trials [35,56,59], suggesting that vegetarian dietary patterns may reduce the need for medications and combined with standard therapy may be particularly advantageous for managing glycemic control in people with type 2 diabetes. This lowering in HbA_{1c} may also contribute to reducing the risk of major cardiovascular events, as demonstrated by previously published meta-analyses of randomized trials [71–73]. Given the demonstrated one-to-one relationship between LDL-C lowering and cardiovascular risk reduction [74,75], the ~5% observed reduction in LDL-C in our meta-analysis would also translate into a ~5% risk reduction in major cardiovascular events. These risk reductions are an important consideration given that coronary heart disease is the most important cause of premature death in individuals with diabetes [76]. Given that the prevalence of individuals following vegetarian dietary patterns in Europe and North America are low (approximately less than 10% of the population based on available data from national surveys) [77], there is an important opportunity for individuals with diabetes to adopt vegetarian dietary patterns and gain the observed glycemic and cardiometabolic benefits. Furthermore, vegetarian dietary patterns have been shown to be comparable to other therapeutic diets in terms of acceptability and adherence, suggesting their suitability for long term use [77,78]. Other implications of adopting vegetarian dietary patterns include their economic and environmental benefits, which may contribute to greater adoption and adherence [79,80].

5. Conclusion

In conclusion, vegetarian dietary patterns lead to improvements in glycemic control and other established cardiometabolic risk factors in predominantly middle-aged, overweight or obese participants with type 2 diabetes controlled by medications. Our confidence in the pooled estimates for these outcomes is moderate to low. Sources of uncertainty include serious imprecision in the pooled estimates for HbA_{1c}, fasting glucose, fasting insulin, LDL-C, non-HDL-C, triglycerides, waist circumference, and blood pressure; indirectness for fasting insulin and body weight and adiposity outcomes (body weight, BMI, waist circumference), and inconsistency for HDL-C and triglycerides. More research is likely to have an important influence on our confidence in the pooled estimates. More high quality randomized trials testing the effect of vegetarian dietary patterns on glycemic control and other established cardiometabolic outcomes are needed to address the uncertainties, to better understand the impact in individuals with type 1 diabetes and whether there are differences between the different forms of vegetarianism. There is also a need for large randomized trials that extend beyond intermediate biomarkers and assess more patient-important clinical outcomes such as cardiovascular disease, nephropathy, retinopathy, and mortality in people with diabetes.

Funding

The Diabetes and Nutrition Study Group (DNSG) of the European Association for the Study of Diabetes (EASD) commissioned this systematic review and meta-analysis and provided funding and

logistical support for meetings as part of their development of clinical practice guidelines for nutrition therapy. This work was also supported by the Canadian Institutes of Health Research (funding reference number, 129920) through the Canada-wide Human Nutrition Trialists' Network (NTN). The Diet, Digestive tract, and Disease (3-D) Centre, funded through the Canada Foundation for Innovation (CFI) and the Ministry of Research and Innovation's Ontario Research Fund (ORF), provided the infrastructure for the conduct of this project. Effie Viguiliouk was supported by a Toronto 3D Knowledge Synthesis and Clinical Trials foundation Internship Award. David JA Jenkins was funded by the Government of Canada through the Canada Research Chair Endowment. John L Sievenpiper was funded by a PSI Graham Farquharson Knowledge Translation Fellowship, Canadian Diabetes Association Clinician Scientist award, CIHR INMD/CNS New Investigator Partnership Prize, and Banting & Best Diabetes Centre Sun Life Financial New Investigator Award. With the exception of the Diabetes and Nutrition Study Group (DNSG) of the European Association for the Study of Diabetes (EASD) guidelines committee, none of the sponsors had a role in any aspect of the present study, including design and conduct of the study; collection, management, analysis, and interpretation of the data; and preparation, review, approval of the manuscript or decision to publish. The corresponding author had full access to all the data in the study and had final responsibility for the decision to submit for publication.

Conflicts of interest

Cyril WC Kendall has received research support from the Advanced Foods and Material Network, Agrifoods and Agriculture Canada, the Almond Board of California, the American Pistachio Growers, Barilla, the California Strawberry Commission, the Calorie Control Council, CIHR, the Canola Council of Canada, the Coca-Cola Company (investigator initiated, unrestricted grant), Hain Celestial, the International Tree Nut Council Nutrition Research and Education Foundation, Kellogg, Kraft, Loblaw Companies Ltd., Orafiti, Pulse Canada, Saskatchewan Pulse Growers, Solae and Unilever. He has received travel funding, consultant fees and/or honoraria from Abbott Laboratories, the Almond Board of California, the American Peanut Council, the American Pistachio Growers, Barilla, Bayer, the Canola Council of Canada, the Coca-Cola Company, Danone, General Mills, the International Tree Nut Council Nutrition Research and Education Foundation, Kellogg, Loblaw Companies Ltd., the Nutrition Foundation of Italy, Oldways Preservation Trust, Orafiti, Paramount Farms, the Peanut Institute, PepsiCo, Pulse Canada, Sabra Dipping Co., Saskatchewan Pulse Growers, Solae, Sun-Maid, Tate and Lyle, and Unilever. He is on the Dietary Guidelines Committee for the Diabetes Nutrition Study Group of the European Association for the Study of Diabetes and has served on the scientific advisory board for the Almond Board of California, the International Tree Nut Council, Oldways Preservation Trust, Paramount Farms and Pulse Canada.

Jordi Salas-Salvadó reports serving on the board of and receiving grant support through his institution from the International Nut and Dried Fruit Council, and Eroski Foundation. Reports serving in the Executive Committee of the Instituto Danone Spain. Has received research support from the Instituto de Salud Carlos III, Spain; Ministerio de Educación y Ciencia, Spain; Departament de Salut Pública de la Generalitat de Catalunya, Catalonia, Spain; European Commission. Has received research support from California Walnut Commission, Sacramento CA, USA; Patrimonio Comunal Olivarero, Spain; La Morella Nuts, Spain; and Borges S.A., Spain. Reports receiving consulting fees or travel expenses from Danone; California Walnut Commission, Eroski Foundation, Instituto Danone - Spain, Nuts for Life, Australian Nut Industry Council,

Nestlé, Abbot Laboratories, and Font Vella Lanjarón. He is on the Clinical Practice Guidelines Expert Committee of the European Association for the study of Diabetes (EASD), and served in the Scientific Committee of the Spanish Food and Safety Agency, and the Spanish Federation of the Scientific Societies of Food, Nutrition and Dietetics. He is a member of the International Carbohydrate Quality Consortium (ICQC), and Executive Board Member of the Diabetes and Nutrition Study Group (DNSG) of the EASD.

Dario Rahelić has served as principal investigator or co-investigator in clinical trials of AstraZeneca, Eli Lilly, MSD, Novo Nordisk, Sanofi Aventis, Solvay and Trophos. He has received honoraria for speaking or advisory board engagements and consulting fees from Abbott, Amgen, AstraZeneca, Bayer, Boehringer Ingelheim, Eli Lilly, Lifescan – Johnson & Johnson, Novartis, Novo Nordisk, MSD, Merck Sharp & Dohme, Pfizer, Pliva, Roche, Salvus, Sanofi Aventis and Takeda.

David JA Jenkins has received research grants from Saskatchewan Pulse Growers, the Agricultural Bioproducts Innovation Program through the Pulse Research Network, the Advanced Foods and Material Network, Loblaw Companies Ltd., Unilever, Barilla, the Almond Board of California, Agriculture and Agri-food Canada, Pulse Canada, Kellogg's Company, Canada, Quaker Oats, Canada, Procter & Gamble Technical Centre Ltd., Bayer Consumer Care, Springfield, NJ, Pepsi/Quaker, International Nut & Dried Fruit (INC), Soy Foods Association of North America, the Coca-Cola Company (investigator initiated, unrestricted grant), Solae, Haine Celestial, the Sanitarium Company, Orafiti, the International Tree Nut Council Nutrition Research and Education Foundation, the Peanut Institute, the Canola and Flax Councils of Canada, the Calorie Control Council (CCC), the CIHR, the Canada Foundation for Innovation and the Ontario Research Fund. He has received in-kind supplies for trials as a research support from the Almond board of California, Walnut Council of California, American Peanut Council, Barilla, Unilever, Unico, Primo, Loblaw Companies, Quaker (Pepsico), Pristine Gourmet, Bunge Limited, Kellogg Canada, WhiteWave Foods. He has been on the speaker's panel, served on the scientific advisory board and/or received travel support and/or honoraria from the Almond Board of California, Canadian Agriculture Policy Institute, Loblaw Companies Ltd, the Griffin Hospital (for the development of the NuVal scoring system, the Coca-Cola Company, EPICURE, Danone, Diet Quality Photo Navigation (DQPN), Better Therapeutics (FareWell), Verywell, True Health Initiative, Institute of Food Technologists (IFT), Saskatchewan Pulse Growers, Sanitarium Company, Orafiti, the Almond Board of California, the American Peanut Council, the International Tree Nut Council Nutrition Research and Education Foundation, the Peanut Institute, Herbalife International, Pacific Health Laboratories, Nutritional Fundamental for Health, Barilla, Metagenics, Bayer Consumer Care, Unilever Canada and Netherlands, Solae, Kellogg, Quaker Oats, Procter & Gamble, the Coca-Cola Company, the Griffin Hospital, Abbott Laboratories, the Canola Council of Canada, Dean Foods, the California Strawberry Commission, Haine Celestial, PepsiCo, the Alpro Foundation, Pioneer Hi-Bred International, DuPont Nutrition and Health, Spherix Consulting and WhiteWave Foods, the Advanced Foods and Material Network, the Canola and Flax Councils of Canada, the Nutritional Fundamentals for Health, Agri-Culture and Agri-Food Canada, the Canadian Agri-Food Policy Institute, Pulse Canada, the Saskatchewan Pulse Growers, the Soy Foods Association of North America, the Nutrition Foundation of Italy (NFI), Nutra-Source Diagnostics, the McDougall Program, the Toronto Knowledge Translation Group (St. Michael's Hospital), the Canadian College of Naturopathic Medicine, The Hospital for Sick Children, the Canadian Nutrition Society (CNS), the American Society of Nutrition (ASN), Arizona State University, Paolo Sorbini Foundation and the Institute of

Nutrition, Metabolism and Diabetes. He received an honorarium from the United States Department of Agriculture to present the 2013 W.O. Atwater Memorial Lecture. He received the 2013 Award for Excellence in Research from the International Nut and Dried Fruit Council. He received funding and travel support from the Canadian Society of Endocrinology and Metabolism to produce mini cases for the Canadian Diabetes Association (CDA). He is a member of the International Carbohydrate Quality Consortium (ICQC). His wife, ALJ, is a director and partner of Glycemic Index Laboratories, Inc., and his sister, CB, received funding through a grant from the St. Michael's Hospital Foundation to develop a cookbook for one of his studies.

John L Sievenpiper has received research support from the Canadian Institutes of Health Research (CIHR), Diabetes Canada, PSI Foundation, Banting and Best Diabetes Centre (BBDC), Canadian Nutrition Society (CNS), American Society for Nutrition (ASN), INC International Nut and Dried Fruit Council Foundation, National Dried Fruit Trade Association, The Tate and Lyle Nutritional Research Fund at the University of Toronto, The Glycemic Control and Cardiovascular Disease in Type 2 Diabetes Fund at the University of Toronto (a fund established by the Alberta Pulse-Growers), and the Nutrition Trialists Fund at the University of Toronto (a fund established by the Calorie Control Council). He has received in-kind research support from the Almond Board of California, California Walnut Commission, American Peanut Council, Barilla, Unilever, Unico, Primo, Loblaw Companies, Quaker (Pepsico), Kellogg Canada, and WhiteWave Foods. He has received travel support, speaker fees and/or honoraria from Diabetes Canada, Canadian Nutrition Society (CNS), Mott's LLP, Dairy Farmers of Canada, Sprim Brasil, WhiteWave Foods, Rippe Lifestyle, mdBriefcase, Alberta Milk, FoodMinds LLC, Memac Ogilvy & Mather LLC, PepsiCo, The Ginger Network LLC, International Sweeteners Association, Nestlé Nutrition Institute, Pulse Canada, Canadian Society for Endocrinology and Metabolism (CSEM), Barilla Centre for Food and Nutrition (BCFN) Foundation, and GI Foundation. He has ad hoc consulting arrangements with Winston & Strawn LLP, Perkins Coie LLP, and Tate & Lyle. He is a member of the European Fruit Juice Association Scientific Expert Panel. He is on the Clinical Practice Guidelines Expert Committees of Diabetes Canada, European Association for the study of Diabetes (EASD), Canadian Cardiovascular Society (CCS), and Canadian Obesity Network. He serves as an unpaid scientific advisor for the Food, Nutrition, and Safety Program (FNSP) and the Technical Committee on Carbohydrates of the International Life Science Institute (ILSI) North America. He is a member of the International Carbohydrate Quality Consortium (ICQC), Executive Board Member of the Diabetes and Nutrition Study Group (DNSG) of the EASD, and Director of the Toronto 3D Knowledge Synthesis and Clinical Trials foundation. His wife is an employee of Unilever Canada.

No competing interests were declared by Effie Vigiouliouk, Hana Kahleová, Vivian L Choo, Sonia Blanco Mejia, Sarah E Stewart, and Lawrence A Leiter. There are no patents, products in development or marketed products to declare.

Author contributions

Study concept and design: EV, CWCK, HK, DR, JS-S, and JLS. Acquisition of data: EV, VLC, SES, SBM and JLS. Analysis and interpretation of data: EV, CWCK, VC, SS, HK, DR, JS-S, LAL, DJAJ, JLS. Drafting of the manuscript: EV. Critical revision of the manuscript for important intellectual content: EV, CWCK, VC, SS, HK, DR, JS-S, LAL, DJAJ, JLS. Final approval of the version to be published: EV, CWCK, VC, SS, HK, DR, JS-S, LAL, DJAJ, JLS. Study supervision: CWCK, JLS.

Acknowledgements

We wish to thank Teruko Kishibe of Li Ka Shing's International Healthcare Education Centre at St. Michael Hospital for her help in the development of the search strategy. Aspects of this work were presented at the International Diabetes Federation (IDF) World Diabetes Congress, Vancouver, Canada, Nov 30–Dec 4, 2015 and the 34th International Symposium on Diabetes and Nutrition, Prague, Czech Republic, Jun 29–Jul 1, 2016.

Appendix A. Supplementary data

Supplementary data related to this article can be found at <https://doi.org/10.1016/j.clnu.2018.05.032>.

References

- [1] Knowler WC, Barrett-Connor E, Fowler SE, Hamman RF, Lachin JM, Walker EA, et al. Reduction in the incidence of type 2 diabetes with lifestyle intervention or metformin. *N Engl J Med* 2002;346(6):393–403.
- [2] Tuomilehto J, Lindström J, Eriksson JG, Valle TT, Hämäläinen H, Ilanne-Parikka P, et al., Finnish Diabetes Prevention Study Group. Prevention of type 2 diabetes mellitus by changes in lifestyle among subjects with impaired glucose tolerance. *N Engl J Med* 2001;344(18):1343–50.
- [3] Diabetes Canada Clinical Practice Guidelines Expert Committee, Sievenpiper JL, Chan CB, Dworatzek PD, Freeze C, Williams SL. Nutrition therapy. *Can J Diabetes* 2018;42(Suppl 1):S64–79.
- [4] Tonstad S, Stewart K, Oda K, Batech M, Herring RP, Fraser GE. Vegetarian diets and incidence of diabetes in the adventist health study-2. *Nutr Metabol Cardiovasc Dis* 2013;23(4):292–9.
- [5] Snowdon DA, Phillips RL. Does a vegetarian diet reduce the occurrence of diabetes? *Am J Publ Health* 1985;75(5):507–12.
- [6] Chiu THT, Pan WH, Lin MN, Lin CL. Vegetarian diet, change in dietary patterns, and diabetes risk: a prospective study. *Nutr Diabetes* 2018;8(1):12.
- [7] Dinu M, Abbate R, Gensini GF, Casini A, Sofi F. Vegetarian, vegan diets and multiple health outcomes: a systematic review with meta-analysis of observational studies. *Crit Rev Food Sci Nutr* 2017;57(17):3640–9.
- [8] Crowe FL, Appleby P, Travis RC, Key TJ. Risk of hospitalization or death from ischemic heart disease among British vegetarians and nonvegetarians: results from the EPIC-Oxford cohort study. *Am J Clin Nutr* 2013;97(3):597–603.
- [9] Kwok CS, Umar S, Myint PK, Mamas MA, Loke YK. Vegetarian diet, Seventh Day Adventists and risk of cardiovascular mortality: a systematic review and meta-analysis. *Int J Cardiol* 2014;176(3):680–6.
- [10] Chiu YF, Hsu C, Chiu TH, Lee CY, Liu TT, Tsao CK, et al. Cross-sectional and longitudinal comparisons of metabolic profiles between vegetarian and non-vegetarian subjects: a matched cohort study. *Br J Nutr* 2015;114(8):1313–20.
- [11] Chuang SY, Chiu TH, Lee CY, Liu TT, Tsao CK, Hsiung CA, et al. Vegetarian diet reduces the risk of hypertension independent of abdominal obesity and inflammation: a prospective study. *J Hypertens* 2016;34(11):2164–71.
- [12] Pettersen BJ, Anousheh R, Fan J, Jaceldo-Siegl K, Fraser GE. Vegetarian diets and blood pressure among white subjects: results from the Adventist Health Study-2 (AHS-2). *Publ Health Nutr* 2012;15(10):1909–16.
- [13] Appleby PN, Davey G, Key TJ. Hypertension and blood pressure among meat eaters, fish eaters, vegetarians and vegans in EPIC-Oxford. *Publ Health Nutr* 2002;5(5):645–54.
- [14] Orlich MJ, Singh PH, Sabaté J, Jaceldo-Siegl K, Fan J, Knutsen S, et al. Vegetarian dietary patterns and mortality in adventist health study 2. *JAMA Intern Med* 2013;173(13):1230–8.
- [15] Huang T, Yang B, Zheng J, Li G, Wahlqvist ML, Li D. Cardiovascular disease mortality and cancer incidence in vegetarians: a meta-analysis and systematic review. *Ann Nutr Metab* 2012;60(4):233–40.
- [16] Yokoyama Y, Barnard ND, Levin SM, Watanabe M. Vegetarian diets and glycemic control in diabetes: a systematic review and meta-analysis. *Cardiovasc Diagn Ther* 2014;4(5):373–82.
- [17] Wang F, Zheng J, Yang B, Jiang J, Fu Y, Li D. Effects of vegetarian diets on blood lipids: a systematic review and meta-analysis of randomized controlled trials. *J Am Heart Assoc* 2015;4(10):e002408.
- [18] Barnard ND, Levin SM, Yokoyama Y. A systematic review and meta-analysis of changes in body weight in clinical trials of vegetarian diets. *J Acad Nutr Diet* 2015;115(6):954–69.
- [19] Huang RY, Huang CC, Hu FB, Chavarro JE. Vegetarian diets and weight reduction: a meta-analysis of randomized controlled trials. *J Gen Intern Med* 2016;31(1):109–16.
- [20] Yokoyama Y, Nishimura K, Barnard ND, Takegami M, Watanabe M, Sekikawa A, et al. Vegetarian diets and blood pressure: a meta-analysis. *JAMA Intern Med* 2014;174(4):577–87.
- [21] Pan A, Sun Q, Bernstein AM, Manson JE, Willett WC, Hu FB. Changes in red meat consumption and subsequent risk of type 2 diabetes mellitus: three cohorts of US men and women. *JAMA Intern Med* 2013;173(14):1328–35.
- [22] Schwingshackl L, Hoffmann G, Lampousi AM, Knüppel S, Iqbal K, Schwedhelm C, et al. Food groups and risk of type 2 diabetes mellitus: a systematic review and meta-analysis of prospective studies. *Eur J Epidemiol* 2017;32(5):363–75.
- [23] Tian S, Xu Q, Jiang R, Han T, Sun C, Na L. Dietary protein consumption and the risk of type 2 diabetes: a systematic review and meta-analysis of cohort studies. *Nutrients* 2017;9(9).
- [24] Bechthold A, Boeing H, Schwedhelm C, Hoffmann G, Knüppel S, Iqbal K, et al. Food groups and risk of coronary heart disease, stroke and heart failure: a systematic review and dose-response meta-analysis of prospective studies. *Crit Rev Food Sci Nutr* 2017;1–20.
- [25] Schwingshackl L, Schwedhelm C, Hoffmann G, Knüppel S, Iqbal K, Andriolo V, et al. Food groups and risk of hypertension: a systematic review and dose-response meta-analysis of prospective studies. *Adv Nutr* 2017;8(6):793–803.
- [26] Yang C, Pan L, Sun C, Xi Y, Wang L, Li D. Red meat consumption and the risk of stroke: a dose-response meta-analysis of prospective cohort studies. *J Stroke Cerebrovasc Dis* 2016;25(5):1177–86.
- [27] Kim K, Hyeon J, Lee SA, Kwon SO, Lee H, Keum N, et al. Role of total, red, processed, and white meat consumption in stroke incidence and mortality: a systematic review and meta-analysis of prospective cohort studies. *J Am Heart Assoc* 2017;6(9).
- [28] Wang X, Lin X, Ouyang YY, Liu J, Zhao G, Pan A, et al. Red and processed meat consumption and mortality: dose-response meta-analysis of prospective cohort studies. *Publ Health Nutr* 2016;19(5):893–905.
- [29] Schwingshackl L, Schwedhelm C, Hoffmann G, Lampousi AM, Knüppel S, Iqbal K, et al. Food groups and risk of all-cause mortality: a systematic review and meta-analysis of prospective studies. *Am J Clin Nutr* 2017;105(6):1462–73.
- [30] 4. Lifestyle management: standards of medical Care in Diabetes-2018. *Diabetes Care* 2018;41(Suppl 1):S38–50.
- [31] Mann JJ, De Leeuw I, Hermansen K, Karamanos B, Karlström B, Katsilambros N, et al. Evidence-based nutritional approaches to the treatment and prevention of diabetes mellitus. *Nutr Metabol Cardiovasc Dis* 2004;14(6):373–94.
- [32] Higgins JPT, Green S, editors. *Cochrane Handbook for systematic reviews of interventions* version 5.1.0 [updated March 2011]. The Cochrane Collaboration; 2011. Available from: www.cochrane-handbook.org.
- [33] Moher D, Liberati A, Tetzlaff J, Altman DG, PRISMA Group. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *PLoS Med* 2009;6(7):e1000097.
- [34] Moher D, Shamseer L, Clarke M, Ghersi D, Liberati A, Petticrew M, et al. Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015 statement. *Syst Rev* 2015;4:1.
- [35] Kahleova H, Matoulek M, Malinska H, Oliyarnik O, Kozdova L, Neskudla T, et al. Vegetarian diet improves insulin resistance and oxidative stress markers more than conventional diet in subjects with type 2 diabetes. *Diabet Med* 2011;28(5):549–59.
- [36] Lane DM. Online statistics education: a multimedia course of study [cited 2014 April 14]. Available from: <http://onlinestatbook.com/>.
- [37] Luo D, Wan X, Liu J, Tong T. Optimally estimating the sample mean from the sample size, median, mid-range, and/or mid-quartile range. *Stat Meth Med Res* 2018;27(6):1785–805.
- [38] Elbourne DR, Altman DG, Higgins JP, Curtin F, Worthington HV, Vail A. Meta-analyses involving cross-over trials: methodological issues. *Int J Epidemiol* 2002;31(1):140–9.
- [39] Thompson SG, Higgins J. How should meta-regression analyses be undertaken and interpreted? *Stat Med* 2002;21(11):1559–73.
- [40] Borenstein M, Hedges LV, Higgins JPT, Rothstein HR. *Introduction to meta-analysis*. Chichester: Wiley; 2008.
- [41] Sterne JA, Gavaghan D, Egger M. Publication and related bias in meta-analysis: power of statistical tests and prevalence in the literature. *J Clin Epidemiol* 2000;53(11):1119–29.
- [42] Guyatt G, Oxman AD, Akl EA, Kunz R, Vist G, Brozek J, et al. GRADE guidelines: 1. Introduction-GRADE evidence profiles and summary of findings tables. *J Clin Epidemiol* 2011;64(4):383–94.
- [43] Guyatt GH, Oxman AD, Kunz R, Atkins D, Brozek J, Vist G, et al. GRADE guidelines: 2. Framing the question and deciding on important outcomes. *J Clin Epidemiol* 2011;64(4):395–400.
- [44] Balshem H, Helfand M, Schünemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines, 3: rating the quality of evidence. *J Clin Epidemiol* 2011;64(4):401–6.
- [45] Guyatt GH, Oxman AD, Vist G, Kunz R, Brozek J, Alonso-Coello P, et al. GRADE guidelines: 4. Rating the quality of evidence—study limitations (risk of bias). *J Clin Epidemiol* 2011;64(4):407–15.
- [46] Brunetti M, Shemilt I, Prego S, Vale L, Oxman AD, Lord J, et al. GRADE guidelines: 10. Considering resource use and rating the quality of economic evidence. *J Clin Epidemiol* 2013;66(2):140–50.
- [47] Guyatt GH, Oxman AD, Kunz R, Brozek J, Alonso-Coello P, Rind D, et al. GRADE guidelines 6. Rating the quality of evidence—imprecision. *J Clin Epidemiol* 2011;64(12):1283–93.
- [48] Guyatt GH, Oxman AD, Kunz R, Woodcock J, Brozek J, Helfand M, et al. GRADE guidelines: 7. Rating the quality of evidence—inconsistency. *J Clin Epidemiol* 2011;64(12):1294–302.
- [49] Guyatt GH, Oxman AD, Montori V, Vist G, Kunz R, Brozek J, et al. GRADE guidelines: 5. Rating the quality of evidence—publication bias. *J Clin Epidemiol* 2011;64(12):1277–82.

- [50] Guyatt GH, Oxman AD, Kunz R, Woodcock J, Brozek J, Helfand M, et al. GRADE guidelines: 8. Rating the quality of evidence—indirectness. *J Clin Epidemiol* 2011;64(12):1303–10.
- [51] Guyatt GH, Oxman AD, Sultan S, Glasziou P, Akl EA, Alonso-Coello P, et al. GRADE guidelines: 9. Rating up the quality of evidence. *J Clin Epidemiol* 2011;64(12):1311–6.
- [52] Guyatt G, Oxman AD, Sultan S, Brozek J, Glasziou P, Alonso-Coello P, et al. GRADE guidelines: 11. Making an overall rating of confidence in effect estimates for a single outcome and for all outcomes. *J Clin Epidemiol* 2013;66(2):151–7.
- [53] Guyatt GH, Oxman AD, Santesso N, Helfand M, Vist G, Kunz R, et al. GRADE guidelines: 12. Preparing summary of findings tables—binary outcomes. *J Clin Epidemiol* 2013;66(2):158–72.
- [54] Guyatt GH, Thorlund K, Oxman AD, Walter SD, Patrick D, Furukawa TA, et al. GRADE guidelines: 13. Preparing summary of findings tables and evidence profiles—continuous outcomes. *J Clin Epidemiol* 2013;66(2):173–83.
- [55] Kontessis PA, Bossinakou I, Sarika L, Iliopoulou E, Papanoniou A, Trevisan R, et al. Renal, metabolic, and hormonal responses to proteins of different origin in normotensive, nonproteinuric type 1 diabetic patients. *Diabetes Care* 1995;18(9):1233.
- [56] Nicholson AS, Sklar M, Barnard ND, Gore S, Sullivan R, Browning S. Toward improved management of NIDDM: a randomized, controlled, pilot intervention using a lowfat, vegetarian diet. *Prev Med* 1999;29(2):87–91.
- [57] Wheeler ML, Fineberg SE, Fineberg NS, Gibson RG, Hackward LL. Animal versus plant protein meals in individuals with type 2 diabetes and microalbuminuria: effects on renal, glycemic, and lipid parameters. *Diabetes Care* 2002;25(8):1277–82.
- [58] de Mello VD, Zelmanovitz T, Perassolo MS, Azevedo MJ, Gross JL. Withdrawal of red meat from the usual diet reduces albuminuria and improves serum fatty acid profile in type 2 diabetes patients with macroalbuminuria. *Am J Clin Nutr* 2006;83(5):1032–8.
- [59] Barnard ND, Cohen J, Jenkins DJ, Turner-McGrievy G, Gloede L, Green A, et al. A low-fat vegan diet and a conventional diabetes diet in the treatment of type 2 diabetes: a randomized, controlled, 74-wk clinical trial. *Am J Clin Nutr* 2009;89(5):1588S–96S.
- [60] Mishra S, Xu J, Agarwal U, Gonzales J, Levin S, Barnard ND. A multicenter randomized controlled trial of a plant-based nutrition program to reduce body weight and cardiovascular risk in the corporate setting: the GEICO study. *Eur J Clin Nutr* 2013;67(7):718–24.
- [61] Lee YM, Kim SA, Lee IK, Kim JC, Park KG, Jeong JY, et al. Effect of a brown rice based vegan diet and conventional diabetic diet on glycemic control of patients with Type 2 diabetes: a 12-week randomized clinical trial. *PLoS One* 2016;11(6):e0155918.
- [62] Barnard ND, Levin SM, Gloede L, Flores RJ. Turning the waiting room into a classroom: weekly classes using a vegan or a portion-controlled eating plan improve diabetes control in a randomized translational study. *J Acad Nutr Diet* 2018;118(6):1072–9.
- [63] Kendall A, Levitsky DA, Strupp BJ, Lissner L. Weight loss on a low-fat diet: consequence of the imprecision of the control of food intake in humans. *Am J Clin Nutr* 1991;53(5):1124–9.
- [64] Howarth NC, Saltzman E, Roberts SB. Dietary fiber and weight regulation. *Nutr Rev* 2001;59(5):129–39.
- [66] Kahleova H, Pelikanova T. Vegetarian diets in the prevention and treatment of type 2 diabetes. *J Am Coll Nutr* 2015;34(5):448–58.
- [67] Barnard ND, Katcher HI, Jenkins DJ, Cohen J, Turner-McGrievy G. Vegetarian and vegan diets in type 2 diabetes management. *Nutr Rev* 2009;67(5):255–63.
- [68] Vigiouliou E, Stewart SE, Jayalath VH, Ng AP, Mirrahimi A, de Souza RJ, et al. Effect of replacing animal protein with plant protein on glycemic control in diabetes: a systematic review and meta-analysis of randomized controlled trials. *Nutrients* 2015;7(12):9804–24.
- [69] Porta N, Bonet C, Cobo E. Discordance between reported intention-to-treat and per protocol analyses. *J Clin Epidemiol* 2007;60(7):663–9.
- [70] Center for Drug Evaluation and Research. Guidance for industry: diabetes mellitus: developing drugs and therapeutic biologics for treatment and prevention (Draft guidance). Silver Spring, MD, USA: U.S. Department of Health and Human Services Food and Drug Administration; 2008. p. 1–30.
- [71] Ray KK, Seshasai SR, Wijesuriya S, Sivakumaran R, Nethercott S, Preiss D, et al. Effect of intensive control of glucose on cardiovascular outcomes and death in patients with diabetes mellitus: a meta-analysis of randomised controlled trials. *Lancet* 2009;373(9677):1765–72.
- [72] Mannucci E, Monami M, Lamanna C, Gori F, Marchionni N. Prevention of cardiovascular disease through glycemic control in type 2 diabetes: a meta-analysis of randomized clinical trials. *Nutr Metabol Cardiovasc Dis* 2009;19(9):604–12.
- [73] Control Group, Turnbull FM, Abraira C, Anderson RJ, Byington RP, Chalmers JP, et al. Intensive glucose control and macrovascular outcomes in type 2 diabetes. *Diabetologia* 2009;52(11):2288–98.
- [74] Robinson JG, Smith B, Maheshwari N, Schrott H. Pleiotropic effects of statins: benefit beyond cholesterol reduction? A meta-regression analysis. *J Am Coll Cardiol* 2005;46(10):1855–62.
- [75] Manson JE, Tosteson H, Ridker PM, Satterfield S, Hebert P, O'Connor GT, et al. The primary prevention of myocardial infarction. *N Engl J Med* 1992;326(21):1406–16.
- [76] Haffner SM, Lehto S, Rönnemaa T, Pyörälä K, Laakso M. Mortality from coronary heart disease in subjects with type 2 diabetes and in nondiabetic subjects with and without prior myocardial infarction. *N Engl J Med* 1998;339(4):229–34.
- [77] Melina V, Craig W, Levin S. Position of the academy of nutrition and dietetics: vegetarian diets. *J Acad Nutr Diet* 2016;116(12):1970–80.
- [78] Trapp CB, Barnard ND. Usefulness of vegetarian and vegan diets for treating type 2 diabetes. *Curr Diabetes Rep* 2010;10(2):152–8.
- [79] Marlow HJ, Hayes W, Soret S, Carter RL, Schwab ER, Sabaté J. Diet and the environment: does what you eat matter? *Am J Clin Nutr* 2009;89(5):1699S–703S.
- [80] Tilman D, Clark M. Global diets link environmental sustainability and human health. *Nature* 2014;515(7528):518–22.
- [81] Johnston BC, Kanters S, Bandayrel K, Wu P, Naji F, Siemieniuk RA, et al. Comparison of weight loss among named diet programs in overweight and obese adults: a meta-analysis. *JAMA* 2014;312(9):923–33.