

$1/4$ pound = 4 ounces (=120 cc)

$1/8$ pound = 2 ounces (= 60 cc)

2.2 pounds = 1 kilogram = 1000 cc = 1 liter

Appendix

This information is being included to help you more clearly understand some of the diet-related terms you might hear or read.

ABBREVIATIONS

(Metric system)

Na	= Sodium	tsp	= teaspoon	l	= liter
K	= Potassium	tbl.	= tablespoon	cc	= cubic centimeter
P	= Phosphorus	C.	= cup	Kg	= kilogram
Ca	= Calcium	oz.	= ounce	gm	= gram
CHO	= Carbohydrate	lb. or #	= pound	mg	= milligram
Pro	= Protein	mEq	= millequivalent		
Al	= Aluminum	EDW	= est. dry weight		
Kcal	= Calories	AW	= available weight		

WEIGHTS AND MEASURES

1 ounce = 30 cc = 2 tablespoons
 1 tablespoon = 15 cc = 3 teaspoons
 1 teaspoon = 5 cc

1 cup = 8 oz. = 240 cc
 3/4 cup = 6 oz. = 180 cc
 1/2 cup = 4 oz. = 120 cc
 1/4 cup = 2 oz. = 60 cc
 1/8 cup = 1 oz. = 30 cc

4 cups = 32 oz. = 1 quart (qt.) = 960 cc
 1 liter = 1000 cc (40 cc more than a quart)
 1 pound = 16 ounces (= 2 cups = 480 cc)
 3/4 pound = 12 ounces (= 360 cc)
 1/2 pound = 8 ounces (= 240 cc)

how's and why's of diet manipulation, but they cannot follow the diet for you. You are in control!

- Be sure you have a full understanding of your nutritional needs. Your dietitian has many informational sources to share with you including nutrition handbooks, cookbooks, menu ideas, suggestions for dining out and fact sheets. Take full advantage of these resources that are available to you.
- If you do not understand certain aspects of your diet, speak up! Continue to ask questions! No question is ever too small or unimportant.

Good luck, Good Eating, and Good Health!!

intake is of concern to transplant patients because prednisone can raise the sugar in your blood higher than normal. Eating a diet high in sugar, along with taking prednisone, can contribute to blood sugar control problems.

If you are concerned about your current weight, for whatever reason, please mention this to a renal team member. The dietitian can then guide you in proper meal planning for weight gain, loss, or maintenance.

VITAMINS AND MINERALS

If my meal plan is balanced, why do I need to take a vitamin every day?

Your meal plan is as balanced as possible, given the guidelines of your diet prescription. A vitamin supplement replaces the water soluble vitamins (the B and C vitamins) that are washed away in the dialysate. Boiling vegetables in large amounts of water to reduce their potassium content also destroys some vitamins. Folic acid is given to enhance red blood cell production.

In renal failure, red blood cell counts generally are low because the kidney's ability to secrete *erythropoietin* (a hormone which stimulates red blood cell production) is depressed. Iron, erythropoietin, Vitamin D and calcium supplementation is individualized. Please take only the vitamins and minerals prescribed by your doctor.

IN BRIEF

- Your diet is an important part of your overall medical care. Therefore, it is very important for you to follow the meal planning suggestions you receive, just as you would follow all other suggestions from your doctor or other team members. When you meet your dietitian, he or she will probably ask you about your eating habits and will keep you informed about your nutritional status.
- Your meal plan is designed especially for you and may be entirely different from the diet of other patients with kidney disease. In fact, their diets could be harmful to you and vice-versa!
- You are responsible for your food and fluid regulation. Your dietitian and other members of the renal team can give you the

As a rule you don't really have to count calories, but your meal plan, as determined by you and your dietitian, will include suggestions for manipulating your caloric intake primarily from *non-protein* sources to meet your daily energy needs.

Non-protein caloric sources are, obviously, carbohydrates and fats. The reason these caloric sources will be emphasized is that, if you burn protein for energy, the protein cannot and will not be used as it should be for growth, maintenance, and repair of body tissue (muscle, blood cells, etc.).

Solid weight gains and fluid weight gains are frequently confused, but very simply, *fluid weight gains can occur rapidly* in a day or two) and *solid weight changes* (losses or gains) occur *very, very slowly*. One pound of dry weight = 3500 calories, but one pound of fluid weight = 2 cups of fluid. For this reason, we can be certain that most all of the weight you gain between dialysis treatments is *always* fluid weight!

After transplantation, it is not uncommon to gain weight, especially within the first six months. As your kidney begins to remove waste products, you will probably notice that food tastes better and your appetite increases. Also one of the medications (prednisone) you will take can actually stimulate your appetite. As a result, you may overeat and ultimately gain an undesirable amount of weight.

One of the culprits in this weight gain is fat. Fat is a concentrated source of calories and can add unwanted pounds quickly. Therefore, your intake of fat should be limited (to less than 30% of total calories consumed), and your cholesterol and saturated fat intake should be restricted, especially since the medication prednisone can elevate your blood cholesterol to higher than normal levels. Some of the foods that typically add a great deal of cholesterol and saturated fat to the diet are whole-fat dairy products, red meats, fried foods, and commercially prepared cakes and cookies.

Furthermore, if you're watching your weight after your transplant, you will want to limit your intake of sugar. Sugar and concentrated sweets are usually high in calories and low in vitamins and minerals. A large sugar

Wet Weight — Dry Weight = Available Weight

Your machine will then be set to remove your available weight. If the machine was not able to remove all of your available weight, you will “leave a little heavy” and need to be careful of your fluid intake until your next chance for the dialyzer to remove your accumulated fluid.

Signs of nausea, vomiting, cramps, dizziness, sweating, and low blood pressure *may* indicate that you have lost too much fluid. Dialysis personnel may recline your chair, turn the machine pressure down, or infuse some saline (salt water) into your venous blood line. It is important to finish your treatment so that the wastes may continue to be removed from your blood. If these symptoms persist, then you may have gained dry weight and your target dry weight may be increased.

Conversely if you persistently are short of breath, sleep with your head elevated, have swollen ankles and hands or puffy eyes, or have a high blood pressure or headaches, then you are accumulating too much fluid and perhaps your dry weight needs to be lowered.

Ideally, the renal team will be able to maintain you at an appropriate weight, but please report any of the above symptoms immediately so that you may feel your best.

CALORIES

Do I have to count calories too?

CALORIES come from carbohydrates (sugars and starches), proteins and fats. Calories are the body’s main source of energy or fuel and are responsible for changes in your dry weight.

- If you eat *less calories* than your body burns as fuel, you will *lose dry weight*.
- If you eat *more calories* than you burn, over a prolonged period of time, you will *gain dry weight*.
- If you eat the *same number of calories* as your body burns for energy, your *dry weight will remain the same*.

you may have to change a long-standing habit. As before, this is no easy task, but with some effort this habit can and will change.

Thirst, also can usually be controlled. One of the most frequent causes of increased thirst for all of us is a high intake of sodium. Most of us can relate to the fact that after a meal of corned beef or ham (both very high in sodium) we become thirsty. As a result we drink large quantities of water or other fluid. This occurs because our bodies are telling us—by making us thirsty—to dilute the extra sodium in our bodies with extra fluid. Logically then, decreasing your sodium intake should help to decrease your thirst! A high blood glucose level will also make diabetics thirsty. Thirst will also occur if and when we lose too much fluid. This is frequently the case with excess perspiration, diarrhea and/or vomiting.

In addition to all this, patients with renal disease may develop a “false thirst.” This occurs when the nitrogen and other wastes are allowed to build up in your blood. If this seems to be the cause of your excessive thirst, you may be asked to reduce your intake of certain foods, especially high protein foods.

Fluid manipulations may be necessary prior to the initiation of dialysis, during chronic dialysis, or after transplantation. Your physician and/or dietitian will advise you of exactly how much fluid is best for you. The amount of your urine output will govern how much fluid you can drink. If you are receiving dialysis treatments, you will probably be advised to take in enough fluid to gain about 2 kilograms which equals 4.4 pounds (or an amount specified by your doctor) of FLUID WEIGHT between dialysis treatments. The reason some fluid weight gain is desired is that the artificial kidney does remove some fluid during your treatment. If you gain this recommended amount of weight between treatments — you should have a fairly comfortable treatment.

At the end of your treatment, you should have all extra fluid removed. You will be weighed post treatment to see how close you are to your target or DRY WEIGHT. Just before your next dialysis treatment, you will be weighed again to see how much fluid you have retained between treatments. Your weight at the beginning of your treatment is called your WET WEIGHT.

FLUIDS

Why should I limit my fluid intake — I thought that lots of fluid was good for “flushing out” my kidneys?

FLUIDS are good for your kidneys (and your body) only if your kidneys are capable of producing enough urine to almost equal (or better) the amount of fluid you take in.

As the kidneys fail, they frequently (but not always) lose their ability to produce urine. When this happens, the body loses its main method of eliminating extra fluid. Therefore, if you were to drink “lots” of fluid when unable to produce “lots” of urine, that fluid you drank (or ate since many foods have a high fluid content) *would not* “flush out the kidneys.” It would have nowhere to go and therefore would stay in your body.

The first thing that happens when you drink more fluid than your kidneys can turn into urine, is that you gain weight — FLUID WEIGHT! Sixteen ounces of water weighs one pound. Fluid weight gains can occur very rapidly, while solid (muscle and fat) weight gains—which depend on your intake of calories—occur very slowly.

Although our bodies normally contain (and need) a significant amount of fluid, *extra* fluid can destroy normal fluid balance and can cause high blood pressure, edema, shortness of breath or other more severe complications which can require hospitalization. This situation, of excess fluid in the body, is often called “fluid overload.”

“Fluid overload” is an undesirable condition which can usually be prevented—by restricting your intake of fluids. Now, this sounds fairly simple and clear cut until you realize that fluid means more than just water. FLUID IS EVERYTHING WHICH IS LIQUID AT ROOM TEMPERATURE. This includes jello, ice cream, popsicles, sherbert, soups, gravies, sauces, tea, coffee, milk, and other beverages. It also includes *ICE*, *all liquid medications* (including intravenous solutions and blood transfusions), as well as all liquid used to take your pills!

In sickness and in health there are two main reasons for our taking in fluids—*habit* and *thirst*. If you are advised to decrease your intake of fluids,

low quality protein is found in “starchy” foods (breads, cereals, pasta, etc.) and most vegetables.

When your dietitian talks to you about the protein in your meal plan, he or she will advise you to choose most of your total protein allowance from the high quality protein sources. The reason high quality protein is stressed is that even though our bodies need both kinds of protein to function efficiently, the high quality proteins *must* come from the food we eat, but our bodies are capable of making the proteins of low quality.

To complicate matters a bit, in addition to the nitrogen and wastes produced in protein breakdown, foods of high quality protein also tend to contain a great deal of potassium, phosphorus and natural sodium. Perhaps now you can see that there is more than one good reason for you to limit your intake of dietary protein.

If you are not yet being dialyzed, you might be asked to reduce your total protein intake to a fairly low level. If you are being dialyzed, the quantity of protein suggested for you will depend on your body size and general well-being. People on CAPD and CCPD typically need more protein than persons on hemodialysis. Rarely does the protein intake of a person receiving dialysis need to be restricted to an amount less than that recommended for a person without kidney disease. Remember: most of us eat much more protein than our bodies need.

After transplantation, your protein intake will be liberalized. In fact, for the first month after your transplant, you will need to eat a fairly large amount of protein—more than when you were on dialysis. There are two reasons for this. The first is that the transplant surgery itself requires extra protein for healing, and the second is that a medication (prednisone) you will take increases your protein needs.

It will always be very important for you to eat ALL of the protein you are permitted each day. Follow your suggested meal plan closely and enjoy better nutrition!

re-accumulate after a dialysis treatment is over. This is why a potassium restricted diet is needed even when you are receiving effective dialysis. People on continuous ambulatory peritoneal dialysis (CAPD) or continuous cycling peritoneal dialysis (CCPD) may find that their potassium intake may be liberalized somewhat since they are constantly being dialyzed. After transplantation, potassium will be liberalized somewhat if the transplanted kidney is able to produce sufficient urine to eliminate extra dietary potassium. However, in many instances you may be asked to limit your intake of potassium in order to maintain normal blood levels of this mineral because one of the medications (cyclosporine) can cause an increase of potassium in the blood.

PROTEIN

PROTEIN is supposed to be good for everyone—why is it “bad” for people with kidney disease?

Protein is not really “bad” for people with kidney disease. However, if too much protein is eaten, and if the wrong type of protein is eaten at certain stages of renal disease, it can literally make a person sick.

The truth of the matter is that, as with so many other types of foods, most of us eat much more protein than our bodies need. Certainly, we all need protein for growth, maintenance and repair of our body tissues. However, when we eat dietary protein, that protein is “broken down” during digestion so that it can be used effectively and efficiently by our bodies. When protein is broken down, nitrogen and other wastes, which are found in all protein-containing foods, becomes available for the kidneys to eliminate. When the kidneys cannot rid the body of these wastes of protein break-down, these wastes build up in the body and can be measured in the blood. Blood urea nitrogen (BUN) is one blood test which can determine the kidney’s ability to remove protein wastes. If a person with advanced kidney disease eats TOO MUCH protein, the BUN will rise rapidly to a very high level. At the same time, a decreased appetite, nausea, and vomiting, as well as the impaired taste mentioned earlier, may occur.

There are *two types* of protein in food: high quality and low quality. The high quality protein is found in eggs, milk, meat, fish and poultry. The

you are eating a moderate amount of protein, and limiting your potassium intake, your intake of dietary phosphorus should automatically be reduced.

Restriction of dietary phosphorus is usually necessary long before you ever need dialysis. The abnormality in phosphate excretion will continue while you are being dialyzed. People on peritoneal dialysis typically continue to require phosphate binders too, as phosphorus is not well dialyzed. After transplantation, however, if the new kidney works effectively, there usually is no need for you to limit the phosphorus in your diet. In fact, quite frequently transplanted patients are encouraged to *increase* their dietary intake of phosphorus, and even then, some require additional phosphorus supplement.

POTASSIUM

POTASSIUM does not have anything to do with bones or calcium or phosphorus. Potassium is a mineral which we all need for muscle tone. Rarely do we have problems supplying our bodies with sufficient potassium since most all foods contain potassium. This being the case, even a potassium-restricted meal plan will not be potassium-free. It will be somewhat on the low side of a “normal” potassium intake.

Normal kidneys are able to excrete in urine any extra dietary potassium which the body does not need. Therefore, if you are unable to produce sufficient urine (1-2 quarts or more per day) you will be unable to eliminate the potassium your body does not need. Potassium is unique because the build-up of potassium in the blood usually occurs without any detectable warning signals except for maybe weakness. When potassium builds up in the body too rapidly or to too high a level, *it can cause the heart (the most important muscle) to beat irregularly and in some cases to stop.*

Because of the very undesirable side effects of a high blood potassium level, it is in your best interest to follow the guidelines your dietitian gives you. She will try to include as many of your favorite foods as possible to allow for a flexible, well-balanced, lower potassium meal plan.

Limiting intake of potassium is frequently necessary before dialysis, as well as after hemodialysis is initiated. Hemodialysis does remove potassium from your blood, but it does not take very long for potassium to

and fractures may occur with little or no trauma. If the parathyroid glands become hyperactive and enlarged from non-compliance with diet and medications, then surgery may be required to remove some of the enlarged glands.

All this may seem quite complicated, but with your cooperation, your doctor and dietitian will work with you to try to prevent these side effects from occurring by:

1. Keeping your dietary phosphorus intake to about 1 gram per day.
2. Prescribing Vitamin D and supplemental calcium if necessary.
3. Prescribing specific antacids containing aluminum or calcium which you are to take with EVERY MEAL OR LARGE SNACK.

It is important to know that these antacids are NOT prescribed for indigestion: They are to be taken to BIND PHOSPHORUS from your diet in your gastrointestinal tract. This decreases the amount of dietary phosphorus absorbed into your blood stream. USE ONLY THOSE ANTACIDS PRESCRIBED FOR YOU. NEVER TAKE ANY MEDICATION WITHOUT YOUR PHYSICIAN'S APPROVAL OR RECOMMENDATION! If you become constipated from the phosphorus binders, please ask your physician to prescribe a stool softener.

Unfortunately the best food sources of calcium are also the best food sources of phosphorus! THERE IS NO EFFECTIVE WAY OF INCREASING THE CALCIUM IN YOUR DIET WITHOUT INCREASING YOUR PHOSPHORUS INTAKE TOO, AND LIMITING PHOSPHORUS IS OUR PRIMARY CONCERN!

Your dietitian will advise you which specific foods you should adjust in your meal plan to keep your phosphate level within normal limits. Generally, however, dairy products (milk and all milk products, except butter or margarine) are your highest sources of phosphorus. Eggs, certain cereals or grains and many high *potassium* foods (dried fruits, dried peas and beans, nuts, cocoa, and whole grains) are also very high in phosphorus. (This is probably why many people think potassium and phosphorus are the same thing, but you will see that they are distinctly different.) As a rule, if

Remember not every renal patient needs to limit his or her intake of dietary sodium. The level of sodium you need in your diet will depend upon your own particular needs and may be different from the needs of someone else. The above information about sodium is true for the pre-dialysis, dialysis and transplanted patient.

ARE PHOSPHORUS AND POTASSIUM THE SAME THING? No, No, No!

PHOSPHORUS is a mineral which is closely associated with CALCIUM in the body. Phosphorus and calcium work together to help build bones and keep nerves and muscles in working order. To perform these functions effectively, these two minerals need to be present in the blood stream in a definite ratio to one another.

Normally the kidneys are responsible for excreting any excess phosphorus taken into the body from food. This keeps the calcium and phosphorus in balance, which allows for efficient use of both minerals. In kidney disease, however, the kidneys frequently are unable to excrete any extra dietary phosphorus. When the kidneys cannot eliminate dietary phosphorus, the phosphorus content of the blood begins to rise! The extra phosphorus usually binds with calcium and then deposits in joints, blood vessels, and muscle tissue. More calcium is often released from bone to bind with phosphorus, and this weakens bones. Calcium levels may become low due to this binding and deposition action. Calcium blood levels may also become low because oral calcium absorption is impaired. Usually the kidney activates *Vitamin D*, which helps in the calcium absorption process. Renal failure typically inhibits *Vitamin D* activation and therefore sufficient calcium is not well absorbed from oral intake. Calcium and *Vitamin D* supplements may be prescribed in such cases. When the calcium-phosphate ratio is altered, the body tries to remedy the situation by secreting *parathormone*.

In the neck area, we all have four, very small parathyroid glands that produce parathormone. Parathormone draws calcium from the bones in an attempt to increase the serum calcium level and restore the calcium-phosphate balance, thereby weakening the bone structure. Without strong, healthy bones it becomes difficult to sit or walk because of severe bone pain

able to efficiently perform this function. They may either retain most of the dietary sodium, *or*, in some cases, they may cause too much sodium (more sodium than we get from food) to be eliminated in the urine.

Logically then, if your kidneys are not producing much urine, you are not losing much sodium. If your kidneys hold onto too much sodium the extra sodium in your body attracts fluid, and also causes thirst and falsely leads one to drink even more fluid. This excess sodium and fluid can cause high blood pressure and/or swelling of your ankles, or other extremities. This swelling is called *edema*. These symptoms, if not controlled, can lead to other more severe problems, such as congestive heart failure or pulmonary edema, which can require hospitalization. As a means of preventing these problems, if your kidneys are unable to eliminate this mineral, you will be asked to limit the amount of sodium in your diet.

There are many possible levels of modified sodium intakes—from very, very low (requiring special “salt-free” diet foods) to fairly liberal. The “average” dialysis patient, for example, who needs a sodium restricted diet, doesn’t usually need a very low intake of sodium but rather a moderate intake. In this case, the purchase of many special food products is unnecessary. In most instances regular breads and margarine are permitted (in specific amounts), while table salt and very salty foods are to be avoided. Be careful reading food labels. A food may be “salt-free” but rarely are foods “sodium-free” since *most foods contain their own natural sodium*. Your dietitian will give you specific guidelines about *your* particular needs.

Frankly, many people who are accustomed to a high sodium diet have some difficulty adjusting to a low sodium diet because foods cooked or prepared without salt seem very bland or tasteless. This acquired taste for sodium can and will change in time, especially if attempts are made to flavor foods by other means. This can be done by experimenting with various herbs and spices, most of which are low in sodium. Ask your dietitian for a list of herbs and spices and their food complements. Here are a few to get you started:

Rosemary is good on beef roasts and beef stew.

Thyme is good on chicken.

Dill Weed is good on fish.

suggestions for you. It is especially important for you to mention any change in your routine eating pattern such as during bouts of the flue or dental work, to your dietitian. She will try to advise you of ways you can manipulate foods to allow for well-balanced, nourishing meals. Good nutritional practices are extremely important to you in sickness and in health.

How can I ever be expected to follow this diet?

At first all the various diet limitations may be confusing and seem impossible to balance, leaving nothing to eat at all. A slow, methodic learning of each aspect of your diet may best enhance your knowledge. Meal plans from your dietitian with breakfast, lunch and dinner ideas already developed will also be of benefit in demonstrating how the whole diet order is worked into balanced meals. Soon the renal diet will be second nature to you and be part of your daily routine.

It is up to you to control your diet and not let the diet control you. Following a “special” diet is sometimes easier if you, as well as your family and friends, fully understand WHY your diet is necessary so that they can add to your support. It is hoped that the following information, in conjunction with information you receive from your dietitian and other members of the renal team, will help you to understand the why’s of your particular nutritional needs. This in turn will make your new meal plan a bit easier to follow.

SODIUM

What is sodium and what does it do?

Sodium is *part* of salt. It is a mineral we all need *in very limited quantities* for fluid balance. It is found naturally in many foods, but is frequently added to foods (as salt or other sodium-containing ingredients, e.g., sodium glutamate, sodium caseinate) for flavor or as a preservative. As a result, most of us have acquired a taste, through the years, for much more salt (sodium) in our diets than our bodies actually need.

The normal kidneys eliminate almost all of the sodium we get from our diets. Kidneys which aren’t functioning properly, however, may not be

establish our eating habits in our very early years, and changing these habits is quite often very difficult. Your dietitian, the doctors, nurses, social workers and all other members of the “renal team” realize that to modify one’s diet is no easy task. Therefore, when you do follow your recommended meal plan, we are proud of you and pleased as can be. When you don’t follow it, we usually become concerned or even upset. We feel our concern is justified since a diet modification is recommend *only* when we feel it will be in your best medical interest. Your diet can and should change as your medical/nutritional needs change. It is important to note that your nutritional needs will differ from those of someone else, even though that someone else may also have kidney disease and/or require dialysis. This is because no two people have the same blood pressure, weigh the same, and drink and eat the same. We feel that *your diet can* offer you better general health.

What follows is an explanation of the nutritional aspects of your care in relation to kidney disease. It is hoped that this chapter will help to answer some of your questions and clarify other points of interest for you.

Let’s start with what might be your first question if you are on dialysis: *Why do I have a bad taste in my mouth?* or *Why do foods I used to like taste different?*

The kidneys, when functioning normally, play a major role in getting rid of many of the “toxic wastes” which come from the digestion of food. When the kidneys are unable to function normally and the “toxic wastes” which come from the digestion of food begin to build up in the body, many patients develop a bad taste in their mouth. This is referred to as uremic or ammonia taste. It is difficult to prevent, but effective dialysis and certain diet modifications usually improve this bothersome problem.

Many patients have reported that sucking on a piece of hard candy or iced lemon wedge is helpful in temporarily relieving the bad taste. Others have found that tart beverages (in quantities permitted for your meal plan) such as lemonade and limeade are effective. Still others suggest that frequent brushing of teeth and tongue helps. If this is a problem for you, do mention it to your doctor and dietitian. They will probably have some

Chapter 17

FOOD — WHAT DOES IT MEAN TO YOU?

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Before you started dialysis, or maybe even after you were transplanted, you may not have thought much about your food choices and how they affected your health. Maybe you read a magazine or newspaper article once in a while about cholesterol and heart disease or weight control. You don't see much in the news about potassium and phosphorus. The thought of how sodium affects blood pressure and fluid gains for folks on dialysis probably never crossed your mind.

As a renal patient, you probably have experienced numerous changes in your eating patterns. Some of these changes may have occurred because your physician and dietitian felt that a special meal plan would be helpful to you for medical reasons. Other changes may have been "self-induced" when you found that certain foods didn't taste quite right or just didn't agree with you. Perhaps it was never clear to you why certain diet modifications were necessary at one time and not necessary at another time, or why your diet was so much different from that of a friend who also had renal disease..

At any rate, after reviewing your diet with your dietitian, you probably had many questions such as—WHAT CAN I EAT? What must be avoided? How will I live without salt? Are POTASSIUM and PHOSPHOROUS the same thing? or Will my diet change after I get a transplant? These questions, and many others, are good questions and should be asked. Don't ever feel embarrassed or uncomfortable about asking questions, since that is the best way to get all the answers.

YOUR DIET AND EATING HABITS

The word "diet" is not intended to be synonymous with restriction. Your *DIET* is whatever foods you eat. Food—a necessity of *all* life—has probably become more meaningful to you now than ever before, or at least now you probably realize how important it was to you before. We all