

The importance of getting the correct diabetes diagnosis

Here we are at issue 4 already, and the deadline for my editorial falls once more on a bank holiday weekend! In a couple of weeks, I am fortunate to be heading to a warmer, sunnier climate for the 60th Annual Meeting of the European Association for the Study of Diabetes. It's been several years since I attended this event, and I look forward to sharing the highlights in my next editorial. In the meantime, there is plenty of interesting diabetes reading for you to enjoy in this issue!

It has become increasingly difficult for healthcare professionals to secure funding and negotiate sufficient study leave and “time away from practice” to attend face-to-face educational meetings, even those closer to home. The upsurge of high-quality webinars and online courses, many of which are also made available on demand, is welcome, but it's still nice to hear any breaking news when it is first revealed live.

This year, the PCDS re-launched its hugely popular Smart Update conference, which was held face to face in London on 12 July. Unfortunately, practice commitments meant I was unable to attend, but it looked a really interesting programme, focusing very much on the links between diabetes, obesity, cardiovascular disease and chronic kidney disease that we hear so much about these days, but it also included a session on diabetes, obesity and cancer, which was new to me. In our *Conference over Coffee* series, Pam Brown, who spoke at the conference, provides a [summary of the key messages](#) and practice points. Slides from this meeting will shortly be [available here](#).

Clinching the diagnosis

We can learn so much from case reports, and I highly recommend the one in this issue, which tackles the challenges of getting the diabetes diagnosis right. This is something that falls firmly within our primary care remit. In my own practice, with a list size of around 10 000 patients in the last 12 months, 29 people have been

diagnosed with type 2 diabetes and two with type 1 diabetes. But what about the other “types” of diabetes, such as steroid-induced diabetes and type 3c? We are not so good at identifying these less common forms, or at coding them correctly, yet getting an accurate diagnosis is key to initiating a safe and appropriate management plan. You may wish to re-visit the [How to guide](#) we published on diagnosis a few years ago. One type of diabetes that can catch us out is latent autoimmune diabetes in adults (LADA), a slowly progressing form of autoimmune diabetes. [In their case report](#), James and David Morris take us through an interesting case of a younger, non-overweight person diagnosed with type 2 diabetes two years previously who presented with osmotic symptoms, weight loss and abdominal discomfort, and was subsequently rediagnosed with LADA.

Knowing which tests to request to confirm the diagnosis is a challenge, and colleagues often ask about when and how to request a C-peptide test. This is covered in the case report but when doing a bit of background reading myself recently, I also discovered a fantastic one-page algorithm on C-peptide testing developed by the Welsh Endocrine and Diabetes Society (Tabasum et al, 2024), which provides really valuable clarity on this subject. [You can find it here](#).

At the same time, this issue's [interactive case study](#) also focuses on diabetes type and involves two scenarios that relate to maturity-onset diabetes of the young (MODY), a rare form of diabetes that runs in families and is caused by a gene mutation. The two most common subtypes of MODY are covered, with useful learning for us on when to suspect it, what investigations are required and how to manage it.

Prevention of cardiovascular disease

There is nothing new about the concept of prevention being better than cure. Sadly, despite public health efforts and government initiatives to reduce the prevalence of type 2 diabetes,



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rates of the condition are predicted to continue rising, with an estimated 10% of the population expected to have type 2 diabetes by 2035. The Making Every Contact Count (MECC) initiative recommends the building of preventative strategies into routine primary care appointments to reduce modifiable risk factors associated with both type 2 diabetes and cardiovascular disease (CVD). Perhaps a renewed effort is called for, and Michelle Clapham explores opportunities for us to promote primary and secondary prevention of CVD in line with MECC [in her article](#).

By the time people are diagnosed with type 2 diabetes, a cardiovascular risk assessment algorithm will generate a 10-year risk of >10% in most. Lipid management is thus a key priority in our treatment of diabetes and in reducing the risk of CVD. In this issue, Claire Davies provides her responses to more lipid-related questions in the final part of our Q&A mini-series on lipid management, tackling in particular [triglycerides and the use of non-statin drugs](#). So if you are looking for more clarity around when to prescribe ezetimibe, bempedoic acid and the newer specialist lipid treatments, you should find the answers here.

Diabetes Distilled

There is lots of fascinating reading in *Diabetes Distilled* this issue, too. Metformin has, for decades, been a mainstay and indeed the first-line choice for blood glucose lowering in type 2 diabetes, and it is a drug we frequently initiate. The recommendation in the [Summary of Product Characteristics](#) is for the drug to be given during or after meals, presumably because this minimises the gastrointestinal side effects so commonly associated with metformin, and this is certainly the advice I give when I prescribe it. So I was intrigued to learn of a small study published in *Diabetologia* that suggests metformin's glucose-lowering effects are greater when it is given 30 or 60 minutes before, rather than after, food. Although the design of this study, and in particular the method of administration of the metformin as a single dose intraduodenally, is very different to what happens in everyday practice, it is always interesting to open our minds to new discoveries!

As the flu season approaches, attention within primary care turns to the planning and delivery

of mass vaccination (not just flu, of course, but for many, COVID-19 and possibly also pneumonia). [In a previous *Diabetes Distilled*](#), we reported that people with CVD and those with type 2 diabetes had an increased risk of pneumonia and were at greater risk of hospitalisation and mortality from COVID-19 than people without these conditions. In this issue, we see that, while CVD mortality risk was initially higher in the first 30 days post-exposure in people with COVID-19 pneumonia, thereafter the risk levelled out to a similar rate as with non-COVID pneumonia, with around a [fourfold increased risk in both pneumonia types](#). Hospitalisation for any type of pneumonia should, therefore, be seen as a significant risk factor for future CVD death, reinforcing the importance of fully optimising known cardiovascular risk factors in this cohort. Of course, this also highlights the importance of adhering to recommendations on pneumococcal and COVID-19 vaccination in people with type 2 diabetes to reduce the risk of future infection and, hence, reduce associated CVD mortality.

A few years ago, I wrote an article on [how to assess feet to prevent foot ulceration](#) in people with diabetes. I tried to cover the various steps involved: taking a history, performing a visual inspection, the examination and screening for vascular and peripheral neuropathy, risk stratification and, perhaps most importantly of all, education. Sadly, diabetic foot disease remains a huge burden, and during the three-year period up to 2021 there were 166 178 hospital admissions related to foot disease in patients with diabetes, and there were 7766 major amputations (Office for Health Improvement and Disparities, 2024).

This issue, we highlight the important roles that primary care and community teams have in identifying those most at risk of [diabetic foot ulceration](#), how to carry out assessment once ulceration occurs and the improved outcomes when the specialist foot care team is involved within 14 days of presentation. Updated practical guidance from the International Working Group on the Diabetic Foot, published in 2024, is also discussed, with a call to action for us all to review how we undertake diabetic foot education and assessments, assess, and manage diabetic foot ulcers, and ensure we are working closely with our local specialist diabetic footcare team.

I hope you enjoy this issue! ■

References

- Office for Health Improvement and Disparities (2024) *Fingertips: Diabetes*. Available at: <https://bit.ly/3Z24pYo>
- Tabasum A, Evans C, Dayan C (2024) *Guidelines for C-peptide testing in adults with diabetes: Welsh Endocrine & Diabetes Society endorsed guidance*. Available at: <https://bit.ly/3Z5o4Xw>