

# Groundhog Day, COVID and diabetes, and time-efficient resources

**R**e-reading my editorial written as 2020 drew to a close makes me feel as if we are stuck in Groundhog Day, as we face yet another wave of COVID, this time generated by the Omicron variant. There is a palpable feeling of apprehension as we prepare to cope with the very real risk that the NHS, including our own practices, may be overwhelmed this winter. However, there is, too, a more positive view. Having faced similar challenges, learnt so much from previous experiences and survived, this time we have the opportunity to retain the things which worked well, such as our highly effective vaccination programme and flexible ways of working remotely, and can build on that by finding additional ways to minimise the impact of COVID this time around.

## What worked previously?

As face-to-face care became virtually impossible in 2020, we shared ideas in the journal on how to optimise remote diabetes consultations in "[How to undertake a remote diabetes review](#)". As face-to-face consulting and services resumed in 2021, "[How to prioritise primary care diabetes services during and post COVID-19 pandemic](#)" and the [PCDS resource](#) produced in association with ABCD and Diabetes UK helped us find and focus not only on those with poor glycaemic control, but also those with other risk factors for severe COVID or cardiovascular disease. We used searches and audits to identify the people to prioritise, including those with a number of different risk factors that, when combined, placed them at high risk. Over the last few months, we have worked hard to optimise face-to-face consultations and access to blood tests, to gather data and begin to help people make changes to improve control where it had deteriorated with less access to care due to the pandemic. These resources and the data we gathered will provide a useful roadmap for care delivery that we can follow over the next few months.

## What is helpful now?

It is useful to understand the bidirectional relationship between diabetes and COVID-19 and the implications for care delivery. The second part of our [EASD conference report](#) covers Professor Kamlesh Khunti's presentation discussing this, and [Kevin Fernando's piece](#) for *Diabetes Distilled* succinctly summarises the associated publication and highlights our important role in keeping people safe after discharge. Many questions remain unanswered. It is too early to have a clear picture as to whether people found to have new type 2 diabetes associated with COVID will have persistent type 2 diabetes or if this will resolve once the acute illness is past, and whether additional people may develop type 2 diabetes as a delayed consequence of the metabolic derangements occurring during COVID infection. Both groups will require careful follow-up, as will those with "long COVID".

Although a small proportion of people with diabetes were motivated to better self-care during the pandemic with more time to focus on their health, the majority have seen worsening of their mental and physical health and diabetes control over the last two years. Many attribute deterioration to less healthy lifestyle choices, including high-carbohydrate and fatty snack foods, sugary drinks and less physical activity. Although encouraging lifestyle changes may seem counter-intuitive right now, poor lifestyle choices jeopardise good diabetes control and increase risk of serious consequences in those who develop COVID. We now know so much more about the impact not just of diet and physical activity, but also of sleep, stress, relationships and use of risky substances on our immune systems' ability to cope with infections, including COVID, along with impact on glucose, blood pressure (BP) and lipids. Brief or very brief advice from healthcare professionals has been demonstrated to help people choose to change, so asking quick



**Pam Brown**  
GP in Swansea

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questions about lifestyle, as described in our At a Glance factsheet on [lifestyle discussions](#), could have an important impact. We'll share the latest evidence and provide action plans for each lifestyle area in future issues.

Our [“How to identify and manage atrial fibrillation \(AF\)”](#) in people with diabetes quick guide in this issue highlights how important it is for us to win the race to diagnose AF and start anticoagulation before a stroke ensues. AF is more common in people with diabetes, and especially in those with raised HbA<sub>1c</sub> and with albuminuria, with hazard ratios ranging from 1.16 in those with normal albumin and HbA<sub>1c</sub> ( $\leq 52$  mmol/mol), rising to 2.04 with both high HbA<sub>1c</sub> and albuminuria (Seyed Ahmadi et al, 2020). Increased risk of AF is associated with diabetes duration, with an increase of around 3% per year (Dublin et al, 2010). Despite people with diabetes being more likely to receive anticoagulation, the mortality rate in a recent cohort study remained higher compared to those without diabetes (Echouffo-Tcheugui et al, 2017). Possible mechanisms underlying the increased AF risk in people with diabetes include myocardial fibrosis, atrial structural changes and electrical autonomic remodelling (Wang et al, 2019).

How can we continue to identify new AF in remote consultations? Many practices used flu and COVID vaccination appointments as an opportunity to do pulse checks (and to offer weight measurement), and many continue to do this while administering COVID boosters. Recommending home BP monitors that claim to identify irregular pulse rates can help, although we must expect high levels of false positives. If people can feel their own pulse, we can ask them to vocalise or tap out the rhythm during a phone or video consultation, identifying those for whom a face-to-face pulse check and ECG is needed.

Hypertension is a significant risk factor for severe disease and death from COVID, and, with new guidelines published in 2021, we've updated our [“How to diagnose and manage hypertension in people with diabetes”](#). In this issue, David Morris continues his popular [case study series](#), giving us the opportunity to diagnose and manage straightforward hypertension cases before tackling more complex cases in our next issue. We

also include a *Diabetes Distilled* article exploring how [controlling BP](#) may be associated with diabetes prevention.

### **So what might we do differently this winter?**

Einstein defined insanity as “doing the same thing and expecting a different outcome”. So, unless we were happy with all aspects of our care delivery during previous waves, now is the time to ask ourselves what we might choose to do differently this time. As COVID cases soar, right now may be our final opportunity to meet with our team, to review and reflect on our experiences last year, to brainstorm what we would like to do differently this winter, and to highlight any additional resources needed. We can then communicate our needs directly to those who hold the funding or resources – our CCGs, primary care networks, health boards or clusters.

Few of our practice population can self-fund BP monitors, so during remote consultations it is impossible to monitor BP or titrate medication, despite poorly controlled hypertension increasing risk of serious COVID outcomes and diabetes complications. Are there funds to buy these for those who would benefit? Could our pharmacies deliver them along with scripts to those who need them, as they were so helpful in doing with blood glucose meters during the last lockdown?

Undertaking routine and discharge medication reviews and reconciliations is onerous and becomes more so as hospital discharge rates increase. With escalating workload, we often end up tackling these very late in the evening, when we are fatigued and may be more likely to make mistakes. Practice pharmacists are more efficient and more effective at these tasks, but not all practices have access. Could pharmacists in other roles be funded to support practices during these difficult times, and how could pharmacist support be made more available?

We care for many people with type 2 diabetes who require insulin, a large number of whom are frail, elderly, living alone or in care homes. Less family support during the pandemic may increase risk of hypoglycaemia, and hyperglycaemia will further increase risk of serious disease should they be diagnosed with COVID. Greater use of flash

glucose monitoring could improve safety and save sleepless nights, but has significant resource implications: funding the devices; training carers and people with diabetes to change the devices; and training and protecting time for healthcare professionals to learn to interpret results and use them to improve glycaemic control.

These are just three examples of areas where support could significantly help our team optimise care, and every team will have their own priorities. The important thing is to think through what we might do differently now, as it will be so much more difficult at the height of this wave.

### What this journal is doing to help

*Diabetes & Primary Care* is adapting to try to meet our ongoing needs, including developing ever more concise, practical and, we hope, useful tools. Our new “Need to Know” resources are designed to deliver factual information, collated in an easy-to-read, streamlined format. The first two, on [hypertension targets](#) and [SGLT2 inhibitor licences](#), are in this issue. Please check you are using the most up-to-date version, as we will update these regularly. Attendance at webinars and PCDS conferences has been high this year, with follow-up conference reports and on-demand sessions available. However, with learning time limited or absent, our new “[Conference over Coffee](#)” format allows us to deliver key messages from the conferences, literally, in the time it takes to make or drink a cup of coffee. We’d love to hear your feedback so we can continue to improve them.

A huge thank you, once again, to our existing editorial board members, and to our in-house editorial team who have supported Jane and I throughout 2021. Following retirements, we are recruiting new members to our editorial board. So, if you feel you or a colleague have something to contribute, please read our [roles and responsibilities](#) document, and email us at [dpcc@omniamed.com](mailto:dpcc@omniamed.com) with details of your current role(s) and how you feel you could contribute to *Diabetes & Primary Care* journal. If you have a recent CV available, please attach it, but, if not, don’t worry. We are planning a virtual editorial board meeting early in 2022, as soon as COVID workloads permit, and we look forward to working with and learning from board members, old and new, in 2022.

Until then, we hope you enjoy what time you manage to salvage from the vaccine campaign and clinical pressures over the festive season. Remember, we have done this before, and we can do it again. Stay safe. ■

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