Another year over – and here's what we've done!

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Welcome to the final issue of 2024! I say it every year, but where has this year gone? And what a year it has been. Notably, it brought us the excitement of a new medication, tirzepatide, indicated for use in supporting weight loss, along with renewed interest in obesity as a chronic condition. From this development, we hope to see the further advancement of dual and triple therapies.

We also saw huge advances in the use of technology for insulin users with type 1 and type 2 diabetes, with the expansion of continuous glucose monitoring (CGM) and almost being at the point of seeing the widespread use of hybrid closed-loop (HCL) therapy for those with type 1 diabetes. Although we were hoping to see the funding stream promised to make this roll-out a reality, perhaps this come to fruition in 2025, as I am sure that you all have many very eager people with type 1 diabetes waiting to take up this life-changing technology.

This year also saw many challenges, not the least of which were the medication shortages that presented us with so many headaches! From GLP-1 receptor agonists, insulins and the GlucaGen Hypokit, to name but a few, the impacts of these shortages have been far-reaching and are ongoing, but let us hope for better stock certainty in 2025 and beyond.

The increasing complexity that we all face in managing diabetes demands that we must constantly help the diabetes multidisciplinary workforce to evolve. This issue of the journal discusses many of these advancements. Our diabetes inpatient specialist nurses (DISNs) provide an exceptional and much-valued role, improving the experience of people with diabetes whilst in hospital, providing demonstrable improvements in glycaemic control, reducing length of stay and playing a crucial role in the management of acute metabolic complications. These posts were initially funded centrally, with transformational monies. Regrettably, once this money ceased, many of these posts nationally were lost. The comment by Gerry Rayman and colleagues provides an overview of the positive impact of the DISN role and the importance of adequate staffing levels. They also highlight a return on investment (ROI) tool developed to provide trusts with the means to demonstrate the costs and benefits of these roles, with the prospect of securing permanent funding.

Another area of specialism that has seen huge change is the diabetes pregnancy service. These services are now seeing more women with pre-existing type 2 diabetes than with type 1 diabetes. Type 2 diabetes when diagnosed below the age of 40 years is the subject of the T2Day programme, which seeks to address this particularly aggressive phenotype and the cardiovascular and renal complications that it brings. For women of childbearing age, providing such care needs specialist knowledge.

Additionally, the use of CGM and HCL technology in the cohort with pre-existing diabetes has increased exponentially. The diabetes specialist midwife role, discussed by Cathy Jones, encapsulates beautifully this advancement and much-welcomed evolution of roles within diabetes teams, crossing boundaries and providing valued dual specialist care and knowledge.

I began my diabetes nursing journey some 36 years ago. During this time, I have seen many advancements, maintained a huge passion for learning and developed many specialist interests within the field of diabetes. One of these has been the understanding and recognition of types of diabetes other than types 1 and 2.

Over the past few decades, I have witnessed the development of tests that can help us identify the type of diabetes a person has, and provide the understanding needed to recognise those that we may see less commonly (e.g. MODY and type 3c diabetes). At this stage of my career, I find myself

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more frequently telling a person that, yes, they have diabetes, but that the type of diabetes is not yet totally clear.

The use of GAD, IA2 and ZnT8 autoantibody and C-peptide measurements have aided us in this endeavour. Nevertheless, they are not entirely foolproof and I am confident that we still have much more to discover in this fascinating field of diabetes.

In our first Diabetes Portrait, Julie Brake presents an intriguing case that addresses the challenges of accurate diagnosis that we face ever more frequently. In situations of uncertainty regarding the diabetes type, I often return to my mantra of "treat what you see". This was one of the most useful teachings I ever received, from a wonderful general physician many years ago, and has been invaluable in my diabetes career. In such a case, treat the symptoms you are faced with (be it with insulin for symptomatic hyperglycaemia) and, if the case in front of you looks atypical for the diagnosis, continue to search for validation of actual diabetes type.

The final article in this issue again encapsulates the adaptability and specialism that diabetes nursing offers. The case study by Zilan Hama brilliantly describes the adjustments made to facilitate the learning needs of a mother, when her young son was diagnosed with type 1 diabetes. A truly remarkable read.

So, that brings me to the end of this editorial and just leaves me to wish you all a very merry Christmas and peaceful New Year! ■