DiabetesDIGEST
The easy way to stay up to date with developments in diabetes

Editorial

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Editor

The forgotten few

'Education is what survives when what has been learned has been forgotten' – Burrhus Frederic Skinner

Every diabetes clinic across the land has a few. They are usually Caucasian, working-class men aged 40–50 years old with long-standing type 1 diabetes complicated by background retinopathy and running an HbA_{1c} consistently above 8.5%. They pitch up twice a year, never miss an appointment and repeat the same line every time – 'everything is fine, no problems, occasional mild hypoglycaemic episodes once or twice a month, feet OK' – and end the consultation with yet another junior doctor with a cheery 'see you in six months, doc'. We are all aware of the lost tribe of 18–25 year olds but these are the forgotten few; people who seem to have reached a symbiotic relationship with their diabetes where nothing ever changes until they no longer turn up or they meet the consultant at the end of their hospital bed. Unfortunately, they are invariably the ones who do not realise things could be better, that they are at high risk in the future of suffering the ravages that diabetes has the potential to deliver. They are unaware of what could and should be on offer.

The soon-to-be published NICE review on insulin pump therapy is likely to relax the criteria for recommending continuous subcutaneous insulin infusion (CSII) therapy. In addition to fear of hypoglycaemia as one of the main indications for CSII therapy, NICE is likely to suggest that insulin pump therapy should be offered to individuals who struggle to get their HbA_{1c} below 8.5%. NICE has also recommended that CSII therapy should be offered to pregnant women with type 1 diabetes if hypoglycaemia is a problem (NICE, 2008), which means that if a specialist team is looking after pregnant women with diabetes, it should be also up to speed with insulin pump therapy.

So, it looks as if the UK should no longer be lagging behind most of the rest of Europe when it comes to using technology in diabetes care. Clearly, some areas will struggle to set up an insulin pump programme – but there are already established centres who I suspect would be more than happy to provide education, support and training for clinicians who are new to CSII therapy. Some centres may choose not to offer insulin pump therapy, but the people with diabetes under their care do have a right to access it if appropriate, and mechanisms need to be in place for this to happen. Across the UK, awareness of insulin pump therapy, as an option for people with type 1 diabetes, will need to increase.

Living with type 1 diabetes is very difficult for many people. Balancing life, work, relationships, travel and sport with the unpredictability of the prevailing blood glucose levels can be a huge task for anyone with the condition. It is, therefore, important that both the person with type 1 diabetes and the healthcare professional have as much knowledge as possible of the science and psychology of diabetes. They should also be able to access the 'tools of the trade' including modern technologies such as insulin pump therapy.

The dust seems to be settling following recent political upheavals in diabetes care. I believe that type 1 diabetes care should remain part of specialist hospital practice, and that all people living with the condition should be able to access the technologies available for easing the burden associated with this serious medical condition.

NICE (2008) *Diabetes in pregnancy: management of diabetes and its complications from preconception to the postnatal period*. NICE, London