7th National Diabesity Forum Conference: The future is upon us – practical insights

The National Diabesity Forum Conference, which took place on 2 July 2015 at The Thistle Hotel Marble Arch in London, aimed to give delegates practical insights into how to manage diabesity today. The key topics covered were the changes to commissioning for weight management services, new approaches and techniques to tackling diabesity and what's on the horizon in terms of drug therapies, surgery and alternative less-invasive procedures.

The 7th National Diabesity Forum was chaired by Suresh Muniyappa, Treasurer of the NDF, and he began the conference by welcoming delegates.

The current situation

Julian Barth, Chair of the Clinical Reference Group for Obesity, NHS England, and Consultant in Chemical Pathology and Metabolic Medicine, Leeds

Julian Barth set the scene for the day's conference by explaining the current situation in regards to obesity and type 2 diabetes prevalence in the UK and guiding delegates through the upcoming changes to services commissioning. From April 2016, Clinical Commissioning Groups (CCGs) will have the responsibility for commissioning Tier 3 and the surgical management of obese patients. Tier 3 is the multidisciplinary management of obesity including a medical specialist. The commissioning of Tier 1 and Tier 2 will remain the responsibility of Local Authority. Tier 4 will remain part of the remit of NHS England but will consist only of the care of complex medical cases, paediatrics and adolescents and revision surgery. Dr Barth highlighted the challenges for 2016 will be in providing an effective joined-up approach between the different tiers of care. The coming months will also represent a challenge for CCGs who will need to operate in clusters since the volume for commissioning of obesity surgery will be too small for individual CCGs.

The "Generation Game": Diabesity in the family

Lucinda Summers, Consultant in Endocrinology, Salford Royal NHS Foundation Trust and Honorary Senior Lecturer, University of Manchester

Lucinda Summers presented data demonstrating the genetic and environmental factors that suggest diabesity starts at home.

Dr Summers went on to show delegates that there has been an increase in the number of recorded pregnancies among women with existing diabetes. This is due, in part, to more women with type 1 diabetes being able to successfully reach full term and type 2 diabetes being diagnosed in women of child-bearing age, particularly in those of South-Asian or African-Caribbean origin. An increase in the number of pregnancies in older or obese women has led to more gestational diabetes. The take-home message from the session was that potential mothers should be made aware of the risk of diabesity in pregnancy well before conception. Opportunistically approaching the subject of pregnancy with obese women of child-bearing age is a good way to approach the subject.

Another topic covered in this session was whether it is possible to achieve a whole-family intervention and approach to diabesity. Dr Summers provided the example of SOFT (Standardized Obesity Family Therapy), a Swedish programme that is working efficiently to target the family as a unit. In the UK, a multi-disciplinary team approach may be logistically too difficult; however, the way forward could be in developing a "whole-system" approach.

Managing lesser-known comorbidities and complications

Sunil Nair, Consultant in Diabetes and Endocrinology, Chester

Sunil Nair presented the third talk of the conference and spoke on lesser-known comorbidities and complications, namely non-alcoholic fatty liver disease (NAFLD) and obstructive sleep apnoea.

Dr Nair provided information on diagnosis, presentation and the available management algorithms for these conditions. Both conditions are comorbidities of obesity and type 2 diabetes, so weight loss and weight management are pivotal in managing these comorbidities.

Pharmaceutical treatments in people with diabesity: Now and where next?

Cliff Bailey, Professor of Clinical Science and Director of Biomedical Research, Aston University

Cliff Bailey's presentation covered the available treatments for type 2 diabetes and obesity. He explained how anti-diabetes medicines that promote the "incretin" effect, such as glucagon-like peptide-1 receptor agonists and dipeptidyl peptidase-4 inhibitors, can improve glycaemic control without causing weight gain, while sodium–glucose co-transporter-2 (SGLT2) inhibitors offer a different approach to reduce hyperglycaemia and encourage weight loss.

Future medicines for type 2 diabetes may

come in the form of tissue-specific inhibitors of glucocortoid action and agents based on intestinal and adipocyte hormones that have weight-lowering properties, such as analogues of oxytomodulin, PYY and leptin. For obesity, options other than orlistat may soon be available; namely liraglutide (3 mg), which was launched in the US in April 2015 and was approved and has been granted licence by the European Medicines Agency earlier this year.

Asked in the question session whether healthcare professionals should be concerned about prescribing SGLT2 inhibitors after reports of diabetic ketoacidosis (DKA) among users, Prof Bailey reported that there have been very few cases of DKA reported in people with type 2 diabetes. The message to patients who are using SGLT2 inhibitors and are worried should be ensure fluid intake remains high, especially in warmer weather, and keep taking their prescribed insulin.

Diet and motivation: A "how to" guide

Jen Nash, Director of Positive Diabetes and Chartered Clinical Psychologist, London

The session presented by Jen Nash began by focusing on the power of motivation in relation to dieting. Dr Nash began by saying that struggling with weight loss did not mean that motivation was necessarily the problem; everyone is motivated to follow the values that are important to them, so it is not a case of "creating" motivation but finding ways to improve lifestyle that tap into individuals' existing motivation.

The medical model views obesity as the problem to be solved. Psychological models consider that for many, obesity is a symptom of distress, and until we address the distress, we will struggle to solve the weight problem. It is equally important to understand the "why's" of eating behaviour (e.g. for comfort, distraction etc), as well as the "what" and "how much". With this in mind, Dr Nash considered whether it is time to shift the treatment of obesity from a medical to an emotional paradigm. Dr Nash touched on the benefits of a mindful approach during consultations to reduce stigma and to normalise the feelings of patients, provided conversation starters for delegates to use in their time-limited consultations and also shared the 8 Fs "EatingBlueprint" framework, which delegates can implement in their own lives and share with patients.

Latest thinking on bariatric surgery and devices

Suresh Muniyappa, Consultant in Diabetes, Endocrinology and Weight Management, Mid Yorkshire Hospitals NHS Trust, and Treasure of the NDF

Studies show that reducing weight improves life expectancy in people with diabesity, so there is need to develop an effective treatment for type 2 diabetes and obesity. Surgery is a very effective means of treating obesity and the associated comorbid conditions.

However, bariatric surgery is expensive and no country has the infrastructure to treat their entire obese population this way. Dr Muniyappa's presentation explored the current guidelines for bariatric surgery, the complications following surgery that are often forgotten (such as excess skin) and the potentially less-invasive devices that could take the place of surgery in the future. These newer devices may provide reversible interventions with fewer complications than surgery, which can be done in the out-patients setting. At present, none are approved for use in the NHS so more development and research is imperative.

Head-to-head debate: "In 10 years' time, the bariatric surgeon will be extinct"

Roger Ackroyd, Consultant General Surgeon, Sheffield; Nick Finer, Consultant Endocrinologist and Bariatric Physician, and Honorary Professor at the National Centre for Cardiovascular Preventions and Outcomes, London

Surgeon Roger Ackroyd outlined the surgical options for obesity and diabesity and explained how surgery was the only real option for very obese people. He did not believe the bariatric surgeon would be extinct in 10 years' time, especially as NICE has recently extended the guidance on bariatric surgery to people with lower BMIs. He presented data and evidence to delegates on the numbers of procedures taking place in the UK and explained how he favoured the gastric sleeve over other surgical procedures. He ended his argument by saying surgery is safe and effective for people with diabesity, although if the bariatric surgeon was to become extinct, this would be as a result of commissioning power returning to Clinical Commissioning Groups, which would revert access to surgery back to a postcode lottery. Changes to the tariffs of different procedures may also impact on the number and type of surgical procedures carried out in the coming years.

Nick Finer, who stood for the motion that the bariatric surgeon would be extinct in 10 years' time, began by suggesting that robotics may be the first step in the decline of the bariatric surgeon. On a more serious note, the extinction of the bariatric surgeon may come in the form of a name change to metabolic surgeon as the role and effect of surgery on type 2 diabetes becomes clearer. Prof Finer agreed surgery was effective, but that it was not without its problems, mainly that bariatric surgery causes an abnormal physiological state that the body must adjust to. Also, there is huge variation among bariatric patients in the weight loss achieved after surgery, and there are currently no predictors on who will do well post-procedure. So what are the other options that could take the place of surgery? The role of gut microbiota and flora and glucagon-like peptide (GLP)-1/glucose-dependent insulinotropic polypeptide (GIP) dual agonist combination therapies may provide the answer.

Before hearing both sides of the motion, the delegates were three quarters against the motion and this remained after both presentations were heard. However, the debate proved to be lively, raised interesting questions and left delegates with much food for thought. ■