NICE type 2 diabetes guidlines: A GPSI's perspective

Wow! For 6 years we've been waiting for this document, which is supposed to nail down the way that type 2 diabetes is managed in the community. Given the pace of change in diabetes therapeutics it was always going to be like this years fashion output – looks good now but rapidly becomes out of date!

As for diabetes, the guidance doesn't mention the DPP-IV inhibitors (sitagliptin and vildagliptin) which are relatively new and have little experience or evidence base. Strangely, when talking about basal insulins, it also doesn't mention insulin detemir which has been in use in the UK for over 5 years.

From a GPSI and specialist angle there is a lot to get excited about. Patient education is heavily emphasised, but there will undoubtedly be plenty of need and demand for professional education to understand the algorithms and make sure that professionals appreciate the momentum which drives the steps in therapy. For instance, there is a welcome weight given to early initiation of insulin and the progression from a basal insulin regimen to twice-daily premixed and basal–bolus insulin regimens. Exenatide, a relatively new injectable incretin mimetic, is suggested as an option in people with a BMI over 35kg/m^2 where the balance of improving diabetes control without weight increase is felt to be important from a psychological, biochemical or physical perspective.

Given the increasing numbers of younger females with diabetes being diagnosed, there is a lot of scope for specialist community-based pre-conceptual clinics. Apart from stressing the need for optimal glycaemic control, there are several issues around hypertension (ACE inhibitors and ARBS are contraindicated in pregnancy) and lipid control (there are issues around statin and fibrate use in pregnancy) which will need expert advice.

Even risk assessment to decide on optimal lipid and anti-platelet therapy is going to pose challenges. The NICE guideline group has come down in favour of using the UKPDS risk engine for estimating cardiovascular risk over the conventional Framingham risk engine or the newer QRISK engine. Although more appropriate (Framingham significantly underestimates cardiovascular risk for people with diabetes), this engine is not currently integrated with many GP software systems and needs to be used as a stand-alone tool, which may reduce its usage.

Interestingly, in the lipid algorithm the guideline not only suggests a target total cholesterol of <4.0mmol/l and an LDL-cholesterol of <2.0mmol/l with the use, if necessary, of simvastatin 80mg (not a good idea in high-risk groups such as South Asians), but continues to promote ezetimibe – despite the negative results of the ENHANCE study published in March 2008 (Kastelein et al). Despite concerns about the increased risks of myopathy and rhabdomyolysis, the combination of a fibrate plus a statin is suggested in people with a triglyceride level over 2.3mmol/l. In my experience this is by no means an uncommon scenario.

There is appropriate attention paid in the guidelines to psychological and renal issues, as well as the management of individuals with neuropathic pain, erectile dysfunction and gastroparesis. The multidisciplinary teamworking ethos of community-based specialist teams is ideally placed to support and advise GPs and people with diabetes in the management of these common but hard-to-manage problems and engage secondary care support when needed. This is particularly true for foot care which, although covered in a separate NICE guideline, is core to high-quality diabetes provision.

Given the incredible increase in the numbers of people newly diagnosed with diabetes there is enough work in this well-written guideline to keep GPSIs busy for a long time to come! ■

Kastelein JJ, Akdim F, Stroes ES et al (2008) Simvastatin with or without ezetimibe in familial hypercholesterolemia. *NEJM* **358**: 1431–43

Brian Karet

Brian Karet is a GPSI in diabetes at Leylands Medical Centre, Bradford.