Thumbs-up for NICE guidelines

Many years ago, Robert Tattersall commented that diabetes could be "managed with negligent ease by those inclined to do so". Nowadays, the combinations and permutations of treatments are verging on the bewildering, but despite this, the achieved standard of care is often unsatisfactory. This means either that the treatments are not as useful as the manufacturers make out or they are not used effectively. There is certainly no shortage of people with the condition and therefore the amount of money to be made by industry will inevitably continue to attract more and more investment in seeking the definitive treatment, which is likely to take the form of a polypill.

A recent editorial in the *Lancet* highlighted the fact that nine available drug classes for treating type 2 diabetes have been introduced in the past 10 years, all of which are 8–10 times more expensive than the older and usually more potent agents: insulin, sulphonylureas and metformin (Kahn, 2009). For the newer agents a drawback appears to be a lack of direct comparisons with older agents for a long enough period of time to provide evidence about effectiveness and safety. Nevertheless, these agents are available, the marketing departments in the companies are in full swing, and people with diabetes have been reading the *Daily Mail* and "Google-ing" like there is no tomorrow. It is human nature to think that "newer" is "better", but when it comes to drug therapies, history and experience tell us to remain cautious.

The recent NICE guidance on newer agents for blood glucose control in diabetes (NICE, 2009) is particularly welcome and is full of common sense. It is, however, a lengthy tome and so is unlikely to be read in detail except by industry and healthcare commissioners. The recurrent theme is the understanding and recognition that hypoglycaemia remains the number one worry for people using glucose-lowering medication. The clear winners are the dipeptidyl peptidase-4 inhibitors and thiazolidinediones. The glucagon-like peptide-1 receptor agonist exenatide has also found a place before insulin in those with a BMI ≥35 kg/m^2 and specific psychological or medical problems associated with a high body weight. For slimmer individuals NICE is relatively specific that exenatide should be used rather than insulin if the use of the latter "would have significant occupational implications or where weight loss would benefit other significant comorbidities related to obesity". In clinical practice this is probably a missed opportunity for patient choice, particularly with such an arbitrary BMI cut-off.

The main losers are long-acting insulin analogues. The guidance suggests use of neutral protamine Hagedorn (NPH) insulin in preference to insulin glargine or insulin detemir. As a clinician, the concern is that people requiring insulin would have to "earn" a long-acting insulin analogue by experiencing hypoglycaemia on NPH insulin first. Given the often prolonged psychological consequences of the experience of severe hypoglycaemia on subsequent self-targets for glycaemic control, this is not such a good idea.

The most encouraging aspect from the guidance is that we all should find out whether the drugs do work as they are supposed to, with specific figures given about expected achieved HbA_{1c} levels after specific lengths of time. This is common sense and I am sure will appeal to those spending the money on buying the drugs. It may also provide much better "person-centred" care, in that people will vote with their feet and stop taking the drugs if they have unpleasant side-effects. All in all, a thumbs-up for NICE on this one. ■

Kahn R (2009) Diabetes technology – now and in the future. *Lancet* **373**: 1741–2

NICE (2009) *Type 2 Diabetes: Newer Agents for Blood Glucose Control in Type 2 Diabetes. NICE Clinical Guideline 87.* NICE, London. Available at: http://tinyurl.com/nujdv (accessed 27.05.09)

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