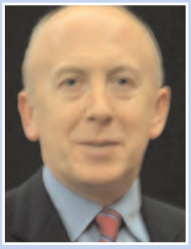
PCDS

Primary Care Diabetes Society

The latest news and views from the Primary Care Diabetes Society

Fine tuning: The way forward with the QOF?



In Martin Hadley-Brown's editorial in this issue of *Diabetes & Primary Care*, proposals are made for a way forward for diabetes and the General Medical Services (GMS) contract's Quality and Outcomes Framework (QOF). A revision is welcome but the feeling among commentators is that it should be a fine tuning of the existing indicators rather than a major revision.

Dr Laurence Buckman, co-chairman of the QOF review team has said recently: 'The QOF was intended to pay GPs and their practices for work already done, if they were delivering quality of care, or to encourage them to take an evidence-based approach in the delivery of care to those aspects of medicine that could be quantified in a way that was acceptable to the people that pay us' (Medendum Group Publishing, 2005). The evidence had to satisfy certain criteria. It had to be published and peer-reviewed, be applicable to primary care and preferably come from the UK.

Concerns

The success as well as the universal applicability of the current framework must continue to apply. Some authorities are calling for the introduction of both educational and dietary advice to be included as indicators, but many are concerned about the applicability and resource implications of these suggestions.

Those of us who believe in evidence-based diabetes care, widely applied through UK general practice, should be very pleased with the initial success and would welcome a minor revision without any wholesale change of course.

Colin Kenny
Acting Chair, PCDS, and GP,
Dromore, County Down

Medendum Group Publishing (2005) Quality and outcomes framework undergoes first review. *Guidelines in Practice* **8**(5)

QOF indicator figures released

The disease prevalence figures for diabetes have now been released for England, Scotland and Northern Ireland *(Table 1;* British Medical Association, 2005). The Welsh assembly will publish its figures soon.

We now know that many practices achieved very high figures for QOF indicators. Figures from Scotland published recently in *Pulse* show that 96% of practices achieved the maximum achievable points in diabetes.

The high figures reflect very well on practices, which have achieved a great deal in about 15 months, since the details of the framework were released.

British Medical Association (BMA; 2005). BMA, London.

Table 1. Disease prevalence figures.

	Northern Ireland	Scotland	England
Diabetes (%)	2.8	3.3	3.35
Coronary heart disease (%)	4.06	4.53	3.46
Hypertension (%)	10.04	11.7	10.85

Primary Care Diabetes Europe

In 1997 the first conference of the St Vincent Declaration Primary Care Diabetes Group (SVDPCDG) established primary care in the European diabetes community. Renamed Primary Care Diabetes Europe (PCDE) in 2000, there are now over 3000 people on the membership database. The organisation has a legal constitution and an executive body. Members are drawn from all primary care professionals working with diabetes patients. We are very pleased to be closely linked with the UK Primary Care Diabetes Society (PCDS) and are completely supportive of its aims. Members of PCDS automatically have free membership to PCDE unless they state otherwise.

We promote primary care diabetes throughout Europe and the Accession States. Our executive committee has members from seven nations and we have national contacts throughout the regions we cover. We promote research in primary care diabetes, hold annual conferences and are hoping to publish a peer-reviewed journal in association with a global publishing house in the very near future.

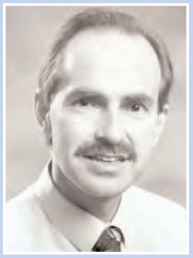
There are many diverse systems of primary diabetes care throughout Europe. Identifying common issues and themes remains a significant challenge for PCDE. But the reality is that primary care will increasingly shoulder the rising burden of diabetes in the populations we serve.

I would like to draw your attention to the PCDE conference in Athens on 10–11 September 2005. If any readers have carried out audit or research work in diabetes we would very much welcome your contribution in the form of an abstract and poster (if selected).

If you dislike warm evenings, Greek ruins or a Mediterranean diet then Athens is clearly not the place to go. But if you are thinking of a long hot weekend in early September before winter tightens its grip, think Athens. For any further details about the Athens meeting or PCDE membership please contact Paula Laterveer, PCDE Administrator, on lacro@compuserve.com

Neil Munro
Chairman, PCDE, and
GP, Claygate

Upcoming therapies for diabetes



Cliff Bailey

As the number of individuals with diabetes, especially type 2 diabetes, continues to rise, and the importance of achieving glycaemic targets is ever more apparent, we are treating more intensively, addressing attendant cardiovascular risk and applying all the rigor of good practice. Yet good control is often elusive for a substantial proportion of patients. (Bar the occasional game of golf) this cannot necessarily be blamed on the physician or (apart from occasional overindulgence or lack of compliance) the patient: it is the progressive natural history of a complex disease process that presents a 'moving therapeutic target' for which we do not always have exactly matching medications available. Hence the need for new therapies.

Combination therapy

Fixed-dose combinations are emerging around the world and in the UK, where we currently have Avandamet (a combination of metformin and rosiglitazone). Such combinations can assist compliance by reducing pill burden and allow lower doses of two agents to be used to achieve control while improving tolerance and reducing side effects. It is likely that other fixed-dose combinations of existing oral antidiabetic drugs will be introduced (e.g. metformin with pioglitazone, and rosiglitazone with glimepiride). Combinations of metformin and sulphonylureas are available in some countries, and further ahead there is the possibility of combining antidiabetic agents with antidyslipidaemic and/or antihypertensive agents.

Incretin mimetics

Analogues of the incretin hormone glucagon-like peptide-1

(GLP-1) are being developed to enhance glucose-induced insulin secretion after a meal. They act through a different cellular mechanism to sulphonylureas and meglitinides, and offer a range of other interesting effects such as mild satiety, slowing gastric emptying, reducing weight and suppressing glucagon secretion. Most enticing are the preclinical studies (Deacon, 2004) showing increased β-cell division and neogenesis, and evidence that this can occur in a clinical context is eagerly awaited. At present the preparations require subcutaneous injection and have been reported to cause nausea, but hopefully severe hypos should not occur, at least if given as the only antidiabetic medication. Most advanced in development is exenatide, a molecule originally found in the saliva of an American lizard.

Inhibitors of the circulating and cell-surface enzyme dipeptidyl peptidase-IV (DPP-IV) act, at least in part, by preventing the degradation of endogenous GLP-1, so producing a similar spectrum of effects to GLP-1 analogues. Conveniently, these agents are orally active, but it has to be remembered that DPP-IV inhibitors can prolong the half-life and increase the activity of a range of other peptides, which could influence their therapeutic profile (Drucker, 2003).

Other agents

A cannabinoid receptor-1 (CB1) inhibitor (rimonabant) has recently been shown to assist lifestyle measures as an antiobesity agent. It reduces appetite and reduces fat deposition, particularly in abdominal adipose tissue (Van Gaal et al, 2005). Additionally this agent is helpful in smoking cessation (and preventing weight gain during smoking cessation), reducing triglycerides and improving insulin sensitivity in obese people with diabetes. It is an oral agent, and if the side effect profile is as encouraging as the initial clinical trials, this could be a valuable new treatment.

Inhaled insulins are attracting much interest, and a dry powder preparation (Exubera) is presently being evaluated by regulators. This could be most useful in providing prandial bolus delivery of rapid and short-acting insulin to supplement injections of long-acting insulin, or to supplement oral agents in type 2 patients. As long as lung function is unaffected, this could be coming soon. Other types of agents advanced in development include the dual PPARα-γ agents that act rather like a thiazolidinedione and a fibrate combined, providing a therapy for control of both glycaemia and various lipids.

In the USA, a soluble analogue of amylin (Symlin) has just been approved as an adjunct to insulin therapy that reduces glucagon secretion, slows gastric emptying and helps weight control with a satiety effect.

This is a taste of the types of agents we might anticipate for the future to assist in the treatment of diabetes.

Cliff Bailey
Head of Diabetes Research, Aston University, Birmingham. Dr Bailey is key note speaker at the PCDS Conference at The Belfry, Warwickshire, 11–12 November 2005

Deacon CF (2004) Therapeutic strategies based on glucagon-like peptide 1. *Diabetes* **53**(9): 2181–9
Drucker DJ (2003) Therapeutic potential of dipeptidyl peptidase IV inhibitors for the treatment of type 2 diabetes. *Expert Opinion on Investigational Drugs* **12**(1): 87–100
Van Gaal LF et al; RIO-Europe Study Group (2005) Effects of the cannabinoid-1 receptor blocker rimonabant on weight reduction and cardiovascular risk factors in overweight patients: 1-year experience from the RIO-Europe study. *Lancet* **365**(9468): 1389–97