*Meeting report from the*

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# Towards coordinated diabetes care: A multidisciplinary approach to a multifaceted condition

# Metabolic syndrome

'Metabolic syndrome is a useful concept for identifying individuals at high risk of cardiovascular disease and diabetes mellitus and treating them', according to Sir George Alberti, Emeritus Professor of Medicine, Newcastle. However, there is a lack of uniform definition or known aetiology and some people question whether it even exists. Key components of the syndrome include: glucose intolerance, hypertriglyceridaemia, increased apolipoprotein B, hypertension and reduced levels of HDL-cholesterol, small dense LDL and fibrinolysis. Diagnosis is complicated by the differing definitions for the syndrome (such as those from the World Health Organization, European Group for the Study of Insulin Resistance, International Diabetes Federation).

Metabolic syndrome is very common, with reported prevalence in different populations using the International Diabetes Federation definition in the range 26–48%. People with metabolic syndrome have an increased risk of developing cardiovascular disease (Risk ratio [RR] 2.50 for men and 1.58 for women) and type 2 diabetes (RR 4.76 for men and 5.66 for women).

# Obesity – the challenge in general practice

***'Dietary strategies can aid weight loss, but it is important that the patient likes the proposed diet.'***

'Helping people who are overweight or obese to lose weight is an important function of primary care, where 90% of patient contact occurs', according to Pam Dyson, a dietician from Oxford. The GMS contract will provide incentives to support weight loss. Checking the weight and height of all people who attend a GP practice is a quick way to accumulate data on obesity as almost 80% of patients pass through a surgery each year. Asking people to self-report this data is unreliable, as on average height is overestimated by 1.4 cm and weight is underestimated by 1.7 kg. Identifying patients and intervening early is valuable as obesity is associated with numerous diseases: type 2 diabetes, hypertension, dyslipidaemia, osteoarthritis, metabolic syndrome, congestive heart failure.

Prevalence of obesity in adults in the UK has increased from 7% in 1980 to 24% in 2004. As a result, 66% of the adult population is now overweight. Obesity has increased significantly in children as well, with 22% of boys and 28% of girls overweight in 2002. Overall, obesity has grown by 400% in the last 25 years.

In relation to diabetes, 80–90% of people with type 2 diabetes are overweight or obese, but intentional weight loss can reduce mortality by 25%. Bariatric surgery can produce a weight loss of >50%, although only around 5000 such procedures were performed in the UK in 2005. Drug treatment options include the lipase inhibitor Orlistat, the centrally acting appetite suppressant sibutramine and the selective cannabinoid-1 receptor antagonist rimonabant. Increased physical activity with dietary treatment can lead to weight loss, although increased physical activity alone is not as effective. Finally, dietary strategies can aid weight loss, but it is important that the patient likes the proposed diet.

# Recognising depression in people with diabetes

People with diabetes have a higher prevalence of depression than the general population, according to Arie Nouwen, Senior Lecturer in Clinical Psychology, Birmingham. A meta-analysis concluded that 31% of people with diabetes have significant symptoms of depression and 11% have major depression. The incidence of depression is higher in women, but there is little difference between those with type 1 or type 2 diabetes. This is important for health professionals involved in treating diabetes because depression is associated with poor self-care and metabolic control, increases in the risk of diabetes-related complications and increases in the use of health services.

In the past, it was assumed that people get depressed because they get diabetes, said Dr Nouwen. But it is now known that depression generally precedes a diagnosis of type 2 diabetes by many years. In fact, a major depression disorder increases the risk of developing type 2 diabetes. Literature seems to suggest that depression in diabetes mainly occurs in people with a history of a major depressive disorder or depressive symptoms. For people with type 1 diabetes, there is a period of high-risk for onset of depression following diagnosis.

Dr Nouwen suggested that symptoms of depression often go unrecognised in people with diabetes. One of the reasons for this is that there is an overlap of symptoms (i.e., fatigue, change in diet, difficulty sleeping). In other cases, the symptoms of depression are seen as secondary and the efficacy of treatment may not be recognised. The treatment of depression in people with diabetes is as effective as it is for people without diabetes.

*'People with diabetes have a higher prevalence of depression than the general populations.'*

# Refer appropriately for specialist nephrology care

Between 35% and 45% of people with type 1 diabetes and approximately 20% of people with type 2 diabetes will develop nephropathy. This is according to Kevin Harris, Consultant Nephrologist and Clinical Director of Renal Services and Urology, Leicester, who said that diabetic nephropathy now accounts for 20% of end stage renal failure in the UK.

Dr Harris then outlined the sort of patients who should be referred for specialist care. This includes atypical presentations (short duration of diabetes, no retinopathy, haematuria), suspected renal artery stenosis, complications of chronic kidney disease, severe proteinuria, those progressing despite optimal therapy and those with a given level of renal function (i.e., creatinine levels >150 µmol/l).

Thirty per cent of people start renal replacement therapy after a 'crash landing' (i.e. as an emergency, out of hours case). Dr Harris thought that 50% of these cases could be prevented if those likely to need renal replacement therapy were better identified.

Dr Harris also reminded delegates that there are 27 Quality and Outcomes Framework (QOF) points available for GP practices in relation to the care of patients with chronic kidney disease.

# This house believes that pre-diabetes should be treated pharmacologically


'Pharmacological treatment of "pre-diabetes" is an illogical strategy for reducing the disease burden associated with hyperglycaemia,' said Simon Griffin (Programme Leader at the Medical Research Council, and a practising family doctor, Cambridge) opposing the motion 'pre-diabetes should be treated pharmacologically'. He pointed out that lifestyle interventions are a more cost effective way of preventing progression of pre-diabetes than drugs and the effects are longer lasting. He also suggested that population and individual approaches targeting diet and physical activity are necessary to tackle obesity, hyperglycaemia and related complications.

For the motion, David Kerr (Consultant Physician, Bournemouth) stated that 'it is illogical to expect our patients to lose weight purely through exercise and diet alone.' He continued, saying that: 'Because the number of people with diabetes is increasing at an alarming rate it is surely the responsibility of the prescriber to prescribe any pharmacological intervention that exists and has been shown to help in weight loss to his or her patient.'

David then went on to mention a sample of recent major drug trials that have shown much benefit in the obese population; he also stated that there are not any diet and lifestyle intervention trials that have unequivocally shown any clinically significant benefits in weight loss.

However, when it came to the vote at the end of the head-to-head debate the vast majority of the audience sided with Simon Griffin and voted against the motion.

# Innovations in diabetes therapies

Ending the conference, Neil Munro (GP, Surrey, and Associate Specialist in Diabetes at Chelsea and Westminster Hospital, London) discussed new innovations in diabetes trials and treatments.

He started with discussing the newly published guidelines jointly published by the American Diabetes Association and the European Association for the Study of Diabetes, and how it may affect the treatment of people with diabetes in the UK. These guidleines suggest aggressive treatment of the condition by introducing metformin alongside lifestyle intervention at diagnosis, with insulin initiation being considered as second-line therapy.

The many trials Neil discussed included PROactive, ADOPT and the Treat-to-Target Trial. He also discussed many new experimental drugs such as the incretin mimetics.