PCDS
Primary Care Diabetes Society

The latest news and views from the Primary Care Diabetes Society

Issues concerning optimal diabetes care

For this edition of the PCDS newsletter within *Diabetes & Primary Care,* I have put together a pot-pourri of matters to discuss among which I hope you will all find something of interest. This is an exciting time to be involved in the management of diabetes in primary care. We are being asked to take on more responsibility for organising and providing the medical care of people with diabetes. This brings challenges, opportunities and responsibilities. There are medical and technical competencies to be mastered, relationships with people with diabetes and fellow professionals to be nurtured, and all the time the knowledge that we are dealing with a condition where optimal management really does make a difference to morbidity and mortality. As a society, the PCDS exists to enable more people to receive optimal care from those they turn to, through constantly working to improve the standards we reach and aspire to.

Martin Hadley-Brown, GP, Thetford, Norfolk

New pharmacological agents

This year, two new classes of pharmacological agents are becoming available to add to our therapeutic armoury. We will cover them in more detail elsewhere in the coming months, but expect to hear more of the incretin mimetics and of DPP-IV inhibitors. Given that the incretin agonists are injection-only agents, it is most likely that the oral DPP-IV agents will gain earlier use in primary care. The first, sitagliptin, is now available for prescription here.

However, just at the time that new agents have appeared, there has been much discussion in the USA about the safety of another popular oral hypoglycaemic agent, which itself was a new addition to our repertoire only some 5 years ago. No less an institution than the *New England Journal of Medicine* carried a meta-analysis and supporting editorial raising worries about the safety of rosiglitazone. It may be that in the USA, there is a political agenda relating to criticism of the FDA that has exaggerated the significance of a flawed meta-analysis. Nevertheless, the prominence offered to the story should remind us of how high a profile field we work in. It will probably be months or even years before we have a truly accurate view of the balance between benefit and risk for rosiglitazone and, as always, we then have to consider whether or not that balance also applies to other drugs in the class.

Meanwhile, as prescribers, we have to decide with each individual what their best treatment options are now. Every medication we prescribe either has potent and complex effects on those taking it, or is ineffective – impotent, to coin a pun. We should not be offering medication unless the potential consumer already has a significant morbidity or risk which we seek to minimize. Thus, we offer people with diabetes a variety of antihypertensive drugs: statins to reduce cholesterol, then a variety of hypoglycaemic agents, perhaps supplemented by aspirin. It may be a measure of the success of these strategies that the RECORD trial, which seeks to show whether or not rosiglitazone offers cardiovascular benefits to people with diabetes, is seeing fewer myocardial infarcts and deaths among its volunteers (both taking and not taking rosiglitazone) than expected (Home et al, 2007). Of course, for the people we prescribe to, this is the best possible news! As a patient, how much does it matter which of your tablets is stopping your heart attack as long as the job is being done?

Nevertheless, you and I all know that none of our antidiabetes medications are ideal. All fall short of ideal efficacy and all have potential adverse effects. This is why we should all be excited that new classes of medication are available, whilst balancing our exuberance with some caution about the possible unknowns that only experience will unveil.

So, watch out, in these pages and elsewhere, for more information about current and future new agents.

Home PD, Pocock SJ, Beck-Nielsen H et al (2007) Rosiglitazone Evaluated for Cardiovascular Outcomes – An Interim Analysis. *New England Journal of Medicine* [Ebub ahead of print]

Where next for the QOF?

At most meetings I attend to discuss diabetes care, the topic of the 'Quality and Outcomes Framework' from the 2004 GMS2 contract arises. Sometimes heated debate ensues, often revealing serious misunderstandings about the philosophy and reasoning behind the GMS contract and the place of the QOF within it. I make no apologies for repeating the view that QOF has driven more improvement in general practice diabetes care than any other initiative. National Service Frameworks, NICE guidance and local guidelines all have influence, particularly among existing achievers. None, however, has driven the general improvement in performance brought about by the simple necessity of practices meeting QOF targets in order to survive. Ultimately, the people we treat are the beneficiaries if they are receiving at least the fundamental necessities of diabetes care. 'Tickbox medicine' beats 'forgotten medicine'. However, most of us aspire to much more than the essentials, and good general practice is about performing to the highest achievable standards. Thus, we aim for blood pressure control well below 145/85, may aspire to lipid levels within the JBS2 targets, and are aware that for most people with diabetes, an HbA_{1c} level of 7.4% is not ideal. As the representative organisation of diabetes professionals in primary care, we may hope to have some influence on considerations of future QOF targets in the diabetes domain. Not expecting fundamental changes in the QOF over the next year, we are seeking to put most weight behind introducing an indicator recognising progressive reduction in HbA_{1c} level of 1% over a 12-month period, currently omitted. We believe this would encourage further efforts to work with all individuals to improve glycaemic control in ways appropriate to them even if this does not lead to achievement of the 10% or 7.5% levels. It is an ambition shared with Diabetes UK and, of their aspirations, it is the one we are in closest agreement with.

Website

Since the formation of PCDS, we have been ambitious to develop our website beyond its initial capabilities. So far, we have had little more than the ability to register membership and advertise our annual conference in November. Our GPSI members have a discussion forum, but that has so far been the limit of our extended web functionality. Soon we hope this will change, with a revamped website with more information, links and the ability to offer you more involvement with the interests of your society. For PCDS members, there will be a wide range of forums and access to past issues of *Diabetes and Primary Care*, *The Diabetic Foot Journal*, the *Journal of Diabetes Nursing* and other journals from the SB Communications Group. In addition, there will be regular e-newsletters and online booking for PCDS and other events organised by the SB Communications Group. It is very much hoped that all this will be implemented by the beginning of August and we will keep you abreast of its progress.

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Diabetes & Primary Care JOURNAL

3rd National Conference of the Primary Care Diabetes Society

The Hilton Birmingham Metropole, Birmingham (16–17 November, 2007)

Achievements, challenges and controversies in primary diabetes care

Have you taken the time yet to look at the programme for the PCDS November conference? Again, we have tried to compile a programme with much of interest to all. Sessions will concentrate on the practicalities of structured education and various aspects of clinical care, and our debate will consider the relative importance of diet and physical activity in preventing diabetes. We shall consider both type 1 and type 2 diabetes, and hear about the latest developments in new therapies. For those involved in service development and planning, or eager at least to be familiar with the environment in which we work, practice-based commissioning will be explained and discussed. As ever, the content of the programme is only part of the reason for attending. The opportunity to share ideas, experience and enthusiasm with fellow colleagues is always a key part of any meeting and there will be no better opportunity this year than at Birmingham on Friday 16 and Saturday 17 November. For more information, see pages 159–162.

Session 1	**Screening and education: The cornerstones of good practice?**
10:45–10:50	**Chair's introduction** Martin Hadley-Brown
10:50–11:05	**Conference opening** Mike Pringle
11:05–11:35	**Vascular screening in primary care** Melanie Davies
11:35–12:05	**Structured education for type 2 diabetes: What works?** Sue Cradock
12:05–12:35	**Saving feet** Neil Baker
Session 2	**Interactive masterclasses**
13:45–14:45	**Masterclasses: 1st rotation**
	1. Insulin in type 2 diabetes (the Insulin Decision Tree) Lorraine Avery
	2. Looking after people with type 1 diabetes in the community: Life, insulin and everything Brian Karet Bev McDermott
	3. Motivational interviewing Mark Davies
	4. Pre-conception counselling in primary care: Improving pregnancy outcomes Roger Gadsby
	5. Hypoglycaemia: The patient's nightmare? Gwen Hall, Debbie Hicks
	6. Carbohydrates: A balancing act Francesca Arundel
	7. Practice-based commissioning: Experiences from the pilot sites Azhar Farooqi
14:45–15:45	**Masterclasses: 2nd rotation**
Session 3	**Keynote lecture**
16:20–17:15	**Waist matters: Prevention of cardiovascular disease and diabetes** Kamlesh Khunti
Session 4	**Satellite symposium**
17:15–18:45	**Diabetes, abdominal obesity and the endocannabinoid system** Supported by an unrestricted educational grant from Sanofi-aventis
Session 5	**Breakfast satellite symposium**
	Type 2 diabetes: Turning evidence into practice Supported by an unrestricted educational grant from GlaxoSmithKline
Session 6	**Prevention: Better but more difficult than a cure**
10:00–10:30	**Prevention of cardiovascular disease: How low is low?** Naveed Satar
10:30–11:30	**Head-to-head debate: 'Diet is more important than physical activity in preventing diabetes'** Pam Dyson, Mike Baxter
12:00–12:40	**Hot topics** Neil Munro
12:40–13:15	**The Primary Care Diabetes Society Annual General Meeting**

Working with others

To round off this discussion whilst remaining with the theme of trying to exert influence for the benefit of all involved in provision or use of diabetes care, I shall turn to politics! We maintain cordial relationships with a number of other organisations who share common interests – I have already mentioned Diabetes UK. Others include the Primary Care Cardiovascular Society, National Obesity Forum and Cholesterol UK. Over the last 2 years we have worked with them to lobby all-party parliamentary interest groups in diabetes and vascular diseases and also to raise awareness of our needs and concerns at the political party conferences. It is never easy to assess the success of such efforts but we have a responsibility to do our best to ensure that diabetes remains high in the awareness of all who make decisions affecting healthcare provision.

Finally, I am delighted to mention the appointment of Dr Kamlesh Khunti, one of our founding committee members and a leading figure in UK primary care diabetes research, as Professor and Head of the Division of General Practice and Primary Health Care in the University of Leicester. We congratulate him and look forward to continuing to work together within PCDS.