



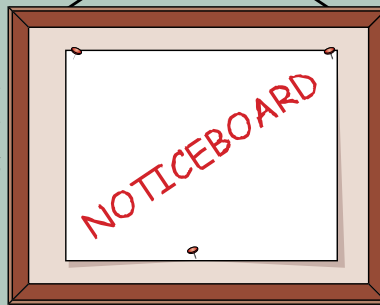
*Debbie Hicks,  
Nurse Consultant in  
Diabetes, Enfield*

**D**o you ever wonder if other people are doing the same as you and that you might just be re-inventing the wheel?

Now is your chance to find out by using the

Noticeboard section in the *Journal of Diabetes Nursing*. As a member of the journal's editorial board, I have for some time now wanted to create an

opportunity for myself and other nurses involved in diabetes care to pose a quick question or share a fleeting thought with other healthcare professionals without having to write a whole article or phone round an array of colleagues.



The idea of Noticeboard is much the same as an internet message board where people can place requests, thoughts, ideas – in fact anything they want to share – as a brief message on this page. We at the journal will then encourage other readers to comment in the next issue, thereby enhancing ongoing debate

and discussion but with a minimum of effort on the part of participants.

#### Easy and efficient way to share ideas

The great advantage of the journal's monthly frequency is that we can be reactive to the needs of our readers. We hope that Noticeboard represents an easy and efficient way to share ideas and to receive answers to questions you want answered.

#### The 'DSN dilemma'

**Q** Something has been occupying my thoughts for some time and it is a subject which I suspect other diabetes specialist nurses must ponder. The 'DSN dilemma' I speak of is that of the way in which we explain, or choose to explain, the seriousness and potentially debilitating effect diabetes can have on a person's life. As nurses, much of our work involves trying to motivate people with diabetes to achieve better glycaemic control. But how well do we carry out this 'duty of care' and how forcefully should we make our point? It is often difficult to pitch a consultation correctly and each person will deal differently with diagnosis of diabetes. As a 'rookie' DSN I was so keen to impart all my knowledge to helpfully(?) enlighten my patients about this condition.

I recently received a GP referral: a 17-year-old girl with newly presenting type 1 diabetes, who arrived red-eyed and bewildered. I soon discovered that she had a fierce determination not to listen to, or do, anything which I or any other healthcare professional might suggest. My point here is that sensitivity to our patients' needs is vital and any explanation of potential complications to this young person would, of course, have been totally inappropriate. For the curious, this girl is now self-injecting confidently (if not happily) and the long road of self-discovery with the inevitable 'yo-yoing' of rebellion and acceptance lies ahead.

My own personal feeling is that we should be sensitive, certainly, but also clear, realistic and, above all, honest with our patients. I would be interested to hear other views on this 'dilemma'.

*Angela Flanagan,  
Diabetes Specialist Nurse, St George's Hospital, London*

#### Calculating insulin doses in newly diagnosed children on MDI

**Q** How do other diabetes care teams calculate insulin doses for children newly diagnosed with diabetes on multiple daily injections (MDI)?

*Emma Day, Clinical Nurse Specialist  
(Paediatric Diabetes), Birmingham  
Children's Hospital, Birmingham*

**A** In our centre we do not currently use MDI on diagnosis, but have done in years gone by. My response would be the same as for any insulin initialisation on diagnosis: dose should be based on weight and age.

Calculate the total daily dose of insulin in accordance with age and body weight: 0.5–1 units/kg/day pre-puberty and 1–1.5 units/kg/day during puberty. Give 50% of this as basal insulin, then divide the remaining insulin between the three main meals taking into consideration the size of the meals in the child's normal eating patterns. Adjust as needed from this starting point.

*Helen Thornton,  
Clinical Nurse Specialist, Preston*

Please send any responses to the above or future questions or comments to Debbie Hicks at NOTICEBOARD, 15 Mandeville Courtyard, 142 Battersea Park Road, London, SW11 4NB (email: notice@sbcommunicationsgroup.com or fax 020 7627 1570)



### Blood glucose levels and breast-feeding

**Q** Having been in this business a good few years, and having given advice to many mums with diabetes regarding blood glucose levels and breast-feeding, I decided it was time to update the advice into structured guidelines. I am having difficulty finding any current/relevant literature. I would be interested to hear how any of you have addressed this issue, and has there been a study?

*Jo Head, Lead Clinical Nurse Specialist in Diabetes, Marlfield Cottage Diabetes Education Centre, Winchester*

**A** Unfortunately, none of my colleagues from other units have guidelines; however, some references that may be of use are described below. Davies et al (1989) reported that women with type 1 diabetes require 25–27% less insulin than their pre-pregnancy requirements. Blood glucose monitoring should be done before every feed as an indicator that the insulin doses are correct and to assess how much carbohydrate is needed. The mother may also benefit from a reduction in the dose of long-acting insulin taken to prevent nocturnal hypoglycaemia (Piercy and Williamson, 2001). Another reference that may be of use is Clay (2005). Postpartum, we recommend a reduction of 15% of the pre-pregnancy insulin dose and advise women to increase their carbohydrate intake. To avoid hypos they are encouraged to do blood glucose testing prior to a feed and advised they may need a snack during some feeds if blood glucose levels are low.

*Jane O'Brien, Diabetes Specialist Midwife, Stockport*

Clay T (2005) Colostrum harvesting and type 1 diabetes. *Journal of Diabetes Nursing* 9(3): 111–6

Davies HA, Clark JD, Dalton KJ, Edwards OM (1989) Insulin requirements of diabetic women who breast feed. *British Medical Journal* 298(6684): 1357–8

Piercy CN, Williamson C (2001) Medical disorders in pregnancy. In: Chamberlain G and Steer P (eds) *Turnbull's Obstetrics*, Third Edition. Churchill Livingstone, Oxford

**A** I am not aware of any studies recommending an optimum blood glucose level for breast-feeding with diabetes, but there are a number of studies suggesting how potential difficulties in establishing breast-feeding can be minimised. Poorly controlled diabetes is often associated with delays in milk production and interference with 'let down' reflex. In general, tight metabolic control, particularly the avoidance of hypoglycaemia, is recommended (Hartman and Creegan, 2001; Walker, 2002; Abayomi et al, 2005). At our centre we recommend a further reduction of insulin dose postpartum (approximately 20%) and encourage women to increase their carbohydrate intake by 50–60 g per day. Carbohydrate snacks are encouraged prior to each breast-feed or expression of breast milk. Women are advised to aim for blood glucose levels of 4–7 mmol/l pre-meal and <9 mmol/l 2 hours post-meal (as for all non-pregnant individuals). If blood glucose levels are on the lower side of normal, prior to a feed we recommend a carbohydrate snack to prevent a 'hypo' during the feed.

*Julie Abayomi, Specialist Dietitian, Liverpool Women's Hospital, Liverpool*

Abayomi J, Morrison G, McFadden K et al (2005) Can CSII assist women with type 1 diabetes in breastfeeding? *Journal of Diabetes Nursing* 9(9): 346–51

Hartman P, Creegan M (2001) Lactogenesis and the effects of insulin-dependent diabetes mellitus and prematurity. *Journal of Nutrition* 131(11): 3016S–20S

Walker M (ed; 2002) *Core curriculum for lactation consultant practice*. Jones and Bartlett, London.

**A** In our trust (Pennine Acute NHS Hospitals Trust, Lancashire), we have used the World Health Organization (WHO)'s review of the literature (WHO, 1997) and additional resources such as Cornblath et al (2000) to put together evidence-based guidelines. The guidelines direct early feeding (within an hour of birth for babies of mothers with type 1 diabetes or type 2 diabetes requiring insulin) with 3-hourly feeding being encouraged for the first 24 hours of life. Keep the baby warm and enable prolonged skin-to-skin mother and baby contact. The first blood glucose test is performed at 4 hours post-birth to allow for physiological adaptation of the newborn following birth.

We encourage mums with diabetes to hand-express colostrum from 36–37 weeks' gestation to stimulate an increased production of colostrum before birth. Mum can bring her frozen colostrum in with her, which can then be used in response to a low blood glucose or delayed feeding. Colostrum is a fantastic substance for bringing blood glucose levels up rapidly as it has a ketogenic response enabling the baby to release alternative brain fuels (free-floating lactates and ketone bodies). It is important that we encourage and support mums with diabetes to breast-feed as there is evidence that exclusive breast-feeding for 6 months reduces a baby's risk of infections and allergies (inclusive of mothers with type 1 and type 2 diabetes).

*Val Finigan, Infant Feeding Coordinator, International Board Certified Lactation Consultant, Lancashire*

Cornblath M, Hawdon JM, Williams AF et al (2000) Controversies regarding definition of neonatal hypoglycemia: suggested operational thresholds. *Pediatrics* 105(5): 1141–5

World Health Organization (WHO; 1997) *Hypoglycaemia of the Newborn: Review of the literature*. WHO, Geneva