

Meeting report

The 10th Symposium on Diabetes Care

Nottingham, UK, 28–29 March 2007. The event was sponsored by Novo Nordisk

Do women bear the brunt of diabetes?

'The impact of diabetes on women and girls is different from that on men and boys and it is by identifying these differences that should help us to improve the care they receive,' said Anne Dornhorst, Consultant Physician, Hammersmith Hospital, London.

Both biological (for example physical, psychological and emotional) and societal (such as family roles, responsibilities and life expectations) differences play a huge role on the impact of the condition at all stages of life.

In one example of the physical effects of diabetes, the CEMACH (Confidential Enquiry into Maternal and Child Health) report of 2005 demonstrated that perinatal mortality in those women with diabetes remains 2–5 times more frequent than in pregnancies not complicated by the condition. Increasingly, it is maternal type 2 diabetes which complicates pregnancy; its outcomes are very similar to those seen in mothers with type 1

diabetes.

Interventions proven to improve pregnancy outcomes, such as tight glycaemic control in early pregnancy and supplementary folic acid, are often not being utilised. Therefore, better planning of pregnancy, pre-pregnancy counselling and peri-conception support could already achieve improvements in outcomes. Achieving these goals is a challenge for both women with diabetes and health care systems.

As for the more societal effects of diabetes, the diagnosis of type 1 diabetes among children most often leads to the mother changing her lifestyle to accommodate the care needs of the child. 'In this way', explained Dr Dornhorst, 'she is quite literally left "holding the baby".' Of mothers with children under 5 years of age, 52% are in employment with two-thirds of these working part time. However, it is notable that 40% of women who work part time do so on an hourly rate less than that of men.

Diabetes and driving

'Hypoglycaemic unawareness, potentially very dangerous when driving, may be more likely among certain groups,' said Ken MacLeod, Consultant Physician, Exeter.

Healthcare professionals should therefore look out for people who fit into any of the following categories: a history of severe hypoglycaemia; have a long duration of diabetes; require intensive insulin therapy; have poor hypoglycaemic awareness; have a high frequency of hypoglycaemia; require strict glycaemic control.

A US study showed that while driving performance

was not disrupted by mild hypoglycemia nor after recovery from moderate hypoglycemia, moderate hypoglycemia itself disrupted steering, causing significantly more swerving and spinning.

Moderate hypoglycaemia also resulted in an apparent compensatory slowing.

Global driving performance decrements were observed in 35% of the participants, only 50% of whom stated that they would not drive under similar conditions.

Driving decrements were unrelated to demographic or driving history variables.

Liraglutide on the horizon

Liraglutide represents a strong pipeline drug for Novo Nordisk – a once-daily, injectable GLP-1 analogue which, according to Jacob Sten Peterson, (a researcher for Novo Nordisk), lowers HbA_{1c} as well as reducing body weight among people with type 2 diabetes. Phase IIb data demonstrates that liraglutide provides both fasting and postprandial blood glucose control with the improvements in HbA_{1c}

being associated with neither major nor minor hypoglycaemic events.

A recent randomised controlled trial demonstrated a 1.7% reduction in HbA_{1c} after 14 weeks of monotherapy compared with placebo. In addition, nearly 50% of liraglutide-treated participants reached ADA target levels for HbA_{1c}. Liraglutide is associated with a low risk of nausea, with the frequency of side effects decreasing over time.