# Meeting highlights: 13th Scottish Conference of the PCDS

**The 13th Scottish Conference of the PCDS was held virtually on 20th October 2020. With presentations on topics including diet and physical activity, medicines optimisation and mental health, the conference addressed the issues that impact the most on day-to-day diabetes care in Scotland. While over 200 primary healthcare professionals attended on the day, many more have since accessed the on-demand sessions online. In this article we provide a brief overview of the key learning points from each of the sessions and masterclasses; however, we encourage readers to attend the on-demand sessions in their own time: click here to access.**

## Complications of diabetes: The unknown unknowns

**Kevin Fernando, GPwSI in diabetes and education, North Berwick**

- **Addison's disease** (primary adrenal insufficiency): although rare (1:10 000), this is 10 times more common in people with type 1 diabetes.
  - Anyone with type 1 diabetes presenting with unexplained hypoglycaemia or diabetic ketoacidosis should raise suspicion for Addison's disease.
  - An unexplained reduction in total insulin dose of >15–20% (due to frequent hypoglycaemia) should raise suspicion.
  - Abnormal pigmentation also warrants further investigation.

**Resource**
www.addisonsdisease.org.uk

- **Diabetic eye disease:** An individual with diabetes complaining of acute or subacute onset of blurred vision, floaters or field loss should **always** be taken seriously and be considered for urgent referral.
  - Diabetic kidney disease often goes hand in hand with diabetic retinopathy: look for other causes of kidney disease if no retinopathy is present.
  - Retinopathy is strongly predictive of cardiac autonomic neuropathy: look for signs and symptoms of this in people with significant retinopathy.
- **Periodontitis:** this is now included as a potential risk factor for cardiovascular disease. Tooth brushing and professional cleaning are associated with reductions in cardiovascular events over 10 years.
  - Compared with conventional treatment, intensive periodontal treatment reduced $HbA_{1c}$ by 6.6 mmol/mol (0.6%) over 12 months.

## Diabetes and physical activity: Is sitting the new smoking?

**Jason Gill, Professor of Cardiometabolic Health, University of Glasgow**

- Sitting is **NOT** the new smoking!
- Undertaking more physical activity at any intensity is associated with a range of health benefits, including lower risk of mortality and type 2 diabetes, and improved glucose control. However, sitting in itself simply represents one end of the activity spectrum, rather than a special case.
- Intervention data suggest that reducing sedentary behaviour sufficiently to change health outcomes may be harder than simply increasing physical activity.
- Moving, rather than stationary standing, is the minimum increment over sitting likely to induce a substantial metabolic benefit.
- Accumulating activity throughout the day is one approach to be more active that provides metabolic benefits.
- Having a separate focus on sedentary behaviour unnecessarily complicates messaging for changing activity behaviours and can lead to suboptimal "solutions" (e.g. standing desks).
- A simple message to move more, more often, rather than the dual message of reducing sitting time and increasing physical activity, is conceptually more straightforward and more consistent with the evidence base.

## Severe mental illness and diabetes

**Zoe Sherwood, Inpatient Diabetes Specialist Nurse, Birmingham and Solihull Mental Health NHS Foundation Trust**

- We need to develop a strong working link between primary care and Mental Health Trusts; after the initial set-up, it will save time and money and, more importantly, improve patient health outcomes.
  - Examples of benefits include no more duplication of tests, increased holistic care and closer healthcare professional support networks. It is possible for Mental Health Trusts to have a regular outpatient clinic at primary care facilities, enabling mental health support in primary care and adding physical health support to mental health services.
- Gold-standard is only gold-standard if suitable for the individual. Sometimes a "thinking outside the box" standard will be more likely to work.
- For people with severe mental illness, medications that require three- or four-times-daily administration are least likely to be successful. Once per day is preferential, twice per day at most.
  - "On waking" may mean lunchtime for these individuals, with no breakfast and a late meal – would that alter your treatment plan?

- Foot care is often extremely neglected, as is access to retinal screening appointments. Do they need additional support to access rather than being declared non-attending?
- I recommend taking a Mental Health First Aid course. This 2-day course is the mental health equivalent of first aid at work. It would be an excellent addition to your CPD and a valuable course.

## Masterclass: Deconstructing dietetic advice

**Jessica Fletcher, Diabetes Specialist Dietitian, NHS Highland, Argyll and Bute HSCP**

- One size does not fit all when it comes to the dietary management, or prevention, of type 2 diabetes.
- Refer to evidence-based guidelines, such as NICE, SIGN and Diabetes UK Nutritional Guidelines, when discussing diet with patients.
- Weight management is the cornerstone of type 2 diabetes prevention and management in those living with overweight or obesity. Even a 5% weight loss can significantly reduce the risk of developing type 2 diabetes.
- Practise in a way which is person-centred and encourage patients to move slowly towards their goals whilst being sensitive to stigma and discrimination.
- Discourage patients from following fad diets or "quick fixes". Unfortunately, there is a lot of misinformation out there and change does not happen overnight.
- Seek guidance from, or refer to, your local dietetic teams. There are a lot of changes and enhancements going on across Scotland in services for those living with, or at risk of developing, type 2 diabetes as a result of the type 2 diabetes prevention framework.

## Masterclass: Hitting a nerve: Neuropathy in diabetes

**Paul Newman, GP, Glasgow**

- Good glycaemic control prevents and delays the progression of neuropathic complications.
- **Distal symmetrical polyneuropathy (DSPN)** is the most common form of diabetic neuropathy. Neuropathic pain (burning) is often the first symptom. Hyperalgesia may be present. Prevention is the main focus.
- **Cardiac autonomic neuropathy (CAN)** leads to increased mortality and morbidity. Advise physical activity to avoid deconditioning. Volume repletion with fluids and salt is the mainstay of treatment; low-dose fludrocortisone and midodrine may also be beneficial.
- **Erectile dysfunction** is very common and is due to nerve and endothelial damage. However, there is a poorer response to sildenafil-type drugs in diabetes due to neuropathy.
- For **diabetes-related diarrhoea**, codeine phosphate is generally the most effective drug.
- For **gastroparesis** (signs include erratic glucose control, bloating and unexplained vomiting), treatments include metoclopramide, domperidone and erythromycin (although there is weak evidence for the latter).
- **Painful neuropathy** is under-reported and undertreated. Amitriptyline, pregabalin, duloxetine and tramadol can be prescribed.

## Masterclass: What next after metformin?

**Nicki Milne, Community Diabetes Specialist Nurse, Manchester**

- Think of the individual's personal characteristics: current lifestyle, clinical characteristics, comorbidities, motivation and emotional health, cultural and socioeconomic circumstances.
- Individualise: consider appropriate $HbA_{1c}$ target; medication's side effects, ease of use and impact on weight, hypoglycaemia and diabetes-related complications.
- Share decision-making: inform and educate the person and consider their preferences; effective consultations involve motivational interviewing and goal-setting.
- Use resources (see box below).
- Ensure timely review: at least once/twice per year, and at least every 3 months if goals are not being met.
- Review medications for efficacy, and stop those that are ineffective.

### Resources

- ADA/EASD consensus report
- How to use SGLT2 inhibitors safely and effectively
- How to use GLP-1 receptor agonist therapy safely and effectively
- What next after metformin? (a GPnotebook Shortcut)