Cardio DIGEST

Editorial

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Cardio Digest: a progression towards the inevitable

With the undeniable relationship between diabetes and cardiovascular disease, it seems only right that from out of a journal such as Diabetes Digest should evolve the new Cardio Digest. I was delighted when David Kerr, editor of Diabetes Digest, invited me to take on the editorship of Cardio Digest. Our aim is to create a publication that is relevant to all healthcare professionals interested in the areas of diabetes and cardiovascular disease and that focuses on the most important aspects of both.

In this, my first editorial, I would like to focus on type 2 diabetes which has reached epidemic proportions, and continues to increase inexorably. As the major cause of mortality in the type 2 diabetic patient is coronary heart disease (CHD), this too continues to increase. The long awaited announcement of the implementation strategy of the National Service Framework for diabetes, together with the recent introduction of a variety of guidelines such as the inherited guidelines from NICE on the treatment of hypertension and hyperlipidaemia in patients with type 2 diabetes, should assist in the primary and secondary prevention of CHD in this large group of patients. In order to reduce the number of type 2 diabetic patients, strategies should also be utilised to prevent the progression of high risk groups from developing type 2 diabetes.

Perhaps the practice of clinicians should return to its roots by considering lifestyle implications for both development of type 2 diabetes and CHD. Despite the widely opposing views previously held in terms of diet, Professor Mann provides an excellent review on the current evidence for promoters and retarders of both CHD and type 2 diabetes (*see my commentary on page 66*). A clear evaluation of the available data is presented and demonstrates the necessity for reduction of weight and saturated fat intake, with an increase in the unsaturated components and the intake of unrefined carbohydrate and fibre. Emphasis is also placed on the Finnish and USA Diabetes Prevention Trials, both of which demonstrated a marked reduction of progression of impaired glucose tolerance to overt diabetes mellitus by modifications of diet and exercise. Clearly such lifestyle altering programmes need to be undertaken on large scale in order to reduce the numbers of patients with type 1 diabetes and CHD. It would be a remarkable achievement if the National Service Framework for either type 2 diabetes or CHD would deliver this.

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In the meantime it is necessary for all clinicians to aggressively treat hypertension and hyperlipidaemia. Controversies regarding treatment targets for both continue. In terms of hypertension the definition and treatment targets are becoming clearer, though the recent NICE guidelines have made the task considerably more difficult and complicated. Likewise, the indications for and treatment targets of treatment with hypolipidaemic agents have become confused on grounds mainly of recent data from large scale published randomised trials.

Where are we now then? Numerous reports indicate poverty of appropriate treatment for both hypertension and hyperlipidaemia, particularly in patients with diabetes mellitus. Consequently, simplicity of definitions, indications for treatment and treatment targets are required. Perhaps the various separate, august bodies should sit together with the hopeful aim of achieving consensus. Until that utopian target is achieved, we should aim to fulfil the more simple guidelines in order to stem the epidemic of CHD in type 2 diabetes.