Diabetes and the crimes of Procrustes

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Everyone needs to be shoehorned in to a box these days. You can't just be poorly, you need to have a "non-specific viral illness". The requirements of the all-powerful Quality and Outcomes Framework have made it a necessity for everything to be coded, and for diabetes it is no different.

If you've got diabetes it has to be coded as type 1 or type 2. But, as anyone dealing with large numbers of people with diabetes knows, it is not that simple. With screening and increased awareness, we often pick people up in the very early stages of a progressive condition, and it is not always people with type 2 diabetes that get detected but also those with type 1 – not all of whom obey the textbook and go into crashing diabetic ketoacidosis over a weekend. Some, and it is more that a few, can drag on for weeks with symptoms of hyperglycaemia before the penny drops.

We're all becoming familiar with maturity onset diabetes of the young (MODY) now, and it shouldn't be too hard to consider patients who have the more serious transcription factor MODY, as they are not just significantly hyperglycaemic but have a very strong family history. For those with the most common type, MODY 3, being diagnosed correctly can make a tremendous difference to their lives, as testified by this headline in my local paper:

> **DIABETES MUM CAN BIN THE NEEDLE NOW** – *A diabetic mother who has had to inject herself with insulin every day for ten years has now swapped the syringe for a simple tablet* (Telegraph & Argus, 2005).

People with glucokinase MODY can be a whole lot harder to diagnose because of their mild presentations, and they are often misdiagnosed as having type 2 diabetes. However, it is important to pick them up – if only to reassure them of the very low risk of complications.

When older people get diabetes it is obviously type 2 … err, no! An increasing number of people are being detected with latent autoimmune diabetes of adults (LADA). This is essentially type 1 diabetes presenting in older people and this should be suspected in those who do not respond well to oral agents and have a personal or family history of an autoimmune disease – for instance hypothyroidism, or a mother with type 1 diabetes.

Sometimes we just have to be suspicious. We know that people on long-term steroids are more likely than others to develop diabetes, but we should also check people on long-term thiazide diuretics or phenytoin. We've all heard about the doctor who got free drinks for life by diagnosing acromegaly in a publican. He also probably had diabetes, but some chronic alcoholics with pancreatitis also develop diabetes, and they may not be so generous! We also need to check that girls with polycystic ovary syndrome have regular checks for diabetes. And surely no one could forget the young guys with dark skin and big livers who used to be dragged out for medical school and postgraduate exams (those with what is known colloquially as bronze diabetes).

"And what's this Procrustes guy got to do with diabetes?", I hear you ask. Well, he was an ancient Greek with a macabre hobby. Procrustes owned an iron bed on which he invited every passerby to lie. If the guest proved too tall, he would amputate the excess length; short victims were stretched on the bed until they were long enough. Nobody ever fit in the bed because it was secretly adjustable. The moral is that one size doesn't fit all in life, nor in diabetes. The following piece by Simon Page tells all. ■

Telegraph & Argus (2005, May 30) *Diabetes mum can bin the needle now.* Newsquest Media Group, Bradford