Insulin Dependent Diabetes Trust

July 2007 Newsletter

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Do Not Believe The Rumous!

- Pork insulin ***WILL*** continue to be available after the end of 2007.
- It is only Novo Nordisk that has chosen to discontinue pork insulin.
- IDDT has received an incredible number of calls from worried people who have been misinformed by doctors and health professionals and told that there will be no animal insulins after the end of 2007. This is NOT true.
- Wockhardt UK [CP Pharmaceuticals] pork insulin will continue to be available in vials and cartridges with a normal NHS prescription.

This chart shows Wockhardt equivalent pork insulins:

Wockhardt Pork insulin	Novo Nordisk Pork insulin
Hypurin Porcine Neutral	Pork Actrapid
Hypurin Porcine Isophane	Pork Insulatard
Hypurin Porcine 30/70 Mix	Pork Mixtard

Pork Insulin Continues - The Message Needs Emphasising!

As editor of the Newsletter I decided to use the front page of this Newsletter to try to dispel rumours or misguided assumptions that are

flying around about the future availability of pork insulin.

IDDT is receiving calls from people who are very concerned because they have been informed, or more accurately, misinformed, about the future of pork insulin. They are being told by health professionals that pork insulin will not be available after the end of 2007 and one of our members reported seeing a poster in his hospital clinic saying exactly this. This is simply not true!

- Only Novo Nordisk has chosen to discontinue their pork insulins.
- Wockhardt UK is continuing to supply pork [and beef] insulin in both vials and cartridges.
- There no need for anyone to have to change from pork insulin to synthetic 'human' or analogue insulins - it is simply a matter of changing the brand of pork insulin not the type [species] of insulin. The front page gives details of the Wockhardt insulins that are the equivalent to the Novo Nordisk ones that are being discontinued.

At our meeting with the Dept of Health last year we predicted that misinformation about would be rife once Novo Nordisk announced the discontinuation of their pork and it is! We requested that safeguards were put into place so that patients received the correct information and were not having to face the worry of changing to synthetic human or analogue insulins, especially important for people who have already experienced adverse reactions to synthetic insulins. Clearly whatever safeguards were put into place have not worked very well, but we did try!

Another Warning!
This change to Wockhardt Hypurin Porcine insulins has the advantage that for the first time, pork insulin users have the choice of using a pen. However, another error that is happening, is that prescriptions are being issued for the wrong pen. The pen that is required for pork insulin is an Autopen Classic and NOT an Autopen 24 which is for use with Lantus only.

Commercial Decisions Can Harm People

By Jenny Hirst

The insulin manufacturers make no secret of the fact that the discontinuation of animal insulins is a commercial decision - it is based on profit not patient need. Perhaps understandable from the drug companies' perspective but their commercial decisions can, and sometimes do, cause harm. Recently the reality of the commercial decisions to discontinue animal insulins truly came home to me when I was contacted by a diabetes nurse specialist working in a US hospital.

The nurse is looking after a lady with Type 1 diabetes who is allergic to GM synthetic insulins - she went into a diabetic coma and almost died, so it is vital that she is treated with pork insulin. The lady is on a low income so the hospital managed to obtain $2000 from an emergency fund to purchase a 4 month supply of pork insulin from the UK but the fund is now gone and all other avenues have been exhausted. The nurse's question was:

"Do you have any ideas how we could go about getting this lady affordable pork insulin. Her life truly is depending on it."

IDDT told her of other countries where pork insulin is available and at a lower cost than importing from the UK, but even this is unaffordable. The lady will probably die, indeed, she may even have died by the time you receive this Newsletter. I am sure that you will find this as sad and unacceptable as I do. This lady's life is under threat as a direct result of the pharmaceutical companies' commercial decisions. But let's not forget, companies are run by people but clearly by people who have very different views from many of us - I like to sleep in bed at night.

Commercial pressures make insulin unaffordable in China
Commercial decisions can also harm thousands, if not millions of lives. When we reported that Novo Nordisk had made a large investment in a GM insulin producing plant in China, we wondered the effect this

would have on people with diabetes in China.

Anecdotally we now hear that it is much the same as other countries where there are many poor people. Adults and children have been using locally produced pork insulin made by Wanbang Biochemical at a cost of only RMB10 per 10ml vial - just over 1US dollar. But now they are being switched to human insulin in cartridges for pens which costs around RMB69 made by both Novo Nordisk and Lilly. In addition there is RMB360 per month for needles and strips - doctors recommend testing 3 times a day. The total monthly income for poor farmers living in the countryside is between RMB 100-300 and even city dwellers on average or below average incomes have difficulty affording these costs.

Once again animal insulin is vital because it is affordable and for this reason alone many, many lives are saved. The fear is that the pressures to adopt foreign GM insulins will increase and the much cheaper locally produced animal insulins will disappear and lives will be lost.

By the way, the reasons being given for the switch to human insulins are that the pork insulin is not stable and the body rejects the pork insulin after 1 or 2 years - presumably this wasn't happening before human insulin appeared on the Chinese market! All very similar to the stories we were told in the 80s in the UK...

IDDT's Annual Meeting - just a reminder
Our 2007 Conference will take place on Saturday October 13th 2007 and we hope that many of you will join us. As usual it will be at the Paragon Hotel in Birmingham and if you would like further details, please contact Bev Freeman at IDDT on 01604 622837 or e-mail bev@iddtinternational.org

What The Papers Say

"Coming soon: the shopping channel run by drug firms"
The Guardian, May 21, 2007 by Sarah Boseley
Sarah Boseley reports that four of the world's largest drug companies are proposing to launch a TV station to tell the general public about their drugs. It appears that 'The European Patient Information Channel' as industry is calling it, would be a dedicated interactive digital channel that could also be available on the internet. It will be funded by the industry with health news and features but, at its heart, would be detailed information from drug companies about their medicines. In other words, advertising of their drugs thinly disguised as information! The Guardian has already seen a 10 minute pilot DVD!

As we have reported many times before, the pharmaceutical industry have been lobbying hard to bring about changes in the EU regulations to remove the ban on direct-to-consumer-advertising [DTCA] of medicines - a ban aimed at protecting the public. They failed to have this ban removed a couple of years so now they want 'direct-to-consumer-information' - in other words, advertising their products under a different, and perhaps more impressive, name. Industry argues that allowing advertising would increase their competitiveness and has hinted that companies would relocate to the US if they do not get their way. The US allows DTCA and drug company profits have soared.

The EU is consulting on these potential changes as we write with the case for lifting the restrictions being led by the trade arm of the EU Commission, DG Enterprise and notably not by the health arm, DG Sanco. This demonstrates that the trading aspects ie sales and profits, are driving this proposed change and not the health aspects ie concerns for protection of the public from misleading information, over exaggeration of benefits and playing down possible adverse reactions to drugs.

According to the Guardian, the Pharma TV channel is backed by a number of influential patient groups that are themselves heavily

funded by drug companies but consumer organisations are strongly opposed. [Not sure how the EU defines the difference is between patient groups and consumer groups.]

It is very disturbing that patients' groups are backing the whole idea of industry providing information direct to patients and even more disturbing that the European Patients' Forum approved of the Pharma TV channel! It is equally disturbing that the European Commission only allowed two patients' groups on to the working party set up to discuss the changes in the rules. Sorry to be cynical yet again, but how were these two groups chosen and are they both heavily funded by industry?

The International Society of Drug Bulletins [ISDB] which produces consumer publications that analyse drugs and draw comparisons between them, warns that the industry is not a reliable source of trustworthy information. The US and New Zealand allow drug companies to advertise to the public and the ISDB says in both these countries this has been shown to be detrimental to health.

Pulling together

The prospect of a TV channel run by the pharmaceutical industry and self-regulated is a frightening prospect. There will be:

- more people taking more drugs
- more people taking unnecessary drugs for conditions that will go away without drug treatment
- more people making demands on their doctors for specific drugs that may not be appropriate
- more people receiving biased information and not the full picture
- greater expenditure on drugs from the public or the private purse.

The list is almost endless and surely cannot be in anyone's best interest, other than the pharmaceutical industry. It has to be the time for patients, the public, the medical profession and all the allied health professions to pull together to prevent any changes in the existing regulations.

Where There's a Will There's A Way

People with diabetes are finding ways to obtain the animal insulins they need

Canada - further to the news in the April 2007 that many of the provinces in Canada have authorised coverage of Hypurin Porcine insulins, we are pleased that the Ontario Drugs Program will also now authorise reimbursment of Hypurin on an 'Exceptional Access Basis'. People in Ontario who qualify for Ontario Drug Benefits will have Hypurin reimbursed at the pharmacy level providing their doctor requests coverage based on their intolerance to synthetic insulin. People in Alberta and Manitoba are still waiting for formal approval.

Switzerland - the patient group, Forum Insulin Switzerland (FIS) which is affiliated to IDDT has now organised approval to import Semilente from Polfa in Poland.

Germany - people in Germany are now regularly receiving pork insulin made in Argentina and the comments are that it is wonderful to have good, clean pork insulin again.

Australia - Hypurin Porcine Neutral and Hypurin Porcine Isophane insulins are now available through the Special Access Scheme from Aspen Pharmacare based in Australia and so no longer have to be imported from the UK.

For further information about obtaining animal insulin contact Jenny at IDDT in the UK, Tel +44 (0)1604 622837 or email jenny@iddtinternational.org

Sorry For The Errors!

- On page 4 of the April Newsletter the header was 'Mascular Degeneration' when it should have read 'Macular Degeneration'!
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- On page 11 the calculation for Body Mass Index should have read weight in kilograms divided by the square of your height in metres! (Remember: 1cm = 0.39 in, 1kg = 0.15 stones)

Avendia [Rosiglitazone] and Heart Attack Risk

Avandia [rosiglitazone] made by GlaxoSmithKlein is one of the biggest selling drugs for Type 2 diabetes but a review published in the New England Journal of Medicine [May 2007] hit the headlines around the world.

The review, by leading cardiologist Dr Steven Nissen, evaluated 42 studies that compared patients taking Avandia with patients not using the drug which included almost 28,000 patients, 15,560 of whom were taking Avandia. The findings suggest that people on Avandia have a 43% higher chance of suffering a heart attack and a 64% greater risk of death from cardiovascular causes such as heart attack and stroke. Risk figures are always difficult to understand and it is easier to look at the actual figures:

- Among patients taking Avandia, 86 had heart attacks compared with 72 patients not on the drug.
- 39 patients taking Avandia died from cardiovascular causes compared with 22 not receiving the drug.

The general view is that the risk is small but people with Type 2 diabetes are already twice as likely to suffer heart disease and stroke than the general population so if a drug to treat diabetes itself increases the risk, then it is a serious issue.

The one piece of advice that is clear from all organisations is: If you are taking Avandia, then you should not stop taking it but if you have concerns, you should discuss these with your doctor.

Reactions
There are various reactions which highlight the uncertainties associated with Avandia and leave both doctors and patients in a quandary...

GlaxoSmithKlein fairly predictably, "strongly disagrees" with the conclusions of the meta-analysis. But they did carry out their own meta-analyses - one in September 2005 and a second August 2006 and both showed a potential danger but a lower risk of 30% compared to Nissen's 43%. This information was passed to the FDA [drug regulatory authority in the US].

The FDA say that they are still working on the analysis but American politicians have now become concerned at the time this is taking.

Leading physicians in the US seem divided about whether patients should stop taking Avandia.

Prof David Nathan at Harvard University said: *"Patients and physicians need to take this seriously, in the absence of other data."* While calling the Nissen analysis *"imperfectly done,"* he also said *"Since heart disease is the major killer of people with diabetes, it's hard to imagine why you would use a drug that might increase the risk of heart disease."*

John Buse, president-elect of the American Diabetes Association said he's not sure the findings are strong enough to encourage wholesale switching from Avandia but others are calling for the FDA to restrict access to Avandia.

The American Diabetes Association says: *this study deserves*

serious thought and follow-up. The overall level of risk associated with rosiglitazone [Avandia] appears to be small, but nonetheless one that must be considered carefully.

Diabetes UK says: *"Diabetes UK does not believe that these findings are cause for alarm. Glitazones are not presently recommended for people who have had, or who are at high risk of having, heart failure. We welcome research into the effects of rosiglitazone - however, this study, by its own admission, has limitations and the results are not conclusive. Any suggested link into an increased risk of stroke and death from cardiovascular complications for people taking rosiglitazone needs much more research. The Medicines and Healthcare products Regulatory Authority [MHRA] states that rosiglitazone is a safe and effective treatment for those with Type 2 diabetes".*

But this is not what the MHRA said on May 23 2007: *"Warnings about this risk [of heart problems] have been present in the product information since 2000. …In September 2006, following a comprehensive review within Europe of the available data from clinical trials, the product information was updated to reflect more fully the risk of heart failure and to include a warning about the potential small increased risk of myocardial infarction in patients receiving roiglitazone compared to those receiving placebo [dummy pill]."*

NICE Guidance on the glitazones, the family of drugs to which Avandia belongs, even in 2003 made recommendations for further research to include [i] the long-term impact on cardiovascular risks and [ii] the incidence of micro- and macrovascular diabetic complications.

The Lancet says the results raise a signal of concern and indicate the need for more reliable information about Avandia's safety.

So what should people do?
This is one occasion when we're glad it's not IDDT's role to offer advice. We can only provide readers with the information that there are uncertainties about the safety of Avandia and uncertainty amongst doctors about whether people should continue to use it. At this stage, the best we can offer is to discuss your options with your doctor.

And more...

Warning that Avandia may cause increased risk of bone fractures
In March 2007 GlaxoSmithKline [GSK] issued a warning to women and doctors of an increased risk of bone fractures when taking Type 2 diabetes medications containing rosiglitazone - sold under the names of Avandia, Avandamet and Avandaryl. The warning came after GSK reviewed the Diabetes Outcome and Progression Trial [ADOPT] in which 4,360 people with Type 2 diabetes were followed for 4 - 6 years to compare rosiglitazone medications to metformin and glyburide [sulphonylurea] on their own.

The trial discovered a pattern of fractures in women taking rosiglitazone which occurred in the upper arm, hands and feet. These are not places where osteoporosis in postmenopausal women is commonly seen - it is usually in the hip or spine. Men in the study taking the three types of rosiglitazone did not show a difference in fracture rates. In the US people using any of these medications are being advised to report fractures as an adverse reaction.

And even more...

Prevention of Type 2 with Avandia - change of heart
Last year a major breakthrough was hailed when a large study called "DREAM" [Lancet Sept 2006] reported that Avandia appeared to prevent Type 2 diabetes in 60% of a group of people at high risk of developing it. But a follow-up study has shown that when people stopped taking Avandia, they began to develop diabetes at the same rate as people in the study who had been given a placebo rather than a real drug.

The British Medical Journal [27 April 2007] suggests that the results of DREAM should not be adopted in the real life situation. The authors dispute the wisdom of putting lots of people on a costly drug to prevent some of them from developing Type 2 diabetes - especially when

increasing exercise and improving diet lowers the risk of diabetes to the same degree! The lead author states: *"If I do nothing, 25% of high-risk people will eventually need a drug. And instead of letting them find out who that 25% is, I give it to 100% of my patients. No obvious benefit. Clear waste of societal resources. And a distraction from a clear message of lifestyle changes."*

When looking at prevention, it is important to consider the side effects of the drug being used. Avandia has side-effects in some people - weight gain, fluid retention, a raised risk of heart failure, bone loss and bone fractures and macular oedema [fluid retention in the eye].

Avandia doesn't seem to have a lot going for it right now!

Carpel Tunnel Not Caused by Repetitive Hand Movement

Carpel tunnel syndrome is more common in people with diabetes than the average population. The carpel tunnel is a narrow, rigid passage of ligament and bones at the base of the hand that contains tendons and the median nerve, which runs from the forearm to the hand. If there is thickening of irritated tendons or other swelling the tunnel narrows and the median nerve is compressed causing symptoms.

Symptoms
These often start gradually at night during sleep with burning, tingling or itching in the palm of the hand and fingers, especially the thumb and first two fingers and this can progress to daytime pain, weakness or numbness in the hand and wrist that may extend up the arm.

Causes
It is thought to be a combination of factors that put pressure on the nerve and tendons, rather than a problem with the median nerve itself. The most likely cause is congenital with some people just having a narrower tunnel but other common factors are injury to the wrist, over-activity of the pituitary gland, rheumatoid arthritis, and fluid retention.

It has been suggested that repetitive hand use eg typing, is a possible cause but this was not based on scientific evidence.

New research
Recent research has found that genetics, rather than repetitive hand use, is responsible for carpal tunnel syndrome. [American Academy of Orthopaedic Surgeons annual meeting: February 20, 2007]

However, according to the researchers genetics do not provide the whole answer.

Age, genetics, obesity, diabetes, thyroid, various types of hormonal conditions, even pregnancy are predisposing factors but there are external factors that will bring on the symptoms. So the researchers suggest that a person may have a genetic or multi-factorial predisposition to carpel tunnel syndrome but something may cause the symptoms to develop. In other words, people who use their hands continuously and laboriously don't get carpel tunnel more frequently eg construction workers don't get it any more frequently and nor do court reporters who don't stop using their hands all day for hours on end.

The study authors suggest that these findings may affect disability, workers' compensation and personal-injury claims.

Neuropathy and Antiderpessants

IDDT has had quite a lot of queries from people who have neuropathy [damage to nerves] and are being treated with antidepressants and they find this difficult to understand. The reason for prescribing

antidepressants for neuropathy is based on the suggestion that it might inhibit the pain pathways in the central nervous system. [Drugs and Therapeutics Bulletin April 2007].

When a simple painkiller such as paracetamol is ineffective in treating painful neuropathy, the next treatment is with what is known as a tricyclic antidepressant such as amitryptyline. Other options are available including duloxetine [sold as Cymbalta and Yentreve] which has been specifically approved for peripheral neuropathic pain. It is recommended that its use is assessed 2 months after starting treatment and then 3 monthly. The trials carried out with duloxetine showed that there was a significant reduction in pain when compared to a placebo [dummy pill].

Just a reminder about looking after your feet to try to prevent neuropathy

- Wash the feet daily with mild soap in water that is warm but not hot.
- Test water temperature with a thermometer or elbow to be sure it is not too hot.
- Although the feet should be washed daily, avoid soaking them.
- Dry the feet well, especially between toes, by patting them with a towel, not rubbing.
- Use talcum powder or cornstarch to help keep the feet dry.
- Apply a moisturiser but avoid use of lotion between the toes, where moisture forms.
- Inspect the feet daily for blisters, scrapes, cuts, sores and other wounds.
- If vision is impaired, examine the feet by touch from toe to heel.
- Use a hand mirror or floor mirror to help with inspections.
- Ask a relative or carer to help if self-examination is not possible.
- Avoid harsh chemicals such as Epsom salts and iodine.
- Check with a chiropodist before treating calluses, corns and bunions.

When cutting your toenails:

- Clip the nails about once a week along the contour of the toe.
- Smooth the edges with an emery board if needed.
- Avoid cutting the corners to prevent ingrowing nails.
- Trim the nails after bathing for easier cutting.
- Avoiding nail fungus by using footwear in damp public areas such as showers and pools.

Reports

- **IDF Report - the UK does not come out of this well!**

The International Diabetes Federation surveyed people with Type 2 diabetes in Britain, France, Germany, Italy and Spain to find out whether they were aware of the risks associated with diabetes and how well they were controlling it through diet or drugs. Generally the survey found widespread ignorance about diabetes and what blood glucose levels should be achieved but also that many people had a false sense of security about how well they were doing.

The HbA1c test is used to measure control of blood glucose levels and in healthy people this is between 3.5 and 5.5% but the target levels for people with diabetes to aim for differ from country to country. The UK has the highest HbA1c target in Europe - set at 7.5 per cent, but the survey found that the UK has the lowest proportion of people achieving this level.

- In all five countries surveyed, people thought their HbA1c levels were “OK” or “a little high” even though all of them had HbA1cs higher than their country’s target.
- Generally people were not aware that their diabetes was poorly controlled and tended to treat it as ‘mild’ with a low risk of complications.
- In the UK almost 60% of people with Type 2 diabetes had not been given specific recommendations about how often they should check blood glucose levels compared with only 20% in Germany.
- There was also widespread confusion about what a good HbA1c

actually was - Spanish patients quoted an average of 7.07%, French 7.59%, German 8.08%, Italian 8.12% and British 8.41%.

In The Times [April 16th, 2007] Dr Tony O'Sullivan, the IDF's European president said:

"We are spending huge amounts of money on chronic illnesses but we aren't flexible enough to adapt to meet the needs of these people. The medical model isn't working. We have got to be more flexible and forgiving. There are a lot of people who miss appointments and simply don't go back because they think they will be criticised."

But Simon O'Neill of Diabetes UK put the responsibility firmly on the shoulders of people with diabetes when he said: "People with diabetes need to better understand the risks they face and work in partnership with their health-care professionals to better control their condition."

Here we go again - blaming the patient! Yes, people with diabetes must take some responsibility and the majority of them do but Dr O'Sullivan's approach shows much greater understanding. He recognises that the needs of people with Type 2 diabetes are not being met and a different approach is needed.

Whatever the UK is doing is not really working and it's not difficult to see where the changes should come:
Education - provide better education so that people understand not only how to manage their diabetes but the importance of managing it. The average person with diabetes gets 3 hours a year with health professionals!

Diet - why does the UK insist that the diet for people with both types of diabetes should be high carb [and low fat]? When carbohydrates are eaten, insulin is necessary to turn them into glucose to provide the energy the body needs but people with Type 2 diabetes either do not produce enough insulin, their insulin doesn't work properly or they produce it at the wrong times. So why oh why are they advised to eat high amounts of the carbs their bodies can't handle?

Reduction of medication - if people ate less carbohydrate and exercised more, some would stay off medications for longer, others would need less medication, whether tablets or insulin. This would also reduce the drugs adverse effects including hypoglycaemia for those on insulin. Reducing medications would also reduce the total cost of diabetes to the NHS or provide funding for better education!

Testing blood glucose levels - don't allow PCTs to refuse or restrict the supply of blood glucose test strips to people with Type 2 diabetes [or Type 1!]. Educate people about how and when to test, and what to do as a result of the tests.

- Picker Institute - "vulnerable patients are left hanging on"

A report by the Picker Institute [2006] for the Dept of Health has said that patients and carers were frequently pushed from person to person, or from organisation to organisation and encountered "sheer brick walls" when trying to gain information on what support is available. It warned that carers and people with diseases such as multiple sclerosis and diabetes were "left dangling" as calls went unanswered.

One study in the report found that few health information materials included a clear presentation of the likely outcomes of treatment, a discussion on clinical controversies and uncertainties or an understanding of the role of patients in decision-making.

The second study looked at how patients and carers find out about local services and how to access them.

People wanted information about:

- voluntary support groups
- support for the family or carers
- specific services for various conditions eg for people with diabetes
- Information about benefits and how to claim
- How to comment on or complain about services.

The findings were interesting and will be recognised by many of us:

- Health professionals [often the first port of call for patients] do not systematically or proactively provide their patients with information for accessing local services.
- There is a lack of co-ordination between information providers across boundaries - geographical and organisational.
- There is a lack of effective sign-posting ie plenty of information out there but people don't know how to find it.

The report called for a single point of contact in every neighbourhood where those in need could access trained staff. Health Minister, Rosie Winterton responded with "We absolutely agree that information should be proactively given to people who use the NHS." She didn't say hoe this is going to be achieved.

Healthcare commission report - check ups for people with diabetes are happening but education is lacking

The Healthcare Commission [a sort of NHS watchdog] survey of people with diabetes suggests the NHS is meeting Government standards on diabetes check-ups but people with diabetes need to be offered more help to manage their diabetes themselves. Only one in 10 people with diabetes has been on an education course. [April 2007]

Over 68,500 people responded to the survey from across England along with 1,500 GP practices and all 152 Primary Care Trusts [PCTs].

The positive findings:

- Almost all the respondents said they receive annual check-ups to assess whether their condition is under control.
- Most said they had been tested for complications in the last year which included checking blood pressure (98%), long-term blood glucose levels (91%), weight (91%), and cholesterol (89%).

The negative findings

- Only 11% of respondents had attended an education course on diabetes and how to live with the condition, yet one in four people who had not been on such a course said they wanted to attend one.
- 17% of people with diabetes did not know if they had Type 1 or Type 2 diabetes.
- More could be done to improve the care that people with diabetes received while in hospital. Of the 19% respondents who had been admitted to hospital in the last year, 68% said that all of the staff were aware they had diabetes but one in ten said that 'none' of the staff provided what they needed to manage their diabetes.
- 11% of hospital inpatients with diabetes said that they 'rarely or never' received food suitable for them and 9% that they 'rarely or never' received food at a suitable time to help them manage their diabetes.

The detailed findings of the survey have been provided to all PCTs to enable them to identify areas of improvement in the services they commission and provide for people with diabetes.

Patients Can Report Adverse Drug Reactions

You can now report any suspected adverse reactions you experience, so do use this right. You only have to suspect, not prove, that adverse effects are caused by a drug. Adverse drug reactions can occur immediately or days, weeks or even years after taking a medication.

Here's how to report any adverse reactions:

- **If you have access to the internet**: go to www.yellowcard.gov.uk and CLICK on submit a Yellow Card report. On this site you can also check the adverse reactions reports already made.

- **If you prefer to use a paper Yellow Card reporting form**: telephone the MHRA on 0207 084 2000 or e-mail patientreporting@mhra.gsi.gov.uk and ask for a form to be sent through the post.

You can also check on adverse reactions already reported by going to the same website www.yellowcard.gov.uk The information is 12 months out of date again and the analysis of the adverse reactions only includes those up to May 2006. IDDT has raised this in the past and on Jan 8 2007, Steve Webb MP asked a Parliamentary Question on our behalf. Health Minister Andy Burnham's answer was: *"The MHRA is currently implementing a major upgrade of the drug safety monitoring database and data reporting systems...Subsequent to this redesign, the MHRA will update the adverse drug reaction data on a three-monthly cycle."*

I think we've heard this before!

Also: report faulty medical equipment
The Medicines and Healthcare products Regulatory Agency (MHRA) is asking people in England to report medical equipment that has developed faults and was obtained from a GP's surgery, hospital, pharmacy or clinic. The MHRA will investigate the incidents and take the necessary action. The aim is to reduce the number of adverse incidents with medical equipment - the MHRA handles 8,500 incidents related to faulty medical equipment annually, approximately 1,500 of which result in serious injury or death.

One of the concerns of the MHRA is blood glucose meters giving out a false high readings which can lead to patients self-administering the wrong insulin dose.

Faults can be reported as follows:
Tel: Adverse Incident Hotline 0207 7084 3080 e-mail: aic@mhra.gsi.gov.uk
Website: www.mhra.gov.uk then click on 'Report medical device adverse incidents' or write to: MHRA [Devices], Market Towers, Nine Elms Lane, London SW8 5NQ

Whatever Next?

Insulin from plants?
After meetings with the FDA, SemBioSys Genetics, a biotechnology company is to continue to develop their plant-produced insulin [from the safflower]. SemBioSys believes its safflower-produced insulin can reduce capital costs by 70% and product costs by 40% or more compared to existing insulin manufacturing.

Cloned cows to produce 'human' insulin
Scientists in Argentina have created four cloned, genetically modified calves capable of producing 'human' insulin in their milk when they are adult. Once the milk is obtained from the genetically modified cow, it will be purified and refined to extract the insulin.

The company involved is predicting that other pharmaceutical products could also be produced this way because the human gene of interest is inserted into the embryo before implanting it into a surrogate mother cow. Similar techniques have already been used to produce human proteins in goats and cows.

This company maintains that producing insulin this way will be 30% cheaper and that just 25 insulin-producing cows would be enough to supply the 1.5 million people with diabetes in Argentina.

Jenny's comments: all this sounds a bit like science fiction and somehow makes me feel uncomfortable. But then 30 years ago who would have thought that the majority of people with diabetes would be using so-called 'human' insulin made from bacteria? We were promised that the first synthetic human insulin would be much cheaper than animal insulins but as this has never been the case, we have to be a bit suspicious about claims about costs...**IF** these insulins prove to be safe and effective **AND IF** they be 30% or 40% cheaper, then many lives will be saved, especially in developing countries.

Could this cause concern for the three major insulin producers who presently have a very comfortable global monopoly which dictates

prices and choices of insulin? Will they have to lower their prices by 30% or will they simply buy up the company in Argentina to maintain their control? An interesting thought!

More On Analogues

The reduction in the choice of insulins both now and in the future caused by the insulin manufacturers makes it vital that patients have information about their treatment choices. With the increasing use of insulin analogues and the lack of information about their long-term safety, it is important that we all look closely at what information is available. However it is important that we look at sources of information that are reliable and independent.

A new Cochrane Review
Long-acting insulin analogues versus nph insulin (human isophane insulin) for type 2 diabetes

April 2007
K Horvath, K Jeitler, A Berghold, SH Ebrahim, TW Gratzer, J Plank, T Kaiser, TR Pieber, A Siebenhofer Cochrane Database of Systematic Reviews 2007 Issue 2 (Status: New)

Insulin analogues are the latest form of GM synthetic insulin and this review compares long-acting analogues glargine [Lantus] and determir [Levemir] with long-acting 'human' isophane [NPH] insulin for Type 2 diabetes. For us to have an informed choice of treatment, it is necessary to look at evidence from high quality systematic reviews and Cochrane Reviews provide just such evidence.

The authors' conclusions are:
"If at all there is only a minor clinical benefit of treatment with long-acting insulin analogues for patients with diabetes mellitus type 2 treated with "basal" insulin regarding symptomatic nocturnal hypoglycaemic events. Until long-term efficacy and safety data are available, we suggest a cautious approach to therapy with insulin glargine or detemir."

Below is the 'Plain Language Summary' but the full review can be found on the Cochrane Database www.cochrane.org

Plain language summary
No unambiguous clinical benefits of treatment with long acting insulin analogues in the majority of people with type 2 diabetes mellitus demonstrated
NPH (Neutral Protamine Hagedorn) insulin is the current standard for basal insulin in the blood glucose lowering therapy in people with type 2 diabetes mellitus. The mode of action of this insulin is highly variable, which may be the cause for the difficulties some people with diabetes have to achieve current goals for long-term metabolic control. Therefore, new insulins which are thought to show more favourable properties of action have been developed: insulin glargine and insulin detemir. Because of their theoretical advantages, it is thought that treatment with these new insulin analogues might lead to a beneficial effect, for example less hypoglycaemia or a better metabolic control, possibly resulting in higher quality of life and treatment satisfaction less late diabetic complications such as problems with eyes, kidneys or feet and myocardial infarction, stroke or death.

Although epidemiological studies indicate that high concentrations of blood glucose carry a higher risk for these late complications, evidence for a beneficial effect of glucose-lowering therapy is conflicting. Following from the different results of large clinical trials, interventions seem to carry different substance specific beneficial or adverse effects. As a consequence, conclusions on the effects of different blood glucose lowering interventions on these outcomes can not be drawn from their effect on blood glucose concentration alone. Methodological quality of all the studies was rated low ("C"). Eight studies investigated altogether 2293 people. Trials lasted between 24 and 52 weeks. Our analysis of the currently available long-term trials comparing long acting insulin analogues with NPH insulin

showed that insulin glargine and insulin detemir were almost identically effective compared to NPH insulin in long-term metabolic control (HbA1c). Fewer people experienced symptomatic overall or nocturnal hypoglycaemic episodes with treatment with either of the two analogues. No conclusive information on late complications or on possible differences in the number of fatalities exists. For insulin glargine one study found a higher rate of progession of diabetic retinopathy in patients treated with insulin glargine, while in another investigation the opposite result was found. It was thus not possible to conclude for certain whether insulin glargine treatment is safe or not.

From the retrieved trials it was also not possible to draw firm conclusions on the effects of these new insulins on quality of life or their cost effectiveness. Until long-term data on benefit and risk are available, we suggest a cautious approach to treatment with insulin glargine or insulin detemir.

If this language is not plain enough, let's make it plainer...

- We know that Lantus, Levemir and human long-acting insulins are the same in terms of blood glucose control as measured by HbA1s.
- We know that fewer people in the studies experienced symptomatic overall or night hypos with both the two analogues but we don't know about the numbers of hypos without warnings [asymptomatic].
- We don't know if treatment with Lantus and Levemir results in more or less complications over time or if there are any differences in death rates.
- We don't know if Lantus causes higher rates of retinopathy - one study showed it did and one that it didn't, so we don't know if it's safe or not.
- We don't know if these insulins improve quality of life or not.
- We don't know if they are cost-effective or not.
- We do know that the authors recommend a cautious approach to their use.

From this review we know two things - there are an awful lot of uncertainties about long-acting analogues and the authors' recommendation for a cautious approach to prescribing these insulins is not being adopted in the UK and many other countries.

Yet more on analogues

Using insulin analogues in young children with type 1 diabetes

The authors of this report [Ref 1] start by acknowledging that achieving good control without hypoglycaemia in children with Type 1 diabetes is a challenging goal. They previously studied control in young children between 1993 and 2003 and found that the main predictors of hypoglycaemia were:

- younger age
- longer duration of diabetes
- higher insulin dose
- injection regime.

However, insulin analogues were not included in this study so the authors have now investigated 7,266 children with Type 1 diabetes for 2000-2005 to include insulin analogues. The age groups studied were [i] less than 5 [ii] 5 to 7 and [iii] 7 to 9 and hypoglycaemia was defined in 3 categories. Grade 2 was moderate episodes with some neurological dysfunction eg the child could not respond and needed outside assistance but oral treatment was successful and Grade 3 was severe neurological dysfunction where glucagon or intravenous glucose was necessary eg loss of consciousness, seizures, inability to rouse from sleep.

The results:

- The average daily injection frequency increased in all age groups between 2000 and 2005
- The use of both short- and long-acting analogues increased in all age groups
- There was a slight increase in hospitalisations for ketoacidosis in all groups.
- HbA1cs were stable at around 7.5%

- There was a decreasing rate for Grade 2 and Grade 3 hypoglycaemia for the two younger-aged groups but an increase in the 7 to 9 year olds.

However read on...
When the researchers took into account the effects of age, gender, duration of diabetes etc [known as confounding factors] the results were very different.

- The likelihood of raised HbA1cs [higher than 7.5%] was greater in children using long-acting analogues
- The likelihood of a severe hypo [Grade 2 or Grade 3] was significantly higher with long-acting analogues
- No differences were found with the use of short-acting analogues
- There were more episodes of severe hypoglycaemic episodes [Grade 2 or 3] in the youngest age group of children confirming the 1993 to 2003 findings.

So what do we conclude?
This was an observational study and conclusions about causes cannot be drawn from observational studies but….

Some reports have shown that there was a reduction in hypoglycaemia with the use of insulin analogues but these were small studies carried out in special study conditions. The findings in this latest report are from a large number of children in 'real life conditions' and the results conflict with those of small studies - more hypos and poorer HBA1cs with long-acting analogues.

The authors note that insulin treatment in this age group has significantly changed over the five years studied with increased use of analogues and more frequent numbers of injections per day.

The findings raise questions
The number of injections a day can affect the lives of young children in many ways including the problems of having to inject at school and increased numbers of blood tests. If there are real benefits for children of less hypos and better HbA1cs, then the extra injections are worth it but if the are more hypos and poorer control [or even no difference] then why use analogues that require more daily injections? Perhaps a thought for discussion.

Just a final comment - we have to wonder what the results would be if a similar study was carried out in adults using analogues.

NOTE: It is slightly surprising that long-acting analogues are used in children as young as under 6 years as the SPC documents produced by the insulin manufacturers for approval in the UK state the following:

For Lantus: recommended in children 6 and above because the 'safety and efficacy has not been demonstrated in children under 6.

For Levemir: 'has not been studied in children under 6'.

So if either of these are being prescribed for children under 6 years old, then this is 'off-label' and the manufacturers are not responsible if anything goes wrong.

Ref 1: Severe Hypoglycaemia, metabolic control, and diabetes management in young children with type 1 diabetes using insulin analogs - a follow-up report of a large multicentre database.

Eur J Pediatr DOI 10.1007/s00431-007-446-7

Retinopathy Screening

Are the targets being met?
The government targets were set so that 80% of people with diabetes should be screened by March 2006 and 100% by December 2007.

In answer to a Parliamentary Question [PQ] in May 2007, Health

Minister Rosie Winterton stated that the latest figures for December 2006 show that 1,203,639 people with diabetes received screening for diabetic retinopathy in the previous 12 months. Although a week later in answer to another PQ [131925] she gave the figure as 1,478,223 or 78% of people with diabetes. This looks as if the first stage of the targets have been met. If this is 78% of the total number of people with diabetes, the total number of people works out as 1,773,876 but a report by Dr Sue Roberts, the National Clinical Director for Diabetes, states there are 2.35 million people with diabetes which means that only 60% have been screened - quite a way off government target!

Confusion about screening
IDDT has received quite a lot of queries about the screening systems in different localities. Primary Care Trusts [PCTs] received government funding to set up screening programmes to meet government targets of screening everyone with diabetes in their areas. PCTs decisions have not been the same in all areas but whatever system has been adopted, everyone has to use the chosen this system.

Clearly this does not suit everyone, not to mention that at a time when patient choice seems high on the government's agenda, patient choice in terms of where and by whom they have their eyes screened has been removed. The systems vary from mobile screening vans moving around an area to private companies being employed and everyone having to travel to one location at a given time.

One of the frequently expressed concerns is that people who have gone to their local optometrist regularly for screening are being told that they can no longer do this, unless they pay £20.00. This charge is made because the PCT will no longer pay optometrists to carry out screening - so is not the fault of the optometrist. The advantages for patients of using their local optometrist are clear - they can go at a time convenient to themselves [no time off work] and they can be screened close to home.

The other point of confusion people have expressed is that they are unsure of the qualifications of the person carrying out the screening and who checks the results. We recommend that you contact your Primary Care Trust with such questions.

How, when and where screening should take place has been discussed ad infinitum but like it or lump it, the arrangements for screening have been made.

Screening is vital
Whatever system is on operation in your area and however inconvenient, it is vital that you have your eyes screened for retinopathy annually as early detection and early treatment can prevent the progression of retinopathy.

Note: There will be discussions about screening at IDDT's Annual Conference in Birmingham on October 13th.

Blood Glucose Test Strips - Restrictions

Complaints keep coming in from people with both Type 1 and Type 2 diabetes that are either being denied tests strips or having the numbers restricted by their GP practice. Let us be clear:

Test strips ARE available on the NHS
As recently as March 2007, in answer to a Parliamentary Question, Health Minister Rosie Winterton stated:

"Blood glucose testing strips are available on national health service prescriptions and are available free of charge to people with type 1 and type 2 diabetes whose condition is controlled by insulin or tablets."

Therefore any restriction of refusal to supply blood glucose test strips is being made at local level by Primary Care Trusts [PCTs] and/or your GP Practice. We have to assume that this is based on cost, what

other possible reason can there be?

Let's look at the costs

- At the last price review of suppliers' charges for their products to the NHS, the cost of blood glucose test strips was reduced, so the NHS is paying less now than in the past.
- Figures given by Minister Rosie Winterton in answer to another Parliamentary Question [19 April 2007] show that for the first 9 months of 2006 the number of bottles of test strips supplied was 4,263,166. So for the whole year, an average of 2.5 bottles of strips were provided for every person with diabetes. We know that some people don't use any at all because their doctor does not advise it and we also know that others with Type 1 diabetes use many more strips. But even so the cost 2.5 bottles per person per year of around £50.00 is not very much weighed against the costs of an overnight stay in hospital as a result of not being able to test.
- The same figures for 1997 show that just under 2 bottles per person per year were being supplied, so the use is not increasing significantly, it is the number of people with diabetes that is increasing the costs of test strips.

"Self-management is key for people with diabetes to have control over their lives." This statement was made by Dr Sue Roberts, National Clinical Director for Diabetes in a Dept of Health Press Release [May 17 2007]. Yet self-management is only possible if people have access to the tools necessary to do this and for many this means having access to test strips.

Where's the logic?

- It appears that the case for refusing to supply test strips to people with Type 2 diabetes is based on two main points, the first being that many people with Type 2 diabetes do nothing as a result of their blood glucose tests. Well, this is probably because they have never been advised what to do! Again quoting Dr Sue Roberts: in any given year, the average person with diabetes will spend only 3 hours with a health professional. This is hardly time to learn anything other than the very basic facts about diabetes and not the intricacies of blood glucose testing.
- The second reason given is that there has been some research showing that blood glucose testing does not improve HbA1c results in people with Type 2 diabetes. Well if people aren't given any more than 3 hours a year for the whole of their diabetes care and treatment, then HbA1cs are unlikely to improve!

Does it matter what research shows?

For people with Type 1 diabetes and many with Type 2, blood glucose testing makes them feel safe and comfortable. Knowing what their blood glucose levels are at any given time prevents anxiety and improves quality of life and this has absolutely nothing to do with HbA1cs.

***Rumour* has it that people with Type 2 diabetes are not going to be supplied with test strips at all but they should use urine testing!**

Urine testing was generally dismissed many years ago because it actually measures glucose in the urine which could have been there for 2 to 3 hours. So it is only a rough guide to what blood glucose levels were a few hours ago unlike blood glucose testing which tells people what is happening at that moment. The other major drawback to urine testing for patients is that it is viewed as messy and 'dirty'.

What to do if you are refused test strips or have the number reduced

- Complain to your GP practice manager and explain why you need test strips
- If this fails tell the practice that you are going to complain to the PCT
- If this fails, complain to the PCT
- If this fails contact your local MP and tell him/her pointing out the Minister's statement above.

Just a note: many years ago when as a Trustee and Chairman of the Voluntary Groups Section of the then British Diabetic Association [now Diabetes UK] I was involved in the lobbying campaign for blood testing strips to be available on the NHS because we were having to buy them. After 20 years, it feels like we've done a full circle and this is in an NHS that we are told is improving and putting patients at the centre of care. Really?????

Thank You to our Readers

Zimbabwe
Many of you responded to the letter in IDDT's April Newsletter from the group of people with diabetes in Zimbabwe. We thank you for your thoughts, good wishes and your offers of help with supplies of insulin and needles to help their plight. We have passed on your good wishes but unfortunately we are not able to send supplies directly to them in Zimbabwe as there is no guarantee that the supplies would reach the people who need them. We can only send supplies to a doctor or clinic who will agree to take responsibility for them and their distribution to patients. As you know we do send unwanted, in-date insulin and other supplies to developing countries but this is only done under strict controls with a signed protocol from a doctor running a diabetes clinic. Our partners, Insulin for Life, in Australia have sent free supplies to the Zimbabwe Diabetes Association since 2003 and will be doing so over the next year.

10Km London Fun Run
At the time of writing, the Fun Run has not taken place but I can report that our runners are getting prepared and are encouraged by your support. Many thanks to all our members who have been getting sponsors for our runners and to those of you that have already sent in your sponsorship money.

Don't forget to get your sponsorship form and money back to IDDT before September 3rd as this is the day of the draw to select 3 sponsors who will each receive £50 M&S vouchers. Please make cheques payable to 'IDDT' and send to: IDDT, PO Box 294, Northampton, NN1 4XS

From our own Correspondents

It's good to help
Dr Matthew Kiln and Jenny Hirst

It is a great pleasure for me to express my deep thanks and gratitude for your kindness in sending me the information pack together with its enclosures. I do hereby acknowledge with thanks. The information pack provided knowledge to the concerned people with the latest, highly technical, skilful information and of great interest to all readers.

I retrieved your website which is highly rich and gives technical information and I printed of it for my office library.

Once again, please accept my thanks and appreciation and wishing you all the best.

Director General, Executive Board, Council for Health Ministers for GCC States,

Riyadh, Kingdom of Saudi Arabia

Listened to at last!
Dear Jenny

You may remember that I contacted you a couple of months ago regarding the problems I was having with my analogue insulins. My consultant told me last June that Novo Nordisk pork insulin I have been using for several years without any problems, was being

discontinued and that I had no choice but to change to human insulin. Even though I had tried this in the past, it never agreed with me and I had huge problems with it but my consultant was not interested in this and insisted that I had to change to human insulin. I have now been on NovoRapid and Lantus insulin for almost a year and it has been hell - constant hypos, my blood sugar is uncontrollable and my life has been one long battle for the whole time I have been on this awful stuff.

I found out from your website that there is another supplier of pork insulin and you sent me a very helpful information pack. I have just had my annual review and I am very happy to report that my consultant has changed me back to pork insulin! I am now on the Hypurin Porcine Isophane and Neutral injections. My consultant was very sympathetic to the trouble I had been having with the analogues and agreed with me that they were not suitable for my blood sugar control. The ironic thing was, I actually had a hypo while I was at the clinic so she was able to see first-hand what it was doing to me! The diabetic Nurse Specialist also said that I should be on the Hypurin pork insulin, so it was very reassuring to know that our concerns were addressed, and that I was listened to, finally.
My wife and I are very grateful to you for all the information and helpful advice you gave us; we wouldn't have got the problem sorted so easily without your help. Wishing the IDDT continued success.

By e-mail

Results of driving campaign
Dear Jenny,

I have been a type 1 insulin dependent diabetic of 46 years and for the last 8 years have been campaigning on important driving licence issues relating to visual field loss through laser treatment and fitness to drive. People have lost their driving licences unnecessarily because of an unfair system of assessment when their retinopathy and field loss has been stable.

As a result of the meeting I attended with the Dept of Transport and the DVLA last year and the workshop following it, I am delighted that with the unswerving support of my consultant and IDDT's Jenny Hirst, all the issues have now been addressed by the publication of key recommendations which are now being implemented.

I was pleased to see that in IDDT's April Newsletter there was an article about the new criteria for driving with visual field loss and advice for people facing the removal of their driving licence.

For drivers who think that they may have lost their licences unfairly, I recommend the following course of action. Firstly take a test on a Goldman machine which uses dynamic rather than static targets. The DVLA has a list of approved centres where this instrument can be located if you cannot find one at your local eye clinic. Keep copies of the results, one for the DVLA and one for your own records. Complete a normal licence application form and send it to the DVLA enclosing [i] your test result [ii] a covering letter requesting that your case is looked at again in the light of the recent recommendations made to the DVLA and [iii] a letter from your ophthalmic consultant confirming that your condition is stable.

Any further queries should be taken up with the DVLA, who will

deal with all applications on an individual basis, and should now be in

a position to offer up-to-date advice

Mrs Jackie Banks

Comments: I would like to thank Jackie for her tireless efforts on this campaign, which at times I know has been exhausting and disheartening but her determination won the day!

IDDT Goes to Westminster

Well actually we haven't bee recently because you, our members have been doing all the work by asking your MPs to sign an Early Day Motion [EDM] calling for NICE to assess all insulins and provide guidance on their use. 106 MPs have signed the EDM.

Progress?
We were pleased to report in the April Newsletter that Health Minister, Any Burnham had asked his officials to draft a request to NICE that they review all insulins and issue guidance for their use. However, we heard nothing and therefore Adrian Sanders MP, Chairman of the All Party Parliamentary Diabetes Group asked a further PQ asking for a progress report. This was then answered by another Health Minister, Caroline Flint, who basically said the Dept of Health would not be making a request to NICE.

So two completely conflicting responses from two Ministers in the same government department! Strange but we are following this up…

MPs write to the Secretary of State for Health
Instead of signing the EDM, many more of your MPs have written to the Secretary of State for Health or asked Parliamentary Questions [PQs]. These are now being answered by Lord Hunt and I am afraid that the correspondence is long and tortuous. He is now answering with responses that we received 2 years ago and which we thought had been settled in discussions with the Dept of Heath. Still we plod on with determination not to give up. We have genuine concerns and they need addressing.

So we are very grateful to you and to all the MPs for the continued help and support. We'll keep you posted.

Searching For Good Health - Your Views are Welcome

Dr Katharine Morrison

I am continuing my efforts to change the way people with diabetes are treated by not just fighting with my medical colleagues but by starting off an educational course for people who are overweight, have metabolic syndrome and type one and two diabetes. It is published online at www.dsolve.com Please check in. Your contributions as fellow activists in your search for good health with diabetes are very welcome.

New Drug for Type 2 Diabetes Approved

A new drug, Januvia has been approved for use in Type 2 diabetes for use in addition to diet and exercise either alone or in combination with other commonly prescribed drugs. It enhances the body's own ability to lower blood sugar levels in Type 2 diabetes. Clinical trials show the new pill works just as well as older diabetes drugs, but with fewer side effects like weight gain. The drug made by Merck and Co. Inc., also known as sitagliptin phosphate, is unlike any other drug for Type 2 diabetes and works by increasing levels of a hormone that triggers the pancreas to produce more insulin while at the same time signalling the liver to stop producing glucose. The most common side effects of Januvia are upper respiratory tract infection, sore throat and diarrhoea.

Did you Know?

Fruit juices vary considerably in the quantity of nutrients per calorie.

According to a study from the University of Florida 100% pure orange juice and ruby red grapefruit had better “nutrient profiles” than other common fruit juices, including apple, grape, pineapple and prune. Pink grapefruit juice had the highest “nutrient density”, orange juice ranked second and white grapefruit juice came third. [Journal of Food Science, May 2007]

Holidays - A Few Tips

Going by plane
If you are carrying insulin on board an aircraft, you will need a letter from your GP explaining that you have to carry insulin and other diabetes equipment on board with you. Remember insulin should not be packed in the hold as the temperature can be below freezing and this can damage your insulin.

Holiday Insurance
If you have diabetes, travel agents are not the best people to provide holiday insurance. Shop around but always declare your diabetes and any other medical conditions otherwise if anything goes wrong and you need to use the insurance, you may not be covered. If you are going on holiday in Europe, remember to take your Eurpean Health Insurance card [EHIC] and proof of being a UK resident eg driving licence.

Keeping your insulin cool with FRIO Wallets
FRIO wallets are designed to keep your insulin cool and safe for a minimum of 45 hours, even in temperatures of 100 degrees Fahrenheit. Depending on what country you are in, they have stayed activated for about a week. The main advantages are that there are no bulky ice packs, you do not have to worry about finding a freezer to get supplies of ice and the wallet is light to carry. It is activated by immersing it in cold water for 5-15 minutes. The panels of the wallet contain crystals and these expand into gel with the immersion in water. The system relies on the evaporation process for cooling.

Vials and pens can be put into plastic bags to keep them dry without affecting the cooling properties of the wallets but FRIO also supply a zip stop water proof liner at an extra cost.

Note: ONLY the vials that should be put in the plastic bag and NOT the whole pouch.

The FRIO wallet comes in four sizes:

- Individual – for carrying one pen only.
- Duo pen - for carrying 1 pen and two 3ml cartridges or just 2 pens.
- Small – suitable for two 10ml vials of insulin.
- Large – suitable for one pen and two sets of cartridges or 4 10ml vials or 5 disposable pens.
- Extra large – carries 20 x 3ml cartridges, up to 8 pens or a mix of both.

For further information or to order a wallet contact the manufacturers at: FRIO UK, PO Box 10, Haverfordwest SA62 5YG

Tel 01437 741700
e-mail info@friouk.com
website: www.friouk.com

Kitbags to keep all your diabetes equipment in one place
Desang kitbags can keep all the tools of good diabetes management (blood testing kit, sugar supply and insulin as well as space for personal notes) in one, good looking place. They vary in price from PVC ones at £19.99 to luxury leather ones at £59.99. You can buy on-line by visiting www.desang.net

While on the Subject of Holidays

Following the increased security on flights, one of our members is concerned because his wife cannot take Lucozade on to the plane. This is her usual treatment for hypos and he is concerned that she will not have this with her. Other people may have similar worries because the treatment of hypos has not been fully explained.

If a hypo occurs, then any sugary drink or food is OK to raise the blood sugars quickly. It does not have to be Lucozade, it could be full blown Coca Cola which is accessible almost everywhere, or it could be a chocolate bar. It is then important to eat some slow, long-acting carbohydrate such as a sandwich to keep the blood sugars up until the next meal.

Patient Cleanliness Code to Avoid Hospital Bugs

Sadly it is now not unusual for people who have to go into hospital to be more concerned about hospital bugs than the actual procedure that they are having.

In November 2004, then Health Secretary John Reid pledged that MRSA would be halved by April 2008. Since then there have been a string of reports from the government's NHS watchdog, the Health Commission showing that not only are these targets not going to be met, but that there is a further problem with another hospital bug - Clostridium difficile (or C. difficile). This air-born bug is causing more than twice as many deaths as MRSA. The Commission blamed inadequate infection control measures in hospitals and declining levels of cleanliness.

C. Difficile is a bacterium found in the gut of up to 3% of healthy adults and 66% of infants. It rarely causes problems but it can cause illness when its growth goes unchecked. For example, treatment with certain antibiotics can disturb the balance of the 'normal' bacteria in the gut allowing the C. difficile to thrive. It can cause mild or severe diarrhoea or in some cases severe inflammation of the bowel.

Advice from the Patients' Association

The Patients Association drew up a Patients' cleanliness code to advise patients how to avoid the superbugs while in hospital and this may be useful for our readers:

- Wash before going into hospital
- Ask relatives to launder nightwear and bring toiletry supplies
- Visitors should be freshly showered or bathed
- Visitors should not sit on the bed
- Patients in isolation should not have visitors [but rely on the telephone]
- Ask staff and visitors to wash their hands
- Take medical wipes into hospital with you and clean your hands after using a bottle or bed pan
- Collect your own bedside rubbish

'Hidden' Fats Removed From Foods

Trans fats or "hidden" fats made from vegetable oil have been linked to raised cholesterol and heart disease. According to the Food and Drink Federation they are being cut from around £1.5bn worth of foods including hundreds of well-known brands such as Horlicks, Mars and Weetabix.

Trans fats - the hidden bad ones!
Trans fats [also called trans fatty acids] are bad fats that raise the level of bad cholesterol [LDL]. They occur naturally in some dairy products, in beef and lamb but nearly all convenience foods contain them.

Just one gram of trans fats a day can increase the risk of heart disease. It is not difficult to eat one gram a day - a KFC of crispy strips of chicken and fries contains 4.4.gms of trans fat, McDonalds McNuggets and fries 3gms and a Burger King Whopper with fries 2.3gms.

But beware! It is not compulsory that manufacturers list trans fats on food labels.

They are hidden in many of the foods we eat but we can be unaware of them as they may not be included on nutritional information on food labels. They don't even have to be listed as ingredients unless a specific trans fat claim is made such as 'low in trans fats'. At best 'hydrogenated vegetable oil' or 'partially hydrogenated vegetable oil' may be on labels.

Pesticides May Increase the Risk of Gestational Diabetes

Research [Diabetes Care March 2007] has shown that exposure to agricultural pesticides during the first trimester increases the risk of a woman developing gestational diabetes [diabetes during pregnancy]. The study was carried amongst farmers wives.

Of 11,273 women who became pregnant 506 reported having gestational diabetes within 25 years after entering the study. 57% of the women had mixed or applied pesticides at some time in their life and the proportion was similar in those with and without gestational diabetes. However, women who mixed, applied or repaired pesticide equipment during the first trimester had a more than twofold increased risk of developing gestational diabetes. By contrast, women with residential exposure to pesticides or indirect exposure during the first trimester had no increased risk and nor did women who had mixed or applied pesticides before the study when they were not pregnant.

This study may have significant public health benefits and farmers' wives may be advised to avoid handling pesticides during pregnancy.

Insulin Pumps - Petition Online for the Prime Minister

There's a petition online to 10 Downing Street asking for insulin pumps to be available for everyone. As we know whether or not people are able to obtain an insulin pump on the NHS is very much a postcode lottery, so if you would like to sign the petition, go to http://petitions.pm.gov.uk/diabetes

What is Splenda?

According to the TV ads it is "made from sugar, so it tastes like sugar"

This something that several people have raised with IDDT because it seems a fairly misleading advert. It also seems that we are not the only ones who think so. In the US Splenda holds 50% of the market for sugar substitutes but it seems that there is likely to be a fully-fledged legal battle between makers McNeil Nutritionals [part of Johnson & Johnson] and the Sugar Association regarding the marketing campaign, "made from sugar, so it tastes like sugar". This is because it does not truthfully reflect the end product, which contains sugar. Splenda's web site, www.splenda.com states that it starts with sugar, but is then converted into a no-calorie non-carbohydrate sweetener; this process selectively replaces three hydrogen-oxygen groups on the original sugar molecule with three chlorine atoms. At least you now know what's in Splenda and the choice is yours!

Carers to Benefit From Righr to Request Flexible Working

After consultation with business, unions and carer's groups, carers will have the right to request flexible working to help them care for their relatives who are ill or disabled from April 6th 2007. The definition of a carer will be an employee who is or expects to be caring for an adult who:

- is married to, or the partner or civil partner of the employee
- is a near relative of the employee. A "near relative" includes parents, parent-in-law, adult child, adopted adult child, siblings (including those who are in-laws), uncles, aunts or grandparents and step-relatives
- falls into neither category but lives at the same address as the employee.

This could help carers of people with diabetes who are disabled or who cannot be left alone because of their loss of warnings of hypoglycaemia.

It is part of a package of family friendly measures introduced in the Work and Families Act 2006 by the Dept of Trade and Industry, Tel 020 7215 5000 website: http://www.dti.gov.uk

levemir and Tablets

Novo Nordisk has received European approval for once daily use with oral antidiabetic drugs for Type 2 diabetes. The press release for Novo Nordisk says that Levemir has a 24 hour action with one injection a day and that there is less weight gain than with long-acting human insulin eg Insulatard, with less risk of hypoglycaemia.

Snippets...

GPs damn the Blair decade

Doctor magazine [1.5.07] released a survey showing that more than two-thirds of GPs believe general practice has deteriorated since Tony Blair came to power. The survey also claims that the vast majority of GPs are pessimistic about the future of the profession. 69% said general practice was in worse shape now than ten years ago, while just 18% thought it had improved and 13% believed it had stayed the same. The survey respondents were also dismissive of practice-based commissioning, which forms the backbone of government plans to reform NHS services. Some 69% cent said the initiative had produced no benefits for patients in their practices.

Nearly two thirds of health staff would not be happy to be a patient in their own NHS trust!

The 2006 Healthcare Commission survey of more than 128,000 NHS workers found that nearly two thirds of them would not be happy to be patients in their own NHS trust and only 45% of them felt that patients were a top priority, down from 50% last year. Just 39% agreed they would be happy with the care provided in their own trust, with 27% disagreed and 33% neither agreeing or disagreeing - slightly worse than last year. The positives in the survey? Work related stress fell from 39% in 2003 to 33% and the staff witnessing errors with potential harm for patients fell from 49% to 38% over the same period.

More praise than prescriptions!

These are the words in a report in the Ventura County Star [22.3.07] about inhaled insulin, Exubera! The praise is for trying to find a new way of administering insulin but it is not selling as well as the manufacturers expected. "I think Pfizer will wish they had never gotten into this. I doubt they'll regain their investment," said Dr. John Buse, president-elect of the American Diabetes Association, who participated in Exubera's trials. "There is no advantage to Exubera and there may be a safety risk. I see it as my job to talk people out of (using) it."

The message may be getting through

In the US, for the first time in more than 15 years, more adults drink a cup of coffee daily than drink a soft drink daily. A survey of nearly 3,000 adults found that 57% said they drank coffee every day [up from 56% last year], but only 51 percent drank a soft drink daily, down a remarkable 6% from a year ago.

Beware of sugar content!

Some savoury foods have a higher than expected sugar content eg meals such as Tesco crispy beef with sweet chilli and Asda's sticky chilli chicken had more sugar content than vanilla ice cream. The Food Standards Agency classifies a product as having a high sugar content if it has more than 15g of sugar per 100g or more than 18g if the portion is more than 100g. Asda's sticky chilli chicken contains 19.2g of sugar per 100g and Tesco crispy beef with sweet chilli sauce has 23.1g per 100g. Even more surprisingly, Weight Watchers oat digestive biscuits contain 20.5g of sugar per 100g - nearly 4% more than McVitie's digestives although they do contain less fat. Vanilla ice cream contains 17.9g per 100g.

Under current labelling regulations, supermarkets are not legally obliged to include nutritional information on a food product unless a specific claim such as "low sugar" is made.

If you would like to join IDDT, or know of someone who would, please fill in the form (block letters) and return it to:

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From Your Editor – Jenny Hirst

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