INDEPENDENT DIABETES TRUST
Newsletter
June 2019 Newsletter, Issue 101
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HOLIDAY TIPS

Holidays are approaching and whether staying in this country or going abroad, for families with diabetes, this means more planning and a bit more care when you are away. IDDT has published a booklet, Holiday Tips, which includes useful information for holidays. This is included in our Holiday Pack and if you would like one of our packs, just call IDDT on 01604 622837, email enquiries@iddtinternational.org or write to IDDT, PO Box 294, Northampton NN1 4XS. The Holiday Tips are also on our website: www.iddtinternational.org

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CATARACT SURGERY RESTRICTED BY SOME CCGS – IT'S RATIONING!

People across England are being denied vital cataract surgery by their local Clinical Commissioning Groups (CCGs) as over half of CCGs include the procedure in lists of treatments they consider to be of 'limited clinical value'.

Research by the Medical Technology Group (MTG) in March 2019 has shown that 104 of the 195 CCGs in England restrict access to cataract surgery. These CCGs include cataract surgery on their lists of 'Procedures of Limited Clinical Value' which are normally reserved for complementary therapies or cosmetic procedures where there is little evidence to prove their cost effectiveness or clinical benefit. Yet in the national clinical guidelines published by the National Institute for Health and Care

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Excellence (NICE) in 2017, the cost effectiveness of cataract surgery, is stated *'a high success rate in improving visual function, with low morbidity and mortality'.*

The result of these restrictions on cataract surgery is that people across the country are being denied access to a procedure firstly, to which they are entitled and secondly, to a procedure which is likely to restore their eyesight, prevent accidents such as trips and falls, enable them to continue in employment, not to mention reading and watching television, all of which leads to a better quality of life.

The research also suggests patients are being treated differently depending on where they live – the postcode lottery again! For example, Basildon and Brentwood CCG restricts access to cataract surgery but nearby Barking and Dagenham CCG offers the procedure to all patients.

What is a cataract?

The lens in the eye is a transparent crystalline structure behind the pupil of the eye. It helps to refract incoming light and focus it on to the retina. When a cataract forms the lens becomes cloudy or opaque so preventing the light that passes through the pupil from reaching the retina and the image or picture on the retina is not clear. Surgery simply removes the cloudy lens and puts a clear one in its place, so people regain their vision.

Cataract surgery is usually very successful and should be performed when the vision has dropped to the point where it is interfering with daily activities. Cataracts are part of the natural aging process and develop in adult life, what varies, is that the age of onset differs from person to person. In people with diabetes, cataracts can develop at a younger age.

Advice: if you are diagnosed with cataracts but you are refused an operation, complain to your local CCG and quote NICE guidelines.

As IDDT's Co-chair…

Not only am I Co-chair of IDDT but I am a retired optometrist and I find it unbelievable that a cataract operation is put in the same category as cosmetic surgery when it is a relatively simple operation with low risk, yet untreated can lead to serious visual impairment and blindness. If CCGs are only looking at costs, then they are also failing to see the bigger picture - the costs of the State benefits and possible costs of carers to which these people will be entitled.

I also have to question the thinking of any CCG which denies people a cataract operation for all the reasons stated above but also because if cataract surgery doesn't take place, the lens becomes opaque and the retina cannot be examined by an eye specialist. Therefore, any changes in the retina, such as the development of diabetic retinopathy or macular degeneration, cannot be seen by the optometrist or ophthalmologist and therefore cannot be treated.

The MTG research also showed that other procedures are being restricted by some CCGs – hip and knee replacements, hernias and of course, the FreeStyle Libre! So, there is another question that springs to mind, by restricting cataract surgery and other procedures, are CCGs, and NHS England, hoping that more people will pay privately to be able to see again or walk again? If we have the money, and therefore the choice, wouldn't we all opt to be able to see or walk properly? But it doesn't make it fair, right or within the principles of the NHS!

The one thing that seems clear, is that when making these decisions, CCGs do not appear to be considering the quality of life of the people in their areas.

Note: the Medical Technology Group is a coalition of patient groups, research charities and medical device manufacturers that is working to make medical technologies available to everyone who needs them. Concerned that the treatment patients receive is being determined by where they live, not what they need, the MTG is launching Ration Watch to highlight variation in local commissioning and call for changes to eradicate the postcode lottery.

‘PRE-DIABETES’ – A CHANGE OF HEART?

Regular readers of our Newsletters will know that IDDT has never approved of the term ‘pre-diabetes’ and below are some of the reasons.

People view it as a diagnosis of a condition, which actually they haven’t got! They may be at risk of Type 2 diabetes but they don’t have a condition or diabetes.

People are put under unnecessary stress and anxiety thinking they have a diagnosis when actually only one on ten of those classed as having ‘pre-diabetes’ actually go on to develop Type 2 diabetes.

It makes patients of people who are actually healthy!

By contrast, telling people they are at risk of diabetes enables them to take steps to try to avoid it without causing as much stress and anxiety.

The term ‘pre-diabetes’ has been rejected as a diagnosis by the World Health Organisation but is still widely used in the UK and US. Now experts have agreed that labelling people as having ‘pre-diabetes’ could do more harm than good, even Richard Kahn, the American Diabetic Association’s (ADA) former chief scientific and medical officer who helped to coin the term, has rejected it, saying was a “big mistake”.

It was also criticised in 2014 when many people labelled with the condition did not go on to develop diabetes. In addition, it has not only led to huge sums of public money being spent on ineffective treatments many of which have serious side effects, but it has also fuelled moves by the pharmaceutical industry, diet and fitness professionals to target people with so-called ‘pre-diabetes’.

Research (in the journal Science) shows that the term has continued to be used but also that the standard average blood glucose levels have been lowered which means that more people are being labelled as having ‘pre-diabetes’. Figures suggest a third of adults in the UK (about 16 million people) qualify as pre-diabetic under the ADA criteria, while only about 3.3 million have been diagnosed with Type 2 diabetes.

Prof Andrew Hattersley, from the University of Exeter, said the issue is a matter of definition. *“It is not a ridiculous concept to identify people who are close to having diabetes. People just below the threshold will benefit from the lifestyle advice given to those just above the threshold. However, the scientific evidence for ADA’s low thresholds is very weak, and that broadening the definition to such a degree means huge numbers of people with very little increased risk will be classed as pre-diabetic.”* He added that potentially the most effective ways to reduce the development of diabetes would be to push for changes in food regulations, taxation and town planning to try to improve the environment in which we all live.

Here’s the latest from the International Diabetes Federation (IDF)

The IDF take a different stance in an article in their Journal (April 2019) suggesting that many doctors don’t tell their patients they have pre-diabetes and if they do, people see this as a ‘wait and watch’ scenario rather than taking any action to change their lifestyle. The authors believe that staging the severity of Type 2 diabetes is a better way and suggest that ‘pre-diabetes’ is exchanged for ‘stage-1 diabetes’ when blood glucose levels are impaired and are higher than normal. The problems are not difficult to see - mainly confusion between Type 1 diabetes and stage-1 diabetes!

Where does IDDT stand now?

We still do not use the term ‘pre-diabetes’ but believe that telling people that they are at risk of Type 2 diabetes provides them with the opportunity to change their lifestyle without causing unnecessary anxiety. They then have the choice to eat more healthily and be more active, both of which are good for their general health.

It's all about rationing!

Type 2 diabetes and testing

As we are only too well aware, the vast majority of people with Type 2 diabetes who are not taking insulin are not allowed blood glucose test strips on the NHS. Recently people who have been using test strips for many years are being told by their GP that they can no longer have them and are calling IDDT to ask how they are now supposed to control their diabetes.

Management of Type 2 diabetes usually begins with lifestyle changes, followed by the addition of oral blood-glucose-lowering medications, progressing to additional drugs and insulin if needed. Blood glucose is monitored by measuring HbA1c every 3 to 6 months. The aim is to keep HbA1c ideally below 6.5% or 48mmol/mol.

This may be alright if people do have their HbA1c tested every 3 to 6 months. However, many people with Type 2 who contact IDDT are only having their HbA1cs tested once or twice a year so can go months not knowing what their level of control is!

What does NICE guidance for Type 2 diabetes say?

It recommends that self-monitoring should not be routinely offered unless the person:

- is taking insulin,
- has low blood glucose (hypoglycaemia),
- is taking tablets that may increase their risk of hypos while driving or operating machinery,
- is pregnant or planning to become pregnant.

Doctors may consider offering self-monitoring of blood glucose in the short-term for people starting treatment with steroids or to confirm suspected hypoglycaemia.

New Cochrane Review - self-monitoring of blood glucose provides no important benefit for most people with Type 2 diabetes

A 2012 Cochrane review found that monitoring gave only small improvements in blood glucose that were not maintained beyond six months. A new review has been carried out to find out whether there is now enough evidence to revise clinical practice.

The results were similar to those of the earlier Cochrane Review - that for people with Type 2 diabetes who are not using insulin, any benefit from self-monitoring is small, doesn't last beyond six months and this is not enough to be clinically important or outweigh the costs and personal inconvenience of long-term self-testing. However, it is worth noting that people who had poorer blood glucose control at the start of studies had a greater benefit from self-monitoring.

New study contradicts this!

Research carried out at Swansea University has shown that adults with Type 2 diabetes can achieve superior improvements in HbA1c with structured self-monitoring of blood glucose compared with usual care.

The researchers recruited 323 adults with Type 2 diabetes for at least 1 year for a randomised controlled trial to assess structured self-monitoring of blood glucose (SMBG). The participants were not taking insulin and had an HbA1c level between 50 mmol/mol (7.5%) and 119 mmol/mol (13%). They were randomly assigned to one of three groups:

- structured SMBG alone,
- structured SMBG with telephone support from nurses,
- control group.

Each participant had their HbA1cs checked at 3, 6, 9 and 12 months.

Results

In the SMBG-alone group, participants were educated about and trained for testing before breakfast, 2 hours after breakfast and 2 hours after the "main meal" of the day twice per week. The SMBG plus telecare group did the same but also received monthly calls from study nurses. The control group just received general diabetes education.

- HbA1c levels decreased for the combined SMBG groups (8.6% to 7.4%) and the control group (8.7% to 8.3%), but the researchers found that the average decrease in HbA1c for the combined SMBG groups was larger (12.2 mmol/mol, or 1.1%) than in the control group (3.3 mmol/mol, or 0.3%).
- The researchers also reported an 8.9 mmol/mol (0.8%) estimated treatment difference when comparing the combined SMBG groups with the control group.
- No statistically significant differences were found when comparing the SMBG alone and SMBG telecare groups. (Diabetes Medicine, February 2019)

IDDT asks if NHS England is going to take any notice of this research or going to continue to issue instructions that people with Type 2 diabetes not taking insulin cannot test their blood sugars, even if this leads to better control and ultimately reduces the risks of complications? Or is it all just about money?

THE IDDT'S LOTTERY DRAW WINNERS

We are delighted to announce the winners of our latest monthly lottery draws. They are as follows:

Winners of February 2019 draw are:

1st prize of £540.00
goes to Kenneth from Luton

2nd prize of £405.00
goes to John from Nottingham

3rd prize of £270.00
goes to Susie from Salisbury

4th prize of £135.00
goes to Geoffrey from Chepstow

Winners of the March 2019 draw are:

1st prize of £546.24
goes to Patricia from Waltham Abbey

2nd prize of £409.68
goes to Colin from Swindon

3rd prize of £273.12
goes to ANON. from Bingley

4th prize of £136.56
goes to Pritam from Walsall

Winners of the April 2019 draw are:

1st prize of £539.04
goes to Anon. from Chesterfield

2nd prize of £404.28
goes to Irene from Melton Mowbray

3rd prize of £269.52
goes to Sarah from South Shields

4th prize of £134.76
goes to Kenneth from Luton

Note: the winners of the draws for May, June and July will be announced in our September 2019 Newsletter and will be available on our website.

A huge 'Thank You' to everyone who supports IDDT through the lottery.

If you would like to join in for just £2.00 per month, then give us a call on 01604 622837 or email jo@iddtinternational.org

OBTAINING THE FREESTYLE LIBRE ON THE NHS

On March 7th, NHS England published a document containing the criteria for people with Type 1 diabetes to obtain the FreeStyle Libre free on an NHS prescription. It is difficult to understand the logic, the thinking or the fairness of the criteria. For instance, it does not mention children or adolescents with Type 1 diabetes, a group who really need this device both for comfort and to encourage them to test more frequently. Equally, it does not mention other conditions along with Type 1 diabetes which we know makes control more difficult. Let's take another look…

The criteria for obtaining the Libre on the NHS

1. People with Type 1 diabetes or with any form of diabetes on dialysis and insulin treatment who are clinically indicated as requiring intensive monitoring more than 8 times daily, as demonstrated on a meter download /review over the last 3 months. Or for people with diabetes associated with cystic fibrosis.
2. Pregnant women - 12 months in total inclusive of post-delivery period.
3. People unable to routinely self-monitor blood glucose due to disability who require carers to support glucose monitoring and insulin management.
4. People for whom the specialist diabetes team determines have occupational or psychosocial circumstances that warrant a 6month trial of the Libre.
5. Previous self-funders of the Libre where their health professionals are satisfied that their clinical history suggests that they would have satisfied one or more of these criteria prior to them commencing use of Libre had they been in place prior to April 2019 AND has shown improvement in HbA1c since self-funding.
6. For those with Type 1 diabetes and recurrent severe hypos or impaired awareness of hypos, NICE suggests that Continuous Glucose Monitoring with an alarm is the standard. However, if the person with diabetes and their clinician consider that a Flash Glucose Monitoring system would be more appropriate for the individual's specific situation, then this can be considered.
7. For people who are already using the Libre and obtaining sensors on the NHS but do not fit into the new criteria, then CCGs should consider providing it if people fall into existing local CCG criteria and there have been observable improvements in their glucose management or psycho-social wellbeing (such as depression, stress or anxiety levels).

Other requirements

1. Education on Flash Glucose Monitoring has been provided (online or in person)
2. Agree to regular reviews with the local clinical team.
3. Agree to scan glucose levels no less than 8 times per day and use the sensor more than 70% of the time.
4. Previous attendance, or due consideration given to future attendance, at a Type 1 diabetes structured education programme (DAFNE or equivalent if available locally).

Funding arrangements

The document also states the funding arrangements for CCGs and gives the maximum amounts that CCGs will be reimbursed for the ongoing costs of the sensors. In 2019/20 CCGs will be reimbursed for up to 20% of their Type 1 diabetes population.

It contains a list of all CCGs, the total number of people with Type 1 diabetes in each CCG and 20% of this number, so there may no longer be a postcode lottery of availability, instead availability is being rationed to 20% in each CCG. For instance, in Darlington CCG the 20% figure is 112 patients with Type 1 diabetes, so what happens if you are patient number 113 but still fit into the criteria for the Libre on the NHS?

Where to obtain the FreeStyle

The document says that the Libre on the NHS can be obtained from either the hospital clinic (secondary care) or from your GP practice (primary care) depending on where you receive your treatment.

Your reports…

Members' reports to IDDT all suggest that they have had to obtain it from the hospital clinic, not their GP even when the GP is supportive. One person was refused the Libre by a hospital consultant who hasn't seen him for 7 years because he sees his GP for treatment! It is also obvious at this stage, that some CCGs are still using their own criteria in place before April 2019 and therefore refusing people who actually do fit into the new criteria.

In some areas, people are having to sign a contract that they will meet the criteria AND that their information can be shared, anonymously, but who with? One member who has had Type 1 diabetes for 42 years was told he would have to go on a carb counting course – he has been carb counting for 42 years!!!

IDDT recommends:

- If you don't have a meter that keeps a record of your test results, make sure you record them for the last 3 months.
- If you do obtain a Libre on the NHS, it is only available initially for 6 months and future supply is dependent on demonstration of improvements in diabetes self-management, such as an improved HbA1c, time in target glucose range, improvements in DKA or hypoglycaemia or psycho-social wellbeing.
- If you are already using the Libre and paying privately, then it is important that you keep records of any improvements you have experienced if you want to try to obtain it free on the NHS.

Other FreeStyle Libre news

DVLA update guidelines to include flash and continuous glucose monitoring

From February 15th 2019 drivers have been able to use flash glucose monitoring (FreeStyle Libre) and continuous glucose monitoring (CGM) devices to take glucose readings before they drive or during their 2 hour breaks in driving. Previously, drivers have had to check their glucose levels with a finger prick test.

The guidelines have been updated following discussions with the Secretary of State for Transport's Honorary Medical Advisory Panel on driving and diabetes.

Facts

- The new guidelines on glucose testing apply to car and motorcycle drivers who treat their diabetes with insulin. The requirements for glucose testing for bus and lorry drivers remain the same (finger prick blood testing).
- Drivers can still use finger prick blood test readings if they choose to and the updated guidelines include information for drivers who still prefer to test in this way. The guidelines also include guidance for drivers who treat their diabetes with tablets, diet or both.
- If using flash or CGM monitoring, drivers must still confirm their blood glucose level with a finger prick test if:

1. their glucose level is 4.0 mmol/L or below
2. they experience symptoms of hypoglycaemia
3. the glucose monitoring system gives a reading that is not consistent with the symptoms they are experiencing (for example, they feel the symptoms of hypoglycaemia but the reading does not indicate this)

Drivers who treat their diabetes with insulin must tell DVLA. Drivers who treat their diabetes by diet only do not need to tell DVLA. If in any doubt, drivers should speak to their GP or a medical professional involved in their treatment.

FreeStyle Libre online education programme launched

A series of free online modules and workshops designed to ensure people get the most out of the FreeStyle Libre are taking place, These modules will be available free to watch on the DTN-UK website: https://abcd.care/node/778 They are aimed at both healthcare professionals and people with diabetes and are being delivered by the Diabetes Technology Network UK (DTN-UK) as part of its FreeStyle Libre Education Programme. DTN-UK is linked to the Association of British Diabetologists (ABCD) and supports healthcare professionals involved in the delivery of technologies designed to improve the lives of people living with diabetes.

Research shows benefits for the first 6 months

An audit of the FreeStyle Libre in 70 hospitals by the ABCD has shown that diabetes control improved in people with Type 1 diabetes during the first 6 months of its use - lower glucose levels in people with high levels before using it and a reduction in hypoglycaemia.

The audit compared the findings over the first six months of FreeStyle Libre use with the year preceding its use. Initial information was collected from 3,382 people, with HbA1c results on 715 people before and after use of the FreeStyle Libre.

A spokesman for ABCD said that about 8 in 10 people reported that their glucose level was below normal less often than previously and hypoglycaemic attacks during the day and at night occurred less frequently in about three out of ten people. There was also a significant improvement in a measurement of how aware someone is of blood glucose falling to dangerously low levels. The spokesman also said: "These preliminary findings need to be confirmed over a longer period but if confirmed suggest important benefits to people with diabetes and to the wider community by avoiding expensive complications of diabetes and reducing hospital admissions."

THE **GLOBAL SITUATION** WITH **INSULIN** SUPPLIES

Some 400 million people - more than half of them in China, India and the US - aged 20 to 79, are living with Type 2 diabetes and their numbers are expected to climb to more than 500 million by 2030, according to a study in the Lancet Diabetes and Endocrinology. However, around half of those who need it, possibly the majority in Asia and Africa, will not be able to obtain it as already one in two people with Type 2 diabetes do not have access to the insulin they need. The researchers define access as availability and affordability.

In addition to the cost, a supply chain must be in place that can handle and safely distribute a refrigerated drug and the various supplies such as sterile needles and syringes.

Global control

Scientists say that insulin has remained expensive over the years because three multinational companies - Novo Nordisk, Eli Lilly and Sanofi - control 99% of the £16bn global insulin market in terms of value and 96% in terms of volume. Although more than 90 of 132 countries have no tariffs for insulin, it still remains expensive for many due to taxes, steep mark-ups, and other supply chain costs.

In terms of the availability of insulin, David Henri Beran of Geneva University Hospitals and University of Geneva, states that the global control of the insulin market means that countries have a small number of suppliers to choose from, "and this factor has resulted in people having to change the type of insulin they take as companies have withdrawn some formulations from the market. Globally, problems of affordability and availability of insulin are threats to life and challenge the very concept of a right to health."

Why is there no generic insulin?

Insulin was discovered nearly 100 years ago by scientists at the University of Toronto and they sold the patent to the university for $1 because they wanted everyone who needed their medication to be able to afford it. Usually, a generic version of a drug is produced once the patent has run out but that didn't happen with insulin. One of the reasons is that insulin is a hormone and harder to copy. Biosimilars have become available more recently but they are not generic and are still relatively expensive.

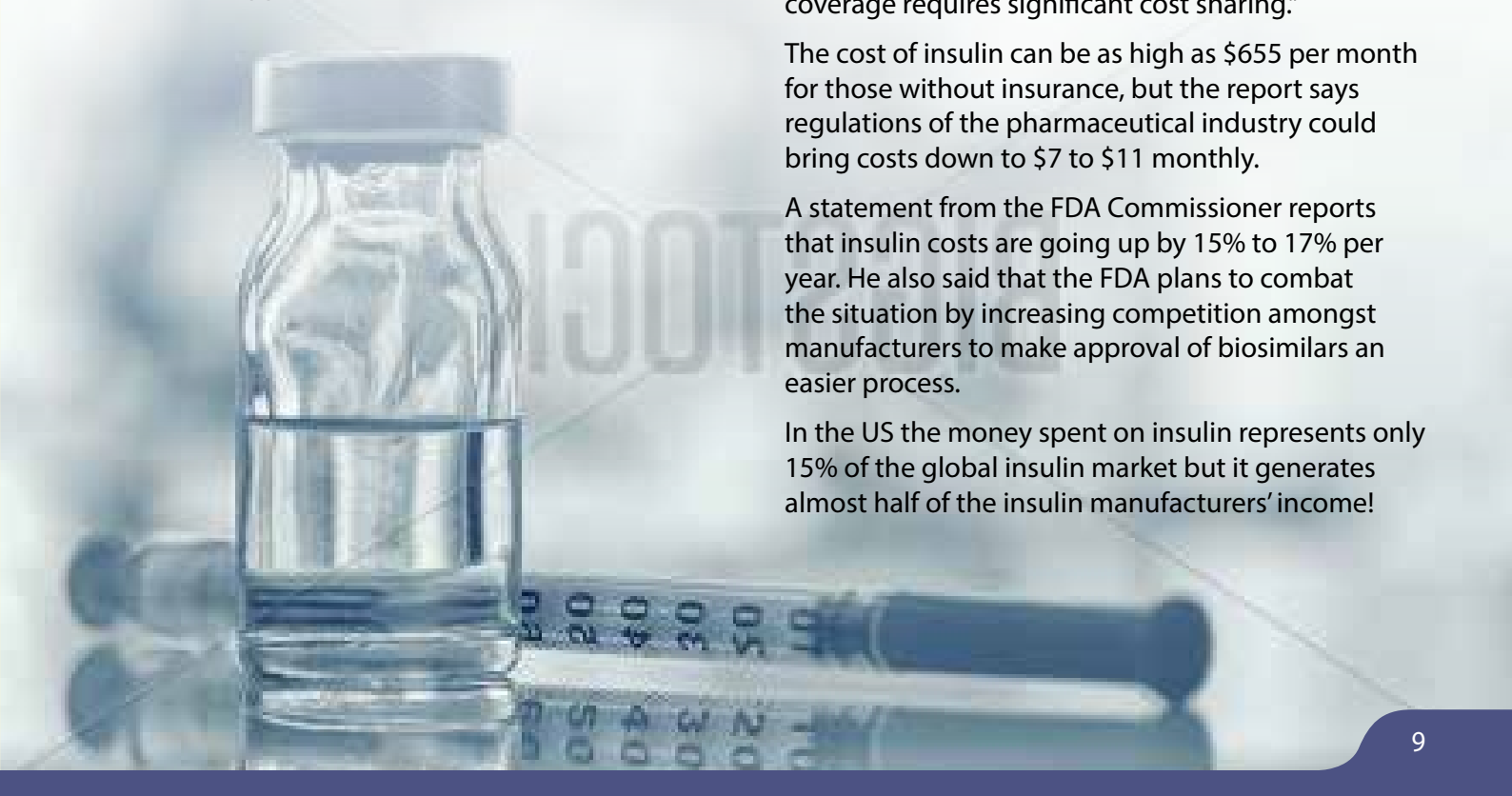
And in the US - many people with diabetes struggling to afford insulin as prices soar

This was a headline in USA Today (21st March) following a Congressional Oversight and Reform Committee report. The report says that many people with diabetes are struggling to afford insulin as prices continue to soar. It notes that "all people with Type 1 and some with Type 2 need the drug" and explains that "regular price hikes make insulin difficult to afford for the uninsured and those whose coverage requires significant cost sharing."

The cost of insulin can be as high as $655 per month for those without insurance, but the report says regulations of the pharmaceutical industry could bring costs down to $7 to $11 monthly.

A statement from the FDA Commissioner reports that insulin costs are going up by 15% to 17% per year. He also said that the FDA plans to combat the situation by increasing competition amongst manufacturers to make approval of biosimilars an easier process.

In the US the money spent on insulin represents only 15% of the global insulin market but it generates almost half of the insulin manufacturers' income!



Structured education for Type 1 and Type 2 diabetes

Education is key to increasing people's ability to look after themselves and manage both types of diabetes. Here are the figures for 2016.

Diabetes type	Newly diagnosed with diabetes in 2016	Offered structured education within 12 months of diagnosis	Attended structured education within 12 months of diagnosis
Type 1	8,975	3,460	405
Type 2 and other	207,630	155,980	18,045

The relatively small number of people attending education courses has to be a major concern. NHS England states that it is working to reduce inequalities and widen routes of access to structured education but if we look at how it intends doing this, all the proposed ways are by offering digital self-management support programmes.

- Access to Healthy Living for People with Type 2 diabetes (HeLP Diabetes) - an evidenced online self-management tool for those with Type 2 diabetes.
- NHS England has made £2 million available to implement and evaluate digital delivery models for self-management education for people living with Type 2 diabetes.
- Clinical commissioning groups who have been given transformation funding, will increase uptake of structured education by commissioning digital services if it has been agreed that this would best meet the needs of the local population.

All these methods are 'digital' and therefore does this assume that everyone will have the ability and access to digital technology? Not everyone wants it. So are the inequalities reduced, or just different?

When the NHS Long Term Plan is implemented, it will set out further detail on how the NHS will further expand provision of structured education and the pace at which local systems will widen provision and routes of access.

IDDT Event 2019 – 'InDependent and Empowered'

We are pleased to announce that this year we are holding an Event for you, again at the Kettering Park Hotel. You will see from the event booking form accompanying this newsletter that it will be an interesting day with speakers and group discussions.

The title is 'InDependent and Empowered' to reflect some of the issues that affect people living with diabetes. As restrictions are put on treatment choices, appointments with doctors and health professionals take longer and there are limited improvements in the numbers of people having all their annual checks, now more than ever do we, as patients and family carers, need to be able to take care of our own health and, if we can, be more assertive to ensure that our health needs are met.

We hope that you and your family members - the spouses, the partners and the parents of those with diabetes will also be able to come to the event. To reflect this, we have a discussion group specifically for 'carers'.

We hope that many of you will be able to join us, so just complete the form and return it to IDDT. Remember, the date for your diary is October 26th 2019!

IF YOU SHOP ON **AMAZON**, HERE'S HOW YOU CAN HELP IDDT

AmazonSmile is a simple and automatic way for you to support IDDT every time you shop, at no cost to you. When you shop at smile.amazon.co.uk, you'll find the exact same low prices, selection and convenient shopping experience as amazon.co.uk, with the added bonus that Amazon will donate a portion of the purchase price to your selected charity, IDDT.

How do I shop at AmazonSmile?

To shop at AmazonSmile simply go to smile.amazon.co.uk from the web browser on your computer or mobile device. You may also want to add a bookmark to smile.amazon.co.uk to make it even easier to return and start your shopping at AmazonSmile.

Which products on AmazonSmile are eligible for charitable donations?

Millions of products on AmazonSmile are eligible for donations to charities by Amazon. You will see eligible products marked "Eligible for AmazonSmile donation" on their product detail pages. Recurring Subscribe-and-Save purchases and subscription renewals are not currently eligible.

Can I use my existing Amazon.co.uk account on AmazonSmile?

Yes, you use the same account on amazon.co.uk and AmazonSmile. Your shopping cart, Wish List, wedding or baby registry, and other account settings are also the same.

How do I select a charitable organisation to support when shopping on AmazonSmile?

On your first visit to smile.amazon.co.uk you need to select a charitable organisation to receive donations from eligible purchases before you begin shopping. Amazon will remember your selection, and then every eligible purchase you make at smile.amazon.co.uk will result in a donation to IDDT.

How much of my purchase does Amazon.co.uk donate?

Amazon will donate 0.5% of the net purchase price (excluding VAT, returns and shipping fees) of your eligible AmazonSmile purchases. The purchase price is the amount paid for the item minus any rebates and excluding shipping & handling, gift-wrapping fees, VAT, and service charges, and less any rebates, returns, and bad debt. From time to time, Amazon may offer special, limited time promotions that increase the donation amount on one or more products or services or provide for additional donations to charitable organisations. Special terms and restrictions may apply. Please see the relevant promotion for complete details.

Pharmaceutical News

New smart pens could change the way diabetes is treated – a news release in the US from Novo Nordisk

Abbott and Novo Nordisk recently announced a partnership that will integrate insulin dose data from Novo Nordisk pre-filled, durable connected pens directly into the digital health tools compatible with the FreeStyle Libre system. (FreeStyle LibreLink mobile app and LibreView cloud-based system)

Novo Nordisk also announced partnerships with Roche, Dexcom and Glooko and these companies will integrate insulin injection information into their apps/platforms. So, the new smart connected insulin pens, the NovoPen 6 and the NovoPen Echo Plus, will also be able to connect to the Dexcom G6 CGM and the Diasend diabetes management platform (Glooko). The new connected pens are reusable and include a tiny screen that displays the last dose. They are already approved in Europe (CE marked). Reusable smart insulin pens are to launch first, followed by the Bluetooth attachment for disposable pens later in 2019. The attachment will transmit the insulin dose, time of dose and the type of insulin being injected to a phone app (an important safety precaution to avoid mix-ups). The new smart pens can almost duplicate what an insulin pump can do but at a much lower cost. (March 2019)

Application for Fiasp to be available for children and adolescents

Novo Nordisk has submitted label updates to the European Medicines Agency (EMA) and the US Food and Drug Administration (FDA) for use of Fiasp as a new mealtime insulin for children and adolescents with Type I diabetes. Fiasp has a faster acting profile of action compared to fast-acting insulin NovoRapid (aspart) and can be administered at the start of the meal.

The submissions are based on the results from the onset 7 trial which investigated the efficacy and safety of Fiasp compared to NovoRapid in 777 children and adolescents with Type 1 diabetes. The results showed superior control of overall blood sugar levels with Fiasp, as well as significantly lower blood sugar levels one hour after the meal.

New ulcer treatment could prevent 3,000 amputations a year

A unique interactive wound dressing, called Urgostart, for venous leg ulcers and diabetic foot ulcers that could prevent more than 3,000 diabetes-related amputations has been recommended by NICE (The National Institute for Health and Care Excellence).

The conclusion of the NICE medical technology guidance is that UrgoStart is associated with increased wound healing compared with non-interactive dressings and could result in fewer ulcer-related amputations. The NICE guidance committee acknowledged the robust clinical studies which 'showed an increase in the rate of early wound healing with UrgoStart in patients with venous leg ulcers compared with standard treatment' and will result in significant cost savings for the NHS and improved quality of life for patients.

NICE's decision means that thousands more people with venous leg ulcers and diabetic foot ulcers could benefit from this unique wound treatment. At any one time 115,000 people in the UK develop a diabetic foot ulcer and 278,000 people are treated for venous leg ulcers every year. Leg ulcers and diabetic foot ulcers take an average of 200 days to heal. If half of the people with a venous leg ulcer were treated with UrgoStart there would be an annual cost saving of £75 million to the NHS. If half of the people with a diabetic foot ulcer were treated with UrgoStart, the NHS could save £19.6 million per year.

'Robotic' pill to eliminate injections

Rani Therapeutics, a company backed by Google's parent company, has carried out its first human test of a capsule that eliminates the need for people to inject when administering drugs for chronic conditions such as diabetes. The pill travels from the mouth through the stomach and into the small intestine. Here the capsule dissolves and a tiny balloon inflates from a chemical reaction creating gas which in turn pushes a tiny dissolvable needle into the wall of the gut. Neither the balloon inflation nor the needle piercing the gut wall can be felt because there are no pain receptors here.

The shape of the capsule was inspired by the Leopard tortoise, commonly found in Africa, which has a steep, domed shell that allows it to right itself if it rolls on to its back. The capsule works in a similar way as the domed shape ensures the needle is turned towards the stomach wall.

This method may take several years to reach the market. It could also solve storage problems in hotter countries because they keep fresher for longer. (Science, February 2019)

Insulin analogues versus human insulin for Type 2 diabetes

Short-acting insulin analogues act more quickly than regular human insulin. They can be injected immediately before meals and lead to lower blood sugar levels after food intake. Whether people with diabetes really benefit from these newer insulins is debated.

A review published in Cochrane database of Systematic Reviews (January 2019) has shown that no clear benefits or harms could be seen between the treatments with short-acting analogues and regular human insulin in non-pregnant adults with Type 2 diabetes, although the certainty of evidence was poor.

The trials

There were 10 eligible trials with 1388 participants receiving short-acting insulin analogues and 1363 receiving regular human insulin. The trials lasted between 24 to 104 weeks and showed a low incidence of severe hypoglycaemic events and no clear differences between the two treatments. The number of non-severe hypoglycaemic episodes overall was 0.08 events/participant/month but with very low-certainty evidence.

No trials included all-cause mortality as a primary outcome or investigated long-term effects, and results concerning nocturnal hypoglycaemic episodes were questionable. None of the trials were blinded (so study participants and study personnel knew who was getting which treatment), making risk of detection and bias very high, and several showed inconsistencies in how methods and results were reported.

Results

The reviewers are uncertain whether short-acting insulin analogues are better than regular human insulin for long-term blood glucose control or for reducing the number of times blood sugar levels drop below normal (hypoglycaemic).

- The studies were too short to reliably investigate death from any cause.
- There was no clear effect of insulin analogues on health-related quality of life and no information on late diabetes complications, such as problems with the eyes, kidneys, or feet.
- No study reported on socioeconomic effects, such as costs of the intervention and absence from work.

The overall certainty of the included studies was low or very low for most outcomes, mainly because all studies were carried out in an open-labelled way so participants and researchers knew who was getting which treatment. Several studies also showed inconsistencies in the reporting of methods, and results were imprecise.

IDDT Comments - with the results of this reputable review, should prescribers not question the use of the more expensive analogue insulins?

NHS NEWS

Prescription charges increased from 1 April 2019

For people who do not have a Medical Exemption Certificate, the prescription charges have increased as follows:

- Single Charge - £9.00
- 3 month Prescription Payment Certificate (no change) - £29.10
- 12 month Prescription Payment Certificate (no change) - £104.00

Note: People taking medication for their diabetes are entitled to free prescriptions but people with Type 2 diabetes on diet-only have to pay for any prescriptions they need.

Therapy for diabulimia

Announced in February 2019, a new NHS service is to offer therapy for the eating disorder, diabulimia, to counteract the impact of harmful social media.

Diabulimia is a condition where people with Type 1 diabetes restrict their insulin intake to lose weight which can lead to serious complications including blindness and amputations. It is most common in young people aged between ages 15 and 30 with two in five women and one in ten men with Type 1 diabetes thought to have diabulimia.

Due to the potential damage that social media can have on young people's mental health, people with the condition will be coached to deal with unrealistic body images. People who are referred to this new service will also be offered daily structured meal planning and clinical support to manage their insulin intake. Also provided will be:

- eating disorder teams including team members specialising in mental healthcare and Type 1 diabetes,
- specialist day care centres including structured meal planning and advice on glucose and insulin management,
- tailored care ranging from hospital stays where necessary and help in the community to provide advice on diet, insulin doses, as well as mental health support,
- training for healthcare workers to increase their knowledge of the condition,
- online learning will be provided for people with diabulimia, carers and families so they can better understand the condition and support their loved ones.

The services will be piloted in London and the South Coast when treatment for diabetes and mental health will be joined up. This will happen later this year and if successful, will be rolled out across the country. NHS England promises to treat 95% of all children and young people with an eating disorder in one week for urgent cases and four weeks for routine cases by 2020/21.

Increase in lower limb amputations, again!

There were 26,378 lower limb amputations related to diabetes in England from 2014 to 2017. Figures analysed by Diabetes UK show a significant rise in minor lower limb amputations (26.5%) defined as below the ankle, and a more gradual increase in the number of major lower limb amputations (4.1%), defined as below the knee. As a result, Diabetes UK is calling for NHS England to commit to maintaining the Diabetes Transformation Fund beyond 2019.

Much work appears to be going on for once people have problems and are in hospital but the emphasis should be on prevention – ensuring that foot problems are picked up at an early stage before the serious problems occur. This is not helped by many people not having access to an NHS podiatrist,

It is vital that everyone living with diabetes knows how to look after their feet, and check them regularly and to know what to look for, so don't forget that IDDT has a free booklet, Looking After Your Feet, just call IDDT on 01604 622837 or email enquiries@iddtinternational.org

MATT HANCOCK WATCH

As regular readers are aware, we regularly ran a 'Jeremy Hunt Watch' when he was in charge of Health and now that his replacement, Matt Hancock has been in post for some time, it seems that we should start a 'Matt Hancock Watch'!

Increase in NHS private contracts (April 2019)

Speaking to the Health Select Committee in January, Secretary of State for Health and Social Care, Matt Hancock said: "There is no privatisation of the NHS on my watch, and the integrated care contracts will go to public sector bodies to deliver the NHS in public hands." However, he has now been accused of going back on this pledge to halt privatisation in the NHS after it emerged that more than £100 million-worth of private health contracts are currently out to tender.

According to analysis by the House of Commons library, 19 new contracts worth £36 million have been put out to tender since mid-February with the largest contract being to run an NHS 111/ Clinical Assessment Service for five years in Kent, Medway and Sussex, estimated to be worth £91 million on its own.

According to the Department of Health and Social Care Annual reports, the total spent on private sector providers has more than doubled in the last decade, from £4.1 billion in 2009/10 to £8.8 billion in 2017/18. The contracts have been issued under Section 75 of the Health and Social Care Act 2012, which allows the National Health Service Commissioning Board and CCGs to procure deals with private sector providers.

Health secretary wants NHS to roll out genetic tests to detect diseases

Matt Hancock hails genetic testing as a 'game-changer' but critics raise racial bias and 'fatalism' concerns.

Speaking at the Royal Society, he said he recently took a commercial genetic test that showed he was at increased risk of developing prostate cancer and he was shocked by this result. Hancock called for a national debate about the ethical issues around genetic testing for diseases and for predictive genetic tests for common cancers, heart disease and diabetes to be rolled out on the NHS without delay.

However, experts have criticised him for this for the following reasons:

- The tests have been largely developed using genetic information from white Europeans so the tests give less accurate results for people from different ethnic backgrounds. It surely cannot be contemplated that the NHS has a test which only works for white people!
- Genetic tests could create unnecessary stress, confusion or what is known as 'genetic fatalism' where people give up on efforts to maintain a healthy lifestyle because they believe they are genetically destined to get a particular illness.
- The value of genetic testing for common diseases has been overstated, since only people at the extremes of the distribution would have significantly higher or lower risk than average.

APOLOGIES FOR ERROR: Talking therapies – we made an error on Page 17 by giving the website address that only applied to certain areas. If you feel that talking therapies would help you, then discuss this with your GP to find out what is available in your area.

Keeping Type 1 diabetes at bay?

As we know, insulin is produced by the beta cells in the pancreas and Type 1 diabetes is caused by the beta cells failing to produce enough insulin because they have been attacked by the body's own immune system. Research has focussed on preserving beta cell function by preventing the immune system from attacking them. However, researchers at the University of California have turned this thinking upside down and shown that in animals Type 1 diabetes could be kept at bay by clearing out defective insulin-producing beta cells.

"This is a paradigm shift for T1 diabetes therapy," said Professor Anil Bhushan, who led the study. "These data suggest the problem may not be an immune system gone awry. Instead, perhaps therapies should find a way to do the job the immune system is failing to do: clear the senescent cells early on."

The team found evidence that people with Type 1 diabetes have a problem with the DNA repair that causes beta cells in the pancreas to stop functioning properly and leak signs of damage on to their neighbours – known as secretory senescence. The researchers found signs of this DNA damage and secretory senescence in mice, but also in pancreatic tissue donated by six deceased patients with early stage Type 1 diabetes and in living donors with early signs of diabetes.

This suggests they may have identified an early marker of diabetes, but also points to a possible way to stop it. Senescent cells, those too old or damaged to function, are usually removed over time by the immune system but in Type 1 the researchers found the signs of damage that had become so widespread that the immune system goes into overdrive and destroys the whole insulin-producing structure beyond recovery.

Testing this theory in mice genetically engineered to develop Type 1 diabetes, the researchers found that the mice responded to recently approved cancer drug Venetoclax. In trials, 75% of the animals in the control group developed diabetes by 28 weeks old, but only 30% given a two-week dose of Venetoclax developed it and the healthy beta cells were left untouched by the immune system.

The usual warning applies – this is early days and much more research needs to be carried out but at least it is a different way of looking at Type 1 diabetes. (Cell Metabolism, February 2019)

Insulin pump therapy is expensive and overall benefits still not clear

According to research from Sweden, insulin pump therapy (CSII) for Type 1 diabetes is associated with additional costs when compared with multi-daily injections (MDI) of insulin but whether or not the extra costs bring extra benefits to users is still not clear. The researchers say that more time is still needed to fully assess this.

These conclusions come from an analysis of over 14,000 people with Type 1 diabetes on the Swedish National Diabetes Register, with a third of them being on insulin pumps and two thirds using multi-daily injections. The average annual costs for pump therapy was just under $13,000 while costs for multi-daily injections were just over $9,000.

The majority of costs associated with pump therapy were health costs (73%) including medications and disposables. The same health care costs associated with multi-daily injections made up 63% of the total costs. Other costs were higher for pump therapy including outpatient costs and dealing with complications. In terms of health outcomes, the researchers highlight that the number of events overall was low but in some people rates were higher with pump use.

The researchers suggest that the 9 years follow up used in the analysis may not be sufficient to detect any meaningful differences in the two treatments. As a result, they say that while the costs appear to be higher for pump therapy, it is still not clear that this translates into greater benefits for the user. (Diabetes Care, April 2019)

And in children and young people with Type 1 diabetes…

In this study, multiple daily injections (MDI) and pump therapy (CSII) were compared in terms of their safety, efficacy, and cost in the first year after diagnosis of Type 1 diabetes. 294 patients across multiple centres in England and Wales with a new diagnosis of Type 1 diabetes between the ages of 7 months and 15 years were randomised to receive either MDI or CSII within 14 days of diagnosis. Researchers found that HbA1c at 1 year was not significantly different between the CSII and MDI groups. In addition, there was no significant difference in the proportion of patients achieving a HbA1c less than 58 mmol/mol.

Interestingly, parents reported an improvement in quality of life scores with CSII, as compared to MDI, but children did not. CSII was more expensive by $2,474 per year and was not associated with a significant difference in incremental cost per quality adjusted life year.

Therefore, the researchers concluded that there was no glycaemic control benefit to pump therapy compared to MDI in the first year after a diagnosis of Type 1 diabetes, despite it being more expensive. (BMJ 19th April 2019)

Common misdiagnosis in people over the age of 30 years

People with Type 2 diabetes diagnosed after the age of 30 are often misdiagnosed when, in fact, they have Type 1 diabetes, according to a UK study carried out at Exeter University.

The study involved 583 people with insulin treated diabetes who had been diagnosed after the age of 30 and these were compared with 220 people with severe insulin deficiency who had been diagnosed before 30 years of age.

The results showed:

- 21% of those treated with insulin and diagnosed after 30 had severe insulin deficiency and therefore had Type 1 diabetes, not Type 2 diabetes.
- Of this group, 39% did not receive insulin when first diagnosed and 46% had self-reported Type 2 diabetes.
- Of the people who became dependent on insulin within 3 years, 44% developed a severe insulin deficiency and they had similar characteristics to those diagnosed before the age of 30. However, the group that retained some insulin production had lower risks of Type 1 diabetes, antibody positivity and higher BMI.

The researchers concluded that there are clinical similarities between Type 1 diagnosed before and after 30 years of age and this highlights the importance of correct diagnosis as early as possible. They also stated that clinicians should be aware that the majority of patients needing insulin within 3 years of diagnosis will have Type 1 diabetes, even if they were initially thought to have Type 2 diabetes and did not need insulin at diagnosis.

The latest on aspirin

Cardiovascular disease is the most common cause of premature mortality in people with diabetes but the benefits of aspirin have been debated for many years because of the potential adverse effects of intestinal bleeding.

The benefits of aspirin for secondary prevention, which is use in people who have already had a serious cardiovascular event, is well established with an estimated relative risk reduction of further cardiovascular events of up to 25%. However, the role of aspirin in primary prevention (giving aspirin to people at risk of cardiovascular disease), has been uncertain but three large studies in the last year have clarified the evidence for doctors.

- The use of aspirin for primary prevention, although effective in reducing cardiovascular events, is outweighed by the significantly increased risk of bleeding.
- Aspirin should not be routinely prescribed for primary prevention in people with or without diabetes.
- The priority to reduce cardiovascular risk should include optimal glycaemic control, blood pressure management, smoking cessation and lipid lowering treatment. (Practical Diabetes, Vol 36 No. 1)

Implantable pouch device for children with Type 1 could be the future

We have heard much about islet cell encapsulation, a form of transplantation of insulin producing islet cells but the challenge is that the body's autoimmune system attacks the cells so immunosuppressant drugs are required. These drugs can cause side effects which in children can be dangerous, so this technique is not recommended for them.

This latest research uses implanting a small pouch containing the islet cells which can respond to blood glucose levels by releasing insulin when needed. The pouch prevents the immune system attacking the cells.

The cells need oxygen to stay alive and the researchers have developed a battery powered oxygen generator which is implanted under the skin and recharges wirelessly. The islet cells survive and function better with this oxygen supply.

The researchers are hoping to carry out clinical trials within the next 4 years. If successful, it will be a way of helping children with Type 1 diabetes. (Endocrine Connections, March 2019)

FLYING

Medical Device Awareness Card now available

The new Medical Device Awareness Card is now available to help with airport security. It covers both Insulin Pumps and Continuous Glucose Monitoring systems and is sponsored by the UK Civil Aviation Authority and Airport Operators Association.

Insulin pump and CGM manufacturers advise that these medical devices should not be exposed to x-ray screening and full-body airport scanners. Regulations allow passengers with these devices to ask for an alternative security screening process.

Despite the protocols in place, there have been negative experiences at airport security resulting in the issue of the Medical Device Awareness Card. The card provides information for both the Security Officer and the passenger as follows:

Medical Device Awareness Card: Security Officer

- Passengers with a medical device such as an insulin pump or Continuous Glucose Monitoring system should not be screened by a security scanner; if they opt out of this, they must be offered an alternative screening method.
- Passengers must never be asked to remove a medical device from their body for screening.
- Medical devices (including spare devices) should not go through x-ray machines. Alternative screening processes can be undertaken such as hand search, supported by ETD.

Medical Device Awareness Card: Passenger

- Don't forget to bring your medical evidence (e.g. letter from a medical practitioner) to confirm use of your medical device. Have this ready to show the Security Officer, along with this card.
- Make the airport Security Officer aware of the device, exactly what it is and where it is located.
- If you are carrying a spare medical device, remove it from your cabin bag before the x-ray and let the Security Officer know.
- Contact the airport if you have any concerns or queries before you travel: note that screening equipment and processes may differ from airport to airport.
- Check with your return airport (if outside the UK) on their arrangements for screening medical devices.

For more information visit:

www.change.org/p/airport-authorities-standard-policy-for-insulin-pumps-at-airport-security

Current statements from the major manufacturers, February 2019

Medtronic: www.medtronicdiabetes.com/customer-support/traveling-with-an-insulin-pump-or-device

Roche: www.accu-chek.co.uk/insulin-pumps

FreeStyle Libre: www.freestylelibre.us/support/faq.htm

From our own correspondents

Be careful about completing your driving licence application online!

One of our Type 1 members phoned today to warn other people of his experience with the DVLA online driving licence application.

In 2009 he had laser treatment on his eyes but since then has no further treatment. In 2016 his licence was renewed without any problems and without a field test being required. Just recently he received a reminder that his licence was due for renewal and the letter said that he could now complete this online, so he did.

He was then informed that he had to go to Specsavers for a field test. On telephoning the DVLA to find out why this was as his eyes have not changed since 2016, he was told that if he had completed the paper application, then it would have been handled by a real person and he would not have been required to have a field test but the computer system could not do this.

It appears that if you have had laser treatment at any time, then you will have to go to Specsavers for a field test because the online system can't differentiate between people whose eyes have settled down since laser treatment and those whose eyes have not.

Our member was then told to ignore the request and his licence would be issued without visiting Specsavers for a field test!

His advice to others: if you have diabetes and have ever had laser treatment, do not use the online driving licence application system.

By telephone

Hypo behaviour

Hello Jenny,

I was at a friend's house with my daughter and had an unexpected severe hypo. My friend called 999 and the paramedics arrived. They treated my hypo but they said I would have to be taken into hospital. I asked if my daughter could come with me but they said she would have to stay with my friend. I was still behaving strangely from the hypo and argued with them. Eventually they said that unless I did as I was told they would have to section me. I was horrified by this and still am. Their understanding of what happens when people are hypo was completely lacking. I wonder if this has happened to anyone else?

By telephone

Transforming my life

Dear Jenny,

I thought you and your readers may be interested in an IDDT member's experience of Continuous Glucose Monitoring (CGM). I have been using a Dexcom G6 system for over 6 months. The only downside has been the pain in my purse (£159 per month). It is no exaggeration to say that it has transformed my life. I had always resisted changing from porcine insulin as back in the 1980s when I was switched to human insulin I had terrible problems and I was fearful of losing my hypo warnings.

Having CGM has allowed me to go on to a different insulin regime (bolus 9 units Tresiba and 2 units Novorapid at mealtimes - which are now flexible). My hypo warnings have been lessened but they are less frequent and less 'off the edge of a cliff' in nature. I am also on a low carbohydrate diet. Now I have confidence that I will be awoken if I have a night hypo and alerted in the day. I can also adjust my blood sugars if higher than liked with my new fast-acting insulin.

Basically, it has given me back a normal life. I should say I've been a diabetic for well over 40 years. As I'm in my mid-70s, I was becoming increasingly worried about managing my diabetes myself and later it being managed by carers. With CGM both the overall picture and the immediate reading will be of use, and carers can be 'followers' who will be able to see the CGM reading in real time.

L.R. - *South West*

InDependent Diabetes Trust

SNIPPETS

Young people in the UK are less healthy than in similar high-income countries

A report published by the Nuffield Trust and the Association of Young People's Health examined 17 indicators of health and wellbeing in young people aged 10-24 years in 19 similar high-income countries in and outside Europe.

Young people in the UK are more likely to die from asthma, be obese or overweight or have a poor quality of life from long-term conditions, such as Type 1 diabetes than most young people in similar countries. For all the years studied, the UK's obesity levels in young people were closer to the worst performing country, the USA, than the best performing country, Japan.

Not all beta cells are destroyed

Genetics and the immune system are very involved in Type 1 diabetes, but not all beta cells are destroyed and not all functioning may be lost either. C-peptide and proinsulin are still being processed in many of these patients.

- A longer duration of the disease does not lead to progression of beta cell dysfunction.
- Research showed that people diagnosed with Type 1 diabetes when they were older had more functioning beta cells than people diagnosed when they were younger.

Diabex warning!

Internet users may have seen adverts for Diabex patches which claim to cure Type 2 diabetes. These are patches containing various herbal ingredients, which of course, do not cure diabetes. However, they should not be confused with Diabex which is the brand name for metformin in some countries (eg Australia), which is the first line treatment for Type 2 diabetes.

IDDT has picked up several adverts and been sent emails for similar patches, so it seems to be the latest scam.

Government must 'rein in' drug companies to reduce the NHS medicines bill

NHS England has released figures that show that the NHS spent a record £20.2 billion on drugs last year, a rise of 10% on the previous year which is faster than the growth in the NHS budget, despite a recent cash injection.

In addition, 7 out of 20 of the most expensive medicines were developed from publicly funded research. It is the second year running that the NHS spent over £1 billion on medicines where public funds played a substantial role in their development.

Health campaigners have warned that the NHS drugs bill will continue to rise unless the government takes action to tackle what they describe as the "exploitative behaviour of the pharmaceutical companies". Rightly, they point out that the public are paying twice for these medicines (i) when they are developed by publicly funded research and (ii) when paying the high prices charged to the NHS. Some are so costly the NHS will not fund them and people suffer as a result.

This is a global situation and if companies refuse to drop their prices, the call is for governments to pursue their legal right to procure affordable generic versions of patented medicines.

Canabis use increases the risk of DKA

People with Type 1 diabetes who use cannabis are at an almost twofold increased risk of developing diabetic ketoacidosis compared to nonusers. Researchers interviewed 450 people with Type 1 diabetes in Colorado and found that those who used cannabis had an average HbA1c level of 8.4%, compared with 7.6% among non-cannabis users. (JAMA Internal Medicine, November 2018)

FROM YOUR EDITOR – JENNY HIRST

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