



Insulin Dependent Diabetes Trust

October 2011 Newsletter



Diabetes Everyday Eating

“I want to be told what I can eat – not what I can’t.”

IDDT is frequently contacted by people who want advice about their diet. Very often, particularly just after diagnosis, people feel confused about the advice they are given on healthy eating. They feel insecure about what they are eating and how this may affect their diabetes or they simply do not have enough information about diet. These feelings may hold equally true for family members who will also have a role in the changes to diet that the household may have to make.

Very often, people are told that they need to eat healthily, lose weight and to stay away from sugary and fatty foods. This particularly applies to people with Type 2 diabetes and while this advice is not bad advice, it can leave people without the information they need during a stressful

time. As one gentleman said “I want to be told what I can eat – not what I can’t”.

And what about people with Type 1 diabetes? If you are lucky enough to go on a DAFNE education course or to have an insulin pump, you are taught to count carbohydrates. If you were diagnosed before 1986 you were automatically taught to count carbs. However, the introduction of ‘Healthy eating’ for the general population resulted in carb counting almost disappearing for people with diabetes. Most of those who had carb counted continued to do so, but there is a whole generation of people using insulin who have never been taught. Perhaps just as importantly, there is a whole generation of health professionals who have not been fully trained in carb counting in order to teach their patients to do it safely and achieve the best blood glucose control possible.

In the real world, we cannot suddenly expect this situation to be rectified - simply because of sheer numbers and time. There is evidence that carb counting is beneficial for people taking insulin and equally, that it is important that people with Type 2 diabetes taking tablets are aware of the effects carbohydrates have on blood glucose levels. There are real health benefits from carb counting and IDDT believes that we cannot sit back, wait and do nothing.

It is for these reasons IDDT has produced a 4-week Menu Plan prepared by Consultant Dietician, Dr Mabel Blades. The Menu Plan is not intended to be a substitute for an individual diet plan prepared by a dietician or other health professional. It is intended to give people ideas about what they can eat – everyday, affordable meals in an easy to look at way. It provides an introduction to counting carbohydrates and is a stepping stone to learning more about diet and diabetes.

It will be especially useful to anyone who has been newly diagnosed or who has had a member of the family diagnosed. It is based on the principles of healthy eating and could help with weight loss.

‘Diabetes Everyday Eating’ is available free of charge from IDDT to people who live with diabetes and to health professionals to give to their patients. Copies can be obtained by contacting IDDT: Tel 01604 622837, email martin@iddtinternational.org ordering on our website www.iddtinternational.org or writing to IDDT, PO Box 294, Northampton NN1 4XS

Pump News

Flying – cabin pressure can affect insulin delivery

Researchers in Australia have reported that changes in cabin pressure during flights may cause insulin pumps to deliver too much or too little insulin which could possibly put sensitive diabetes patients at risk. Those who are very sensitive to small changes in dose are the ones who are going to be most sensitive to this – children and adults on

small doses. They recommend disconnecting the pump before take off and after landing and making sure there are no air bubbles in the insulin before reconnecting it. Other researchers say that this does not seem to be a frequent and recurring problem.

After learning about a 10 year old girl with Type 1 diabetes whose blood sugar dropped about an hour after take off, the researchers found cases of other pump users with the same problem during flights. They put 10 pumps on a commercial flight and found that during take off, when the air pressure is decreasing, the pumps delivered about 1 to 1.4 extra units of insulin. During the descent, when pressure was increasing, about 1 unit of insulin was sucked back into the pumps causing them to give out too little insulin.

To prevent dangers when flying, they recommend the following:

- Cartridges should only contain 1.5 mL of insulin.
- The pump should be disconnected before take off, then remove air bubbles and reconnect while cruising.
- Disconnect again before landing and prime the line with 2 units of insulin after landing before reconnecting for good.
- The pump should also be disconnected during flight emergencies when there is a big drop in cabin pressure.

It is possible that other big changes in pressure could cause pumps to deliver too much or too little insulin, such as ski-lifts.

[Diabetes Care, Aug 4, 2011]

Low Glucose Suspend insulin pump reduces hypoglycaemia in children

A German study involving 21 children and young people with Type 1 diabetes showed that in this group, the Medtronic sensor-augmented pump, the Paradigm Veo system, there was a reduction in hypoglycaemia without the risk of severe hyperglycaemia or diabetic ketoacidosis [DKA].

The Medtronic pump consists of an insulin pump, a continuous glucose monitor, and a component that first issues a “pre-alarm” if the sensor

detects a reading below a preset level. If there is no response on the part of the patient and the glucose level continues to drop to a second preset level, the pump then alerts again and stops the basal insulin infusion for 2 hours or until there is a response. At 2 hours, the basal infusion resumes. If the glucose level is still too low at 4 hours after resumption, the cycle begins again. This process can be interrupted by the patient at any time.

Results:

- During the 6 week study, a total of 1,298 alerts occurred, of which 853 (66%) were shorter than 5 minutes because the patients reacted immediately and there was no automatic interruption of insulin delivery.
- The frequency of alerts was 2.56 per patient per day, of which 78% occurred during the day [6:00am to 10:00pm]. However, because the patients were far less likely to respond to the alarms while sleeping, the frequency of insulin delivery disruptions was far more common during the night.

The Veo system is sold in 45 countries but it is not currently available in the US as the Food and Drug Administration [FDA] recently issued a guidance for manufacturers for such systems specifying the types of testing that must take place to address safety issues, including a concern that the device might overcorrect the hypoglycemia, resulting in hyperglycemia and/or DKA. **Note:** the study was funded by the manufacturers, Medtronic.

Hackers can remotely manipulate insulin pumps

At the Black Hat Computer Security Conference in Nevada in August 2011, insulin pump user, Jerome Radcliffe, showed that insulin pumps are vulnerable to determined hackers. With some difficulty, he was able to reprogramme his Medtronic pump remotely so that it responded to another remote and he could make it do more or less what he wanted, such as deliver the wrong dose of insulin as these devices have no security. Increasing numbers of medical devices are hooked up to communication systems so that health professionals can be involved in a patient's care from a distance eg pacemakers,

operating room monitors, and ICU equipment. So far, there have been no reports of hackers interfering with insulin pumps but these findings are of concern because the potential is there and for hackers, hacking is the goal.

Scientists in Massachusetts are developing jammers that can be worn and they claim they would defend medical devices from the hacker's signals.

Medtronic said it doesn't plan to fix the weaknesses in current products, but is adding encryption and other security measures to the next generation of products to deter hackers. This could take several years to hit the market, in part because of a lengthy government approval process.

Radcliffe said the response from Medtronic was inadequate, because the devices could be fixed sooner with a "patch," and current Medtronic pumps are left with outdated software code that can be exploited.

Using animal insulin in pumps

IDDT receives quite a lot of queries from people using pork insulin who want to use this type of insulin with pump therapy. All too often they are wrongly told that they cannot use animal insulin in a pump. This is not true as any type of insulin can be used in a pump as long as the activity profile of the insulin is taken into account.

Experiences of people with diabetes using animal insulin in a pump

By Jane Essex and Phil Coates

A relatively small number of people use animal insulin and in the majority of cases this is because they experience adverse effects when using human and analogue insulins. As a result only three studies have been published investigating the use of animal insulin in pumps and only one of these highlighted a hypothetical problem based on the theoretical possibility that the larger molecules of the animal insulin could block the cannula.

This study describes the experiences of a small group of people with Type 1 diabetes who use animal insulin [pork or beef] in a pump. The findings of the survey showed:

- Participants reported successful use of animal insulin in pumps requires a good level of knowledge on their part.
- Participants were strongly committed to their insulin of choice, and had based their decision on personal experience.
- Participants reported varying levels of support by healthcare professionals for their choice to use animal insulin.

By far the most common reason for using, or wanting to use, animal insulin either by injection or with pump therapy was improving the warning signs of hypoglycaemia. [Journal of Diabetes Nursing, Vol 15 No 1]

Here are some tips from Dr Jane Essex for using pork insulin in a pump.

Firstly, the differences in operating the pork/pump combination are all those you would expect of an insulin that is more slowly absorbed into the bloodstream. Its onset of action is slower and the injected insulin has a more sustained effect. The practical considerations arising from this are:

1. People do not find that the 'short cut' functions e.g. 'bolus wizard' or similar work for non-analogue insulins because of the very different profiles of the insulins. Stick to the usual insulin: carb ratio and work it out in your head. Square waves and such like are pretty meaningless with such a sustained release insulin, though splitting the bolus into two doses spaced out by an hour or even two can be tried e.g. for pizza or fish and chips or other very slowly released carbohydrates.
2. The bolus will need to be given ahead of the meal unless it is a very low GI carbohydrate. People who inject animal insulin are usually accustomed to injecting 30 minutes before eating and just need to treat a pre-prandial bolus in the same way as their injection.
3. When looking at patterns in blood glucose levels and insulin basal rates, you probably need to trace back 6 hours before the time you're considering, rather than the commonly used figure of 4

preceding hours for analogues.

4. The more sustained release of pork insulin means that the injected insulin may be a little more prone to variation in release e.g. due to exercise or the skin being warm or cold. This is also true for injected slow-release insulins, but you may be more aware of it when using a pump.
5. Although pump users commonly need less insulin than they were injecting, the drop with animal insulin is likely to be less than analogue users, possibly only 80% of the drop that an analogue injector might experience, though trial and error is the only way to gauge it in the end!

Supply Problem With Apidra Insulin

Notice issued by Aventis, September 2011

Sanofi, the makers of Apidra [insulin glulisine] have had a supply problem at their factory. This has meant that the usual supplies have not been manufactured. As a result some people may have a problem obtaining supplies of Apidra. Sanofi have solved the problem, but it is likely to be December before normal supply is resumed.

What should you do?

To help make sure that as many patients as possible can obtain the medicines they need, please don't ask your doctor or nurse for a new prescription of Apidra until you are reaching the end of your own supply.

Your pharmacy will do everything they can to fulfil your prescription. In some cases this may not be possible. If this happens, your pharmacist will speak to your doctor to let them know that your usual insulin is not available. Your doctor or nurse will then look at what other insulin may be suitable for you as a temporary measure until Apidra is available again. Your pharmacist might be able to supply this after speaking with the doctor, or they might ask you to go back to see your doctor

before a choice is made.

Where can you get more information?

Sanofi has a 24 hour-a-day Patient Support Line. The Support Line will be able to help with your questions, and will have up-to-date information as to when Apidra will be available again.

The Patient Support Line is: 0845 606 6887

Your doctor, nurse or pharmacist will be able to help you if you still have questions about your care or your medicines.

IDDT News

Christmas cards

In the present economic climate, it has been a tough year financially for everyone and IDDT is no exception. Buying IDDT Christmas cards is one way that you can help to raise the much needed funds to support IDDT to help people with diabetes.

The cards cost £2.95 plus p&p for a pack of 10 and if every member bought just one pack, it would be a great support to IDDT.

Christmas may seem a long way off but it will be here before we know it, so order our Christmas cards today! If you haven't received our order form, call 01604 622837 or e-mail enquiries@iddtinternational.org

Thank you for donating unused insulin and other supplies

Once more we express our appreciation for all the in-date, unwanted supplies insulin, blood glucose test strips and needles etc. Here is a message from Dr. Kaushik Ramaiya, in Tanzania where we send the bulk of our supplies: "I am most grateful for your support. One of the reasons for our success has been your unending support."

'My Life with Diabetes – 61 years of Carb Counting' by Tony Huzzey

We informed you about this interesting book in the July Newsletter – all about Tony's life with Type 1 diabetes. He was diagnosed at the age of 12 – 61 years ago. Carb counting is not the often described revival for Tony as he has managed his diabetes by the three golden rules – insulin, carb counting and exercise. His experiences are an inspiration to young people, their parents and adults with Type 1 diabetes.

If you would like a signed copy of Tony's book, you can order it through IDDT by sending a cheque for £10.00 payable to Tony Huzzey to IDDT, PO Box 294, Northampton NN1 4XS

New Free Leaflets From IDDT

Your Diabetes - Know Your Rights

We still do not know exactly how the NHS will be run or how we as patients, will be able to ensure that we receive the high quality care that we have been promised, and to which we are entitled. But we do know that there are going to be changes. We also know that there are going to be cuts in expenditure, some of which are already being made. For all of us, as patients or family carers, our health and wellbeing is our priority. We want diabetes, and any other conditions, managed to the high standard we need and deserve and this leaflet will help to achieve that.

It puts together a range of information which includes knowing your rights as a patient, the standards of care you should expect, what to do if things go wrong and how to effectively manage your appointments or consultations.

Also included is chart to remind you of the 9 tests which should be carried out at your annual review. The chart enables you to keep

a record of which tests are carried out by completing the date and ticking the box for each test. At your review, ask if all 9 tests have not been carried out, if not ask why not and if necessary, ask for the tests to be carried out.

Diabetes - Stress, Anxiety And Depression

It is well recognised that people with long-term conditions such as diabetes, are more likely to suffer from depression. Living with diabetes means that there are more likely to be in stressful situations which cause anxiety, yet many people do not seek treatment and when they do, their conditions are often not identified. This leaflet provides information about stress, anxiety and depression and the treatment options.

For copies of the new leaflets contact IDDT: Tel 01604 622837, email enquiries@iddtinternational.org or write to IDDT, PO Box 294, Northampton NN1 4XS

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Evidence Home Blood Glucose Testing Results In Improvements In People With Type 2 Diabetes

Some people with Type 2 diabetes not taking insulin have been testing their blood glucose levels at home and some people would like to do so, but many are prevented from doing so because of views that people with non-insulin treated Type 2 diabetes do not benefit from testing. As regular readers know, these decisions are not a blanket ban by the Department of Health, but decisions made at local level either by GPs or Primary Care Trusts. The basis for this argument is lack of evidence to show any benefit as measured by the long-term HbA1c test.

Of course, this decision assumes that everyone is the same, and they

are not, and forgets to take into account that some people feel better and more relaxed when they test. It's called quality of life!

A study has been now carried out by Dr W Polonsky, psychologist at the University of California, showing that self-monitoring improves control in Type 2 diabetes. It has to be said that the study was funded by Roche who have something of a vested interest as they make test strips. Nevertheless, scientists, experts and decision-makers take note of other research funded by the pharmaceutical industry, so why not this study?

The STeP study

This was a multicentre, randomised study involving 483 poorly controlled people with Type 2 diabetes not taking insulin. They were split into 2 groups, one followed their usual care and the other tested in a very structured way by measuring their blood glucose 7 times per day on 3 consecutive days 2 weeks prior to their quarterly diabetes appointment with their GP. Between these 3 days, patients could do as much or as little testing as they wanted but it was only those 21 measurements obtained on the 3 consecutive days that formed the basis of doctor/patient discussion and treatment changes at the 3 monthly visit.

Results

- Over 12 months average HbA1cs fell from 8.9% to 8.0% in usual care group but dropped to 7.7% in the structured testing group. There was a significant drop in before and after meals glucose levels at all meals in the structured testing group.
- Measurements of depression showed a drop in both groups but the reduction was significantly greater in the structured testing group and they also showed a significantly greater drop on diabetes-related emotional distress.
- Interestingly, patients in the structured testing group achieved greater improvement in HbA1c than did controls while using significantly fewer blood glucose test strips.

Conclusions

The message from the study is that it is not the quantity of self-monitoring of blood glucose that makes the difference but the quality and the treatment changes by the doctor every quarter. As we have always advocated, this study supports the view that testing in people with Type 2 not requiring insulin, needs to be accompanied by education on how and when to test followed by action by changing the medicines according to the results. [Presented at the Conference on the Management of Diabetes in Youth in August 2011]

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Can Scientists Find A Way To Halt Type 1 Diabetes?

Research is going on at 140 centres in the UK, as well as Europe and the US, to test a drug which prevents the body's immune system from attacking the insulin-producing cells in the pancreas. It has already been shown that the new drug stops the immune system attacking the pancreas. The hope is that in people with newly diagnosed Type 1 diabetes the new drug, codenamed DiaPep277, will help people to continue producing some of their own insulin and that it will allow the pancreas to recover and make enough insulin to completely support the body's needs. Interestingly, one report said "It will also reduce the risk of side effects linked with synthetic insulin which can mirror diabetes complications...."

The new drug which would have to be injected, possibly for 2 years, is made from a protein called a long-chain heat peptide. It was invented by Professor Irun Cohen at the Weizmann Institute in Israel.

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Winter Is Coming...

This makes it the time for the seasonal flu jab

The flu jab is offered first to people in 'at risk' groups and this includes people with diabetes, pregnant women and the elderly. It gives good protection [70-80% reliability] against all strains of flu and lasts for a year. Flu viruses are spread rapidly by infected people through coughs and sneezes.

The flu jab for 2011/12 protects against 3 strains of flu virus including H1N1, the strain behind the swine flu epidemic in 2009. NHS Choices website states:

"It is important to realise that H1N1 is no different from other strains of flu in regards to the principles of creating a vaccine to protect against it. Its inclusion in this year's seasonal flu jab poses no additional risk. It is included because it is likely to be one of the major flu strains circulating in Britain this winter."

The pneumo jab

What has become called the pneumo jab is a vaccination which protects against pneumonia [inflammation of the lungs]. Pneumococcal infections are caused by a bacterium with many different strains and can lead to serious health conditions. They can affect anyone but some groups of people have a higher risk of the infection developing into a serious health condition. These include:

- children who are under two years of age – they are vaccinated as part of the childhood vaccination programme,
- adults who are 65 years of age or over,
- children and adults with certain long-term health conditions.

Pneumococcal infections are easily spread from person to person by close or prolonged contact with someone who has the infection. The bacteria are present in tiny droplets that are expelled when someone who is infected breathes, coughs or sneezes. You will also be infected if you breathe in these droplets or if you touch any droplets that might have landed on a surface and then transfer them to your face.

Once the bacteria have entered your body, usually through your nose or throat, they can either lie dormant or they can multiply and cause

health problems such as pneumonia.

When you see your GP for a seasonal flu jab, ask whether you also need the 'pneumo jab' to protect you. It's available to everyone aged 65 or over, and for younger people with some serious medical conditions, including diabetes.

The Effects Of Steroids On People With Diabetes

Steroids may be used to treat other conditions that can be present in people with diabetes. They are a group of drugs that have an impact on diabetes control and management. Steroids cause hyperglycaemia [high blood glucose levels] due to insulin resistance, increased glucose production from the liver, reduced transportation of glucose and reduced insulin secretion.

- In someone who already has diabetes or is unable to produce more insulin to compensate for the effects of steroids, then hyperglycaemia will occur.
- In someone who has risk factors for Type 2 diabetes, such as family history, being overweight etc, then there is a risk of developing steroid-induced diabetes. They will then usually need life-long treatment for diabetes.

Steroids may be used to treat conditions such as asthma, arthritis or chronic obstructive pulmonary disease [COPD]. People receiving chemotherapy often have high-dose steroids with each cycle of treatment.

Awareness of the effect of steroids

If you are prescribed steroids, it is very important that you are made aware of the effects they can have on your diabetes, especially when given in high doses. It is equally important that if you are prescribed steroids by your GP, you make the diabetes clinic aware of this because

they can account for sharp rises in blood sugars. For example, you could be given a steroid injection for arthritis, tennis elbow or carpal tunnel.

- These injections usually cause a short period of raised blood sugars [1 or 2 days] but this is significant and can be corrected by changes in diabetes medication eg increasing insulin doses.
- It is important to remember that blood glucose levels will rise while you are taking steroids but will drop again as the steroids are reduced and stopped, so insulin treatment must be adjusted accordingly to avoid serious hypoglycaemia.

What happens to blood glucose levels with steroids

Usually steroids are given in the morning when blood glucose levels tend to be reasonable. This means that blood glucose levels tend to rise for the rest of the day and then drop during the night as the effects of the steroid wear off. The aim of treatment is to try to cope with the rise in blood sugars during the day without causing hypoglycaemia later in the evening or during the night.

Steroids and insulin treatment

For people taking insulin and steroids pre-planning of insulin doses is required rather than reacting after the event and 'playing catch-up'. Generally an increase in insulin dose will be needed and/or a change of insulin regime for the period of steroid treatment.

Everyone is different and what insulin and regime suits one person, does not necessarily suit another. So it is essential to discuss any insulin and regime changes with your health professional and be sure that you know how to safely adjust your insulin doses in response to the changes in blood glucose levels caused by the steroid treatment.

Steroids and tablet-treated Type 2 diabetes

For people with Type 2 diabetes on tablets, treatment with high dose steroids also poses problems because the action of the steroids and diabetes tablets do not match in terms of the rise and fall in blood glucose levels. This results in the tablets for diabetes not sufficiently preventing the rise in blood glucose levels and because of their

prolonged action, they may cause night time hypoglycaemia. People who are not already testing their own blood glucose levels will need to be taught how to do so.

Generally an increase in tablets will be necessary but if you are already on maximum dose, then insulin treatment may well need to be started. There are tablets for Type 2 diabetes which are of short duration and given before meals [Starlix and Prandin] and they are less likely to cause hypoglycaemia. However, the most commonly used treatment in these circumstances is for insulin to be prescribed for the duration of steroid treatment. If the steroid treatment is regular then changing to insulin treatment is thought to be easier for the patient.

Note: If you are taking steroids and would like to chat to John, a member of IDDT who has had a lot of experience using insulin and steroids, his email address is johnbruton@the-tardis.fsnet.co.uk or to talk to him on the phone, call IDDT on 01604 622837

Setting The Priorities For Research

Type 1 Diabetes James Lind Alliance Priority Setting Partnership

Regular readers will remember the work which started over a year ago to identify gaps or unanswered questions in research on topics which are important to people living with Type 1 diabetes, their doctors and healthcare professionals – those at the sharp end of managing diabetes! Doctors, health professionals and people living with diabetes were asked to submit questions which are important to them. Over 1000 were received and after a long process and many discussions by the steering group, this number was reduced to 24 questions. Importance was given to try not to miss the many important points raised in the questions.

A final workshop was held in May 2011 which was attended by people with Type 1 diabetes, family carers, nurses and doctors. A final list of the group's top 10 priorities was achieved in addition to the overarching, long-term aspiration for research – to know if stem cell

therapy is an effective treatment.

Workshop results - Final Top 10 type 1 diabetes treatment uncertainties

OVERARCHING RESEARCH ASPIRATION FOR TYPE 1 DIABETES	
Is stem cell therapy an effective treatment/cure?	
1	Is it possible to constantly and accurately monitor blood sugar levels, in people with type 1 diabetes, with a discrete device (non-invasive or invasive)
2	Is insulin pump therapy effective? (immediate v deferred pump, and comparing outcomes with multiple injections)
3	Is an artificial pancreas for type 1 diabetes (closed loop system) effective?
4	What are the characteristics of the best type 1 diabetes patient education programmes (from diagnosis to long term care) and do they improve outcomes?
5	What are the cognitive and psychological effects of living with type 1 diabetes?
6	How can awareness of and prevention of hypoglycaemia in type 1 diabetes be improved?
7	How tightly controlled do fluctuations in blood glucose levels need to be to reduce the risk of developing complications in people with type 1 diabetes?
8	Does treatment of type 1 diabetics by specialists (e.g. doctors, nurses, dieticians, podiatrists, ophthalmologists and psychologists) trained in person-centred skills provide better blood glucose control, patient satisfaction and self-confidence in management of type 1 diabetes, compared to treatment by non specialists with standard skills?
9	What makes self management successful for some people with type 1 diabetes, and not others?
10	Which insulins are safest and have the fewest long term adverse effects?

The next stage of this process is to widely publicise these priorities to interest researchers and funders to carrying out research into these topics which are important to people with diabetes and their clinicians.

IDDT funded this Partnership and would like to thank all those who made it happen, especially Sally Crowe, Ann Daly and Katherine Cowan.

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RapidCalc Insulin Dose Manager – Free Offer

We've managed to get our hands on a limited number of copies of this sophisticated new iPhone insulin dose calculator for our members. The developers are making them available to interested IDDT members who are insulin dependent and own an iPhone or iPod touch. In return they are looking for constructive feedback to help guide future product development. RapidCalc was developed in the UK in collaboration with diabetes professionals in Brisbane, Australia where it is currently the subject of a health service trial looking to improve glycaemic control in people who have attended a DAFNE course. Details of the product are available on the RapidCalc website www.gilport.com/rapidcalc. For more information on the offer contact Bruce Alport bruce.alport@gilport.com

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NHS News

Delay in cataract surgery

A report of a survey of GPs [July 2011] says that some cataract patients are being forced to wait longer for treatment by their GP practices. On average people will have to wait an additional 15 weeks for NHS treatment after 20% of GP practices changed the criteria they use for referral for cataract surgery.

85% of GPs said this had a negative effect on patient's quality of life but 27% said they will be postponing the point at which patients are referred for treatment. Under the new criteria:

- Each eye must reach a certain level before treatment can begin – meaning that the vision must drop to that level. Many people will be left with one eye being treated but having to wait months for the second eye to be treated due to having to go through this referral process again.
- People who have cataracts but 20:20 vision will not be eligible for treatment until their vision drops to the minimum driving standard.

The Department of Health stated, "*Primary Care Trusts and GPs should ensure that the clinical needs of each patient are taken into account and they should not be delaying or introducing bans on access to treatment.*"

IDDT's advice: if you are in this position and the developing cataracts are affecting you, what you do or can't do and your quality of life, challenge the decision.

Note – if you would like IDDT's free leaflet about eyes, just call IDDT on 01604 622837 or write to IDDT, PO Box 294, Northampton NN1 4XS

NHS waiting times

According to a report in The Daily Telegraph, the number of people having long waits for NHS treatment has risen by 61% in the last year – 11,857 patients have been waiting over 6 months compared with 7,360 in the previous year to June 2010. The Times reports that while the NHS is meeting its commitment to treat 90% of people in 18 weeks, the numbers who are not seen in that time has risen by 40%. The Guardian reports that managers have been struggling to ensure that patient care has not been affected by budget cuts, however patient waiting times have "leapt" in the last year.

NHS prescriptions

The 28-day limit on prescriptions has been put into question. A GP

Online survey and Freedom of Information request has revealed that of the 104 PCTs that responded, 11% said they promoted the 28-day limit on prescriptions. An additional 32% said they went further and issued guidance to GPs to limit prescriptions to 28-days. This is despite opposition from patients and doctors.

Apparently this is an attempt to “*manage long-term prescribing budgets more accurately*” and “*reduce the occurrence of large stocks of medicines being held in domestic homes*”.

This system is inconvenient for patients, involves surgeries in more work and no one seems to have pointed out, is more costly to the NHS – pharmacists are paid dispensing fees based on the number of items they dispense. For people with long-term conditions, such as diabetes whose medication remains the same, a 3 month prescription [like it used to be!] would result in a two thirds reduction in dispensing fees alone! If the GP is happy there are no compliance issues or misuse of medicines, then surely the 28-day rule is just costly, unnecessary and inconvenient for many.

The Government is setting up a steering group to address the estimated £300 million wasted on medicines each year by the NHS in England. It aims to produce an action plan to improve repeat prescribing and patients’ understanding of the use of medicines.

NHS IT system failure

Tony Blair’s initiative to create an IT system of integrated, centralised patient records by 2007 to improve patient care must go down in history as an expensive failure. It had a staggeringly high budget of £11.4 billion and 9 years later, the Department of Health has spent £6.4 billion the central goal of the project has had to be abandoned because it is unable to produce a universal system. [Public Accounts Committee report, August 2011]

Of the two commercial companies involved, one has failed to deliver most of the systems and the other is being paid £9 million at each NHS site, something that normally costs other organisations outside

the programme £2 million. The Department of Health is now relying on individual NHS Trusts to develop systems that are compatible with the central programme. The likelihood is that there will be a variety of systems that are incompatible.

The NHS is to use common clinical language

The adoption of a common clinical language in electronic communications between doctors, nurses and other health professionals in all healthcare organisations is expected to provide better patient safety. The Information Standards Board for Health and Social Care has approved the use of SNOMED Clinical Terms - a fundamental standard. All NHS organisations, independent providers and information system suppliers have been informed of the need to use SNOMED CT when providing care. [August 2011]

SNOMED CT is available in more than 50 countries and is already widely used in the UK. The announcement says that the terms are easy for clinicians to use and can be understood by patients and their families.

More prescription drugs than ever being prescribed

The UK annual drugs bill has soared to more than £9 billion according to newspaper reports. This is an increase of nearly 70% in the last decade. The number of prescriptions issued now averages 17 a year for every person in the UK with the most common drugs being statins and ACE inhibitors. The drugs bill for diabetes is the most expensive to the NHS at £713.2 million.



Update On Driving Regulations For Diabetes

As readers know, as a result of changes in the EU law in August 2009, the DVLA has been considering changes to the driving regulations for diabetes, in addition to epilepsy and vision. The DVLA proposals on driving and diabetes eventually went out to consultation which ended

on April 28th 2011 and the changes to the present regulations were put on the DVLA website on August 17th 2011. They are set by the EC Directive 91/439/EEC and are based on advice of the Secretary of State's Honorary Driving Panels.

The changes will come into effect in October 2011 and they affect anyone taking insulin or taking medications that may cause hypoglycaemia [certain tablets used to treat Type 2 diabetes can induce hypoglycaemia]. According to figures produced by Diabetes UK, and quoted in a Daily Mail article [20.08.11], the changes in the regulations for car drivers [C1 licences] potentially affect about 1 million people.

Changes to the standards for driving cars and motorcycles - Group 1 vehicles [DVLA website, 17th August 2011]

The following changes introduced by the EU have applied since September 2010.

- **There must not have been more than one episode of severe hypoglycaemia within the preceding 12 months. Severe hypoglycaemia is defined by the DVLA Driving Panel for Group 1 as one requiring the assistance of others.**
- **There must not be impaired awareness of hypoglycaemia. Impaired hypoglycaemia awareness has been defined as an inability to detect the onset of hypoglycaemia because of a total absence of warning symptoms.**

The EU Directive for Group 1 vehicles actually states:

10.1. Driving licences may be issued to, or renewed for, applicants or drivers who have diabetes mellitus. When treated with medication, they should be subject to authorised medical opinion and regular medical review, appropriate to each case, but the interval should not exceed five years.

10.2. Driving licences shall not be issued to, nor renewed for,

applicants or drivers who have recurrent severe hypoglycaemia or/ and impaired awareness of hypoglycaemia. A driver with diabetes should demonstrate an understanding of the risk of hypoglycaemia and adequate control of the condition.

Changes to the standards for driving buses and lorries - Group 2 licences, HGV and PSV licences [DVLA website, 17th August 2011]

Changes in the driving regulations issued by the DVLA are due to take place in October 2011 and have applied since September 2010. The changes will remove the blanket ban for people being treated with insulin and medications [sulphonylureas and glinides] which carry the risk of hypoglycaemia, and allow them to apply for a Group 2 licence. The following criteria have to be met.

- **There has not been any severe hypoglycaemia event in the previous 12 months.**
- **The driver has full hypoglycaemic awareness.**
- **The driver must show adequate control of the condition by regular blood glucose monitoring, at least twice daily and at times relevant to driving. It is recommended that applicants with insulin treated diabetes will need to have used blood glucose meters with a memory function to measure and record blood glucose levels for at least 3 months prior to submitting their application.**
- **The driver must demonstrate an understanding of the risks of hypoglycaemia.**
- **There are no other debarring complications of diabetes.**

As there is to be a requirement to provide three months blood glucose readings before an Independent Medical Assessment [IMA] is carried out, anyone considering applying for a Group 2 licence should start recording blood glucose readings now.

Note: According to the magazine, Commercial Motors, DVLA has confirmed that it will cover the costs of IMAs or people with diabetes wishing to apply for Group 2 driving licences.

IDDT actions

It goes without saying but people with diabetes have no wish to drive unless they are safe to do so and IDDT wholeheartedly supports this. IDDT welcomes the change in the regulations for Group 2 drivers in that it addresses the need for people to be treated as individuals and removes the blanket ban. However, we do have concerns about some aspects of the regulations for Group 1 drivers, cars and motorcycles.

1. The main thrust of our concern is the inclusion of night hypos as one of the two severe hypoglycaemia events within 12 months which will result in reassessment of fitness to drive. [Verbal confirmation from the DVLA that nocturnal severe hypoglycaemia is included. 22.08.11] What evidence is there that nocturnal hypoglycaemic events impair the driving ability and pose a greater safety risk during waking hours?
2. How will total absence of warnings be measured? Indeed, is it possible to measure this?
3. There is a lack of clarification of some of the definitions which could lead to either misinterpretation or different interpretations by different people. For example, what exactly is meant by 'requires the assistance of others'? Does this mean requires the assistance of paramedics or does it mean the assistance of a family carer?

There has to be greater clarity of what is meant by 'assistance'. Is a mere nudge to someone in bed to tell them to wake up and eat classed as assistance of others or is it if physical help to recover has to be given? Health professionals may interpret the meaning differently from those with diabetes and their family members.

'Lack of hypo awareness' can be misinterpreted – family carers are renowned for recognising the early warning signs before the person with diabetes, but that does not necessarily mean that there is a lack of awareness that is unsafe.

IDDT has written to the Minister of Transport and the DVLA Driving and Diabetes Panel on the above points and we will keep you informed.

Here are a few reminders

- If you are refused a licence, then the DVLA will tell you when you can reapply and send you a notice of your right to appeal the decision in a magistrates court if you live in England or Wales.
- When you fill in your DVLA questionnaire to assess your medical fitness to drive, if your diabetes is controlled by insulin, you do have to sign a declaration which states that you agree to test your blood glucose before driving and at times relevant to driving. This is a legal document.
- Remember many meters have memories, so if you are involved in an accident, then your meter can be checked to see if you tested before driving.
- You need to be obtaining enough blood glucose test strips from your GP to be able to prove, if necessary, that you are carrying out the required number of tests.
- If you have Type 2 diabetes treated with tablets and move to insulin treatment, you have to tell the DVLA and your motor insurers.

For further information:

- To check what medical conditions you need to tell the DVLA about, visit www.direct.gov.uk/drivingandmedicalconditions
- There is information on driver licensing in a booklet 'Driving Licences' [D100] which is available from the DVLA, DVLA local offices and from Post Offices or by visiting www.direct.gov.uk/driverhealth
- The DVLA can be contacted on 0300 790 6806 for car and motorcycles: on 0300 790 6807 for lorries and buses between 8.00am and 5.30pm, Monday to Friday. In writing to Drivers Medical Group, DVLA, Swansea SA99 1TU or email eftd@dvla.gsi.gov.uk

Staying out of hospital – more important than ever!

The new driving regulations where more one severe hypo in a year [defined as needing the assistance of others], have highlighted the need to stay out of hospital as a result of low blood glucose levels. Never has '4 is the floor' been more important and never has 'good

control is the avoidance of hypoglycaemia as well as the avoidance of hyperglycaemia' been more meaningful.

People with diabetes at risk of hypoglycaemia are placed in a very difficult position – targets are set for blood glucose levels and over the years, they have got lower and lower to reduce the risk of complications. However, as we all know, with this tight control the risks of severe hypoglycaemia are three times greater. Increased numbers of hypos are also known to increase the risks of hypo unawareness – another factor that may lead to the loss of driving licence.

The dilemma

Naturally, doctors, health professionals and people with diabetes are concerned about reducing the risks of long-term complications – the reason the experts keep setting HbA1c targets lower and lower. The dilemma for people with diabetes is balancing trying to achieve these targets while trying to drive safely and avoid severe hypos. Perhaps there is a difference in emphasis between the priorities of doctors and health professionals and people with diabetes, especially those who drive. The inability to drive can significantly reduce the quality of life for many people with diabetes – those who drive for a living may lose their jobs, those who live in rural areas without a decent bus service, for young people who want to drive like their peers, not to mention the effect on 'family carers'.

The realities

One of the realities of the treatment of diabetes is that we have not been provided with the tools to avoid hypoglycaemia. Treatment with insulin and some of the tablets for Type 2 diabetes, causes hypoglycaemia while at the same time aiming to prevent blood glucose levels rising too high [hyperglycaemia].

In trying to achieve this balance, each person is different, they have different lives, views and priorities. So target HbA1cs have to be set for each individual to take into account their way of life and their personal priorities in terms of balancing the risks of severe hypos and quality of life.

To some extent we are all guilty of looking at the targets set by health experts and believing that we should all aim for these without taking into account various individual factors, such as, do we live alone, do we drive a car for a living? Both of these are examples of increasing the risk of hypos by aiming too low, even though this may be the recommended HbA1c level.

It has been well recognised for some time that individual HbA1c targets should be set for people with Type 1 diabetes, but a recent Cochrane Review [Cochrane Database of Systematic Reviews 2011, Issue 6] concluded that HbA1c targets for people with Type 2 diabetes should also be tailored to individual patients and take into account potential risks and benefits. The review compared the merits of intensive versus conventional glycaemic control. Intensive control increased the risk of severe hypos by 30% without providing significant differences in all-cause mortality and cardiovascular mortality.

Staying out of hospital

In view of the new driving regulations, staying out of hospital as a result of hypoglycaemia is very important as admission will be recorded and counted as one of the two severe hypos and high HbA1cs indicate 'poor' control, again something the DVLA ask about.

New research has shown a direct link between keeping HbA1c levels in a safe range and keeping out of hospital in 24,750 people with Type 1 diabetes. [Diabetes Care 2011; 10.2337/dc10-2099]

- People with HbA1cs between 7.7 and 8.7% had the lowest odds of going into hospital.
- People with the highest HbA1cs, between 10.8 and 28.4% were nearly 3 times as likely to be admitted to hospital.
- Those with the lowest results, between 4.4 and 7.1% were 1.29 times as likely to be admitted.

In writing about this research, IDDT is not advocating that anyone alters their targets but it is interesting information to discuss with your diabetes team, especially if you are concerned about hypoglycaemia and driving.

Driving – and finally

In order to comply with the DVLA changes, there has to be some joined up thinking between the Department of Transport and the Department of Health, PCTs or whoever is deciding how many blood glucose test strips people can have. The Driving regulations dictate that it is essential that people are prescribed the amount of test strips they need not only for their normal number of tests a day, but also to cover EVERY TIME they get into a car to drive.

IDDT is only too well aware from our members of the attempts to cut back on the number of test strips people are being prescribed – a bottle of 50 just miraculously drops off the prescription! For people to stay within the driving laws, this can no longer happen, so if necessary, point this out to your GP practice when ordering the number of strips you need.

Effect Of Mixing Different Insulin Analogues

An interesting article in Practical Diabetes [Vol.26No 26] about a needle phobic patient raised issues that maybe readers have not thought about. As this patient was needle phobic, he was using a subcutaneous cannula device instead of injections. Contrary to advice, he was using the same device to give both Lantus [glargine] and Novorapid.

The manufacturer of Lantus advises that it has not to be diluted or mixed with short-acting insulin analogues and it should only be used if it is clear and colourless. This is because unlike most other insulins which are soluble at neutral pH [measure of the degree of acidity], Lantus is soluble at a pH of 4. This means that it is slightly acidic which is why it can sting when injected.

The diabetes team mixed 50 units of Lantus with 50 units of Novorapid

in a syringe and also with Humalog and Apidra. They also did the same with Levemir. All the short-acting insulins mixed with Lantus immediately formed a white cloudy precipitation which settled at the bottom of the syringe. This did not happen with Levemir. Adding Lantus with a slightly different acidity to an insulin that has a neutral acidity results in an alteration in both insulins and reduces the effectiveness of the insulin dose.

Relevance to injections

The effects of mixing two different types of insulin applies to injections with pens [or syringes], especially if one is Lantus. The two injections of long and short-acting insulins should be given in two separate sites as the precipitation that showed in the syringe experiment could happen in the subcutaneous layer of the skin. The long-acting insulins are slow release and remain in the layer of skin, so it is important that short-acting insulins are injected at a site well away from where the long-acting analogues were injected.

News From NICE

Updating the guidelines for Type 1 and Type 2 diabetes

After consultation, NICE announced that it will be updating the guidelines for Type 1 and Type 2 diabetes. [August 30 2011]

Guidance for kidney failure

NICE has issued new guidance to help people with kidney failure make informed decisions about which choice of dialysis treatment to have. NICE recommends that people with kidney failure should be given balanced advice so that they can make informed decisions about their choice of kidney dialysis treatment, even if they have to start dialysis quickly. This includes information on the impact of treatment on their working lives, daily routines and social activity.

What is kidney failure?

It is also known as Stage 5 chronic kidney disease and is a condition where the kidneys have lost their ability to function. It can be one of the complications of diabetes. It is treated by dialysis which filters waste products and excess fluid from the blood because this can no longer be done by the kidneys.

There are two main types of dialysis - haemodialysis and peritoneal dialysis. Both treatments are effective so the choice often depends on a person's lifestyle and circumstances.

Peritoneal dialysis

This is usually performed at home or at work while people go about their normal activities or a different type can be done at night while sleeping. With this treatment, blood is cleaned inside the body using a special fluid via a tube inserted into a small space in the abdomen. Some people prefer this treatment because with the right training it can be performed safely at home and not in hospital or a dialysis centre.

According to NICE, peritoneal dialysis should be considered as a first choice for children 2 years old or younger, people whose kidneys still make some urine and adults without other significant illnesses.

Haemodialysis

This is normally performed in hospital. Here, blood is cleaned by taking blood out of the body and passing it through a machine.

According to a statement from NICE, they have published this guideline to encourage doctors and nurses to consider the individual circumstances of their patients alongside their clinical requirements. This guidance can be found by visiting the NICE website: <http://guidance.nice.org.uk/CG125>

NICE not recommending Lucentis for treatment of diabetes macular oedema

The National Institute for Clinical Excellence [NICE] issued final draft

guidance on the use of Lucentis [Ranibizumab] for diabetes macular oedema in England and Wales. It has decided not to recommend its use on the basis that it is 'not a cost effective use of NHS resources'. Lucentis is a new treatment for diabetic macular oedema, which affects around 50,000 people with diabetes and leads to visual impairment and blindness if not treated. It is a swelling in the area of the retina that provides detailed vision. Laser treatment has been the standard treatment on the NHS for the last 25 years and while this does stop deterioration, it has not been shown to improve vision. Over time laser treatment can cause damage to the surrounding area of the retina. Lucentis can improve vision and improve quality of life.

NICE has rejected the use of Lucentis on the grounds of cost. The injections cost £742 per eye and some people will need several monthly injections. Ultimately the cost of looking after people with sight loss is far greater, not to mention the effect on people's lives. People already being treated with Lucentis should have the option to continue with their treatment until they or their doctor decide it is appropriate to stop.

At the time of writing NICE had not issued final guidance and there have been appeals against this decision.

Note: Pfizer has withdrawn their licensing application for Pegaptanib, another drug for the treatment of macular oedema, making Lucentis the only option possible at the present time.

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Modern Technology And Diabetes

Mobile phones, the internet and other mobile communications are increasingly being used to help people with diabetes to control their blood glucose levels. The use can vary from using two way communication with a health professional by transmitting blood glucose results who replies with advice, to various Apps.

What else does technology have to offer?

In today's world where iPhones and iPods just seem to be part of life and certainly something that seem to be just a natural part of life for today's children and young people, apps are available to help those with diabetes and other medical conditions.

The US Food and Drug Administration [FDA] in the US is consulting on introducing regulations to cover smartphone apps with health and medical functions to avoid a situation where apps which could potentially cause harm if they do not work as advertised.

- **New app for teens with Type 1 diabetes**

This app for children and young people aims to make their busy lives and the challenges of diabetes a little easier. It is called DiaPETic and it designed to that encourage glucose testing, track the results on a chart and help to provide a better understanding of the best diet to stay healthy.

DiaPETic is an iPhone and iPod Touch app that allows young users to create a pet avatar. Similar to other apps, users gather points that they can redeem for accessories for their pet avatar. The fun is in 'unlocking' new items, and your avatar can morph into a new animal over time. You can watch a video on DiaPETic at: http://www.youtube.com/watch?v=cHaa9f1_6kE

- **Medtronic MiniMed's Carb Counting with Lenny** is designed for children and teenagers with diabetes. It includes a free download on the Apple Store for iPhone, iPod Touch, and iPad, and features a nutrition guide and interactive games designed to reinforce healthy eating.
- **In the US WellIDoc** has created an app for diabetes management used by an organisation called Visiting Nurse Service. It is being used in a two-year pilot programme with New York youngsters with diabetes who are given app-loaded smartphones to track the user's lifestyle, such as diet and exercise. This information is then instantly shared with a healthcare professional.

From Our Own Correspondents

Five Don't Drive

Dear Jenny,

You have a letter from R.L. of Suffolk in your July newsletter about driving. The advice given to me by my nurses at my hospital was the same, 'Five Don't Drive'. They emphasised this point very strongly along with always test before driving however short the trip. I think it's much safer to eat something before driving even if it does push up blood glucose levels later. I have also noticed from my limited and somewhat hushed conversations with other people waiting at the diabetic clinic that some people like to keep their blood levels permanently higher just so that they can drive without fear of going hypo. Many people with diabetes (including myself) have a great fear of losing their licence and not being able to drive because of the loss of warning signs. I had this problem a few years ago and six weeks without a car was very difficult as I couldn't even get to work and thought I may never drive again. So, please advise R.L. that testing and eating before driving is very good advice who ever it comes from.

By email

To Mr R.L. – Driving I changed my specialist!

Dear Jenny,

I would like to say to Mr R.L. that 'Five don't drive' is good advice. I have Type 1 diabetes and was banned from driving 3 years ago due to no hypo warnings on analogue insulin. My specialist would not change my insulin, so I changed specialists. I now travel to a different hospital where I was put on pork insulin and I have regained my hypo warnings and a renewed driving licence for 12 months.

Mr H.P.
Bucks

It maybe faulty needles

Dear Jenny,

Mrs. L.J. reported faulty pens in the July Newsletter. I suspect it is not the pen, but the needles which may be faulty. I use the Luxura pen and find that 1 in 10/15 needles do not fit properly and unless there is a perfect seal the pen will not work. I use the HD microfine 8/31 mm gauge needles and know if the needle is a dud as soon as I fix it to the pen. I used the disposable pens before but was not happy with them as occasionally I had a doubt if in fact I had injected the insulin or not. In my view, the Luxura pen and cartridges are much better.

By email

It could be the cartridge cap

Dear Jenny,

One night I was taking my Levemir and I held my pen differently and, as I injected, it felt wet. It was leaking insulin. I checked the cartridge and found the end cap was loose. When I did an air shot a little insulin leaked out, of course, when under pressure when in me it would leak more. I got a new cartridge and it too had its end cap loose. I have contacted Novo Nordisk but thought your members should be aware of the problem I experienced.

*Mr G.H
By email*

Pain clinic for neuropathy

Dear Jenny

Here's a little bit of information you may like to share with your readers. After years of various aches and pains including diabetic neuropathic pain [burning, shooting, stabbing, stinging etc], a pain clinic pain specialist doctor put me on cymbalta. Within 2 weeks my pain levels had dropped considerably. I hope someone else can benefit by taking this tablet.

By email

The safety and worthiness of animal insulins

Hi Jenny,

I've been importing animal insulin into the USA from the UK for years and have recently applied to renew my permit. The application fee has gone up 50% and there are more forms to fill out. I had filled out my forms and mailed them a cheque. I then had to fill out form VS-16-3 so that they "can renew the permit." Well, I faxed the form and received another email stating that "Payment is a processing fee (non-refundable) and does not guarantee permit approval or shipment release." Nice, huh?

I can only use animal insulin since my body has had life-threatening reactions to the genetically engineered products. Even my doctor says that he is surprised at what such good shape I am in after 33 years. I think it is NOT by coincidence that I am in good shape. It is by making good decisions about my health and especially my choice of medication.

I hope the USDA does not stop the import of this life-saving drug. I'm not sure what my options would be if they did this. Thanks for promoting the safety and worthiness of animal insulins. It really does make a difference in people's lives!

*By e-mail
USA*

Novopens reduced in size

Dear Jenny,

Neither my Consultant, nor Diabetic Nurse, Pharmacist or their wholesaler, or my GPs seem to be aware that Novo Nordisk no longer produces a pen which can dial up 70 units of Insulin. The last one was the bog standard Novopen 3, which has been discontinued. Now both Novopen 3 and 4 stop at 60 units but it took me a week to discover this.

I phoned Novo Nordisk and was told that their research showed that the body cannot take more than 60 units of insulin at one time at one site so I would need to inject in 2 places. I am surprised by this research because about 12 years ago, the Professor at my clinic said I should take as much insulin as necessary to get the blood sugar down and he increased my morning dose to 64 – this worked. Later, I was getting too many hypos before lunch so I slightly reduced the dose to 62. Again this worked. Needless to say, from my personal experience, I query the depth of any research which has been done. Maybe it has been published in Danish and nobody in UK has read it? I am personally satisfied that one size does not fit all.

Obviously this is going to create problems for more and more people as their present pens wear out. It seems wrong to me that the decision should be a generalised one from a manufacturer, rather than an individual one from an experienced clinician. Failure to explain and communicate adds to my suspicions, though if the doctors found the research to be thorough, that would be a different story.

In my particular case, I find the present regime to be satisfactory and a recent HbA1c blood test showed 6.8% which is just the right side. My injection sites are OK but the Consultant has drawn attention to deterioration, so I definitely do not need more injections.

I would like to know, do Novo Nordisk have a monopoly, or are there other suitable manufacturers? I have no particular wish to change while everything is going OK, but I may have no choice one day. And I am not sure that Novo Nordisk really deserves my business.

*By e-mail
AA*

Diastix for urine testing

Dear Jenny,

I recently went to my GP) to reorder my repeat prescription and was annoyed to discover that I could no longer obtain Diastix urine testing

strips on prescription. I don't order them very often but I do like to keep a supply at home for occasional testing. If feel it is a backward step to withdraw something which is an aid to self-management. I wonder if other people have been refused Diastix?

*M.W.
West Midlands*

IDDT comment: as far as IDDT is aware, Diastix are available on prescription. It is the means of testing for people with Type 2 diabetes who are not allowed blood

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New HbA1c Units

To be expected - confusion over HbA1cs in nursing journal!

As regular readers will know, IDDT has expressed our concern about the change to the new HbA1c units, now due to take place at the beginning of October 2011. Apart from questioning the necessity for such a change, our concerns have mainly been the confusion that could arise for people with diabetes, especially if they have not received very much information from their health professionals.

It seems our concerns are justified, when looking at a Diabetes Supplement entitled 'Diabesity', [Practice Nursing 2011, Vol 22, No. 6] the authors confused the new units used for HbA1c and the units for self-monitoring blood glucose levels. Needless to say, IDDT wrote to the editor of Practice Nursing pointing out the error and the online version of that edition was changed.

Just to remind you again!

Table showing the current percentage HbA1c measurements and the new (IFCC) measurements.

HbA _{1c} Current	New HbA _{1c} from June 2011 (mmol/mol)
6	42
7	53
8	64
9	75
10	86
11	97
12	108
13	119

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ACTOS, The Small Risk Of Bladder Cancer – New Safety Warnings

As reported in IDDT’s July 2011 Newsletter, Actos [pioglitazone], a treatment for Type 2 diabetes, was withdrawn in France prior to the conclusions of a review by the European Medicines Agency [EMA] completed in July 2011.

In brief, this review makes the following recommendations for people already using Actos or Competact [Actos and metformin combined] or where their use is being considered:

- Actos and Competact should not be used if there is a history of bladder cancer or blood in the urine that has not been investigated with tests.
- If you are already using, or before starting treatment with Actos or Competact, your doctor should assess you for the risk factors – age, current or past history of smoking, exposure to some occupational or chemotherapy agents or previous radiation therapy to the pelvic

region.

- In elderly patients, the use of Actos or Competact should be carefully considered because the risk of bladder cancer increases with age.
- Treatment with Actos or Competact should only be continued after 3 to 6 months if there is a benefit. Treatment should be stopped in patients who do not respond adequately to treatment with either of these drugs.
- Similar monitoring should also take place in people already taking Actos or Cmpmetact.

A Direct Healthcare Professional Communication on the risk of bladder cancer with Actos and Competact is being circulated to healthcare professionals in the UK.

Advice for patients following the Review

Patients should not stop taking Actos without consulting their doctor. Patients receiving Actos should immediately report to their doctor any visible blood in their urine or bladder problems such as pain while urinating or urgency to urinate. Patients receiving Actos will have their treatments evaluated by their doctor at their next scheduled appointment.

NOTE: Following the decision by the EMA, Germany maintains that doctors should not start new treatments with Actos. France is continuing to suspend it and in September, after an independent review, France’s Transparency Commission recommended that Actos and Competact are removed from the list of reimbursed drugs on the basis that the “tolerability profile of pioglitazone [Actos] is a cause for concern” and adds that the product’s efficacy-adverse event ratio does not seem “sufficiently favourable”. Some mixed messages here!

Note: Actos and Bones

Research continues to investigate the effect of Actos [and others in this class of drugs] on bone density. Present recommendations are that Actos, and this class of drugs, should be avoided in people with diabetes who have a high risk of fracture eg those with osteoporosis.

A Warning Again - Changes In Strips

Here is a useful warning from one of our members

I was prompted to write by the letter titled 'changes in strips' in the July Newsletter. I have been struggling with this problem for some time. I am a 'brittle diabetic'. Any changes make a big difference to my control.

My control suddenly became much worse, and I couldn't work out what was going on. It was a long time before I realised it was the change in blood testing strips. My team at hospital told me the new test strips gave a reading 10% higher than the old ones. I tried removing 10% from all my readings. My control did not improve much. I rang customer services at Roche and was told that actually the new strips give a reading anything between 10-15% higher, and that removing 12.5% would gauge what the reading would have been.

Accurate blood testing results are vital to anyone, but especially to someone like me. I have an insulin pump with animal insulin in it because I'm sensitive to human and analogue insulins. I take 6 as my optimum reading – a figure I have used for 40 years. When I do a blood test now, and it reads 6.9, then taking the upper percentage, 15% higher, that means my blood is really at my optimum level of 6. But if the machine reads 7.5 for instance, what action do I take? In the old days, I'd do a correction. But now, 7.5 is quite near my optimum level. The problem about this is when you are going about your daily life, it's very difficult to work it all out and keep each part of the equation in your brain. Because when I get 7.5, I might remember that this is a new reading, and I might not. If I do not remember, then I will probably do a correction to take me down to 6. But actually - that's too far, remember? It should down to 6.9. What I will have done is taken my blood sugar (in old terms) down to - well I cannot do the maths! But lower than I want to be!

When my blood sugar is low, it becomes even more vital to get it right, but even harder to work out correctly. In fact I've found I can't and just have to pretend the machine is using the same levels as it was

before. There's no doubt about it, this has seriously mucked up my control, something I find terribly distressing.

What I want to know is - who decided to do this, and why? I have read that doctors wanted the readings to correspond with the readings the hospital gets when they do HbA1c to save any confusion. For THEM I presume. What about us? Have the optimum readings we've been given all these years really been so arbitrary it doesn't matter if they are all suddenly upped between 10 and 15%? Is it really more important that trained, good at maths medical staff have blood levels easier to work out than the people who are doing blood tests, several times a day, every day, every month, every year?

What makes this all INSANE, is the fact that the machines don't read your blood plasma at all. They are still reading whole blood, because that is what you are putting on the strip. The strip somehow changes the way the machine reads your old, safe, understandable whole blood to convert it to a plasma reading. How accurate is this process I wonder?

In extreme frustration. [Name supplied]

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Bits And Pieces

Hypowallet

This is the latest portable hypo kit that can be carried around by people with diabetes and/or their carers. It is supplied by BBI Healthcare, the suppliers of GlucoGel [previously HypoStop]. Each wallet contains:

1 x 10 Pack of chewable Orange GlucoTabs

1 x 60ml shot of GlucoJuice

2 x 25gms of GlucoGel

1 X Treatment Card

1 X 'I have Diabetes' contact card.

Further information can be found by visiting www.hyposite.co.uk

Hypo-fit changes its name

Hypo-Fit has changed its name to GSF-Syrup but it is still available on an NHS prescription. It is used for the treatment of hypoglycaemia. Each box contains three sachets of syrup containing 13.4 grams of carbohydrate and the sachets come in different flavours.

Improvements to Lilly's HumaPen Memoir lead to UK shortage

In June Lilly announced suspension of the HumaPen Memoir insulin pen to make improvements. Replacements will not be available until 2012. There is no need to stop using the Memoir but before you need a replacement you should contact your doctor or you can call Lilly's device helpline on 0800 783 6764.

Discontinuation of OptiSet, OptiClik and OptiPen Pro 1 pens

The above pens are all made by Sanofi-aventis and they will be discontinued at the end of 2011.

- The OptiSet, a prefilled disposable pen will be replaced with the SoloStar ClikSTAR prefilled disposable pen.
- The OptiClik and the OptiPen Pro 1, both reusable pens, will be replaced with the ClikSTAR reusable pen.

Both these pens will dose up to 80 units, unlike all other pens.

New safety device for insulin pens

BD AutoShield Pen Needle is designed primarily to reduce the risk of needlestick injuries for health professionals and others involved in diabetes care. It is compatible with all pens used for insulin treatment. The shield automatically locks after the injection. The needle is also hidden from view and may be helpful for people with needle phobia. BD AutoShield Pen Needle can be ordered by visiting www.bd.com/hyperdermic/products/autosshield/

Pain Gone

This is a handy device shaped like a fat ballpoint pen for relieving pain. It is a simple one minute treatment which works by delivering a controlled electronic frequency straight to the point of pain. It is rather

like a modern version of the Tens machine [Transcutaneous Nerve Stimulation] and can be used for any chronic pain, pain from arthritis, sciatica or tennis elbow. It is fully self contained with no leads, pads or batteries and works over clothing.

It has been clinically tested and approved as a Class IIa Medical Device. More information is available from Tower Health, Tel: 08450 066077 or from their website www.tower-health.co.uk

NHS Reforms – Thank You For Your Part

We would like to thank all our members who lobbied their MPs about the proposed NHS Reform Bill. You made your feelings known at a time when it seemed that it was only doctors and nurses who were raising objections. While it is absolutely right that they should, people at the sharp end of the changes are actually us or our children, the patients. Who is better placed to be concerned than people with chronic conditions who have to use the NHS on a regular basis? So a big thank you to everyone.

There were 92 amendments to the original Bill and this is now going through the parliamentary procedure.

In announcing the changes, Health Secretary Andrew Lansley said

“The Forum confirmed that there is widespread support for the principles underpinning our plans for change: greater patient choice, ‘no decision about me, without me’, more control for doctors, nurses and frontline professionals, a focus on quality and results for patients, more information and more clout for the public. These changes now will help us make those principles a reality.”

What happens now?

- If you want to find out more about the Government's modernisation

plans visit www.dh.gov.uk/healthandcare

- The independent NHS Future Forum report can be found at: <http://healthandcare.dh.gov.uk/future-forum-report> This Forum will continue to lead on listening in the NHS, ensuring an effective communication channel with the NHS. Among other areas they will focus on education and training; patients' rights and public health.

Confused About Salt

Newspaper articles have had misleading stories about the intake of salt following the publication of a Cochrane Review entitled "Reduced dietary salt for the prevention of CVD [cardio-vascular disease]". The Cochrane Review looked at previously published trials that assessed the effects of reducing dietary salt. The authors found that small reductions in salt intake, associated with small reductions in blood pressure, were consistent with other studies BUT that the studies were too small to provide enough information to understand the effects on mortality and cardiovascular disease. They concluded that the evidence for reducing salt intake is not robust.

But true to form the newspapers interpreted this as "Salt is safe".: What does NICE say about salt?

NICE published guidance in June 2010 calling for an acceleration of the reduction in salt in the general population from a maximum intake of 6g per day per adult by 2015 and 3g by 2025. NICE guidance will not change as a result of the Cochrane Review.

Snippets

US adults consume more meals and more calories

According to researchers in N Carolina, the number of daily meals and snacks eaten by American adults increased from 3.8 in 1977 to 4.8 in 2006. The study found that while meal portions have stabilised in recent years, in 2006 Americans were consuming 570 more calories a day than they were in the 1970s. Nearly 40% of the extra calories come from sugary drinks. [PLoS Medicine, June 2011]

High dairy food intake in adolescence may cut risk of Type 2 diabetes

New research has shown eating plenty of dairy foods as a teenager may reduce the risk of developing Type 2 diabetes during adulthood by 38%. Scientists examined the relationship between the amount of dairy food eaten during adolescence and the incidence of Type 2 diabetes in 37,038 adult women from the US Nurses' Health Study. They found women who had a high intake of dairy foods in their mid-teens had a 38% lower risk of developing Type 2 diabetes in middle age than those who had a low intake of dairy foods. The positive effect of dairy foods was even greater for women who maintained the high dairy intake as adults. In addition, women who gained the least amount of weight during adulthood were the ones who had eaten the most dairy when they were a teenager. [Eur J Clin Nutr 2011]

Gardening may inspire older adults to eat more vegetables

Older adults who garden are more likely to eat vegetables than non-gardeners, according to an online survey by two Texas Universities. The researchers conclude "that gardening intervention programs late in life would be an effective method of boosting vegetable and fruit consumption in older adults". One might question why such research was carried out, as this seems a little obvious and not just for older adults. Encouraging younger adults and children to grow fruit and vegetables would probably have the same effect!

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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