



Insulin Dependent Diabetes Trust

June 2012 Newsletter



The Health and Social Care Bill becomes law.

After over a year going through Parliament and 374 amendments generated by the House of Lords, on March 20th MPs cast their final vote and the Health and Social Care Bill was approved by a government majority of 88. On March 27th, it received Royal Assent and will now be known as the Health and Social Care Act (2012)

Different terminology is being used to describe the changes in the NHS that will have to take place – the more positive amongst us are calling it restructuring of the NHS while the more negative amongst us are calling the destruction of the NHS. Whichever side of the fence one sits on, it is clear that there are going to be major changes in

the NHS with GPs taking control of most of the NHS annual budget of £106 billion, cuts in the number of health organisations and the introduction of more competition into services. All this has to take place at a time of financial cut backs.

Somehow the staff working in the NHS have to be brought together to work in a system to which they all raised serious objections on the basis that patient care will suffer. Those of us who have had to work in systems that go against our beliefs, know this is not going to be an easy task and it will not be surprising if the morale of some NHS staff sinks to an all time low.

Possibly the most frightening aspect of the new system is that it is not based on evidence that it will actually work. It strikes me as an odd society that has a great deal of regulation and bureaucracy to ensure that there is evidence of safety and efficacy of prescribed drugs

and to ensure that research is safely and ethically carried out, yet a change to the whole structure of the NHS is brought in without any real evidence. We are not even being given a reason for the structural changes, certainly not a reason that stands up. Like it or not, Members of Parliament, our representatives, have made the decisions about our future services. David Cameron and Andrew Lansley may well go down in history but it will not be for the same reasons as Beveridge and Bevan.

Yes, it leaves many of us as patients feeling insecure. Since July 5th 1948 we have had universal healthcare provided free according to need. Is the Health and Social Care Act setting in place a return to an insurance-based system with personal health budgets, year of care funding for long-term conditions and with Foundation Trust Hospitals being able to raise nearly half their funding from private patients? Could we return to the days our parents and grandparents remember, when you didn't call the doctor because you couldn't afford the fees? When services can be provided by 'any qualified provider', will we even know who is providing the services?

Even before the Health Bill had finally passed through Parliament, a giant outsourcing company called Serco had become preferred bidder for the £140 million deal to provide services in Suffolk and 3 days after the Bill was passed, Virgin Care signed a contract worth £500 million to take over the entire provider section of NHS Surrey. Is this the beginning of the end of the NHS as we know it?

Let us hope that this negative approach is ill-founded. However, as patients, we will need to be vigilant to ensure that we receive the care and services which will enable us to receive timely, essential treatment to maintain our health.

Note: if you would like a copy of IDDT's leaflet 'Diabetes – Know Your Rights', just call IDDT on 01604 622837 or email enquiries@iddtinternational.org

Hard copies of the NHS Constitution can be obtained from the

Department of Health, telephone 0800 123 1002. If you have access to the internet, go to: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113613

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News From The Dvla On The Licence Changes

March 2012 update

The DVLA has revised their application form for people with diabetes renewing or applying for a driving licence for the first time. The forms have been redrafted to take into account the expressed concerns of people with diabetes and organisations for them. The intention is to clarify what people are expected to report when applying for or renewing their licence. The redrafted form is being tested at the present time.

There still does not appear to be any news on the inclusion of night hypos - two severe hypos during the previous 12 months can result in a licence being revoked or not granted.

In the meantime, it seems grossly unfair for people to lose their driving licence as a result of the forms which are now being redrafted. The need to redraft seems to be an admittance that the original forms led to confusion, so surely decisions should be delayed until the new forms are available?

Driving and hypoglycaemia - what are doctors being advised to do? The Association of British Clinical Diabetologists [ABCD] has recognised that the EU Directive on standards of driving in diabetes will have a significant impact not only on drivers with diabetes but also on the doctors who complete medical reports for the DVLA. The ABCD has clarified their response to the Directive and this basically advises doctors on their actions with their patients on the most important change - hypoglycaemia. [Practical Diabetes Vol. 29 No1] It seems

sensible that people with diabetes know what advice their doctors are receiving, so below are the key points in the ABCD recommendations to doctors.

Just a reminder, the changes are:

- If a Group 1 driver [car/motorcycle] has had two or more hypos requiring assistance from another person, day or night, in the previous 12 months, they must inform the DVLA and be advised not to drive.
- If a Group 2 driver [bus/lorry] has one or more hypos in the previous 12 months, they must inform the DVLA and be advised not to drive.

What is a reportable hypo?

The requirement of assistance would include:

- admission to Accident and Emergency,
- treatment by paramedics,
- treatment by a partner/friend with glucagon or glucose because the person with diabetes cannot do it themselves.

It does NOT include another person offering or giving assistance when the person is aware they are hypo and able to take action independently.

The ABCD is therefore advising hospital doctors to take great care to elicit an exact history of each hypo and chart it carefully in the records. It advises primary care teams to consider referral to specialist teams patients who have suffered one severe hypo requiring assistance because a second one could lead to loss of driving licence and loss of job.

What if people do not report their hypos?

While people may not report their hypos to their doctor, reports of hypos may be sent from the ambulance team or A & E to the patient's GP. In this case, the ABCD advise that it would be 'sensible to see the patient and inquire about the frequency and severity of hypoglycaemia'. If there have been two severe hypos requiring assistance from another

person in the previous 12 months, the doctor MUST inform the patient that they need to notify the DVLA and advise the patient not to drive. The same applies to a Group 2 driver who has had one severe hypo.

What about unconfirmed night hypos?

Doctors may suspect that severe night hypos are happening to people who live on their own but these are not witnessed, because the person lives alone! This would not necessarily be an episode that should be reported, although the doctor may advise the patient to notify the DVLA. Silly though this sounds, people who live on their own and have severe night hypos, may be advantaged as far as reporting to the DVLA is concerned, although of course, not for their own health and wellbeing. If hypo unawareness is suspected, then it is advisable to refer the patient to specialist care.

What about hypo unawareness?

The ABCD suggest that for a Group 1 licence, where a patient's home monitoring results show blood glucose levels of below 3mmol/L but reports no symptoms, this should be classed as hypoglycaemia unawareness. If hypoglycaemia below 3mmol/L without any awareness is typical of a patient's hypos, then this may be classed as completely unaware and the patient should report this to the DVLA and be advised not to drive. When blood glucose levels are below 3 and there are no symptoms, cognitive dysfunction during the hypoglycaemia is likely to be present and there is a risk of severe hypos. People with these types of hypos should be referred to specialist care for a review of their regime.

Group 2 drivers have to have complete awareness, so any degree of unawareness results in the licence being revoked.

What are a doctor's responsibilities if a patient continues to drive when they are not fit to do so?

The ABCD says that any doctor who is aware that a patient is not fit to drive, should advise the patient not to do so and to inform the DVLA. If the patient does not notify the DVLA or refuses to do so, under

General Medical Council guidelines the doctor is allowed to notify the DVLA. However, it is advised that it is good practice to confirm the conversation in writing to the patient and also inform the patient that their insurance is no longer valid.

What about people with Type 2 diabetes?

If Type 2 diabetes is treated with metformin, then this does not cause hypos. However, if sulphonylureas are added to the treatment, then they can cause hypoglycaemia. The ABCD say that if everyone treated with sulphonylureas were to be encouraged to test, this would hugely increase the cost of blood monitoring. [IDDT would question whether this is a good enough reason to not test?] It is stated that the greatest risk of hypos on sulphonylureas is in the first 3 months of treatment so 'it would seem sensible to maintain current practice and only encourage extra testing in people who are starting treatment, experiencing hypoglycaemia or with reduced awareness'. They also note that the highest risk of hypos in people with Type 2 diabetes prior to starting treatment with insulin is late afternoon.

A Group 2 driver on a sulphonylurea or glinide is required by law to test blood glucose levels at least twice daily and at times relevant to driving.

ABCD recommendations for safe blood glucose levels for driving

- In a person with good hypo awareness, normal blood glucose levels are adequate but ABCD recommend testing before driving and at no longer than 2 hourly intervals while driving.
- In a person with impaired awareness, ABCD recommend not driving without eating if blood glucose is under 7mmol/L although 5mmol/L is probably safe for a drive of under 10 minutes.

Type 1 Research

This latest news on research into Type 1 diabetes has also been

published in our Parents Bulletin, so to those who receive both publications, we apologise but they are important pieces of research.

Faustman research – many people with Type 1 diabetes may produce insulin for decades

It has been thought for many years that the beta cells in the pancreas stop producing insulin within a year of the diagnosis of Type 1 diabetes, although it has been known that there are rare exceptions to this.

The latest study from Denise Faustman and her colleagues in the US has shown that the pancreas continues to function at some level decades after the diagnosis of Type 1 diabetes. It has also shown that beta cells appear to be preserved even years after the pancreas has apparently stopped functioning.

C-peptide is produced at the same time as insulin and is used as a marker to show whether insulin is still being produced, so using a specially sensitive method, the researchers found that in 182 people with Type 1 diabetes:

- C-peptide production can persist for decades after diagnosis and remains responsive to blood sugar levels.
- Although C-peptides levels were lower amongst people who had a longer duration of Type 1 diabetes, the decrease was gradual over time and not sudden as previously thought.
- 10% of people who had Type 1 diabetes for between 31 and 40 years still produced C-peptide and beta cell function remained in tact at very low levels of C-peptide.

The importance of this study is that it shows beta cell function and insulin production can go on for many years and therefore it may be possible to find a therapeutic intervention to prevent or delay the development of Type 1 diabetes. Even in people with long-term diabetes it may be possible in the future to boost their existing beta cells. [Diabetes Care, March 2012]

More information about this research can be found at www.faustmanlab.org

Risk of Type 1 diabetes - 100,000 people screened

A press release issued in March 2012 from a large international study, 'TrialNet', says the researchers have reached a milestone. They have screened 100,000 people to detect which ones are at risk of developing Type 1 diabetes. The aim is to try to predict who will develop Type 1 diabetes and when it will require treatment so early diagnosis will help to prevent patients from developing diabetic ketoacidosis.

Screening is provided free of charge to relatives of people with Type 1 diabetes. They have a 15 times greater risk of developing Type 1 diabetes than people with no family history. Those who show an increased risk can then choose whether or not to take part in further studies to explore ways of trying to prevent Type 1 diabetes developing.

At present TrialNet researchers are looking at two prevention studies.

- To find out if an experimental drug called teplizumab can prevent or delay the onset of Type 1 diabetes. Previous studies of teplizumab have shown that it helped to preserve insulin production in newly diagnosed people.
- To find out whether one daily insulin capsule taken by mouth can prevent or delay the onset of Type 1 diabetes. A previous study suggested that oral insulin might delay Type 1 diabetes for up to 10 years in people with certain antibodies.

This is an important study because Type 1 diabetes is increasing worldwide and although the peak ages for diagnosis are between 11 and 14, the greatest increase in diagnosis is in children of a young age.

Research – beta cells contribute to the cause of Type 1 diabetes

As an autoimmune condition, in Type 1 diabetes the autoimmune system attacks cells in the body. The white blood cells attack the insulin-producing beta cells in the pancreas which results in Type 1 diabetes. According to new research, many of the genes that influence the development of Type 1 diabetes are also found in the insulin-producing beta cells in the pancreas. This suggests that the insulin-producing cells themselves play a role in the attack.

This research, conducted in Belgium, was extensive and catalogued 15,000 genes expressed in human islets cells. They found that many of the known genes involved in Type 1 diabetes are also present in human islet cells. When these same cells are exposed to cytokines, which are released by immune cells, they trigger the onset of diabetes. They also noticed that there are changes in the expression patterns of these genetic structures, although we ordinary people may not understand what this means! However, the researchers concluded that the islets themselves contribute to causing the autoimmune system's attack on the beta cells which ultimately leads to Type 1 diabetes.

This research could lead to more research on the survival of beta cells in the early stages of the development of the condition. [PLoS Genetics, March 2012]

Yet another possible cause – beta cell stress

Researchers have found that a specific type of cellular stress takes place in the insulin-producing beta cells before the onset of Type 1 diabetes. They believe that this stress may trigger the autoimmune attack on the beta cells.

Researchers showed that in a mouse model of Type 1 diabetes, the beta cells became very stressed early in disease process and before the development of Type 1 diabetes. In response to this stress, the beta cells activated a process that leads to their death.

Although the study does not state that this is the cause of Type 1 diabetes, it does show the possibility that beta cell stress could be part of the process triggering the autoimmune response that leads to Type 1 diabetes. Again, this study demonstrates that the process of developing Type 1 diabetes occurs long before it is diagnosed, so it may be possible to develop methods to delay or prevent the process occurring. [Diabetes, March 2012]

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Can Retinopathy And Maculopathy Be Prevented?

One of the most common and understandable fears of people with diabetes is that they may develop long-term complications of the eyes – diabetic retinopathy and diabetic maculopathy. People with Type 1 and Type 2 diabetes can be affected by retinopathy and it can also affect people who have 'well-controlled' diabetes.

Treatment

To date the first line treatment for both conditions is laser treatment.

There are two new drugs available which are injected – Lucentis and Avastin. These are called anti-VEGF drugs [anti-vascular endothelial growth factor]. However at the time of writing, NICE has not approved the use of Lucentis by the NHS as it maintains that it is not cost effective. An appeal against this decision failed so pressure is now being put on the manufacturers to lower the price. Avastin, although shown to help in the treatment of maculopathy and cheaper than Lucentis, has not been approved for use in this condition.

Laser treatment is only used when retinopathy and/or maculopathy are sufficiently advanced and then it is to prevent the condition getting worse, it is not a cure. Once laser treatment is given, blind areas are left on the retina and depending on the size and location of these areas, they can affect the visual field and the ability to drive.

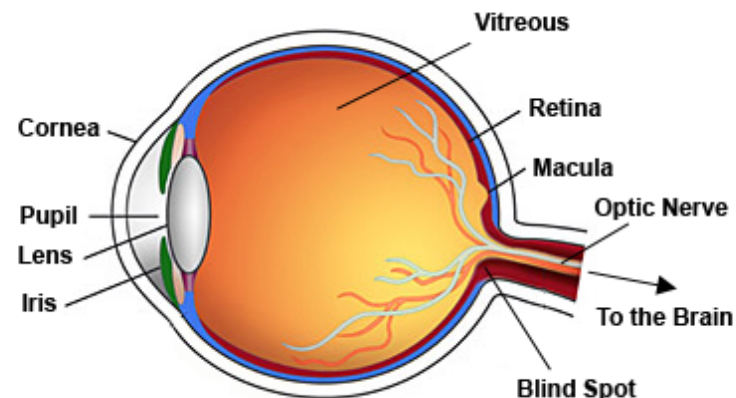
We need prevention – IDDT offers small amount of funding

To date apart from the advice to keep blood glucose levels as near normal as possible or 'keep good control', there is no way of preventing retinopathy from developing. The annual screening programme for people with diabetes picks up any problems early in the development of retinopathy but what we need is prevention of the condition.

IDDT Trustees have become quite excited about new clinical research which has investigated the prevention of retinopathy and maculopathy

and they have agreed to provide a relatively small amount of funds towards a larger study. The principle behind the new research is simple but makes sense and the device used is non-invasive. Before explaining the research, let us discuss the anatomy of the eye and retinopathy and maculopathy.

The Eye



For sight to take place light must be able to pass to the retina at the back of the eye. The light passes through cornea [the clear circular part at the front of the eyeball] and enters the eye through the pupil. It then passes through the lens and the vitreous to be focused on the retina. The focused light or images of what we have been looking at are then passed down the optic nerve to the brain.

The retina - is a light sensitive layer that lines the interior of the eye. It is made up of light sensitive cells known as rods and cones. The rods are necessary for seeing in dim light and the cones best in bright light and are essential for receiving a sharp accurate image. Cones can also distinguish colours. The retina works much in the same way as film in a camera.

The macula - is the yellow spot on the retina at the back of the eye and is the area with the greatest concentration of cone cells. It is the

area of greatest acuity of vision such as reading.

The optic disk - is the visible portion of the optic nerve on the retina. The optic disk is the start of the optic nerve where messages from cone and rod cells leave the eye and pass along nerve fibres and so transfer all the visual information to the brain. The optic disk is also known as the 'blind spot'.

What is diabetic retinopathy?

Retinopathy is usually classified according to its severity which may not be the same in both eyes. There are two classifications of diabetic retinopathy:

Background retinopathy

This is the first stage of the development of retinopathy and it is rare before 8 to 10 years of diabetes duration. At this stage the vision is normal and sight is not threatened. If there are diabetic changes present such as small haemorrhages, fatty deposits [exudates] or abnormal blood vessels [microaneurysms] then this is a sign that the retinopathy is worsening and the doctor will be alerted to arrange more frequent follow ups.

Proliferative retinopathy

This is where the small blood vessels [capillaries] block and starve the retina of nutrients causing new vessels to grow. These new vessels are fragile and may bleed into the vitreous. This then affects the sight and may cause floaters, dots or lines and if severe may cause clouding of the vision or loss of vision.

If the vessels grow on the iris, they can cause a rise in pressure in the eye and severe, painful glaucoma. The new vessels eventually cause scar tissue and this can lead to a retinal detachment where the retina becomes detached from the back of the eye resulting severe loss of sight.

What is diabetic maculopathy?

Diabetic maculopathy is a condition which can occur as a result of retinopathy. It is damage to the macula, the area which gives us the

fine, central vision needed for reading or watching TV.

Macular Oedema

Macular oedema is the most common form of damage and occurs when the blood vessels near the macula leak fluid or protein on to the macula. The leakages can become hard and exudates can form. This condition is known as Clinically Significant Macular Oedema [CSMO].

The symptoms of maculopathy are usually blurring of the central vision which is noticed as difficulty reading or recognizing faces. In a mild form, maculopathy may resolve itself naturally but most people will need treatment.

The new research

Research by G.B. Arden and S.Sivaprasad and published in Eye, The Journal of the Royal College of Ophthalmology [14 December 2011] tested the hypothesis that keeping an eye with mild retinopathy light adapted during sleep will help to prevent diabetic retinopathy. This work was developed over more than a decade by Professor Arden and his colleagues through step by step research.

Background information

The retina is supplied with blood from the blood vessels in the choroid and from the central retinal artery. It has the highest oxygen usage of any tissue of the body. The brain also has a high usage, 20% of the total uptake of the body but the retina is even higher.

Previous research has shown that when dark adaptation takes place, such as at night or in a dark room, the rods in the retina need a lot more oxygen – about twice as much as their normal need. It is more than they can obtain from the blood vessels in the choroid, so they take it from the inner retina. So it appears that the normal retina is on the verge of being deprived of oxygen. Deprivation of oxygen is called hypoxia.

The diabetic retina and oxygen demand

In diabetes, trivial decreases in availability of oxygen to the retina can

produce hypoxia. For example, mild hypos could produce hypoxia. There is evidence that changes in the retina occur long before any damage to the retinal blood vessels is noticeable. The changes can be alterations in colour vision, contrast sensitivity and dark adaptation but these are partially and promptly reversed by inhalation of oxygen. So the diabetic retina is short of oxygen before the onset of changes in blood vessels.

Previous research has also shown that small extra periods of reduced supply of oxygen to the retina can make diabetic retinopathy worse. Importantly it has also shown that the loss of rods due to any form of damage has a protective effect.

Dark adaptation and the role of rods

Dark adaptation decreases by half the demand of the rods for oxygen. Thus, preventing dark adaptation would be expected to leave more oxygen available for the retina to use. If the retina is supplied with more oxygen, then it is feasible that this could prevent retinopathy by reducing the chances of hypoxia.

The researchers developed light masks which are worn while asleep. They emit low level light which does not appear to disturb patients' sleep but the light is enough to diffuse through the closed eye lids to reduce the light adaptation by the rods. The rods, therefore, do not need as much oxygen so more oxygen is available to the retina to prevent hypoxia.

The studies

Patients with mild non-proliferative diabetic retinopathy and early diabetic oedema slept for 6 months wearing the light masks. 34 out of 40 people completed the study. The results showed that the condition of the retina improved at 3 months and the improvement continued for 6 months in study eyes but in the fellow eyes [those not illuminated] the condition deteriorated.

Secondary to this main outcome, the results also showed that visual acuity and colour contrast sensitivity improved significantly in study

eyes and deteriorated in the fellow eye.

An editorial in 'Eye' by JR Heckenlively, University of Michigan [2011, 25, 1533-1534] points out that the study shows proof of concept – the idea works – and points out that large clinical studies are now needed. He also points out that this is an inexpensive, non-invasive method of treating proliferative retinopathy that could have very real benefits for patients in addition to cutting treatment costs and ongoing care costs.

Professor Arden stresses that the studies have only been carried out in people at the early stages of retinopathy, such as those who have had retinopathy screening and have been told there are some changes but not sufficient to treat with laser.

So what next?

Professor Arden and colleagues in 10 NHS Trusts have applied for funding for a large scale clinical trial. Even if funding is granted for further studies, it will take 4 years for the new research and the results to be published. It's a long time to wait if you have diabetes, and are beginning to develop retinopathy in this period. However, based on over a decade of research carried out by Professor Arden and his colleagues, masks are now in full production by a firm called KeepSight for those who are beginning to develop retinopathy. For more information or to obtain a mask, contact KeepSight - visit their website www.keepsight.co.uk or telephone 01202 679797. IDDT is not advocating that everyone with early retinopathy buys light masks but we are keeping readers informed that they are available for people to try if they so wish.



Apologies For Error – Timesulin

We apologise for the error on page 15 of the March 2012 Newsletter in which we said that the Timesulin device was £25.00 for two. In fact,

the cost was **£25.00 for one** and at the last check on the website [04.04.12], one cap costs £32.00. My apologies for the original error.

Just to remind you, the Timesulin is a cap that fits on to injection pens and displays the amount of time that has passed since the last dose of insulin was injected. It can be used with the following pens:

- Solostar – for Lantus and Apidra.
- Kwikpen – for Humalog, Humalog 50/50 and Humalog 75/25.
- Flexpen for NovoRapid, NovoMix 30 and Levemir. It can also be used for Victoza. and Victoza.

Apologies too for promising to publish more information about the organisational changes in the NHS in this edition of the Newsletter. I am afraid there wasn't the space.



Blood Pressure

Over recent months, the newspapers have been covering diabetes and nearly always highlight the problems, and the costs of diabetes to the NHS. One of the issues that has been discussed is high blood pressure, so we thought this Newsletter should take a look at blood pressure.

High blood pressure [hypertension] is a key concern for the general population but especially for people with diabetes. It often causes no symptoms and no immediate problems but if you have high blood pressure your heart has to work harder to pump blood around your body and over time this can weaken it. It can also damage the walls of the arteries or cause a blockage and both of these situations can cause a stroke. So high blood pressure is a major risk factor for serious cardiovascular diseases such as:

- **Coronary heart disease** where the main arteries supplying blood to the heart become clogged with fatty deposits [plaques].
- **Heart attacks** where the blood supply to the heart is blocked.

- **Strokes** where the blood supply to the brain is interrupted.
- **Thrombosis** caused by blood clots in the blood vessels.
- **Aneurysm** where there is a weakness in the blood vessel wall which forms a bulge in the blood vessel.

According to NHS Choices in 90 – 95% of cases in the general population there is no single identifiable reason for a rise in blood pressure but all the evidence suggests that lifestyle plays a significant role. The main factors influencing high blood pressure are:

- age – half of people over 75 have high blood pressure
- lack of exercise
- overweight
- poor diet
- excessive alcohol consumption.

In the general population about one in three adults in England have high blood pressure with around 18% of men and 13% of women not receiving treatment for it. People of Afro-Caribbean origin are more likely to develop high blood pressure than other ethnic groups.

How is blood pressure measured?

Blood pressure is measured in millimeters of mercury [mmHG]. Two measurements are used:

- Systolic pressure – the blood pressure exerted when the heart beats to force blood around the body.
- Diastolic pressure – the blood pressure when the heart is resting between beats.

The measurement of the systolic pressure is given first for instance 130 over 80 or 130/80mmHg and this means the systolic pressure is 130mmHg and the diastolic pressure is 80mmHg.

High blood pressure and diabetes

High blood pressure is usually defined as having sustained blood pressure of 140/90mmHg or above. If you have diabetes your doctor will probably want your blood pressure to be below 130/80mmHg. Unfortunately as we are aware, having diabetes raises the risk of

heart disease, stroke, kidney disease and other complications, so having high blood pressure raises these risks even more.

About 25% of people with Type 1 diabetes and about 80% of people with Type 2 diabetes have high blood pressure. Figures from the latest National Diabetes Audit information for England showed that only 50.7% of people met their blood pressure target during 2009/10, improving just 0.7% from the previous year.

According to a Diabetes UK survey, 90% of people with diabetes are receiving regular blood pressure checks by health professionals. It is important that this happens so that you and your doctor can work together to manage your blood pressure.

Treatment

High blood pressure can be treated or prevented in some cases, by making lifestyle changes such as eating a healthy diet, exercising regularly and reducing alcohol intake. Often medication is necessary and people with diabetes may be given drugs known as ACE inhibitors [angiotensin receptor blockers] because they are thought to also have a protective effect on the kidneys. However, other blood pressure-lowering drugs may be used. ACE inhibitors may also be given to protect the kidneys even when blood pressure is not high.

Recent research - taking blood pressure pills at night

The findings of a 5-year study have shown that the timing of blood pressure medication with the person's body clock makes it more effective and offers greater protection against heart attacks, strokes and other cardiovascular diseases. [Chronobiology International, Oct. 2010] This could well change the way blood pressure medication is given and have a significant impact on the type of treatment people with high blood pressure receive. The results were quite amazing:

- The group of patients who took at least one of their medications at night had a third of the number of cardiovascular disease episodes experienced by those taking all their blood pressure medications in the morning.
- Taking at least one blood pressure medication at bedtime was the

best way to achieve normal sleep-time blood pressure but also the best way to control day-time blood pressure.

Historically, medical professionals have worked on the assumption that sleep-time blood pressure levels will drop by 10-20% from daytime levels. However, for many patients this doesn't happen and sleep-time therefore becomes a high risk period. If you are taking blood pressure tablets, then do discuss this with your doctor before making any changes.

Recent research – are the targets correct?

There is some debate about how low the targets for both systolic and diastolic pressures should be as shown in the studies below. If you are in doubt or you feel that targets being set for you are too low, then this is something to discuss with your doctor.

Diastolic blood pressure too low has risks in Type 2 diabetes

Treating blood pressure so the diastolic pressure is below 70mmHg in people with Type 2 diabetes can increase the risk of cardiovascular problems according to recent research. [Healthcare Republic 16.11.10] The researchers, who studied 1,791 people with Type 2 diabetes and high blood pressure, said that although evidence supports the recommendations for the upper levels of blood pressure, there is little evidence on how far blood pressure should be lowered.

This research supported blood pressure levels of about 140mmHg and a diastolic [the lower number] of below 80mmHg. However, it also found that people with a diastolic pressure of below 70mmHg were nearly twice as likely to have a cardiovascular event as those with higher diastolic blood pressure. This risk increased at even lower levels of diastolic pressure – those below 60mmHg were 28 times more likely to have a cardiovascular event. If this is something that concerns you, then you should discuss it with your doctor.

Risks of tight control of blood pressure may outweigh the benefits

Some guidelines call for a more aggressive approach to treating high

blood pressure in people with diabetes but in a recent study carried out in Spain, researchers found that the stroke preventing benefits of bringing the systolic blood pressure below 130mmHg may be offset by an increased risk of cardiovascular problems such as cardiovascular death, myocardial infarction, stroke, or hospitalisation for congestive heart failure. This risk was greater in people with diabetes than those without diabetes.

The researchers explained that in both diabetic and non-diabetic patients, progressively greater systolic blood pressure reductions were accompanied by reduced risk of the above problems only if systolic blood pressure levels ranged from 143 to 155 mm Hg. They recommend that aiming for around or below an initial systolic blood pressure of 130 mm Hg treatment should be implemented with caution because of the possibility of unwanted cardiac effects that could counterbalance the benefits of aggressive blood pressure reduction for stroke. This might also apply to diastolic blood pressure values of 67 mm Hg or less. [J Am Coll Cardiol 2012;59:74-83]

Pharmaceutical Industry News

New Unifine Pentips Plus

Owen Mumford has launched a new pen needle – Unifine Pentips Plus. It has been designed to improve the inconvenience of changing the needle and according to the manufacturers it is easy to remove, easy to handle and easy to dispose of. It is compatible with all major pen devices and available in four sizes: 5mm, 6mm, 8mm and 12 mm. For more information, visit www.owenmumfords.com

Bydureon receives NICE approval

In the March 2012 Newsletter we reported that NICE had given approval for Bydureon, the once-a-week version of Byetta, also called exenatide. The guidance for use in the NHS has now been published. Exenatide is injected and improves blood glucose control by increasing

the amount of insulin the body produces and by reducing glucagon production in response to eating which stops the liver overproducing sugar when it is not needed. Bydureon only has to be injected once a week unlike Byetta which has to be injected twice daily. In many people, this type of drug results in weight loss.

The NICE recommendations are that you should be able to have Bydureon with two other drugs [metformin and either a sulphonylurea or a thiazolidinedione] if your blood glucose levels are not under control [above 7.5%] AND:

- you have a body mass index [BMI] of 35 or above and you have health problems associated with this OR
- you have a BMI of less than 35 and treatment with insulin would make it much more difficult for you to do your job or other health problems which would be helped by weight loss. [This will benefit people with Type 2 diabetes who drive for a living and where insulin treatment could result in job loss.]
- you should also be able to have Bydureon if you are not able to take the other drugs for Type 2 diabetes.

You should only be given Bydureon after 6 months if tests show that it is working well enough.

Novo Nordisk likely to proceed with once weekly Victoza

Not surprisingly, Novo Nordisk has announced that it is likely to proceed with its experimental version of once weekly Victoza, which would be in direct competition to Bydureon as it is from the same class of drugs. This is called degludec and its intended global brand name is Tresiba. Two phase 3 studies published in The Lancet [April 27, 2012] compared the new insulin with Lantus [glargine] and it appeared not inferior or any less safe than Lantus for both Type 1 and Type 2 diabetes.

At the end of 12 months, HbA1cs were similar, a reduction of 1.1% for degludec and 1.2% with Lantus but there was a reduction in rates of hypoglycaemia in Type 2 diabetes and night hypos in both Type 1 and Type 2 diabetes. Having said this, the editorial in The Lancet said “the

differences in hypoglycaemia rates were small in absolute terms”.

New company enters the insulin market

In May 2012 IDDT received a press release stating that ADOCIA, a biotech company, signed a licensing contract worth \$10 million for development of a fast-acting insulin analogue giving an exclusive worldwide license agreement with a major pharmaceutical company. The statement also said ADOCIA has successfully completed two phases I and II studies on the formulation of a fast-acting human insulin, Hinsbet(R).

SimpLance Lancing device

This is a new lancing device for obtaining blood for blood glucose tests. It is a sealed unit of single use lancets which means that you don't have to handle the needles and the risk of infection is reduced. It contains 20 micro-lancets with 4 depth settings. The needles are silicon coated for pain-free testing [according to the manufacturers]. It is a circular flat gadget and you simply push a lever to load a fresh lancet and then press the test button to get the blood sample. The lancets are available on prescription.

For people with internet access, you can see the device by visiting www.simplance.co.uk or you can call BBIHealthcare on 0845 677 33 49.

New Mandatory Standards Of Care For Children And Young People With Type 1 Diabetes

In April 2012, The 'Best Practice Tariff for Paediatric Diabetes' was announced and this means that every child or young person with Type 1 diabetes in England can expect an improvement in their level of care from now onwards. The document sets out 13 mandatory care

standards for paediatric diabetes teams to meet.

The full details are available in the June issue of IDDT's Parent's Bulletin, so if you would like a copy, call IDDT on 01604 622837 or email enquiries@iddtinternational.org The details are also available on the homepage of our website www.iddtinternational.org

All About Feet

Looking after your feet

Over the last few months many of the newspapers have covered frightening statistics about diabetes and amputations. While it is essential that we know the risks, it is even more important that people with diabetes are made aware of the need for regular, proper foot checks. In this way, early diagnosis of any problems can lead to early treatment so that many amputations can be prevented. It is estimated that 80% of amputations are potentially preventable.

Unfortunately some people are never told about the importance of foot care but the laid down standards of care state that you are entitled to:

- **A structured education programme, annual review and ongoing education.**
- **People with, or at risk of, foot ulceration should receive regular reviews by a foot protection team. Those with a foot problem requiring urgent attention should be referred to a foot care team within 24 hours.**

Remember, this is what you are entitled to and in order to ensure that you and your feet are looked after properly, you must try to ensure that this is the care you receive.

Neuropathy

Neuropathy is one of the common complications of diabetes. It is damage to nerves caused by inflammation, often brought on by high

blood glucose levels and long-term diabetes. The symptoms include severe tingling and pain and in some cases loss of nerve sensitivity so that people are unaware that they have injured their feet or legs because they cannot feel the pain of the injury.

A team of neurologists in the US introduced a new set of guidelines for the treatment of diabetic neuropathy.

The treatment of diabetic neuropathy has always been difficult, as what seems to work for one person, doesn't seem to work for everyone. Recently a team of experts carried out a review of high quality research and developed recommendations which showed:

- The seizure drug pregabalin [called Lyrica] is effective at treating nerve pain and can improve quality of life but may not be suitable for all patients.
- The seizure drugs Gabapentin and valproate [called Depakote and Epilim] show some effectiveness.
- Antidepressants [such as venlafaxine, duloxetine and amitriptyline] also show some effectiveness as do painkillers such as opioids and NSAIDs.
- TENS machines, portable devices which stimulate nerves may also be effective.

The experts say that in the US many people are receiving inadequate treatment for diabetic neuropathy, which can be a disabling condition. This may be the case in the UK, so as there are different treatment options, it is important that these are discussed with your doctor.

Note: If you would like IDDT's information leaflet 'Neuropathy' which contains information about foot care, then call IDDT on 01604 622837 or email enquiries@iddtinternational.org

Diabetic vascular disease

As the article on neuropathy shows caring for the feet properly and having the correct foot checks at the correct time is essential. However, although neuropathy is the main cause of foot and limb problems in people with diabetes, peripheral artery disease is another important

cause of foot ulcerations in about a quarter of those affected.

I think that most of us have heard that 'healing takes longer in people with diabetes' but we may never have really known why. One of the main reasons for this is arterial disease. When an ulcer on the leg or foot develops, the body needs a tenfold increase in blood supply to heal an ulcer but in disease of the arteries this is prevented from happening making healing more difficult.

Diabetic vascular disease can be divided into peripheral arterial disease [also called peripheral vascular disease] and microvascular disease.

Microvascular disease

This causes abnormalities to the capillary network – the network of small blood vessels. This condition rarely causes complete occlusion of the blood supply so it is possible to improve the vascular supply to the foot and help repair ulcers. This can be angioplasty, arterial stents and bypass surgery.

Peripheral artery disease

This is the main cause of foot ulcerations in people with diabetes. It is large blood vessel disease which leads to narrowing of the arteries that supply the legs and feet. This narrowing leads to decreased blood flow which can injure and damage nerves and other tissues. The narrowing of the arteries is caused by atherosclerosis of the major arteries.

Atherosclerosis

This occurs in people with diabetes in a similar way to people without it. It is a build up of plaque [fatty material] inside the artery walls which restricts the blood flow through the vessel.

However, in people with diabetes the distribution of the plaque is different as the blood vessels below the knee are often blocked and there is a hardening of the arterial walls. The artery walls are normally elastic but when they harden they cannot dilate to allow for greater

blood flow. In people without diabetes when an artery is blocked, there is an enlargement of the smaller blood vessel network so that a supply of blood does get to the foot. However, in people with diabetes this 'second' supply network does not develop therefore occlusions of the vessels are more common.

Who is affected by peripheral artery disease?

In the general population it is largely seen in older people. According to NHS Choices, it affects 2.5% of people under 60, 8.3% of people 60 – 69 and 19% of people over 70. In people with diabetes it tends to develop at a younger age.

The classic symptoms of peripheral artery disease are:

- Pain, aching, fatigue, burning or discomfort in the muscles of the feet, calves or thighs. These symptoms usually occur after walking or exercise and go away after a few minutes of rest.
- Initially the symptoms may only happen when walking uphill, walking faster or walking longer distances. Gradually these symptoms come on more quickly and with less exercise.
- The feet and legs may also feel numb when resting, cool to the touch and the skin may be pale.

In people without diabetes ulcers may not occur until the latter stages of these symptoms but in people with diabetes, they tend to occur in the earlier stages.

When peripheral artery disease becomes severe, there may be:

- Pain and cramps at night. Pain and tingling of the feet or toes which can be so severe that even the weight of the bed clothes is painful.
- Pain that is worse when the leg is elevated and improves when you dangle your legs over the side of the bed.
- Ulcers that do not heal.
- Impotence.

Treatment

There are ways that people can help to look after the condition

themselves.

- Exercise – walk or take another exercise to the point of pain then rest. This balance of exercise and rest may improve circulation but always discuss exercise with your doctor.
- Look after your feet properly by inspecting for any injuries, cuts or scrapes and see the doctor if these occur. Wear well-fitting shoes. Check for any loss of sensation or changes in shape of the foot.
- If you are overweight, try to reduce your weight and if your cholesterol is high, try to eat a low fat diet.
- Try to make sure that your blood pressure is well controlled.
- Try to keep your blood glucose levels under control.
- Stop smoking.

Medications may be needed to control the condition and your doctor will discuss these with you. If the condition is severe then surgery maybe necessary and this may be with angioplasty or stenting. Angioplasty is where a balloon is used to stretch the artery and a stent is a tiny metal structure, a bit like scaffolding, that holds the vessel open. It maybe necessary to have artery bypass surgery of the leg which usually provides good symptom relief.

NHS News

Nurses concerned about NHS 111

As previously reported, the government ultimately intends that calls to NHS Direct to seek medical advice will be handled by a new non-emergency number, NHS 111. The aim is to cut costs by clinical staff not handling many of the calls. NHS 111 is currently being piloted in seven sites. The Department of Health analysed the 79,484 calls to 111 for February 2012 and found that only 31% were handled by clinical staff. The Royal College of Nurses [RCN] is calling on the government to pause and reconsider the move this low figure suggests that many anxious people are being passed from pillar to post and end up taking unnecessary trips to GPs or A&E.

Scotland improves access to insulin pumps

At the end of February 2012 the Scottish Government announced that all eligible under 18s with Type 1 diabetes will have access to insulin pumps. Funding of at least £1 million will be provided to the NHS Boards to help them provide insulin pumps to those in this age group who need them. In addition they are tripling the amount of pumps available to all Scots.

Health Secretary, Nicola Sturgeon, announced that insulin pump therapy will be made available to 480 children and teenagers who could benefit from it and the number of insulin pumps available to all Scots is to increase to 2,000, a tripling of the number available at present.

Scrapping pharmacy pilot of cardiovascular screening

A Department of Health pilot project in which people who were at 20% or greater risk of developing cardiovascular disease were identified on GP systems and invited to attend lifestyle advice sessions at their pharmacy or their GP surgery. Analysis of the results showed that people were unwilling to attend sessions at community pharmacies, so the government's plan to take this forward has been scrapped.

The resulting report also warned that the needs and preferences of patients can easily be lost when developing new services. Perhaps this is not really a surprise as people cannot change their views of the different roles of GPs and pharmacists just because the government wants them to.

Will this happen to the 'New Medicines Service' where people with Type 2 diabetes can receive advice and education about their condition from pharmacies? Will they expect to receive this from their GP too?

We Need Your Help

No, we're not asking for money!

We are planning a new booklet for people with Type 1 diabetes and their families but not just a factual booklet that covers what happens to the pancreas. There is a lot more to living with diabetes than this!

To state the obvious, whether we have diabetes or not, everyone is individual and everyone is different. We have different personalities, different life experiences, different family situations and different ways of dealing with things. So we would like to hear about your experiences of living with Type 1 diabetes, whether at diagnosis, or after 50 years!

Diagnosis

When Type 1 is diagnosed, there are some recognised feelings that are common to most people – shock, denial and so on - but each person will deal with it in their own way. This may depend on many issues – age at diagnosis, the reactions of family and friends, the experiences in hospital and many, many more. For some people, diagnosis may feel like the end of the world, while others may be relieved that the diagnosis was not something worse. Some may see it as a challenge, while others may see it as nothing but a nuisance.

Living with Type 1 long-term

What's long-term? 5 years, 10 years, 30 years, 50 years? One thing is sure, over time feelings about living with diabetes change. They will be different in each person and they may well be different in the same person at different stages of their lives for a wide variety of reasons. After 30 years of diabetes, some people may feel really proud of their achievements in living with the condition, while others may feel totally fed up of having it.

Let's not leave out the families

Whether you are a parent, a partner or spouse of someone with diabetes, diagnosis and living with Type 1 diabetes has its affects too. Again these will vary from person to person and over time.



What do we want from you?

We want our booklet to be sensitive to the needs and experiences of people living with Type 1 diabetes and for that we need your help. Please write and tell us how you feel about Type 1 diabetes, whether at diagnosis, after several years or just on that particular day. If you are a parent or partner, we want to hear from you too. You could probably all write a book of your own, but please keep it to about 500 words or a side of A4 paper! We will not use your name in any publication unless you want us to. Write to Jenny Hirst, IDDT, PO Box 294, Northampton NN1 4XS or email jenny@iddtinternational.org

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Recycling For IDDT

We are very grateful to our members who support us through their donations and could not manage without you, especially in the present economic climate. We have always avoided asking for money but look at other ways that you can help us – by recycling.

You are doing a great job with this and we are very grateful – empty ink cartridges and unwanted mobile phones and we have enclosed another envelope with this Newsletter for you to send off any of your unwanted phones or cartridges.

More recently you have been helping us by sending IDDT unwanted CDs and DVDs. We are still collecting these, so if you are having a clear out – think of IDDT!

We are grateful too to the people who recycle by selling goods on e-bay and at the same time making a donation to IDDT.

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From Our Own Correspondents

Simple advice!

Dear Jenny,

Thank you for your Newsletters, they are always helpful and instructive. I have had Type 1 diabetes for over 72 years and always say to anyone I meet who is newly diagnosed “Stick to the rules”!!

Mr S.G.
South West

Calling all pork insulin users in Lincolnshire

Dear Jenny,

I have been diabetic for 34 years and for most of that time I have used pork insulin. (apart from the usual change because it was being discontinued - 20 years ago!)

At a recent meeting with a diabetes specialist nurse at Lincoln County Hospital I was told that “the only people on pork insulin in Lincolnshire are those who are old and reluctant to change” I was amazed at this attitude. If there are any other diabetics in Lincolnshire on pork insulin I would love to hear from them, surely I can't be the only one and I don't consider myself 'old'!

Please contact me on 01777 228146 or email sharon.fishwick1@btinternet.com

Sharon Fishwick

58 years of Type 1 diabetes

Dear Jenny,

My letter is inspired by the excellence of your March 2012 Newsletter, striking as it does so many reminiscences. In 1953 I was diagnosed at the age of 18 with 'severe diabetes mellitus' and was prescribed what was then the relatively new lente insulin once a day. When I was diagnosed I remember feeling that my world had come to an end but my first diabetes consultant told me I was a very fortunate young man as I was one of the first people in that part of the country to be in receipt of lente insulin.

Perhaps over many years, this may have been my reason for stoutly resisting any change from my once daily regime.

One of the greatest boons for me was the introduction of the spring-powered gun [the Palmer injector] and although this has been replaced with throw away pens, I still use the slim line syringe to this day.

One observation your readers might find of interest is that I have had the 'flu injection for many years without any untoward effects – until last year when it included the swine 'flu vaccine. My blood glucose levels went to HI [high] on the meter, something I have never experienced in my life. It took some days to get my sugars back into perspective, at the end of which I ended up with a massive hypo involving emergency services.

This letter has paid insufficient tributes to my dear wife who has been my constant carer and who above anyone else has been responsible for keeping me 'in good nick'!

Finally, your Newsletter is a more friendly and comfortable publication that doesn't attempt to talk down to its readership and I wish you continued success.

Mr P.B
W Mids

Length of GP consultations [given by phone]

I recently had an appointment with my GP and had more than one issue to discuss but I was told that I would have to make another appointment to discuss the second issue. Even so my consultation must have lasted longer than the allocated time because my GP's phone rang twice to warn him that I had had my allocated time.

I have heard of other people being told that they have to make a further appointment if they wish to discuss more than one problem, but I wondered if anyone else has had their appointment interrupted

by telephone reminders to tell the GP they have had their allocated time?

It seems to me that to have to make two appointments and two visits to the GP does not make economic sense certainly not for the patient, who will have two lots of travel costs and time off work on two occasions. Is this something to do with GPs having to meet targets?

M.P.

South East

Note: Some GPs will allow you to make a double appointment if you have two or more issues that you need to discuss but you need to state this when making the initial appointment.

Holiday Tips

The holiday season will soon be upon us. If you are going abroad to find the sun, it may be the first time you have travelled since your diabetes or your child's diabetes was diagnosed. Whether going on holiday abroad or in this country, it is best to plan ahead. There is one thing to remember - anticipation of holidays and the day of travel causes excitement, especially in children.

General Tips

- Excitement can affect blood glucose levels, so it is important to test regularly and be prepared for some low blood glucose levels.
- Hypos may be unexpected due to changes in routine, in temperatures or in the amount of exercise taken, such as swimming or sightseeing, so always be prepared. It is a good idea to take plenty of glucose tablets with you because they won't melt, leak or become sticky in high temperatures.
- When travelling always wear identification that states you have diabetes, especially if you take insulin, and if possible, gives an emergency telephone number.

Precautions when travelling by air:

- Insulin should not be packed in your suitcase. This will be placed in the hold where the temperature can be below freezing which is likely to damage your insulin. Your blood glucose meter should also not be packed in the hold.
- Carry two lots of insulin, testing equipment and syringes/pens and distribute them between two different lots of hand luggage. Luggage does get lost and it could prove difficult to replace your diabetes equipment.
- You should always carry a card to say that you or your child has diabetes. You will need a letter from your GP to explain that you have to carry insulin and other diabetes equipment on board with you. Once you have this letter, it can be used again for future trips. It is a good idea to make several copies of this letter.
- Always take more insulin than you need in case of breakages. The country that you are travelling to may not have the type of insulin you need. It is also a good idea to take an extra prescription with you, just in case.
- When you come home it is sensible to throw away the insulin you took on holiday as heat, bright light and vibration can all damage it and make it less effective.
- It is worth remembering that ordering a 'diabetic' meal on flights often means that they are low in carbohydrates, so it is probably not a good idea. On long journeys it is a good idea to have snacks to hand in case there are long periods without meals.

Precautions for pump users

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]

Time zones

Generally short-haul flights require little or no adjustment and insulin injections can be carried out as normal. It is advisable to wait until the meal has arrived before injecting to avoid hypoglycaemia.

Longer journeys that cross time zones are more complicated and it is a good idea to discuss this with your diabetes nurse. Westbound journeys extend the day and extra insulin may be needed. Multi-dose regimes make this easier because Rapid-acting insulin can be given every 3 to 4 hours as needed. Eastbound journeys shorten the day and so the time between injections. It may be necessary to reduce the dose of long-acting or pre-mixed insulin. It can be helpful to keep your watch on 'home' time to keep track of your insulin doses.

Beating jetlag

Travelling across several time zones will probably cause some degree of jet lag. Symptoms include daytime sleepiness, fatigue, disorientation, poor concentration, headache and irritability. There are a number of ways to relieve jetlag:

- Avoid caffeine and alcohol on the plane - drink plenty of water or fruit juice.
- Eat modestly at times that correspond to the usual mealtimes as this will help your body to readjust to the new time zone.
- After a westward flight, stay awake while there is daylight and try to sleep when it is dark.
- After an eastward flight, get up in the morning but avoid bright light and go outdoors in the afternoon.
- Take moderate exercise, perhaps by sightseeing.

Holiday Insurance

If you or your child has diabetes, travel agents are not the best people to provide holiday insurance. Shop around but always declare your diabetes and any other medical conditions, otherwise you may not be covered if anything goes wrong and you need to use the insurance. If you are going on holiday in Europe, remember to take your European Health Insurance card (EHIC) and proof of being a UK resident eg driving licence. The EHIC is available at the Post Office or online at <http://www.applyehic.org/applynow.html>

The Golden Rules - with or without diabetes

1. Obtain comprehensive travel insurance, and read the small print.
2. Research your destination – know the local laws and customs.
3. Tell someone where you are going and leave them emergency contact details.
4. Take enough money and have access to emergency supplies.

Useful Resources

VoyageMD (www.voyagemd.com)

VoyageMD has been created by Professor David Kerr to provide information for people travelling with diabetes. The site recognises that travelling with diabetes can be difficult and stressful – from lack

of information, airport procedures, flight delays and changes in time zone. VoyageMD aims to provide all the necessary information so that preparing for a trip is easy and stress free.

The Foreign and Commonwealth Office: www.fco.gov.uk Tel 020 7088 1500. This office can help Britons abroad through its embassies, high commissions and consulates. Consular assistance is available in various circumstances such as hospitalisation or when some serious crimes against British people have been committed.

European Health Insurance Card [EHIC]: www.ehic.org.uk Tel 0845 605 0707

National Travel Health Network and Centre: www.nathnac.org

Keep your insulin cool

There are different methods and carrying cases for keeping insulin and insulin pens cool.

The Cool Ice Box Company Ltd

There is a wide range of different sized cool packs to carry insulin and you will shortly be able to purchase the two smaller sizes from IDDT from IDDT's online shop, just visit www.iddtinternational.org or you can just give us a call on 01604 622837.



The company also supply large cool boxes for people who are going

abroad for longer periods of time and need to take larger quantities of insulin. You can view these by visiting their website: www.coolicebox.co.uk

Medicool Diabetes Insulin Cool Bags

Arctic Medical supply cool bags which are designed to keep insulin and other medications within the required temperatures. They contain re-freezable gel bags.

There is a variety of sizes and designs. You can buy online by visiting <http://www.arcticmedical.co.uk/index.html> or telephone 01227 832400, or write to Arctic Medical Ltd, Unit 19 Barham Business Park, Elham Valley Road, Barham, Canterbury, CT 4 6DQ

FRIO Wallets

FRIO wallets are designed to keep your insulin cool and safe for a minimum of 45 hours, even if the temperature is over 100 degrees Fahrenheit. There are no ice packs, as it activated by immersing it in cold water for about 5-15 minutes. The panels of the wallet contain crystals and these expand into gel with the immersion in water. The system relies on the evaporation process for cooling. To order a FRIO wallet the manufacturers can be contacted at: FRIO UK, PO Box 10, Haverfordwest SA62 5YG, tel 01437 741700, e-mail info@friouk.com visit: www.friouk.com

Finally - coping with diabetes and the heat of summer

Drink plenty of water as dehydration can raise blood glucose levels. Sunburn can raise blood glucose levels, so avoid spending long hours in the sun and wear sunscreen of at least 30 SPF and children or people with pale skin should use 50 SPF.

Shield your meter from the sun and test strips should be kept in a cool, dry place.

People who use a pump may need to protect the adhesive patch from perspiration by using an antiperspirant at the contact site.

In very hot weather insulin is absorbed more quickly, so test regularly to avoid hypos.

Perhaps worth remembering.....It is holiday, so enjoy it!

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To remind you – HbA1cs measurements have changed

This is just to remind you that the HbA1c measurements have changed. Here is a table showing the old DCCT HbA1c measurements and the new IFCC measurements.

HbA1c (DCCT) (%)	New HbA1c in mmol/mol
6	42
7	53
8	64
9	75
10	86
11	97
12	108
13	119

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NHS Diabetes Supports ‘Diabetes – Everyday Eating’

IDDT is delighted to be able to tell you that NHS Diabetes is now supporting our booklet, ‘Diabetes – Everyday Eating’. We launched the booklet in the middle of October 2011 and since then we have

sent out 40,000 copies directly to people with diabetes and bulk orders to health professionals who are giving it to their patients. We are on our second print run and the front cover now has the NHS Diabetes logo and inside there is a quote from Anna Morton, Director of NHS Diabetes who says, "I'm delighted to support the Trust with this 'everyday eating' publication. Successfully self-managing diabetes is key to avoiding the complications of the condition and diet is an essential part of this. This booklet gives useful everyday advice and suggestions for menus throughout a whole month, including take aways and eating on a budget."

The Trustees of IDDT are very appreciative of the support shown by Anna and her team at NHS Diabetes and we again would like to thank Dr Mabel Blades and Martin Hirst for the work they put into developing what is obviously much needed help for people with diabetes.

The booklet came about as a result of listening to people with diabetes – whether taking tablets or insulin, people with Type 2 diabetes were frequently telling us that they didn't know enough about diet and just being told to eat healthily did not give them enough guidance. Then one day a gentleman hit the nail on the head and said, "I want to be told what I can eat, not what I can't eat" as a result of which 'Diabetes – Everyday Eating' came about.

Healthcare professionals, we call for your understanding...

We are really pleased that health professionals are using 'Diabetes – Everyday Eating' to help their patients and there is no limit to the number of copies we will supply. The booklet remains free, as do all our booklets and leaflets, but due to the unprecedented demand for multiple copies, I am afraid that for the first time, we have had to introduce a handling charge to cover delivery etc.

We have not done this lightly but I am sure that you will appreciate that as a relatively small charity we cannot sustain the handling costs for the numbers that are being ordered, especially with the recent increase in postage. So the handling charges for multiple copies of 'Diabetes Everyday Eating' are:

- Individual copies are FREE of charge.
- Orders of up to 10 copies are FREE of charge.
- For orders over 10 copies, there is a charge of £7.20 per box.

A box contains 50 copies and we send an invoice with the copies.

We really do not wish to deny people with diabetes access to the booklet which is obviously so useful. Being given it by their healthcare professional is the ideal way for them to receive it, so if payment of the handling charge is a problem, do give us a call on 01604 622837.

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Six Marathons In Six Days!



Benjamin is number 506

We would like to offer our congratulations to Benjamin Readman for completing the Marathon des Sables. This is an international event which involves completing 6 marathons in six days across the Sahara desert and the participants had to carry everything they needed for the week in their rucksacks!

Benjamin, now 32, is the eldest son of one of IDDT's Trustees, Veronica Readman and he was diagnosed with Type 1 diabetes when he was 2 years old after chicken pox. Benjamin was fine when he got back and went back to work the next day. Needless to say, even after all these years and having two children with diabetes, his Mum spent the whole week worrying and it probably took her longer to recover! This really is a case of Type 1 diabetes not stopping you doing anything you want to do.

IDDT'S Annual Conference 2012



Our Annual Conference will take place on Saturday, October 13th 2012. It will be at the same Hotel as last year – the Kettering Park Hotel, Kettering. It is a central location for many people with a good road access and by rail it takes an hour from St Pancras.

The programme and booking form is included with this mailing for you. As you will see, we have some very interesting speakers and I am sure you will find their talks useful and informative. 'Insulin – How does it behave in your Body' by Dr Laurence Gerlis. IDDT's Medical Adviser, is something that will interest us all and I am sure Dr Mabel Blades talk on 'Nutrition Nuggets' will have something for everyone.

The middle of the day is broken down to discussion groups of your choice. As we know, this is a great way to learn from others and also to learn that maybe we are not alone with our concerns.

To complete the day, we are delighted to welcome Professor Geoffrey Arden to our conference for the first time to talk about retinopathy and Professor Gary Adams, one of IDDT's Trustees, will round the day off, no doubt showing his usual enthusiasm commitment to people with diabetes.

We do hope you will be able to join us to learn more about diabetes from our speakers and from other people who live with diabetes in the discussion groups in relaxed and friendly atmosphere. It was very popular last year and so we are taking bookings on a first come, first served basis.

New Position Statements On Analogue Insulins – Interesting!

Diabetes UK issue position statement on analogue insulins

Readers will remember the exposure by the BMJ of the news that £625 million was spent on the prescribing of analogue insulins when the recommended human insulin alternatives would probably have been just as effective and considerably cheaper - 47% cheaper!

The National Institute of Health and Clinical Excellence [NICE], the organisation that issues guidance for prescribing, recommends that people with both Type 1 and Type 2 requiring insulin should be started on human insulin as first line treatment and analogue insulins should only be prescribed in particular situations. However, despite the lack of evidence of benefit of analogue insulins for the majority of people, this recommendation has been ignored and now 85% of people who need insulin in the UK are prescribed analogue insulins.

IDDT as always argued that the huge amount of extra money spent on analogue insulins with little benefit for the majority, could be put to far better use – more diabetes specialist nurses, more education courses, greater access to insulin pumps and much more.

Now Diabetes UK has issued a position statement on analogue insulins and the key points are as follows:

“Diabetes UK recommends that all insulin analogues should be available to people with diabetes in the same way as human or animal insulin. The decision of which insulin is most appropriate should be made in consultation between the person with diabetes and their healthcare team and should follow NICE guidance. ie human insulins should, in general, be tried as first line treatment, with analogues being introduced if optimal control cannot be attained.

This position statement relates to the use of analogue insulins when commencing insulin therapy rather than changes in prescribing policy of those already well controlled on analogue insulins. Diabetes UK

recommends that people who are already established on analogue insulin and well controlled should continue with their treatment.

Diabetes UK would like to see pharmaceutical companies addressing the issue of cost to ensure that new and novel therapies are affordable in the current climate and are supported by robust evidence of superiority to established therapies.”

And the IDF has also issued a Position statement on analogue insulins The International Diabetes Federation [IDF] has published a Position Statement on the provision and choice of diabetes treatments in resource-limited settings. [Diabetes Voice Sept 2011, Vol 56, Issue 2] The introduction points out that a major contributory factor to the difficulties of access to insulin is a failure to use the least costly and most effective sources and types of insulin and other drugs for diabetes. It was interesting to read the following statement:

“Considerable insulin cost savings may be possible by using animal (pork or beef) or biosynthetic human insulins rather than analogue insulins. The benefits of analogue insulins are small but their costs are very high.”

Just a thought... With the present state of the NHS and all the cuts that have to be made, is the UK a resource-limited country?

And while we are talking about analogues...

Manufacturers of Lantus say ‘No rise in cancer risk’

Readers will remember we reported that studies have been published suggesting that there is a greater risk of cancer with Lantus [glargine] insulin. It was sufficient for the European Medicines Agency [EMA] to state that the evidence is inconclusive, a stance that the FDA in the US also took. The EMA requested long-term studies and they gave this job to the manufacturers, Sanofi.

According to the Pharma Times [December 2011] Sanofi presented fresh information to the World Diabetes Congress in Dubai at which their lead investigator said *“in the context of all available information,*

the current evidence supports that insulin glargine is associated with no increased risk of cancer compared to other insulin therapies.”

IDDT would just add that we need to look at the wording of this very carefully! What he is actually saying is, all we know at the moment suggests that glargine is no different from other insulins. True long-term studies have to be carried to actually prove this so at present, it is another case of ‘absence of evidence is not the same as evidence of absence’.



Can I Be Removed From My GP’s List?

This is a question that arises sometimes because people are not sure what the situation is, especially if for some reason, they feel that they need to make a complaint about something that has happened with their GP or GP practice.

What are the rules?

- Violence or threatening behaviour by the patient is the only valid reason for removing patients with immediate effect. The General Medical Council’s guidance states that if a patient has been violent, stolen something from the premises or has acted inconsiderately and unreasonably, then a doctor may find it necessary to end the professional relationship. If this occurs the practice must inform the police and the primary care organisation immediately and confirm their decision to the patient in writing.
- Misuse of the service is another possible reason for the removal of a patient. This could be for persistently requesting visits and not being prepared to go to the surgery or for failing to attend appointments despite warnings.
- Removing a patient who has moved out of the practice area is acceptable.
- Removing patients for making a complaint is not a valid reason for removal from the GP list. While the GP may see this as the doctor/

patient relationship having broken down, a patient may be making a complaint about one specific incident but otherwise be happy with the GP. It is also possible to move the patient to a different GP in the practice to avoid any possible difficulties.

- Removing whole families because of difficulties with one family member is not acceptable.

If a GP decides to remove a patient for reasons that don't fit into the immediate removal category, then the GP practice is required to warn a patient in writing that they are at risk of removal and give the reasons. Patients must receive the letter in the 12 months prior to the removal. If the practice does then decide to remove a patient, it must write to the patient and to the primary care organisation.

Snippets

The amounts are too huge to imagine

According to a report covering the US and the top five countries in Europe by GBI Research [Feb 2012], the global diabetes market for the pharmaceutical industry is growing rapidly due to the increasing diabetes population particularly in the US, the UK and Germany. In 2010, the global diabetes market was estimated at \$29.3 billion with Type 2 diabetes sales being worth \$21.0 billion. Insulin analogues dominated the market, followed by oral hypoglycaemic agents. By 2017, the global diabetes drugs market is forecast to be a record \$47.2 billion with the Type 1 diabetes market expected to be \$13.2 billion, and the Type 2 diabetes to be \$34.0 billion.

Dogs again

It's not for the first time that it has been shown that dogs reduce stress. Now research carried out in the US has shown that access to dogs at work, whether their own or other people's, reduces stress in the workplace and boosts morale. Yes, but imagine the chaos of having dogs around!

Coffee is OK

There has been conflicting results from studies about whether drinking coffee puts people more at risk of chronic disease such as heart disease, stroke and cancer. However, a recent study carried out in Germany has shown that drinking coffee is not harmful to healthy adults. Coffee drinkers were less likely to develop Type 2 diabetes. 42,000 healthy adults in Germany were followed for 9 years and were checked every two to three years to see whether they had developed any health problems. The result was that coffee drinkers and non-coffee drinkers had similar risks of developing one of the diseases. The researchers commented that coffee doesn't actually prevent Type 2 diabetes but it could be that some of the chemicals within coffee could be having a positive effect on metabolism.

Waiting times for surgery not quite what we are told

According to the Patients Association waiting times for surgery have increased by an average of 6% between 2010 and 2011. The study was based on information gained under the Freedom of Information Act from 93 hospital trusts in England and the findings contradict the Department of Health's statements that waiting times are falling.

Gluten Free Diets – An Update

By Dr Mabel Blades, Freelance Dietitian and Nutritionist

On 1st January 2012 the rules about making claims as regards which foods are gluten free changed.

Background

A number of people suffer from coeliac disease and while this used to be regarded as a simple food intolerance, it is now regarded as an autoimmune disease where the body's immune system attacks its own tissues (thus there is a link with Type 1 diabetes). In people with coeliac disease the autoimmune reaction is triggered by gluten,

which is the name of the protein found in wheat, rye and barley. Some people with the condition are also sensitive to oats.

Numbers

In the general population about 0.75% of people suffer from Coeliac Disease, but it rises to 2-10% in those with Type 1 diabetes. Therefore the NICE guidelines recommend that all people with Type 1 diabetes are screened for coeliac disease.

What is gluten free?

In the past as long as foods did not contain wheat, rye, barley or any products derived from them they could generally be described as gluten free.

With the realisation of the sensitivity of some to gluten and how little contamination is required to cause a problem, it was decided that only foods which contain no more than 20 parts gluten in a million parts of food can be labelled as gluten free. This legislation came into effect on 1st January 2012. Now the only food which can be described as gluten free is:

- Specially made foods for people with gluten intolerances such as pasta made from rice instead of wheat flour
- Everyday foods such as soup made only from vegetables which would contain less than 20 parts per million

No gluten containing ingredients

To assist people with coeliac disease caterers and food businesses can make a factual statement to let customers know it does not contain any gluten containing ingredients. So look out for this on foods and menus.

Extra information

Additional information on this can be obtained from the Food Standards Agency, <http://www.food.gov.uk/> and also Coeliac UK, <http://www.coeliac.org.uk/>

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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PO Box 294
Northampton
NN1 4XS

Name: _____

Address: _____

Postcode: _____

Tel No: _____

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From Your Editor – Jenny Hirst

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