Insulin Dependent Diabetes Trust

September 2012 Newsletter

Registered Charity No 1058284 - Issue No 74

We Can't All Be Olympians But...

Prior to the start of the Olympics, there was a wide range of feelings from great enthusiasm, horror at the amount of money being spent, working life being threatened by traffic congestion, not to mention for some people sheer enthusiasm for watching the all the sporting events and for others absolute boredom! Then there were the objections that wrong messages were being given to children by the major sponsors being purveyors of high calorie junk food and drinks companies, McDonalds, Coca Cola and Cadburys. At least campaigners succeeded in forcing these companies to give up the tax concessions they were offered as part of their sponsorship deals.

Writing five days into the Olympics, it seems that Britain has done a superb job and the nation is caught up in sporting fever. The questions about the amount of money being spent seem to have disappeared but it is worth remembering that one of the reasons given to justify this expenditure was that it will encourage us all to be more active – but will it and will there be a long-term benefit on public health?

The present emphasis for public health is on increasing physical activity, or taking more exercise, not just to avoid the 'obesity epidemic' but also for prevention of many other health conditions. For some children and teenagers, it is easy to see that that the Olympic sportspeople provide role models and real encouragement to be out there trying to achieve the school team, county sports and even to represent their country. However, in terms of public health, there is a big difference between the Olympic sports and public health. For the Olympics athletes are highly trained, highly committed and highly competitive and it is very different from increasing physical activity levels of the general population in our everyday lives. Perhaps we

need to be clear that this sport with a capital S which is very different from what is needed for the general public - an increase in physical activity or another way of putting it, is less inactivity.

A recent study has shown that cutting down on the amount of television we watch may boost a person's life expectancy by 1.4 years and restricting the amount of time someone spends sitting down to less than 3 hours could increase life expectancy by 2 years. The study also showed that adults spend an average of 55% of their day in "sedentary pursuits". [BMJ Open 12.07.12] According to studies in The Lancet, inactivity is a risk factor comparable to smoking or obesity. As we know only too well from all the publicity, 30 minutes walking a day makes a big difference to our health, yet how many of us do it? Sometimes there doesn't seem enough time - too busy to fit it in after a day's work is common for many of us or sometimes we feel too tired. However, sometimes we may have conditions that prevent us from walking or make walking difficult. A recent study in people with diabetes over the age of 65 has shown that diabetes is linked to slower walking speeds because of reductions in muscle strength and muscle quality. [Diabetes Care, May 17th 2012].

For those that can walk but never quite get around to it, a recent study has shown that wearing pedometer encourages people to take more steps. The New Zealand study of 300 people 65 and over who were healthy but relatively inactive, tracked their activity levels for a year. One group wore pedometers and the other didn't. They received encouragement from a doctor and regular telephone counselling.

Wearing a pedometer nearly doubled the time they spent walking. Over the course of a year, both groups significantly increased their activity levels but those given a pedometer increased their by 50 minutes compared with 28 minutes for those without one. While there was no change in weight in either of the groups, there was a significant improvement in blood pressure in both groups. [Annals of Family Medicine, July 2012]

It seems that the pedometer encouraged people to walk more because they set themselves targets and measured themselves against their own targets. So not unlike the Olympic athletes, having a target to beat does seem to work.

Contact IDDT for a FREE pedometer

If you feel that a pedometer would help you, IDDT is happy to send you one – just call IDDT on 01604 622837 or email enquiries@iddtinternational.org

DVLA Issues New Driving Guidelines

On June 21st 2012 the DVLA issued new guidelines aimed at making it easier for drivers with diabetes treated with insulin to understand the new driving rules to comply with the European Directive introduced in 2011.

Along with many other organisations, IDDT complained to the DVLA and the Minister of Transport that the questions on the application form were not easy to understand and were misleading. This applied particularly to those about severe hypoglycaemia and as a result they have been giving the wrong answers, and so have their doctors. In some cases this has meant that licences have been lost unnecessarily. The DVLA makes it clear that hypoglycaemia is classed as blood glucose levels below 4 mmols/l and the new form now asks the following questions relating to hypoglycaemia:

- If you have NOT experienced an episode of hypoglycaemia, are you aware of what the symptoms are?
- If you have had an episode of hypoglycaemia, do you get warning symptoms? If yes, are you always aware?
- Have you had more than one episode of severe hypoglycaemia in the last 12 months? **Please only count episodes where you needed help. Do NOT count episodes where you were given**

help but cold have treated it yourself.

Further points to clarify some of the questions that IDDT has been asked are:

- You MUST sign the declaration that you will test before and every two hours when you drive. [This is to let the DVLA know that you understand that you have to test while driving.] This is a legal requirement and a licence will not be issued if this declaration is not signed.
- For numerous short journeys you do not have to test before each journey as long as you test every two hours while driving.

Type 2 diabetes and are treated with diet only

If you receive the medical assessment for [Diab 1] and you are treated with diet only, then you do not to complete section one. You should send the form back to the DVLA with a covering letter explaining your treatment is diet only.

However, if you have had laser treatment in both eyes [or the one remaining eye if you only have one eye] then you need to fill in Section 2 of the Diab 1 form.

Note – Parliamentary Question

On July 10th 2012, John Thurso MP asked the following Parliamentary Question:
To ask the Secretary of State for Transport what information her Department holds on the number of road traffic accidents where the cause of the accident was attributed to the driver having a hypoglycaemic attack in each of the last five years. [116252]

The answer from Transport Minister, Mike Penning MP was:
Information on the number of road traffic accidents where the cause of the accident was attributed to the driver having had a hypoglycaemic attack is not recorded.

So although we are all aware that driving while hypo is dangerous, it appears that there is actually no evidence to show this because no one collects it!

DVLA – confusion for LGV drivers!

The changes in the driving regulations were positive for people with vocational licences to drive buses or lorries – they allowed people treated with insulin to apply for an LGV licence. However, IDDT has been informed by one of the Transport unions that applicants with diabetes are falling foul of the strict new criteria that were also introduced.

A man being treated with tablets who had been classed as fit to drive at his medical, had his licence LGV revoked because he could not prove that he had been testing his blood glucose levels twice daily for the last 3 months. He cannot re-apply for another 3 months which obviously is putting a strain on his livelihood. He feels dismayed that the DVLA did not do enough to make drivers aware of the strict criteria.

The Union fears that many LGV drivers with diabetes believe that the new regulations only apply to people taking insulin and that they could have a similar shock when they re-apply for their licences.

A further problem arises because many drivers are not being prescribed enough test strips to be able to test twice daily. In the example above, the driver was only receiving 50 strips a month – simple arithmetic shows this is not enough!

The Union tried on a number of occasions to obtain clarification from the DVLA and only after considerable time, did the DVLA respond with the following statement:

"There is a legal requirement that Group 2 (lorry and bus) drivers with diabetes who are either treated with insulin or with tablets which carry a risk of inducing hypoglycaemia must check their blood glucose (sugar) level at least twice daily and at times relevant to driving. For those drivers who are insulin treated, this must be done with a blood glucose meter with a memory function.

DVLA will require drivers to sign a declaration confirming that they will do this. Failure to meet the monitoring requirement will lead to the revocation or refusal of their Group 2 licence."

In the light of this statement, it is essential for LGV drivers with Type 2 diabetes treated with tablets to be aware of the type of drug they are taking because the first line treatment is with metformin which is classed as NOT carrying the risk of causing hypoglycaemia. However, if treated with sulphonylureas, the second drug to be introduced if blood glucose control deteriorates, does carry the risk of hypoglycaemia.

IDDT's advice to LGV drivers on tablets is as follows:

- If treatment is with metformin only, then they are not obliged to test twice daily for 3 months before applying or re-applying for their LGV licence.
- If treatment is with sulphonylureas or other drugs for Type 2 diabetes, then they must test twice daily for 3 months and when driving. They must use a meter with a memory so that they can prove they have complied with the regulations.
- If drivers are unclear which medication they are taking, they should check with their GP.
- Drivers must insist that their GP prescribes enough test strips to enable them to test at least twice daily and at additional times if necessary.

IDDT reminds LGV drivers on insulin or tablets which carry the risk of hypoglycaemia of the following regulations for an LGV licence to be granted:

- 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.
- The driver must demonstrate an understanding of the risks of hypoglycaemia.
- There are no other debarring complications of diabetes.

IDDT has promised to give this situation as much publicity as possible in the light of the lack of information and publicity given by the DVLA

Just To Remind You – Talking Meters

For people with visual impairment, testing blood glucose levels is still an important part of managing diabetes. It is also important to remain as independent as possible, so a 'talking meter' helps with this.

The SuperCheck2 meter is the only meter in the UK that offers this facility. It 'speaks' in clear English, for the visually impaired, children or the elderly and has alarm reminders. Automatic reminders can be set for before and after meals.

The SuperCheck2 is available from Apollo Medical Tecnologies Ltd and they can be contacted as follows:
Telephone: **01636 831201**
Email: info@apollomedicaltechnologies.co.uk
Website: www.apollomedicaltechnologies.co.uk

We Need Your Help!

Have You Experienced A "Lack Of A Hypoglycaemic Warning"?
If So, Please Contact:
Dr Gary Adams
Insulin and Diabetes Experimental Research Group
Faculty of Medicine and Health Science
University of Nottingham
Clifton Boulevard
Nottingham NG7 2RD
Or email Gary at Gary.Adams@nottingham.ac.uk

IDDT Annual Conference, 'Diabetes is More than Medications'

Saturday, October 13th 2012
Kettering Park Hotel, Kettering, Northants

Just to remind you that we are holding our Annual Meeting at the Kettering Park Hotel in Kettering, Northamptonshire, on Saturday, October 13th 2012. Enclosed with this Newsletter is another booking form and the details of the programme which we hope will be of interest.

If you want to stay overnight at the Kettering Park Hotel on Friday and/ or Saturday, you can book directly with the Hotel, Telephone 01536 416666 but do mention that you are with IDDT for a discounted rate. The Hotel has a large car park and for those coming by train, the station is only a few minutes away by taxi. I do hope that you come and join us.

We will be holding our AGM at the end of the Meeting. If you would like to nominate someone for election to the Board of Trustees, then please contact IDDT for details of the role and responsibilities of Charity Trustees for the person you wish to nominate. The closing date for nominations is October 10th. Nominations must be accompanied by a letter of agreement from the person you are nominating and seconded by another member of IDDT.

There will be lots to learn and plenty of time to meet other people with diabetes and their partners in a friendly and informal atmosphere. It is also an opportunity to meet the Trustees and our staff so that we are not just voices at the end of the phone.

If you have any queries about the day, please do give Rita a call on 01604 622837 or e-mail rita@iddtinternational.org

Apologies For Error

Our apologies for giving the wrong telephone number in the June Newsletter for people wanting to obtain a hard copy of the NHS Constitution. The correct number is 0300 123 1002.

Treatment For Macular Oedema – Lucentis Vs Avastin

Recently we received a request for help from a lady with diabetic macular oedema who was advised that she needed treatment with Lucentis.

The macula is the part of the retina that is responsible for fine vision such as reading and macular oedema is the accumulation of fluid within the retina at the macular area. It can lead to a deterioration in vision and in many cases it cannot be treated with laser because this will cause damage.

Our member was advised by the ophthalmologist at her local hospital that she needed treatment with injections of Lucentis, up to 3 injections initially with possible follow up injections. Her local hospital charges £1500 per injection and she has to pay this because NICE has declared that although Lucentis is licensed for this use, it is not 'a wise use of NHS funds'.

The alternative treatment

The alternative treatment is with Avastin which will cost her significantly

less but it is not licensed for treating macular oedema, so neither the doctor nor the manufacturer of Avastin would be held responsible if anything goes wrong. An article in the Daily Mail said the list prices are around £900 per injection of Lucentis and an estimated cost of an injection of Avastin is £60. [July 27, 2012] It also says that results of trials show that the two drugs are equally effective.

Lucentis is used for the treatment wet age-related macular degeneration but again patients have to pay. Some NHS Trusts have been telling consultants to use the unlicensed Avastin rather than Lucentis. However, they have recently backed down on this following a judicial review of the policy as a result of a challenge by Novartis, the manufacturer of Lucentis. There have been cases of adverse events with Avastin but these are thought to be associated with administration not the drug itself.

The pharmaceutical view

Stephen Whitehead, chief executive of the Association of the British Pharmaceutical Industry, said Novartis had taken ‘the right course of action’. He goes to say, ‘It continues to be our view that off-label and unlicensed prescribing should be strictly limited to those circumstances where there is no licensed alternative and where the clinician, in discussion with the patient, decides that this is in their best interests.’

That’s very well for Mr Whitehead to say and principles are great but the lady who contacted IDDT, is the main breadwinner in the family and cannot afford to lose any more of her sight but she equally is not in the financial position to be suddenly able to afford a minimum of £4500 on Lucentis.

For the sake of people’s sight and therefore future quality of life, it is time this problem was resolved. Surely persuading the manufacturer to lower the price of Lucentis so that it would receive NICE approval, is in the best interests of patients and their future health.

Some facts

Lucentis received EMEA approval in Jan 2007. Again, this is based on extensive trials to show it is safe and effective. It can be used for all lesion types in wet AMD. The trials have shown it to stabilise sight in more than 90 per cent of cases and improve sight in up to 40 per cent of cases.

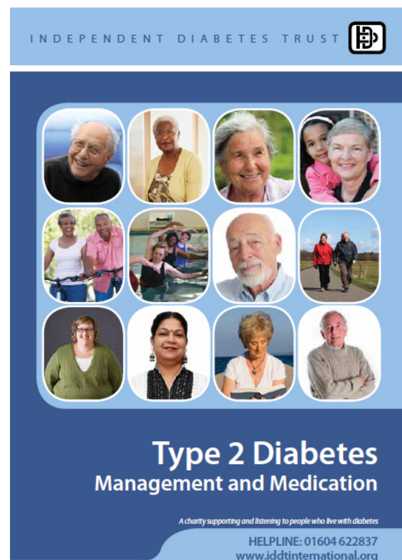
The licence lays down a treatment plan which starts with three injections at four-weekly intervals followed by further injections based on the consultant’s assessment of the patient. Patients need to be monitored every four weeks. In practice, patients receive on average eight injections in the first year and six injections in the second year.

Avastin has not been approved by the EMEA for the use of treatment in the eye as it has not gone through proper clinical trials to determine safety and how effective it is. It has been approved as a treatment for colon and rectal cancer and is therefore readily available. When Avastin is used for the treatment of wet AMD, it is given into the eye. Ophthalmologists worldwide have been using Avastin off-label for AMD (‘off label’ refers to prescribing medications for purposes for which they are not licensed).

Avastin has been showing success in stopping new blood vessel growth and clinical observation suggest that its effectiveness and side effects may be similar to those observed in Lucentis and Macugen. Two large-scale long-term randomised controlled trials of Avastin have taken place and are due to report shortly. These results will allow questions about the safety of Avastin in the eye to be properly addressed. It is uncertain at this time how often Avastin injections are given.

‘Type 2 Diabetes – Management and Medication’

IDDT is pleased to announce the launch of its new booklet ’Type 2 Diabetes – Management and Medication’.



The booklet has been produced to help patients better understand the treatments available and the on-going management of their diabetes. The aim is to help them have a better understanding and to reduce the risks of developing long-term complications.

We know from the telephone calls we receive that many patients really don’t receive enough support and information and there is a general lack of education about the progressive nature of the condition.

The booklet explains the different types of treatment and the ways in which different types of medication work, such as tablets and/or insulin. We also explain how the different insulins work, from long-acting to short-acting, and the different ways of administering insulin, from pens to insulin pumps.

‘*Type 2 Diabetes – Management and Medication*’ is available to people with diabetes free of charge, but a small postage & packing charge will be made for healthcare professionals requesting multiple copies. Copies have been sent out with this Newsletter to people we know have Type 2 diabetes, but if you would like a copy or a copy for someone you know, please don’t hesitate to contact IDDT on 01604 622837, by email martin@iddtinternational.org or write to IDDT, PO Box 294, Northampton NN1 4XS.

‘IDDT – Here To Help!’

Last year IDDT expanded its work to include Outreach & Development with the aim of helping more people to access IDDT’s information booklets and leaflets and our listening service. As part of this project IDDT has developed a new promotional leaflet, ‘*Diabetes – Here to Help*’. This can be placed in any public place to let people know how we can help and how they can get in touch with us.

I am sure nearly all of us have experienced talking to people about diabetes and a statement quickly follows, ‘My uncle, brother, cousin, mother, work colleague or neighbour has diabetes’. In fact, we sometimes wonder if everyone knows someone with diabetes. For this reason, we are asking for your help to make sure our ‘*Diabetes – Here to Help*’ leaflet is in as many public places as possible.

It is a three fold sized leaflet which can be easily displayed in places of work, surgeries, community centres and reception areas. The more leaflets we can display, the more people we can support.

IDDT wants to continue to support and inform people with diabetes and we hope that you can join us by getting involved in helping others with diabetes.

If you would like to help to distribute the new ‘*Diabetes - Here to Help*’ leaflet, please get in touch with Bev on 01604 622837 or email on info@iddtinternational.org

Many thanks in anticipation!

Grapefruit And Statins Do Not Mix

One of our members rightly reminded us that we should mention the interaction between grapefruits and statins.

Grapefruit juice stops the production of a substance in the small intestine that helps to break down quite a few different medications, including some of the statins, such as simvastatin and atorvastatin. If grapefruit juice is drunk while taking statins too much of the drugs active ingredient can enter the blood stream which could result in serious side effects such as muscle disorder or liver damage. This interaction can occur up to 3 days after drinking grapefruit juice, so the time you drink the grapefruit juice does not reduce the risk of these side effects. So for example, you cannot drink grapefruit juice in the morning and take your statin later in the day.

There are several options available to you:

- You can cut out grapefruit from your diet and eat other fruits.
- If you really want to continue to eat/drink grapefruit, you could talk to your doctor about using an alternative medication.
- There are statins that do not interact with grapefruit juice and these are rosuvastatin, fluvastatin and pravastatin.

Shift Work And The Risks

It has been known for some time that shift work upsets the body clock [circadian rhythm] and that it is associated with increased risk of high blood pressure, high cholesterol and Type 2 diabetes. There has recently been a large analysis of shift work and vascular problems, such as heart attacks and stroke. Shift work was defined as evening shifts, irregular or unspecified shifts, mixed schedules, night shifts and rotating shifts.

Researchers reviewed 34 studies involving over 2 million people and found that heart attacks and ischemic strokes [caused by a lack of blood to the brain] were more common in people who work shifts than those who don't. Night shifts were associated with the steepest increase risk of coronary events, however, shift work was not associated with increased risk of death from all causes.

The researchers suggest:

- screening programmes could be used to identify and treat risk factors, such as high blood pressure and cholesterol levels
- educating people who work shifts about the symptoms of early heart problems
- looking at shift patterns and whether they could be modified to reduce the risks of health problems.

As we know, shift work is to enable life to carry on at the pace we now have, such as shops until 10pm or even all night and for industry to be efficient and profitable, so if employers don't put these things in place, then may be people have to do it for themselves through regular health checks. For people with diabetes who already are at higher risk of some of these effects, this becomes even more important. [BMJ 26.07.12]

Huge Regional Variation In Patients Having Diabetes Care Checks

The National Diabetes Audit report on care processes, issued June 14th 2012, has revealed that there are huge variations across the country in whether people with diabetes are receiving all nine essential care checks recommended by NICE.

In some parts of the country people with diabetes are up to four times more likely to have them than people in other areas of England and Wales.

The audit shows that while rates are improving, 36 Primary Care Trusts (PCT) in England recorded fewer than half of people with diabetes as having had all their annual diabetes checks. In one PCT, only 16% received all nine checks but one PCT reported that 71% are receiving all nine of their checks. The report also shows that younger people with diabetes below the age of 55 are less likely to have all the

checks compared to older people.

In a press release, Anna Morton, Director of NHS Diabetes, urged all healthcare providers to address these regional variations so that every person with diabetes receives all nine checks. She pointed out that to not do so could result in avoidable complications.

The report can be accessed from June 14 at www.ic.nhs.uk/nda

Note: Do you know what the nine checks are? In IDDT's leaflet 'Know Your Rights' there is a chart showing you all nine checks that should be carried out and you can tick and date when you had each one carried out. If you would like a copy of this leaflet, just call IDDT on 01604 622837, email enquiries@iddtinternational.org or write to: IDDT, PO Box 294, Northampton NN1 4XS.

"Is A High Carb Diet 'Poison To Diabetics?"

Commentary by Jenny HIrst

This is a quote from an excellent article by John Naish in The Times on July 17th 2012, well perhaps I shouldn't make that judgement because I admit to being biased!

The article highlights a 46 year old man with Type 1 diabetes, Martin Milton, who moved from London to New York. Martin was following the recommended NHS diet but when he saw an American doctor for his insulin prescription, the doctor was astonished at the amount of carbohydrate Martin was consuming, and therefore the amount of insulin he needed! This highlights the controversy that has been around for many years – high versus low carbohydrate diets. Indeed, IDDT has covered this in several Newsletters over the years.

Martin goes on a DAFNE Course

Martin was diagnosed with Type 1 diabetes 20 years ago but always felt that his blood sugars control was not consistent and like many people had a couple of severe hypos in the night. Five years ago St Thomas's Hospital invited him to go on a DAFNE education course [**D**ose **A**djustment for **N**ormal **E**ating] where he was told "he could eat what he wanted, as long as he counted the carbs and matched this with the appropriate amount of insulin". He said he was also encouraged to eat pasta and white rice and 60 gms of carb per meal.

It was this that shocked his American doctor – nothing wrong with matching carbs and insulin, that always was the way to control insulin-requiring diabetes but the real question is about eating as many carbs as you like. While on the course his blood sugars were fairly level but following this he still had big hypos, his overall control was not any better and his eyes showed signs of deterioration.

His American doctor told Martin to cut down on as many carbs as possible and fill up with salads and greens. Somewhat sceptical, Martin tried it and very quickly he was using a fraction of his usual amount of insulin. His blood glucose levels were amazingly better, he lost 33lbs and his cholesterol levels had not risen

- **The NHS and the Department of Health advice for the general public and for people with both Type 1 and Type 2 diabetes is high carbohydrate / low fat, around 225 to 300 gms of carbohydrate a day.**
- **The NHS approach is to eat foods with a low glycaemic index, which basically means that they are absorbed more slowly than high glycaemic index foods. However, low glycaemic index foods are still absorbed too quickly for many people to prevent the after meal high blood sugars, especially in those with Type 2 diabetes.**

Let's just think about this...

If you have Type 1 diabetes and eat a high carb diet [or as DAFNE says anything you want,] then this raises blood sugars and more insulin needs to be injected to stimulate the cells in the body to take up the glucose in the blood and to bring blood glucose levels down.

Yet another point to consider is that if you consume a low carb diet and therefore considerably less insulin, the chances of blood glucose levels dropping very low and a severe hypo are significantly reduced. Remember it is insulin that causes hypos not diabetes.

If you have Type 2 diabetes and insulin resistance the body is already struggling to produce enough insulin to metabolise carbohydrates, so why would you eat more of them to make this situation worse?

The argument against a low carb diet is that this will mean an increase in fat intake to provide energy, which increases the risk of heart attacks. But this argument just does not hold water – it is quite possible to eat a very healthy low carb diet without increasing fat intake. There is research that shows that a low carb diet /high fat diet improved blood sugar levels, insulin dose dropped by a third and cholesterol levels improved with an increase in good [HDL] cholesterol.

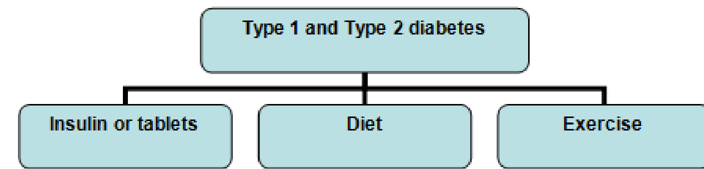
This just seems like common sense

Whether looking at Type 1 or Type 2 diabetes, the body can't deal with carbohydrates, so why would you eat a high carbohydrate diet? There are signs of movement by various recognised organisations in the direction of low carb diets, but the general advice of high carb diet for people with diabetes does not change. Could it be for lack of scientific evidence? If so, it is worth remembering that when the 'healthy eating' diet came in 1986, there was no evidence for this either – it was merely assumption that this had to be better than eating a high fat diet.

I don't even ask that the advice should be for everyone to eat a low carb diet, I'd be happy with a reduced but restricted carb diet, which maybe would be easier for people to follow. It seems like plain common sense and this prevailed in our household – we never did go to a high carb diet.

Meanwhile the controversy continues...

Yet no one funds research to provide the answers. Let's not forget the three factors in the treatment of both types of diabetes which are all important and inter-related.



- There's masses of research into insulin and medications – yes much of it by the pharmaceutical industry to bring in new and ever increasingly expensive insulins and drugs.
- There's masses of research into exercise, one only has to look in the newspapers to see the latest advice on exercise – 30 minutes walking a day, get up and down from your chair more often, walk up steps don't take the lift and on and on.

Is there an equal amount of research into diet? There certainly doesn't seem to be with the exception being for the treatment of obesity, but this is treating effects not causes and while there may be many factors involved, investigations into basic diet must surely be top of the agenda. There has been no changes in dietary recommendations since 1986 – an unbelievable 26 years ago! This was the era when most people were still using syringes to inject, tight control was not on the agenda and blood glucose monitoring was for those who could afford it. Research has led to changes, in everything except diet!

Could it be that research into diet might result in one huge U-turn having to be made, not just for people with diabetes but for the general population too?

Diabetic Ketoacidosis

Diabetic ketoacidosis, also referred to as DKA, is a serious complication of diabetes caused by a lack of insulin in the body. It usually occurs in people with Type 1 diabetes but it can occur as a complication of Type

2 diabetes and is usually triggered by severe illness.

The lack of insulin means that the body cannot break down glucose so the blood glucose levels rise very high. As the body cannot obtain energy from glucose, it breaks down fat as an alternative source of energy. During this process, ketones are produced and these cause breath to smell of a characteristic smell of pear drops or fruity smell.

What do ketones do?

When DKA occurs and ketones are produced they interfere with the body's metabolism and person will feel ill. The more ketones that are produced the more ill the person will become. If DKA is not treated there are serious complications such as severe dehydration, coma, swelling of the brain.

Who is affected by DKA?

Unfortunately many children are not diagnosed until they are in DKA which can be life threatening. Around 1 in 4 cases of DKA are in people who are unaware that they have diabetes. NHS Diabetes is trying to increase the awareness of DKA amongst doctors and health professionals so that children and adults are diagnosed before they reach this stage.

In people with already diagnosed Type 1 diabetes, DKA is relatively common, especially in children and teenagers, and it accounts for about half of all diabetes related admissions to hospital.

Symptoms of DKA

- Passing large quantities of urine frequently
- Feeling thirsty
- Vomiting
- Stomach pains
- Deep, rapid breathing or shortness of breath

Other symptoms can include:

- Decreased appetite
- Decreased consciousness
- Dulled senses that may worsen to a coma
- Tiredness
- Headache
- Muscle stiffness

If any of the symptoms occur and blood glucose levels are high, then medical help is essential.

Testing for ketones

The standard way for testing for ketones is using urine testing strips. These are available on prescription but can also be bought over-the-counter. The test strip is dipped into the urine and the strip will change colour. This is then matched to a colour on the chart on the side of the bottle of strips which will give you the result.

Some blood glucose meters have been developed that test for ketones as well as blood sugars – the FreeStyle Optium made by Abbott and the GlucoMen LX Plus made by Menarini Diagnostics. The ketone tests are carried out in a similar way to measuring blood sugars.

Interpreting the results:

- Under 0.6 mmol/L is normal
- 0.6 -1.5mmol/L indicates that more ketones than normal are being produced so it is advisable to test again in 3 to 4 hours.
- 1.6 – 3.0mmol/L is a high level of ketones and could result in DKA, so contacting your health professional is advisable.
- Higher than 3.0mmol/L is a dangerous level of ketones and you should seek immediate medical attention.

Causes of DKA

Apart from undiagnosed Type 1 diabetes, there are some common causes of DKA - infections, injury, a serious illness, or surgery. Not following the recommended treatment, in particular missing insulin injections, is another common cause and in adolescents and adults – drug misuse and alcohol misuse.

Treatment of DKA

- In the early stages of DKA, it may be possible to relieve the symptoms and bring down blood glucose levels with injections of insulin.
- In the more advanced stages of DKA, it is necessary for people to be admitted to hospital for treatment with insulin and fluids to replace those lost by urination and vomiting.
- The cause of the condition, such as infection, will be found and treated in hospital.

Prevention of DKA

- It is important that people with Type 1 diabetes, or their carers, learn to recognise the early warning signs and symptoms of DKA.
- Following the treatment plan and taking regular doses of insulin.
- Regular blood glucose monitoring to detect any changes or unusual levels.
- In people with infections or who are using an insulin pump, measuring ketones can give more information than just measuring glucose alone. Insulin pump users need to check to see that insulin is still flowing through the tubing and that there are no blockages, kinks or disconnections.

The message is clear...

If you notice any of the symptoms of DKA and blood glucose levels are high, then seek medical help immediately.

GPs Favour Longer Consultations

Members of IDDT have raised the question of GP 10 minute appointments not being long enough, especially for long-term conditions such as diabetes where there may well be more than one thing to discuss. There have been cases where people have been told that if they want to discuss a second item, they have to make another appointment. Well, it seems that the Royal College of GPs agrees with this view and they are proposing that GPs should be encouraged to offer 15 minute or more consultations to provide more ‘holistic’ care for patients. The College is considering whether GPs should routinely offer longer consultations to people with long-term conditions. These are just some of their responses to a 2011 report by the Independent Commission on Generalism.

Time To Meet IDDT And Time For Honesty Centre Pages

Just a handful of people started IDDT and for the reasons many people start organisations, we were driven! We were driven by the needs of people with diabetes, we were driven by power of the pharmaceutical industry to simply withdraw a type of insulin some people needed and we were driven by the lack of consideration shown to people who needed animal insulin. We were amazed and appalled at the influence the pharmaceutical industry had over prescribers but perhaps most of all, we were shocked that the experiences of people with diabetes were ignored and counted for nothing.

We set up IDDT with no real plans for the future, except to fight the battle to retain animal insulin for those people who needed it. However, underlying this was another more subtle battle – a fight for the respect people with diabetes deserve and to have their experiences and knowledge recognised as valid.

IDDT founding principles

In setting up IDDT, there were principles or standards that we had to adopt.

- **Trust** - we knew that we had to be an organisation that people could trust.
- **Reliability** – we knew that we had to provide information that was unbiased and based on evidence, not assumption or opinion.
- **Honesty** – we knew that we had a duty to be honest with people

with diabetes, even if sometimes that honesty meant taking risks.

- It goes without saying that these principles mean that IDDT cannot, and does not accept any pharmaceutical industry funding, unlike other diabetes associations both here and abroad.

At the same time, we are very much aware that this lack of industry sponsorship restricts what IDDT is able to do, especially in view of our other overriding belief:

- **Free information** – we believed that information should be free to everyone so that ability to pay does not deny anyone the information they need to enable them to have a truly informed choice of treatment.

Well, all that was nearly 20 years ago and our principles and beliefs have never changed, but it is time for some more honesty – honesty about IDDT and our financial position.

Is it possible to be too successful?

From the small group of people who started IDDT as volunteers, we have grown so that our quarterly Newsletters go to over 24,000 people.

- We have over 10,000 health professionals on our database who receive our Newsletters and who order our various booklets and leaflets in bulk to give to their patients – people with diabetes, the very people we want to reach.
- We continue to develop our booklets and leaflets in response to what people tell us they need. We have sent out over 50,000 requested copies of our booklet 'Diabetes – Everyday Eating', not to mention our other key publications, 'Understanding Your Diabetes', 'The Hospital Passport' and our most recent booklet, 'Type 2 Diabetes – Management and Medication'.
- We run a successful website.
- Above all, we run a helpline where people are listened to and maybe helped to come to decisions that are right for them.
- We collect and send to developing countries unwanted, in-date insulin and other supplies which costs us over £5,000 a year.

And finally, to cope with all of this, we have had to increase the number of people we employ and this means the costs of the bureaucracy involved. Do I need to say more than the dreaded Health & Safety Regulations? Fire extinguishes, lighting etc all cost money – it grieves us, but we have to comply with the law.

Who are the people that do all this?

The answer is 5 staff, a student one day a week and me, the Co-Chair. As you can imagine, they all work incredibly hard and although they all have job titles and job descriptions, actually it is a question of everyone mucking in to make sure everything happens as it should.

Left to right: Bev, Kevin, Caroline, Martin and Rita on one of this year's sunny days.

As Co-Chair, I can say that IDDT does a fantastic job – the ever increasing membership and demand for our publications is proof of that. The praise we receive from you, our members, tells us so.

Quote from Australia:

"*Thank you from my heart for your fantastic contribution in keeping diabetics all over the world informed of developments. You have provided invaluable information and I cannot begin to imagine the stress and frustration this must have caused you when dealing with bureaucracy and intractable producers of insulins.*"

Yes, in a funny way we have been too successful.
Could we have foreseen such growth? Could we have foreseen the demand for our publications? Our success has meant ever rising costs, in a difficult economic climate. To forgo our core principles of trust, reliability and honesty, is not an option for us because we would be letting down our members and people with diabetes and their families.

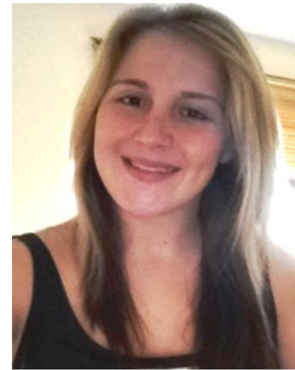
We are extremely grateful to those of you who make voluntary donations to IDDT, without you we could not exist. We always vowed that we would not be a charity that was forever begging from our members, and we never have but maybe there are ways in which you could help.

- **Could you receive the Newsletters by email? This costs us nothing.**
- **Could you make a £2.00 monthly donation by standing order? If 1000 readers did this it would increase our income by £24,000 a year - a fantastic help to IDDT!**
- **Could you buy our Christmas cards? The order form is with this Newsletter and if everyone bought just one Pack, it would be great.**
- **To healthcare professionals, please understand that while our leaflets are FREE we have had introduce a delivery charge for bulk orders.**
- **Do you have contacts with organisations or businesses that would make a donation to IDDT?**

Do you have any ideas for raising much needed funds? If so, please contact me, jenny@iddtinternational.org or call me on 01604 622837.

I can only say again, that we are grateful for your help and donations but this is a heartfelt plea for your help.

And then there is always a little fundraising...
Amelia is our student who works a day a week and the summer holidays for IDDT. In 2 hours she raised £60 amongst her teenage friends. They had a' bring and buy' of clothes they no longer wanted and sold each item for £1.00. I think we all have clothes in our wardrobe that we know we'll not wear again or children have clothes they have outgrown, could you do what Amelia did for IDDT?



Huge Criminal Charges For Drug Company Giant

UK pharmaceutical company GlaxoSmithKlein [GSK] made history but for all the wrong reasons when it paid the largest ever healthcare fraud settlement for illegal activities over 10 of its drugs – 3 billion dollars. The company pleaded guilty to charges that included hiding vital safety information from the FDA [the US drug regulator], marketing its drugs for unapproved uses, embezzling money from government funds and bribing doctors to prescribe some of its drugs.

Problems were first raised in 2001 by an employee, Greg Thorpe, which led to internal investigations. According to reports, he was sacked rather than the company making any changes.

Of particular interest to those of us with diabetes, or involved in diabetes, is that one of the drugs was Avandia, a treatment for Type 2 diabetes which makes the body more sensitive to insulin. Our Newsletters have discussed this many times over the last few years. GSK admitted that it failed to report 7 years worth of safety problems with Avandia which was virtually banned in the EU in 2007 when it was found to increase the risk of the heart attacks.

According to the now CEO of GSK, the company has now changed their practices for compliance, marketing and selling.

And in the UK MPs raise the issue in Parliament [04.07.12]...

Chris Ruane, MP asks: Whether there have been any inquiries into bribery by the pharmaceutical and drug sector related to treatment in the NHS in the last 30 years. [115956]

Paul Flynn, MP says: That this House congratulates the US Department of Justice for again successfully prosecuting GlaxoSmithKline (GSK) for tricking and bribing doctors into prescribing children with dangerous anti-depressants, hiding scientific evidence, manipulating articles in medical journals and lavishing bribes on doctors; notes that this deplorable conduct fatally harmed patient health, cheated taxpayers and violated public trust; and calls for the prosecution of GSK in the UK where similar abuses occurred.

What about Actos and risk of bladder cancer?

Actos [pioglitazione] belongs to the same family of drugs as Avandia and again we have written about it, and the risks associated with it, several times in our Newsletters. According to information from various sources and research, Actos does not carry the same risks of heart attacks as Avandia but observational studies have shown that Actos increases the risks of bladder cancer. The risk is still low but is there.

Two studies have now been published which show the following:

- A study published May 31 2012 in BMJ (British Medical Journal) concluded that in people with Type 2 diabetes taking Actos, there is an increased risk of bladder cancer. If it is taken for 2 years the risk of bladder cancer is doubled. They also showed that Avandia does not have the risk of bladder cancer.
- A study published July 3 2012 in the Canadian Medical Association Journal also showed an increased risk of bladder cancer in people with Type 2 taking Actos. This increased risk is believed to be associated with the high levels of insulin in people with Type 2 diabetes and as insulin is a growth hormone, the cancer cells can use insulin to grow.

So where does this leave us?

In an accompanying editorial in the BMJ, Dominique Hillaire-Buys and Jean-Luc Faillie from the Department of Medical Pharmacology and Toxicology in Montpellier, France say "*it can confidently be assumed that pioglitazone increases the risk of bladder cancer. It also seems that this association could have been predicted earlier.*"

Considering that the benefit of pioglitazone in reducing cardiovascular events is questionable, they suggest that "*prescribers who are ultimately responsible for therapeutic choices can legitimately question whether the benefit-risk ratio of pioglitazone is still acceptable for their patients with diabetes.*"

Useful Organisations

Diabetic retinopathy – Calibri Audio Library

If you suffer from diabetic retinopathy you may have trouble reading books this is where Calibre Audio Library can help.

Calibre Audio Library is a charity which provides a postal audio book service for people who are visually impaired, have dyslexia or are unable to read a normal print book. Calibre has 6,000 fiction and non-fiction titles on MP3CDS or USB memory sticks which can be played on commercially available players.

Members can create their own booklist or let the library choose their books from 60 different categories. The books are sent out in pouches and once you have finished a book you return it and the next title is sent to you. There is no postal charge or fines for late or damaged books.

There is one-off joining fee of £35 and thereafter you can enjoy a

lifetime of great books. You will need to sign a membership form so you either print one off their website www.calibre.org.uk or call the friendly Membership Services Team on 01296 432 339 who will be happy to send one to you.

Pre-conception counselling – new website

Women with diabetes who are planning to have a baby are advised that the safest way for both them and their future baby is to attend special pre-conception clinics before they are pregnant. It is known that good control of blood glucose levels is better for mother and child. A new website has been developed to raise awareness of reproductive health among women with diabetes. For women considering pregnancy, it is well worth a visit – the link to the website is http://go.qub.ac.uk/womenwithdiabetes

From Our Own Correspondents

Removing my test strips

Dear Jenny,

You may recall our exchange of emails, in March this year, regarding the decision of my GP and health authority to withdraw the prescription of lancets and Blood glucose test strip from people with Type 2 diabetes on Metformin.

However, after my complaint about this, it was agreed a so-called compromise whereby I would be allowed to test my blood glucose levels on the basis of two tests a week every second week! This has proved unsatisfactory to me as it does not give the reassurance of daily monitoring.

Indeed I attended my GP's Diabetic Clinic last week and was informed that my medication would require to be increased from 4x 500mg tablets a day to 5 a day. This after being on stable medication for over 18 years. The nurse maintains this has nothing to do with monitoring being reduced from daily to fortnightly.

By email

Blood pressure fallen since change to pork insulin

Dear Jenny,

I managed to get my GP to change my insulin from Novorapid and Lantus back to Hypurin Porcine Neutral and Porcine Isophane.

After many years of very high blood pressure no matter what drugs I took, after changing to Porcine I found that my actual blood pressure has gone down considerably, about normal. I therefore wonder if anyone else has found this after changing to animal insulin?

Many thanks for your help.

By email

Note from Jenny: very interesting and if you have had a similar experience of blood pressure reducing after changing to animal insulin, please email jenny@iddtinternational.org or telephone me on 01604 622837

Free IDDT Hospital Passport Is Really Needed!

The latest figures from the National Diabetes Inpatient Audit published in May 2012 show that nearly one in three hospital inpatients with diabetes are affected by medication errors. To help to protect yourself against medication errors in hospital, obtain an IDDT Hospital Passport: telephone IDDT on 01604 622837, email martin@iddtinternational.org or write to IDDT, PO Box 294, Northampton NN1 4XS.

Medication errors in hospitals

A National Diabetes Inpatient Audit [NaDIA] report publishes May 17th 2012 has shown that nearly one in three hospital patients with diabetes are affected by medication errors. This is a small improvement on last year. The audit examined bedside data for 12,800 patients and 6600 patient questionnaires, covering subjects including medication errors and patient harm over a seven day period in October 2011. It involved 11,900 patients in 212 English hospitals and 900 patients in 18 Welsh hospitals.

During the seven day audit period hospitals in England and Wales made at least one medication error in the treatment of 3700 inpatients. 32.4 per cent of patients (3,430) experienced at least one medication error in the previous seven days of their hospital stay.

Patients with errors suffered with:

- More than double the number of hypos [low blood sugars] compared to people without errors.
- 65 patients developed ketoacidosis [DKA] during their hospital stay. This was worse than last year when the number was 44. DKA occurs when blood glucose levels are consistently high which suggests that insulin treatment was not given for a significant period of time.

Medication errors were recorded under two types – ‘prescriptions error’ and ‘medication management error’.

Prescription errors

- 20.7% of patients with diabetes experienced a prescription error – an improvement on last year when it was 25.5%.
- The most common error was failing to sign off information that insulin had been given on the patient’s bedside notes. This happened to 11.1% of patients – last year it was 12.7%.

Medication management errors

- 18.4% of patients with diabetes experienced medication management errors – an improvement on last year when it was 19.7%.
- The most common error was failing to adjust medication appropriately when the patient has a high blood glucose level. This happened to 23.9% of patients – last year it was 27.9%.
- 17.4% of patients with medication errors had a severe hypoglycaemic attack while in hospital compared to 7.5% without medication errors.

The report can be accessed at www.ic.nhs.uk/nda

In commenting on the report the lead clinician Dr Gerry Rayman made the following points:

- *Training [of health professionals] needs to be mandatory to reduce hypoglycaemia and prevent DKA occurring in hospital for which there is no excuse: its occurrence is negligent and should never happen.*
- *Controlling diabetes can be difficult, more so when people are ill and unable to eat and drink. This is why knowledge, experience and skill of diabetes specialist staff are so important. There is no doubt that big improvements in care and patient safety can happen by ensuring that hospitals are adequately staffed with inpatient diabetes specialist teams.*

Fructose

What is fructose?

It is a form of sugar found in fruits, vegetables, honey and corn oil. When fructose is joined to glucose, it makes sucrose. Sucrose is plentiful in sugar cane, sugar beet, corn, and other plants. When extracted and refined, sucrose makes table sugar. It is also found in high-fructose corn syrup which is the most common sweetener in commercially prepared foods. It is found in a wide range of foods and beverages, including fruit juice, soft drinks, cereal, bread, yogurt, ketchup and mayonnaise. But we should question whether it is the best sweetener – read on...

What happens to fructose in the body?

Just about every cell in the body can break down glucose to use for energy but only the liver cells break down fructose. The process inside the liver is complicated but one of the end products is triglyceride – a fat. Uric acid and free radicals are also produced. Triglycerides can build up in the liver and cause liver damage and when released into the bloodstream, they are part of building up plaque on the artery walls. Free radicals and uric acid can also cause damage. High fructose can also cause insulin resistance, which can lead to Type 2 diabetes.

The history

In the 1970s the Americans discovered that they could produce more food, more cheaply by using corn oil. Unfortunately corn oil contains fructose which interferes with a hormone called leptin which reduces our feeling of fullness – so we eat more food which results in some people putting on weight. At that time it was believed that it was eating fat as opposed to just calories that gave us heart disease. So people who were trying to eat healthily were persuaded to buy low fat foods and they did not realise that low fat foods didn't necessarily mean low calories. When you look at what fructose does in the body, this apparently low fat diet, rich in sugar and therefore fructose, is actually a high fat diet!

What followed is almost history in that fructose in added sugars such as sucrose and high-fructose corn syrup was put in soft drinks and other foods. In the early 1900s, the average American consumed about 15 grams of fructose [about half an ounce] while today the average consumption is 55grams a day, with adolescents eating significantly more. While these are figures for the American population we have no reason to think that the UK situation is any different and almost certainly the trend will be the same – a huge increase in the consumption of fructose. Simultaneously there was a rise in obesity, insensitivity to insulin and a new condition known as non-alcoholic fatty liver disease in the United States and countries around the world.

Research

Some people may be more sensitive to fructose

Recent international animal research into the role of fructose and diabetes has found that fructose can be metabolised by an enzyme that exists in two forms:

- one is responsible for the action of fructose in producing obesity, fatty liver and insensitivity to insulin,
- the second may have protective qualities in response to sugar.

The researchers believe that this could explain why some people may be more sensitive than others to the effects of fructose.

High intake of corn syrup leads to weight gain and obesity

Two studies in rats have shown some interesting results.

- Rats with access to high-fructose corn syrup gained significantly more weight than those with access to table sugar in water, even when their overall caloric intake was the same. Long-term consumption of high-fructose corn syrup also led to abnormal increases in body fat, especially in the abdomen, and a rise in circulating blood fats called triglycerides. The concentration of sugar in the sucrose solution was the same as found in some commercial soft drinks, while the high-fructose corn syrup solution was half as concentrated as most soft drinks.
- Compared to animals eating only rat chow, rats on a diet rich in high-fructose corn syrup showed characteristic signs of the metabolic syndrome, including abnormal weight gain, significant increases in circulating triglycerides and increased fat around the belly [visceral fat]. Animals with access to high-fructose corn syrup gained 48% more weight than those eating a normal diet.

These studies were carried out at Princeton University, published in 2010 and funded by the US Public Health Service.

Fructose and diabetes – is the problem over-consumption?

Fructose may not be as bad as originally thought. A study published in Diabetes Care [June 2012] reviewed 18 trials with 209 participants who had Type 1 and Type 2 diabetes and found that fructose significantly improved blood glucose control. However, the researchers warned that there should be caution until longer and larger studies are

performed.

The participants ate test meals where fructose was incorporated or sprinkled on to test foods such as cereals or coffee and the diets with fructose had the same amount of calories as the ones without.

The main difference in these studies and real life is that the participants were eating controlled meals with the same calorie intake and not consuming fructose in addition to their meals or as it often is, hidden in foods where we don't really expect it. Nevertheless, as the researchers commented, the problem may be one of over consumption of fructose rather than fructose itself. Time and longer and larger studies will tell.

What do we know?

We know that higher consumption of fructose is *associated* with obesity, diabetes, non-alcoholic fatty liver disease, heart disease and cancer but we don't know that it *causes* them.

We also know that not all sweeteners are the same and we should choose carefully because some do contain fructose. For instance, a recently advertised sweetener called 'Sweet Freedom' is made up of 23% fructose whereas others do not contain any fructose.

Dr Mabel's Pages

Dr Mabel Blades is a freelance, consultant dietician and nutritionist and we are delighted she has given time to IDDT to provide some useful interesting thoughts and advice from her experiences.

Food And Happiness

With it being such a miserable summer for a lot of people with the weather and the economic issues, I thought I would update something I wrote a while ago.

Richard Laynard described happiness as "feeling good and enjoying life". A study in 2001 showed that those who experienced more positive emotions lived longer than those who did not.

Our diet in the UK has changed dramatically over the last 3 decades with a greater consumption of processed foods, more sugar and salt, less fibre, less vegetables and less omega 3 fatty acids.

Some researchers believe that this change in diet may have contributed to a rise in depression. Depression and stress can alter food consumption, with some sufferers avoiding food and others over eating. So here are some tips:

- **Eat regular meals** – so this includes breakfast, lunch and dinner.
- Eat meals with companions – eat with family and friends – socialising makes us happier.
- **Shop for foods and cook food** – how lovely to see that cooking comes out as so important.
- **Take adequate fluid** – that all important 2 litres per day. A lack of fluid can lead to feelings of tiredness and a lack of mental alertness.
- **Include some caffeine** – so coffees, chocolate, teas and colas can be useful but only small amounts. [Chocolate is associated with pleasure and happiness but not good for blood glucose levels! It contains substances such as the stimulants theobromine and caffeine.]
- **Include a small amount of alcohol**. However, when taken in excess alcohol has the reverse effect.
- **Take adequate carbohydrate**, especially those with a low GI. (glcaemic index) Carbohydrates stimulate the production of serotonin which is one of the mood enhancing hormones. Low GI foods also help to keep the all important blood glucose level.
- **Ensure that the diet contains enough iron, magnesium and selenium.** A lack of iron is well known to be associated with iron deficiency anaemia. This results in symptoms such as tiredness and apathy, which are hardly likely to precipitate a happy state of mind. A lack of the trace element selenium is thought to have a negative effect on mood.

- **Take foods containing omega 3 fatty acids.** Lack of omega 3 fatty acids has been associated with irritability, depression and low moods.
- **Take foods containing B vitamins and vitamin D.** A lack of vitamin D is associated with a low mood and depression and B vitamins are regarded as being essential for mental health.
- **Try to be a healthy weight but not over slim** – size 14 was found to be the happiest size for women.

Knowing What Not To Say!

When you live with someone with diabetes for a long time, you learn that there are things you just do not say and I'm sure that we all know a few of these.

- Are you hypo? This is almost bound to result in an emphatic 'no'!
- Parents - have you got your glucose with you? Irritates them beyond belief!

Whether a parent or a partner living with someone with diabetes, there are many other things that we do or say that can be an irritation to the person we care about. We do them because we care, but we don't always realise the effects.

Here are just a few but there's probably many more!

1. Never say, should you be eating that?
2. If I get a drink, don't ask if I'm high, I might just be thirsty like you are sometimes.
3. Don't sneak a look at my blood sugars without asking.
4. Don't comment on my blood sugars unless I ask.
5. f my blood sugars are not what they should be, don't criticise but recognise that I am doing my best and it is not always easy to think about everything, every day of every year.
6. If I am a bit down about my diabetes, don't offer meaningless reassurances like 'it could be worse'. This won't make me feel any better and implies that diabetes is no big deal – it is. It is hard work, it never goes away and sometimes I am just tired of dealing with it.

Here are some of the things that we can do:

1. Ask me if I need help and in what ways – the ways to help may be very different from what you think.
2. Support me through temptations by joining me in living a healthy lifestyle.
3. Understand that sometimes, I know what I should do but I don't always do it – I'm human!
4. Offer love and encouragement.

Parents and partners have feelings too

Parents and partners also have their perspective on living with diabetes – it's not easy for them either:

- You are not 'allowed' to comment on blood sugars, to look at the results or sometimes to even go to the clinic with them, yet you are expected to pick up the pieces if there is a severe hypo. This doesn't seem quite fair!

Sometimes the needs and feelings of parents and partners have to be understood and taken into account. It is especially hard for parents because no one expects children with diabetes to understand the worries and concerns of their parents, so joining a Parents' Support Group can be really helpful.

For partners it is different, there really needs to be communication between the person with diabetes and their partner to create a better understanding of each other's concerns and feelings. This means sitting down and talking about things when life is calm and running smoothly - not immediately after a 'crisis' such as a severe hypo.

Note: If you live with someone with diabetes you ay find our leaflet 'Diabetes – for Family Carers' useful. If you could like a copy, just

call IDDT on 01604 622837, email enquiries@iddtinternational.org or write to IDDT, PO Box 294, Northampton NN1 4XS.

Yet More Holiday Tips From You, Our Readers

Every year in our summer newsletter we publish our Holiday Tips article and every year we try to make improvements so that you can enjoy a safe and happy holiday. In response to the article this year two of our members contacted us with their own experiences and tips and we thought we should pass them on to you.

One of our members and her husband regularly fly abroad to Italy and France and although she does require to carry any medical equipment relating to her diabetes, her husband has a medical condition that requires him to carry equipment that includes a small pair of scissors. As advised he carries a letter from his GP, as should anybody carrying insulin pens, syringes blood testing equipment etc. This had proved to be fine when flying into major airports. However, recently they flew into a more provincial airport where the customs officers did not understand the letter as they could not read English, resulting in an unpleasant and unnecessary search of both his body and luggage. On their return home, they were talking to their son about the experience and he advised that they use Google Translator (http://translate.google.co.uk/?hl=en&tab=wT) to get French and Italian versions of the letter. Since then they have flown to several provincial airports and have had no further problems. So, if you are travelling abroad and taking diabetes supplies with you then get the letter you have from your GP translated into the relevant language to avoid any potential problems.

Another of our members regularly flies to Thailand and he advises notifying airports in advance that he will be carrying medication and sharps. His second piece of advice applies to anyone travelling to hot countries, which is to purchase a digital thermometer that not only tells you the current temperature but also records the highest and lowest temperature. This can then be placed in the fridge alongside supplies of insulin and used to adjust the temperature of the fridge to ensure it is running at the optimum temperature for storing insulin.

NHS News

More on NHS 111

In the June 2012 Newsletter, we reported on the Royal College of Nursing's concerns about the fact that in the trials of the new NHS non-emergency number, 111 only 31% of the calls are being handled by clinical staff – the aim of the government being to cut costs. Now GPs have repeated their concerns too. A yet to be published report has shown that the proposed service offered by 111 will increase GP, A & E visits and ambulance call outs.

This report is expected to be published towards the end of this year but already it is being reported that 19 PCTs have chosen who is going to provide the service in their area and only 3 plan to use not-for-profit GP led organisations.

The roll out of the new NHS 111 has been extended to October 2013 for 'some cases'. However, Royal College of Nursing Chief Executive and General Secretary, Dr Peter Carter, has stated that this extension does not go far enough and he has called for a total pause on the 111 process until the final evaluation report on it is published and considered. It is hard to understand why decisions to go ahead have already been taken before the findings of the pilot studies have been considered – why do the pilots at all? Aren't decisions supposed to be based on evidence of benefit?

Legislation change for nurse and pharmacist prescribers

Following a change in drug legislation nurse and pharmacist

independent prescribers can now prescribe controlled drugs including morphine, diamorphine and prescription strength co-codamol. Independent prescribers will also be able to mix a controlled drug with another medicine for patients who need drugs intravenously. There are up to 20,000 nurses and midwives and 1,500 pharmacists who are independent prescribers.

General Practice records to be available online from 2015

Under the government's 'NHS Information Strategy' by 2015 all patients will be able to access their general practice records online to order repeat prescriptions, view test results and make appointments. Patients will also be able to communicate electronically with general practice staff. However, GPs can choose not to provide patients access to historical records that may have been written without patient access in mind.

This was published on May 21st 2012 in a document called 'The Power of Information: Putting all of us in control of the health and care information we need' which claims that a better use of information can help healthcare professionals to prioritise face-to-face support "where it is needed".

Apparently, half of GP practices already have IT systems with the capability to provide patients with electronic access to their records but less than 1% offer this service. According to Mr Lansley, these proposals will ensure that the NHS will become easier to understand, easier to access and will drive up standards of care.

The choice of where to have blood tests

The Department of Health plans to give NHS patients the choice of where they receive common diagnostic and monitoring tests, including blood tests and heart scans. GPs will be expected to advise patients on their possible options. A statement from the Department says that from April 2013 patients will be able to choose where and when to have tests carried out and by which provider, unless there are medical reasons not to.

Outcomes strategy for long-term conditions

The Parliamentary Under-Secretary of State for Health, Earl Howe, confirmed that an outcomes strategy for long-term conditions is being prepared. [24th May 2012] A companion document will be published on diabetes alongside the strategy at the end of 2012. A cardiovascular outcome strategy is also being developed and that will set out the important links between cardiovascular disease and diabetes.

What does outcome strategy mean? Basically it means measuring the results of a process. In the case of health, it means measuring the success or otherwise of the treatment plans that are in place. For example, if one area of the country has on average higher HbA1c results in their patients with diabetes, then this is an outcome measure and that area will need to look at possible causes to make improvements.

Rationing care by the back door

A report in the magazine, GP, says that more than 90% of Primary Care Trusts [PCTs] in England are imposing thresholds or limits on referrals for procedures they class as 'non-urgent' or of 'low clinical value'. [20th June 2012] This means that patients can be denied treatment until their conditions worsens.

101 PCTs responded to a Freedom of Information request and of these, 91% had measures in place to limit GP referrals for 2012/13.

- 66% had limits in place for cataract surgery - some PCTs will only fund cataract surgery for one eye.
- 59% restrict bariatric surgery – some restrict this to patients with a BMI over 50 when NICE guidance says it should be offered to patients with a BMI of over 40.
- 59% limit joint surgery.

GPs and charities are accusing PCTs of introducing waiting lists by the back door, which they are! Health Minister, Simon Burns, told GP 'If local health bodies stop patients having treatments on the basis of cost alone, we will take action against them.'

Our comment would be that unless our GP tells us that we cannot be referred due to cost, we won't know!

Not enough support for people with a long-term condition

Information collected during part of 2011 and the first 3 months of this year shows that 88% of patients rate their overall experience of general practice as good. 93% of patients have some level of confidence and trust in the last GP they saw. However, only 64% of people with a long-term condition, such as diabetes, feel they have enough support from local services to manage their condition but 90% of these patients rate their experience of their GP surgery services as good.

Fall in satisfaction with the NHS

The British Attitudes Survey published in June 2012 has shown that public satisfaction with the NHS has had the largest ever fall from 70% in 2010 to 58% in 2011. Patients were interviewed and many are concerned about privatisation, commercialisation and fragmentation of the NHS. So this sharp fall appears to be closely linked to the NHS reforms which should concern government.

Dream Trust - My New Bike!

Following the last updates from Dream Trust, in India, a heartwarming offer of help was made by one of IDDT's sponsors. Having to walk miles to school everyday is not something many of us can imagine but for Sayli Bhute, it is what she had to do for a small amount of classroom time. Sayli said she would like a bike so she could cycle to school to spend more time on her studies. After her sponsor contacted IDDT, we spoke to the Dream Trust about the cost of bicycle and within a week her sponsor donated the equivalent of RS.3300 (£45) which enabled Dream Trust to purchase a bicycle for 12 year old Sayli. Living at home with her parents and younger sister and on twice daily insulin, Sayli can now devote more time to her studies as she has her new mode of transport! This picture shows Sayli is clearly delighted and she wrote a letter of thanks to her sponsor for this very kind and generous gift.

This is just one example of the kindness of the Dream Trust Sponsors and we would like to say a big thank you to all those who continue to support the children and young people at the Dream Trust.

You've Probably Seen This But It's Great!

How Is Norma?

A sweet grandmother telephoned St. Joseph 's Hospital. She timidly asked, "*Is it possible to speak to someone who can tell me how a patient is doing?*"
The operator said, "*I'll be glad to help, dear. What's the name and room number of the patient?*"
The grandmother in her weak, tremulous voice said, "*Norma Findlay, Room 302.*"
The operator replied, "*Let me put you on hold while I check with the nurse's station for that room.*"
After a few minutes, the operator returned to the phone and said: "*I have good news. Her nurse just told me that Norma is doing well. Her blood pressure is fine, her blood work just came back normal and her physician, Dr. Cohen, has scheduled her to be discharged tomorrow.*"
The grandmother said, "*Thank you. That's wonderful. I was so worried. God bless you for the good news.*"
The operator replied, "*You're more than welcome. Is Norma your daughter?*"
The grandmother said, "*No, I'm Norma Findlay in Room 302. No one tells me anything!!!*"

We Don't Advertise But...

As regular readers know, we do not accept advertising but at the same time we do want to provide information that may be useful to you. The information below is in response to the questions we have recently been asked.

*** Remember Your diabetes ID – here are some suppliers**

Medic Alert	**The ID Band Company Ltd**	**IdentifyMe Limited**
MedicAlert House 327-329 Witan Court Upper 4th Street Central Milton Keynes MK9 1EH	PO Box 146 Glossop Derbyshire SK13 9AG	The Studio 7a Wells Avenue Manchester M25 0GN
Freephone 0800 581420 www.medicalert.org.uk	Tel 0845 269 4523 www.theidbandco.com	Tel: 0845 125 9539 or 0161 870 6044 http://www.icegems.co.uk/mens-medical-alert.html

News From NICE

NICE issues guidance on preventing Type 2 diabetes

This public health guidance has been issued for everyone who is involved in identifying people at high risk of developing Type 2 diabetes and in preventing or delaying its onset. This not only involves GPs and other health professionals but also commissioners and managers in the NHS and local authorities. It may also be of interest to people who are at high risk of developing Type 2 diabetes and their families as well as the general public.

The guidance is not putting forward a national screening programme for Type 2 diabetes but the recommendations remind GPs and healthcare professionals that age is no barrier to people developing or being at risk of developing Type 2 diabetes. There are 20 recommendations within the guidance.

Issued in July 2012, the guidance can be found by visiting: http://guidance.nice.org.uk/PH38

Amendment – NICE Quality standards for adults with diabetes [July 13th 2012]

In the NICE Quality Standards for diabetes, statement number 10 said:

"*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.*"

This has now been amended because as originally written, it did not separate out the care of people '**with**' foot ulceration from care of those '**at risk**' of foot ulceration. People **with** foot ulceration require urgent medical attention and referral to and treatment by a multidisciplinary foot care team. As the statement was originally written, there was a risk of people with foot ulceration being inappropriately reviewed and referred. Quality statement 10 has therefore been amended to deal only with those 'at risk' of foot ulceration, and a new quality statement 11 has been included on 'foot problems requiring urgent medical attention'.

The key points to remember are:

- **People with diabetes at risk of foot ulceration receive regular review by a foot protection team in accordance with NICE guidance.**
- **People with diabetes with a foot problem requiring urgent medical attention are referred to and treated by a multidisciplinary foot care team within 24 hours.**

The amended quality standard is now available on the NICE website: http://www.nice.org.uk/guidance/qualitystandards/diabetesinadults/diabetesinadultsqualitystandard.jsp

Snippets

Hair follicles and the immune system

Researchers in Japan have found that hair follicles play an important role in the immune system by directing the movement of immune cells into different layers of the skin. [Nature Immunology Online 2012]

Jogging increases lifespan

Research carried out in Denmark compared 2,000 joggers with less active people and found that jogging for half an hour a week increased life expectancy by up to 6 years.

Americans are healthier than they were

According to US government figures, between 1997 and 2006 overall death rates in people with diabetes dropped by 23% and there was a 40% drop in their death rates from heart disease and strokes. The lead researcher reported that people with diabetes are now less likely to smoke than in the past and they are more likely to be physically active. Better control of high blood pressure and high cholesterol levels may also have contributed to the improvements. The study looked at information from 250,000 patients. However, obesity continues to rise and this is a major cause of the increase in Type 2 diabetes.

US new guidance on obesity

New guidance from the US Preventative Services Task Force recommends that all obese people should be referred for intensive behavioural treatments at diagnosis. It also recommends that all obese people seen in primary care should receive counselling to promote a healthy diet and active lifestyle. Seems like good advice but is it affordable and do we have enough trained counsellors?

Australians are heavier than they were

According to a report from the Australian Institute of Health and Welfare, Australians have a long life and a positive outlook but they have one of the highest levels of obesity in the world. One in four Australian adults and one in twelve children are obese.

The weight of the world's population

Researchers at the London School of Hygiene and Tropical Medicine have described the obesity in the world's population as 'a major threat to environmental sustainability. Apparently the world's population now weighs an estimated 287 million tonnes.

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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Northampton
NN1 4XS

Name: ____________________

Address: ____________________

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Postcode: ____________________

Tel No: ____________________

From Your Editor – Jenny Hirst

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