InDependent Diabetes Trust

March 2013 Newsletter

Registered Charity No 1058284 - Issue No 76

Calling You!

In the December 2012 issue, we reported the findings of the Public Accounts Committee into the management of adult diabetes. No one could fail to recognise that people with diabetes are being let down by the system. While some people may live in areas where care is excellent, many others are being badly let down by the quality of care, which varies dramatically across the country.

This is happening despite numerous documents with recommendations for standards of care – from the National Service Framework for Diabetes in 2001 to the NICE Quality Standards for adult diabetes in 2011. Yet Diabetes UK recently published results from a survey which showed that last year there were no improvements in standards of care – they rightly call it 'the lost year'.

How many more 'lost years' can we afford?
This question is easily answered – none. The health of so many people with diabetes is being adversely affected and they are truly losing years because they are not receiving the care they need to manage their diabetes.

But we also have to look at the costs and question whether NHS funds are being spent in the wisest way?

A report issued in August 2012, *'Prescribing for Diabetes in England: 2005-06 to 2011-12'* highlighted the increased costs of diabetes to the NHS for 2011-12 compared to 2005-06.

- Diabetes prescriptions have for the first time topped 40 million a year, a rise of nearly 50% on six years ago.
- The net cost of diabetes drugs also rose by just under 50% in the same period - faster and greater than for prescriptions overall,

where items increased by 33%.

- The overall cost of all drugs to the NHS fell last year by just over 1% but the diabetes drugs bill increased by nearly 5%.
- Diabetes drugs accounted for a net ingredient cost of £760.3 million, a 4.8% (£35.2 million) rise on 2010/11 and a 47.9% (£246.3 million) rise on 2005/06.

These differences are too great to simply put down to the increase in numbers of people with diabetes.

What is missing?
Certainly not reports on the situation – there are plenty of those! Lacking is the will, political or otherwise, to follow these up with ACTION to bring about change. Reports are of little value unless they are acted upon and that certainly does not seem to be the case.

The reaction of the then Health Minister to the report on costs was: "*the rise in the cost of the diabetes drugs bill is also being driven by new more expensive medication, which is effective at helping diabetes sufferers...*" [Does he actually KNOW that the new, expensive drugs are more effective? Many of them have not been around long enough to gather the evidence for such a statement and research does show that the cheapest Type 2 drug, metformin, is still the most effective!]

He goes on: "*We know the risk of developing Type 2 diabetes can be reduced by eating a healthy diet and increasing activity levels. That's why last year we launched a call to action to wipe five billion calories off the nation's waistline each day and through Change4Life we are encouraging everyone to eat less and move more.*"

Do Ministers and the Department of Health really believe that Change4Life is going to sort out all the problems?

Diabetes UK's Chief Executive, Barbara Young responded with "We n*eed a government-funded awareness-raising campaign on the risk factors and symptoms of Type 2 diabetes and we need to get much better at identifying people at high risk so they can be given the support they need to prevent the condition.*" Awareness alone is not going to do it. While we do need to diagnose people at risk and help them to prevent diabetes developing, we actually need positive action to provide better care and treatment for the people who are actually living with diabetes now!

The action we are seeing is negative – diabetes is being downgraded!

NHS Diabetes is being closed down at the end of March 2013
For 12 months diabetes will be looked after by a 'Transition body' before being moved to the 'New Improvement Body'. Diabetes is not being treated separately but simply put in the category of 'long-term conditions'. So with the closure of NHS Diabetes, diabetes is effectively being downgraded to just another long-term condition.

Strategic Clinical Networks are not viewing diabetes as a priority
These Networks were set up for specific patient groups or conditions in 12 geographical areas to improve health services and reduce variations in services across the country. The first Clinical Networks are for the following conditions: cancer, cardiovascular disease, mental health and maternity and children's services.

Once again, diabetes is not being seen as a separate condition with its own Strategic Clinical Network but in this case, it is being put into the Cardiovascular Disease Network. While there may be some logic to Type 2 diabetes being put in with cardiovascular disease, Type 1 diabetes does not belong in this category because it is an autoimmune condition.

So who is going to do the innovative thinking to improve the health of people with diabetes?
Without specific organisations within the NHS dedicated to diabetes, this is a question that must be answered. Despite the huge costs of diabetes, all the technological advances and new expensive drugs and insulins, blood glucose level targets are not being met by the majority of people. Surely Government and the Department of Health

should be asking why this is the case – it's too easy just to blame the patient!

We need to see investigations into ways of changing behaviour to help people improve the self-management of their diabetes and ways to help doctors and healthcare professionals to provide better support for people living with diabetes. The World Health Organisation suggests that improving self-management "may have a far greater impact on the health of the population than any improvement in specific medical treatments". Improving such skills helps people with diabetes develop confidence to manage their condition more effectively and make better use of their consultations with their doctor or healthcare professional. Some researchers and doctors are already doing this but in an ad hoc way, making it a long way off becoming national policy.

We have to conclude...

- Services for people with diabetes are failing, or at best there are no improvement,
- blood glucose targets not being met by the majority,
- the numbers of people with both Type 1 and Type 2 diabetes are predicted to rise and
- diabetes is a huge cost to the NHS.

Yet diabetes is not being seen as a priority but just another long-term condition or a cardiovascular condition.

IDDT is calling on you, our members and readers, to take action NOW by writing to your MP! We need to ensure that people with diabetes are not sidelined, that the NHS structure is in place to ensure they are given priority within the NHS to provide the much needed improvement in their treatment and care.

Included with this Newsletter is a draft letter for you to use to write to your MP and instructions on how to lobby. If we can help you, do call IDDT on 01604 622837.

WRITE TO YOUR MP NOW!

NICE Updates

NICE does a u-turn on drug to treat macular oedema

As reported likely in our December Newsletter, on January 4th 2013, in a final draft guidance NICE has recommended that Lucentis [ranibizumab] is to be available on the NHS in England and Wales as an option for treating diabetic macular oedema.

The macula is the central part of the retina and is used for colour vision and perception of fine detail, such as reading. Diabetic macular oedema is a swelling of the macula area which can lead to severe visual impairment, so the possibility of successful treatment with Lucentis is very important.

The manufacturer submitted updated analyses of the drug's effects and agreed a confidential access scheme with the Department of Health to make Lucentis available with a discount. So Lucentis is now recommended as an option for treating visual impairment due to diabetic macular oedema if:

- **The eye has a central retinal thickness of 400 micrometres or more at the start of treatment and**
- **the manufacturer provides Lucentis with the discount agreed in the patient access scheme (as revised in 2012).**

People presently receiving treatment with Lucentis whose disease does not meet the above criteria should be able to continue treatment.

Lucentis is given by injection into the eye. It works by preventing the production of a protein called vascular endothelial growth factor (VEGF) which causes increased permeability of the blood retinal barrier. By inhibiting VEGF, Lucentis can decrease the swelling and limit visual loss or improve vision. According to the manufacturer's evidence, gains in clearness of vision associated with Lucentis were greatest in people with thicker retinas and more severe visual impairment.

According to the International Diabetes Federation approximately 14% of people with diabetes have macular oedema which increases

to 29% for people who use insulin for more than 20 years.

[The final guidance is due February 2013, after we go to print].

Walking and cycling: Public health guidance, PH4 November 2012

This guidance sets out how people can be encouraged to increase the amount they walk or cycle for travel or recreation purposes. It is for commissioners, managers and all those involved in the environment, parks, leisure and transport planning as well as people who promote walking and cycling in a voluntary way. The recommendations cover local programmes, policy and planning and schools, workplaces and the NHS.

Obesity working with local communities: Public health guidance, PH42 November 2012

This guidance aims to support effective, sustainable and community-wide action to prevent overweight and obesity. It sets out how local communities can achieve this with support from local organisations and networks. The recommendations may also help people who are already overweight or obese to lose weight, or to prevent them from gaining further weight, but it does not cover clinical management for people who are already overweight or obese. Again this guidance is for local policy makers, commissioners, managers, practitioners and other professionals working in local authorities, the NHS and the wider public, private, voluntary and community sectors.

Footcare – Prevention Of Ulcers

We read in the press that every week about 100 diabetes-related amputations take place and 85% of them are preceded by ulcers. According to the International Diabetes Federation 80% of amputations could be prevented with the right care.

While there are good guidelines on treating foot ulceration, it seems that there is not enough money and/or staff to develop a good strategy for prevention. This certainly is a case of prevention being better that cure!

The recommended preventative measures include well fitting shoes and the use of insoles for those at risk of developing an ulcer, not to mention seeing a podiatrist on a regular basis. The two main factors that cause ulcers are reduced circulation and increased plantar pressures – plantar pressures are areas on the soles of the feet where specific pressures occur. These can lead to a break in the skin so allowing infection and ulcers to develop.

The use of Insoles

Insoles can be used to help to prevent the above from happening. There are various insoles available.

Liqua Care – are gel insoles containing non-toxic precisely measured liquid that flows through a liquid control system with anatomically designed channels controlling the direction of flow. This ensures stability during walking or standing and matches the flow of liquid to the structure of the foot. Research has shown these to be a cost effective therapeutic insole with many advantages over other insoles, the main one being that if suitable footwear is being used, these insoles can be fitted without any modifications and do not take up too much room in the shoe.

Foot ulcer care system – a new therapeutic shoe system has been launched, called the Kerraped Plantar Ulcer system. It is designed to mechanically offload pressure from the ulcer and surrounding area. It consists of a therapeutic shoe and an insole with removable plantar pegs which is easily adapted to the person's individual offloading requirements.

The pegs are removed by the health professional and as long as the Kerraped is available in the clinic, this tailor-made system is available the same day which prevents people from having to use unsuitable footwear. It is available in a range of sizes to accommodate bulky dressings and is easy to take on and off. From December 1st 2012

it is available on NHS Drug Tariff. More information is available from Crawford Healthcare by visiting www.crawfordhealthcare.com or calling 01565 654920.

Are custom-made insoles necessary?
Little difference between custom-made and prefabricated insoles in reducing peak plantar pressure
A recent study found that prefabricated insoles perform equally to custom-made insoles in reducing peak plantar pressure and ulceration risks in people with diabetic neuropathy. The researchers found no difference between the insoles in reducing peak pressure. The only difference was that the custom-made insoles were slightly more effective in reducing forefoot pressure. The researchers recommend that where appropriate the most cost effective prefabricated insole should be considered. [J Foot Ankle Res. December 2012]

Swedish study confirmation
A new study carried out in Sweden has found that shoe inserts, foot care, regular checkups and other simple interventions can reduce amputations among people with diabetes by more than half.

The researchers have been studying foot complications since 2008 with a view to preventing overloading of the sole of the foot to minimise the risk of ulcers. In this latest study they assessed 114 people who had diabetes for 12 years and were at risk of developing foot ulcers. Each participant wore one of three different types of insole the results showed:

- 0.9% developed new foot ulcers during the first year compared with 3 to 8% in similar groups of people with diabetes.
- Good shoes and insoles can reduce pressure on the foot by 50% compared with going barefoot.
- All three types of insoles distribute pressure under the sole.
- Only 67% of the patients had been offered podiatry care despite the fact that 83% had calluses. [To be presented at the International Conference on Prosthetics and Orthotics in Hyderabad, India.]

Conclusions
Good fitting shoes, shoe insoles, regular podiatry checks and information can prevent ulcers and significantly reduce amputations. ***If you have neuropathy and/or are at risk of foot ulcers, do not delay – talk to your GP or health professional straight away. Insoles do not have to be expensive!***

What's New?

New hypo alert system
Night hypos are a real worry for many people, and for partners and parents. A hypo alert system for night hypos has been introduced by AIMEDICS called the HypoMon for children and young adults with Type 1 diabetes. It consists of a wrap around chest belt to monitor the physiological changes during hypoglycaemia via an ECG and a radio transmitter attached to the belt to transmit the information to the receiver. The receiver is effective for a range of 10 metres and so can be positioned by the bed or in the next room.

In studies, the HypoMon detected 80% of night hypos, including severe ones. The alarm triggers on the belt and the monitor when the physiological signs of a hypo occur. The system is calibrated using blood glucose levels before bed. The HypoMon has been approved for use in those with Type 1 diabetes between the ages of 10 and 25 years. For more information visit www.hypomon.com or phone 0844 3814840.

'Patch' for delivering insulin in Type 2 diabetes
PaQ® Insulin Delivery Device is a discreet device that provides consistent basal insulin delivery for three days, as well as on-demand bolus insulin, for people with Type 2 diabetes who need insulin to control their diabetes. It is a small device made up of a reservoir of insulin attached to a reusable insulin monitor.

The PaQ® made by CeQur has received CE mark approval. Studies suggest that this simple insulin infusion may improve control and

quality of life for people with Type 2 diabetes and of course, it will be useful in people who fear insulin injections.

It is available to purchase at some hospitals and online. More information is available by visiting www.cequrcorp.com

Self-Monitoring – A Change In The Evidence!

As we regularly report in our publications, one of the most common problems that people express to us is the restriction on the supply of blood glucose test strips, or in many cases of people with Type 2 diabetes, the refusal to prescribe any at all!

The evidence for this from a review was that self-testing in Type 2 diabetes made no improvement in HbA1c and this was the message health professionals took on board even though the review did not take into account the benefits of testing if you live with diabetes. These are the feeling of safety when you know what your blood sugars are doing, reducing the risk of hypos, learning the effects of different foods on blood sugars etc.

A review of the review!

A large scale Cochrane Review has looked at the evidence again and found that newly diagnosed people with Type 2 diabetes who are not on insulin are achieving significantly better HbA1cs if they have access to blood glucose testing.

Why the difference? One of the reasons is that the studies included in the first review excluded people who had previously shown interest in self-testing many of whom buy their own test strips. So the studies that excluded these people did not, and cannot, give a true representation of people with Type 2 diabetes in the UK.

Another study shows self-monitoring improves glycaemic control in Type 2 diabetes treated with tablets. This study published in Diabetes Metabolism Research and Reviews has shown that self-monitoring of blood glucose in people with Type 2 diabetes improves control as measured by HbA1cs.

Interestingly, in this 24-week study of 137 people three groups were compared – no testing, testing by taking blood from the finger tips and testing taking blood from the palm of the hand. The results showed:

- HbA1cs remained unchanged in the group that did not test but was decreased in the finger tip and the palm groups.
- Compliance with testing was greater in the finger tip group than the palm group.
- A patient questionnaire showed that 84.1% of the finger tip group and 90.2% of the palm group were satisfied with blood glucose monitoring.

The researchers concluded that self-monitoring of blood sugars is beneficial in people treated with tablets and blood testing using the palm is a useful way of doing it.

'Fighting for your test strips'

As we know, it is not possible to 'fight' this matter nationally because the Department of Health has placed no restrictions on blood glucose test strips. The decision to not prescribe or restrict numbers of strips, is a local one, so IDDT's advice has always been to explain to the practice manager why you need strips, or need more strips and if this has no effect, to take the matter up with your local Primary Care Trust [PCT]. However, from April 2013 PCTs will no longer exist, so it is a matter to take up with your GP.

Here are the key points to use.

For people with Type 1 diabetes and those with Type 2 diabetes taking insulin:

- To maintain the tight control that is necessary and with present 4

plus injections a day, at least 125 strips a month are necessary.
- To take into account times of illness or stress, additional strips are needed.
- The new driving regulations state that people have to test before driving and at least every 2 hours on long journeys. The extra number of strips to conform with the regulations will vary from person to person.

For people with Type 2 diabetes not taking insulin:
- The Cochrane review shows that people with Type 2 diabetes do benefit from testing and their HbA1cs are improved and this should be pointed out if you are refused test strips.
- The only tablet that does not cause hypoglycaemia is metformin, so for people taking any of the other tablets for Type 2 diabetes there is a risk of hypos and therefore, the driving requirements to test before driving apply to them too to reduce the risk of hypoglycaemia.

Whatever type of diabetes you have and however it is treated, NICE guidelines say that self-testing should be available as part of the education people with diabetes should receive.

So don't be fobbed off without test strips or without the number you require – it's your health and welfare that is at stake!

In putting your case, you are supported by a statement made by Anna Soubry, Parliamentary Under Secretary of State for Health. On November 27th 2012 she made the following statement:
"We have been made aware that some people with diabetes have experienced difficulties in accessing blood glucose testing strips. General practitioners should prescribe these in accordance with National Institute for Health and Clinical Excellence and Driver and Vehicle Licensing Agency guidance, and clinical need. They should ensure appropriate patient education."

Empathetic Doctors Benefit Patients

Previous studies have shown that when doctors undergo short training programmes to improve their empathy, patients benefit significantly. Empathy is defined as being a mainly mental state in which the health care professional has a proper understanding of patients' worries, concerns, agonies, pain and overall suffering - and is committed to helping them.

Now a study of doctors and patients with diabetes has shown similar results - doctors who show empathy have patients with better outcomes, compared to doctors who had low empathy scores. These were measured on practical and important issues for people with diabetes – HbA1cs, cholesterol levels, acute hospital admissions for coma and diabetic ketoacidosis. [Academic Medicine, Sept 2012]

Connective Tissue Disorders

Connective tissue is the material between the cells of the body that gives tissues form and strength. It also is involved in delivering nutrients to the cells around the body. It is made up of dozens of proteins including collagens. These proteins vary in quantity to provide different structures with varying functions: bone, cartilage, tendons and ligaments as well as fatty and elastic tissues.

Many connective tissue disorders are caused by mutations [alterations] in genes for building tissues and these mutations may change the structure and development of skin, bones, joints, heart, blood vessels, lungs, eyes and ears. Some connective tissue disorders are not directly linked to these mutations but some people may be genetically predisposed to becoming affected. Inherited connective tissue disorders may not be evident at birth but may appear after a certain age or after exposure to a particular environmental stress.

Frozen shoulder and chiroarthropy [diabetic prayer] are two common

connective tissue disorders that are common in people with diabetes.

Frozen shoulder
Frozen should, also called adhesive capsulitis, occurs in 3% of the population, most commonly in people over the age of 40 and more often in women. It is more common in people with diabetes, affecting between 10 and 20% of those with diabetes. Although this has been known for some time, no one knows why it is more common in people with diabetes. It usually lasts for about 30 months and goes through three distinct phases.

An early sign of frozen shoulder is when lifting the arm above the head, reaching across the body or behind the back is difficult. This is followed by pain and stiffness, often worse at night, the pain then reduces but the range of movement is more limited and may last for 4-12months. In the final stage, the condition begins to resolve but can last up to 3 years during which time, the shoulder becomes less stiff and there is increased movement. Sometimes surgery may be needed to restore movement.

The cause is unknown but thought to involve an underlying inflammatory problem. The capsule around the shoulder joint thickens and contracts leaving less space for the upper arm bone to move around. It can also occur after long periods of immobilisation eg after injury or surgery.

Treatment – initially drugs such as aspirin or ibuprofen are usually given to reduce the inflammation and pain and also avoidance activities that cause pain. Other treatments include muscle relaxants, physiotherapy, exercises, heat or ice therapies, corticosteroid injections but usually surgery only takes place if there is no improvement after several months. Some people have reported a positive response from acupuncture.

Chiroarthropathy [diabetic prayer]
This is often called limited joint mobility and in people with diabetes generally involves the small joints of the hands, although it can affect larger joints such as wrist, shoulder, knees and hips. It usually affects:

- 4 -14% of the non-diabetic population
- 8.4 - 55% of people with Type 1 diabetes
- 4.2 -77% of people with Type 2 diabetes

Studies show a wide variation which could be due to genetic or racial factors or incorrect diagnosis. However, it does increase with the duration of diabetes Chiroarthropathy is usually painless but numbness and pain may be present if there is also neuropathy or angiopathy of the hand. Most people do not report the problem until there is some deformity or loss of movement of the fingers. The affected fingers are swollen with a thick, tight and waxy skin and there is an inability to press both hands together hence the term, diabetic prayer. Other disorders of the hand, such as carpel tunnel syndrome and Dupuytren's contracture, have different and distinct clinical features. Chiroarthropathy is linked with more serious microvascular complications of diabetes eg retinopathy, nephropathy and neuropathy, so diagnosis is important. The causes of chiroarthropathy are not really understood.

Treatment - because of the relationship with the microvascular complications of diabetes, improved diabetic control is advised but there is no well established treatment. Physiotherapy is important to maintain movement and prevent further deterioration. Surgery and corticosteriod injections may help in severe cases.

For Our American Readers

Pork insulin no longer available online from Canada
Some years ago, the discontinuation of pork and beef insulins in the US led to a lot of distress for the people who need them, especially those who are unable to tolerate GM synthetic human and analogues insulins.

It is possible to import pork insulins [and beef] on a personal importation basis from Wockhardt UK but this process requires a

letter from a doctor in the US stating that pork insulin is essential treatment. However, many people in the US cannot find a doctor who is prepared to write the necessary letter and prescription.

Wockhardt UK received marketing approval for Hypurin Regular Pork and Hypurin NPH Pork insulins in Canada early in 2006 and it has been possible for Americans to buy these insulins over-the-counter in Canada without a doctor's letter. In addition, at least two pharmacies were providing these pork insulins by ordering online without a doctor's letter. Unfortunately, it appears that this service has now been stopped with no explanation. It is NOT due to a shortage of the Hypurin Pork insulins.

At the present time, it appears that people in the US who need Hypurin Regular Pork and Hypurin NPH Pork insulins will have to import from Wockhardt UK Ltd.

Urinary Tract Infections

Diabetes raises the risk of urinary tract infections. In a recent study 135,000 people with Type 2 diabetes were matched with a similar number of people without diabetes and over a period of 2 years the risk of urinary tract infections was 61% higher than in the people without diabetes. The US researchers concluded: 'Our results confirm that patients with diabetes are at an increased risk of developing UTIs across all age categories.' [J Diabetes Complications 2012, online 13 August]

More about urinary tract infections or UTIs as they are commonly known

- UTIs are very common and can be painful and uncomfortable but usually pass in a few days or can easily be treated with antibiotics.
- They are more common in women than men. Children also get UTIs although this is less common.

What is the urinary tract?

The urinary tract is the system that makes urine to get rid of waste products from the body and consists of:

- the kidneys, which make the urine,
- the ureters, the tubes that lead from the kidney to the bladder,
- the bladder where the urine is stored and
- the urethra, the tube that carries the urine from the bladder and out of the body.

Causes of UTIs

A UTI develops when part of the urinary tract becomes infected, usually by bacteria which enter through the urethra. Often there is no obvious reason why the infection occurs, although some women may develop a UTI after having sex. UTIs are NOT sexually transmitted infections [STIs] but irritation from having sex can sometimes trigger a UTI.

UTIs in men are much less common than in women and should be investigated to find the underlying cause. Possible causes can include a narrowing of the urethra, a previous STI, a balder stone or a problem with the prostate gland.

Different types of UTI

UTIs can occur in any part of the urinary tract.

An infection in the lower part of the urinary tract [bladder and urethra] or the upper part [kidney and ureters] is often referred to as lower and upper UTIs. Upper urinary tract infections are potentially more serious because there is a risk of kidney damage.
An infection of the bladder is called cystitis and an infection of the urethra, urethritis.

Symptoms of a UTI

- Pain or a burning sensation when urinating [called dysuria].
- A need to urinate often.
- Pain in the lower abdomen.

When to see your GP
UTI symptoms can be mild and pass within a few days without treatment but if the symptoms are very uncomfortable or last for more than 5 days, you should see your GP. However, if you have diabetes, you should see your GP. You should also see your GP if you have a UTI and:

- you develop a high temperature,
- your symptoms suddenly become worse,
- you are pregnant.

Treatment
Antibiotics can speed up recovery time and are usually recommended for women who have repeated UTIs. Sometimes long-term use of antibiotics can prevent the infection returning.

Complications of a UTI are not common but can be serious. They usually only affect people who already have a health condition such as diabetes or a weakened immune system. Hence it is important for people with diabetes to see their GP if they develop a UTI.

Doughnuts For Breakfast Anyone?

IDDT responds to MP's suggestion that people with type 2 diabetes should have to pay for treatment.
This is IDDT's response to one MP's suggestion that Type 2 diabetes is a lifestyle condition caused by things, such as eating doughnuts for breakfast and as such, people with Type 2 diabetes should have to pay for treatment. As a charity for people with diabetes, we were appalled by Dr Phillip Lee's suggestion that Type 2 diabetes is a lifestyle condition caused by such things as eating doughnuts for breakfast and as such people with Type 2 diabetes should have to pay for their own treatment. In a briefing to the Institute of Economic Affairs, he made the suggestion that people with Type 2 diabetes, and 'other lifestyle conditions', should lose their right to free NHS prescriptions. Such statements are frightening for people with diabetes. We and many other charities would resist such actions with vigour.

As he is a GP, we were amazed at his lack of understanding of the nature of Type 2 diabetes. It is not simply a 'lifestyle condition', there is a strong hereditary factor involved, so some families have a susceptibility to developing Type 2 diabetes and some cultures have a much greater risk of developing the condition.

We would like to remind Dr Lee that generally speaking Type 2 diabetes develops after the age of forty and therefore the majority of people have paid for their free NHS treatment over the last 20 years and more! In addition, many people with Type 2 diabetes are not receiving the education programmes and not receiving the blood glucose test strips they need to manage their diabetes, so cuts in NHS provisions are already being made for this group of patients.

To follow Dr Lee's recommendations means that some families simply would not be able to afford treatment, especially the more expensive drugs and the insulin many people eventually need. The resulting effect would be that greater numbers of people would suffer from the complications of diabetes, which in turn would cost the NHS even more money or is he proposing that we simply leave these people to suffer ill health, blindness, amputations, increased hospital admissions and premature death?

We also have to question what other conditions he considers to be due to lifestyle – heart disease, stroke or some types of cancer, all of which could be classed as being associated with obesity, overweight, lack of exercise and other so-called 'lifestyle choices'. Is he really recommending that free treatment is denied to all these people?

Speaking Of Doughnuts: Sweet Cravings

By Dr Mabel Blades Freelance Dietitian and Nutritionist
Most people get a real desire for sweet things from time to time. For those with diabetes this can be especially hard as it is less easy to eat the chocolate or whatever without an impact on blood glucose levels. From experience these cravings vary markedly from person to person

and what suits one person does not always suit another.

Background
We all have taste buds and some of them detect sweet flavours. Some people say the innate liking for sweet things is due to breast milk tasting sweet! Also many of the more comforting foods are sweet like the puddings, confectionery and other sweet items –these are also the items, which boost blood glucose levels.
So what can we do when we are hit by that desire for something sweet?

Ideas
Sometimes the desire for something sweet is almost like the need for a pick-me up when we feel tired or a bit jaded. Whichever food you choose sip or eat it slowly. This is because the signals of satisfaction take a little while to travel from your stomach to the brain.

Sometimes that feeling may be due to boredom, so it may be worth trying to distract yourself , for example, by going for a walk, phoning a friend or washing the car.

Fluids
Sometimes our bodies mistakenly tell us that we are hungry when actually we are thirsty and this mistaken feeling of hunger can be interpreted as the desire for something sweet. So, firstly check you are not actually dehydrated, try the following:

- A glass of water.
- Low calorie squash.
- Diluted fruit juices - a mixture of say orange and pineapple gives a pleasant flavour.
- Water with an effervescent vitamin tablet - gives a sweet and satisfying flavour
- Low calorie drinks, like dry ginger
- Hot fruit tea
- Low calorie hot chocolate or malted milk

Low Blood Sugar
This can leave you feeling a craving for sweet items and it is imperative you increase blood sugar levels by having a mixture of quick-acting, rapidly absorbed carbohydrate and a slower acting one.

- A slice of granary bread with a couple of teaspoons of honey or syrup.
- Porridge topped with syrup and slices of banana.
- Crisp bread with peanut butter or chocolate spread.
- Pineapple with a scoop of ice cream and a swirl of syrupy topping.
- Cereal bar.

Hunger
Sometimes those cravings are due to genuine hunger, so here are some ideas for snacks to satisfy your hunger:

- Pieces of ham or low fat cheese on a piece of bread.
- Small jacket potato with low fat spread.
- Boiled egg.
- Strips of raw vegetables with a dip made from low fat yogurt, flavoured with paprika or use a tomato salsa dip.
- Slice of frittata.
- Pot of yoghurt or soy desert.

Comfort eating
Sometimes you may just want to eat simply because you feel cold, a bit down or it is simply a wet, dreary day. These are some healthy yet comforting options:

- Home made popcorn - made in the pan and topped with sweetener or parmesan cheese. The warmth and the bulk of homemade popcorn is very satisfying.
- Bowl of vegetable soup with lots of different vegetables and lentils.
- Big bowl of salad made with lots of leaves and grated vegetables and some oven baked croutons.
- Roasted seeds or nuts.
- Boiled egg with granary soldiers - evocative of childhood.
- Beans on toast.

- Egg mixture with cooked potatoes and various vegetables like a frittata.
- Homemade bread or drop scones are easy to make and the smell of baking is very comforting.

Just sweet things

When simply nothing but something sweet will do, you can try:

- Chewing gum.
- Fruit like strawberries or rhubarb dipped into a granular sweetener for that sweet taste and sugar like crunch.
- A square of dark high cocoa solid chocolate allowed to melt very slowly in the mouth.
- A bowl of low calorie jelly –this is very low in calories or carbohydrate so you can eat the whole bowl.
- A plain fromage fraiche topped with a chocolate sauce made from one of the low calorie instant chocolate sachets with a small amount of water.
- Porridge, custard or blancmange made with a sweetener and skimmed milk...
- If you make a sugar free jelly with less water or mix gelatine and low calorie squash, you can make some firm jellies, which can be eaten like sweets.

Finally, if it comes to the point when you cannot be satisfied by anything but say a chocolate bar then try not to feel too guilty but you may need to cut down on the amount of carbohydrate at your next meal or alternatively, you could, if you use insulin, adjust your dose. Another option would be do some extra exercise to use up that extra glucose.

Miserable? 7 Behaviours You Need To Stop

By Scott M. King, September 12th 2012

This article was in an American magazine, Diabetes Health and was written by Scott King who has had Type 1 diabetes for 38 years. We received permission to reprint it for you and I hope you find it as

interesting as I did...

Diabetes self-care is much more fun when I'm happy. It's so much easier when I have a smile on my face. For a long time I thought negative emotions could be controlled or denied. I thought I could just put on a smile and they would go away. But they didn't.
Then I ran across the work of David Reynolds PhD. In his book, "Pools of Lodging for the Moon," he presents a list of seven behaviours that make us miserable. Now, whenever I am feeling down, I review this list and sure enough, I have been doing one of these seven behaviours.

Doing any one of these will cause me to be miserable. I have found that it's possible to stop doing these, and have been much happier because of it! Before we read this list, I want to present a concept that has been life-changing for me - understanding that I can't control my feelings, but I can control my behaviour.

Feelings are an important part of human life. Some feelings we really enjoy, like happiness, confidence and love. Other feelings we don't enjoy, like fear and loneliness.

I used to try to change or ignore my negative feelings - but it never helped. We can't control our feelings, we cannot make them go away. Just like we don't say, "I digest my food," or "I circulated my blood." They just happen. The best way to handle feelings is to acknowledge them, accept them, and learn from them.

On the other hand, we can control our reactions and behaviours. We are completely responsible for our behaviour regardless of our feelings. (This is where it's important to know our purpose or goal, so we can stay on track in doing what needs to be done. The list below consists of seven behaviours that we can control. With practice we can stop them altogether and live a much happier life. Being aware

of these behaviours in ourselves is the first step to creating a happier life.

Seven Ways to be Miserable
1. Unnecessary Comparison
2. Fighting Reality
3. Self Focus
4. Purposeless Living
5. Unhealthy Lifestyle
6. Negativism
7. Lack of Gratitude and Appreciation for Being Alive

1. Unnecessary Comparison – if I spend time thinking how things "ought" to be, I can make myself pretty miserable. *"My HbA1c should be as good as Johnny's. I shouldn't have so many lows."* It's a strategy people use to keep themselves feeling terrible. Much misery comes_from_choosing to beat ourselves up for not being good enough. This is not about avoiding changes, we need to make changes, but there needs to come a sound recognition of the way things are, and an acceptance, even though we may want to change them.

2. Fighting Reality - reality presents itself to us the way it is. I may not like my height, but if I spend time wishing I were taller, I can keep myself pretty miserable. I may not like having diabetes, but if I spend time denying it, I will be miserable. Fighting reality also includes procrastination. Reality presents deadlines that we can't avoid, like paying bills. When we tell ourselves *"I can do that later"* and then we miss the payment deadline, we're miserable.

I have been a procrastinator my whole life, and it has made me miserable! Since I realised that procrastination is really fighting reality by lying to myself, a change has taken place in me. Now that I know this behaviour causes me to be miserable, I can make a choice. I can't change my feelings, but I can change my reaction to these feelings.

3. Self Focus – when we are too focused on ourselves, we miss the very varied and interesting reality we live in. Many things happen everyday that I could take personally. For example, if someone doesn't call me back or answer my emails, I can make up all kinds of stories about why. *"They don't like me, they're not answering me on purpose, they're upset with me."* I am making this all about me and it makes me unhappy. Usually the person calls later and the delay had nothing to do with me.
I have found when I stop making up stories and taking things personally, I am much happier.

4. Purposeless Living - purpose gives us something to focus on, pulls our attention together so we're not fragmented by our fear. Following your bliss may sometimes be bliss, sometimes misery - that's normal.

5. Unhealthy Lifestyle – are you eating right/regularly? Are you getting enough exercise? Are you sleeping well? If not, you can't expect your mind to be focused and together. Sloppy or unhealthy lifestyles lead to sloppy thinking and an unhealthy mind. Mind and body are one. Your body I can see, but your mind only gives me indications of its existence through your behaviour. That's all we can know, I can't see your mind. Your mind is guided through healthy physical life habits.

6. Negativism - can't, don't want to, don't like it the way it is, shouldn't be this way, won't work. If you sit with shoulders slumped and say over and over, *"It's hopeless, no one cares about me,"* you will start to feel helpless and hopeless. This is why it can be damaging to watch the news everyday.

7. Lack of Gratitude - many writers express in their works how gratitude is essential for happiness. David Reynolds also reminds us there are many things to be thankful for that we often forget. Right now I am sitting on a chair while I type. Someone built this chair, and I am thankful I have it to support me while I sit. Someone in my childhood taught me how to read, and I am very appreciative of that! I am also really thankful my home has a vacuum cleaner someone built

for me, and there is someone down at the electric company keeping power going so I can clean when I need to. This list goes on and on.

With regard to my diabetes, I am very thankful that insulin was discovered and made available for me to be alive. Also, I depend on my meter to help me decide when and how much insulin to take. I'm feeling uplifted just reminding myself of these things.
"If the only prayer you said in your whole life was, 'thank you,' that would suffice" - Meister Eckhart

Shop at IDDT

Cool boxes for carrying insulin from IDDT
IDDT is offering these cool boxes for carrying your insulin at the special price of only £15.00 while stocks last.

This hard backed zip up personal insulin pen pack carrier has a dark navy cover, net zip up pouch inside to hold cooling gel pack, a divider to keep gel pack off medication and several elasticized loops for holding pens.

- Keeps insulin at 2 - 8 degrees for 8 hours at ambient temperature 35 degrees
- Comes with Soft Gel pack
- Fits into a jacket pocket or handbag.
- Great when travelling in hot climates, and for going out and about

Order online from our shop at
http://www.iddtinternational.org/?page_id=2135
Phone IDDT on 01604 622837 or write to IDDT, PO Box 294, Northampton.

By The Way...

Cereal bars not as healthy as all that!

A study by Which? has shown that cereal bars contain high levels of fat, sugar and are high in calories. Of the 30 best selling cereal bars, 16 of them have more than 30% sugar. For example, Nutrigrain Elevensies was found to contain nearly 4 teaspoons of sugar, 18g, which is 20% of the recommended daily allowance for the general population. Kellogs, the manufacturers, responded to this by saying they were confused because they didn't understand why anyone would think it was a cereal bar! Could it possibly that it's because Kellogs are known for making cereals???

However, there are cereal bars that are healthy – the Nakd Apple Pie, Alpen Light Apple and Sultana. Which? noted that Weetabix Oaty Strawberry Crusher was the healthiest for children as it has low salt content and medium levels of fat and saturated fat.

Sanofi-Sponsored Studies Show No Increased Cancer Risk – Really?

In 2009 four studies suggested a possible increased cancer risk following treatment with Lantus [insulin glargine] - a long-acting insulin analogue made by Sanofi and their best selling medicine. The 2009

studies showed mixed results but this was sufficient for the European Medicines Agency to request more research.

In June 2012, three more studies were presented to the American Diabetes Association's Annual Meeting [ADA]. In them data was analysed on 615,000 patients after one to three years of treatment in five European countries and the US. The use of Lantus was compared with other long-acting insulins.

Can useful conclusions be drawn?
The simple answer is 'no'. The slightly more correct answer is that there was little evidence in the people studied. However, there are serious flaws in drawing any conclusions from these studies.

- The people studied had only been treated with insulin for just over a year in America and 3 years in the European countries and cancers can develop over many years. So these studies do not provide evidence that Lantus is safe over long-term use.
- If Lantus was compared to other long-acting insulin analogues, how do we know that they do not have the potential cancer risk?
- The studies were not independent, but were funded by Sanofi, the manufacturers of Lantus who have a vested interest in minimising information about potential cancer risks, especially as sales of Lantus last year reached 3.92 billion euros. Indeed, a statement from Riccardo Perfetti, a vice president at Sanofi said, *"Independently from what region of the world, what methodology you use, what specific type of cancer you look at, the result is simple - there is no increased cancer risk in patients using glargine".* This can only be said to be true over a maximum of 3 years use, not long-term use!
- A statement from the ADA says that Lantus does not lead to increased cancer risk, although they did admit that one study found a "suggestion" of a relationship between Lantus and a *"modest"* increase in breast cancer risk and adds *"but only in new insulin users".* Does that make it alright then? Everyone is a new insulin user at some point, so if there's a "suggestion" of a risk of breast cancer with Lantus, would anyone choose to go on it?

A more cautious attitude by the researchers
A statement from John Buse, Director of the Diabetes Centre at North Carolina University, says, "The preponderance of evidence suggests that there is no increased risk of cancer associated with relatively short-term use of insulin".

Laurel Habel, one of the American investigators said, such results "should be viewed cautiously, given the relatively short duration of glargine use and the large number of associations examined." She also pointed out that the development of cancer can take years to decades, additional follow-up of the study participants will be needed to determine whether glargine is associated with an increase in breast, or other forms of cancer".

Where do we go from here?
Until or unless long-term independent research is carried, it can only be said that the jury is still out on the long-term safety of Lantus. The important issue for people with diabetes is that they know this and are given a choice of insulin treatment.

What's The Government Doing To Prevent Type 2 Diabetes And The Increasing Costs?

In a Parliamentary Question, Mr Stewart Jackson, MP asked the Secretary of State for Health what steps he is taking to support the prevention of Type 2 diabetes. The response was:
"Type 2 diabetes is closely linked to lifestyle factors such as being overweight and physical inactivity. The Government is committed to tackling overweight and obesity, and has published ***'Healthy Lives, Health People: A call to action on obesity in England'*** *which sets out our commitment to key programmes such as Change4Life, and the NHS Health Check.*

We are also continuing to fund and support the full rollout of the

NHS Health Check programme, which includes assessing the risk of diabetes for people aged 40-74 and supporting them in managing or reducing that risk. From April this year [2013] we propose to mandate local authorities to secure local delivery of the risk assessment element of the programme. Economic modelling has shown the potential for the programme to prevent over 4,000 people a year from developing diabetes and to detect over 20,000 cases of diabetes and kidney disease earlier." [14th January 2014]

What does this mean for us all?

Mandating local authorities effectively means that local authorities HAVE to carry out the NHS Health Check to assess people risk of diabetes and to pick up people with Type 2 diabetes who are not aware they have it. This should lead to fewer complications so for people already living with diabetes, there should be long-term savings by the NHS, not to mention the health benefits for individuals. Meanwhile, those of us between 40 and 74 look forward to receiving our mandatory appointments for our NHS Health Check.

Adult Type 1 Diabetes Campaign

In IDDT's December 2012 Newsletter we raised the question *'Is Type 1 Diabetes Being Sidelined?'* The question was largely caused by the shift of people with Type 1 diabetes away from specialist care to primary care, GP surgeries. While we commented that it is remarkable and to the credit of primary care staff that they have developed an understanding of Type 2 diabetes in a relatively short time, we questioned whether they have developed sufficient understanding of the problems and issues facing people with Type 1 diabetes.

Interestingly, we later read of a campaign by the Association of British Clinical Diabetologists [ABCD] which addresses the special needs of adults with Type 1 diabetes and suggests that these needs are being increasingly overlooked due to the rising numbers of people with Type 2 diabetes. The campaign makes the following points:

- Successful management of Type 1 diabetes requires expert knowledge of insulin management by both the patient and the healthcare team.
- Complications of insulin treatment, requiring hospital admission are much more common in Type 1 diabetes than Type 2 diabetes and death rates in this group are higher than the general population of the same age.
- People with Type 1 diabetes are lost within the system created by the present commissioning framework which creates barriers to their referral to the specialist team. This means that people with Type 1 diabetes are being denied the help and support of the broader network of specialist nurses, dietitians, podiatrists and doctors.

We wholeheartedly support the ABCD campaign in calling for recognition that adults with Type 1 diabetes are a distinct group among those with diabetes and services need to be arranged in a way that recognises this fact. This includes greater collaboration between primary [GP practices] and secondary care [hospital diabetes clinics]. Our only comment would be that the campaign is called the 'Lost Tribe' – the lost tribe being adults with Type 1 diabetes and we're not sure how people with Type 1 diabetes will view this description!

Questions Asked By You

Why has my doctor has ordered blood tests for Vitamin B12?

Research has shown that people who take metformin to treat Type 2 diabetes may be at risk of developing Vitamin B12 deficiency. New research carried out in the US between 1999 and 2006 suggests that giving supplements of Vitamin B12 at the recommended levels may not be enough to treat the deficiency. [Diabetes Care, January 2012]

Information was collected on 1600 adults with Type 2 diabetes aged 50 and older and 6,900 adults in the same age group without diabetes. The researchers found:

- B12 deficiency was present in 5.4% of people with diabetes taking metformin compared to 2.4% of people with diabetes not taking metformin and 3.3% of people without diabetes.
- The use of supplements containing Vitamin B12 was not linked to a reduction of B12 deficiency in people with diabetes but with supplements, there was a two thirds reduction in the deficiency in people who did not have diabetes.

The researchers suggest that further research is carried out to learn how much B12 is needed to correct the deficiency. They also need to find out if raising B12 levels in people with diabetes who are taking metformin and have low Vitamin B12 levels will improve their symptoms.

What does Vitamin B12 do?
It has a variety of purposes including a role in metabolism as well as a role in the function and development of the brain, nerves and blood cells. Symptoms of Vitamin B12 deficiency include weakness or tiredness, rapid heartbeat, pale skin, easy bruising and stomach upset. If it is untreated then it can damage the nerve cells and this can cause numbness or tingling of the toes, difficulty walking and depression.
The current recommendation is that people over 50 should consume 2.4micrograms of Vitamin B12 daily from ether fortified foods or supplements.
Note: If you think you may have Vitamin B12 deficiency, it is important to talk to your doctor before taking any supplements.

What is DIDMOAD?
DIDMOAD stands for **D**iabetes **I**nsipidus, **D**iabetes **M**ellitus, **O**ptic **A**trophy (degeneration of the nerve to the eye), and **D**eafness. It is a genetic disease which is also called the Wolfram syndrome. Patients usually also have serious abnormalities of the nervous system that can be accompanied by behaviour problems and psychiatric hospitalisations.

DIDMOAD or Wolfram syndrome is inherited as an autosomal recessive traitwhic h is one of the ways that a trait, disorder or disease can be passed down through families. Brothers and sisters of a child with the syndrome each have a 25% chance of receiving the gene from both parents and having the syndrome. The syndrome is caused by a mutation in the gene responsible for the production of a protein called wolframin, resulting in loss of function of this protein. [It then gets too complicated for this Newsletter, and me! Jenny]

We Do Appreciate Your Help!

Following our pleas for help, we are really grateful to all the people who volunteered to receive our Newsletter electronically. Postage is our biggest single expenditure, so any savings we can make with this are very much appreciated. If you could help by reading the Newsletter electronically, do let us know, just email tim@iddtinternational.org and include your postcode.

Thank you too to all the people who set up monthly donations by standing order. Just £2.00 or £3.00 a month is a regular income for IDDT and very much appreciated, so if you can help in this way, please give us a call on 01604 622837.

Many thanks for your help!

From Our Own Correspondents

Justin Webb got it wrong!
Dear Jenny,

I was extremely disturbed to read a comment in the Radio Times [Point of View, Dec 1-7th 2012] by Justin Webb (whose picture was featured in Balance's 250th Edition), in which he stated *"... Humalog, a synthetic insulin that type-one diabetes patients rely on to stay alive. Without it they would have to use animal insulin, which is less*

predictable and can pass on infections."

Where has he got that untrue and dangerous information from? Is it some health professional pushing synthetic insulin? I have been diabetic for over 50 years and have refused to use synthetic insulin. I am still on the same beef insulins as when I was diagnosed, with the addition of protamine zinc insulin about 25 years ago. I am very rarely ill my only complication is neuropathy in my toes. Many people like me with long-standing diabetes have no wish to transfer to synthetic insulins, when they are perfectly happy with the well-proven animal insulins. Indeed, many people find they are unable to tolerate synthetic insulins and have to return to animal insulin, so it is essential they are always available.

I have written a letter of complaint to the BBC and emailed Diabetes UK suggesting that they ask Justin Webb where he got this untrue and misleading information from, as it is another nail in the coffin for animal insulin.

Mrs E.B.
By email

Reduction in carbohydrates, reduction in insulin dose and weight loss!

Dear Jenny

I have Type 2 diabetes taking insulin and since I changed from metformin to insulin my weight has increased and is continuing to do so. I tried the information you gave on insulin vs weight gain and reduced my intake of potatoes and bread which in turn reduced my dosage of insulin. I lost 10lbs in a month with my weight reducing from 12st 9lbs to 11st 13 lbs.

Previously my insulin dose was Lantus 50 units and Humalog 26 units 3 times daily. Now it's was Lantus 38 units and Humalog 16 units 3 times daily. Prior to this my average sugar readings were 7.6 rising to an increase of 9.4 initially but I persevered with the reduced insulin dosage. As a result my average is now 7.4 !! Thank you so much for your help.

Mr M.B.
By email

It brought a smile

Dear Jenny,

A smile hit my face when I read the letter by Mr C.G. 'Being Caught Out'. About 10 years ago my wife who knew that I always ate either Corn Flakes or Weetabix with milk as my morning breakfast cereal which seemed to work for me in managing my glucose levels, suggested I try a different cereal for a change. I agreed to look at other possible cereal options and next time we went shopping I commenced an analysis of the sugar / carbohydrate content of all the different packets of breakfast cereal on the supermarket shelves. I was absolutely horrified to note the large quantities of sugar content in many of the cereal packets! I therefore decided to stick to either Corn Flakes and Weetabix as my two preferred cereals and was delighted to have this option endorsed recently by a dietitian at a diabetes conference who also suggested porridge as another alternative.

The plot thickened when I watched Brian Cox present his TV programme 'Addicted to Pleasure' when he revealed the history of the British trade in sugar and how we capitalised on this very profitable business in Victorian and Edwardian times. The cameras followed Brian Cox, who has Type 2 diabetes, to his annual diabetes and ophthalmic check at hospitals in Dundee along with an MRI experiment to show the fast effect of sugar on the brain function. The ophthalmologist who checked his eyes confirmed all was well but advised he had seen many patients with diabetic retinopathy over the years one of whom had experienced high blood glucose levels leading to a massive ophthalmic haemorrhage which eliminated all vision from one eye requiring correction by vitrectomy. The message to all IDDT members is simple, manage your diet and your glucose levels as best you can so as to minimise and hopefully eliminate risks of problems with diabetic retinopathy and other potential diabetic complications.

Derek Beatty, Edinburgh

Secondary diabetes
Dear Jenny,

Thank you for sending me IDDT Newsletters which I find most interesting. In 1991 I had a welcome life-saving liver transplant, needed because I had an inherited liver condition from which my sister died.

It went well until 2003 when rejection occurred. This was sorted out by taking steroids, which in turn gave me Type 2 diabetes! I managed well on insulin but then the manufacturers stopped making the one I was using [Mixtard 30] and I was put on NovoMix 30 which sent me haywire. I am now getting it under control.

Over the years I have trekked thousands of miles nationwide promoting organ donor cards with great success as well as raising much money for charities. My wonderful donor was a 25 year old teacher from France who unfortunately died in a car crash but she carried a donor card. Ever since her parents have been kept informed of my activities which they wanted and I feel proud that I have not disappointed them. But Jenny – this diabetes is something else!

MR G.S.

[Mr G.S. sent us a newspaper cutting of him walking from Edinburgh to Marble Arch which referred to him as 'Mr Diabetes 2'.]

My GP recognises his strengths
Dear Jenny,

I was interested to read the article, "Is Type 1 Diabetes Being Sidelined." I agree that moving care of patients with Type 1 diabetes away from specialist care does not make sense. My own experience is that GPs who claim to do a better job than the local hospital tend to get out of their depth quite quickly when they get results that they don't expect. One of the best GPs I've had in recent years had an interest in diabetes care, but recognised his strengths and was pragmatic in his approach - GP care where appropriate, local hospital where appropriate.

By Email

Specialist care for Type 1 diabetes
Dear Jenny,

After your article about Type 1 diabetes being sidelined in the December 2012 Newsletter, I thought you may find my experience of interest.

Last May when visiting my GP he said it was time for my HbA1c test and I replied that as I going to see the Consultant at the hospital early next month, it would be a waste of money to have two done. He reported that he was no longer paying for my visits to the Specialist as he and the nurse had recently been trained!

I said that if that was the case, I would transfer to another doctor to which he retorted that all doctors in the area [name withheld] had made a similar decision, so I would receive the same answer. I said that in that case I would go to a specialist privately and as I was about to leave, he suggested that I should write to him and explain why I would prefer to go to the diabetes clinic and he would consider it!

Now some months earlier he was telling me to increase my glargine [Lantus] dose which resulted in several night hypos. I made an appointment through my consultant to see the specialist dietitian and nurse. Having had Type 1 diabetes for over 50 years, I found their help and understanding completely at odds with my GP and we managed to achieve better control and a return to 'normality'.

To continue the saga: I contacted you and you advised me to go the Patients Association which I duly did and they confirmed that as a person with Type 1 diabetes, I was entitled to have the 'service' that I needed. I wrote to my GP and after sometime he relented and said that he always wanted his patients to feel confident about their treatment.

I feel that GPs are given instructions to deal with all diabetes patients in the same way and to be quite frank, there are different problems with Type 1 and Type 2 diabetes and more so with long-term patients.

With the advice of IDDT and the Patients Association, people do need to stand up for their due rights but some times and for some people, this is not always possible.

I thank you for the help and advice you gave me.

Mr. B.P.
Midlands

For Our Welsh Readers

The Welsh Government is seeking comments and views from clinicians, NHS managers and service users [patients] on their document *'Together for Health - a diabetes delivery plan'.* The plan sets out their vision for the population of Wales and what this means for NHS diabetes services. Around 7% of adults in Wales are being treated for diabetes and it is one of the most common chronic diseases in childhood.

We apologise to members in Wales who may wish to respond for giving such short notice as the closing date for comments is March 15th 2013 but this is due to our Newsletter dates.

Consultation on the draft document 'Together for Health - a diabetes delivery plan' is available online
http://wales.gov.uk/consultations/healthsocialcare/diabetes/?lang=en
If you want to respond, you can do so in the following ways:
Email: adultsandchildrenshealth@wales.gsi.gov.uk
Post: Adult and Children's Health, Medical Directorate, Welsh Government, Cathays Park, Cardiff CF10 3NQ
Additional information: telephone: 029 2082 5717

Introducing The Association For Nutrition

IDDT has recently partnered with the Association for Nutrition (AfN) to try and provide mutual benefit to the members of both organizations. Alice Cameron (Communications & Marketing Manager) of the AfN explained what they do. She writes:

"Have you ever tried finding a nutritionist? There are thousands out there so if you search online you'll be presented with a dazzling array of qualifications and claims. The media furore following Which? Magazine's controversial investigation of nutritional therapists highlighted just how much confusion exists around the terms nutritionist and nutritional therapist. Of course, it's vital for anyone seeking reliable nutrition advice that they are able to find highly qualified practitioners who base their practice on best available evidence, as opposed to those who are less well trained or might advocate processes such as detoxification, optimal nutrition and use of supplements, which in many cases cannot be justified by existing scientific evidence.

- Any Registered Nutritionist using the letters RNutr by their name is a nutrition professional who has been accepted onto the UK Voluntary Register of Nutritionists (UKVRN) only after meeting rigorously applied training, competence and professional practice criteria.
- All Registered Nutritionists have a degree in nutritional science or substantial peer-recognised professional nutrition experience and adhere to a strict Code of Ethics and Statement of Professional Conduct.
- The UKVRN is governed by the Association for Nutrition (AfN) which aims to protect the public and assure the credibility of nutrition as a responsible profession.

On the AfN website, www.associationfornutrition.org, we provide a Search The Register function, so it's very straightforward either to find a Registered Nutritionist near you or to double check that someone

claiming to be on the Register actually is. This online listing includes registrants' status, contact details, professional profile, specialism and links to their social media and website. If you don't have access to a computer, just call our office (020 7291 8352) and we'll check for you.

Apart from Registered Nutritionists, the other category of registrant on the UKVRN is Associate Nutritionist (ANutr). Associates are recent graduates in nutritional science who have yet to gain the practical experience required for full registration but want to signpost their commitment to the principles which underpin the UKVRN, to peers across the field, employers and the public. They are seizing the opportunity to do their bit to grow this body of professionals and progress it towards our goal to attain protection of title for nutritionists and greater confidence among the public.

In fact, AfN is defining and advancing standards of evidence-based nutrition practice at all skill levels within the health and social care sectors, to ensure that everyone who provides nutritional information to the public is competent and confident to do so. We have developed the online tools for members of the wider workforce to self-assess their nutrition competences, work towards an AfN Certificate of Nutrition Competence and access further training they might need through a range of AfN Certified Courses. We will launch this scheme later on this year so that doctors, nurses, health visitors etc are equipped to deliver sound, more consistent nutrition messages for your benefit."

IDDT Apologises For Delivery Charges For Multiple Copies But...

All IDDT booklets and leaflets will remain free of charge. We are delighted that healthcare professionals are ordering multiple copies of our booklets and leaflets to give to their patients and we are grateful for the help and support that healthcare professionals are giving to people with diabetes in this way.

In just over a year, IDDT has supplied nearly 135,000 copies of 'Diabetes – Everyday Eating', 85,000 copies of 'Understanding Your Diabetes', nearly 26,000 copies of 'Type 2 Diabetes – Management and Medication' in just over 6 months and thousands of our leaflets on diabetes topics.

However, IDDT is a charity relying entirely on voluntary donations and due to the large and increasing demand for multiple copies of the booklets and leaflets by healthcare professionals for their patients, it is with regret that we have had to introduce a delivery charge for orders of more than 20 copies in total.

So in future the delivery charges will be as follows.

Number being supplied	**20 copies**	**21 to 50 copies**	**51 to 100**
Delivery charge	FREE 6 monthly	£7.20	£9.20

- For orders over 100 copies, please contact IDDT for the cost of delivery by telephone 01604 622837 or by email enquiries@iddtinternational.org
- We will supply orders of 20 FREE copies once every 6 months.
- Invoices will be sent with the order.
- If funding the delivery charges is a problem, we are happy to supply FREE multiple copies of Publication Lists for healthcare professionals to give to their patients so that they can order direct from IDDT.

Education

The Diabetes National Service Framework and the National Institute for Health and Clinical Excellence (NICE) both support and recommend education programmes for people with both Type 1 and Type 2 diabetes, starting at the time they are diagnosed.

Type 1 diabetes

The well recognised education programme for people with Type 1 diabetes is DAFNE which stands for Dose-Adjustment for Normal Eating. There are other programmes run in different areas which have different names but DAFNE is the basis for these. Many areas have a waiting list of people wanting to attend DAFNE courses, especially as attendance of a DAFNE course has become a requirement for anyone wanting insulin pump therapy.

DAFNE is a structured education programme for 8 people with Type 1 diabetes that focuses on adjusting insulin based on the amount of carbohydrate eaten at each meal. No foods are forbidden on DAFNE. The courses run over 5 days with a booster session 6 weeks later.

Evaluation of DAFNE

A recent study has evaluated the impact on quality of life and HbA1c levels of DAFNE on people with Type 1 diabetes. The researchers measured participants' HbA1cs 8 weeks before the DAFNE course and 6 and 12 months afterwards. They found:

- There was an improvement in HbA1cs 6 months after the course.
- The level of improvement was higher in those with higher HbA1cs before the course.
- Some improvement was lost at 12 months but levels were better than before the course.

The researchers also looked at what impact DAFNE had on the quality of life of people with Type 1 diabetes. A significant number of participants reported an improvement in their quality of life at 6 and 12 months.

Type 2 diabetes

There are education programmes for people with Type 2 diabetes, the most well known one being DESMOND which stands for Diabetes Education and Self Management for Ongoing and Newly Diagnosed. Again this programme is carried out in groups but is not as intensive as the DAFNE and usually takes place over several weeks.

Early studies showed that DESMOND was successful in giving patients a positive outlook and feelings about their diabetes were improved. They also showed health benefits over 12 months but the long-term effects were not measured.

However, a study published in the British Medical Journal [BMJ] in April 2012 states that there are no long-term benefits for people with Type 2 diabetes from group education programmes.

In this study, there were two groups of people with Type 2 diabetes and one received the education programme and the other received routine GP care. The impact of the education programme was evaluated over 3 years. The researchers collected information on body weight, cholesterol levels, HbA1cs as well as history of depression, quality of life, lifestyle habits, beliefs about illness and what medications they were taking.

After 3 years both the lifestyle and clinical results were the same in the groups that received the education programme and the one that didn't, although the participants' beliefs about illness seemed to have improved. These results are disappointing and clearly more research is needed into the education programme and what patients actually need.

And in children...

A study published at the same time focussed on an education

programme named ‘Talking Diabetes’. This investigated healthcare professionals’ techniques of helping children with Type 1 diabetes. Again this study found that at 12 months, the programme had no impact on quality of life or blood glucose levels.

What do we really need to know?
The BMJ study had the advantage of looking at people who had been on an education over a longer period of time, 3 years, whereas the studies of the effects of DAFNE and DESMOND only looked at the effects over a 12 month period. The fact that some improvement was lost after 12 months does not necessarily mean that the education programmes are not good but it does suggest that what common sense tells us – a one off education programme is not enough for people with long-term conditions, such as diabetes.

Both Type 1 and Type 2 diabetes are with us for life. Not only do our lives change over time and our health needs change so changing our needs, but both conditions require our constant attention. There are ongoing daily challenges for people with diabetes: healthy eating, being physically active, taking medications as recommended, self-monitoring of blood glucose levels not to mention coping, problem solving, awareness of risk and sometimes simply feeling fed up with all of this. We need continued education to learn how to handle the changes that occur and to provide support and encouragement when things get tough.

Education needs to be ongoing throughout life and a one-off course is not the answer – at the risk of sounding like a politician of the past, it needs to be “Education, Education, Education.”

Medical Students Not Taught About The Benefits Of Exercise

According to an article in the British Journal of Sports Medicine, most medical students are not taught about the benefits of exercise. A survey of 31 medical schools and found instruction was “sparse or non-existent” with only four teaching undergraduates about the benefits of physical activity in each year of the course. The total amount of time spent on teaching physical activity averages only four hours compared with an average of 109 hours for pharmacology [the effects and uses of drugs].

The researchers suggest there is a ‘major disconnect’ between undergraduate medical education and clinical guidelines for long-term conditions and public policy and future doctors need to be able to manage long-term chronic disease, which obviously includes diabetes.

Snippets

Shop the perimeter of the store first
When you’re in the supermarket looking through your list of items, remember that healthier items are on the perimeter of the store. Almost all supermarkets are set-up with fruits, vegetables, dairy, meats and fish on the perimeter. The junk food lurks in the centre aisles. The longer you spend shopping on the outside, the healthier your meals will be.

Memory may play a role in appetite
Short-term memory may predict a person’s hunger level, according to a study in PLoS ONE. Researchers looked at 100 adults who

consumed a bowl of tomato soup and found those who perceived eating a larger bowl reported feeling less hungry than those who thought they'd eaten a smaller bowl, irrespective of how much they actually ate.

Birthplace of Banting to be restored.
Banting House National Historic Site of Canada is to receive a grant of $147,419. With this and the help of volunteers and donors, Banting House will be restored and maintained for future generations. It was at Banting House that Dr Frederick Banting had the idea that led to the discovery of insulin which has saved millions of lives. Banting House is recognised as an important part of Canadian history.

Team Novo Nordisk
After the Olympics insulin manufacturer, Novo Nordisk, announced the formation of 'Team Novo Nordisk', a global sports team made up of more than 100 cyclists, triathletes and runners all of whom have diabetes. It will be led by the world's first all-diabetes pro-cycling team. During 2013, these athletes will compete in more than 500 sporting activities around the world. The men's pro-cycling team will compete in the USA Pro Cycling Challenge, the Tour of Britain and the Paris-Tours with the ultimate goal of joining the Tour de France. According to Novo Nordisk's vice president for Global Marketing and Medical Affairs, the aim is to raise awareness, educate, empower and inspire people with diabetes.

Sleep deprivation has gender-specific effects on appetite
A study published in SLEEP [December 2012] showed that lack of sleep was associated with increased levels of the hunger-stimulating hormone, ghrelin, in men but not in women. Researchers also found sleep deprivation appeared to reduce the levels of satiety hormone GLP-1 [giving the feeling being full] in women but not in men.

Another myth!
It is said that some exercises and diets promote their "detoxifying" capabilities,but health experts are sceptical. There is no scientific evidence to support the idea that fasting, yoga, meditation or sweating have any special ability to clear the body of toxins. Dr. Elizabeth Matzkin, chief of women's sports medicine at Harvard Medical School, says, "The human body is designed to get rid of what we don't need".

The power of the pharmaceutical giants
GlaxoSmithKlein [GSK] has been named and shamed by the Forum of Private Business and enters the Hall of Shame. It has increased its payment times to suppliers from 60 days to as much as 95 days. So they order goods/supplies from companies and then don't pay for them for 95 days!

Suppliers have little choice but to agree to the new payment terms because they fear they will lose business, something they cannot afford to do, especially small companies. GSK is the fourth largest pharmaceutical company in the world and very profitable. To quote the Forum *"It is, however, a company concerned only with boosting its own profits whatever the cost to smaller firms, and has scant regard for the consequences of its actions. Most people will see this as the worst type of corporate greed imaginable."*

A Few Words Of Thanks

We would like to take this opportunity to say a big thank you to the people who work closely alongside IDDT. Without the help and support these people give us, we would not be able to achieve all that we do. So, in no particular order, a big thanks to Veronica Wray (Veronica Wray Public Relations), Rupert Campbell – Black (IT-MK Limited), Oliver Jelley (Orange Juice Communications), Una Illing (U.S. Illing Accountancy Services), Stuart Lacey (Website Support), Nigel Frost (Newsletter Design), Chris Searle (Hamilton House Mailings) and Ron Naylor (Acorn Print Media).

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

IDDT
PO Box 294
Northampton
NN1 4XS

Name: ——————————————————————————

Address: ——————————————————————————

——————————————————————————

Postcode: ——————————————————————————

Tel No: ——————————————————————————

From Your Editor – Jenny Hirst

IDDT welcomes the submission of letters and editorial articles for consideration of publication in future issues of the IDDT Newsletter. The editor and trustees do not necessarily endorse any opinions or content expressed by contributors and reserve the right to refuse, alter or edit any submission before publication. No part of this publication may be reproduced in any form without the prior written permission of the editor.

InDependent Diabetes Trust
PO Box 294
Northampton
NN1 4XS

tel: 01604 622837
fax: 01604 622838
e-mail: enquiries@iddtinternational.org
website: www.iddtinternational.org