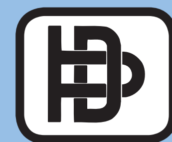
InDependent Diabetes Trust Newsletter



June 2015 Newsletter, Issue 85

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We have not been idle

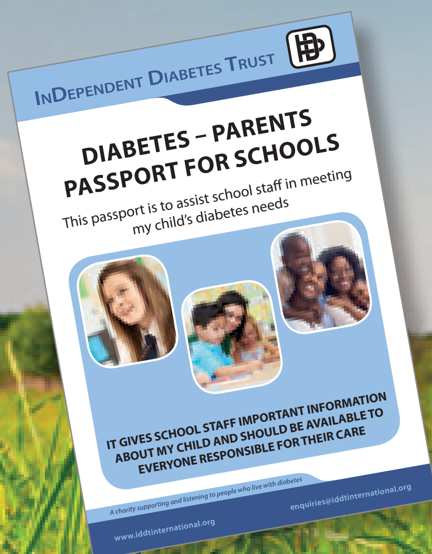
This Newsletter is being written before we know the outcome of the General Election, so the outcome is still anyone's guess. Initially it was IDDT's intention to produce a 'manifesto' from the results of the member's survey stating what we want to see for people with diabetes from the next government. Indeed, many other charities have done this but we had second thoughts. Our view is that in the rhetoric and promises coming from all Parties during their campaigns, IDDT's 'manifesto' would get lost and be ineffective. We hope there is a better chance of it being effective once we have a new government, so we will be publishing it later in the year.

In this issue…

- Exemption Certificates
- Win a year's supply of Pomegreat juice
- Continuous Glucose Monitoring
- What is MODY
- Ramadan and fasting

In the meantime…

we have launched our new Parents Passport for Schools



IDDT is a charity that actively listens to its members and is all too well aware of the difficulties that children with diabetes and their parents and families face in everyday life when managing the condition. One area that proves particularly problematic is managing the condition at school. With this in mind, IDDT has produced a new, free booklet, a Parents Passport for Schools.

The passport has been designed to provide a means by which parents can formally let schools know how to manage their child's diabetes and in turn support schools to comply with SEN regulations, as well as informing teachers about the condition. IDDT has produced similar documents for use in hospitals and also in care settings, such as residential care which have been very well received and proved very popular. As with all our leaflets, the passport is FREE.

The passport contains a wide range of information on how a child's diabetes is managed, including:

- Dealing with high and low blood sugar levels.
- Food and mealtimes.
- Insulin administration and blood testing.

IDDT hopes that the passport will prove to be a valuable tool for families with a child with diabetes, teachers with a child with diabetes in their charge, school nurse and SEND co-ordinators. To get your FREE copy call IDDT on 01604 622837, write to IDDT at PO Box 294, Northampton NN1 4XS or email enquiries@iddtinternational.org

Reduced production and release of Insuman Basal, Comb and Rapid insulin

As a result of a problem with the manufacturing process of Insuman, the production and release of all batches of Insuman Basal, Comb and Rapid (cartridges and pre-filled pens) has been reduced. The official announcement says that temporary supply disruptions are expected in Bulgaria, Czech Republic, Hungary, Norway and Poland. However, IDDT has become aware of people in the UK having difficulties obtaining their supplies of Insuman.

Healthcare Professionals in countries affected will be informed of the shortage by the company and are recommending prescribing an alternative human insulin. Healthcare Professionals should ensure that patients monitor their blood glucose closely during the switch to a different human insulin.

For further information visit the European Medicines Agency website www.ema.europa.eu

News from NICE

NG3 New guidance: Diabetes in pregnancy: management of diabetes and its complications from preconception to the postnatal period

The first National Diabetes Audit of Diabetes in Pregnancy showed that there has been little improvement over the last 10 years in some outcomes of pregnancy for women with diabetes. Some of the key points are:

Pre-pregnancy planning – it seems that most women with Type 1 and Type 2 diabetes do not recognise the importance of pregnancy planning and many are entering pregnancy with poor glycaemic control, not taking sufficient folic acid or taking medications that may be harmful. So the recommendations emphasise the importance of discussing pregnancy planning with women with diabetes from adolescence onwards. The NICE Guidance says that there is no convincing evidence of increased harm from oral contraceptives, so they can be used if there are no contraindications.

Blood glucose level targets – new targets based on those for women without diabetes are recommended for women with pre-existing diabetes and gestational diabetes. However, these levels can be difficult to achieve for women with Type 1 diabetes, so individual targets are recommended.

Diagnostic criteria for gestational diabetes– there has been important new evidence so that the diagnostic criteria for gestational diabetes have been lowered.

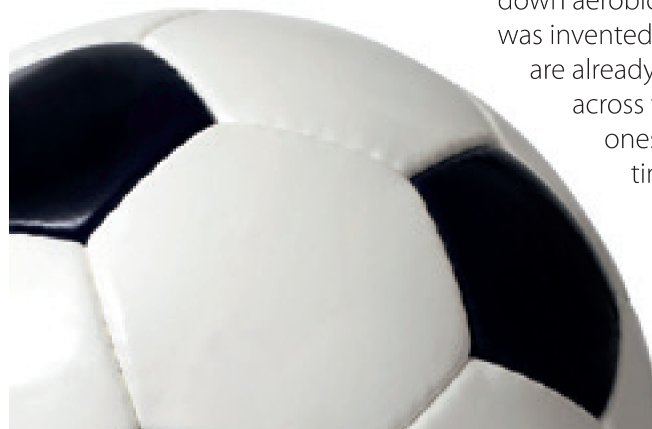
This new guidance, NG3, can be found on the NICE website www.nice.org.uk

Something for the men
walking football

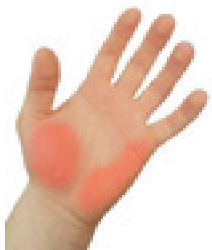
Walking football was designed as a way of tackling both inactivity and social isolation for older men and those men who have health conditions. Walking football is supposed to involve a free kick every time a player runs although this is sometimes flouted but this rule means that the game appeals to a wide range of fitness levels.

While it is more leisurely than the real thing, it can still be fiercely competitive and of course there are the benefits of camaraderie which older women tend to get at sitting down aerobics or tea dances. It was invented 6 years ago but there are already 225 registered clubs across the country with new ones springing up all the time.

If you have access to the internet, just Google 'walking football' to find a game near to you.



Four new blood glucose test sites with the same response time as finger tips



The common belief, presently held by many endocrinologists, is that blood taken from finger tips for monitoring blood glucose levels is more current and accurate than blood drawn taken from other sites, such as the forearm, shoulder and stomach. Sadly for many people with diabetes the fingertips have the most pain nerves which causes discomfort as well as leaving the finger tips bruised, calloused and with reduced sensitivity.

Researchers have found four new test sites that appear to give the same response time and accuracy as finger tips. These sites are located on the fleshy area of the palms, on a line between where the thumb joins the palm and the centre of the wrist and fleshy area along a line connecting where the pink area joins the palm to the wrist.

To prove this, the researchers carried out tests in people without diabetes, people at risk of Type 2 diabetes and those with diabetes under control. The tests consisted of simultaneously taking blood samples from alternate sites, such as the forearm, fingertips and from the palm areas mostly after rising from a night's sleep. Repeated tests were carried out at 5 and 10 minute intervals.

Blood glucose levels on the palm areas of both hands consistently matched those on the finger tips well within meter accuracy. However, the other sites, forearm, shoulder and stomach lagged behind the palm areas by 22 minutes but also only reached 70% of the rise from static levels to peak levels.

So this study suggests that the palm areas are suitable alternatives to finger ends because they are equally accurate and have less pain nerves. Using these areas also allows finger ends to heal and regain sensitivity.

Important warning – if you are considering trying testing using these new sites, it is important to talk to your doctor before doing so to ensure that there are no special reasons why you should not do so.

Ramadan 2015 and fasting

This year it is expected that the fast of Ramadan will commence at sunset on Wednesday June 17th 2015 and last for 29 or 30 days, to July 17th 2015. During this month it is expected that Muslims who participate will abstain from food, water, beverages, smoking, oral drugs and sexual intercourse from sunrise to sunset. The length of fasting has special consequences for people with diabetes, especially those taking insulin and the risk of complications increases with longer periods of fasting.

People with diabetes may be exempted from fasting but the majority of people with diabetes do fast and this can lead to acute complications, such as hypoglycaemia, hyperglycaemia, diabetic ketoacidosis and dehydration, most of which are as a result **of a reduction of food and fluid intake and the timing of meals**.

There are no evidence-based guidelines for safe fasting so people should have an assessment with their diabetes team before Ramadan and if they are ill during fasting, then they should seek advice from their diabetes team.

Driving News

Field tests, the DVLA and Specsavers

IDDT has received several calls from people who have had laser treatment and therefore are required to have a visual field test in order to renew their driving licence. The expressed concerns are:

- The DVLA states that they <u>have</u> to go to a Specsavers shop so they do not have any choice of which optometrist to attend.
- Problems relating to the quality of the test carried out by the Specsavers they attended, such as nerves were not taken into account and they were not offered a further test, as happened with their previous optometrist.

Diabetes UK has also received similar complaints and has reported their discussions with the DVLA.

- Last year the DVLA gave a contract to Specsavers to carry out ALL their visual field tests, so field tests from other optometrists are not accepted.
- The person carrying out the field test should ensure that the test is carried out properly.
- If there is obvious evidence of nerves, or you feel the test has not been conducted properly, you should say so and further tests should be carried out. All the charts will be submitted to the DVLA and they will usually accept the best one.

What is MODY

The overwhelming majority of people living with diabetes have diabetes as a result of complex interactions between their genes and their environment. It is certainly known that the majority of people with Type 2 diabetes, and probably many with Type 1 diabetes, are genetically disposed to the condition as a result of many genes.

However, for a minority of people, diabetes is as a result of a single gene and this type of diabetes (monogenic) is called MODY – maturity onset diabetes of the young. MODY is thought to affect between 1% and 2% of people with diabetes although it could be more as it often goes undiagnosed. There are three main features that help to make it different from Type 1 and Type 2 diabetes:

- diabetes often develops before the age of 25,
- there is usually a strong family history of diabetes in successive generations,
- treatment may be by diet or tablets and it does not require insulin treatment.

Six sub-types of MODY

In any one person, MODY is caused by a single gene but there are six MODY variants each caused by a different single gene. However, MODY 3 is the most common in European populations (70% of all types of MODY). In MODY 3 insulin production is normal in childhood but reduces with age, micro and macro- vascular complications can occur and treatment with sulphonylureas initially is more effective than insulin, although insulin may be required eventually.

Personal experience of MODY

Samantha, now in her forties, was diagnosed with Type 1 diabetes when she was 9 years old but unusually, she was treated with diet and metformin for the first 2 years before being put on short and long-acting insulins and treated as someone with Type 1 diabetes. However, she has always had very marked highs and lows and has put on weight, despite living a healthy lifestyle.

Needless to say, she has received suggestions that she was not trying to control her blood sugars and has been through the guilt and anxieties that go with 'failure to achieve her targets'. Yet it is surprising that over the years, her various diabetes teams did not suspect that something was not right because children with Type 1 diabetes cannot manage on diet and metformin. She also has a very marked family history of Type 2 diabetes.

It is good to report that after talking to IDDT, she asked her diabetes team to explore whether she could have MODY, which proved to be the case. She now takes metformin but no rapid-acting acting insulin with her meals and is gradually reducing her long-acting insulin which at the moment is half what was her daily dose.

Research

Distinguishing between MODY and Type 1 diabetes in children and adolescents

The urinary C-peptide/creatinine ratio (UCPCR) and fasting C-peptide level can assess beta-cell function in clinical practice. This study shows that the UCPCR and fasting C-peptide levels in children and adolescents can distinguish those with MODY from those with Type 1 diabetes with high specificity and sensitivity.

C-peptide is a protein that connects insulin's A-chain to its B-chain in the proinsulin molecule. Measuring C-peptide can help to determine how much of a person's own natural insulin is being produced as C-peptide is secreted in equimolar amounts to insulin. Serum creatinine is an important indicator of renal health because it is an easily measured by-product of muscle metabolism. Creatinine levels in blood and urine may be used to calculate the creatinine clearance, which correlates with the glomerular filtration rate.

(Hormone Research in Paediatrics. Doi: 10.1159/000375410)

Holiday Tips

Holidays are approaching and many of you will be preparing to go on holiday in this country or abroad. Going on holiday for people with diabetes requires more planning, especially for those treated with insulin. The security at airports and on flights means that carrying injection devices and insulin on planes requires arrangements to be made. Below there is some advice on caring for your feet on holiday and tips for treating sunburn. IDDT also provides a Holiday Pack with tips on looking after diabetes in hot weather, carrying tablets and insulin to other countries and holiday insurance. If you would like a Holiday Pack, call IDDT on 01604 622837, write to IDDT at PO Box 294, Northampton NN1 4XS or email enquiries@iddtinternational.org

Diabetic holiday foot syndrome

Research has shown that there is a greater risk of foot ulceration that can lead to serious complications during holidays, especially those taken in hot countries, hence the name 'Diabetic holiday foot syndrome'. Among 435 people studied, 17 experienced foot lesions during foreign holidays, 10 of whom reported a foot lesion for the first time. The people with holiday foot damage were a younger age, mainly male and their diabetes was of shorter duration.

The causes of diabetic holiday foot syndrome were:

- direct injury
- unaccustomed exercise
- walking barefoot on the beach or in the sea
- burns from walking barefoot on hot pavements
- wearing inappropriate inflexible bathing shoes.

If you need further warnings for your holidays, the research also showed that nine out of the 17 people had to be hospitalised for infections as a result of the foot damage and the average stay in hospital was 11 days.

The researchers conclude that there is a need to increase education about foot care at holiday periods and that this should include preventative measures for those people at high risk of foot lesions. (Prac Diab Int March 2001 Vol 18 No2)

Simple steps to combat sunburn

The British Skin Foundation has issued advice on what to do if you do get sunburnt. Here they are:

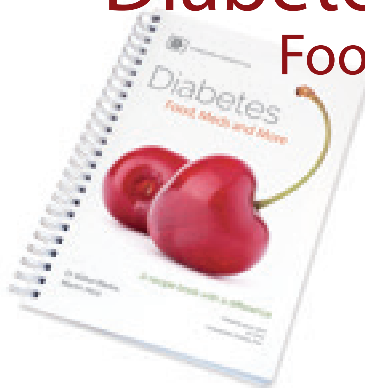
- Keep the sunburnt area covered, stay in the shade until it has healed and wear cotton clothing.
- Over-the-counter analgesics or painkillers can relieve the pain and reduce any inflammation (if there are no contraindications).
- Cool the skin by applying a cool, compress for 15 minutes or by having a cool bath / shower. Do not rub your skin with a towel, just pat it dry.
- Reduce peeling by using un-perfumed cream or lotion after a bath or shower to soothe the skin and repeat this as necessary.
- Leave blisters alone, do not pop them as this can lead to infection and scarring.
- Rehydrate as sunburn can lead to fluid loss through the skin, so drink plenty of water and avoid alcohol.

By the way…

In the last Newsletter we had an article that quoted Health Minister, Jane Ellison who said that GPs are paid annually for assessing nerve damage and poor blood supply to the feet in people with diabetes.

In January 2015, Earl Howe, told the House of Lords that a new National Diabetes Foot Care Audit will report in March 2016 and will identify differences in foot care across England which 'will lead to an overall improvement in management and outcomes for patients'. He also said that as part of its focus on the Cardiovascular Disease Outcomes Strategy, NHS Improving Quality (NHS IQ) is working with the National Clinical Director for Obesity and Diabetes to identify potential areas of service improvement, such as diabetic foot disease.

Diabetes
Food, Meds and More



With summer coming we can look forward to lighter recipes for the warmer weather. So you might like to look at IDDT's recipe book. It is available to members at the reduced price of £7.99 plus £1.50 P&P.

To order

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

The IDDT Lottery

We would like to thank all the people who have joined in the IDDT monthly Lottery – over 200 entries at the time of writing so the 1st prize will be at least £115.00, 2nd prize over £85.00, 3rd over £55.00 and 4th over £25.00. The Lottery draw for June will take place at the end of the first week in July, so there's still time to enter – just fill in the form which is with this Newsletter. The winners will be contacted directly and will be announced on our website and in the next Newsletter.

It's a good idea!

From Adam Booker

Have you ever felt hypo when out and felt in your pockets for that dextrose packet, sweet or whatever it maybe you always keep on you, just in case? Then you realise it's not there and you're not near a shop to buy something.

What do you keep on you when doing exercise or a sporting activity such as swimming, riding a bike, skiing, or even rock climbing?

Have you sent your child off to school with that nagging feeling that they have forgotten their dextrose and hoping they don't have a hypo?

If you are a bit older, have you been sitting in your favourite chair, feeling a bit low but with nothing to hand?

It's amazing how fast a hypo can come on and if you're not prepared it can, and will catch you out! Nobody likes having a hypo whatever their age that's for sure. After having Type 1 diabetes for over 40 years and trying out water skiing for the first time, perhaps not a good idea after nearly breaking my leg and one very big hypo in the water, I had a thought. What if we can keep the energy boost needed always at hand, maybe not for all situations but certainly when we need it or want it?

So after many, many years and a bit of money, I have finally had a patent granted in the UK and the USA for my idea. This means for all us with diabetes and our families my idea can help to combat a hypo and an energy boost is closer than ever to being available – it is a comfortable wrist strap containing a disposable replaceable insert that holds 15gms of glucose. The picture shows the prototypes and I would be very interested to have your readers' views, questions or interest in using the NRGBand. Please email me at info@nrgband.net

Exemption

If you are over 18 and under 60, living in England, and you use insulin or medicine to manage your diabetes you are entitled to free prescriptions but you must have a medical exemption certificate. (Prescriptions are free for everyone in Scotland, Wales and Northern Ireland)

There has been a 'crackdown' on people with diabetes claiming free prescriptions without an exemption certificate and this has led to some people being fined up to £100 and more. If you have been issued with a fine and received no reminder letter, then you can call the NHS BSA and explain this to them – the telephone number is 0300 330 9291.

Just a note: From 17th September 2014 to 16th January 2015, 5,572 patients paid a penalty charge in full, with a further 2,252 patients opting to pay in instalments.

A Date for your Diary

Although we won't be having a conference again this year we will still be holding our Annual General Meeting. The meeting is free to attend and will be held on Saturday, 17th October at the Kettering Park Hotel, Kettering. The meeting will start at 12.30pm and we will provide a sandwich lunch, discussion sessions and our speaker will once again be Dr Gary Adams. (It would be helpful for catering numbers if you could let us know if you are coming) So we hope that many of you will still be able to join us for the afternoon. More details will be available in the September 2015 issue.

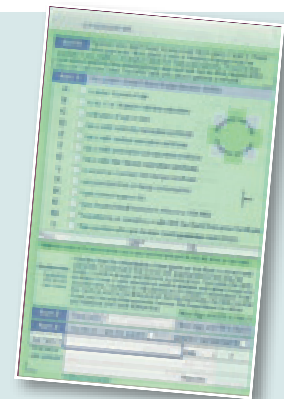
Recycle 4 Charity

We would like to thank everyone who helps IDDT by using Recycle4Charity. Unfortunately from April 1st 2015 there has been a policy change regarding mobile phones.

Due to Royal Mail's policy changes in prohibited goods, mobile phones via Freepost bags can no longer be accepted and Royal Mail will make a surcharge to Recycle4Charity for each phone sent via Freepost. Clearly this means that any benefit to IDDT will be lost as this surcharge will be passed on to IDDT.

This policy does not affect the donation or ability to recycle inkjet cartridges through the Freepost recycling envelopes, so please keep these coming to continue to help us raise funds. If you would like Freepost recycle envelopes, just call IDDT on 01604 622837 or email enquiries@iddtinternational.org

Certificates
free prescriptions (England)



Why did this happen?

The NHS Business Services Authority (NHS BSA) issues and renews medical exemption certificates and has been issuing reminders since 2002.

- If you were registered for a certificate then, or have been registered since then, you should receive reminders to update your certificate.
- However, if you did not have a certificate in 2002 or if you have moved without registering your new address, then you will not be on the NHS BSA's system and will not have received any reminders.

The responsibility for checking exemption from paying for prescriptions was carried out locally but in 2014 this was transferred to the NHS BSA with a more thorough checking system. This has resulted in fines being issued to a lot of people, many of whom did not realise they needed a certificate. Pharmacists have a responsibility to check that you have an exemption certificate when you collect your prescription but clearly up to now, this has not been done very thoroughly.

What now?

A new process has been introduced whereby if someone has made a claim for medical (or maternity) exemption and there is no evidence they hold an exemption certificate, they will still receive a penalty charge. However, this can be cancelled if they submit a valid application for a medical (or maternity) exemption certificate within 60 days of the receipt of the penalty charge notice.

Where a penalty surcharge has already been paid, a payment equal to the amount of the surcharge will be refunded but not the cost of the prescription.

How to obtain a medical exemption certificate

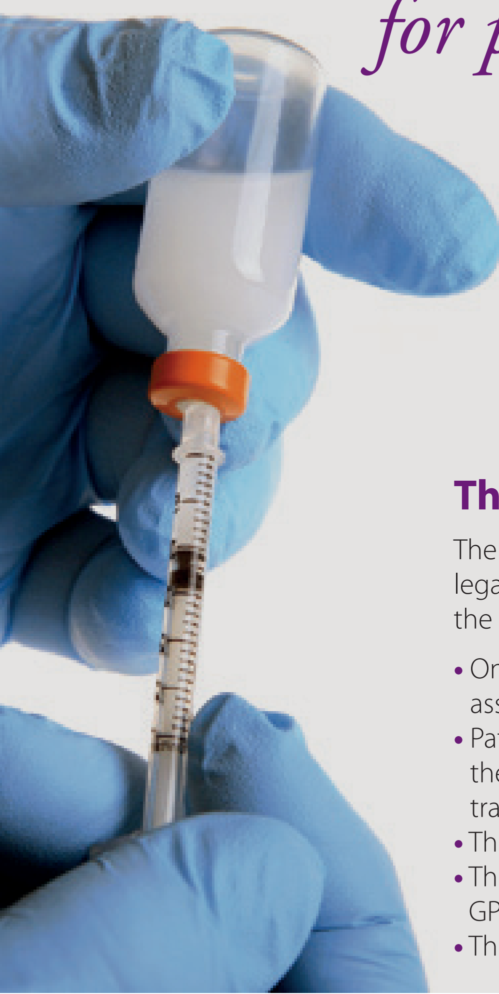
- Obtain form FP92A from your GP surgery.
- Complete the form and return it to your GP for signing and the surgery will send it off.
- If you do not have a certificate or your application is being processed, you will need to pay for your prescription. Ask your pharmacist for a FP57 receipt and refund claim form so that you will be able to claim the money back once your certificate has been issued. (It is backdated by a month from when it is issued.)

The certificate is valid for 5 years and you should receive a renewal reminder letter a month before it expires.

If you move house, remember to inform the NHS BSA!!

NEW GUIDELINES

for pre-loading syringes for later use



A small number of people are not able to manage insulin pens for various reasons – poor manual dexterity, visual impairment or reluctance to change from injections using syringes. For many years in these cases, nurses have pre-loaded syringes with insulin and left them in the fridge so that people can continue to manage their diabetes and maintain their independence.

The guidance on this practice has not been updated since 2006 and before issuing new guidelines, the Royal College of Nursing (RCN) asked for the views of senior diabetes specialist nurses and found that 20% did not know that pre-loading syringes with insulin was outside the Medicines Act and only 20% were aware that pre-loading syringes with insulin is not considered best practice.

The key point of the new Guidelines

The aim of the new guidelines is to ensure patient safety and that nurses are aware of the legal position when undertaking pre-loading insulin syringes. Therefore the main points in the guidelines are as follows.

- Only registered nurses should be involved in pre-loading syringes and not healthcare assistants.
- Patients must have the capacity for this practice, they must be assessed to make sure they can't use any other type of device, such as an insulin pen and they must receive full training and education.
- They must be able to describe the signs, symptoms and treatment of hypoglycaemia.
- There must be a local policy in place about pre-loading insulin syringes and the patient's GP must have agreed to this practice.
- The patients must have a care plan in place.

NHS News

NHS prescription charges increased

In England the cost of an NHS prescription went up by 20p in April and is due to rise again next year. The new charge for each medicine or appliance dispensed is £8.05, increasing to £8.25 in 2016. The cost of prescription prepayment certificates to cover prescription costs for three or 12 months will remain unchanged at £29.10 and £104, respectively.

90% of prescriptions are dispensed free of charge to people on low incomes, children, people over 60 and those with certain long-term conditions, including diabetes for people taking tablets or insulin.

The current system of exemptions for prescription charges in England has not changed since 1968. It is outdated and unfair to many people with long-term conditions not exempted from charges. The whole system needs an overhaul as the prescription charges can deter people from taking the prescribed medicines they need which can result in higher health costs in the future. Wales, Scotland and Northern Ireland have scrapped all prescription charges.

NHS dental charges also increased by up to £5 from 1 April 2015

From April 2015, the charge payable for a band one course of treatment will increase by 50p from £18 to £18.50.

The dental charge for a band 2 course of treatment will increase by £1.50 from £49 to £50.50.

The charge for a band 3 course of treatment will increase by £5 from £214 to £219.

Storage of pre-loaded insulin syringes

The pre-loaded syringes must be placed in a sealable container and the container and the syringes must be labelled. If the insulin is administered more than once a day, there should be separate containers each administration time even if the doses are the same.

The containers should be stored in the middle of the fridge, not towards the back, at temperatures between 2 and 8 degrees and for a maximum of 7 days.

Re-suspending insulin

If the type of insulin is isophane, or is a cloudy insulin, then the syringe should be rotated back and forth at least 20 times until it is evenly re-suspended. This also warms up the insulin making it less painful when injected.

Lantus (insulin glargine) is not suitable for use in pre-loaded syringes.

IDDT Tax disc!

As you will be aware the old paper tax discs are being phased out this year but instead of throwing away your old tax disc holder, use it to show your support for IDDT – ask for your **FREE IDDT TAX DISC**.

The disc is the same size as the old disc and is even perforated – so show your support for us and ask for your IDDT tax disc today! Just call IDDT on 01604 622837 or email martin@iddtinternational.org

Continuous glucose monitoring

IDDT receives quite a few questions about continuous glucose monitoring (CGM), its effectiveness and cost. CGM provides a continuous measure of the interstitial glucose levels which is a measure of the glucose in the fluid within cells and not the glucose in blood. There is a time lag between glucose in interstitial fluid and in the blood. So CGM provides a pattern of glucose levels, alarms for thresholds for high and low glucose levels and prediction of hypo and hyperglycaemia.

Studies suggest that for people with Type 1 diabetes using multiple daily injections (MDI) or insulin pumps, CGM is useful for improving glycaemic control and/or decreasing severe hypoglycaemia. However, the problems with research to demonstrate benefits of CGM are that over the years the monitors themselves have been changed / improved so that by the time the research has been completed, the monitors used in the studies have changed. Also many of the studies are small and earlier ones excluded the very people who could benefit – those with high HbA1cs and frequent severe hypos. Many of us know people who really benefit from CGM but larger studies are necessary to demonstrate the benefits and if these benefits apply equally to various categories of people, such as those using a pump or those with severe hypos.

CGM is for glucose trends

CGM shows trends in glucose which are useful for people using insulin to see if there are patterns in glucose levels. However, this does not replace home self monitoring of blood glucose levels (finger prick tests) which is essential for making all decisions about insulin doses.

In some clinics, continuous glucose monitors are loaned to patients when blood glucose levels are adrift to find out if there are any trends and make any necessary adjustments to the insulin regime alongside self-monitoring of blood glucose levels.

Barriers to the use of CGM

- Cost, not just of the monitor but the ongoing supplies of the sensors. CGMs are over £1000 and the sensors around £50.00 each. In some areas they are available on the NHS, particularly for people without hypo warning signs.
- 'Double' testing, both CGM and finger prick blood glucose testing increases costs. There is also evidence that some people do not self-monitor blood glucose as often as they should when they are using CGM.
- When the sensors come towards the end of their life, there is evidence that the accuracy of the device is questionable.
- CGM requires greater training, education and face to face sessions with patients and therefore increases the involvement of health professionals.

Using continuous glucose monitoring is about choice but only in the more affluent countries.

Government dietary guidelines did not

Dietary recommendations introduced for 220 million US and 56 million UK citizens by 1983 did not have sufficient supporting evidence from randomized controlled trials…

I heard this news on the BBC while I was driving and I have to confess to punching the air like a football supporter! Our longstanding members and those who have attended our conferences know that IDDT has argued the case that the dietary recommendations of low fat / high carbohydrate advised for the last 30 years are not, and never were, based on evidence. We have argued that the low fat, high carb diets simply do not make sense, especially for people with diabetes.

If you eat more carbs than needed for the energy you use, then the excess carbs will put weight on in the general population and in people with diabetes. In people with Type 1 diabetes this results in the need for higher insulin doses (which also increases weight) and a greater risk of hypoglycaemia. In people with Type 2 diabetes, greater weight means more medication is necessary.

Understanding why the guidelines were introduced

The guidelines were introduced in 1977 by the US government and in 1983 by the UK government. We fully understand their introduction aimed to reduce coronary heart disease (CHD) by reducing fat intake and increasing the carbohydrates to replace the fats. However, it is incredible that something as important and far reaching as national diets in leading countries can be introduced without evidence that (i) they do what they are supposed to and reduce CHD and (ii) without investigating the possible consequences of the proposed guidelines. Up to now, no analysis of these guidelines has ever been undertaken.

The new review

The review that made me punch the air (Open Heart, BMJ, Feb 9 2015) examined evidence from randomised controlled trials available to the US and UK regulatory committees when they made their decisions to implement the new guidelines, before 1983. The trials looked at the relationship between dietary fat, cholesterol levels and the development of cardiovascular disease.

There were a total of 2,467 male participants in 6 dietary trials, some given the low fat / high carb diet (the intervention group) and some (the control group) ate a normal diet. The results showed:

- There were 207 and 216 deaths from cardiovascular disease in the intervention group and control group respectively, so little difference.
- There were no differences in all-cause mortality and non-significant differences in CHD mortality resulting from the dietary interventions.
- The reduction in cholesterol levels was significantly higher in the intervention groups but, and this is a big but, this did not result in significant difference in CHD or all cause mortality.

The researchers could only conclude that government dietary fat recommendations were untested in any trial before being introduced and without any supporting evidence from randomised controlled trials.

Latest News – experts say diabetes patients must cut carb intake

An editorial in the British Journal of Sports Medicine, 22nd April 2015 by researchers from the UK, South Africa and Australia says that cutting carbohydrate intake should be the primary strategy for treating diabetes as it is the single most effective approach for reducing all features

have sufficient supporting evidence

of the metabolic syndrome. They also say that the benefits of cutting out foods like crisps, chips, cakes and sugary drinks occur even in the absence of weight loss. The prevalence of Type 2 diabetes increases 11-fold for every 150 additional sugar calories consumed daily compared to the equivalent amount of calories consumed as fat. They also point out that sugar calories promote fat storage and hunger but fat calories induce the feeling of fullness.

The editorial was highly critical of public health messages as being 'unhelpfully focussed' on maintaining a healthy weight through calorie counting rather than the source of the calories, which is the important factor. It also points out that our calorie-laden diets now generate more ill health than physical inactivity, alcohol and smoking combined.

The evidence now suggests that up to 40% of those within normal weight range will still have some of the harmful metabolic abnormalities typically associated with obesity.

And in the US...

A US review of the best documented and least controversial studies was published at a similar time as the BMJ review. It is very outspoken about the dietary guidelines and makes the following statement.

"The current state of diabetes care in the US health system shows the inability of existing recommendations to control the epidemic of diabetes, the failure of low fat diets to improve obesity rates, cardiovascular risk or general health and continual reports of serious side effects of commonly prescribed diabetic medications.

The immediate benefits of carbohydrate restriction in diabetes patients include reduction of high blood glucose, less requirement for weight loss, fewer side effects than medication therapy and the reduction or elimination of medications (in Type 2 diabetes). The current evidence supports the use of low-carbohydrate diets as the first approach to treating Type 2 diabetes and is an effective adjunct to pharmacology in Type 1."

Information from the National Health and Nutrition Examination Surveys indicate a large increase in carbohydrates as a main contributor to excess calories in the US from 1974-2000. Carbohydrate intake in men rose from 42% to 49% and in women from 45% to 52%. There is information to suggest a link between increased carb consumption and increased diagnoses of Type 2 diabetes.
(Nutrition. 2015;31(1):1-13)

What happens now?

It is hardly surprising that the publication of these reviews has led many experts to defend the original guidelines. For example, Professor Christine Williams of the University of Reading, told the BBC that the claim that evidence for the dietary recommendations was insufficient is "misguided and potentially dangerous". This begs the question, was it actually misguided and potentially dangerous to introduce national / international guidelines without rigorously gathered evidence?

Just a note...

it would be wrong to suggest that the increase and link between obesity, overweight and Type 2 diabetes is totally due to the high carb/low fat diet. Many other factors have changed over the last 30 years – more sedentary lifestyles, using cars instead of walking, increased use of processed food and sugar-laden drinks. However, these changes only serve to emphasise the need for Public Health England and NHS IQ, the department responsible for diabetes, to update the dietary recommendations for the general public and for people with diabetes and to ensure that such recommendations are based on evidenced.

STRIDING OUT for diabetes

We wish to thank everyone for taking part in IDDT's '***Striding out for IDDT***' during the weekend of June 6th and 7th. Whether you are walking, running or cycling, our thanks go to you for not only raising needed sponsorship funds for IDDT but showing how important it is to take exercise. Our thanks also go to Oliver Jelly, as pictured, who organised the weekend and the flagship run from Market Harborough to Northampton along the Brampton Valley Way.

Mum takes on marathon for son and raises money for IDDT

A mum whose son was diagnosed with Type 1 diabetes in late 2014 has taken on a fundraising challenge for IDDT. Angela MacAusland is in training ahead of October's Bristol to Bath marathon and says the 26.2 mile-challenge is helping her to come to terms with the diagnosis.

She said: "Sometimes in life we get thrown things we don't want or need, but when this happens, some people grow strong and face whatever stands in their path. When my 22 year-old-son Elliot was diagnosed with Type 1 diabetes, even though it was a shock to all of us, he has taken everything in his stride and I am incredibly proud of him for just dealing with it and getting on with life. I feel helpless at times, and want to help, so I am channelling my energies into doing something worthwhile by raising funds for IDDT."

Angela added, "Training for, and running, a marathon is hard work. I will be thinking of my son every step of every mile that I take from now to the finish line and beyond. Anything you can give will be appreciated by the charity, and of course by me."

Keep up with Angela's story on Twitter @ AMPMPALtd. To sponsor Angela, visit https://www.justgiving.com/AngelaMarathon15.

REPORTS

NHS Five Year Forward Review – where does diabetes fit in?

In March 2015, NHS England published its business plan for 2015/16. It sets out ten priorities intended to improve access to services for patients, drive for better value for money and build the foundations for the future health and care system.

Where does diabetes fit into the plan?

Fourth on the list of priorities but as 'Obesity and preventing diabetes'! We are all well aware that *preventing* diabetes should be a priority but surely the 3 million people who are already living with diabetes should also be a priority?

They are not included, clearly people with Type 1 diabetes are not included as it cannot be prevented and is unrelated to obesity. Diabetes fits into the NHS category of 'long-term conditions' but IDDT believes this is not good enough. Diabetes should have its own place within the NHS system as we did before NHS Diabetes was dismantled.

We are forever being told how much diabetes costs the NHS, yet the various National Audits show that people with Type 1 and Type 2 diabetes are not getting the care they need and deserve. With less than half receiving the NICE 9 key essential health checks to look after their health now and in the future, it is hard to understand why diabetes is not an NHS priority.

National NHS Diabetes Prevention Programme

In March, a joint alliance between Public Health England, NHS England and Diabetes UK announced the start of the National NHS Diabetes Prevention Programme which aims to reduce the 4 million in England otherwise expected to have Type 2 diabetes by 2025.

This is based on randomised controlled trials in various other countries which show 30 to 60% reductions in the incidence of Type 2 diabetes over 3 years in high risk adults by intensive lifestyle change programmes to support people to lose weight, exercise and eat better.

The UK Prevention Programme will start by targeting 10,000 people at high risk of developing Type 2 diabetes and then will be rolled out nationally. Initially, there will be 7 areas involved which will investigate ways to pinpoint people at high risk. Public Health England is also working with Imperial College Hospitals where there is a weight loss pilot for NHS staff which could provide a blueprint for the national roll out.

Independent Diabetes Trust response

IDDT issued a public response in which we welcomed the National NHS Diabetes Prevention Programme. However, we added that we need to know more specific details about how the programme will work as there are many unanswered questions.

- Helping people to change their lifestyle requires education and importantly, ongoing support, as evidence suggests that without ongoing support, people simply revert to their previous habits. Will there be ongoing support?
- Where will the resources come from? Such an ambitious programme will require additional resources – funding and increased numbers of GPs and health professionals. We presently have a situation where many people already diagnosed are not receiving the 9 key annual checks to prevent or delay diabetic complications, so an expansion of staffing levels is essential for people already diagnosed.
- Where will the extra funding come from? Are there plans to hand the programme to the private sector?

We need more detailed plans of how this will be rolled out nationally to provide the public across the country with equal access to the Diabetes Prevention Programme.

Response from the Royal College of GPs (RCGP)

The RCGP welcomed the Prevention Programme and acknowledged that Type 2 diabetes is a debilitating condition and simple lifestyle changes can go a long way to preventing its onset. However, they point out that simply telling people what to do is not enough and lifestyle changes require ongoing support and access to help over time. They say that GPs are well placed to prevent illness but they need more specific details about how the scheme will work and also assurances that general practice will have the appropriate resources, including more GPs.

Target for NHS health checks missed

Part of the planned Diabetes Prevention Programme involves the NHS health checks as an effective way of detecting those at risk of Type 2 diabetes, but is this really the case?

The NHS health check is intended to offer all patients aged 40 to 74 a series of tests every 5 years aimed at early detection of conditions such as heart disease, stroke and diabetes. This is the responsibility of Public Health England (PHE) which had a target uptake of 66% by the end of March 2015 and 75% before the end of 2017-18.

Last year 49% of people offered a check received one and uptake between April 2014 and January 2015 was just 46%, so it is unlikely that 66% target will be achieved.

Why such a poor attendance?

- The programme has been accused of targeting the worried well and diverting money away from people with serious conditions.
- Leading GPs have expressed doubt about whether the programme should continue as it repeatedly misses the uptake targets.
- In 2014, a study suggested that the scheme offered no advantages over GPs finding cases when people attend surgeries for other reasons.

The scheme costs £300 million a year and PHE is legally required to demonstrate a year-on-year increase in uptake of the programme. There will need to be a change in the number of people offered checks and the numbers of people who respond for this to be an effective part of the National Diabetes Prevention Programme.

From our own correspondents

More thought for older people with Type 1

Dear Jenny,

I am a lady of 83 and have had Type 1 diabetes since I was 16 years old. I live on my own and my constant fear is having hypos, especially when my body jerks. I keep my blood sugars higher than I should because of hypos.

Very little is written or advised about older people with Type 1 diabetes, especially for those of us living on our own. We need help quickly with a bad hypo. I don't know the answer to this but wish more thought and advice was available.

Anon

Jenny's comments: *we try to specifically include articles for older people in the Newsletters, especially important for people who have had Type 1 diabetes for many years. There is little research involving older people with Type 1, so, for instance, do we know the best treatment or whether insulin needs change? We do know that older people tend to lose their hypo warnings so are at greater risk of hypos. The writer says 'I keep my blood sugars higher than I should...' Perhaps the advice she has received is inappropriate, she is elderly, living on her own and having severe hypos, so surely she should have been advised to change her target blood sugars to a higher level and not feel guilty about it.*

Foot care – no recall

Dear Jenny,

Despite meeting the CEO of Lincolnshire Community Health NHS Trust last October, I have never understood why people with diabetes in this county are not afforded any sort of recall in terms of feet checks?

I stressed to him, 'that despite having two charcot feet, the second one underwent reconstruction, I do not 'fit in' with any checking system, unless I try to 'wriggle' through a maze of questions and 'rough handled' as if I'm wasting their time? My argument is that since my operation, one shoe/boot fit, I have never appeared on any list for regular checks... that's two years ago!

Whatever the minister says, is simply not happening, there are too few specialist nurses and podiatrists in this county. Medical care is divided between two trusts and GP's and the less articulate people fall through the hole which then contributes to the ever increasing cost of diabetes care.

I insisted that I need two consultations per year but this has fallen on deaf ears and I am still fighting on several fronts, I really wonder what part of me will survive the longest?

By email

Note: Lincolnshire is on its own!

Win a years supply

of pomegreat juice drinks

Just answer the simple question below:

How many pomegranates are featured on the front of a pack of pomegreat juice drink?

Answer
a) 4
b) 5
c) 9

Email your answers to: **enquiries@pomegreat.com**

Postal entries to **165, New Greenham Park, Newbury RG19 6HN**

Please mark postal entries with Pomegreat/IDDT June 2015 Competition **OR** use Pomegreat IDDT June 2015 Competition as the subject line.

Closing date for this competition is 30 June 2015 and the winner will be chosen from the correct entries received.

The winner will be chosen on 1 July 2015 and will be notified by email and/or post.

One years supply of juice drink is the equivalent of 1 carton per week for 12 months. No cash alternative is offered.

Summer's coming VITAMIN D

Calls for free Vitamin D supplements

According to new NICE guidance one in five people in the UK may now be deficient in vitamin D and NICE suggests that free supplements should be given to the elderly and children.

A lack of exposure to sunlight is putting large sections of the population at risk of vitamin D deficiency which can cause rickets in children and osteoporosis and cancers in adults. The number of hospital admissions of children with rickets has increased ten-fold over the last 20 years. There are suggestions that children get too little sunshine because they spend more time indoors on computers and game consoles.

Professor Mitch Blair, Officer for Health Promotion, is quoted in the Guardian:

> *"Living in the UK, you simply cannot get enough vitamin D from the sun or through diet. So we have to be looking at options such as widespread availability of supplements, fortification of foods and better guidance for healthcare professionals on how to spot the signs and symptoms of vitamin D deficiency so they can act quickly."*

Prevention of Vitamin D deficiency in children

- The recommendations are for exposure to sunlight for short periods during summer months – 3 to 4 times a week between May and September without sunscreen.
- Dietary intake should be rich in vitamin D and calcium but only a few foods, such as oily fish and eggs, contain significant amounts of Vitamin D. Vegetarians and vegans may only obtain small amounts of Vitamin D through their diets.
- A few foods are fortified with small amounts of vitamin D, such as margarine, some cereals and yoghurts. Children at risk of vitamin D deficiency should be encouraged to take a multivitamin supplement during the winter months.

Vitamin D deficiency does not affect progression of Type 1 diabetes

Vitamin D is a major regulator of calcium levels and bone metabolism and it also influences the immune system. Previous studies have shown that people who have been recently diagnosed with Type 1 diabetes had significantly lower vitamin D levels but this deficiency does not seem to influence the progression of the condition.

Pre-diabetes for Type 1 is defined as the presence of multiple autoantibodies. Within the children with positive autoantibodies, a few went on to develop Type 1 diabetes quickly but this was independent of their vitamin D levels.

The researchers suggest that vitamin D deficiency precedes the onset of Type 1 diabetes and this may be a result of an immune response. Therefore they suggest in the case of this group of children, vitamin D deficiency should be considered and it may be that supplements of vitamin D should be considered at an early stage in Type 1 diabetes. [Diabetologia March 2014]

Not a common complication

taste and smell in diabetes

Although rare, diabetes can impair the senses of smell and taste. Losing these senses can have serious consequences on those who are affected. We tend not to appreciate how much the senses of smell and taste give us pleasure until we don't have them, but it can also be dangerous. For instance, if the gas is accidentally left on, someone with an impaired sense of smell will not pick it up.

Sense of smell

When there are chemicals in the air they are dissolved in the mucus in the nasal passages and these are detected by nerves which give us our sense of smell. One of the causes of an impaired sense of smell may be diabetic neuropathy and one study has shown that people with painful neuropathy are more likely to have an impaired sense of smell. Research has also shown that people without diabetes complications have the best sense of smell.

Taste

Taste is more complicated and involves the sense of smell, the tongue and mouth, the saliva and some of the cranial nerves. In the general population taste worsens with age, smoking and glucose levels.

Research has again shown that those with diabetic complications are more likely to have an impaired sense of taste. This was linked to age, duration of diabetes, peripheral neuropathy but not with glycaemia. Some drugs can also affect the sense of taste, for example, metformin for the treatment of Type 2 diabetes can cause taste disturbance, usually a metallic taste.

Treatment

It can be difficult to recognise these conditions but if impaired smell or taste is suspected, it is important to seek the help of experts. The first course of action is to have any nasal or sinus diseases treated and to have dental treatment. However, in many cases there is no treatment so the following may help:

- have good oral and dental hygiene and regular dental care,
- stop smoking,
- artificial saliva for those with dry mouth.

It is important to remember that if there is impaired taste, then care is needed with unfamiliar or spicey food. Care also needs to be taken not to eat too much sugary food or to put extra sugar in food and drink because the sweetness cannot always be detected.

More research is necessary to increase awareness of these problems and to understand how diabetes affects these senses.

Interestingly reduced sense of taste may increase weight loss after surgery

A study has shown that an adverse effect after weight loss surgery (bariatric) is that some people can't taste food as well as they did before surgery.

The study involved 88 severely obese people with an average age of 49 who were tested before surgery and 3, 6 and 12 months afterwards and the results showed:

- 87% of people had taste changes, including 42% who said they ate less because the food did not taste as good.
- Those with decreased taste lost 20% more weight over 3 months than those with higher taste sensitivity.
- It was not just flavour that influenced weight loss but the intensity of the flavour and those with diminished taste intensity lost the most weight.

(American Society for Metabolic and Bariatric Surgery, news release, Nov. 4, 2014)

Pharmaceutical News

Saxenda makes progress in Europe

Saxenda made by Novo Nordisk has now received marketing approval in Europe for the treatment of obesity in adults alongside a reduced calorie diet, increased physical activity, with a BMI of 30 or more (obese) or 27 to 30 (overweight) and at least one other weight related problem. Treatment should be stopped if weight loss does not reach 5% of the starting weight after 12 weeks.

Saxenda is the drug liraglutide (the same as Victoza for the treatment of Type 2 diabetes) but is given in a 3mg dose to treat obesity, whereas Victoza is given as a 1.2mg dose. It is expected to be on the market during 2015. (Practical Diabetes, Vol. 32 No.2)

Novo Nordisk carries out trials for new faster-acting insulin aspart

Novo Nordisk has announced completion of phase 3a trials comparing a new faster acting insulin aspart with NovoRapid (insulin aspart) in people with Type 1 and Type 2 diabetes. The new insulins are Onset® 1 and Onset®2 for Type 1 and Type 2 diabetes respectively. This new faster-acting insulin aspart has two new excipients to ensure early and fast absorption.

In the trials, the new insulins were non-inferior (not better /not worse) to NovoRapid for HbA1cs and there was less increase in post-meal glucose levels. The glucose lowering was achieved faster in Type 1 diabetes but there was a higher rate of hypos within the first hour after start of a meal and within the first 2 hours in Type 2 diabetes. Novo Nordisk expects to apply for regulatory review around the end of 2015.

Toujeo – Sanofi's next 'blockbuster' insulin vs Abasaglar?

Lantus loses its patent this year and unsurprisingly, manufacturer Sanofi is introducing a new long-acting, once daily, more potent insulin called Toujeo. Its strength is 300U, not the normal 100U.

Be prepared! The press are predicting that Sanofi will mount an aggressive campaign to switch people from Lantus to Toujeo, presumably whether people need a change of not, as we have seen in the past with other insulins!

The competition between companies looks likely to be fierce because Lilly and Boehringer are marketing their new biosimilar version of Lantus, called Abasaglar.

Minimising the risks of medication errors

With the introduction of these new high strength insulins, the European Medicines Agency is consulting on guidance to minimise the risk of medication errors by people with diabetes and health professionals. We will keep you informed.

What are biosimilars?

Biosimilars medicines are a biological medicine, such as insulin, manufactured to be similar to an existing licensed biological medicine with no meaningful differences from the original medicine in terms of quality, safety and efficacy.

These drugs have undergone stringent testing before being authorised but there may still be gaps in the evidence for their safety and efficacy. Like all new medicines, there is a lack of information and knowledge on the long-term safety, so it is important that a systematic method of monitoring long-term safety and effectiveness of biosimilars is in place.

According to Professor Alex MacGregor, Chair of the BSR Biologics Register, clinical trials of biosimilars for autoimmune conditions have only been carried out in new users and not people using the original drug. This means the effects and safety are unknown in people who have the original drug changed to a biosimilar. There needs to be a systematic collection of information on adverse reactions as is currently the situation with 'normal' medicines to ensure that people can make informed choices about their treatment.

The clear reason for using biosimilars is that they will cost less than the original drug or insulin.

IDDT's note of caution

Our members have plenty of experiences and serious adverse effects following the introduction of the first synthetic human insulin. At that time there was no evidence of its long-term safety and effectiveness. Systematic reviews showed that research had not been carried out to compare important issues for people with diabetes, such as mortality and complication rates with those of animal insulins.

Too many children and young people with diabetes not getting the care they need

The National Paediatric Audit report by the Royal College of Paediatrics and Child Health, March 2015, has shown that in England and Wales only 16.1% of young people aged 12 years and older are receiving the 7 annual checks that every child with diabetes should have. This is a slight improvement from the last audit but still very worrying.

The report states that not having the 7 health checks leaves many children and their families missing out on the chance to prevent health problems and this combined with a lack of diabetes education is contributing to too many children showing early signs of serious long-term complications.

- Over 25% of children with Type 1 diabetes aged 12 and over have blood pressure above their target.
- Over 7% have early signs of kidney damage.
- Over 14% are already experiencing problems with their eyes, blurred or partial loss of vision which is particularly alarming.

The report points out that there are considerable variations according to area in completion of the 7 care processes, treatment targets and complications and these are primarily the responsibility of paediatric diabetes units.

Current standards for care, which are due to be updated in 2015, are published by NICE in CG15, '*Type 1 diabetes: Diagnosis and management of Type 1 diabetes in children, young people and adults*'.

The 7 key checks for children over 12 years should receive are:

- HbA1c – NICE says that levels less than 58mmol/mol indicates good glycaemic control and levels over 80mmol/mol is defined as poor control.
- Height and weight
- Blood pressure
- Urinary albumin
- Cholesterol
- Eye screening
- Foot examination.

Thyroid and coeliac disease screening

In addition to the above, it is important that children and young people with Type 1 diabetes are screened for thyroid disease and coeliac disease. These are both autoimmune conditions and as Type 1 diabetes is also an autoimmune condition, the risk of developing such diseases is increased.

The report recommends that paediatric diabetes units should ensure that children and young people with diabetes

'Smart' insulin works in mice

Researchers at Utah University have developed what they describe as a 'smart' insulin which is automatically activated in response to blood glucose levels. For example, if blood glucose levels rise, the new compound is activated to quickly to bring them down to normal. The smart insulin, Ins-PBA-F, remains in the system for 24 hours. Basically it is a glucose sensor attached to the insulin molecule so that the modified insulin can sense glucose.

The research has only taken place in mice with induced Type 1 diabetes but one injection of smart insulin normalised blood sugars in the mice for a minimum of 14 hours. The researchers are now developing the smart insulin to be suitable for human beings – it sounds promising…. (PNAS Early Edition, Feb 10th 2015)

Interesting devel

Human-insulin producing stem cells

As we know, Type 1 diabetes is an autoimmune disease that leads to the destruction of insulin producing beta cells in the pancreas. This can be treated by transplanting pancreatic beta cells or cadaveric pancreatic organs but there are only a very small number of donors. Now researchers have found new stem cells that can produce insulin and reduce blood sugar levels.

The researchers used reprogrammed human skin cells to create new stem cells which were transplanted under the kidney capsules of (diabetic) mice. Blood glucose levels declined slowly to normal or near normal levels over 150 days showing that the stem cells were producing insulin and then remained steady.

Part

are screened for thyroid and coeliac diseases. At present, this is being achieved in only about half of the children and young people.

Psychological assessments

NICE also recommends psychological assessment of children and young people with diabetes by multidisciplinary teams to try to avoid the possible development of depression, eating disorders or the taking of drugs. Expert psychological reviews take place in less than half of children and young people with diabetes and again the report recommends that paediatric diabetes units ensure that there is annual screening to identify those who need expert psychological assessment.

Structured education programmes

NICE recommends age-appropriate structured education programmes for the on-going management of children and young people with diabetes but currently there is no nationally agreed programme, despite the many examples of good practice in England and Wales.

The 2013/14 audit shows that only 45.2% are receiving some form of structured education annually but this varies from 11.1% in the South West to 62.0% in the North West. Further investigation into these figures is required but it is clear that there is a great need for better access to structured education for children and young people with Type 1 diabetes.

So what are parents supposed to do?

IDDT's advice is to make a list of what care children and young people with Type 1 are supposed to receive at least annually – the 7 key checks, thyroid and coeliac disease screening, psychological assessment and structured education and keep a diary of when these are provided.

If they are not offered or provided, then in the best interests of the health and wellbeing of your child, ask for them and keep asking until they are provided. If we look back in history, it is only through patient / parent demand that syringes and needles became free on the NHS and the same happened with blood glucose testing strips. Yes, times have changed, but the right to good care has not, so don't stop asking for the care and treatment that your child or young person needs and deserves.

opments for Type 1 diabetes

The researchers concluded that this type of stem cell made in a laboratory may be a new option for the treatment of Type 1 diabetes. In addition, by not using embryonic cells, the need to wait for a donor pancreas would be eliminated as would be the need to take immunosuppressive drugs. (PLOS ONE. January 2015; 10:1371)

Women with Type 1 diabetes at greater risk than men with Type 1

According to Australian research, women with Type 1 diabetes have a greater risk of dying from any cause and more than double the risk of dying from heart disease than men with Type 1 diabetes. In people without diabetes, women live longer than men but this does not appear to apply to women with Type 1 diabetes and the reasons for this are not known. The researchers suggest that:

- women may have a harder time controlling blood sugar levels due to changing hormone levels, especially during puberty, menstruation and the menopause, all of which can affect the body's sensitivity to insulin causing fluctuations in blood glucose levels.
- High blood glucose levels may cause more damage to women's blood vessels than to men's.

This suggests that young girls and women with Type 1 diabetes may need additional monitoring of their blood sugars and to make sure that they are checked for other major risk factors, such as blood pressure. Women may need to be treated earlier with drugs to prevent heart disease and stroke.

Dr David Simmons of the University of Western Sydney said that he doesn't think that blood glucose control is worse in women than men but everyone with Type 1 diabetes needs better ways of controlling their blood sugars including the prevention of hypoglycaemia. (The Lancet Diabetes & Endocrinology Feb 6 2015)

Ethical duty to report all clinical trial results – even past hidden ones

For the first time ever, the World Health Organisation (WHO) has taken a position on clinical trial results reporting. The WHO now says that researchers have a clear ethical duty to publicly report the results of all clinical trials. Significantly, the WHO has stressed the need to make results from previously hidden trials available. This is a landmark move for consumers as all clinical trial results will be available, not just the ones that show positive results!

The WHO has also called on organisations to take responsibility to ensure that results from all trials get reported in their sectors.

Hospital catering reforms are 'hopelessly weak'

Minimum food standards are to be introduced to NHS catering contracts from April 2015 but food writer, Prue Leith, says the contract changes are 'feeble' and will not eradicate poor quality food and wastage in hospitals. She describes the quality of hospital meals, such as tired, plastic-wrapped sandwiches and grey, mushy ready meals, as a scandal and worth less than "a row of over-processed beans". Ms Leith accuses the health secretary, Jeremy Hunt, of ducking the issue, and says that the hospital food standards panel established by the Department of Health has been undermined by inviting food manufacturers, including one of the biggest suppliers of hospital food, on to the panel.

Diabetes receives NHS Innovation Challenge prizes

Thirteen projects received NHS Challenge Prizes providing them with a share of £650,000. Winners included a project by King's College Hospital which reduced A&E visits by 45%, showed 43% fewer hospital admissions and 22% fewer hospital bed-days, saving £225,000 over 12 months.

The project focused on the psychological impact of living with diabetes after realising that a complex combination of depression and social exclusion was preventing some people with Type 1 diabetes from accessing services. They used new ways of bridging gaps between mental, social and clinical care by adding a psychiatrist, community support workers and trained volunteers to the diabetes team. The new £50,000 award will be used to roll this out to new areas and test a new e-learning model that could be used by other diabetes teams.

Eating eggs

Research carried out in Finland found that men who consumed four eggs each week were 37% less likely to have Type 2 diabetes compared with men who ate just one egg a week. The study also found that eating four eggs each week was associated with reduced blood glucose levels. These findings persisted even after such factors as exercise, BMI, smoking and fruit and vegetable consumption were taken into account. However, the researchers warn that people who already have Type 2 diabetes should not increase their egg consumption as this appeared to increase heart disease in those already diagnosed. (American Journal of Clinical Nutrition, March 2015)

Chocolate and a low carb diet

Chocolate may increase weight loss when combined with a low carbohydrate diet and exercise regime, according to a study recently published in the International Archives of Medicine (March 2015). The researchers found that people who consumed 42 grams of 81% dark chocolate daily, while following a low carb diet, lost 10% more weight than those who did not consume chocolate.

Prescription drugs

Figures published by the Health and Social Care Information Centre in December 2014, showed that half of women and 43% of men in England are regularly taking prescription drugs with an average of 18.7 prescriptions per person in 2013. The most prescribed drugs were statins, painkillers and antidepressants.

From your editor – Jenny Hirst

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