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ABCD Newsletter

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Reality checks

Peter Winocour, Chairman

I have just 'celebrated'? 30 years working in the NHS and have been experiencing a little battle fatigue. Apart from being startled at the youthfulness of policemen and FYPs you know you have been round the block a few times when you recognise 'new' NHS schemes as rehashed initiatives from a previous generation. My prediction for the next government's 'big idea' – GP fund holding revisited.

I am undoubtedly a little more pensive given the recent tragic news of the deaths of two valued colleagues and friends – Trevor Blair and Ken MacLeod. Apart from the undoubted sadness for their families, I know we all valued Trevor and Ken for their sound clinical judgement and the good company they offered, and their passing represents a real loss for diabetes in the UK.

Since my first Chairman's report, the last six months have been busy ones. ABCD recruited a public communications company in line with our strategy outlined at the May AGM. Our first serious independent foray was to promote our recent position statement on gliptins and exenatide – this went well but the press interpretation of our measured approach was misinterpreted as protectionism by specialists. One positive outcome was that our summary guidance was published verbatim, and I am grateful for that.

Our independent ABCD exenatide audit has been a great success and a benchmark for future activity for ABCD and I think wider afield. I pay tribute to Bob Ryder who had the foresight to set it up, recruiting over 5000 cases from the UK, and helping us better understand patient selection and determinants of efficacy and safety. The work will be presented at both EASD and IDF, further raising the profile of ABCD as a force for good! By the time you read this newsletter we should have a prospective nationwide liraglutide audit set up.

It seemed that the *Diabetologia* papers on insulin glargine and risk of development of cancer came out of nowhere. A prompt response from ABCD has been issued, with a cautious interpretation of the main study from a German health registry. The biggest challenge from what some may perceive as 'epidemiology gone wild' is how you deal with the genie once out of the bottle. We saw this with rosiglitazone, and despite the RECORD study, I wonder if another meta analysis could redress that balance. Unfortunately, not everyone accepts that causation cannot be inferred from this sort of data analysis, particularly some of the popular tabloid daily papers.

In this edition of the newsletter, Eric Kilpatrick brings his expertise to bear on the HbA1c assay, warts and all. I would like to think a mature group of clinicians are there to challenge dogma, and hope that we continue to debate contentious issues in ABCD. Is a prespecified tertiary end point a basis for changing clinical practice? – hopefully a topic for

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INSIDE

discussion in our next newsletter in the spring.

And what about aspirin for primary prevention of CVD in diabetes? We debated this at our spring meeting and the audience still supported its use in high risk microalbuminuric type 2 diabetes, given that this was part of the cocktail that reduced all adverse outcomes in Steno-2. ABCD is now part of the revised Joint British Societies Guidelines on Prevention of CVD working group and, as our representative, I will have the opportunity to cover this, the role of glycaemia, high dose statins, type 1 diabetes and other areas that should feature in JBS3.

The first sitting of the Specialty Certificate Examination (SCE) in diabetes and endocrinology has just taken place, with ABCD working alongside the Society for Endocrinology, Diabetes UK and the Federation of Royal College of Physicians. This was the most successful specialty exam to date with 39 entrants, of whom 36% were from UK where the pass rate was 64%. We were concerned to ensure that only those candidates in a UK training scheme would be eligible to use a post nominal title of MRCP UK (Diabetes and Endocrinology) at attainment of their CCT, and I am confident this has been agreed with the Federation of Royal Colleges of Physicians. ABCD will be represented by Dinesh Nagi, Ketan Dhatariya and me at the SCE board later this year as we set the exam for 2010.

At this point I will welcome Ketan as our new young consultant committee member, and extend my thanks to Lynn Higgs who has stood down from our committee after making a major contribution during her six years in post.

I must also welcome Nick Morrish who has been co-opted to ABCD committee through his role on the Specialty Advisory Committee (SAC). We have long felt ABCD needed to have an official role in the national advisory training committee, and I am delighted that Nick is representing us although he now needs to balance 'three hats' given his other roles. There will be a commitment to training diabetologists in new integrated models of service in England requiring experience in primary-community care and exposure to the workings of PCTs.

Every time I mention services in England, I feel a 'virtual' elbow in the ribs from colleagues in Scotland (not necessarily Alan Patrick!) reminding us that ABCD IS a four-nation UK organisation. I am therefore delighted that from discussions I have had with Donald Pearson, the Diabetes Clinical Lead for Scotland, that our Scottish Rep Alan Jaap has been invited to join the Scottish Diabetes Group and will ensure we have a conduit between us, ensuring our views are conveyed and we are able to learn and benefit from innovations in Scotland. The best we can manage in the short term is that our Spring 2010 meeting will be held in Gateshead, very handy for a commute from Lothian.

The commissioning of diabetes services is vital for our speciality and remains a major challenge. The concept of diabetes 'teams without walls' and integrated care is correct but the practical delivery of this remains elusive. I hope that one of the unexpected benefits of the economic downturn is a recognition that integrated care will be better for patients and more cost effective for health care systems. If the rationale for whole scale transfer of care from hospitals was the expense of consultants and the out patient tariff, this is no longer the case given pay parity with general practitioners. We need to be where the action is, and I do not mean a visit to a GP practice to see six patients on metformin, but innovative programmed activities with an emphasis on primary care education, and a focus on early, more proactive input to younger type 2 diabetes. At present as specialists, we are simply reactive to those patients by whom family practitioners are most challenged, often a bit late in the day. Those of us who have had the opportunity to work closely with general practice recognise diabetologists can offer a great deal at an earlier stage in the patient journey.

The Joint British Diabetes Societies – In Patient Group (JBDS-IPG) has been busy and will be delivering over the next few months. Our input to the group will help in the production of diabetes metabolic emergency guidelines that are contemporary and applicable, and will in turn ensure the national Map of Medicine project content is properly fit for purpose.

The ABCD jewel in the crown of this activity will be the national audit of intensive glycaemic control in ACS led by Maggie Hammersley and hopefully applied in a centre near you. It is planned to recruit 40 centres where diabetologists and cardiologist collaborate and will have to meet the challenge of tight metabolic control alongside acute angioplasty. The JBDS-IPG have also been able to contribute to an integrated care pathway for emergency diabetes foot care, in patient diabetes standards and peri-operative guidelines.

The National Diabetes In Patient Audit Day has been developed by our colleague Gerry Rayman, and should have been completed by the time this newsletter is issued. It offers a tremendous opportunity to provide a snapshot of what I think most of us recognise will be a wake-up call to the NHS to beef up the resources and specialist diabetes medical and nursing staffing, to deliver education and care to over 15% of in patients with diabetes – whether they are aware of their diagnosis or not!

Our ABCD audit award this year focuses on in patient care in Scotland and England and I am pleased that this was successfully bid for by Jonny McKnight and colleagues, who will provide vital additional information as to what lies beneath the surface of diabetes in hospital. This is clearly a vital core area for diabetologists and ABCD, and it is very appropriate that we are holding our first joint meeting with RCPL on in patient diabetes. The programme has been made available to you and is on our website. I have co-organised the meeting with Geoff Gill and hope many of you will attend what should be a high quality meeting.

We continue to work with the Society for Endocrinology on a vital issue for DGH endocrinology, potentially impacting on service and training if it is not sorted. The National Definitions Set for Endocrinology was designed to outline which tertiary services should be commissioned by SHAs for populations of one million. The original draft included such exotic conditions as hypercalcaemia and thyroid disease! Alongside RCPL we are trying to instil some common sense here.

We are back on track with the Primary Care Diabetes Society (PCDS) who we had hoped to organise a joint meeting with in 2009. This is still on our agenda but may not be possible till 2010-2011. However the executives of both ABCD and PCDS are meeting in October, and hoping to build on a joint statement on high quality diabetes care that we both contributed to in 2007. Ultimately, the future of British diabetes needs all health care professionals working collaboratively. The many primary care physicians and nurses committed to diabetes care will always wish and value specialist support, and those less engaged even more so. With over 1 in 20 adults currently living with diabetes there is no question we need to develop a population approach to service design, and there is no shortage of patients.

An uplifting musical ditty from the pen of Jerome Kern to finish:

'*Nothing's impossible I have found*
For when my chin is on the ground
I pick myself up, dust myself down, and start all over again'.

A report from the Association of British Clinical Diabetologists (ABCD) spring meeting

Bristol Marriott Hotel City Centre, Bristol, 7-8 May 2009

The ABCD spring 2009 meeting was held in Bristol and attended by over 70 delegates. The diverse programme encompassed aspects of clinical practice, service design and delivery as well as pertinent endocrine topics.

Mike Dixon's pre-prandial lecture made for interesting debate over dinner – "Integrated diabetes care: challenges ahead for specialist diabetes services." If only the Department of Health chose to tap into the expertise sitting around the tables!

The presentations from the main meeting on Friday seemed to encompass something applicable to every delegates' day to day practice. One of the main attributes common to all of the speakers is that they work in the 'real world', where patients do forget to take tablets, commissioners do have selective hearing loss and there are not more than 24 hours in a consultant's day!

Simon Eaton set a high benchmark, kicking off the meeting with his presentation on "Care Planning in diabetes: what is all the fuss about – aren't we doing this already?" Just focusing on one point – the case he made for giving patients information pre consultation (HbA_{1c}, BMI etc) in order to maximise benefits from the interaction was unequivocal. There was consensus that true care planning rather than mere tokenism would require major changes in both attitude and service design, but the message was that even small steps can be made toward clinically relevant care planning. As a result, at the top of my 'to do' list is now to revisit the letter sent out to patients informing them of the time of their out-patient appointment and to use this opportunity to prompt them to think about setting their clinic appointment agenda in advance.

Ryaz Malik's presentation on 'Painful diabetic neuropathy' made us focus on clinical specifics; in particular the benefits of the combination, low-dose approach, familiar to us in the treatment of hypertension, being applied to neuropathic pain and the potential misinterpretation of data due to negative trial results not being published.

Mark Davis applied a humorous and pragmatic approach to "Psychology input for adult diabetes care –a luxury or a necessity?" Would he be keen to work in Manchester – please?

The debate challenged us to re-think "standard practice" in the light of pertinent evidence. As a group we're probably all comfortable with a 'bespoke approach' to using aspirin in the primary prevention of vascular complications but this may not be so with our non-specialist colleagues.

One of the highlights of the meeting was the presentation of the first analysis of the "ABCD Nationwide Exenatide Audit" by Bob Ryder. The data were interesting, confirming many of our individual suspicions. For example it seems that heavier patients with better glycaemic control at initiation of exenatide lose the greatest amounts of weight. There was also a suggestion from the data that some patients with very poor glycaemic control actually put on weight when started on exenatide as the glycaemia comes under control. Of greatest concern, the data revealed that strict adherence to the current licence for using exenatide in the UK, such that in order to avoid co-treatment of exenatide and insulin, insulin is discontinued when exenatide is started, may lead to worsening of glycaemic control and this worsening of control may be considerable. This, it seems, is more likely to occur with higher initial weight and lower initial HbA_{1c} – ie in heavy patients whose diabetes is relatively controlled by the insulin whose insulin is stopped when exenatide is started. Collection and analysis of data on specialist prescribing and clinical outcomes in around 7000 patients of a newly available drug has got to be good news for patients. It was proposed that prospective data should be also collected on liraglutide when this is launched.

Steve Shalet's edited endocrine highlights presentation was pitched at the right level; as was Rob Murray's "Dopamine agonist and valvular heart disease – where next?" To have a synopsis of the data and the size of the problem put into perspective was a luxury – with the message being, 'no need for panic' but some judicious changes in prescribing practice are warranted with quinagolide likely to become first-line treatment in those newly diagnosed with hyperprolactinaemia (if not considering pregnancy).

Aresh Anwar proved that the ABCD Clinical Award 2007/8 money has been well spent on the "Pregnancy and diabetes" audit. The data was depressing, if not surprising, highlighting the fact that we are failing our fertile female population. Aresh's data showed nationwide injudicious prescribing of statins, ace inhibitors and so on in the pregnant population. It is incumbent on all of us, as diabetologists, to convey the correct messages to both patients and our other health care colleagues.

The final presentation on "Insulin resistance and metabolic syndrome and macro vascular disease: cardiology perspective" was given by Mark Kearney.

Susannah Rowles
Pennine Acute Trust

Meet the committee – Dr Ketan Dhatariya

I qualified from the University College and Middlesex Hospital Medical School in 1991. I then did my SHO posts in Essex followed by a stint in Intensive Care in London. I started my diabetes career on the Isle of Wight, and continued with a succession of registrar jobs in South East Thames. For two years during my SpR training I was also a part-time GP in the evenings. My initial interests lay in intensive care medicine and I did my one year Out Of Program Experience in ITU and anaesthetics after which I was awarded intermediate accreditation in that speciality. I finished my diabetes and endocrine training in 2001, but instead of taking up a consultant post immediately, I opted to do research into the uses of DHEA at Mayo Clinic in Minnesota, where I endured their harsh winters. Upon my return to the UK I was appointed at the Norfolk & Norwich Hospital.

I am married to a pharmacist and we have two children who take up most of my time. Beyond my family, my main interests are all aspects of film and cinema.

Secretary's notes

Colleagues will be aware of the recent publications suggesting a possible link between insulin glargine use and the diagnosis of cancer. Following feedback to the committee that ABCD needed to be more proactive and have a higher profile, ABCD has recently engaged a public relations management company, Different PR, to enable us to communicate more effectively with patients and colleagues and healthcare professionals. As a result we issued this press release on glargine.

"ABCD response to possible link between increased risk of diagnosis of cancer and the use of insulin glargine (Lantus) in diabetes:

This week, four studies have been published on the website of the journal *Diabetologia*, a highly respected peer reviewed scientific journal, which raise possible concern about an increased risk of diagnosis of cancer in people with diabetes using the long acting insulin glargine (Lantus)[1].

Glargine is the most widely used long-acting insulin in the UK and has been available for almost 10 years. It has been of benefit to many patients particularly those at risk of overnight hypoglycaemia.

In the largest study from a German health insurance registry, although there was no increased risk of cancer associated with Lantus compared to other insulins, when the data were adjusted for dose, there was a modest association with overall risk of diagnosis cancer, when Lantus was the only insulin prescribed.

A study performed in Sweden demonstrated no increase in overall risk of diagnosis of cancer, but there was an increased risk of diagnosis for breast cancer associated with Lantus insulin used alone. Two further studies performed in the UK did not confirm these results.

Interpretation of these studies is complicated by confounding factors such as the type of older patient with type 2 diabetes who would be treated with glargine alone.

The studies were based on reviews of case records recording diabetes treatment and development of cancer. All the reports are observational epidemiological studies, which CAN ONLY examine relationships and are UNABLE to show CAUSE and EFFECT. They must be seen in this respect and considered inconclusive, not least given differing results.

An extensive and thoughtful editorial reflected on the importance of the issue as the suggested link between glargine and progression of cancer was plausible. A firm statement was made that there was no evidence from this research of any harm from glargine in type 1 diabetes, in men generally, or showing any association with premenopausal breast cancer.

ABCD notes the comments of the European Medicines Agency (EMEA)[2] and supports their investigation into this issue. ABCD also urges the international diabetes research community urgently to work with the regulatory authorities to determine what further studies are needed to clarify this issue because of the concern that will be felt by people with diabetes and specialists caring for them.

The EMEA states that: "On the basis of the currently available data, a relationship between insulin glargine and cancer cannot be confirmed nor excluded. However, the concerns raised by the four studies require further in-depth evaluation….

Patients being treated with insulin glargine are advised to continue their treatment as normal. At this time there is no recommendation that patients should change their current treatment. In case of any concerns, patients should consult their doctor."

At the present time, ABCD does not recommend that people using glargine (Lantus) change to another long acting insulin, but where people are concerned about the risk, and may wish to change their insulin, that they have the opportunity to discuss the situation with a diabetes specialist.
Warn patients not to stop their insulin.

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1. http://webcast.easd.org:80/press/glargine/ glargine.htm
2. www.emea.europa.eu/humandocs/PDFs/EPAR/ Lantus/ 40847409en.pdf"

OTHER NEWS

We also released a press release following our recent position statement on GLP1 analogues and gliptin treatments. If any ABCD members hear of any data or other diabetes related news, which they feel would benefit from an ABCD viewpoint, please contact me directly.

HYPOGONADISM IN MEN WITH T2DM

Roger Fisken has started the debate on the increasing interest being shown in the idea that a sizeable proportion of men with type 2 diabetes suffer from hypogonadism and that they are likely to benefit from the use of testosterone supplementation. He suggests that there is an unmet need which causes non-specific symptoms and which we need to go looking for. The committee of ABCD is now considering whether ABCD should release a consensus statement on this important issue. There does not seem to be enough data to support a position statement on this yet.

NICE

ABCD continues to provide evidence for NICE, and is currently requested to work on the technology appraisal on Clopidogrel and dipyridamole for the prevention of occlusive vascular events, and has worked on the Levemir technology appraisal. We want to provide the evidence which is representative of the practice and expertise across the UK, and will seek best opinion from the membership, and we will be asking our regional champions to help identify possible experts for future appraisals.

AUDIT

The 2009 ABCD audit has been won by Dr John McKnight with an audit of Inpatient Diabetes Care across NHS Lothian and a large centre in England, "The effectiveness of the use of information technology, the Scottish Patient Safety Programme and Think Glucose".

This will identify patients with diabetes. It will audit the frequency of blood glucose measurement at the initial point of assessment, the frequency the diagnosis of diabetes was mentioned in the referral letter from primary care in those cases admitted to hospital via this route; how often the diabetes team is involved in the management of these individuals and whether or not this affects outcomes. The audit will also look at glucose management in hospital, length of stay, patient safety and satisfaction following the introduction of 'Think Glucose' methodology.

HbA1c for diabetes diagnosis: is it all it seems?

Eric S. Kilpatrik

The findings of the International Expert Committee on the role of HbA1c in diabetes diagnosis was presented to the ADA conference in June 2009 and their report was published in Diabetes Care the following month.[1] The Committee (comprising members appointed by the ADA, EASD and the IDF) recommended that diagnosis in type 2 diabetes should now usually be made solely on the basis of an HbA1c confirmed to be ≥6.5%, without the need to measure a plasma glucose concentration in the subject. It now falls on national and international diabetes organisations to decide whether this is the most appropriate means of establishing the presence, or otherwise, of the disease. This article summarises the advantages of using HbA1c but also focuses on the problems that such a move could present.

Advantages to using HbA1c to diagnose diabetes

The Expert Committee document highlights many of the advantages to using HbA1c. These include the undoubted benefit of being able to test in the non-fasting state. Also, the biological variability of HbA1c within an individual is somewhat smaller than that of fasting glucose and considerably less that of 2 hour glucose (CV 3.6% vs. 5.7% vs. 16.6% in one study[2]), so it should be possible for repeated measurements to be more consistent using HbA1c. There is also the argument that, by giving an estimate of glycaemia over the preceding few weeks or months, HbA1c could provide a more complete view of glycaemia than a one-off fasting glucose or the artificial conditions of an OGTT. HbA1c measurement is also the most common means of guiding management and adjusting therapy, so its use for diagnosis would simply be an extension of this role.

One of the main hurdles previously to even considering using HbA1c for diagnosis has been the lack of standardisation in the assay, meaning that results could vary depending on the particular laboratory method used. Now that this is being addressed through IFCC standardisation this particular reservation should now be less of an issue.[3]

Disadvantages to using HbA1c to diagnose diabetes

Given these advantages, it would appear that the case to move to HbA1c for this purpose is a compelling one. However, there are also some real problems which could be encountered in any wholesale move to this means of diagnosis. Indeed, the Expert Committee authors accept many of the inherent problems there can be in using HbA1c for diagnosis but do not discuss the practicalities that the limitations are likely to cause. For example, we know that while one HbA1c instrument might be able to identify and account for certain haemoglobinopathies but not others, a different analyzer could pick up (or miss) a completely different spectrum of abnormal haemoglobins. Just how, therefore, are we going to be sure that someone does not have a haemoglobinopathy which is causing them to be diagnosed (or not) inappropriately? In patients already known to have diabetes, the NIH recommend being mindful of this possibility in people of African, Mediterranean or Southeast Asian heritage, citing that this should be considered when glucose measurements are discrepant to that of HbA1c, when the HbA1c result is unexpected, when the result is greater than 15% (sic) or when a value changes drastically following a change in laboratory method. But if HbA1c is the sole means of diagnosis and there is encouragement not to self-monitor glucose until insulin treated how, without concurrent haemoglobinopathy screening, will we identify many of these patients?

Do we also need to exclude the common condition of iron deficiency anaemia, where the HbA1c can be 1-1.5% higher than usual,[4,5] coming down after iron treatment? Should we actively be eliminating the possibility of haemolytic anaemia in anyone we want to test? What about patients with renal failure, which can cause a variable effect (through haemolytic and iron deficient processes as well as the formation of carbamylated haemoglobin) on HbA1c, as well as conditions such as HIV where HbA1c appears 1% lower in patients on treatment? The Committee authors breeze over the effect of ageing (0.4% higher in 70 rather than 40 year olds apparently despite the same glucose tolerance)[6] and ethnicity (0.5% higher in afro-caribbeans than caucasians)[7] because their 'etiology and significance are unclear'. So in the meantime we do not know if we will be wrongly singling out the elderly and non-caucasians subjects to be diagnosed with the condition.

Even the move to IFCC standardisation and numbers, although necessary for a number of reasons, will not instantly bring with it an improvement in assay performance either. Instead, if an analogy is made between lab HbA1c analysers and wristwatches, then IFCC standardisation is the equivalent to setting our watches to an atomic clock rather than the Big Ben of DCCT/NGSP harmonisation. However this, in itself, does not make our watches immediately more accurate. And so, as recently as June 2009, UKNEQAS found that the spread (±2SD) of HbA1c values around 6.5% (48mmol/mol) amongst 251 UK labs was anywhere between 5.8 and 7.2% (40 and 55mmol/mol). Not to mention, from a global perspective, that this performance is what is able to be achieved in a developed country with the both the resource to measure HbA1c and over a decade of method harmonisation.

Suddenly these issues, and the potential list of tests required in addition to the 'simple' HbA1c, seems to make the idea of just fasting overnight for a glucose test much more appealing.

There also remains the concern of how well HbA1c compares with glucose in predicting microvascular risk, even after excluding subjects where HbA1c measurement is likely to pose a problem. The main figure in the Report shows three studies (Pima Indians, Egyptian and NHANES populations) demonstrating that the risk of retinopathy increases with rising FPG, 2hr glucose and HbA1c levels at roughly the same decile, inferring that the tests are interchangable. However, this would be expected within a population no matter how poorly one of the tests predicts risk compared to another. What is not mentioned is that in all three studies ROC curves show fasting and/or 2hr glucose measurement (with all its inherent biological variability and poor GTT reproducibility) to be superior to that of HbA1c. Before considering any change, we also need to know how the current WHO recommendation of measuring 2hr glucose in IFG patients (as practised in many countries) compares to that of solely measuring FPG or HbA1c.

Lastly, there is the cut off of 6.5% itself. A prelude publication to the Expert Committee Report looked towards HbA1c to help reduce the time between diabetes onset and diagnosis and to pick up the third of patients who have diabetes but do not know it.[8] According to NHANES data, 50-60% of patients with a FPG≥7mmol/L will have an HbA1c <6.5%, which actually adds patients to this missing third as well as delaying the time to diagnosis for most when compared to current criteria.[8] What this also means is that, for subjects where it is already known that HbA1c measurement will be unreliable, the use of glucose criteria will presumably make them 2-3 times as likely to be diagnosed as having diabetes as someone where HbA1c can be used. And what of a person with a fasting glucose of 10mmol/L and an HbA1c of 6.4% (47mmol/mol)? Will they have diabetes or not?

Measuring fasting and 2hr glucose values to diagnose diabetes has its own well documented limitations but, for reasons including those described here, there may be less risk that these measurements could lead to an individual subject being completely misdiagnosed in the way that HbA1c potentially can. The hope is that there is much further discussion before decisions are made by the ADA, EASD, IDF and WHO about the merits of an 'HbA1c-only' approach.

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The Stockholm marathon experience

We made it! After months of 'hard' training we completed the Stockholm Marathon on the 30 May 2009. It was a great personal achievement and what made it even more worthwhile was the fact that we raised just over £1000 for the ABCD Charitable Trust. Since we both work in diabetes and endocrinology we wanted to raise money for a charity that aims to improve the quality of care provided within this speciality. We would like to say a huge thanks to everyone who sponsored us.

Running through a picturesque city like Stockholm was without a doubt a wonderful experience. Although, after about 25km in 28-30C, it was somehow difficult to appreciate the beautiful surroundings! Seeing the finishing line at 42km was definitely the highlight of the day. Was it worth it? Yes absolutely. Would we do it again? That remains to be decided. Raising money for charity is always worthwhile and our fitness level is now better than it has been for years. Overall, it has been an unforgettable experience and we would highly recommend it. The ABCD Diabetes Trust is now registered on the justgiving.com website.

Thanks again to everyone who sponsored and supported us.

Monika & Rachel

Dr Monika Reddy & Dr Rachel Troke, SpRs in Diabetes & Endocrinology

ABCD MEMBERSHIP APPLICATION

Membership of ABCD is open to all Consultant Physicians with an interest in diabetes patient care in the NHS and all SpRs in Diabetes and Endocrinology. At present, the annual membership fee is £50. If you are interested in joining the Association, please write to the ABCD Membership Secretariat at the following address with your contact details, professional qualifications and your current post title.

Elise Harvey, ABCD Secretariat, Red Hot Irons Ltd
PO Box 2927, Malmesbury SN16 0WZ
Tel: 01666 840 589
email: eliseharvey@redhotirons.com

When your application has been approved, you will be sent a Standing Order form for your annual subscription.

Royal College of Physicians
and
Association of British Clinical Diabetologists

DIABETES - A HOSPITAL PERSPECTIVE

Tuesday 26 January 2010

at the Royal College of Physicians,
11 St Andrews Place, Regent's Park, London NW1

Over 10% of NHS beds are occupied by patients with diabetes, representing a major burden of care. These patients have a variety of clinical problems, including coronary syndromes, stroke, foot ulceration and acute metabolic emergencies. Their management is often complex, and duration of admission frequently prolonged. This conference brings together a group of speakers with wide experience and expertise, who will define and discuss the problems of in-patient diabetes care and explore potential improvements and solutions.

Audience: This conference is aimed at all those practising general medicine as well as consultants and trainees in diabetes, senior diabetes specialist nurses and interested GPs.

09.30	*Registration and coffee*
09.55	**Opening welcome and remarks** Professor Ian Gilmore, President, Royal College of Physicians Dr Peter Winocour, Chairman, Association of British Clinical Diabetologists Chair: Dr Peter Winocour *(Conference co-organiser)*
10.00	**The burden of in-patient diabetes.** **Setting the scene and meeting the challenge** Dr Rowan Hillson MBE, National Clinical Director for Diabetes, Department of Health
10.40	**The status of in-patient diabetes care provision** Professor Mike Sampson, Consultant Physician, Norfolk and Norwich University Hospitals NHS Foundation Trust
11.20	Coffee
11.40	**In-patient diabetes nursing - an underused resource** Maureen Wallymahmed, Diabetes Nurse Consultant, Aintree University Hospitals NHS Foundation Trust
12.20	**Managing diabetes-related metabolic emergencies** Dr Mark Savage, Consultant Physician, Pennine Acute NHS Trust
13.00	Lunch
	Chair: Professor Geoff Gill, Chair, RCP Joint Specialty Committee for Diabetes and Endocrinology *(Conference co-organiser)*
14.00	**Insulin, hospitals and harm** Dr John Scarpello, Deputy Medical Director, National Patient Safety Agency

14.40	**Diabetes footcare in hospital!** Louise Stuart, Consultant Podiatrist, NHS Manchester and Dr Gerry Rayman, Consultant Physician, Ipswich Hospital NHS Trust
15.20	Tea
15.40	**Effective perioperative diabetes care** Dr Daniel Flanagan, Consultant Physician, Derriford Hospital, Plymouth
16.20	**Acute illness and diabetic control** Dr Maggie Hammersley, Consultant Physician, John Radcliffe Hospital, Oxford
17.00	Close of conference

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