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ABCD Newsletter

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EDITORIAL

What a year

Mark Savage
Editor, ABCD newsletter

It is difficult to know where to start with this edition of the newsletter. Elections, a hung (or balanced) parliament; another English NHS reorganisation (groan), new agents for diabetes, including new insulins; and the loss of the InnoLet device and Mixtard 30.

We have also recently heard that we need to say goodbye to what might have been an old friend, rosiglitazone. After all the expectation that the PPAR-gamma agonist class would be the start of a new era of more effective therapies for type 2 diabetes – GSK have now withdrawn it. How are the mighty fallen and physicians humbled.

I am sure most members saw the *Panorama* programme and will have been somewhat concerned about the serious issues raised. Personally, the under-resourcing of the regulatory authorities, and their consequent inability to examine the raw data from studies (a surprise to me), is a major concern that, even in these financially difficult times, must surely be addressed.

Future trials may have to be set up, run and interpreted independently of the sponsoring pharmaceutical company whose product is under investigation.

Some commentators have argued that any new medications should show benefit over existing therapies before being licensed. All well and good but this might open a big can of worms: how does one define benefit? On one hand one could insist on there being evidence of cardiovascular benefit, and on the other benefit of glucose reduction (safely) *per se* should reduce microvascular complications. And we do really need some treatments that do not cause hypoglycaemia, weight gain, and which are safe to take in renal and liver failure. So baby and bath water come to mind; although we are inevitably entering a new era of stricter licensing of newer agents. Healthy scepticism after this debacle will be applied by most to the DPP-4s, SGLT-2s etc; however, this is probably a good rather than a bad thing.

ABCD is once again closely involved with the inpatient audit co-ordinated by Gerry Rayman on behalf of NHS Diabetes (England) and once again the Celtic nations are contributing. We in Manchester were not too disappointed with our rankings but, like most have a long way to go before we have anywhere near a system that is ideal. The closing of the loop is a major challenge for all of us, but not as challenging as getting the resource to improve the service.

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A report from the Association of British Clinical Diabetologists (ABCD) Spring Meeting

Hilton Newcastle Gateshead, 7 May 2010

Welcoming participants to the 27th ABCD meeting, Chair Dr Peter Winocour (Queen Elizabeth II Hospital, Welwyn Garden City) described the Gateshead venue, with its sweeping vista over the Tyne, as probably the most scenic venue for an ABCD meeting.

ABCD wants to be fully engaged with the NHS Diabetes Research Network, Dr Winocour said, and members want to know more about its work. He introduced its Director, Professor Des Johnston, who described the new research environment in the NHS, and the policy drivers behind it.

The role of the diabetologist in fulfilling the research aspirations of the NHS

Since 2003, health policy has recognised the value of clinical research for patient outcomes and the UK economy, Professor Johnston said, culminating in the 2006 *Best Research for Best Health*, which established the current strategy for R&D in the NHS and created the National Institute for Health Research (NIHR).

Clinical research networks and centres form the infrastructure through which the NIHR supports and facilitates research. Diabetes was among the topic-specific networks established to direct research to priority areas (see www.ukdrn.org). There are eight local diabetes research networks and diabetes specialty groups extend coverage throughout England. Local research networks provide resources to primary and secondary care, funding consultant and GP sessions, staff (research, managerial and administrative) and other costs (*eg* pharmacy).

Recent policy initiatives have reaffirmed the benefits of research for NHS patients. NHS providers will soon be required to include in their quality accounts the number of patients recruited for clinical research and Strategic Health Authorities will state how they have supported NIHR and facilitated collaboration with the NHS.

A model of foot care in the community for people with diabetes

In the past 15 years the number of patients needing foot care has doubled but the number of podiatrists has not changed. The key to targeting resources to patients with the greatest need, said Dr Graham Leese (Ninewells Hospital, Dundee), is to change the culture from foot examination to risk stratification, invest in education and training for podiatrists, rationalise antibiotic use, improve links between out-of-hours services and diabetic foot services, and develop consistent patient information.

In Scotland, the proportion of patients with recorded foot screening has increased from 25% to 55% and recent years have seen declining rates of ulceration and amputation. There is now funding for a national co-ordinator for diabetic foot services and a national plan envisages support for developing local foot networks, increasing foot screening to 75% and developing accredited training programmes for specialist skills.

National Diabetes Information Service

The purpose of the National Diabetes Information Service (NDIS) is to make the information held by the NHS useful to the people who are running its diabetes services, explained its Clinical Lead, Dr Bob Young (Salford).

Via its portal (http://ndis.ic.nhs.uk), NDIS offers online analytical and reporting tools for health needs assessment, comparative performance analysis and health service activity. Examples of the type of analysis possible include comparing diabetes complication rates between health economies, assessing local risk factors for complications and comparing the performance of PCTs. Reports now online include the Diabetes Patients Experience Project, the National Diabetes Audit, and the Prescribing for Diabetes in England data. More on foot care, pregnancy, and diabetes in children and young people, are in development.

ABCD debate: this house believes that every obese male patient with type 2 diabetes should be screened for hypogonadism

Proposing the motion, Professor Hugh Jones (Barnsley) said the NICE guideline on type 2 diabetes recommends annual review of erectile dysfunction in men with diabetes. Anyone who adheres to the guidance is screening for hypogonadism, he argued.

Erectile dysfunction is increasingly common with age in men with diabetes, and the prevalence of hypogonadism and low testosterone levels is significantly higher in these patients than the general population. Low testosterone is associated with raised levels of cytokines, severity of atherosclerosis, modifiable cardiovascular risk factors and an increased risk of death.

International management guidelines recommend that men with diabetes who have erectile dysfunction should have their testosterone level measured. Testosterone replacement improves hypogonadal symptoms including erectile dysfunction, reduces body fat and improves insulin resistance and glycaemic control in men with type 2 diabetes.

The main argument against the motion is the lack of evidence for testosterone replacement from randomised clinical trials, said Dr Richard Quinton (Newcastle). The putative benefits of testosterone replacement are derived from observational studies and history has shown this is unreliable.

In the 1980s and 1990s, large observational studies provided apparently strong and consistent evidence that HRT reduced mortality in women. Only with randomised intervention trials did it become clear that HRT actually increased the risk of some cancers and cardiovascular events. We face a similar scenario with testosterone replacement therapy, Dr Quinton warned and, given the fundamental lack of evidence for treatment, it is wrong to advocate screening for hypogonadism.

Before the debate, the majority of the audience were against the motion, with eight for and three abstentions. Afterwards,

the motion was overwhelmingly defeated but the number for the motion had increased to 11, with three still abstaining.

Endocrine disorders

Aldosterone exerts multiple cardiovascular effects, said Professor John Connell (Dundee), outlining the role of the adrenal cortex as a cause of secondary hypertension. Summarising the management of primary aldosteronism, he said that imaging may identify an adrenal adenoma, for which surgery should be considered. Equivocal or normal imaging may indicate glucocorticoid-remediable disease, which can be confirmed by adrenal vein sampling. The options for treatment are unilateral adrenalectomy for adenoma or drug therapy, including glucocorticoids, aldosterone antagonists (eplerenone, spironolactone) and high-dose amiloride.

Describing the referral pathways for neuroendocrine tumours, Dr Andy James (Newcastle) said that carcinoid tumours are the commonest presentation seen by endocrinologists. In Newcastle, the multidisciplinary Neuroendocrine Tumour Service, supported by laboratory and radiology services, offers a multimodal approach to management that includes embolisation, surgery, systemic chemotherapy and radiotherapy. Somatostatin analogues relieve symptoms, reduce circulating hormones and stabilise tumour growth in more than half of patients. For the future, new PET ligands will deliver substantial improvements in imaging and radiolabelled somatostatin analogues are expected to improve targeting of treatment.

ABCD clinical audits

The ABCD nationwide audit of combined treatment with exenatide and insulin represents real-world clinical use and all its problems, said Dr Bob Ryder (Birmingham).

The audit findings on weight loss and glycaemic control have been announced at earlier meetings. Dr Ryder completed the presentation of the first analysis of the data by reviewing the use of exenatide and insulin in combination.

A total of 2257 patients (37%) were treated with the combination. Overall, it was considered safe and effective. Of 1584 patients who continued insulin after starting exenatide, 201 (12.7%) discontinued insulin, achieving significant weight loss (10kg), but weight loss also occurred in patients continuing insulin.

Mean HbA_{1c} fell by 0.81% but worsened in half of patients; risk factors were lower baseline HbA_{1c} and greater three-month weight loss. This suggests that insulin not be stopped when exenatide is initiated but tapered off in appropriate patients. Only one case of severe hypoglycaemia was reported.

Dr Gerry Rayman (Ipswich) presented data from the 2009 National Inpatient Audit Day, providing a snapshot of diabetes care of 14 259 patients in 219 UK hospitals. About one-third of patients were aged over 80 and more than a third used insulin. During their hospital stay, over a third of those taking insulin experienced a treatment error and one quarter experienced more hyperglycaemia than usual. Fewer than one-third of patients could recall having a foot inspection and about one in 30 developed a foot complication while in hospital.

The data show that we are not doing very well, Dr Rayman concluded. Although patients' experience of hospital was often not bad, about one-sixth described it in negative terms. This information should be used to benchmark services and negotiate service improvements, with re-audit to drive change.

Understanding the curability of type 2 diabetes

Is the progression of type 2 diabetes inevitable? asked Professor Roy Taylor (Newcastle). His research suggests a surprising answer.

Accumulation of fat in the liver is one of the earliest changes associated with type 2 diabetes, he explained. There is wide variation between individuals in the extent of intra-organ fat that precipitates type 2 diabetes, but everyone with type 2 diabetes has excess liver fat.

Excess fat in liver and muscle inhibits the action of insulin, resulting in raised glucose production. Studies in patients undergoing severe calorie restriction show that marked weight loss is associated with normalisation of glycaemic control. However, this gain has been documented in the first four weeks after gastric bypass surgery – before weight change occurs – because sudden calorie restriction is associated with a rapid increase in insulin sensitivity.

A negative calorie balance will normalise plasma glucose at a rate proportional to the energy deficit. Professor Taylor's research has shown that a diet providing 600 kcal/day reduces liver fat by 30% within seven days, with normalisation after six weeks. Fasting plasma glucose falls to within the normal range after one week and stabilises thereafter. These findings suggest that type 2 diabetes may be reversible, he said, though further work is needed to determine the implications of this research for clinical practice.

ABCD WEBSITE AND NATIONWIDE AUDIT

Message to all liraglutide users: please contribute your patient's data to the ABCD prospective nationwide liraglutide audit. A useful tool is provided free which will allow you to monitor and analyse data on your own patients and also easily contribute their data to the nationwide audit: http://www.diabetologists.org.uk/liraglutide.htm

Website (www.diabetologists.org.uk): Keep an eye on the noticeboard for the latest information. Powerpoint presentations from ABCD meetings can be downloaded from the members only, password-protected, website. A complete database of ABCD members is held there. Please check your details are up to date. Any member can easily use the Sharepoint technology to set up a nationwide audit.

ABCD website officer, Bob Ryder, can supply user name and password for the members-only website and advise on the above. Tel: 0121 507 4591 Email: bob.ryder@swbh.nhs.uk

Chairman's report

Diabetes in the age of austerity

We are slowly witnessing the impact of the 'difficult decisions' the new coalition government has to make. As far as healthcare, and specifically diabetes, is concerned it still feels a bit like a phony war, although I am aware of murmurings of service cuts in Merseyside. I suspect we ain't seen nothing yet. The government spending review in October may make matters clearer but I think when the dust settles in 2011, the proverbial may hit the fan.

Is diabetes managed cost-effectively? Mr Clegg has asked public service workers for help and perhaps ABCD should let him know. We all must recognise there is poor use of resources in the NHS – duplication of investigations, projects of dubious value, non-jobs and bureaucratic waste. Continued use of therapies that have ceased to benefit patients is a consideration we need to raise awareness of. Diabetes ring fenced budgets could enable us to shift such savings to the services and therapies we need to introduce earlier in the care pathway.

My local integrated diabetes service has been 15 years in the making and is plodding along towards something more concrete in the autumn. One famous royal once said, 'There were three people in the marriage' – but our healthcare system has to contend with an even more cluttered state of affairs involving the acute trust management and clinical teams, the provider and commissioning arms of the PCT, and the practice based commissioner GPs – all with different agendas and expectations.

A good example of how inefficiencies develop relates to a problem which I suspect is not uncommon. Post-Darzi Care Closer to Home has encouraged discharge of up to 1000 patients in some localities from acute trust diabetes clinics to new service provision in the community by either consultant or community DSNs.

Consultant-only service provision will inevitably have less capacity than hospital-based services providing training for CT2 and ST3 posts, but some commissioners have used financial imperatives to transfer to less expensive community models than tariff based care and advised that there is no room for training registrars, with concern that consultants may skive off and leave it to their juniors. The consequence is that community clinic capacity is less than 50% of the hospital clinic it has replaced.

It's déjà vu all over again

The new Secretary of State for Health, Andrew Lansley, has indeed suggested that GPs hold the key to the cost-efficient running of the NHS as I predicted (Autumn 2009 newsletter – Issue 15), and is going full steam ahead with GP mega-fundholding and the abolition in time of PCTs and SHAs. It seems clear to me that a tiny number of entrepreneurs aside, many GPs naturally think small and want to do the best they can for their patients within their practice – essentially this could prove to the disadvantage of others. Diabetologists by contrast should provide support throughout the local population.

The concept of services being devolved to practices and, God help us – to individual patient budgets, will, to my mind, yet again ensure wasting of time and energy, as well as precious financial resources, rather than the need to budget for the wider sector. Without specialist engagement in this planning process this 'new' approach to purchasing of healthcare clearly is doomed to fail. The NHS Alliance, who ABCD have worked with, has again recently emphasised this need for collaboration but there seems little evidence that commissioning PCTs can grasp the need to engage local specialists in the process, despite the efforts of the Teams without Walls project led by RCPL, RCPGP and RCPCH.

New blood, new roles

Our ABCD committee is rapidly evolving and expanding. Following the Gateshead AGM we have created a new academic subgroup whose role will be to ensure position statements are set to rigorous standards and that any operational research and audit projects have the *imprimatur* of the group. They will also moderate the ABCD's input into training and examinations, and will hopefully act as a beacon to engage more closely with academic colleagues who we hope would want to be part of ABCD. The subcommittee is chaired by Professor Alan Sinclair, and supported by Professor Stephanie Amiel. As part of my drive to ensure new colleagues are on board we have established a younger academic position and I am delighted that Dan Cuthbertson from the University of Liverpool will be joining the committee.

I want to thank our Scottish and Welsh representatives Alan Jaap and Alan Rees who have stood down, and welcome Johnny McKnight and Aled Roberts to succeed them.

The recent committee election was well contested. I am delighted that Susannah Rowles was re-elected. Her energy and enthusiasm is much valued, possibly to be matched by Partha Kar, who was appointed to the young consultant post within five years of appointment. Ian Scobie has also joined us from the opposite end of the age spectrum – providing a degree of symmetry and a wealth of experience from his Deanery roles.

It appears there may have been a little dragging of heels centrally on revalidation. ABCD are keen to be well ahead with speciality aspects and Patrick Sharp, who led on this, has been co-opted to continue his role.

We would want to continue to work closely with YDF where the future of UK diabetologists rests, and I am sure that Marc Atkin will pass on the reigns to his successor from that organisation so we continue the link.

A further welcome development has taken place with Gerry Rayman taking on the role of specialist care champion with Diabetes UK. Gerry continues on the ABCD committee and I am confident his liaison will benefit specialist care.

ABCD spreading its wings

ABCD is a recognised specialist group and I was pleased that in addition to our ongoing close contact in England with the NCD for diabetes we were invited to support the National Clinical Director for Liver Disease. We have invited Mark Strachan from Edinburgh to advise on metabolic liver disease, overcoming what I feel can be a rather parochial four separate nation approach to UK wide issues.

ABCD input to the Specialty Certificate Examination continues – the exam entry in 2010 was dramatically higher with over 180 candidates. ABCD has recently met with the RCPL examination leads to ensure the 2011 exam supports its primary intention. The vast majority (although not all) specialist societies expressed the need to ensure post nominals were only awarded to successful candidates who were part of a UK training programme leading to a Certificate of Completion of Training (CCT). However, in so doing is recognition that this may disincentivise non-UK candidates and thus keep exam costs high.

The Map of Medicine (MoM) remains a challenge, with proposals for arbitrary yearly changes to a small number of pathways. Although RCPL has agreed to support and endorse the project through review of the pathways through the Joint Speciality Committees (JSC), this inevitably involves ABCD through our speciality society input to the JSC. MoM is an independent commercial organisation, and I remain troubled by the time and energy devoted freely by specialists to this endeavour. Despite that, we seem to end up firefighting released pathways on the web that have no legitimacy. A good case in point was the recent appearance of an MoM on insulin therapy which was reminiscent of a poor quality essay from a first year medical student project.

One major achievement over the last two years has been the output of Joint British Diabetes Societies (JBDS) chaired by Maggie Hammersley. Along with Diabetes UK and the Diabetes In Patient Nurse network, ABCD have agreed future funding to complete the work programme of JBDS.

I am also representing ABCD on a different Joint British Society – the JBS on CVD prevention is developing JBS3 – this will separate CVD risk of type 1 from type 2 DM, develop the concept of lifetime risk, and most importantly provide revised visual information for patients to help their decision making.

Best practice or evidence based practice?

In the coming months two important ABCD position statements will be published, one on male hypogonadism in type 2 diabetes and the other looks at the use of the HbA_{1c} assay for the diagnosis of diabetes. Both areas are controversial and I hope the papers will offer a pragmatic current perspective while more research is carried out in these areas.

A recent editorial by Edwin Gale in *The Lancet* put the politics of guidelines under the spotlight. The issue was whether new guidelines which are variations on a theme offer anything new, and how best to secure their uptake by healthcare professionals. A more provocative article appeared in *Diabetologia* at the same time, casting doubt on the role of the expert consensus committee (it was by another expert consensus group!)

HbA_{1c} is a good case in point of the difficulties alluded to. A decision was made by an earnest body representing the EASD and ADA over one year ago, yet a WHO report is still awaited and I feel will be unable to support a comprehensive role for HbA_{1c} for diagnosis of diabetes without glucose confirmation. Our ABCD position statement is at odds with the recommendations of the EASD and ADA and is endorsed by the Association of Clinical Biochemistry. Who is right?

I feel the answer is that the current uncertainty is due to a fundamental difference between the findings of carefully constructed academic research using one central lab and the inherent analytical and biological issues affecting the assay. Looking to over-ride legitimate issues on either side of the argument is certainly not serving the interests of patient welfare. ABCD has suggested that after stratification of diabetes risk using a simple risk score, HbA_{1c} results can be used to rule in and rule out those with and without type 2 diabetes, leaving a more manageable number who require clarification using standard glucose criteria.

One current concern I have relates to linking glycaemic control and macrovascular outcomes. In the USA the FDA's stance seems to have bypassed the notion that we use hypoglycaemic agents to reduce microvascular disease and promoted the need for CVD outcome studies to justify licensing. However, the impact on macrovascular disease due to lowering glucose may require sample sizes of many thousands lasting at least 10 years, at prohibitive cost.

Meanwhile we know from DCCT, UKPDS and ADVANCE that standard hypoglycaemic therapy can reduce the development and progression of microvascular disease. We must ensure well designed studies with gliptins, GLP-1 analogues SGLT-2 inhibitors examine renal and retinal outcomes.

This is even more important when reviewing the recent National Diabetes Audit on renal failure and new registrations of blindness which suggest that in the UK we may not be making the impact on these critical microvascular end points.

It may prove more possible for national and international consensus on inappropriate or dangerous practice so at least we don't do harm. We could perhaps start using the findings from ACCORD to recommend an end to efforts to rapidly improve glycaemic control in those older type 2 DM with established CVD who are clearly unable to deal with intensive dose adjustment and focussed self management.

Back to the future

Remember the human v animal insulin and U100 conversions? The withdrawal of Mixtard 30 is this year's administrative reconfiguration – will this prove to be purely transfer to another premixed insulin or many accidents waiting to happen? The reality is that every shift carries casualties – our role is to minimise this and ensure that people receive appropriate support as outlined in our ABCD position statement on Mixtard withdrawal, not least as many patients on Mixtard 30 are often the most vulnerable. The loss of InnoLet even for new insulins remains a surprise and disappointment to me. As an organisation we must strongly support the need to ensure human insulin is not replaced with analogues by stealth.

There is much ahead for ABCD over the next 12 months, not least a major change in our executive, which is due to change at the May 2011 AGM. I will elaborate more in the Spring newsletter. You may or may not agree with the renowned Scottish 'poet' KT Tunstall who sings of the 'beauty of uncertainty' , but as an NHS employee you should have become inured to it.

Peter H Winocour, Chairman

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.

Meet the committee – Partha Kar

Dr Partha Kar trained in the Wessex region between 2002–2008. He did his MD looking at the effects of flavonoids on endothelial function and markers of inflammation under the guidance of Professor Michael Cummings. He joined Portsmouth Hospitals NHS Trust in August 2008. Since August 2009, he has taken over as the clinical director of the Diabetes/Endocrine department. In this role, he has been championing the cause of inpatient diabetes care, as well as being involved in negotiations with PCT/GP leads to re-model diabetes and endocrine care in his locality. He has also been appointed the Trust Clinical Lead for the Emergency Stream, focusing on LOS and delayed discharges.

His main area of interest is around pituitary disease and he runs a clinic for patients with pituitary disease in conjunction with the neurosurgical team based at Wessex Neurosurgical Centre, Southampton. He also leads the Young Persons Clinic in diabetes, which occurs once a month with the paediatric diabetes team. In addition, Dr Kar holds general diabetes and endocrine clinic in peripheral/community sites based at Gosport and Fareham.

As a registrar, Dr Kar was chair of the YDF and SpR representative on ABCD committee. He continues to maintain close links with both organisations and is a strong advocate for supporting trainees to help develop training and future jobs. He takes a keen interest in education and holds the role of college tutor in Queen Alexandra Hospital, Portsmouth, developing G(I)M training for specialist trainees in all medical specialties.

His other interests include cricket, football and socialising (an activity vouched for by many of his colleagues and peers!).

Message regarding the NaDIA

The first National Diabetes Inpatient Audit (NaDIA, new name to distinguish it from the National Diabetes Audit [NDA]!) was very successful in raising the awareness of inpatient diabetes care and engaging diabetes teams. The feedback has been extremely positive and we have had many examples of improvements in service following the audit. We hope such improvements will continue as the audit cycle is repeated.

The first audit was very much a pilot. We have learnt a great deal and in the light of this, and your feedback, we have improved the audit forms making the data easier and quicker to collect. Ambiguous questions have been removed and electronic data capture will make analysis and return of the data to you much quicker. You will also be able to have your own forms back on an electronic database for you to analyse as you wish (*eg* speciality by speciality or ward by ward). This time we hope to be able to more reliably determine whether quality of care links to staffing levels. We will also be collecting information of service changes and innovations to determine whether these have resulted in improvements in those organisations that have introduced them. All very exciting!

We are delighted that so many have expressed enthusiasm to continue the audit cycle by taking part in this year's audit and that so many have already registered.

Some of you have suggested that you might skip this year. I am writing to encourage you not to do so as, although some of the questions are the same, thus allowing a degree of benchmarking with the original audit, only the newly designed forms will allow complete benchmarking in the future. If you skip this year, 2012 will be the first date by which you will be able to fully assess change in practice.

To register please contact Heather Stephens, the Diabetes Inpatient Audit Project Manager, at heather@innove.info. Gerry Rayman, National Clinical Lead for Inpatient Diabetes, NHS Diabetes, Gerry.rayman@ipswichhospital.nhs.uk. Tel: 01473 704183.

Association of British Clinical Diabetologists AUTUMN MEETING

18–19 November 2010

Friday 19 November

09.00 **Incretin based therapies in type 2 diabetes; present and future**
Professor Melanie Davies

09.45 **Making sense of cardiovascular outcomes in recent diabetes trials**
Professor Miles Fisher

11.00 **The ABCD debate: Dual blockage of RAS in type 1 diabetes should be standard for most patients with microvascular disease**
For the motion: Dr James Walker, Edinburgh/Against the motion: Dr Colin Close, Taunton

13.30 **Endocrine topic 1: Genetic testing for MEN-1 and MEN-2: who, where and when?**
Professor Raj Thakker, Oxford

14.10 **Endocrine topic 2: Endocrine and metabolic consequences of obstructive sleep apnoea (OSA)**
Dr Shahrad Taheri, Birmingham

14.50 **Revalidation in the NHS – how will it work?**
Dr Ian Starke, RCP London

15.50 **The surgical panacea for diabetes – facts, fictions and flights of fantasy**
Dr Jonathan Pinkney, Truro

For further details visit: www.diabetologists.org.uk