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ABCD Newsletter

The Official Bulletin of the Association of British Clinical Diabetologists

EDITORIAL

Amblyopia Diabetikais

Peter Daggett
Editor, ABCD Newsletter

Greek scholars among you will note that the word "diabetikais" is in the dative plural. The condition described therefore is not blindness of diabetics, something with which we are all familiar, but blindness to diabetics, a recently recognized affliction of hospital managers. Once thought to be uncommon, it is now seen increasingly often and is believed to result from exposure to the miasma in management offices. Epidemiologists tell us that the more senior the person affected, the worse the symptoms are. They include a belief that diabetes is not a real disease and that anyone can manage it, an insistence that there are in any case enough staff and a conviction that there is no point in investing for the future. In the final stages, there comes a Panglossian delusion that all will be well in the best of all possible worlds.

There is a closely related condition called ignoramus artifex saccaron* that causes diabetologists to be invisible to managers. What causes this? First, diabetes does not require any sort of practical procedures to be performed and since thinking is given a low priority in the NHS, our work is simply ignored. Second, the same people who consistently make a mess of diabetes are usually the ones with the time to sit on committees. They take the view that since they can do everything, specialist advice from diabetologists is not needed. Third, our patients meekly accept that dilettantes from another speciality must know what they are doing because they are consultants and never moan when the inevitable happens. Finally, diabetologists are too polite and rarely tell patients that their treatment by another specialist has been wrong.

continued on page 2

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INSIDE

Editorial: Amblyopia Diabetikais	1
ABCD future meetings (notice)	2
Highlights of the ABCD Autumn Meeting	3
Inhaled insulin on the way	4
Contribute to your ABCD website (notice)	4
Controversy: A series of unfortunate events	5
Glitazones with insulin (notice)	5
Chairman's Report	6
ABCD Membership Application Form	6

continued from page 1

Ten per cent of patients in hospitals have diabetes and a study presented at the last EASD suggested that when there is any heart disease the proportion increases to 70%. When diabetes is not managed properly, recovery from any associated disease, and therefore discharge from hospital, is delayed. This has serious economic and logistical consequences, but our specialty is still not given the resources to do what we know we can. To the tiro economist, the equation seems simple. If it is cheaper to prevent something than to deal with it once it has occurred, it makes sense to prevent it. Amblyopia diabetikais blocks that thought process. If diabetes services were given even 5% of the average hospital's budget, an expert could see every diabetic patient in every ward and advise colleagues in other disciplines how to treat them properly. As it is, the best that most of us can do is "fire-fighting". We are asked to come and rescue staff (and patients) from ham-fisted management when things are spiralling out of control. That usually occupies a bed for another three or four days, at a cost of up to £1,000. Since this happens frequently, the cost of a nurse specialist's salary would very soon be recouped, but this is never considered.

We and our teams, though, must bear some responsibility for the parlous state of diabetes care in most hospitals. We are so committed to looking after our patients, that we don't look after ourselves. Our nurse specialists are dedicated to their work and when one is ill or on leave, they work extra hard to fill the gaps. The result of their altruism is that those in authority do not perceive that there is a problem. When told by the doctors that help is needed to maintain a safe service, accusations of shroud waving are made. The only way to persuade hospital managers that there is a crisis is to prove that there is. Abandoning people would not however be acceptable to those who look after diabetic patients. This is known and as a result there is no imperative to appoint the extra staff who are needed. Burnout is the result and this does seem to be increasingly common within our specialty.

Is there a way forward? I think there is, but it will involve a combination of creative accounting and blunt speaking. If a department with an annual budget of £2 million were told by the chief executive to give up 1% of its budget, they probably wouldn't miss it. Most medium sized hospitals have three or four such departments and about £80,000 could be released. The average diabetes department has a budget of around £400,000 and, by intelligent reallocation of funds, a 20% increase could be achieved. That would allow us to increase staffing to a level that could cope with the increasing number of diabetic patients coming through the door every day. Blunt speaking will be needed, because chief executives and others will have to be told that diabetic patients who are not treated by experts will complain. Blackmail perhaps, but it might just work.

** For the illiterati, this means, "we ignore sugar experts"*

ABCD Spring 2005 Meeting

Wednesday/Thursday, 6/7 April 2005
The Majestic Hotel, Harrogate

PROGRAMME
Wednesday, 6 April

5.30-7.00pm	Annual General Meeting
7.00-8.00pm	The ABCD Lecture: Diabetes and Endocrinology : united we stand, divided we fall *(Professor John Wass, Secretary, Society for Endocrinology)*
8.00-8.30pm	Reception
8.30pm	Dinner

PROGRAMME
Thursday 7, April

9.00-9.45am	Update on indications for and limitations of continuous glucose monitoring systems *(Dr Steve Hurel, University College Hospital, London)*
9.45-10.30am	Pathophysiology and management of gastro-intestinal complications *(Dr Marie-France Kong, Leicester General Hospital)*
10.30-11.00am	Coffee Break
11.00am-12.30pm	The ABCD Debate: Insulin therapy should be the treatment of choice for type 2 diabetes complicated by CHD *(Proposer: Dr Miles Fisher, Glasgow Royal Infirmary; Opposer: Professor Simon Heller, Sheffield University Hospital)*
12.30-1.30pm	Lunch
1.30-2.15pm	Identification and management of diabetic Charcot neuroarthropathy *(Dr Matthew Young, Edinburgh Royal Infirmary)*
2.15-3.30pm	Survey of cardiovascular risk and treatment amongst UK consultant diabetologists - do we practice what we preach? *(Dr Peter Winocour, QEII Hospital, Welwyn Garden City)*
	Glargine use in Type 2 diabetes and pregnancy *(Dr Ian Gallen, Wycombe General Hospital)*
	Report on joint ABCD-Diabetes UK Working Party *(Dr Richard Greenwood and Dr Peter Winocour)*
3.30-4.15pm	A critical look at emerging therapies for diabetes *(Professor David Matthews, OCDEM)*
4.15-4.45pm	Tea - Close of Meeting

Further details from: Gilly Botte, Event Manager, ABCD, C/o Innervate Ltd, Golden Cross House, 8 Duncannon Street, London WC2N 4JF. Tel 0207 4845312, Email gilly@innervate.co.uk

ABCD AUTUMN MEETING
The Autumn meeting of ABCD will be held in London on Thursday 27th October, preceded by the British Thyroid Association at the Royal Free Hospital on Wednesday 26th October.

Highlights of the ABCD Autumn Meeting

Jurys Great Russell Street Hotel, London WC1, 11/12 November 2004

Chairman Richard Greenwood announced a record-breaking attendance of well over 100 at this year's Annual Autumn Meeting. Members met to debate the role of interventional radiology in the management of diabetic PVD and to hear state-of-the-art presentations on topics of interest to UK diabetologists.

SUCCESSES & FAILURES IN DIABETES CARE IN THE LIGHT OF THE DIABETES NSF

Peter Winocour (Consultant Physician, East and North Herts NHS Trust) and John Dean (Consultant Diabetologist, Bolton Diabetes Centre) gave their own takes on the reasons for failure and success respectively in diabetes care post-NSF. Dr Winocour said the ingredients for a poorly resourced and less effective integrated diabetes service were typically: a merged trust on two acute sites; an historically poorly resourced service; a single-handed senior consultant in post; several commissioning PCTs with ill-defined catchment areas; primitive IT in the acute Trust; a profusion of PCT-SHA middle management; public health doctors and SHAs not actively engaged with service providers; archaic OP department infrastructure, with no dedicated diabetes resource; Diabetes Implementation Groups without teeth; the new GMS contract; and influential informed GPs who are not representative of the majority of PC physicians.

Dr Dean described an integrated diabetes care service in Bolton, an area with 10,500 people registered with diabetes and 55 general practices, of which 80% offered structured diabetes care and 96% were included in an "integrated diabetes information system", managed by the single PCT. Three-quarters of the diabetes patients were treated solely in primary care (PC). A community-based Diabetes Specialist Team, operating from the off-site Bolton Diabetes Centre, managed the remaining 25%. The aim was to reduce this to 15%. District-wide patient and professional education and screening programmes were in place, together with specialist clinics and a 24-hour specialist advice line.

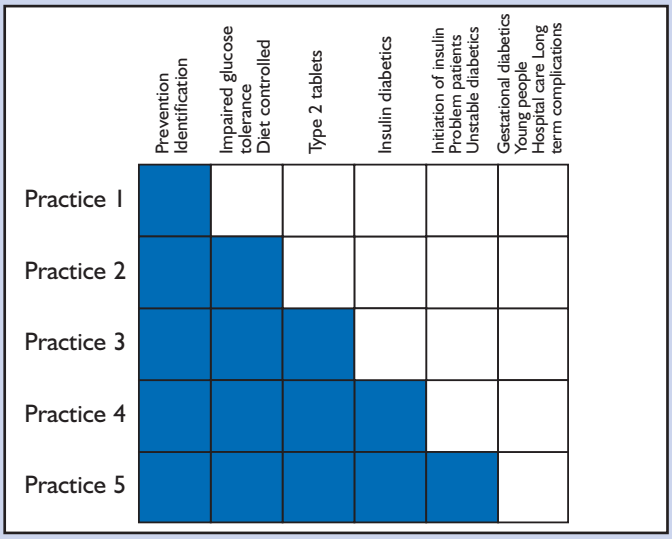

Figure 1. Defined levels of provision by practice in Bolton *(Dean)*

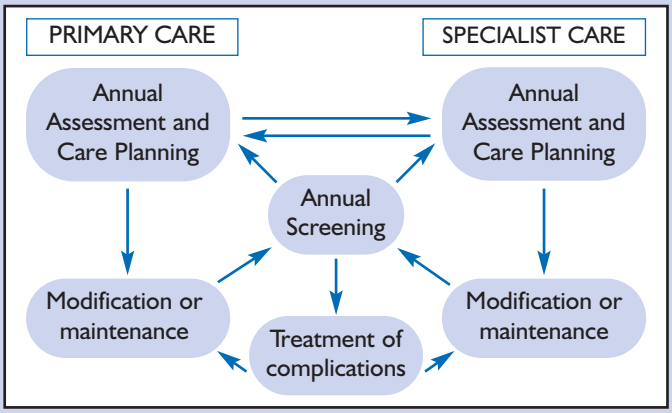

Figure 2. Agreed pathways of care in Bolton *(Dean)*

The objectives of the service were: avoidance of gaps or duplications in service; smooth and quick referral from PC for advice; increased specialist input into PC settings; and consistent high-quality patient-centred care. A model for agreeing the levels of services provided by each practice and the specialist team is agreed and is being implemented as are agreed pathways of care (Figure 1 and 2). The LIT had been delegated responsibility by the PCT so had teeth and oversaw all aspects of the Diabetes NSF. Staff had clear remits. The aim of this integrated approach was complete, local and consistent care by adequately trained professionals, access to specialist services when needed, being seen in the most appropriate setting, and involvement in planning and monitoring integrated care.

LONG-TERM FOLLOW-UP OF THE DCCT AND UKPDS COHORTS

Amanda Adler (Consultant Physician, Addenbrookes Hospital, Cambridge) said that at the end of the DCCT, 95% of patients had enrolled in the observational follow-up, the Epidemiology of Diabetes Interventions and Complications Study (EDIC). Three quarters of patients who had been receiving conventional therapy (CT) switched to intensive therapy (IT). After five years there was far less progression in the former IT than the former CT patients in retinopathy and microalbuminuria and former CT patients were more likely to develop hypertension than former IT. The full five-year results of the Post-Study Monitoring of UKPDS patients were soon to be announced but it was known that BG had remained fairly steady in the CT group but deteriorated in those formerly on IT. Blood pressure had also converged.

In the TRIPOD and 4-S study follow-ups, as with EDIC, the benefits conferred by particular treatments had been shown to continue long after administration of these drugs ceased. It could be argued that early treatment of BG is important, that early treatment is more important than later treatment and even that only early treatment is important. Hyperglycaemia had long-term but not acute effects on the underlying pathophysiology of microvascular complications and IT should be started as soon as possible. HCPs should treat abnormal values as vigorously as symptoms.

OTHER TOPICS COVERED AT THE MEETING

The ABCD Debate: "Interventional radiology should be the initial course of management in diabetic PVD", proposed by Trevor Cleveland *(Consultant Radiologist, Sheffield Vascular Institute)*, opposed by Malcolm Simms *(Consultant Vascular Surgeon, University Hospital, Birmingham)*, was carried by a large majority.

"Non-alcoholic fatty liver disease - current concepts and treatment strategies" *(Chris Day, Professor of Liver Medicine, University of Newcastle upon Tyne).*

"Managing gestational diabetes" *(Sean Dineen, Addenbrookes Hospital, Cambridge, and Robert Fraser, Senior Lecturer and Consultant Obstetrician, University of Sheffield).*

"Lipid-lowering therapy in diabetes post-CARDS - what more do we need to know?" *(John Betteridge, Professor of Diabetes and Endocrinology, University College Hospital, London).*

See also April 2005 issue of Practical Diabetes International for a more detailed report

Inhaled insulin on the way, but perhaps more questions than answers?

Ian Gallen, Wycombe General Hospital

The first inhaled insulin to be made available, Exubera® (Pfizer Sanofi-Aventis), is keenly awaited by our patients and the UK is likely to be the launch market. Many diabetologists are sceptical that inhaled insulin works reliably and this paper provides an up date, so that we can advise our patients, colleagues and commissioning bodies appropriately.

How does it work?

Each of the major pharmaceutical companies has its own inhaled insulin administration device, but Exubera® is likely to be the first available. A deep breath delivers insulin in dry powder form and the large surface area of the lung enables the large insulin molecule to cross from the alveoli by transcytosis. It is then released and taken up by endothelial cells to be released into the blood stream. After inhalation, about 20% is available for absorption, but given a sufficient inhaled dose, this is clinically effective. The onset of action is similar to that of analogue insulin after subcutaneous injections, with a duration of action which is between analogue and soluble insulin.

There are five steps to insulin administration. First, a ring pull extends the chamber. The dried insulin is inserted using a blister pack containing 1 or 3mg of insulin and the device is then pressurized using the handgrip. The blister is punctured and insulin is aerosolized into the holding chamber. A single large breath is taken from the chamber and held for about 10 seconds. If further doses of insulin are required, the process is repeated. The device, which has a life span of one year, must be cleaned weekly and the transjector changed every two weeks. We do not know how much it will cost yet.

Does it work, is it safe and do people want to use it? What does inhaled insulin do to the lungs? Is inhaled insulin effective, and what are the differences between inhaled and injected insulin regarding hypoglycaemia? Inhaled insulin produces cough in about 20% of subjects, but this reduces in frequency and intensity with time. In a short-term pilot study comparing inhaled and injected insulin in Type 1 and Type 2 diabetics, pulmonary function was generally unaffected. There was however reduced carbon monoxide diffusing capacity and this would be of concern if it continued to decline with prolonged treatment. The improvement in glycaemic control seen during six months treatment with inhaled insulin in both Type 1 and Type 2 diabetes is comparable with that seen using subcutaneous injections. There is a very small reduction in the frequency of hypoglycaemia events for both types of diabetes with inhaled insulin. Both Type 1 and Type 2 diabetics had improvements in treatment satisfaction on inhaled insulin. Most people who were previously treated with subcutaneous insulin and even those on tablet treatment opted to continue inhaled insulin at the end of the trial.

How much inhaled insulin is needed?

Inhaled insulin should be taken 10 minutes before eating. 1 mg equates roughly to 3 IU subcutaneous insulin and a suggested calculated starting dose is 0.15mg per kg/3 for each meal. In two recently reported studies, mean daily inhaled insulin dose was 14mg in Type 1 diabetes, and 17 mg in Type 2 diabetes. Dose adjustments are made in a similar way to those with prandial injected insulin.

Who might benefit, and who will get inhaled insulin?

If there were no cost, safety of efficacy constraints, most people with insulin-treated diabetes might like to try bolus inhaled insulin with their basal insulin. The amount of insulin required however is greater than for subcutaneous injection and the devices will not be cheap to make or maintain. This means that diabetologists will have to consider carefully who might benefit most from inhaled insulin. We can all identify a core of mainly Type I patients, who have poor glycaemic control and who would benefit from multiple daily insulin administration, but who do not want more frequent insulin injections. It is likely that such people will be the earliest to transfer to inhaled insulin, but what about people with Type 2 diabetes, who have reached the end of effective tablet treatment? Should inhaled insulin be the treatment of choice for those who are now started on once-daily long-acting insulin or twice-daily mixed insulin regimens? Many would say no, but if the patient choice outlined in the NSF means anything, this option will have to be offered. General Practitioners and more specifically their Practice Nurses are already very familiar with inhaled medicine for respiratory illness and could probably supervise inhaled insulin therapy. Diabetologists, though, would have to decide which patients were not suitable for inhaled insulin. They would include smokers and recent ex-smokers, people with significant lung disease and women who may become pregnant. The potential that inhaled insulin therapy offers to improve glycaemic control in children with Type 1 diabetes through reduction in the difficulties and embarrassment of injections away from home is also attractive and I hope that they will be offered this therapy with little regulatory delay.

Exubera® offers a novel and interesting new mode of treatment for our patients. Whether meaningful improvements in objective measures of patient outcomes are achievable remains to be demonstrated. It is likely that there will be enormous demand for inhaled insulin and people with diabetes are already trying to access Exubera®. As always, commissioners of health care worldwide will have to balance any increased cost against health and quality of life benefits.

CONTRIBUTE TO YOUR ABCD WEBSITE!

www.diabetologists-abcd.org.uk

Powerpoint presentations from the ABCD Autumn meeting can be downloaded from the website. Please contribute to audits of triple oral therapy, glargine in pregnancy and glitazones with insulin (see below). Also on the website are recently published position papers on Glitazones and Retinopathy Screening.

ABCD Website Officer, Bob Ryder, can supply user name and password for the members only website.
Tel No: 0121 507 4591 Email: bob.ryder@swbh.nhs.uk

CONTROVERSY

A Series of Unfortunate Events

David Levy
Whipps Cross University Hospital NHS Trust

"GPs with a special interest will take on new roles that have, until now, always been the exclusive preserve of hospital consultants - particularly in the area of chronic long-term illness."
(John Hutton, HSJ Conference on Practice Based Commissioning, 7 December 2004)

Diabetes and endocrinology is the most threatened medical specialty in the UK. I would be surprised if, after the onslaught of the next few years, many of us outside teaching centres remain in posts that bear the slightest resemblance to what we are doing at present. Some of us may have no jobs at all. Is this a wildly paranoid view? I don't think so: all the elements for a major change in the NHS in England have been quietly put in place over the past five years, with barely a whisper reaching professional, let alone public, consciousness. Alyson Pollock, in her recent book NHS plc, has unearthed many of the pieces of this distasteful jigsaw. You will remember the NHS Plan of 2000, which was uncritically endorsed by the medical great and good. It paved the way for the continued general enfeeblement of the profession via Bristol, Alder Hey, Shipman and the GMC. The NHS Plan allowed a raft of non-legislated changes to be initiated, almost imperceptibly but inevitably culminating in the unassailable moral high ground of "patient choice". The doctrine of "payment by results" will ensure that all acute Trusts will be fighting for their lives over marginal costs of routine elective procedures. The establishment of Practice Based Commissioning could prove the knockout blow to diabetes and endocrinology. It will ensure an internal and external market that will make its Thatcherite prototype look like a village car-boot sale. Into the resulting fragmented mêlée will come practitioners from abroad, lured by the commercial potential of £100 bn a year organisation, enabled and emboldened by EU and WTO/GATS rulings on liberalisation of trade barriers. The final collapse will be neatly topped off by the planned abolition of PCTs and SHAs. Et voilà, mes amis.

Might all this prove fatal for our specialty? Probably not immediately, because we will be tolerated for a few years while frenetic attention is lavished on really important specialties that bring in the Trusts' profits. Thereafter the microscope will fall on us, by which time most diabetes management will have been moved to the community. The repositioning of diabetes as a completely primary care-based specialty won't this time be the short-lived mess of the late 1980s: witness Mr Hutton's slightly chilling words. In areas where sufficient GP expertise can't be found, then big business will get the contracts. Specialists might just be tolerated, probably practising in out-of-town Diagnostic and Treatment Centres. OK, what about endocrinology? It barely registers on the management radar in most hospitals. Most general physicians in other specialties rather like managing the odd interesting case (not difficult, no procedures); the thyroid stuff is mostly straightforward (lumps can go to ENT); anything else could go to slightly expanded tertiary centres (quite a lot of it already does in London).

In desperation, then, what about acute general medicine? Surely we are safe there? No hope. The hordes of fast-tracked acute general physicians now in training, together with nurse practitioners and nurse consultants will take care of all that, thank you very much Dr Levy. And without your grumpy reluctance to deal with expedited discharges to embrace 98% 4-hour wait targets in A&E and to being resident on-call physician of the week. There may be exceptions - those apparently blissful partnerships like Bolton which we heard about at the November ABCD meeting - but there won't be many, and once the profit motive creeps in, even these might fray a bit at the edges. Many of us are still in uncomfortable, uncommunicative or frankly dysfunctional relationships with our PCTs. Time and the Department of Health's patience will run out, especially in NSF target territory (the whole of NE Thames, for example, has already openly declared it won't reach the 2006 retinopathy screening target; that'll make us really popular). We need a clear statement of our exceptional skills that places us where we should be: conducting our local diabetes orchestras. Not playing the back desk of the violas, while nodding sagely and accepting the priority of accessibility issues, customer care and patient choice. Diabetes is a subtle, infinitely variable and in all senses expanding syndrome. Like every specialty there is a core of routine simple stuff, but equally there is diagnostic difficulty, and hideously difficult management decisions to make in a life-threatening condition. There is also a truly brave new world of pharmacological agents and techniques out there. We must continue to lead the profession in this area and not be cowed by aggressive political sound bites. We are starting to get our act together now. If we don't get this right, we may well be done for and Count Olaf will finally have his evil way with the Baudelaire orphans' fortune.

David Levy
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GLITAZONES WITH INSULIN

Despite the CSM/MHRA reminder that glitazones are contraindicated in combination with insulin, many UK diabetologists have felt forced to offer this combination to selected insulin resistant patients because of the lack of an alternative. A letter of advice has been obtained from the Medical Protection Society about the legal position of such diabetologists. The CSM/MHRA reminder and MPS letter are published on the ABCD website. The MHRA advise is based on CSM Yellow Cards. To strengthen the alternative case members are encouraged to add cases of success with glitazones and insulin to the audit on the members only section of the website.

ABCD Website Officer, Bob Ryder

Chairman's Report

I am pleased to report that the Association continues to make steady progress towards the achievement of many of its objectives. Membership has now grown to well over 300, with a welcome increase in SpRs following the Association's decision to extend membership to all SpRs in the speciality. The Association's Autumn Meeting in London on November 11-12 was the most successful so far in terms of attendance (well over 100) and delegate feedback. Many thanks to our Honorary Secretary, Peter Winocour, for organising yet another excellent programme and also to Ken Shaw, our Honorary Treasurer, for once again balancing the books and ensuring that the meeting was affordable for delegates. The main meeting was followed by the first of the Association's new style SpR meetings, organised by Gerry Rayman and supported by Eli Lilly. The programme, entitled "Dilemmas in Diabetes and Endocrinology", included a series of "Meet the Expert" workshops and a session devoted to SpR research and audit projects. Eli Lilly kindly provided a training award of £1,000 for the best presentation, which was won by Dr Manish Khanolkhan from Cardiff. Once again, feedback from the delegates was extremely positive and, henceforth, the Association plans to run these meetings on a regular basis.

There are a number of other positive developments to report including the publication of the first two ABCD position papers on Glitazones and Retinal Screening in *Practical Diabetes International*. These have been very well received. The glitazone paper, written by Lyn Higgs and Andrew Krentz, is especially opportune given the recent advice concerning the use of glitazones and insulin from the MRHA in the October issue of "*Current Problems in Pharmacovigilance*". Also we believe that the retinopathy paper, produced by an ABCD subgroup led by Chris Walton, provides some welcome clarity and practical guidance to support the rather hasty implementation of the national screening programme. Further position papers on insulin pumps and lipids in diabetes are in preparation and we are also working on a clinical guideline for the management of adult diabetic ketoacidosis. My thanks to the committee members and others who have contributed to these valuable initiatives.

I am delighted to report the award of the Association's first Sanofi-Aventis sponsored Clinical Audit grant to Mike Sampson from Norwich for his project entitled "Inpatient Diabetes Care in UK Acute Trusts and the Diabetes Inpatient Specialist Nurse" which was adjudged (anonymously) to be the best of those submitted. I hasten to add that I had absolutely nothing to do with this decision!

As many diabetologists also practice clinical endocrinology, the Association is keen to bridge the gap between the two parts of our speciality. Following our successful "back to back" meetings with the British Thyroid Association we have now organised joint meetings with the RSM and the BES. There will be a joint meeting with the Endocrine Section of the RSM on Transitional (adolescent) diabetes and endocrinology on February 21st. The programme is excellent and it looks as though the meeting will be oversubscribed.

The Spring ABCD meeting will be held in Harrogate on Wednesday 6th and Thursday 7th of April. For the first time, we will be meeting "back to back" with the British Endocrine Societies (which ABCD has now formally joined). I am delighted to report that the distinguished endocrinologist Professor John Wass has agreed to give a keynote address entitled "Diabetes and endocrinology: together we stand, divided we fall." This is a very topical issue because clinical endocrinology, which is largely hospital-based, tends to be ignored by Trust managers and PCTs in their enthusiasm to move diabetes care out into the community. As three quarters of consultant diabetologists also provide a clinical endocrinology service, this has significant service implications for both parts of our speciality.

The Association continues to grapple with a range of current problems. These include Foundation Trusts, the proposed National Tariff for outpatient services (both of which are likely to seriously devalue hospital diabetes outpatient consultations), continuing poor recruitment into the speciality, the implications of "Modernising Medical Careers" for diabetes training and the ramifications of interesting but untested staffing proposals from the NHS Diabetes Workforce and Chronic Disease Management groups, eg Community Matrons. I am grateful to the officers, committee and members of the Association who are helping us to respond to this bewildering array of 'innovations'. I can assure you that the Association is committed to fight to preserve established high quality specialist diabetes services and to resist 'asset stripping' to support untested 'skill mix' initiatives and fanciful new models of care.

Richard Greenwood, Chairman, ABCD

MEMBERSHIP APPLICATION FORM FOR ABCD

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 £25.00. If you are interested in joining the Association, please fill in the application form below and return it to the ABCD Membership Co-ordinator at the following address:

Dr Jeremy Bending
Consultant Physician
District Diabetes Centre
Eastbourne District Hospital
Kings Drive, Eastbourne
East Sussex, BN21 2UD
Tel: 01323 414902
Email: jeremy.bending@esht.nhs.uk

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

Membership Proposal Form

I wish to apply for membership of the Association of British Clinical Diabetologists.

Please use block capitals

Name (in full, please)

Professional Qualifications

Position held

Address

/ Post Code

Tel. No.

Fax No.

Email

Signed

Date