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ABCD Newsletter

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EDITORIAL

Golf anyone?

Mark Savage
Editor, ABCD newsletter

The government seem to have bowed to pressure to re-think the NHS Reform Bill after lobbying from the BMA and many others. It seems unlikely that the government will agree to fundamental changes, but serious modification will possibly save us from the brink of a disaster. Moreover, there already seems to have been some success from lobbying as the bill will be modified so that competition on price will not be permitted and the tariff will remain the standard price at which services must be delivered by all providers.

Nevertheless, assuming that in two years or so that the bill has passed and been enacted, how will diabetes and other chronic disease services interact with GP consortia in England?

I have been giving this some thought and wonder if it will mean a return, in some ways at least, to the situation that few, if any, of us can remember… the Health Service before World War Two. Then we had a plethora of charitable hospitals, local authority hospitals with powerful local GPs dispensing succour and favour to consultants in terms of being 'chummy', facilitating private referrals to subsidise *pro bono* work done by the consultants. It was essential in those days for consultants (for tomorrow, read 'Specialist Teams') to be close to, and involved with, Primary Care. These were the days of 'trial by sherry' and the requirement for all new (male) consultants to have their wives 'interviewed' by the local medical community, and their wives. Not exactly halcyon days.

Times have changed of course, but I wonder if human nature has? Why did our predecessors act in such a way? Well it seems to me they wanted to get along with colleagues; work was difficult, the hours extremely onerous; times in general were hard, a major Depression had just ended and WW2 about to start. (While we are struggling with our economy I do trust that WW3 is not around the corner.)

In life it is better to make friends, not enemies, and this is why ABCD has for many years been trying to get a 'hook' into organisations, both locally and nationally, that have had influence on, or commissioned, diabetes care. There have been notable successes: we managed to upgrade the tariff for diabetes to a meaningful figure; we have had input into NICE guidelines on every diabetes-related issue since NICE was set up; we have co-operated closely with other organisations such as Diabetes UK and the diabetes groups

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representing the Celtic Nations in the Joint British Diabetes Societies and this has already led to recognised guidelines on DKA, hypoglycaemia, the foot, with peri-operative guidelines just hot off the press launched at the DUK conference in early April. It is hoped these series of guidelines will be published as a series in *Diabetic Medicine* as well as *Practical Diabetes International*.

Will all this have been a waste of time in the Brave New World? Personally, I doubt it. While there are many serious dangers which we are all aware of in the NHS bill, GPs are doctors. When we talk to our Primary Care colleagues they understand what we mean when we talk about patients; they want the best service possible and I am optimistic that we can engage with them on a clinical level; while I have had the pleasure of working with some excellent local managers, it is almost always a relief when one of the attendees at a meeting is a GP as they usually 'get it' more quickly. The main challenge is of course that just as the best consultants are not always the best clinical directors (and *vise versa*), the best GPs are not always the best commissioners. Moreover, GPs themselves are very twitchy about the amount of responsibility being put upon them. Locally we are seeing a move towards more engagement from both the (soon to be defunct) PCT and GPs; this is very much welcomed, the penny seems to have dropped and diabetes is no longer seen as 'cook book' medicine.

So, to return to my theme, we as diabetes specialists will need to get ourselves out there and interact with the GP consortia, and this will often be on a personal level; the return to 'trial by sherry' will, I think, not literally return, but human to human interaction will, and probably clinician to clinician; albeit I am sure with some managerial interface. Most consultants (at least in England) no longer play golf, but perhaps both we and GPs should re-learn this great skill for the benefit of our patients and services?!

Lastly, Peter Winocour will be standing down as chairman at our spring meeting in Birmingham, having served three years in post. Peter has led us through some tough times and guided us through the stormy waters with aplomb. The finances have been addressed, membership has expanded and ABCD is now the default organisation in terms of diabetes specialist advice and representation. We recently achieved a long held aim to get representation on the Specialist Advisory Committee of the Royal Colleges.

We are also saying *au revoir* (not *adieu*) to other committee members, namely Dinesh Nagi and Ian Gallen. I am sure Peter, Dinesh and Ian will continue to play an important supporting role in ABCD. Chris Walton is chair-elect and Patrick Sharp becomes general secretary with Ketan Dhatariya as meetings secretary, and Rob Gregory as treasurer. The new 'A Team'… good luck to all!

Chairman's report

Moving on

The end of the NHS?

This is my final contribution to the newsletter as chairman and I will say a little more about that later. Please don't think I am 'jumping ship' just as we (and the rest of the NHS in England) are about to hit the iceberg of the NHS reforms. I am simply going below deck for a little while.

Stockholm and other syndromes

The 2010 EASD in Stockholm proved to be an excellent meeting. The ADDITION study was a well choreographed presentation demonstrating standard multiple risk factor intervention in screen-detected type 2 diabetes leads to a reduction in CVD events. Intensive input with frequent nurse led consultations provided little additional benefit.

However the main highlight at EASD was obviously the fruits of Bob Ryder's labours – the ABCD nationwide exenatide audit. Our inaugural ABCD research fellow Ken Thong delivered an oral presentation on insulin and exenatide confidently and concisely, which was recorded as a podcast highlight from the meeting.

I managed to persuade Chris Walton to join me in the extra-curricular search for live music in Gamla Stan (the old town) and after a trek through driving rain we were rewarded with some heavy duty blues from a character (and he really was) called Maxi Dread.

Having found Stockholm a rather sedate and relaxed place I now recognise it is in fact a place of drama and intrigue – since I returned I learnt our SpR committee colleague Emma Wilmot had been an unwitting participant in a pub brawl resulting in a minor head injury, and Stockholm appears a favoured venue for alleged infractions by Mr Wikileak and (thankfully) for failed terrorist attacks.

Speaking out

I enjoyed reading the excellent critique by Edwin Gale and colleagues late last year on the limitations of tight glycaemic control in type 2 diabetes, and a recent extended news item from the *BMJ* and Channel 4 on the widespread use of analogue insulin in type 2 diabetes, despite this being a relative evidence-free zone. Edwin is one of few independent minds speaking out in British Diabetes and I think ABCD should be visibly active in supporting legitimate critiques of lazy contemporary practice. The challenge with both these issues is being able to 'put the genie back in the bottle' when mixed messages abound.

Carrots and sticks

The QoF success story with diabetes was enabled by funding to support recording of the process of care and may have run its course. In the lean times there may be a case for replacing it with a sophisticated ring fenced budget for diabetes that will change practice and enable targeted use of resources. The principle being proposed by DH on best practice paediatric diabetes tariffs could be extended to insulin choices. The current tariff for childrens' diabetes services will be upgraded if key service markers are met. Perhaps inappropriate insulin initiation and continuation in type 2 diabetes should be linked to a reduction in QoF payments?

ABCD and DH (England)

NICE has invited ABCD to work closely with them in delivering their Quality Standards for Diabetes. Our ideal

comparitor is the passion which acute trusts bring to VTE prophylaxis and hand washing. If our local services were compelled to meet the standards we recommended – 24-hour specialist reviews of hospital admissions with diabetes, specialist care input for early complications, pre-pregnancy care of those with or at risk of DM, and structured education at diagnosis – that would represent a real improvement.

I put quite a bit of effort into responding to the white paper 'Liberating the NHS'. ABCD commented on 'Transparency in Outcomes' and 'Service Commissioning'. We emphasised that DM is a multisystem, multifactorial condition which requires expertise, it is not the same as other long-term conditions, and that seamless cross-sector care is necessary. We focused on the role of specialist care and pointed out that time is needed to demonstrate benefits of this approach, the link with CVD and deprivation. We also emphasised the need for Diabetes Networks with teeth, and the vital role of specialists in commissioning.

I had an acknowledgement from DH but little else. There is still no agreement that consultants are key to supporting the new GP consortia in planning cross sector services. The RCP has also been keeping the pressure up but to no avail. Forgive my cynicism but the Coalition may have given the game away with the stated message of 'Liberation'. Who is imprisoning us? The PCTs or the Government? Who are the freedom fighters? – is it GPs, or the private sector? Perhaps the lesson from history is we may end up with the health care equivalent of third world anarchy.

One important document you should access is the 2011 NHS Operating Framework from the Chief Executive David Nicholson. This specifically mentions diabetes and states what 'should' happen: enhanced retinopathy screening and treatment; more commissioning of insulin pumps; as well as structured education; and improved inpatient diabetes care. Use it to challenge your Trust, your GP colleagues and the PCT (before it disappears).

Lies damned lies and statistics

Many of us take out patient referrals in a reactive and passive manner. For every appropriate case I estimate there are one or two more we don't get to see. This is obvious to me given that between 6% and 52% of patients with diabetes from our local GP practice registers attend our specialist hospital services. Practices with very low referral rates often contain unrecognised pathology. Diabetes care needs to get smarter with earlier specialist input incentivised at reduced costs. Care planning is popular with some clinicians but it takes time and will only deliver improved health outcomes if personalised with clinical as well as what sometimes seems a rather woolly focus.

Many of you will have seen the NHS Atlas recording two-fold variations in foot amputations in diabetes throughout England and other tales of woe. Are these data accurate? We have already seen how over simplistic interpretation of hospital mortality statistics can falsely damn a service. Perhaps rather than being defensive the fault partly lies with us for not enabling generalists (and some specialists) to better understand how to see the wood for the trees.

ABCD should be promoting refining specialist diabetes care from the evidence base –moderate diabetes renal disease is a good example where I see a need for diabetologists balancing individual risk-benefit of several interventions. The National Diabetes Audit from 2009 reports no reduction in renal failure, and QoF returns report relatively low rates for microalbumin screening. We have adequate evidence that defining high CVD-renal risk can enable more targeted care and reductions in all vascular endpoints and mortality, and that early intervention in type 2 diabetes produces greatest benefit.

Our November meeting in London was one of our best attended with reassuring feedback. Colin Close and James Walker set a precedent for the ABCD debate by agreeing with each other that dual RAAS blockade is limited in diabetes. ACEI added to ARBs may be less appropriate than the addition of Direct Renin Inhibitors. We need the results of an ongoing study but in the meantime there is the strongest case for diabetologist support of pre-dialysis nephropathy. Whereas there has been a long overdue review of the need to balance the modest benefits against the risks of intensive glycaemic control in older type 2 diabetes, we still seem to be stuck with the fanciful BP target in albuminuric DM of 125/75. In reality less than 40% can attain this with cocktails of BP lowering therapy, with hyperkalaemia a frequent rate limiting step.

ABCD – our core business

ABCD has a reputation for critical analysis – the independent ABCD GLP-1 audits established by Bob Ryder are a case in point. As a result we have a good idea how and when to use exenatide with insulin. In general use both weight and glycaemic benefits with exenatide were noted in 25% but many more achieve either reductions in glycaemia or weight. Based on our data, ABCD should persuade the MHRA and NICE to sanction current consultant supervised insulin-GLP-1 analogue use.

We now have an education and training sub committee led by Ian Scobie and in turn a place on the SAC. This has been a long held ambition of ABCD and I am delighted that Ian will help steer this. It is clearly vital with the forecasted reductions in training posts and the pressures our SpR face in providing input to acute medicine that we ensure that all aspects of training in both acute and community settings are readily available. ABCD has reviewed current services and training opportunities in 'community diabetes' and will report on this in meetings in 2011.

After a very successful three years with Maggie Hammersley at the helm, ABCD along with Diabetes UK has committed to ensuring the future of the JBDS In Patient group. We have a new chair – Mike Sampson from Norwich,

ABCD WEBSITE AND NATIONWIDE AUDITS

Website (www.diabetologists.org.uk): The website is set to be overhauled. Please send your ideas on how the new website should look and what you would like it to provide to: bob.ryder@nhs.net.

Message to all liraglutide users: please contribute your patients 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 them to the nationwide audit: http://www.diabetologists.org.uk/liraglutide.htm.

Exenatide audit: Two papers on use of exenatide with insulin have been submitted for publication and one on exenatide and NICE guidelines will be submitted shortly. We hope to go back to all contributors for a data update later in 2011.

and a new work stream for diabetes care which will cover nutrition and stroke, admission avoidance and discharge care, self management of diabetes in hospital, and management of HHS. The recent publication of guidance for diabetes care during elective surgery provides an important advance in care.

After a protracted period and a great amount of effort from Phil Norton, one of our trustees, ABCD will now operate as an 'incorporated' organisation – ABCD (Diabetes Care) Ltd working under the auspices of the Diabetes Care Trust (ABCD) Ltd. As a registered charity and limited company the executive are no longer personally liable should we get sued! Otherwise it is business as usual.

ABCD has played an active role in developing the specialist section of Diabetes-E – I recommend you use it to gather a baseline of current local services and enable service and personal revalidation. It is recognised that the programme needs to be refined, especially the issue of validating self reporting but, through Susannah Rowles and Niru Goenka, ABCD will ensure Diabetes-E can be of value to our members.

I was invited to present a brief talk to new MRCP graduates at the RCPL, extolling the virtues of a career in diabetes and endocrinology. I was in full flow and probably had persuaded large swathes of trainees to apply for D and E when my mobile phone went off and spoilt the moment. It could not have been more important – a friend down from Glasgow wanted to check the venue for our curry that evening….
Despite that embarrassment I am still working with RCPL – at the recent Coalition of Specialist Medical Societies meeting, I signed the Memorandum of Understanding for the continuation of the Speciality Certificate Examination (SCE) with Sir Richard Thompson. There were handshakes and photos – a little reminiscent of international trade agreements. ABCD and the Society for Endocrinology have agreed to share the responsibility for the SCE with the Federation of RCPs.

ABCD has long been keen to take a lead in enabling the manpower survey which previously Diabetes UK operated to continue to inform us and act as evidence to push for consultant expansion. After a successful stint coordinating this, Nick Morrish has announced his intention to stand down this year. Following discussions with DUK we have agreed to jointly conduct surveys and report at future ABCD meetings.

Rob Gregory as treasurer-elect has produced a very important proposal to update and expand opportunities for ABCD corporate support which I hope will roll out in 2011.

Our revalidation lead Patrick Sharp attended a workshop at the RCPL at which guidance was produced on who should be responsible for note keeping. Originally it appeared that consultants would be held accountable for the clinical entries of their juniors which seemed an impossible extra burden for us to carry. After a phone call to the 'Health Informatics Unit', I am more reassured that the intention is to improve the quality of medical note keeping by ensuring this is part of the appraisal of those who make the entries and not the hapless consultant who would otherwise need to spend hours trawling through notes for clinical accuracy.

ABCD has established a consultant mentorship programme, a passion of our project lead Dev Singh. This will enable new consultants to have a regular interphase with senior consultants in a structured way that offers opportunities to pass on their wisdom and experience that comes from time on the job.

Nepal needs you!

Diabetes Nepal Conference

Kathmandu, Nepal

9th and 10th December 2011

The first Annual Professional Conference on Diabetes in Nepal is due to be held in December. The organisers are looking for specialists who can deliver lectures in various fields of diabetes to make its first meeting a great success. If you are interested please contact: Dr S M Rajbhandari (Raj), International Advisor, Diabetes Nepal, Chorley and South Ribble Hospital, Preston Road, Chorley PR7 1PP, tel: 01257 245028, email: satyan.rajbhandari@lthtr.nhs.uk

Fare ye well

I will be standing down as chair at our spring AGM in Birmingham, having served three years in post. I have thoroughly enjoyed my time and feel I have accomplished my three core objectives: enabling a sound financial footing for our organisation, increasing our membership, and enhancing our national profile both within and beyond the profession.

My job has been made much easier by the great efforts and support of the committee and my 'dream team' executive – Dinesh, Chris and Ian. ABCD is unique and important for the future of diabetes care throughout the UK. I wish Chris Walton great success as chair elect, supported by his team – Patrick Sharp as general secretary, Ketan Dattariya as meeting secretary, and Rob Gregory as treasurer.

Other colleagues are moving on as well – I particularly want to thank Kate Ritchie who stepped into the breach as our NI rep and will be replaced after our AGM by Hamish Courtney. I want to congratulate Jonny McKnight who remains our Scotland lead and who is now the chair of the Scottish Diabetes Group (a 'McCzar' in all but name).

I anticipate the next decade will be the most challenging of my medical career. ABCD is aware of services where commissioners have pulled the plug except for 'urgent' diabetes care. The voice of the patient through Diabetes UK needs to be heard loud and clear to ensure the naïve view that diabetes equals long term condition equals routine primary care is reversed. I am certain that ABCD will prove vital in taking on such issues and ensuring that our new masters commissioning care in England are fully informed in each locality of the role of specialist diabetologists.

In a spirit of optimism for the future I suggest we adopt the RAF motto –*Per ardua ad astra* (or as Buzz Lightyear sort of put it – 'To infinity and beyond'!).

Peter Winocour
Welwyn Garden City
April 2011

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

London, 19 December 2010

Incretin based therapy

Following a welcome to delegates by ABCD chair, Peter Winocour (Queen Elizabeth II Hospital, Welwyn Garden City), Professor Melanie Davies (University of Leicester) discussed incretin-based therapy. She focussed mainly on the GLP-1 analogues, ranging from the first, twice-daily exenatide (rapid acting with a mainly postprandial glucose activity) to the second generation treatments which are longer acting with important effects on fasting glucose levels and will include once-daily liraglutide, once-weekly exenatide, once-weekly albiglutide and once-daily lixisenatide. She reminded delegates that the incretin-based treatment options are the DPP-4 inhibitors, incretin enhancers which prevent enzymatic degradation of native GLP-1 by DPP-4, and the GLP-1 receptor agonists, which mimic native GLP-1 to restore GLP-1 activity. She pointed out the key differences between the two classes of drugs. As the GLP-1 agonists have a greater effect on insulin production and on first phase insulin response and on reducing the effects of glucagon, there are likely to be differences in glycaemic efficacy between them. Most importantly, she said, gastric emptying is delayed and calorie intake is increased with the GLP-1 agonists, while the DPP-4 inhibitors have no such effects. Professor Davies gave a wide ranging review of recent evidence, which she described as high quality head to head clinical trial data. And she pointed out that it is reasonable to think that the GLP-1 agonists should have benefit in terms of cardiovascular outcomes "because we know that they have a positive effect on reducing triglycerides and blood pressure, and you would expect that all of this would work in the right direction."

Cardiovascular outcomes in recent diabetes trials

Professor Miles Fisher (Glasgow Royal Infirmary) presented data from DCCT/EDIC, UKPDS and VADT, meta-analyses of which confirmed that intensive therapy produced reductions in myocardial infarctions but not in strokes or total mortality. The exception was ACCORD with its increase in total mortality. Professor Fisher voiced some criticisms of the ACCORD study, which, he suggested, had been set up because the Americans were 'very dismissive' of the UKPDS. However, he reminded delegates, the five-year ACCORD results showed little benefit from more intensive lowering of blood glucose levels and blood pressure, nor from antihyperlipidaemic treatment in type 2 patients at high cardiovascular risk. The intensive blood-glucose lowering strategy was halted after 3.5 years due to a higher incidence of death in the intensive glucose lowering group, and Professor Fisher speculated on the reasons for this excess mortality. While there were no differences in the two groups at baseline, there were some at follow-up. Weight gain might have accelerated atherosclerosis, rosiglitazone had been used and hypoglycaemia was not properly studied. And he found the ad-hoc analysis almost incomprehensible. By comparison, the recent large scale ADVANCE study has shown that a slow and steady titration of treatments to a target HbA1c of under 6.5% in patients with long-standing type 2 diabetes and cardiovascular risks demonstrated some microvascular benefit. It was too short a time to show macrovascular benefits but the treatment regimen was safe with few side effects other than hypoglycaemia.

The ABCD debate

The motion that 'Dual blockade of RAS in type 1 diabetes should be standard for most patients with microvascular disease' was proposed by Dr James Walker (St John's Hospital, Livingston), opposed by Dr Colin Close (Taunton & Somerset NHS Foundation Trust) and chaired by Dr Chris Walton (Hull Royal Infirmary).

While acknowledging the importance of macrovascular disease, Dr Walker pointed out that microvascular disease also takes up much clinic time and, indeed, the two conditions exist in a 'deadly symbiosis'. Studies have shown that RAS blockade with either ACE-inhibitors (ACEi) or angiotensin II receptor blockers (ARBs) alone seem to offer little protection in microalbuminuria but is of some benefit in step retinopathy progression. Dr Walker then addressed the roles of dual blockade by adding either aldosterone antagonists or renin inhibitors. Lowering aldosterone may have benefits beyond its haemodynamic effects and spironolactone has been shown to produce a lower fall in ACR than losartan in patients also receiving enalapril. Renin is now considered to be a rate-limiting component of RAS and is increased with ACEi and ARB. Dual blockade with the renin inhibitor aliskiren also produces a lower fall in ACR compared to losartan independent of blood pressure reduction. Dr Walker urged delegates to consider ARBs for patients with high HbA1c in order to reduce their retinopathy risk and to consider spironolactone/aliskiren in those on an ACEi or ARB with controlled BP who have high ACRs

Dr Close warned of the potential dangers of dual RAS blockade: if the combination is too potent, hypotension and hyperkalaemia might occur. And there could be adverse rather than beneficial effects on renal function, such as acute renal failure and a greater loss of GFR.

Short term studies were small and dosages used were sometimes sub maximal. Hyperkalaemia was rare but the effects on blood pressure varied. While a consistent effect on reducing proteinuria was seen, Dr Close suggested that the value of this alone in preventing ESRD remained unproven. The COOPERATE study had appeared to demonstrate a greater lowering of proteinuria with the combination but, due to many concerns about its methodology, is now discredited. A meta-analysis of 21 randomised controlled studies using ACE-i and ARB combinations showed only small increases in potassium serum, a non significant decrease in GFR and a further decrease in proteinuria compared to ACEi alone. The authors had concluded that additional trials with longer follow-up were needed to determine whether the decrease in proteinuria would result in a significant preservation of renal function. The ONTARGET study showed no significant

benefit of the combination of telmisartan and ramipril in the subset of patients with diabetes; furthermore, hyperkalaemia was more common with the combination. Dr Close summarised that in patients with well-controlled hypertension, the benefits of dual blockade remains uncertain. He suggested that an alternative approach for patients requiring proteinuria reduction could be non-dihydropyridine calcium channel blockers which have antiproteinuric effects and synergy with ACEi & ARB.

Before the debate, seven delegates had supported the motion and 70 opposed. Post-debate, despite Dr Walker's eloquence, six of his former supporters now decided that standard dual blockade in diabetes was not a Good Thing.

Medical revalidation in the NHS

Dr Ian Starke (University Hospital Lewisham) updated the meeting on the current structure and procedures of medical revalidation. The aims remain to confirm that licensed doctors are fit to practise to an appropriate standard and to identify, for further investigation and remediation, poor practice where local processes are inadequate. However, there is now a greater emphasis on promoting public confidence in the profession, and encouraging self reflection and professional development. Revalidation will now be based on a continuing evaluation of doctors' practice in the context of their everyday working environment. The revalidation checklist includes peer and patient feedback, continual specialty education, training and development, quality improvement and local or national clinical audit. Reports on annual appraisals will be made by the appraiser to the Responsible Officer (RO), who has a legal obligation to recommend appropriately to the GMC. (It is the responsibility of the GMC to relicense or otherwise). Every doctor will have an RO, who will usually be the medical director of the relevant Trust. Concerns have been expressed that this could lead to a potential conflict of interest, and these are now being addressed. As Dr Starke pointed out, ROs themselves have ROs to ensure fair, unbiased and consistent judgements. ROs will be in place by January 2011; quality assurance issues, piloting and further streamlining will take place during that year with a view to launching in 2012.

Bariatric surgery – the panacea for diabetes?

Bariatric surgery is sometimes advocated as a 'cure' for type 2 diabetes; Dr Jonathan Pinkney (Universities of Exeter and Plymouth) looked at the evidence for this claim. He accepted that it is the only realistic treatment for many with severe obesity and that it can have a major short-medium term impact in terms of early glycaemic improvement. However, he pointed out, tight glycaemic control (the principal benefit of bariatric surgery) is not the main aim in treating type 2 diabetes. Blood pressure and cholesterol lowering with conventional low cost medicines are more effective. The studies on bariatric surgery are mainly small and short term and Dr Pinkney expressed concern about the lack of good quality, long term controlled data. He was also concerned about the safety of the procedure and the potential need for revisional surgery. Many people with type 2 diabetes are elderly, sick, and are not very suitable for bariatric surgery and he suggested that problems caused by it would end up with the physician. "Physicians usually want to simplify long-term management, not to make it more complex," he said.

The endocrine sessions

The speakers on endocrine topics were Professor Raj Thakker (University of Oxford) who explained the importance of genetic testing for Multiple Endocrine Neoplasia (MEN) and Dr Shahrad Taheri (Birmingham) who discussed obstructive sleep apnoea (OSA).

MEN, the occurrence of two or more endocrine tumours in a patient, can be MEN1 or MEN2 (of which there are three variants). Professor Thakker explained that as MEN conditions are inherited autosomal dominant disorders, patients at risk can be screened for mutations in the relevant gene. Early diagnosis and prophylactic intervention (for example, in MEN2b before two years of age, and in MEN2a by age five) can make a profound difference, he emphasised. He suggested screening of any individual with two or more endocrine tumours; where an endocrine tumour has developed at a young age; and when a first degree relative has MEN. He warned of the dangers of misdiagnosis, particularly in MEN1 where it may be confounded by the occurrence of phenocopies.

Dr Taheri told the meeting that OSA could be defined in a number of ways: by the respiratory disturbance index (apnoeas or hypopnoeas per hour), by apnoea duration, by degree of oxygen desaturation, and by a sleep disturbance index. Studies show that OSA is more common than previously thought, is related to age and obesity (a 10% weight gain has been associated with a 32% increase in hypopnoeas per hour) and is more common in men. There are two age peaks; one in childhood (5–6 years) and one in middle age. And it is more common in Afro-Caribbean populations. In hormonal terms there seems to be a relationship between slow wave sleep and Growth Hormone secretion by Gamma-hydroxybutyrate. The presence of OSA in diabetes populations is 'fairly high', said Dr Taheri. It is speculated that OSA might aggravate diabetes and, by the same token, diabetes might itself result in OSA by altering breath control during sleep.

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.

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