EDITORIAL

Holistic diabetes care – empowering patients and practitioners

A number of landmark studies have made it abundantly clear that the goals of diabetes care involve striving for optimal metabolic and blood pressure control. The message is now loud and clear: lower HbA1C, lower low-density lipoprotein cholesterol, and lower blood pressure. Failure to achieve these targets makes the person with diabetes susceptible to macrovascular and microvascular disease, with the attendant consequences. In the clinical situations faced by many practitioners in South Africa, however, attainment of these goals is an unrealistic expectation. Although this should not detract from efforts to maximise metabolic control, the difficulties in achieving treatment targets are an inevitable consequence of the numerous impediments hindering the efforts of even the most dedicated practitioners and patients.

The current issue of JEMDSA describes the barriers that obstruct initiation of insulin therapy in patients with type 2 diabetes in the public health system in Cape Town (p. 94). The description will be familiar to many who work in similar circumstances, and Haque and colleagues are to be congratulated on eloquently highlighting a real problem in diabetes health care delivery. ‘Insulin resistance’ in both patient and practitioner, as well as the problems in the health care system that detract from provision of appropriate therapy as stipulated by the guidelines, is not unique to the Western Cape, and from personal experience is just as much of a problem in KwaZulu-Natal. No doubt many other parts of the country are similarly affected.

What can be done to improve the situation? It is clear from the findings of the Cape Town study that education of health care professionals as well as people with diabetes is a key factor. One of the fears voiced by the medical practitioners in the study was that of hypoglycaemia – a concern echoed by many others and expressed by Cryer as follows: ‘were it not for the devastating effects of hypoglycaemia, diabetes would be rather simple to treat’. Yet sulphfonylurea-induced hypoglycaemia, particularly with glibenclamide and other long-acting agents with active metabolites, is perhaps more of a problem than insulin in causing severe hypoglycaemia.

Providing practitioners with the tools to make informed management decisions is another issue that requires attention. Deciding to advise a person with diabetes to take insulin on the basis of a random capillary glucose level is not optimal. This point was highlighted in the recently published International Diabetes Federation Global Guidelines (accessible at http://www.idf.org), which state that ‘site-of-care capillary plasma glucose monitoring at random times of day is not generally recommended’. As a minimum, fasting capillary plasma glucose should be used to assess control and provide the basis for clinical decisions. In the average primary health care clinic, however, waiting times are long and asking patients to fast for many hours is not a practical solution. Assessment of overall glycaemic control with HbA1C, complemented by self-monitoring of blood glucose (SMBG), is clearly the ideal means of arriving at the decision to initiate insulin (or other therapy adjustments). Measurement of HbA1C should not be seen as a facility only available to secondary and tertiary hospitals; it needs to be made available to primary care clinics on a large scale, and health care officials need to be convinced of the clinical usefulness and cost-effectiveness of providing such support services. Furthermore, there are a number of finger-prick HbA1C machines available and these provide a practical, point-of-care solution that would significantly aid in diabetes management at the primary care level.

Once the decision to implement insulin therapy has been made and accepted, it is equally important to give the person using insulin the tools to monitor therapy by home glucose readings. This requires regular issue of glucose monitoring strips, and clinics in many parts of the country do not provide people with diabetes with these essential items. Again, the IDF guidelines recommend that persons using insulin should be provided with glucose monitoring strips, although the statement in the minimal care section is rather vague: ‘SMBG using meters with strips, or visually read blood glucose strips, should be considered for those on insulin therapy.’

With the support of scientific studies and of international and national guidelines, the barriers not only to insulin therapy but to contemporary holistic diabetes management need to be breached for the benefit of the increasing numbers of people with diabetes. This calls for increased advocacy on the part of the organisations that have been established for this purpose and widespread dissemination of knowledge both to the health care professions and people with diabetes. Empowering people in self help and practitioners in competence has become essential.

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