

# THE MEDICAL PRACTICE AT 48 WIMPOLE STREET

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## **PRACTICE POLICY ON MANAGEMENT OF DIABETES**

### **AIM**

To identify all diabetic patients and ensure adequate control of blood glucose, blood pressure and lipids according to NICE standards as well as educating and giving appropriate life style advice and identifying and treating complications at the earliest opportunity

### **RISK FACTORS ASSOCIATED WITH INCREASED RISK OF COMPLICATIONS**

Smoking  
Hyperlipidaemia  
Hypertension  
Renal impairment

### **POTENTIAL COMPLICATIONS**

Hypoglycaemia  
Hyperglycaemia  
Ketoacidosis  
Nephropathy  
Neuropathy  
Retinopathy  
Peripheral vascular disease  
Ischaemic heart disease  
Cerebrovascular disease

### **LIFESTYLE ADVICE**

Stop smoking  
Maintain or reduce to weight to BMI < 25.0 Kg/m<sup>2</sup>  
Avoid saturated fats – use mono-saturates  
Avoid overtly sugary foods  
Take complex carbohydrates (to half of daily calorie requirements)  
Reduce salt  
Drink < 3units of alcohol daily  
Exercise 5 days a week for 30 minutes at appropriate level of exertion

### **METABOLIC TARGETS & REVIEW STRATEGY**

BMI < 25  
Blood glucose 4-8 mmol/l – ideal  
Blood glucose 5-10 mmol/l - acceptable especially in elderly  
HbA1c < 6.8 – ideal – annual review  
HbA1c 6.8-7.4 - good – 6 monthly review  
HbA1c <7.4 – acceptable but 3 monthly review  
BP < 130 systolic; <85 diastolic  
Creatinine <120  
Urine free from protein

All those with some complication to be seen every 3 months

## **DIABETIC REVIEW**

Assess patient's wellbeing and any symptoms asking specifically for impotence, chest or leg pain on exertion or symptoms of depression

Review home monitoring results

Look for ways to improve control where possible

Ensure lifestyle advice understood and address areas of non-compliance

Weight – BMI

Urinalysis

Blood pressure – lying and standing

Feet – pulses and skin/nail care

Sensory modalities in feet – touch, vibration, proprioception

Retinal exam

Blood glucose & HbA1c

Renal & liver function tests

Cholesterol & LDL

Thyroid function tests every 3 years

## **THERAPEUTICS**

DIET - Diabetic diet advised by qualified dietitian

METFORMIN- for all overweight (BMI > 25) type 2 diabetics inadequately controlled on diet and consider even if BMI <25. C/I if creatinine >130mmol/l

INSULIN SECRETAGOGUES – add to metformin when necessary or can be monotherapy if can't use metformin or if BMI <25. Sulphonylureas first choice and long acting (once daily) ones improve compliance. Consider nateglinide or repaglinide when irregular eating patterns. Be aware of risk of hypoglycaemia

THIAZOLIDINEDIONES et al – use when intolerance of metformin & secretagogue or unsatisfactory HbA1c despite this combination. May take up to 6-10/52 to see full effect

ALPHA-GLUCOSIDASE INHIBITORS – Acarbose does lower blood glucose further but has a high incidence of gastro intestinal side-effects and poor compliance long term

INSULIN – in collaboration with endocrinologist

ORLISTAT –in accordance with NICE guidelines as part of weight reduction if BMI >28

## **AUDIT**

The % of patients with HbA1c measurement in last 6/12

The % of HbA1c measurements in range 6.5-7.5%

The distribution of patients among the therapies, diet alone, metformin, metformin plus insulin secretagogue, plus thiazolidinediones. Use of orlistat. Insulin usage and supervision of this group by other specialists eg ophthalmologists.

## **REFERENCES**

The Royal College of General Practitioners Effective Clinical Practice Unit: Clinical Guidelines for Type 2 Diabetes. Sept 2002

NICE: Orlistat for the treatment of obesity in adults March 2001

NICE (Draft) Type 1 Diabetes. Management of type I diabetes in adults in primary & secondary care. 2004

CN SAWYER  
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