Inaugural national conference of the Primary Care Diabetes Society of Australia

University of Melbourne, Parkville Victoria, Vic, 30th April 2016

The inaugural national conference of the Primary Care Diabetes Society of Australia was held at the University of Melbourne on 30th April 2016. We were delighted to welcome 170 attendees to the conference, comprising health professionals, exhibitors and students.

Mark Kennedy (Honorary Clinical Associate Professor, Department of General Practice, The University of Melbourne, Melbourne, Vic, and Chair, PCDSA) welcomed all attendees to the conference and wished delegates an educationally engaging and rewarding conference experience. He highlighted the wonderful opportunities for learning presented by having attendees and speakers from such diverse areas of primary health care.

Sir Michael Hirst

Diabetes and obesity: Changing the paradigm, a whole community problem needs a whole community solution

Sir Michael Hirst, Past President, International Diabetes Federation, Scotland, UK

Kicking off the conference was a passionate call to arms by Sir Michael Hirst to address the accelerating rates of obesity and diabetes in Australia. He explained how the new Global Diabetes Scorecard (www.idf.org/global-diabetes-scorecard/) can be used to track nations' progress for action on diabetes, hold governments to account and set a baseline for future monitoring. Thirty-seven countries, including Australia, have agreed to adopt the global monitoring framework. We as health professionals have a key role in addressing the diabetes crisis, hopefully averting the appalling prospect raised by the World Health Organization (WHO) that without such intervention, today's children may be the first generation in recorded history who have a shorter life expectancy than their parents.

Following Sir Michael's talk we were honoured to have speakers from the fields of endocrinology, psychology, general practice, obesity research and allied health to provide practical insights to assist us provide evidence-based care to our patients with diabetes.

PCDSA

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Diabetes diagnosis – HbA_{1c}

Professor Peter Colman, Director, Department of Diabetes and Endocrinology, Royal Melbourne Hospital, Melbourne, Vic

Professor Peter Colman explained the rationale of using HbA_{1c} as a diagnostic test for diabetes, as well as the appropriate population groups who should be considered for HbA_{1c} test screening and its limitations.

Practical take-home messages

- It is not recommended that we consider those with an HbA_{1c} between 42–46 mmol/mol (6.0–6.4%) as "pre-diabetic", but that those in that group may have an increased risk of cardiovascular disease.
- HbA_{1c} provides a better index of overall glycaemic exposure and risk of long-term complications with substantially less biologic variability and pre-analytic instability than fasting glucose or oral glucose tolerance testing.
- While an HbA_{1c} value of 48 mmol/mol (6.5%) is recommended as the cut-off point for a diagnosis of diabetes,

a value of less than 48 mmol/mol (6.5%) does not exclude a diagnosis of diabetes using other tests.

Engaging people with non-insulin-treated type 2 diabetes in self-management: Taking a structured approach to glucose monitoring

Professor Jane Speight, Foundation Director, The Australian Centre for Behavioural Research in Diabetes, Melbourne, Vic

Professor Jane Speight outlined a number of strategies for better engaging people with diabetes in self-management. In the midst of the current controversy surrounding funding for self-monitoring of blood glucose (SMBG), she explained that, although SMBG is costly, it is less costly than treating diabetes complications. She pointed out that unstructured SMBG is random, confusing, frustrating and ineffective but that structured SMBG is effective, engaging and economical.

Practical take-home messages

- Structured SMBG is effective, engaging and economical.
- In the "STeP IT UP" study a structured SMBG approach was implemented – blood glucose was measured seven times daily (before and after each meal and before bed) for 3 consecutive days in the week before seeing a GP or diabetes educator. This was associated with an HbA_{1c} reduction of almost 1% (11 mmol/mol) along with improvements in emotional well-being and confidence in diabetes self-care, and a reduction in therapeutic inertia.

Diabesity

Professor John Dixon, Head of Clinical Research, Baker IDI Heart and Diabetes Institute, Melbourne, Vic

Professor John Dixon gave a very thought-provoking overview of obesity and diabetes where he explained that the obesity and diabetes epidemics are so linked that they are inseparable, hence the use of the term diabesity. He said they share the same environmental determinants associated with changes over the last 40 years and that the factors contributing to the increased prevalence of obesity go far beyond just dietary intake and physical activity changes (e.g. smoking rates, epigenetic factors and maternal age).

Professor Dixon concluded by explaining that obesity and diabetes are both conditions of dysregulation and need to be addressed simultaneously. He said we have clear clinical pathways, therapies and responsibilities for managing diabetes, but have negligible services directed to clinically severe obesity. He reiterated Sir Michael's call for a whole-society, parallel approach to achieve effective prevention in the future.

Practical take-home messages

- Aiming for a BMI of <25 kg/m^2 in those who are already obese is not only unrealistic, but also does not achieve additional benefit beyond a 10% weight loss.
- Pharmacotherapy can be a useful adjunctive measure for appropriate individuals, but the use of pharmacotherapy alone is not as effective as pharmacotherapy in addition to a comprehensive weight management program.
- Bariatric surgery is an option for individuals with severe obesity, who have not responded to less-intensive interventions.

Clinical case panel discussion – A multidisciplinary approach

***Dr Nick Forgione**, Principal, Trigg Health Care Centre, Trigg, WA; **Ivan Chan**, Dietitian, Diabetes Australia, Melbourne, Vic; **Nicole French**, Director Senior Exercise Physiologist, Exercise for Rehabilitation and Health, Essendon, Melbourne, Vic; **Jessica Johnston**, Podiatrist, Private Practice, Essendon North, Melbourne, Vic; **Ros Rolleston**, Primary Health Care Nurse and Educator, Australian Primary Health Care Nurses Association, University of Wollongong, Wollongong, NSW; and **Kim Welch**, Director - Lets Talk Life! and RN Credentialed Diabetes Educator, Melbourne, Vic*

A multidisciplinary clinical case panel discussion conducted by Dr Nick Forgione, Ivan Chan, Nicole French, Jessica Johnson, Ros Rolleston and Kim Welch demonstrated why a multidisciplinary approach to the management of diabetes in primary care is so important and effective for optimising outcomes for people with diabetes. It also served to showcase the skills of different primary healthcare providers to assist in understanding overlapping, reinforcing and complementary roles in management of people with diabetes. The speakers highlighted the importance of open and timely communication between care providers and emphasised the benefits of adopting a patient-centred approach to management. The case also illustrated how the roles of different members of the multidisciplinary team change necessarily as people with diabetes develop comorbidities and complications, and as their social circumstances change.

Practical take-home messages

- A multidisciplinary approach to the management of diabetes in primary care is important and effective for optimising outcomes for people with diabetes.
- Open and timely communication between care providers is key.

Managing people with diabetes during illness: A person-centred approach

Professor Trisha Dunning, Chair in Nursing, Barwon Health Deakin University, Melbourne, Vic

Professor Trisha Dunning highlighted a person-centred approach to the management of diabetes during intercurrent illness through primary care and self care. She emphasised the

importance of prevention in relation to episodes of hyperglycaemia and gave many practical examples of how this can be done as part of normal diabetes care. She spoke of the importance of identifying times when illness is more likely for the individual, of educating the individual and their family or carers about appropriate self care generally and during illness, of providing preventative health care (e.g. influenza and travel vaccination and regular medication reviews), of optimising metabolic control and of regularly screening for complications for diabetes.

Practical take-home messages

- Sick day plans must be personalised and should be developed when the person is well. They should include details on who and how to contact for advice, blood glucose targets and medication (anti-diabetes and other) management. Instructions for sick days and how to prevent dehydration should also be covered. Individuals and their carers should have their knowledge of sick day management assessed on a regular basis.
- Clinics should educate patients to recognise deterioration of glucose control early, to seek advice early when control deteriorates, and to monitor blood glucose and ketones accordingly.
- Regular general health checks for comorbidities and dental care should be implemented.

The new class wars: Which class after metformin: DPP-4i, SGLT2i, GLP-1 receptor agonist, or is it still SU?

Dr Gary Kilov, Principal, Seaport Diabetes, Launceston, Tas

In the last 20 years the number of classes of anti-diabetes medication has more than tripled, and Dr Gary Kilov explained that it is often a daunting prospect for clinicians to sort through the drug choices to recommend the best option for the individual with diabetes in the consultation room.

From left to right: Professor Trisha Dunning and Dr Gary Kilov.

Practical take-home messages

The first step in choosing a second line therapy is selecting the appropriate target. The paradigm has shifted from setting glycaemic targets for groups of people with diabetes (e.g. newly diagnosed individuals or people with known cardiovascular disease) to a more individualised approach based on a number of biopsychosocial factors.

- More aggressive HbA_{1c} targets of 42–48 mmol/mol (6–6.5%) are appropriate for individuals who are motivated, have a shorter disease duration and are at low risk of hypoglycaemia. Less stringent targets of 58–64 mmol/mol (7.5–8%) might be more appropriate for people with diabetes at the opposite end of the spectrum.
- Choice of suitable medications can vary according to patient age, body weight, existing complications, duration of diabetes, life expectancy and ability to pay for treatment.

We would like to thank all of our speakers, sponsors, exhibitors and organisers for their support of the PCDSA. The PCDSA is your society – so please contact us at info@pcdsa.com.au with your suggestions for what, or who, you would like to see at next year's conference, to contribute to *Diabetes & Primary Care Australia,* or if you would like an education seminar in your area. We look forward to seeing you at our second national conference on April 29, 2017 in Melbourne, Vic. ■

Citation
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