Missed opportunities for improving health outcomes of patients with diabetes

Dear Editor

It is well recognised that in patients with diabetes, intensive control of a patient's blood glucose can reduce microvascular complications and lowering cholesterol levels can produce reductions in macrovascular complications.[1] Increasing the use of insulin, multiple antihypertensive therapy and lipid lowering drugs are required to achieve optimal clinical targets.[2] However, evidence suggests that, despite treatment, many people with type 2 diabetes do not achieve the recommended targets for HbA1c, lipid and blood pressure.[3,4]

In a recent audit of diabetes care and health outcomes in midwest Western Australia, we compared the control of HbA1c (<7%), total cholesterol (<4 mmol/L) and blood pressure (130/85) between 253 patients with type 2 diabetes receiving and not receiving medication.[5,6]

This audit found three things: patients treated with diet alone were significantly less likely to be outside the target for HbA1c (20%) compared to those treated with an oral hypoglycaemic agent (56%), insulin alone (86%) or a combination of both (100%) ($p<0.001$); a significantly higher proportion of patients treated with lipid lowering agents were achieving the target for total cholesterol compared to those not on treatment (21% vs. 9%, $p<0.05$); and 45% of patients eligible for antihypertensive treatment were not receiving medication, and 59% of patients on antihypertensive treatment were not controlled. Of these, nearly half (49%) of the patients were treated with only one antihypertensive agent.

Explanations given by GPs regarding these results were fourfold: often their initial management of patients is to instigate lifestyle changes; clinical outcomes were hard to achieve because of the regularly changing targets recommended by the RACGP and the prescribing limitations imposed by the PBS; nonattendance of patients to follow up appointments makes it hard to manage appropriately; and GPs were concerned about the adverse effects of initiating medications, the cost of polypharmacy and increasing the risk of poor adherence.

These challenges of patient adherence and self management have been identified by other studies as common barriers to management.[7,8] Nevertheless there appears to be an opportunity for GPs to more aggressively treat their patients as it appears a number of patients eligible for treatment are not receiving medication and those receiving medication are undertreated.[8] Further discussion and research with both GPs and patients is required to explore the factors impacting diabetes control.

Cynthia Porter, Belynda Wheatland
Marisa Gilles, Charlie Greenfield
Combined Universities Centre for Rural Health
Geraldton, WA

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Fatness

Dear Editor

It is time for us now to abandon the expression 'overweight', which has been used by doctors and patients as a euphemism for excessive and unhealthy proportions of bodily fat. In the interests of clarity, honesty and plain speaking; it is time we started using the words 'fatness', 'shape' and 'size' when discussing these issues with our patients.

When talking about fatness with our patients, we should avoid talking about losing weight, which for some patients unconsciously has sinister connotations of illness, as in: 'Uncle Harry had cancer and lost a lot of weight before he died'. Instead, it is more accurate and presents a more positive goal to talk about becoming slimmer. We should set a good example for our patients by refraining from weighing them more often than annually, even if they are wanting to become slimmer. We should also discourage

ADDRESS LETTERS TO

The Editor
Australian Family Physician
1 Palmerston Crescent
South Melbourne Vic 3205
Australia

FAX 03 8699 0400

EMAIL afp@racgp.org.au

our patients from weighing themselves between annual weight measurements – this may avoid the disappointment and discouragement of finding a higher number on the scale than before.

One simple way of following a patient's change in size and shape is to ask about changes in their clothing size. All patients are well aware of these changes and can readily report them to us. Talking about weight should be replaced by rational discussions with our patients about their fatness, shape and size, which are much better indicators of the status of this aspect of their health than is weight.

Oliver Frank
Hampstead Gardens, SA

Menopause

Dear Editor

The article 'Women's decision making at menopause' (*AFP* April 2006) addresses important issues arising from focus groups of women aged 40–64 years.

One conclusion is that GPs need to provide current, inclusive information in the practice setting. In addition, it is noted that participants were sceptical about the reliability of available information because of the perceived influence of pharmaceutical companies.

Some of your readers may not yet be aware of a suite of documents concerning women's options at the time of menopause, which is available from the National Health and Medical Research Council (NHMRC) website at www.nhmrc.gov.au/publications/synopses/wh35syn.htm.

The NHMRC's Health Advisory Committee developed three booklets on hormone replacement therapy (HRT) that were endorsed by the NHMRC in March 2005. The process included rigorous systematic reviews and consultation. The booklets explore the benefits and risks of HRT, as well as other management techniques. One booklet is designed to give health professionals detailed information about HRT; another two provide information to women concerning their options at the time of menopause.

Peter Greenberg
Canberra, ACT

GI malignancies

Dear Editor

Thank you for featuring GI malignancies in the April issue of *AFP*. Your contributors made a compelling case for more research in primary care.

Gastrointestinal malignancies have a relatively high incidence and pose a particular diagnostic challenge in primary care. McMurrick states that many patients remain asymptomatic until the advanced stages of colorectal cancer.[1] Many cancer sufferers appear well, and the symptoms for which the guidelines advocate referral do not appear until it is too late for cure.

In the early stages it is easy to collude with patients and explain away isolated red flag symptoms; most people do not come demanding referral and are happy to accept what they take to be an expert opinion, often despite their own misgivings. Critical to generating a smart response to cancer symptoms is our own frame of reference in primary care. Why is it that a significant proportion of patients with unexplained iron deficiency – patients known to be at high risk of malignancies[2] – are not investigated urgently? What are the indicators of the 'undiagnosed cancer patient' in primary care? When and why does 'Joe Public' seek help with cancer symptoms? Research in primary care is needed that frames the problem within the context of the most important activity that occurs there: the consultation.

Moyez Jiwa
Perth, WA

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