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THE RCPE UK CONSENSUS STATEMENT ON DIABETES

The RCPE UK Consensus Statement on Diabetes (*J R Coll Physicians Edinb* 2010; 40:130–1) states that 'there is good evidence that lifestyle intervention in high risk groups can prevent or delay the onset of type 2 diabetes, but translational research is required to define how to put these findings into everyday practice'.

This is not true. At the 6th World Congress on the Prevention of Diabetes held in Dresden in April this year, a book was launched which contains many of the real-world implementation programmes for the prevention of type 2 diabetes.[1]

Finland leads the world in not only conducting the first randomised control trial to show that lifestyle intervention is effective but also in having the largest diabetes prevention programme, FIN-D2D, which covers more than a quarter of the Finnish population. Among other striking examples are the European Union's DPLAN, which is being conducted in more than 20 countries, and its IMAGE (development and implementation of a European guideline on training standards for diabetes prevention). The largest systematic intervention in the world is funded by the Department of Health in Victoria, Australia, and covers its population over the age of 50 years. The Center for Diseases Control and Prevention in Atlanta, Georgia, has announced that it is starting real-world implementation of type 2 diabetes prevention in seven states.

Full-scale diabetes prevention programmes are now well under way on three continents. For some reason, the UK is lagging behind.

Professor James A Dunbar
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Reference

1 Schwarz PE, Reddy P, Greaves CJ et al., editors. *Diabetes prevention in practice*. Dresden: Tumaini Institute for Prevention Management; 2010.

Author's response

I thank Professor James Dunbar for his informative letter. The Consensus Panel was well aware of the ongoing international work and that intensive lifestyle intervention in certain high-risk groups could be most effective. However, the Panel was most concerned regarding the challenge of translation into standard practice in a large population, particularly for the National Health Service, with the need to elucidate cost-effective economic models of delivery which must be inclusive of the diverse multicultural communities in the UK. Other key uncertainties have to be considered, such as potential unintended impacts on health inequalities by poor uptake of low-income groups, and that the sustainability of behavioural change will be difficult to maintain without supportive physical, social and cultural environments. Hence the Consensus view was that further translational research is required so that this important area is advanced, its costs modelled and delivery concerns resolved, especially in the UK where such feasibility work is now urgent. The UK will undoubtedly benefit from the experience of other countries also developing large-scale prevention programmes and the quoted recently published book is most timely.

Professor Roland Jung
Chair of the RCPE UK Consensus Conference on Diabetes

THE RCPE UK CONSENSUS STATEMENT ON DIABETES OPENS UP MORE QUESTIONS

The RCPE UK Consensus Statement on Diabetes is truly a timely exercise and opens up a lot more questions and debate than it answers! There are some vital points to be specifically addressed and debated by a wider international and inclusively representative group, on the lines of the International Consensus on the Diabetic Foot[1] (which could include the present group), if the conclusions and recommendations are to carry weight and credibility across the globe. I shall highlight a few aspects of the problem of diabetes that the RCPE Consensus statement fails to touch on.

Who can prevent diabetes?

No mention was made of the load of iatrogenic diabetes – thiazide, steroid, antidepressants etc., particularly in the light of the recent evidence of statin-induced diabetes[2] (accounting for nearly 9% of those who use this blockbuster drug, whose promotional gimmicks are as subtle as they are misleading). At a rough estimate, the incidence of new type 2 diabetes mellitus in the UK should be increasing at the rate of 225,000 per year if the estimated non-diabetic users of statins are around 2.5 million! What about the effects of long-term usage of statins in diabetics and the worsening of their carbohydrate tolerance and increased anti-diabetic drug load, including the usage of thiazolidinediones and resultant increased cardiovascular morbidity/mortality?[3,4] This is just the tip of the iceberg; why no mention of all these in the consensus report?

What after metformin?

For an old-time Fellow of the RCPE like me who is still in active clinical practice after four and a half decades, it is rather puzzling to note that the British members of the RCPE consensus group fail to trace or mention the history of biguanides – their clinical and biochemical aspects propounded in a classic monograph by Robert D Cohen and H Frank Woods with a foreward by the redoubtable Sir Hans Krebs.[5] There is no mention of the University Group Diabetes Program study's implications on the elder sibling-drug phenformin[6,7] and the later

reports on metformin-induced renal impairment[8] and increased mortality.[9] Also to be taken into account are vitamin B12 malabsorption-anaemia and irreversible peripheral neuropathy in about 30% of the cases of those treated with this drug and invariably misdiagnosed as diabetic neuropathy![10] Why is there a total lack of interest in doing credible clinical research on the above points? Is the glossing-over of this important money-spinning drug, as noted by Marcia Angell (former Editor-in-chief, the *New England Journal of Medicine*) in her book,[11] due to any nexus between the pharma companies and the medical profession?

I am happy to note that on the positive side the RCPE Consensus Statement mentioned (warned) doctors not to change antidiabetic drugs or combination regimens based on HbA_{1c} levels alone, but to take other factors, including patient inputs, into account.

While commending the final point in the Statement, that a patient-focused, goal-led approaches and clinical information systems (databases, recall, audit and research) are important tools in the successful care of children and adolescents with insulin-dependent diabetes mellitus (IDDM), I would urge your esteemed readership to browse through our patient-care interactive telehealth portal on diabetes (www.diabetopaedia.com). This work is based on 43 years' experience of giving unique comprehensive lifetime free medicare to more than 600 children and adolescents with IDDM in Chennai, India.[12]

Finally, would it be too much to ask the RCPE, which is committed to excellence in the teaching and practice of clinical medicine, to constitute a committee of senior and accredited Fellows of eminence and experience to explore the other systems of healing (Ayurveda, homeopathy, the Siddha system of Indian medicine, to name a few) plus the other modalities of non-medicinal, non-invasive healing practised in various parts of the world, over which more than 150 million diabetics are spread? A study of this nature, with authentication by modern technology, within a timeframe of two to five years, would be truly revealing and rewarding!

Professor CV Krishnaswami
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Authors' response

We thank Prof. Krishnaswami for his letter. A consensus conference convened under the auspices of the RCPE is not designed to be an all-embracing review of a topic, but rather to select a small number of clinically relevant questions and, using an accepted methodology, provide a concise statement after a two-day meeting following considerable preparation and background reading by the consensus panel members. In answer to the points raised by Dr Krishnaswami we offer our responses.

Who can prevent diabetes? The question was designed to consider personal and societal influences on the development of diabetes, with the Panel also recognising the importance of government leadership. While the worsening of glucose tolerance can be caused by certain medicines the absolute numbers affected compared to the risk posed by an ever increasing obese population is likely to be small. At present, statin use is recommended for most people with diabetes.[1]

What after metformin? The Consensus Panel was not asked to review metformin since this question assumed that most people with type 2 diabetes will be tried on metformin provided there are no contraindications and they do not suffer side effects. The advantages and problems associated with other medicines were reviewed in both pre-conference papers and by the conference speakers, but the evidence base is constantly evolving and after discussion the Panel's consensus was to recommend the latest SIGN[1] and NICE[2] guidance.

We are pleased Prof. Krishnaswami agrees with the Consensus Statement regarding the multifactorial outcomes of successful diabetes treatments. The Panel considered it important to move away from a purely 'glucocentric' outcome.

We thank Prof. Krishnaswami for alerting us and other readers of the JRCPE to the website he has quoted. This is a good example of a contemporary medium being used

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for patient, carer and professional education and advice. The final point on other healing methods is beyond our remit; however, the RCPE is committed to education and research and we shall pass these comments to Fellows responsible for the organisation of future meetings.

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[1]Lead RCPE Consensus Conference Co-ordinator; [2,3]Co-chair of the RCPE UK Consensus Conference on Diabetes; [4]Chair of the RCPE UK Consensus Conference on Diabetes

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TUBERCULOUS PLEURAL EFFUSION

I read with interest the paper entitled 'Significant resolution of tuberculous pleural effusion on chemotherapy alone' by LC Loh et al. (*J R Coll Physicians Edinb* 40:100–4). It was interesting to note that the mean age of patients was 41, thus implying that tuberculous pleural effusion is common in young populations.

Pleural effusion typically develops four to seven months following an initial infection as a result of a rupture of a small sub-pleural focus, resulting in a delayed hypersensitivity reaction. The current hypothesis is that this delayed hypersensitivity reaction induces an intense inflammation obstructing the lymphatic pores in the parietal pleura, causing the accumulation of protein in the pleural cavity.

The other indications for a therapeutic thoracocentesis, apart from the ones highlighted in the paper, are as follows:

1. When patients develop a paradoxical worsening of their disease and become increasingly symptomatic after anti-tuberculous treatment is initiated, it is suggested that such paradoxical responses might be due to isoniazid-induced lupus pleuritis;
2. It has also been reported that patients develop a pleural effusion when they are being treated for extra-pulmonary tuberculosis, thus necessitating a thoracocentesis.

Dr A Dwarakanath
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Further reading

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2 Hiraoka K, Nagata N, Kawajiri T et al. Paradoxical pleural response to antituberculous chemotherapy and isoniazid-induced lupus. Review and report of two cases. *Respiration* 1998; 65:152–5. doi:10.1159/000029251

Authors' response

We thank Dr Dwarakanath for the interest in our paper and his insights. The primary consideration for thoracocentesis, whether via a simple needle or chest tube insertion, is for the symptomatic relief of a large pleural effusion or a rapidly accumulating one causing respiratory distress. Mechanisms for the development of pleural effusions in TB can be varied, including the rare occurrence of paradoxical worsening of TB pleural effusion after treatment, as you point out. In any case, therapeutic thoracocentesis should not be delayed when the patient is breathless. In the majority of cases, thoracocentesis would have been carried out for diagnostic purposes and the obvious practice is to drain as much pleural fluid out as possible to expedite recovery at the same sitting.

[1]LC Loh, [2]BK Lim, [3]S Wan Yusuf
[1]Consultant Chest Physician, Penang Medical College; [2]Lecturer, International Medical University, Kuala Lumpur; [3]Consultant Physician, Tuanku Jaafar Hospital, Seremban, Malaysia

FISHING FOR SKILLS IN SELF-CALIBRATION OF DIAGNOSTIC PERFORMANCE

The 'tick box' approach to hypothesis testing (Dewhurst NG. Fishing for a diagnosis. *J R Coll Physicians Edinb* 2010; 40:98–9) and, hence, to the prioritisation of diagnostic tests might, in part, be attributable to the emergence of new working patterns such as the shift system and the European Working Time Directive, which limit the scope for reflective thinking and for continuity of care. The result is an erosion of skills in self-calibration of diagnostic performance. Time to reflect (and to benefit from feedback) is the greatest ally to self-calibration of diagnostic skills, and this goes hand in hand with a continuity of observation and care. The eventual outcome is an ever-decreasing reliance on laboratory tests for the validation of a diagnosis.

Accordingly, in a paraphrase of TS Eliot:

> For most of us, this is the aim
> [Not often] here to be realised;
> Who are only undefeated
> Because we have gone on trying,[1]

the piscatorial analogy is one worth striving for, not only for the purpose of limiting healthcare costs, but also to mitigate the risk of iatrogenic misadventure attributable to 'triple rule-outs' such as the one for pulmonary embolism, myocardial infarction and dissecting aortic aneurysm.[2] Perversely, as well, in spite of the proliferation of diagnostic tests, the initial rate of correct diagnosis can be as low as 55% even in medical assessment units based in teaching hospitals, partly as a result of the fact that 'with the current system there is no mechanism for feedback to the initial assessing team'.[3]

Dr OMP Jolobe
Retired geriatrician, Manchester

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REMEMBERING HENRY MATTHEW

As a Fellow of the College and an Edinburgh graduate I am writing to say how pleased I was to see the photograph of Dr Henry Matthew on the cover of Volume 39, Issue 4 (December 2009) and also, on pages 357–61 of the same issue, the excellent article by AT Proudfoot and LF Prescott on Dr Matthew's seminal contribution to clinical toxicology.

During my clinical years as a student in the Royal Infirmary between 1944 and 1947 I was taught by several eminent physicians, but the one whose approach to patients made the greatest impact on me was Dr Matthew. Always a quietly spoken and modest individual, when demonstrating in the dispensary practice how to take a history and to examine patients, Dr Matthew was particularly gentle, sympathetic and kind to patients, as well as extremely thorough. He was the polar opposite of the general practitioner played by Martin Clunes in the television series 'Doc Martin'. Several of my colleagues had the same positive reaction to Dr Matthew. Colin Murray and I invited him out to dinner (he was the only teacher to whom we ever extended such an invitation). He accepted, and we took him to L'Aperitif, which was a little outside our price range but we had a very pleasant evening there.

Twenty years later, while working as a consultant psychiatrist at King's College Hospital, London, through numerous contacts with patients who had attempted suicide, I became aware of Matthew's contribution to the treatment of self-poisoning and in particular, in 1968, of the increasing use of Mandrax (methaqualone 250 mg, diphenhydramine hydrochloride 25 mg) which, he and his colleagues observed, 'ranked after barbiturates and salicylates as the drug most often used in self poisoning'.[1]

Nevertheless five years later, William Sargant, a prominent London psychiatrist, in a letter to the *British Medical Journal*[2] addressing 'the proper clinical use of Mandrax and methaqualone', stated he had used various forms of continuous sleep treatment since 1940 and that 'recently patients have been kept under narcosis for two or more months while intensive electric convulsive therapy can also be given; the longest course of narcosis has been over four months. Large amounts of phenothiazines have been used but sedatives have to be given as well. We have finally fallen back in the last 500 or more patients on the use of Mandrax or methaqualone in preference to other sedatives such as barbiturates, chloral, Mogadon (nitrazepam), etc. as it seems to produce less withdrawal symptoms and tendency to addiction than the barbiturates and it works so well.' Sargant added, 'I have also used Mandrax as a sedative for many years and find it often preferable to the barbiturates as regards addiction, and more effective as a sedative than Mogadon.' He stated that if any 'committee' doctor would like to check up on clinical realities there were 'hundreds and hundreds of clinical records to consult at St Thomas's and Belmont Hospitals'. Sargant's reference for this statement was, unwisely as it turned out, an introduction to the fifth edition of *Physical Methods of Treatment in Psychiatry*, a book that he had written with Eliot Slater. His letter concluded: 'And please Sir, no more suggested drug bans.'

Matthew, understandably, would have none of this. In a letter to the *British Medical Journal*[3] he stated that although he was not a 'committee doctor' he had checked the reference given by Sargant to the 'hundreds and hundreds' of clinical records of patients treated with Mandrax, which the latter had implied were available in Sargant and Slater's book. In it Matthew found (only) '13 lines on Mandrax in a chapter on chemical sedation and stimulation and two lines on combining Mandrax with a tricyclic antidepressant for sleep'. Furthermore, there was no critical assessment of Mandrax as used in the combined therapy described in the chapter on modified narcosis. Matthew commented that while Sargant had pleaded for no more drug bans, he (Matthew) 'would hope that in view of the outstanding achievement of the voluntary ban on amphetamine prescribing, similar if not more stringent measures to prevent the increasing misuse of Mandrax should be encouraged.'

I last saw Henry Matthew in the early 1970s at a conference on clomipramine in Jersey. He was his usual modest, charming self and it gave me great pleasure to introduce my wife Anthea to him. I am delighted that, through the journal of our College, Henry Matthew will receive more of the recognition that his memory so richly deserves.

Anthony Hordern
Consultant Psychiatrist, North Turramurra, Australia

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Answers to the heart failure device MCQs on page 239:
1: **D**. 2: **B, D**. 3: **D**. 4: **A**. 5: **B**.

HISTORY