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Diabetic supervision

Sir,

I am a member of the Medical Advisory Committee of the British Diabetic Association and we have recently discussed the professional supervision that all adult diabetic patients should expect to receive. Our recommendations are shortly to be published in *Balance*, the monthly magazine for diabetics, and I feel it important that all general practitioners know of these recommendations, since patients will want to discuss some of the points made.

At the time of diagnosis an adult diabetic should expect:

- a full medical examination;
- an explanation of the nature of the condition and of the treatment likely to be required;
- an interview with a dietician to ascertain previous food intake followed by dietary guidelines and the provision of written dietary advice; the arrangement of a follow up for more detailed dietary advice;
- an explanation of the need and provision of the means to monitor the condition, that is urine or blood testing equipment. At this stage further education should be made available. Patients may find it helpful to obtain one of the BDA handbooks;
- advice to inform the DVLC and insurance company (if a driver) and advice concerning exemption from prescription charges;
- initiation of treatment.

Initially patients requiring insulin will need to be seen frequently by a specialist nurse or doctor but they will rarely require admission to hospital. Basic instruction must include injection technique, management of insulin and syringes and how to monitor progress. Hypoglycaemia must be discussed and understood; when it may occur, how to recognize it and how to deal with it. Ketone testing equipment may be provided as well as glucose monitoring equipment and the significance of ketones explained. The education process should continue, to explain how insulin, food and exercise affect blood sugar and how other aspects of life may alter diabetes control.

Patients treated with diet and tablets may need to be seen fairly frequently initially by a specialist nurse and dietician for education, reassurance and evaluation of the effectiveness and understanding of treatment and advice.

In the long term all patients whose diabetes is reasonably controlled should be seen by a specialist nurse, doctor and dietician at regular intervals. The intervals will vary according to individual needs. Some people may only need to be seen annually while others, for example children, should be seen at least three monthly and pregnant mothers weekly. Ideally direct access to specialist advice from a doctor, nurse, dietician or chiropodist should be available between arranged visits to solve problems as and when they occur. Sufficient time should be allowed at visits for adequate assessment, general discussion, advice and continued education.

All diabetic patients should be seen by a doctor annually for a formal medical review. At such a visit weight will be recorded, urine tested for glucose, ketones and protein, and a blood sample taken for glucose and HbA1 measurement. Patients should bring a record of home monitoring results and their blood pressure should be measured. Vision should be checked and the retinae examined after the instillation of dilating drops. If the doctor is at all concerned, the patient should be asked to see an ophthalmologist. The feet and legs should be examined to assess the state of the circulation. They should also be examined for evidence of neuropathy — reflexes and sensation to touch and vibration being assessed. Injection sites should be examined if patients are receiving insulin. An electrocardiogram or heart tracing should be performed as a routine check on people over the age of 40 years or who have had diabetes for more than 15 years. General aspects of coping with life both personally and at work should be discussed. At such annual visits people should also have the opportunity to see the dietician/specialist nurse/chiropodist for further advice. Further visits may be arranged before the next annual review as necessary.

Control of diabetes and the detection and treatment of complications is so important that general practitioners should ensure that patients receive this recommended minimal care.

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Diabetes mini-clinic

Sir,

Diabetes has traditionally been managed by hospital clinics, which tend to be overcrowded and rushed with poor continuity of care. Even shared care with the hospital is sometimes inadequate. The concept of complete care in general practice mini-clinics began in the 1970s, and has been shown to produce metabolic control comparable to hospital clinics. The care of diabetic patients must become increasingly the responsibility of general practitioners. It is a common condition, and with some training, management in the community can provide great rewards for both patient and doctor.

In April 1986 my practice, which is in a multiply deprived inner city area, set up a diabetes mini-clinic. Diabetic patients from the practice population of about 13 000 were invited to register with the clinic, as were those diagnosed since the clinic began. Not all known diabetics have yet been included in the register. The clinic is attended by a hospital physician, a practice nurse, a dietician, a diabetes specialist nurse and myself and is held monthly. Ten to 12 patients are booked at 10 minute intervals.

The practice nurse sees the patient first and tests the urine for protein, glucose and ketones. She weighs the patient, checks the blood pressure and visual acuity and checks the blood glucose by B-M Stix. The nurse also uses the opportunity for health education. The patient then has a