Letters

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Children's Commissioner

I write in great appreciation of the article by Dr Jane H Roberts on Poverty, Violence and Child Protection in the *BJGP*.[1]

However, despite the excellence of the contribution, there appears to be one error — it is incorrect to assert the Sir Al Aynsley-Green is the UK's first Children's Commissioner. Professor Al Aynsley-Green was appointed in March 2005, whereas the UK's first Children's Commissioner was, in fact, the late Peter Clarke, Children's Commissioner for Wales, appointed on 1 March 2001.

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DOI: 10.3399/bjgp08X342390

Managing hyperglycaemia

Drs Munro and Feher provide an interesting, useful overview of glucose metabolism and emerging therapies for managing hyperglycaemia in their recent editorial.[1] However, the elephant in the room they fail to discuss is this: in an asymptomatic patient, how clinically worthwhile is reducing a surrogate marker such as HbAlc?

They state that the recent ACCORD and ADVANCE studies 'show microvascular benefit' from intensive glucose reduction and conclude that 'glucose lowering in type 2 diabetes continues to show clear benefits'. But, just what are these benefits? The ACCORD[2] study did not report microvascular endpoints and the primary outcome of death and major cardiovascular events (which, may be argued, is of greater interest to patients than their HbA1c level) was greater in the intensive glucose group. The ADVANCE[3] study does indeed show benefit, but Munro and Feher do not provide the absolute figures with which we can help our patients make informed decisions. This high-quality, large (n = 11 140) study showed that over a median of 5 years, intensive glucose control reduced the incidence of combined major macrovascular and microvascular events from 20% to 18.1%. We should say to our patients that this recent evidence shows that intensive glucose lowering over 5 years will reduce their risk of a significant event by 1.9% and let them decide. Most mortality in type 2 diabetes is cardiovascular, and an associated editorial makes it clear that on 'the fundamental question of the effect of glycaemic control on macrovascular complications there should be no misunderstanding that the ADVANCE trial had clearly negative results'.[4] These results seem to echo the UKPDS study, for which commentators have pointed out that results are over-hyped and the evidence of benefit in terms of glycaemic control are, at best, very modest (2.4% absolute reduction in microvascular complications over 10 years, and a clinically important reduction in macrovascular events and mortality only seen with metformin and seemingly independent of its glucose-lowering effect).[5]

The authors' appraisal of these new drugs is more positive than a recent *DTB* paper.[6] The bottom-line of the independent review by the *DTB* is that, on the basis of the evidence we have, they cannot recommend their routine use but exenatide may prove to be a useful alternative to insulin in some patients. Previous hype around glitazones and inhaled insulin may have made us cynical, but to quote the *N Eng J Med* again 'we don't need lots of new drugs for diabetes, we just need to use the ones we already have effectively'.[7] I am confident that Munro and Feher do not have any conflicts of interest which may influence their opinion, but it would be nice if the *BJGP* reassured readers by making this explicit, as is common practice in other journals.

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DOI: 10.3399/bjgp08X342408

Authors' response

We are surprised to see that the letter by Dr Curtis is published as a critique of

our editorial on 'Current, new and emerging therapies for managing hyperglycaemia of type 2 diabetes'.[1] He has used the pages of the *BJGP* to promulgate a personal view against the tide of epidemiological and clinical trial evidence that glucose lowering has been shown to reduce microvascular events in type 2 diabetes. On the basis of the extensive evidence, consensus guidelines from national and international diabetes organisations (for example International Diabetes Foundation, American Diabetes Association, Diabetes UK, as well as NICE) have recommended the use of HbA1c as a therapeutic target — which he omitted to address. The newer trials of ADVANCE and ACCORD were trials of 'how low should one go' in terms glycaemic targets as measured by HbA1c. It is of interest that Dr Curtis fails to accept the results of the ADVANCE study where there were published treatment benefits on renal events.

The aim of our editorial was to summarise the differing drug classes available for the management of the hyperglycaemia and not to review major randomised outcome trials. There is now a wider drug choice which might allow tailoring of therapy to individuals — many of whom are overweight or poor responders to current therapies. The progressive nature of type 2 diabetes, ignored by Dr Curtis, is a key therapeutic factor resulting in a need for combination of therapies and thus a potential role for newer therapies. Due to these reasons, plus the limited glucose lowering effects of all drug classes, therapeutic agents with different modes of action to enhance glucose lowering are often required. Current clinical practice often includes considering the use of alternative drug classes that do not affect weight, since this is one of the important adverse effects of subcutaneous insulins, as well as oral insulin secretagogues and thiazolidinediones.

We owe it to our patients to be aware of therapeutic advances and place them in the context of present therapies in order to improve glycaemia and reduce the burden of diabetes-related complications.

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DOI: 10.3399/bjgp08X342417

Undergraduate education

I was sorry to read the Back Pages article by a disappointed student who had met negativity about his choice of general practice as a career.[1] I experienced the same in 1975 from a tutor in my second year ('GP? A bright girl like you? That's a real waste'.) Fortunately, it didn't put me off, and I can reassure all students that many of us have already taken action to ensure that the undergraduate programmes across the UK and Ireland now showcase general practice to advantage. There is evidence that increasing numbers of students are choosing general practice; for example, more than 20% making a firm choice (F Lynch and A Howe, unpublished data 2008) compared to an inconstant 10%[2] in a study 7 years before. This reflects both high quality learning and interesting clinical experience in community-based placements.[3] There is also extensive evidence that general practice is a challenging job (you won't be bored, Dan!) and has more academic opportunities than ever before, including more unanswered research questions than one life of academic endeavour could possibly cover.

It is human to talk up one's own preferences, but sadly students do still hear unfounded stereotyping and prejudice from members of one discipline about others. The RCGP, with its thriving Student Forum, its excellent new MRCGP curriculum, and its undisputed place at the table of the Academy of Royal Colleges, has led a shift of status for GP careers which is well deserved. This student has reminded us that there are still negative role models, but we can reassure him that many medical school and Deanery staff (as well as patients) now understand the value of GPs as clinicians, teachers, and researchers. Look at the work GPs do, not what is said about it — actions speak louder than words.

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DOI: 10.3399/bjgp08X342426

Community hospitals

As a GP trainee, I have worked in district, general, and teaching hospitals alone. However, I recently received the opportunity to do an 8-month rotation in elderly stroke care and orthopaedic rehabilitation at Woking Community Hospital.

Woking Community Hospital provides NHS Walk-in centre and emergency