ABCD Spring meeting in Belfast

Dinesh Nagi, Chair of ABCD, reports from the ABCD Spring meeting in Belfast, 10th-11th May 2017

The ABCD meeting celebrated its 20th anniversary in Belfast. The meeting was at the *Titanic* Belfast, built to commemorate the historic birthplace of the *RMS Titanic*. Several theories surround that unfortunate night when the unsinkable ship was engulfed by the icy Atlantic Ocean with tragic loss of life. Can we learn lessons from this historic event? Yes, we can. According to the latest theory, there was a fire in the engine room of the ship before she set sail, but the decision was taken to go ahead with the historic voyage, which defies belief. Does it highlight the enormous risk human beings were prepared to take nearly a century ago? We have come a long way since then with our risk assessment and, I believe, if we go by the NHS risk assessment tools, the *RMS Titanic* would not have set sail.

This magnificent venue was an ideal place to celebrate the 20th anniversary of ABCD with excellent speakers from the home nations. The new Chairman of ABCD opened the meeting and introduced the first speaker, Professor Patrick Bell, who for a change entertained us not with his academics but with the history of Belfast Docks and the family connection, and the close family life of 'natives' of Belfast, most of whom were Protestants with everybody else being described as a foreigner. Glad the world has moved on! Or has it?

The scientific programme was a healthy mixture of diabetes and endocrinology covering topical areas of relevant day-to-day clinical practice, thanks to the efforts of Russell Drummond, a double win in my view of getting the venue and programme of the highest quality. What a way to say goodbye to your role (not ABCD) and end your tenure as meeting secretary.

Morning session

Pratik Choudhary gave an excellent deep dive into shooting the targets, and gave a passionate expert opinion as a 'type 1 super specialist' of what HbA_{1c} target can be achieved for all. He raised an important question as to what levels of HbA_{1c} we should aspire to achieve. Should it be high quality care for all or a basic minimum? He suggested that most patients with type 1 diabetes in the UK have an average HbA_{1c} which is identical to the control arm of the Diabetes Control and Complications Trial (DCCT).

He reviewed the recent new NICE guidance, which sets targets of HbA_{1c} at 6.5% or lower with a provision that we should agree the target with each adult and take into account their personal life choices or circumstances and avoid problematic hypoglycaemia. In addition, every diabetes service should document the proportion of patients who have an HbA_{1c} below 7.5% as a measurement of some success of the treatment.

He subsequently told us about the association of mortality between poor control of HbA_{1c}, both from the DCCT cohort and other worldwide studies, including of course estimated life expectancy in the Scottish cohort. The message is exactly consistent that poor control of type 1 diabetes is associated with a poor overall mortality in these people and a reduction in life expectancy.

He examined the data in relation to the current guidelines and the quest for glycaemia control, that we should be aiming for an HbA_{1c} of 6.5% or 7.5%. He concluded that we need to set some realistic goals and not become frustrated when trying to achieve that particular target while working with a patient and always continue to strive for better. It made me feel uncomfortable that the performance of patients with type 1 diabetes in the UK lags behind that of Europe. It remains a huge challenge for the diabetes professional community to support our patients with type 1 diabetes in achieving good outcomes and improve quality of life.

The talk on osteoporosis given by Professor Malachi McKenna from Dublin was one of the best talks I have heard on osteoporosis. He discussed not only the clinical algorithm while treating patients with osteoporosis but also recent advances in the use of new agents such as abaloparatide and romosozumab which have shown some promising results for future treatment for osteoporosis. In particular, the take-home message was the risk categorisation of patients with osteoporosis and then customising treatment based on their risk. He talked about sequential treatments of bone resorptive agents and also the difficult issue of a drug holiday, particularly in those with a low risk of future fractures.

This was followed by another controversial endocrine topic by Karen Mullin who focused on the long-term consequences of the Chernobyl disaster, particularly the cohort of children during that time of April 1986 now aged 30–48 who are showing an increased risk of thyroid cancer, with all the data coming out of different countries where the exposure was maximum. The rest of the talk focused on two issues: subclinical hypothyroidism or hypothyroxinaemia (with normal TSH) and thyroxine treatment during pregnancy. The conclusion was that the jury is still out because, out of four studies, two showed negative results while the other two were positive (in my mind it is a draw at 2–2 and we need a replay, not penalties). She finished off with showing some recent published data on treating subclinical hypothyroidism in an elderly population and informed us that the trend has been to shy away from unnecessary thyroxine treatment as the risks outweigh the benefits in treating this population, although decisions need to be made on an individualised basis.

Second session

The second session focused on pregnancy and the first talk was given by Professor Fidelma Dunne, Chairman of the IADPSG, who talked about the burden of gestational diabetes (GDM) and the different criteria for diagnosing it. She focused on why the new IADPSG criteria are now being favoured throughout the world and that possibly by 2018 there will be some harmonisation with these criteria being adopted throughout the world, which would make life easier both for research as well as in clinical practice. She also talked about the varying prevalence of GDM in Europe, which is not solely due to using different criteria but more to population mix. The key message was that the more we diagnose GDM the more we can improve the health of the pregnant mother and have better outcomes for both mother and baby.

Professor David McCance, a good friend

of mine during our days at the NIH in the USA, talked about the management of diabetes in pregnancy and covered all the relevant areas and different challenges faced. Again, the message was quite consistent, in that pre-pregnancy planning and pre-pregnancy counselling is essential for good outcomes for mother and baby. In addition to education and training of the mother-to-be with type 1 diabetes, outcomes can be improved by working together in a multidisciplinary team and providing all the help and support to women with type 1 diabetes who wish to have a family.

This was followed by an audit update by Bob Ryder but delivered by Chris Walton on the already highly successful audit data which are coming out of the excellent National and International Audit set-up, which has provided some insight into the management of diabetes nationally using different new agents and the benefits of setting this up into a very rich database which will help us customise the use of these drugs in real time in managing people with type 2 diabetes.

Afternoon session

The post lunch session was on diabetes conundrums and included talks on gastro-electrical stimulation in diabetic gastroparesis with sharing of the local Glasgow experience, which appeared very promising. The difficulties in treating these patients, particularly those who have diabetes but do not have gastroparesis and probably have idiopathic gastroparesis, remain very challenging.

Mark Davies gave a talk about psychological interventions and, in particular, he focused on performance psychology and discussed this particular branch of psychology exploring factors which help individuals, teams and other groups to achieve their aims by focusing on the process but not on the results. He gave several examples of successful teams, and the whole issue of not following the belief where the target is an end point which leads to nothing but failure based on depression among elite athletes. He suggested that this is all about changing the mind-set so that we can focus on the process, and a similar analogy of psycho-psychology can be used to help our patients with type 1 diabetes.

He discussed the concept of patient burnout in diabetes, when one is not able to take the frustration associated with day-to-day care anymore. He talked about blood glucose targets which are difficult to achieve even in the most motivated patients and the suggestion that setting goals without information about how to achieve these targets could be counterproductive in terms of supporting and maintaining patient self-efficacy in the long run. He finished by telling the story of Paul O'Connell and the difference it made to his life when he focused on performance rather than outcomes and learnt more about enjoying the journey while following these processes rather than looking at the outcome.

The next talk was by Ken Robertson, another Glaswegian clinician, who discussed the difficulties of managing diabetes in the adolescent and transition period. He felt that the current support provided and the management of these patients in the UK lags behind that of Europe and examined the whole issue of how to design services for patients with type 1 diabetes and the role played by different factors in childhood diabetes from school, family dynamics, growth, puberty, developmental, professional support etc. He talked about the local experience of Scotland's super-hospital and the impact this was having in the management of diabetes with, again, a multidisciplinary approach, group teaching, clinical systems, use of technology as well as use of data to help individuals to manage their diabetes. He finished off by talking about the implementation of technology and also the different models they have used in Scotland with an enormous amount of success, and how data can be used to improved clinic care in this difficult age group.

Final session

In the final session, Stella George provided a workforce update. Stella has made excellent progress since she took over this work in the last couple of years, particularly moving on from a paper-based system to a computer-based digital system for collecting the data. She presented the data for 2016 with some highlights. Her talk was particularly enjoyable for me having done this work prior to Stella, and it was nice to see how fast progress is being made working in collaboration with the RCP to collect relevant data for the specialty, which will be very useful for the colleges but also for the ABCD as well as the DOH to plan future workforce issues.

The meeting concluded with a 'Year in Diabetes' by a local expert, Hamish Courtney who in his allocated time of 45 minutes, covered a significant number of recently published research studies. Hamish critically appraised the study of the use of liraglutide and the cardiovascular outcomes in diabetes and various other ancillary studies associated with it. This was followed by data on the use of semaglutide and cardiovascular outcomes and the consistent message of beneficial outcomes. He discussed the life years gained by this multifactorial intervention in patients with type 2 diabetes coming out of the Steno Memorial Hospital and the median survival benefit of 7.9 years. He showed new data on the impact of empagliflozin on the progression of kidney disease in addition to its already known benefit on cardiovascular outcomes and, of course, he talked about the glucose sensing technologies and hypoglycaemia management and type 1 diabetes in a multicentre trial showing some benefit in those patients who struggle. He finished off by talking about the use of the closed loop system during pregnancy in type 1 diabetes. His final slides were on the trends in drug utilisation, glycaemia control and rates of severe hypoglycaemia between 2006 and 2013, showing a decline in the use of thiazolidinediones (pioglitazone) and a rise in the use of the biguanide metformin, an old trusted drug in the management of type 2 diabetes.

Diary date

See you in London 9–10 November 2017.

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