Type 2 diabetes: complex, crowded and costly

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The growing number of patients with type 2 diabetes presents an enormous challenge to clinicians. Although the National Diabetes Audit Report on Complications and Mortality (2012–13) showed a significant reduction in premature death for those with type 2 diabetes, there remains a 34% increased risk of mortality compared to the general population over the previous two years across England and Wales. This equates to an estimated 24 000 additional deaths due to diabetes. The majority of these deaths will be due to cardiovascular disease. This has led regulators to insist that any new diabetes drug has to undergo a cardiovascular safety trial prior to licensing. This issue of Practical Diabetes looks at the need for these trials as well as some of the questions that they raise.

Drugs are often used as the mainstay of treatment for type 2 diabetes. With the recent rapid rise in the number and categories of drugs for type 2 diabetes, the choice can become bewildering and confusing. Clarifying the purpose of treatment – whether it is to alleviate symptoms, reduce the risk of developing complications, or have an impact on the risk of premature mortality (largely driven by cardiovascular disease) – can help patients and clinicians navigate through the options available. In this edition of Practical Diabetes, Jyothis George addresses the issues around recently published reports of cardiovascular outcome trials of glucose-lowering drugs. How can we protect patients from drugs that may worsen cardiovascular outcomes while at the same time incentivise the development of diabetes drugs that reduce premature mortality? Is the non-inferiority design the best compromise? Does the publication of the EMPA-REG study change the bar at which all other diabetes drugs will be judged? There is much to think about for patients, clinicians and regulators.

With the increase in the number of new drugs comes the seemingly inexorable increase in the cost of prescribing. Steve Chaplin summarises the changes in prescribing of medicines for diabetes over the last 10 years as published in the recent Prescribing for Diabetes report from the Health and Social Care Information Centre. Diabetes remains the largest BNF category in terms of cost with nearly £850 million spent on diabetes medicines and blood testing products. While 14% of the prescribed items are for insulin, the cost of insulin prescribing accounts for nearly 40% of the overall spend. Clearly, it is important to both patients and clinician that this expenditure is appropriate and that the insulin prescribed achieves the outcomes set by patients prior to starting the therapy. Reports such as these are very helpful in seeing one aspect of the cost of diabetes, but they need to be linked to outcome audits such as the National Diabetes Audit in order to show what has been achieved for such an increase in spend. Bringing together these audits with a measure of what benefit patients have experienced would give a much more rounded picture of the cost and benefit of the newer drugs that make up the majority of the increase in spend.

This themed issue on type 2 diabetes was timed to coincide with the publication of the NICE guidance on type 2 diabetes. Delays to the NICE publication and the controversy around the guideline should not detract from the three other NICE guidelines in diabetes that have been published this year. These are helpfully summarised in this issue. They cover the care of patients from the earliest time of diagnosis in childhood and adolescence, through their journey of living with type 1 diabetes, into the care of women before, during and after pregnancy. Some of the controversies around the targets set by NICE and the evidence used are highlighted, but the overriding emphasis should be on setting individualised targets with patients and finding ways of achieving these consistently for all our patients.

As NICE considers the numerous responses to the draft guidelines for type 2 diabetes, the emphasis must remain on helping patients achieve their own goals. Underpinning this ambition is providing information to patients in a way that they can understand and use. National audits show that the number of people with diabetes attending and completing education courses remains worryingly low, so it is encouraging to see a report of the development of further self-education modules in this issue of Practical Diabetes. Broader access to effective structured education will be essential to get the best out of any drug and help reduce the excess mortality of type 2 diabetes.

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