Simple but effective interventions in diabetes care

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In this issue of the *MJA*, there is important advice from expert bodies about basic management of diabetes and the investigation of kidney disease, which will inform the everyday care of patients.

Cheung, the President of the Australian Diabetes Society, encourages us to individualise both the glycated haemoglobin (HbA_{1c}) targets that we strive for in our patients and the choice of pharmacotherapy used (*page 196*). There are now so many medicines for treating type 2 diabetes that it is difficult to know what is most appropriate. It is reassuring to read that an old but a good one, metformin, is still high on the treatment pyramid.

After many years of discussion and dissent, HbA_{1c} has finally earned its place as a tool in the diagnosis of diabetes (*page 220*). Although there are important exceptions, an HbA_{1c} level $\geq 6.5\%$ is now regarded as diagnostic for diabetes. This test can be done at any time of day without preparation and, unlike serum glucose, is stable if the blood sample is appropriately collected. Considering that about half of Australians over the age of 25 years with type 2 diabetes remain undiagnosed, and the incontrovertible evidence that effective management reduces complications, a simple diagnostic test is long overdue. It seems appropriate that Medicare now fund this test for this purpose.

Moynihan revisits the curly question of redefining gestational diabetes and the challenges this brings (*page 203*). The trade-off of possible benefit from intervention at lower blood glucose levels needs to be balanced against the risks of over-medicalisation and diversion of resources away from those most in need. The concern of how our medical system will cope has already been aired in the Journal (*MJA* 2011; 194: 338-340, *MJA* 2011; 195: 268).

For too long, diabetes-related foot disease (DRFD) has been inadequately addressed in our health system. Bergin and colleagues remind us that one Australian loses a lower limb every 3 hours as a direct result of DRFD and that this has increased by almost a third over the past decade (*page 197*). They convincingly argue that our health system does not fund evidence-based care that includes basic measures such as wound dressings, total contact casting, walking braces, and suitable footwear and orthotics. In no group is this more apparent than Indigenous Australians with diabetes, who are 38 times more likely to undergo a major leg amputation than non-Indigenous Australians with diabetes. The authors provide valuable management guidance for DRFD (*page 226*) that includes sensible and readily available care such as daily cleaning with saline or water instead of surface antiseptics.

Claessen and colleagues report their troubling finding that the incidence of diabetic ketoacidosis in young people remains high (*page 216*). They encourage education to improve early recognition and diagnosis of diabetes and, hopefully, prevention of this serious complication.

If the kidneys have always presented a bit of a challenge, you may welcome the sensible and simple guidance from Johnson and colleagues regarding the assessment of renal function (*page 224*). As they say, "Optimal detection and subsequent risk stratification of people with chronic kidney disease requires simultaneous consideration of both kidney function ... and kidney damage (as indicated by albuminuria or proteinuria)".

Clearly we know a lot about managing diabetes and its complications, although simple measures that could improve care and prevent suffering, including diet and exercise, are not always put into practice. Diabetes is Australia's fastest growing chronic condition, with a reported 275 people diagnosed every day (http://www.diabetesaustralia.com.au/Understanding-Diabetes/Diabetes-in-Australia). As we get back to basics with management, we need to ponder the larger question of how to stem this alarming tide. Maybe the solutions are simpler than we think.

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Training in the tropics

Go north. That's the message for young doctors looking for broad training in endocrinology and diabetes care and with a good measure of Indigenous experience. In Career overview (*page C1*), Cairns endocrinologist Dr Ashim Sinha describes the benefits of advanced training in a regional area such as far north Queensland. Dr Sinha also has tips for candidates who want to maximise their chances of being chosen for the endocrinology training program. Also in *MJA Careers* in this edition, we profile Professor Don Chisholm AO, whose long and distinguished career has spanned many breakthroughs in diabetes research and care (*page C5*). In Money and Practice (*page C7*), we see how doctors are using social media to connect with their patients, while Road Less Travelled charts the career of public health academic and clinician Professor Bob Cumming, whose job has taken him to the far corners of the world (*page C6*).