Management Issues Relating to Diabetes Status; sharing Diabetes Care and Compliance

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The management of diabetes relates to, either glycaemic control, its monitoring or warding of late sequelae i.e. vascular complications.

The methodology for interacting at different situation will vary greatly. The following aspects of standards of treatment will be presented:

i. Diabetes status
ii. Shared care
iii. Compliance

DIABETES STATUS

A physician may come first in contact with a diabetic in different circumstances.

a) On initial screening and when diagnosis is being arrived at.
b) Patient already receiving some treatment and requiring adjustment.
c) There being an acute metabolic emergency like ketoacidosis or severe hypoglycaemia.
d) Physician being consulted due to inter-current complications e.g. infection, foot problem, gastrointestinal upset, i.e. pancreatitis, cholecystitis.
e) During follow-up, patient being screened for early vascular complications.
f) Patient presenting with burnt-out diabetes but end organ failure i.e. left heart failure or end stage renal disease.

In the first proposition, it is ideal situation for making a composite approach to provide guidance on type of medications, diet programme, extent of exercise and initiate self care learning techniques. In situation 2 & 3, metabolic control takes priority with inputs on adjustments in treatment and requires guidance that there is no recurrence of such a situation. Patient should learn survival skills. In the last categories, probably greater emphasis on non-glycaemic factors will be required. Life style changes as abstinence from smoking increase in physical activity and familiarization with techniques for stress management may have to be emphasised. Again management of hypertension, hyperlipidaemia or obesity may have to be optimised.

SHARED CARE

In sharing of care for diabetes, there are three constituents i.e. patient, family physician and diabetes specialist.

Diabetes is there 24 hours a day, 7 days a week, 365 days a year and all the lifetime. It is very essential that a diabetic should learn about his illness and be conversant with the expected standard for care of diabetes. He should learn self care skills and monitor glycaemia status from time to time. He should be alert as to acute complications and instant institute first aid in such situations.

The family physician also plays a significant role in the care of diabetics. He is most easily accessible for any medical opinion and has familiarity with the social environment of the patient. Probably it is also cost-effective for the patient to seek guidance of family physician for any inter-current illness and non-diabetic related problems.

Specialist for diabetes care has a vital role; firstly on diagnosis he initiates treatment and stabilize the metabolic control. Additionally, through the diabetes care team he provides stabilization inputs for nutritional counselling and through diabetes-educator sets goals of management, teaches self-care skills and programmes for follow-up.

Speciality intervention may be required for managing any metabolic emergency for adjustments of therapeutic measures if blood glucose control is not easily achieved.

It is also advised that diabetes care specialist should overview patient-status annually. At this interval, it is advised to conduct a complete physical examination, biochemical evaluation and other investigative procedures to assess organ status (heart, kidney, eyes, nervous system). Again, consultant should interact with the patient to bring about a suitable behavioural modification to improve metabolic control and regularise monitoring.

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COMPLIANCE

This is an issue often ignored, though very relevant in organising any diabetes care programme. The reasons for non-compliance can be many:

1. A lack of communication between the physician and the patient. Patient has not been informed as to what is expected of him in taking care of his disease and its follow-up.
2. Practical aspects of management have not been demonstrated to the patient. Patient has not achieved the competence to perform the required tasks as self-testing of blood glucose or urine for ketones.
3. There being a lack of family support or working environment and such situations not being conducive for good compliance.
4. Inspite of best efforts, and regular medication patient has not achieved much success and due to meagre results, he/she is not ready to visit the clinic for follow-up.

Last but not the least is the cost factors. Due to economic constraints, patient is not able to follow the treatment regularly.

Some of the situations regarding compliance are illustrated as problem solving with appropriate solutions:

a) Inspite of strict regimen, glycaemic control is not forthcoming:
   Secure a detailed profile (6-7 samples/day) of blood glucose and readjust treatment schedule.
b) Doing everything right and under excellent control, still a vascular event has set in: Check on non-glycaemic risk factors and institute appropriate measures to correct these.
c) Diabetes care is interfering in daily schedule and is time-consuming:
   Evolve a flexible schedule to suit the life style.

To achieve better compliance, diabetes care team is expected to take cognisance of patient's problems, evolve a flexible schedule and provide a support system rather than remain impose an authoritarian regimentation.

There is overwhelming scientific evidence to suggest that improvement in metabolic control, leads to amelioration of symptoms, obviates risk of ketoacidosis, restores the rate of recovery from any infection and normalises wound healing. Management during pregnancy ensures good control and a normal foetal outcome. Attention to associated non-glycaemic factor reduces frequency and severity of vascular disease and thus restores longevity.

The diabetes care team has an obligation to provide continuing care for the diabetics. It requires lying some standards to strive for and introduce quality assurance as to lessen the burden of diabetics. In achieving the objective of a "full life despite diabetes", however primary onus is on the part of the patient and he/she should be made aware of this.