Interactive Audience Question Answers

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Q. 1. Who should be screened for diabetes mellitus?

A. 1. Patients with High risk of diabetes mellitus are advised a screening test.

These include:

* Persons with a family history of diabetes (in a direct relative)

* Persons who are markedly overweight for age/sex.

* Females with a bad obstretrical history or having given birth to an infant weighing > 8lbs.

* Those with history of recurrent skin, genital or urinary tract infections.

This is to be remembered that in any population for every known diabetic, there is one as yet unknown and hence index of suspicious should be kept high.

For any suggestive sign in an individual (premature cataract, cardiovascular disease or spondylosis) a screening test for diabetes mellitus is recommended.

In U.K. one may recommend that all Indo-Asians above age of 40 years should have a screening test.

Q. 2. Should detection of hypertension call for an ECG and serum Cholesterol estimation in all individuals or the scoring system (exclusive of these two parameters) is sufficient for detection of underlying cardiovascular disease?

A. 2. Having identified hypertension in an individual, one should apply scoring system of Professor Shaper to determine risk of coronary artery disease (CAD) and proceed for other investigations based on this lead.

Q. 3. Should Indo-Asians routinely have plasma insulin value determination as CAD risk factor?

A. 3. Not as a routine procedure, but only for research purposes.

Q. 4. Are there ethnic variations in drug response (especially drug use in cardiovascular disease or for diabetes)?

A. 4. There are no known ethnic variations in drug response for the Indo-Asian people. There are, however, known ethnic variations in drug response for cardiovascular disease, in particular amongst American Blacks and British Blacks. I would suspect that it would be only equitable for all new drugs to be checked for equivalence of response in each broad ethnic group.

Q. 5. As fewer Indo-Asians with myocardial infarction, get the opportunity for thrombolytic therapy, is this a major cause for a higher mortality in this group?

A. 5. This is a complicated issue and in reality should be compared with like, for instance, only White diabetics compared with definite Indo-Asian diabetics. When we do this sort of analysis there is infact little difference in mortality. I do agree that a slightly less equitable treatment probably accounts for some of the higher mortality in the overall group, but a part of it also is because of the higher prevalence rate of diabetes in average Indo-Asians.

At A.I.I.M.S. study, mortality following myocardial infarction in diabetes related to glycosylated hemoglobin values; those with good metabolic control had mortality equivalent to the Caucasians (12% within 24 hrs.)

Q. 6. The traditional Indian cooking involves plenty of fat (especially butter, ghee). Is there an alternative?

A. 6. The alternatives that we have been using in Leicester is a gradual change via public health means to improve the type of fat and oil used (switch-over to more monosaturated and polyunsaturated fats) and to gradually reduce the total amount being used. Alterations in methods of cooking e.g. stewing, grilling, tandoori cooking can as well reduce amount of fat required for preparing food.

Q. 7. With existing cultural background, how do you propose to exercise an Indo-Asian female when her activities are very much limited indoors?

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A. 7. Eastern culture is familiar with Yoga Asanas (isometeric exercises). Again, now there is feasibility of advise on indoor exercises e.g. static cycling, skipping or arm raising, simple touch downs and sit ups.
(Many guide books are available for indoor exercises)

Q. 8. Do language translators effectively transcribe the medical information or is it better to provide health education through medium of leaflets, video in respective languages?

A. 8. No language translator effectively transcribes medical information all the time and, therefore, it is probably best to use all methods. One could use a system that the BBC used for a long time, for instance, putting in public health data into the Archers.

Q. 9. What stage can intervention, regarding a change of life style be most useful for immigrant population?

A. 9. This is unknown at the moment.
In those at risk for coronary artery disease, intervention should start as early as possible. One is awaiting for the results of some studies in progress now.

Q. 10. Which diabetic patient needs a referral from G.P. to a specialist or a diabetic clinic in a teaching hospital?

A. 10. Those with complex clinical situations.

In Leicester, general practitioners usually refer insulin-dependent diabetics who are difficult to stabilize at home or have developed complication that requires a specialist's attention.

There is overall recognition that Indo-Asian are at high risk for ischaemic heart disease, hypertension, stroke, non-insulin-dependent diabetes and other non-communicable diseases.

This surge seems to be outcome of over-consumption of refined starches, saturated fat, lack of physical exercise, smoking and emotional stress.

Therefore, it is felt that community awareness programmes on limiting amount of fat intake especially that of saturated fats; use of complex carbohydrates instead of refined starches and concurrent changes in life style i.e. increase in physical activity, abstinence from smoking and learning relaxation techniques to overcome stress would go a long way to contain the emergence of such diseases amongst this population.