DIABETES MELLITUS

Resume of Talk Given by Dr Deborah Bosman at our Public Meeting last October

Dr Bosman began her talk by saying she would include mention of diet (how important is diet?), symptoms, age, heredity, weight and the pancreas.

What is diabetes mellitus? The term itself refers to the excessive production of urine (diabetes) which contains an excessive level of sugar (mellitus = "of honey"). This state is caused by either a lack in a hormone, produced in the pancreas gland, called insulin (Type 1), or an inability of the body to respond to it (Type 2). This is known as insulin resistance.

Insulin fulfils an essential role in controlled carbohydrate metabolism and, in diabetics, the problem with insulin results in there being too much sugar (glucose) in the blood.

10% of cases will be of the unavoidable (Type 1), with 90% suffering from Type 2. Most type 1 patients develop the condition in childhood, whereas Type 2 tends to start later in life.

In Type 1 the failure to produce enough insulin can be caused by such things as alcohol, damage from an infection, surgery or Mature Onset Diabetes of the Young (MODY - which is inherited). Treatment requires careful monitoring of blood sugar and the administration of insulin which has to be injected.

Not managing carbs properly may be as a result of Type 2 'insulin resistance' which can result in weight gain. However, obesity itself is a very important cause of this type of diabetes and an operation to lose weight (bariatric surgery) can switch off a patient's diabetic condition almost overnight. For most patients, in the early stages, treatment is usually with diet and or tablets. Later on, if the pancreas becomes 'tired' or there is a cell defect, patients may need to supplement their treatment with insulin injections. According to the Guardian, our Prime Minister, Theresa May, is one such patient.

Keeping in shape through eating well and regular exercise reduces the risk of getting type 2. Introducing exercise can be complex and might include such activities as walking, running, jogging, cycling, swimming and housework, but may also require a change in lifestyle such as using the stairs instead of using the lift! To lose weight probably requires eating 250-500 less calories every day; exercise is good but probably does not achieve any actual loss of weight.

Symptoms to look for are thirst, tiredness, passing lots of urine, weight loss and infections like thrush. The emergence of type 2 is a slow process (over years), but when you have symptoms, are over a certain age and with family history, screening is recommended. Type 1 tends to occur in younger folk after an auto-immune attack, while type 2 increases in prevalence with age. Complications with diabetes include circulation, blood pressure, cholesterol, eyes and kidneys – any of which may be being affected before diabetes is suspected.

Weight and insulin resistance go together. A body mass index (BMI) of 25 is healthy for diabetes, with 25-30 being overweight, and over 30 being obese. *(BMI is calculated by dividing your weight (kg) by your height (metres) once and then again ie height squared).* A BMI of 30 would require a 10% weight loss, with 1kg per month being a realistic target; no diet is a miracle worker, calorie reduction being the answer; choose healthy food – low in carbs, rich in vegetables, avoid refined sugar, reasonable amounts of protein. Diet for a few months and then have a break.

Dr Bosman went on to say that the unhealthiest snacks are biscuits and ice cream, but suggested that we have everything in moderation! Fruit is good and should be firm as the more 'squidgy and juicy' the more sugar there is. If you are pre-diabetic keep refined intake down, bearing in mind 'life and quality of life' as abstaining completely is miserable. Whatever alcohol you drink will have an effect on your blood sugar, making it rise and then drop, and she indicated that it is probably better to drink a white spirit with diet mixer - but the worst possible is binge drinking.

Metformin is frequently used for the treatment of type 2 diabetes and is a safe drug. Early control is advised with medication and diet to avoid possible damage to all organs. Dr Bosman suggested that if you are over 40, there is history of diabetes in your family or you have vascular problems then you should ask the practice nurse for screening to decide whether annual testing is recommended. If you are feeling unwell, are thirsty, suffer from unintended weight loss act quickly. The prevalence is 8% and there is a similar figure for pre-diabetes.

A very significant percentage of the budget is spent on amputations. Testing of blood sugar is vital for type 1 – up to 8 times a day – with foot care being really important. Understanding how to look after your feet means that problems are discovered early. "Socks off" is Dr Bosman's instruction for all patients to ensure that she is provided with this essential information; podiatry is vital to spot any ulcers which would potentially progress to amputation. 5% of foot problems are likely to be those who 'won't present'.

For an individual therefore diabetes is a very important condition with many patients requiring a special diet, and pills and/or injections to stay well. For the NHS, it is a very significant condition incurring huge costs for both the medication, and also the complications which can arise when the condition is not controlled well enough.

The cost to the NHS of prescribing drugs for diabetes has soared to almost £1bn a year, as the number of people diagnosed with the disease has risen sharply alongside the surge in obesity. The NHS in England spent £956.7m on drugs last year prescribed by GPs, nurses and pharmacists to treat and manage the condition. That sum represents 10.6% of the cost of all prescriptions issued by NHS primary care services in 2015-16.

The health service now spends more on medication for type 1 and type 2 diabetes than for any other ailment. The number of diabetics across the UK as a whole has recently risen to more than four million and has increased by 65% over the last 10 years. *The Guardian Aug 2016*

Things change. Each week at PMG one new case of diabetes is detected and one of pre-diabetes, but the benefits of early diagnosis and, therefore, early treatment cannot be stressed too much – for more information go to **www.diabetes.org.uk.**

NEWSLETTER NUMBER 35 MARCH '17

Pulborough Patient Link

pulborough patient link

- your voice in local health

Pulborough Patient Link invites you to a Public Meeting in Pulborough Village Hall on

Monday 27 March

when

Peter Taylor

Professor of Microbiology
University College London

will give a talk entitled

What Every Patient Needs to Know about Antibiotic Resistance

Talk 7.00 – approx. 8.30 pm

Refreshments and Raffle Draw

We are most grateful to our advertisers for sponsoring our newsletters.

PPL COMMITTEE

Since the last newsletter, there have been several changes to the Committee, one of which was triggered by the appointment of David McGill as a Governor of Sussex Community NHS Foundation Trust. David was Chairman for just two years, but we are fortunate that his appointment does not preclude his staying on the committee, thank you David, (although not as chairman) and so being able to continue to give us the benefit of his knowledge and also to keep us in the picture as far as the Trust is concerned.

Unfortunately, we are saying 'goodbye' to Mavis Cooper. Mavis has kept the minutes for all of the ten years of the committee's existence – a mammoth task! Many thanks to her for all her dedicated service. We also thank Jane Roach for her stint as Treasurer.

Many of you will know Alyson Heath, the recently retired head of St. Mary's CE (Aided) Primary School. She joined the Committee in the Autumn of 2015 and has now taken on the role of Chair. We also have a new treasurer and four additional committee members so are now 'up to strength' again. We look forward to new input from these new faces. Welcome Dona, Jane, Lisa, Pam and Peter.

The Committee is now:

Chair Alyson Heath - 01798 873795
Secretary Dona Sherlock-Fuidge – 01798 873747
Treasurer Peter Jenkins
Alan Bolt – Practice Manager
Drs Tim Fooks, Ray Ghazanfar and Nikki Tooley
Lisa Anderson Cllr Brian Donnelly Lesley Ellis
Pam Haley-Chattaway Stuart Henderson
Jane Kendall David McGill
Robbie Roberts Tilly Spurr

MESSAGE FROM OUR CHAIR

I have lived in Pulborough since 1978 when I married Andy. We have two children Daniel and Charlotte.

Since my retirement I have become involved in many voluntary organisations within the village and further afield. As you would expect from a retired head teacher I am passionate about children getting the very best start in life possible. I have become a governor at two schools, chairman of Family Support Work across East and West Sussex, Chairman of two charities who work in schools - Just Different, highlighting and raising awareness of disability and Just Enough UK, raising awareness of anti-trafficking and anti-slavery issues. In November I am off to Sierra Leone where, as a trustee of Education West Africa, I will be helping run two educational conferences for teachers in the diocese of Bo and Freetown so, as you can see, there is never a dull moment in the Heath household!

Our eldest child Daniel has cerebral palsy and, in the early years, we were so well supported by the doctors in Pulborough who could not have been more supportive and caring. I believe we have an outstanding Practice in Pulborough, and together with the PPL committee I want to celebrate the amazing things PMG offer and gather views, keep up to date with the ever-changing initiatives and support the Practice to further enhance the comprehensive facilities we already have.

If anyone wants to feed back any positives or areas for development the PPL committee would love to hear from you.

Alyson Heath

PMG UPDATE

Dr David Pullan has decided to leave as a Partner at the end of June, having been at PMG since end of 1999, and he will be very much missed by us all. The Partners will be reviewing staffing levels, but we are lucky that Dr Leigh-Anne Bascombe remains as a salaried GP when Dr Eloise Scahill returns working 3 days a week from April. Leigh-Anne has been covering as Eloise's maternity locum for the last year. Dr Katie Armstrong returned from maternity leave at the end of February and is working 2/3rd day once a fortnight.

We continue to be a successful training establishment, currently having two GP Registrars on attachment – Dr Harleen Bedi who takes her exams this month and completes her training in July, and Dr Rosanna De Cata who will be with us until January 2018.

The nursing team is now fully staffed following the recent appointments of Julie Docking, a Health Care Assistant and Philippa Stallard-Penoyre and Tracey Marshall, both as Practice Nurses. Clare Snow, our phlebotomist, has completed her training programme to become an HCA; she will continue with her role in taking bloods, but will be able to extend the care she can offer.

The extra staffing has created availability of appointments and has released Anna Harrison (a Partner and Lead Practice Nurse) to assist with home visits. It also means she can deal with travel clinic applications/ appointments for vaccination.

Electronic Prescribing – 70 % of patients have signed up for EPS, but we would like all patients who have repeat prescriptions to register for this – the process is quicker, easier to audit/track progress of 'scripts' and reduces the workload for GPs and prescription staff, enabling them to devote more time to other aspects of patient care.

The Practice had an Encircle training afternoon on Wednesday 1st March. This is a Government ruling under which Practices have to close for 6 half days a year for training. At these times we are closed for routine appointments, but there is still emergency cover. At the March training the clinical staff had an ECG masterclass and discussed a plan for nurse-led hypertension clinics; also covered was CPR training and work to meet Quality Outcomes Framework (QoF) targets.

Anatomy Word Search

bladder	intestines	pancreas
brain	kidneys	skeleton
ear	liver	skin
eyes	lungs	spleen
gall bladder	muscles	stomach
heart	nose	tongue

G	R	K	I	D	N	E	Y	S	C	T	L	T	V	F	Z	X
P	T	A	M	R	F	Z	N	G	P	F	S	I	H	F	W	E
M	C	Z	E	U	M	H	I	A	O	D	Y	C	V	I	M	E
B	L	A	D	D	E	R	K	L	E	X	P	S	I	E	C	P
Y	W	C	K	S	I	I	S	L	L	R	L	Y	N	L	R	A
U	R	W	G	B	N	X	O	B	M	H	O	M	B	A	B	N
J	J	N	R	J	T	F	P	L	H	T	R	A	E	H	I	C
A	U	A	M	S	E	X	X	A	T	K	R	O	X	A	Z	R
L	I	V	X	S	S	V	L	D	E	F	O	X	K	K	Q	E
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H	B	E	R	E	S	N	A	Q	D	K	M	R	N	Y	G	O
F	P	T	R	U	F	C	W	A	U	Z	K	K	C	Q	N	S
I	Y	O	M	D	O	B	Z	A	A	V	X	A	J	S	O	E
B	K	N	Y	S	P	L	E	E	N	H	C	A	M	O	T	S

DEMENTIA
EIGHT CARE-GIVING MAXIMS FOR DEALING WITH PERPLEXING BEHAVIOURS

Don't try and stop people with dementia from doing something just because it isn't being done 'properly'. Don't take over – give them time to do things in their own way and at their own pace.

People with dementia understand far more than they are ever given credit for. Take care what is said in their presence and don't exclude them from conversations or decisions. Exclusion of any kind can produce anger.

Bossiness is Just Not On. It's very easy to confuse 'caring' with 'controlling' and nothing winds up any one of us more than the sense that someone else is controlling our lives. And if the person we're caring for can't find the words to protest, then resistance or aggressive actions will ensue. So walk away, try again later or distract with music of their taste.

Ask the question 'Who is it a problem for – the person with dementia or us?' If it's us, we should just let things ride. Does it *really* matter that he wants to go to bed with his trousers on, eats mashed potato with her fingers, says there are little green men in the garden? Don't scold, argue, contradict or try to make things 'normal' again – you'll only exhaust yourself. Go With The Flow, however bizarre it seems.

Preserve their autonomy for as long as possible by giving them choice (e.g. what clothes to wear – and not the whole wardrobeful, just between 2 garments!) Celebrate what they can still do, rather than bemoan what they can't. Is the bottle half full or half empty?

There's nearly always a reason for perplexing behaviours – often something/somebody in the environment or events in their past history. Try to spot the cause and change it if possible. 84% of people with Alzheimer's misinterpret what they see in their environment.

If they can't enter our world, we must enter theirs and affirm it. Be prepared to time-travel backwards into their personal history and enjoy fantastic adventures with them in *their* 'real' world instead. If we have to indulge in a few evasions – such as answering the 'fact' that "I need to go home and make the children's tea" with "What's their favourite?" – when was it a sin to make someone happy? Failure to recognise an elderly family member, or confusing generations may be because the person with dementia is living in their head many years ago.

Look behind the illness and reach out to the frightened person still in there who needs to feel secure, respected and cherished.

Barbara Pointon