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# Editorial

Welcome to this issue of *BJPCN*. I find myself, rather like a modern-day Scrooge, worrying about how we will face the next financially challenging years in the NHS. The Government has recently announced a pay freeze for GPs, and Lawrence Buckman, chair of the BMA's GP Committee, warns that this affects not just doctors but all of the members of the teams they work with. This will put pressure on primary care teams, which can spill into day-to-day interaction with each other and with patients. How can we ensure that the quality of patient care is maintained throughout these tough times?

I have two contrasting images of the impact that healthcare staff can have on their patients. I remember a trip in a lift I made when my son was seriously ill in hospital. Over his trolley, two nurses moaned to each other about their jobs and conditions. Their grievances may have been justified, but it was not the time or the place for that discussion.

In contrast, I remember the amazing dedication and communication from the ITU nurses when my son couldn't speak. I don't remember what was in his drip or what the pressure gauges showed, but I do remember the way they spoke to him and our family.

Take a minute to think of the people you spend your time with each day, and the numerous interactions you have. As a respected health professional – and polls consistently show that nurses are right up there, with a recent international survey showing that more than 95% of people have a great deal of respect for the profession – your every word and the way you speak will be remembered, probably repeated to family and friends, and, hopefully, acted on.

It can feel an uphill struggle to keep achieving, learning and being positive as we face financially lean times for the NHS. But, what we say, what we mean, what we do and how we behave can make all the difference to our patients. We hope *BJPCN* will provide some light for the way ahead.

Diagnosing diabetes is high on the agenda in this issue of the journal – rightly so in view of the rapidly increasing numbers of people affected and the huge impact of complications if diabetes is diagnosed late. Professor Mike Kirby explains why an international expert committee has recently recommended that HbA<sub>1c</sub> should be used to diagnose diabetes. He explores the basis for this recommendation, looking at

why HbA<sub>1c</sub> would provide a more accurate measure for diagnosing diabetes than glucose tests and what the change would mean in clinical practice.

A significant barrier to improving the early detection of type 2 diabetes has been inadequate screening using glucose tests that are both time-consuming and inconvenient to perform. Although the oral glucose tolerance test (OGTT) is considered the 'gold standard' – and we will continue to use it for now – it has several drawbacks. Performing an OGTT is time-consuming and costly. Patients have to fast for at least eight hours before having the test and consuming the necessary glucose load on an empty stomach may make some feel ill.

The expert panel argues that a measure that captures chronic glucose exposure over a long period is more informative of the presence of diabetes than a single measure of glucose. HbA<sub>1c</sub> varies less than fasting plasma glucose values and the test is also easier for patients who would no longer be required to perform a fasting blood glucose or oral glucose tolerance test.

Patient education will always play a large part in improving the early diagnosis of type 2 diabetes, but using a simpler and more convenient test such as HbA<sub>1c</sub> will undoubtedly help in detecting the condition earlier.

Sandra Waddingham, Diabetes Co-ordinator for North Lancashire Primary Care Trust, turns the theory into action in this issue's *Hands on* article, looking at who to test for diabetes and what to test. She takes us through the use of Findrisc, the Finnish Diabetes Risk Score, which is a risk assessment tool developed to accurately predict the risk of diabetes. She then reviews how to conduct a fasting blood glucose and

oral glucose tolerance test – which remain the current tests for diagnosing diabetes, and looks at how to interpret the results. To illustrate the points, we follow two typical patients – Edna and Barry – through each stage of the process of diagnosing diabetes.

Chronic kidney disease (CKD) – which all too often results as a complication of type 2 diabetes – sometimes feels like an enigma. Robert Lewis, Consultant Nephrologist at Wessex Regional Renal and Transplant Unit, Portsmouth, provides the answers to ten key questions on CKD. He helps to work through the puzzle of whether an estimated glomerular filtration rate (eGFR) of less than 60 mL/min in an elderly person reflects normal ageing or whether it is CKD. NICE recommends measuring albumin:creatinine ratio (ACR) as opposed to a bedside urine dipstick to identify proteinuria. Is the additional cost and inconvenience justified? And are the blood pressure targets set out in NICE guidance on CKD desirable in the elderly?

The prevention of cardiovascular disease (CVD) is being moved up a gear with the ambitious and wide-reaching NHS Health Check programme. In this issue's *Prevention in Practice* article, I provide a practical guideline for the primary care team on implementing the Health Check programme, setting out who we should be checking, what we should be checking and how we should act on what we find. The aim is to help you to be clear about who to include in the Health Check and what you should check. We follow some people through their Health Check to see what this means in clinical practice.

I hope you find this issue of *BJPCN* useful in your day-to-day work, and as we enter the challenges of 2010, to quote Tiny Tim: 'God bless us, every one.'

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