



Editorial

The last Newsweet of the year!

I've just returned from the ADIPS meeting and have summarised the highlights. Gestational Diabetes Mellitus is certainly a growth industry in more ways than one.

I'm grateful to Virjean Primeau for highlighting the difficulties she has had gaining registration as a diabetes dietitian in New Zealand and hope that the changes the New Zealand Dietetic Association are making will make it easier for others in a similar position.

The team at MidCentral DHB have provided their results of an insulin pump trial in younger people. Pump funding continues to be an issue for all diabetes services and these positive results can only help the cause.

Best wishes to you all for Christmas and the New Year.

Nicole McGrath

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"My doctor told me to start my exercise program very gradually. Today I drove past a store that sells sweat pants."

Summary ADIPS meeting, Adelaide 2008

Nicole McGrath

Peter Damm, Obstetrician and Physician from Denmark, provided his outcome data on the 22 year old offspring of Danish women who had diabetes in pregnancy (either type 1 diabetes or gestational diabetes (GDM)) compared with women with risk factors for GDM but negative screening and a control group from the background population. The risk of type 2 diabetes or impaired glucose tolerance (IGT) was highest in those from a GDM pregnancy at 21% but the offspring of type 1 diabetes mothers also had a significantly increased risk of type 2 diabetes (11% compared to only 4% controls) as did those from the risk factor only group (13%). If maternal glycaemic control was poor in the third trimester of pregnancy, the risk of type 2 diabetes/IGT in offspring was increased fourfold in the type 1 group, 4.5 times in the risk factor group and 7.8 times in the GDM group. His conclusion was that both the hyperglycaemic intra-uterine environment and a genetic predisposition (ie family history of type 2 diabetes) predispose to type 2 diabetes/IGT in the adult offspring of a diabetes pregnancy.

There was much discussion about the implications of the recent HAPO study regarding the diagnostic criteria for GDM. An analysis from John Flack, Endocrinologist in NSW, suggested that if the cut-off fasting blood glucose was lowered from 5.5 mmol/l to 5.0 then there would be a 57.9% increase in the number of women diagnosed with GDM. There was mention that perhaps the New Zealanders have correctly set the 2 hour level at 9.0 (mentioned with much chagrin from the predominantly Australian presenters) and if Australia followed suit (thus giving an odds ratio of 2.0 based on HAPO data) that this would increase the numbers by only 25.8%. There seemed to be a general feeling that the polycose test should be abandoned and that all pregnant women have an oral glucose tolerance test (already the practice in several Sydney centres). There were several presentations on novel ways of managing the ever increasing numbers of women with GDM involving low risk cases (ie not requiring insulin) being managed by the midwife/ diabetes educator and dietitian without need to see the physician or obstetrician. In one study from Brisbane, 90% of GDM referrals were triaged as low risk initially and 46.5% were subsequently referred to the obstetrician/physician clinic (30% for insulin commencement, the rest for obstetric complications).

Lastly, the issue of obesity in pregnancy was raised, not only as a risk factor for GDM but for many other pregnancy complications (eg pre-eclampsia). New advice on healthy weight gain in pregnancy suggested that for women with a normal BMI, recommended weight gain was 2-10kg and for those with a BMI pre-pregnancy of >30, 0-6 kg only. Early pregnancy education (best given by midwives) about weight gain and healthy eating, may help reduce subsequent GDM numbers.

Experience of an Overseas Dietitian

Virjean Primeau

When our esteemed editor asked if I would write an article about my experience as an overseas dietitian, I was quite happy to do so. Of course, I wanted to wait till after I had "cleared the last hurdle" passing my re-sit of the OCRE in December.

Our odyssey began in 2003 when my husband, our three sons & I decided to escape to New Zealand, fearing what four more years of the Bush Administration would mean. No doubt it was a mid-life crisis and pursuit of a simpler life in a beautiful place that moved us to look in the direction of New Zealand.

We naively thought that having a skills shortage of dietitians would bode well for us, as I have been a U.S. registered dietitian for over 25 years. We were soon to learn this was going to be a lengthy, time-consuming process. We filled out the newly revised EOI (Expression of Interest) form on-line and waited to hear.

Meanwhile, I contacted the Dietitians Board to find out what the requirements would be to practice and become NZ registered. From here on there were numerous e-mails and correspondence involving requests for more information, which I would provide, followed by yet again more information requests. The level of scrutiny went back to course descriptions for courses dating back to the 1970's! I can appreciate having competent professionals employed in New Zealand, but I had already been issued proof from the American Dietetic Association that I was a member in good standing since 1978 and it obviously wasn't enough. However, not to be easily discouraged, we went ahead and planned our adventure after receiving our work to residence visas in November 2005. We sold our home, furniture and most possessions, keeping our sons. We drove from Charlotte, NC to Los Angeles, CA stopping to visit friends and family to bid them farewell. We boarded a cargo freighter for a two-week trip across the ocean. Highlights included the stargazing at night and flying fish during the day.

After arriving at the end of March, I was employed to work at the Diabetes Centre at the end of May. However, before I could be issued an IPC (interim practicing certificate), the Board had set forth several conditions, which first had to be met. After meeting those, more conditions were set forth before I could sit for the OCRE in July 2007.

After passing 4 of the 5 questions, it became necessary to re-sit the question I failed, as all questions must be passed with a score of at least 50%. Interestingly, if I had had the question in Dec. back in the test taken in July, I'm confident I would have passed the whole thing the first time through the exam. The exam is based primarily on the papers students complete at Otago University so it is vital to have lecture notes and readings from a recent graduate. Of course, one must make those contacts and I was quite fortunate in having a recent graduate hired as a locum who was willing to help me. Throughout this process, many wonderful people supported me. They did so voluntarily, investing time and resources to enable me to gain registration.

Patience and perseverance are watchwords to guide one thru the process. It can and does get quite frustrating and off-putting for many overseas professionals. In areas where there is a skills shortage it would make sense to have in place a system that can **help people** and streamline the process, rather than discourage them by moving the goal posts or creating additional hurdles to make it more difficult. I am happy to be able to say that some helpful changes have been made since I started the process although more are needed if the brain drain and skills shortage crisis are to be curtailed.

Post Script: Following the writing of this article, I am sorry to report I once again did not pass the one question on public health nutrition and was gutted for the 3rd time! Since it is obvious now that I become too anxious and stressed to be able to think clearly, the Board has offered me the option of taking a paper in Public Health Nutrition which I will complete next year. I was given my APC which I took as a vote of confidence, so I can continue to live and work in Northland. Amen

Living Cell Technologies Trial Approved

On 20 June 2008, the Minister of Health, Hon David Cunliffe, wrote to the National Health Committee (NHC) requesting that the NHC provide him with independent advice on the application that had been made by Living Cell Technologies (LCT) to conduct clinical trials of pig cell transplantation in New Zealand.

On 21 October, a statement was released saying the clinical trial has been conditionally approved. The Minister said in approving the trial he was mindful of the huge potential xenotransplantation had for the treatment of Type 1 Diabetes sufferers.

To read the Government media release in full, please go to:

<http://www.beehive.govt.nz/release/living+cell+technologies+trial+approved>

The NHC's advice can be found in its entirety on the NHC website: <http://www.nhc.health.govt.nz/>

NZSSD wrote a press release regarding the trial's approval and this can also be found on the NZSSD website (www.nzssd.org.nz).

Please contact the NZSSD Secretariat if you require further information. Phone: (03) 4703805. Email: info@nzssd.org.nz

Trial of Continuous Subcutaneous Insulin Infusion Therapy at Midcentral Health (2006-2008).

Nicola Pereira (Paediatrician), Paul Dixon (Endocrinologist) and Mary Yiannoutsos (Diabetes Nurse Specialist)

In 2005, the Midcentral District Health Board (MDHB) approved funding for an initiative in the MDHB Diabetes Service Plan (2006) for a two year continuous subcutaneous insulin infusion (CSII) pump trial for children and youth (0-25 years). Funding was provided for the purchase of 10 pumps per annum for two years plus NZ\$1,800 per annum towards the cost of consumables for each pump. An additional 1.0 full time equivalent (FTE) Diabetes Youth Clinical Nurse Specialist and 0.3 FTE additional Diabetes Dietician time was also funded, although neither position was funded specifically to support the pump programme. Funding for after hours nursing telephone advice for clients for 14 days following commencement of CSII pump therapy was also provided. No funding was available for additional physician/paediatrician time or after hours physician support, project management or access to clinical psychology services.

The time frame required to establish our pump programme was underestimated. Staff training, the purchase of CSII pumps through a tender process and the development of candidate selection criteria, clinical guidelines, data collection tools and audit processes had to be completed prior to commencing clients on CSII therapy. Our first pump start did not take place until February 2007 but we commenced ten children/youth on DHB funded insulin pumps and two children/youth on self funded insulin pumps in 2007 and will have completed a further ten pump starts before the end of November 2008.

All children/youth who submitted a written expression of interest form were considered by our CSII Pump Committee for inclusion in the trial. Children/youth were required to fulfil at least one clinical criterion and all three patient requirements to be selected for CSII therapy. The clinical criteria were recurrent severe hypoglycaemia, hypoglycaemic unawareness, high insulin sensitivity factor, sub-optimal glycaemic control despite multiple daily injections (MDI), pregnancy planning or pregnant, the presence of microvascular complications or co-existent medical conditions. The patient requirements were a demonstrated commitment to home blood glucose monitoring, willingness to quantify carbohydrate intake, and willingness to attend medical follow up.

Follow up data over a minimum six month period are available for 13 MDHB funded clients. Mean haemoglobin A1c (HbA1c) prior to commencing CSII pump therapy was 9.1% (S.D. 1.8). Six months after starting CSII pump therapy, mean HbA1c had decreased to 7.6% (S.D. 0.49). No episodes of severe hypoglycaemia have occurred in any patient following commencement of CSII therapy. In the two years prior to commencing CSII therapy, one patient had 4 episodes of severe hypoglycaemia and two patients each had two episodes. In addition, high levels of satisfaction with CSII pump therapy have been reported by our patients and we have not had anyone discontinue pump therapy to date. We hope to provide more objective data about patient satisfaction in the future using a validated Paediatric Quality of Life Assessment tool.

While we acknowledge that our current patient numbers are small, our results have demonstrated a reduction in mean HbA1c over a minimum of a six month in patients on CSII therapy. The Diabetes Control and Complications Trial (DCCT) (1993) showed that each 1% reduction in HbA1c reduces the risk of developing microvascular complications by up to 30%. It is well established that CSII therapy is associated with a reduced incidence of hypoglycaemia and this has proved to be the case in our patients. If CSII avoids one severe hypoglycaemic event every two years over a six year period (the average lifespan of a pump), then it is cost effective (Health Services Assessment Collaboration Report 2008, University of Canterbury). In addition, our pump trial has increased the skill set of our Diabetes Team. We feel that our results justify our recommendation for ongoing funding of our pump programme.

Job Vacancy: Palmerston North Hospital Specialist Physician Diabetologist-Endocrinologist

This is a new position with a Primary Health Care focus established as part of the Diabetes Service Plan. The purpose of this position is to work within an inter-disciplinary team to provide a high standard of clinical practice and clinical expertise. The successful applicant will contribute to the provision of efficient general medicine, diabetes and endocrinology services to the community and region served by MidCentral District Health Board, the four Primary Health Organisations and Iwi across the district.

Full details of this job, plus links for the application form or to apply online can be found on the following website:
<http://www.midcentraldhb.govt.nz/Working/Vacancies/Medical/VID1410.htm>

Clinical Academic Fellowship in Diabetes Research

Applications are invited for a three year Clinical Academic Fellowship in Diabetes Research. A very generous bequest from the estate of Jens Henrik Jensen has provided for a single three year Diabetes Research Fellowship. The Fellowship is for a medically qualified person wishing to pursue a career in academic medical practice. The Fellowship will provide support for the individual and his/her supervisor to undertake a three year programme of study leading to the award of a PhD.

The full advertisement for this Fellowship can be found on the NZSSD website homepage (<http://www.nzssd.org.nz/>) under the "Latest News" section.

President's Report

Another year comes to a close and with it a new government. It will be interesting to see how the National/ACT coalition approaches health. I am not necessarily optimistic that diabetes will be as high a priority as it was under the last government. It would be a great shame if all the recent work that has gone into initiatives such as the Quality Improvement Plan for example were to be for nothing. It is going to be very important that NZSSD keeps diabetes in the forefront of the next Minister of Health's mind.

There have been several recent developments that I would like to share with you:

- Recently there was the release of the Ministry's figures on the prevalence of diabetes in New Zealand. An estimated 230,000 New Zealanders now have diagnosed or undiagnosed diabetes – a figure that is well above that predicted back in 2001. This brought a flurry of media interest and NZSSD comment.
- I had the opportunity to present to parliamentarians several months ago and was able to push the message about increasing access to long acting insulin analogues and equity of insulin pump therapy. The insulin pump therapy issue has now been picked up by the Ministry and I am hopeful that this will lead to positive action.
- The LCT application has now been approved. NZSSD had a useful role to play in the process that led to this decision. We have requested information relating to the decision so that we can be reassured that decision was in line with our position on xenotransplantation. We will keep you posted.
- The Diabetes Foundation of New Zealand has given NZSSD a grant to fund the position of NZSSD Medical Director for 1 year. This position has been advertised – please see the website for details. This is a really exciting new initiative and could transform our Society if we can successfully fill this position.
- The Edgar National Centre for Diabetes Research was successful in their application to become the Secretariat of NZSSD. They have performed this role for the past 2 years superbly and I am sure will continue to do so. Agreements are being drawn up at the present time and will be in place in the near future.
- The Executive has agreed to a proposal to offer GP's and Practice a 1 year free membership to NZSSD. We are currently just beginning this initiative but hope that it will significantly increase our membership.
- We are very grateful for the "Expert Opinions" written by Helen Lunt and Jeremy Krebs and posted on the website in the last few months. We hope you find these of interest. More are on their way! In addition, we have had a massive amount of feedback on the draft Position Statement on Screening for Diabetes. The final version of this Position Statement will be released in the next few weeks.
- Next years Annual Scientific meeting is coming together nicely. Steph Farrand is the chair of the Organising Committee and has things well under control. It should be a very stimulating and enjoyable conference. Please diary the dates now if you haven't already. We would also like you to encourage your trainees to come to the meeting as there will be a separate section especially for them. The meeting will be held in Dunedin from Wednesday 1st - Friday 3rd July.

The Dunedin Executive is now well in to its final year. It has been a busy role but an enjoyable one. We wish you all a very happy Christmas and New Year.

P. Manning

Meetings 2009

NZSSD Annual Scientific Meeting 30 Jun - 3 July 2009, Dunedin.

New Zealand Wound Care Society Conference May 14-16, 2009. Napier War Memorial Centre, Marine Parade, Napier. Website for more information: www.nzwcs.org.nz

Letters to the Editor: none received

NEWSWEET is the newsletter of the New Zealand Society for the Study of Diabetes (NZSSD).

Contributions are welcome and should be sent to the Editor: Nicole McGrath at: Nicole.McGrath@northlanddhb.org.nz

NZSSD Membership Subscriptions are (still) due!

If you have not paid your membership fee of \$50 for this year, could you please contact the Membership Secretary (Victoria Farmer) by Phone: (03) 470 3805 or by emailing: nzssdmembership@gmail.com Thank you!

Change of details reminder: If you have changed any of your contact details in the past year. Please also contact Victoria Farmer as per the above details. It's imperative that membership contact details be kept up-to-date because most contact with all members is now done by email.

Memberships will once again be renewed 1 April 2009