

# GUEST EDITORIAL

## Type 2 diabetes

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Diabetes is an ever-increasing health care problem in South Africa, similar to many other low- and middle-income countries. With the high rates of overweight/obesity (up to 60% of women and 26% of men) and physical inactivity (63% of men and 49% of women have less than 150 minutes of health-enhancing physical activity per week) found in the latest South African Demographic and Health Survey, this trend is likely continue into the foreseeable future. The need for coherent multifaceted preventive strategies is clear, as is the knowledge that these should commence in childhood. Simultaneously, however, it is critical that we improve care for people who already have diabetes.

There is little doubt that diabetes presents considerable challenges to people with the condition, their families and the health care worker. Our objectives as health care workers are many. In the first instance, to diagnose diabetes early and by so doing, minimise the duration of untreated hyperglycaemia. This should take the form of screening of high-risk individuals, as the yield is likely to be considerably higher using this approach. The standard diagnostic tests for diabetes, namely fasting or random blood glucose measurements and in certain instances oral glucose tolerance tests, are well known. In this issue of *CME* Drs Dave and Weinreich address the contentious issue of whether HBA<sub>1c</sub> should be added to these diagnostic tests. They reach the conclusion that this should not be the case at this time, in agreement with the position by the Society of Endocrinology Metabolism and Diabetes of South Africa.

At the time of presentation it may not always be apparent what type of diabetes the individual has. Dr Raubenheimer provides an overview of the various types of diabetes. This includes the unusual monogenic forms and the atypical ketosis-prone type 2 diabetes, as well as an approach to the therapy of the latter. Once diagnosed, one of our major objectives is to enable the person with diabetes to manage themselves, and further to work hand in hand with us so that he or she will be able to achieve a good quality of life, free from the complications of diabetes with their attendant morbidity and premature mortality. Education is one of the cornerstones of diabetes care. The article by Professor Mash

gives practical guidance on how to develop an educational programme for diabetic patients in your care. The achievement of individualised glycaemic targets is frequently difficult for the person with diabetes and the health care team.

One of the major reasons for the non-achievement of glycaemic control is poor adherence and not the choice of regimen. Unless this is identified and addressed, hyperglycaemia is likely to persist indefinitely, to the detriment of the individual. We should also not minimise the role that active lifestyle modification can play in improving levels of fitness, reducing weight and improving glycaemic control even in long-standing diabetics on glucose-lowering pharmacotherapy.

Monitoring of glycaemia, lipids and blood pressure are routine aspects of clinical care for diabetes, so too is screening for complications to enable early and appropriate referral and intervention. This is covered in the article by Dr Kemp. When renal failure due to diabetic nephropathy occurs in people with diabetes receiving care in the public sector, in almost all cases, palliation alone is offered because of the very limited access to dialysis and renal replacement. Consequently prevention is critical; the means of achieving this and a review of diabetic nephropathy is provided by Dr Okpechi and Professor Swanepoel.

As described by Professor Mollentze, a special approach is required when managing diabetes in the elderly. For example, care needs to be taken with regard to the use of glibenclamide because of an increased risk of hypoglycaemia. There are also concerns about the use of glitazones in this group.

Finally, Dr Blom highlights the importance of cardiovascular protection in type 2 diabetes. The evidence clearly points to the fact that simultaneously addressing multiple risks has a much more beneficial impact on cardiovascular events than focussing on a single risk factor.

We need to rise to the challenge of assisting each person with diabetes to improve their outcome.

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