Australian Diabetes Society/Australian Diabetes Educators Association Scientific Meetings 2008

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I would like to thank DHS Victoria for granting me a bursary to attend the August 2008 Australian Diabetes Society / Australian Diabetes Educators Association (ADS/ADEA) Scientific Meetings held in Melbourne. The national three day conference has long been recognised by its respective members belonging to either association as an essential meeting to attend to acquire and collaborate knowledge from Australian and international experts in the areas of paediatric, adolescent and adult diabetes management coupled with professional networking that is invaluable to practice.

Who are the ADS & ADEA?

The ADS membership is typically from endocrinology or diabetology or medical research and presentations are generally focused on clinical interventions, human and animal research studies funded by the National Health & Medical Research Council (NHMRC) or on occasion, pharmaceutical companies. The ADEA is recognised as the peak body for Diabetes Educators in Australia with its membership that exceeds one thousand predominantly consisting of Nurses, Dietitians and Podiatrists but there are also subscribing Pharmacists, General Practitioners and Endocrinologists. This non-profit professional organisation show cases 'best practice' Diabetes Self Management Education (DSME) from international and national programs. ADEA produces documents such as position statements on 'client centred care', *ADEA Diabetes Educators Code of Conduct* and *ADEA Standards of Practice for Diabetes Educators; and* produce standardised Clinical Best Practice Guidelines such as blood glucose monitoring and sick day management for people with diabetes. This year the focus was promoting the future changes to the ADEA Credentialling System to ensure that the minimum standards of practice for DSME will be benchmarked and that in response to this action the Federal Government will continue to acknowledge ADEA Credentialled Diabetes Educators through their ability to claim on the Medical Benefits Scheme and to issue the National Diabetes Services Scheme for their patients/clients. However, the *pending* ADEA Credentialling system based on the US model will pose challenges for Credentialled Diabetes Educators in the way of *how* they conduct their core business including time allocated to DSME and documentation that will demand electronic database maintenance. In means of introducing change the ADEA has begun promoting to the public what knowledge and skills their Credentialled Diabetes Educator is required to possess. The role of the educator is to acknowledge, facilitate, encourage and support the person with diabetes in making informed decisions about their diabetes self management. An informed decision is defined as one that is consciously made by an individual based on their understanding of the information, advice and available options to protect and promote health (*ADEA 2008, ADEA Position Statement - Client Centred Care)*

This year the SGGPCP were successful in achieving a poster presentation for their abstract based on *Integrated Model for Type 2 diabetes Patient Care* - a strategy undertaken in partnership between the SGGPCP, WDHS Primary Care, the Hamilton General Practice Clinic and the Otway Division of General Practice. DHS Victoria Industry Advisor Kate Gilbert supported the abstract submission by Vicki Barbary and I presented the poster on behalf of the PCP. The poster received much interest during viewing time with request from the ADEA Magazine Editor to write an article for the next edition.

Key Learnings from the Conference Proceedings:
From a Chronic Disease Management perspective I took many relevant learnings from the ADS/ADEA Scientific Meetings as there was a great focus on Chronic Disease Management, Systems Management, Diabetes Self Management particularly the need to combine carbohydrate counting for all people with diabetes with use of the Glycemic Index and the prominence of mental health and the importance of early screening for depression and prompt and appropriate referral, and DSME that integrates a system management approach. There was so much information received over the three days this report has been divided into three parts addressing the key learnings:

i) "Minding the Gap" – addressing those patients who exit the healthcare system,
ii) Enhancing Mental Health Outcomes
iii) Updating & collaborating best practice -implications for clinical practice

Part 1: Minding the Gap!

Dr. Elizabeth Mullins, Senior Medical Risk Advisor, AVANT mutual Group Limited, Australia's Largest Health Professional defence agency: *Golden rules for sweet success in managing risk in diabetes care'* opened the ADEA program reminded us that it is those patients/clients that fall outside health professional's radar e.g. fail to attend appointments etc. that we should be most concerned for, reiterating that you have to "…mind the gap". Dr. Mullins presentation centred on reviewing how to address the challenges to providing quality DSME from a medicolegal and risk management view:

1. As part of DSME the health professional has to explain to the client and family to ensure they make the link between for example, "hypoglycaemia and hyperglycaemia". A general myth is that a "hypo" means high.
2. "Think phone"- ensure backing written documentation so communication between health professionals and provision of feedback to referring source e.g. GP, is provided in a timely fashion.
3. Use of language that patients/clients understand including use of medical jargon, literacy levels and languages other than English (LOTE) using a professional interpreter service.
4. Systems Management – "walk in your patient/clients shoes" to ensure they can negotiate the system that may include adequate signage through surveying patient/client satisfaction. Most importantly, having standard protocols for patients that may "drop out" of the system to attempt reengagement/ follow up.
5. Ensure clear patient/client plan of management and ensure there is a back up plan and that the patient/client is clear what their role is e.g. emergency or out of hours care so they and/or family can self manage and/or initiate emergency intervention
6. Share information across the multidisciplinary team in a timely and effective manner ensuring that it is current as some health services may take up to one month to dictate a letter and send to GP for example. This is "a long term relationship" – the patient/client is central to this relationship.
7. GP Referrals – clarifying the reason that GPs are referring their patients to your service – how can your service support GPs referrals and quality of patient information included in the referral. Acknowledge "clearly this is difficult for you, is there another way? Why is the patient actually attending?" Placing programs on regular times. GPs often complain that 'adhoc' DSME are difficult to refer to. Again also emphasis on systems management to facilitate patients to make a good decision!

A number of my ADEA colleagues abstracts presented that were of great interest and I think worth flagging with the Hamilton and Portland CDM Networks. I thought of the WDHS GP/Primary Care Clinic in relation to the presentation provided by Jane Tsai who presented on ***'A Diabetes Stablisation Service (DSS) in the Community Delivering Results*** which is a program about "minding the gap" where patients with Type 2 diabetes were transferred out of Princess Alexandra Hospital outpatient service. Any patient requiring ambulatory insulin stablisation and/or had an Hba1C of greater than 7% and requiring initiation or ongoing ambulatory insulin stablisation were referred to a primary care based Diabetes Stabilisation Service (DSS). This system had an "upskilled GP" in contemporary clinical diabetes management with a multidisciplinary team within the multidisciplinary system. The Diabetes Educator made phone contact with the 34 patients with Type 2 diabetes (out of 94) requiring insulin twice a week over a 6-month period adjusting insulin. The outcome was an overall improvement in Hba1C was contributed to the upskilling of the GP, a specific primary care hours devoted to stabilising patients with type 2 diabetes, and the telephone adjustment of insulin. The average duration of a patient spends on the DSS is 47+- 38 days. HbA1C has

significantly improved from 8.9%+-1-5% to 7.6+-1.2% (p<0.001). This is a positive result when Professor David Owns, Director Diabetes Research Llandough Hospital, Cardiff, UK reminded us that the UKPDS findings. For those who do not know the UK Prospective Diabetes Study (UKPDS) was a landmark randomised, multicentre trial of glycaemic therapies in 5,102 patients with newly diagnosed type 2 diabetes. It ran for twenty years (1977 to 1997) in 23 UK clinical centres and showed conclusively that the complications of type 2 diabetes, previously often regarded as inevitable, could be reduced by improving blood glucose and/or blood pressure control.

No other causal effects were identified by the researchers such as implementation of "health coaching" multidisciplinary team care planning, GPMP completion or patient satisfaction yet the results are of interest as the service delivered a good result without an Endocrinologist operating in the catchment for this specific subgroup of diabetes patients.

The second abstract of particular interest to ICDM and EiCD projects was the presentation made by Gloria Kilmartin, Diabetes Educator for Goulburn Valley Health (formerly of RMH). Gloria presented on the adoption of the Chronic Disease Management Model (The Wagner Model by GV Diabetes Centre & CDM EliCD project titled ***'Measuring and Improving Diabetes Chronic Illness Care'.*** They reported positive measurement of performance improvement through implementation of the Wagner Model and taking a Continuous Quality Improvement Approach using the annual clinical audit of patient clinical indicators called the Australian National Diabetes Information Audit and Benchmarking (ANDIAB) in addition to using the ACIC Tool 2008 version 3.5 by Judith Schaefer (2000). At baseline and repeated post 3 years project commencement, whereby multidisciplinary team members individually self evaluated their performance as a team in provision of support services. They used the - assesses 7 CDM Components

- Organization of the Healthcare Delivery System
- Community Linkages
- Practice Level
- Decision Support
- Delivery System Design
- Clinical Information Systems
- Integration of Chronic Care Model Components

Or go website www.improvingchroniccare.org, an assessed appropriate and simple to administer CDM Audit tool recommended by DHS website:
www.health.vic.gov.au/communityhealth/cdm/resources.

Kerry Down also from Goulburn Valley Health presented on the ***Development of an integrated rural district nursing diabetes service*** yet again highlighting how this health service is attempting to "mind the gap". The aim was to develop a program of integrated, home based, expert clinical diabetes care between DNS and the Goulburn Valley Health Diabetes Service where previously none existed. Under a Consultative Committee specific protocols and pathways relating to the monitoring of unstable diabetes, insulin initiation and titration, complication assessment and community based referral and liaison. A reciprocal mentoring program was established between DNS and GVHDC enabling the diabetes educators to utilise their diabetes expertise. Quarterly interdisciplinary meeting included quality improvement activities, case conferencing and practice reflection. The outcomes resulted in two fractional EFT DNS DE positions being creating and subsequent to the mentoring program, both are now ADEA credentialled. Over the two year period 244 clients with type 1, type 2 and gestational diabetes were referred for a total of 183o visits. Referral was received for insulin initiation, diabetes complication assessment and sick day management from ED, Acute Units, GVHDC, hospice and GP's. Unstable metabolic control and recurrent hospital presentations are the main reasons for referral. DNS CDE's attended GVH ward discharge planning meetings to facilitate home diabetes management, enhancing quality care outcomes between the transition from hospital and to the home.

Goulburn Valley Health have certainly made some impressive inroads into addressing Chronic Disease Management however, an informal discussion with Gloria Kilmartin, Credentialled Diabetes Educator from the Diabetes Centre assured me that these in roads had taken five years to achieve thus far.

Part 2: Enhancing Mental Health Outcomes through Self Management & Early Screening/Referral

ADEA plenary Dr. Mark Peyrot, PhD in Sociology, a Professor of Sociology at Loyola College and has an appointment on the research faculty in the School of Medicine at John Hopkins University, Kentucky, US. His current research examines psychosocial aspects in the management of and adjustment too chronic disease, especially diabetes. Dr. Peyrot's presentation titled *Practical Strategies for Encouraging Diabetes Self-Management* centred on self-care behaviour as the key to good patient outcomes, with patients needing to be able to make choices and change over time. Patients therefore need information to make informed choices thus self management is based on a partnership between the patient and the provider that is not hierarchical but collaborative relationship. There are a number of rules that Dr. Peyrot recommends to health care providers:

Rule #1: Asking is better than telling – "ask don't tell"!

- It establishes a referent relationship i.e. the patient thinks that you care.
- Establishes what patients need to know and what they are able to do
- Therefore turn's the ball around (resist the temptation to tell them the answer).

Rule #2: Listen to the patient's answers – repeat back what they say to you & don't interrupt. For example ask: "What is the hardest thing about taking care of your diabetes?" Asking this question gives them permission to tell you the issues.

It is also important to "normalise" nonadherence as not everyone can "adhere" 100% of the time, therefore gives permission to discuss with you and open up "a therapeutic alliance".

Knowledge does not transfer into DSME

Providers send steps (8) that lead to behaviour change *Reference: Peyrot & Rubin,* Diabetes Care

1. Involve the patient & Establish a Connection
   - Professional assessment prior to first meeting. Start with patient's agenda and what the patient wants to change, as most patients are unhappy with some aspect of their diabetes management.
2. Ask the question: "What would I see if I were a fly on the wall?' (Patient invited to tell their story)
   - Ask them what is their particular problem(s) but only start with one problem first.
   - Be very specific. For eg. "I eat too much between breakfast, lunch or dinner" versus "When I sit down after dinner at night I eat a bowl of chips and watch television when I am bored".
3. Identify Successes
   - Focus on when it is better to help the patient by enhancing efficacy and motivation and that they achieve some of the time.
4. Set SMART Goals
   - Personally relevant (autonomy driven) i.e. make them feel happy
   - Specific (concentrate actions) e.g Eat 3 low GI foods at dinner or walk 30 mins after midday meal
   - Measurable (how much and how often)
   - Action-orientated (behaviour not physical) – focus the patient on their behaviour not the physiological outcome e.g. how they can/are experiencing weight loss but not the end target weight – eventually the patient will get there.
   - Realistic (not too easy or "trivial") and achievable and not too hard – coaching "take the next step", "take the next step"
   - Time Specific – when will the patient start
5. Identify Barriers
   - Barriers are the most important determinants of (not) attaining goals
   - Then need to identify barriers when setting goals and address them
6. Formulate Strategies
   - Decide how to reproduce prior successes – what has worked before, what has worked in other situations
   - Plan ways of overcoming barriers to success (problem solving) – try to eliminate variers and that the patient has practiced for example, a strategy is that a patient can be given homework to address other barriers
7. Contract for Change
   - Establish Commitment – contract is an "official" commitment

- Establish criteria – need to be meaningful to the patient
- Establish rewards that are relevant to the patient

Editor's Note: Are GP Management Plans intended to be a contract for change as the patient establishes the plan with their doctor, signs it and takes a copy home? If yes, is the GPMP patient friendly – consider literacy level, number of goals set etc.

8.Track Outcomes

- Recording good and bad and why to identify successes and barriers to success
- Reviewing patient plans periodically Patient discuss progress at next meeting (some will be able to do this themselves)
- Reiterating – emphasise need for continued diligence

Rule #3:Plan for Relapse Prevention – everyone lapses

- The goal is to avoid collapse/relapse - need to establish what "we" (patient + HP) are trying to prevent – "patients need to get back on their horse and reprepare themselves"
  E.g. is this what DAFNE (Dose Adjustment for Normal Eating) is attempting to teach the patient inner resources
- 1. Construct own "self identity" – every one does but I can get back on that horse
- 2. Also look for outside assistance e.g. spouse, significant other, health professional
- A reminder – probe emotional distress and psychiatric disorder may interfere with problem solving and self-management. Identify patients with mental health such as depression or anxiety or psychiatric disorders or "burnout" and potentially refer out if needed.
- A general mental wellbeing (not disease specific) screening is recommended, and where the health professional who conducts the initial screening feels it is outside their scope of practice, should refer promptly to an appropriate health professional such as a counsellor, social worker, psychologist or psychiatrist. If there is depression or risk of suicide move immediately but otherwise start with strategies gradually through visits and phone.
- Diabetes "burnout" occurs because there is no power or loss of 'locus of control' or balance of power.
- Strategies for Alleviating Diabetes Distress:
- Enhance Diabetes Specific self efficacy
- Encourage realistic expectations enhance motivation
- Techniques include – motivational interviewing, and Psycho-educational treatment – (coping skills training) and how to deal with "emotional stress").
- Identifying Clinical Depression:
- Cardinal Symptoms – screening tools – PHQ9 (DSM16) from two weeks from initial contact.
- Medication and Behavioural Therapy recommended eliminating depression however; this does not necessarily mean that Glycemic Control will be better and vice-a-versa.

Treating Depression I Diabetes: One therapy for two targets?

Frank Petrak from the Department of Psychosomatic Medicine and Psychotherapy, Ruhr-University of Bochum, Bochum Germany presented in the ADEA Symposium titled *Treating Depression in Diabetes: One therapy for two targets?* Approximately 25% of all diabetes patients experience symptoms of clinical depression according to Dr. Petrak. He presented a number of clinical research papers and recommended use of the ICD-10 Classification (endorsed by 43rd World Health Assembly, 1990) for diagnosing depression that includes the 3 core symptoms of 1. Low mood, 2. Fatigue & 3. Lack of enjoyment for greater than a two-week period. Diagnostic tools should be administered by people appropriately and specifically trained for example, psychologist.

Screening tools (not to be confused with a diagnostic tool) that maybe administered by a health professional following initial training on dispensing screening tools. Dr. Petrak referred to such screening tools as the WHO-5 and the screening tool used in Germany is the PHQ-9 Survey.

Note: The Victorian DHS has adopted the K10 Mental Health & Wellbeing Screen under the ScoT Profile: Psychosocial (Vic DHS, 2006). Professor Kevin Andrews, Clinical Research Centre for Anxiety & Depression (CRUFAD) (Ref: Andrews, Henderson & Hall, 2001, British Medical Journal, 178: 145-153). Early screening then requires management – do we have the capacity in the SGG PCP catchment to deliver services when consumer expectations are raised? Looking at alternative models may be required with psychologists as Mentors for other Health Professionals.

Diabetes Australia and SANE Australia released/launched their guidelines
'*The SANE Guide to Good Mental Health for people affected by diabetes'.* SANE Australia produces a wide range of guides and other useful publications on mental illness – for consumers, carers, health professionals, students and the general community. See website: www.sane.org SANE Australia (2008,p8) reports that Depression and anxiety disorders affect up to half of those living with diabetes at some time, although not all of those will be diagnosed. In addition, around half of all family members will also be affected by mental health problems, including children and young people as well as adults and older people. Research now suggests that diabetes doubles the risk of depression compared to those without diabetes. The chance of developing depression also increases if diabetes compilations worsen. Indigenous Australians have a high rate of diabetes and mental health problems, with generally poorer long-term outcomes following diagnosis that the genral population.

Part 3: Implications for Clinical Management of People with Diabetes/Updates:

'Diabetes Self Care the 7 Steps to Success' to have future implications for CDEs
Launch of 'Diabetes Self Care the 7 Steps to Success' – patient information – booklets, posters to promote available through ADEA office to members. The President Amparo Gonzales and CEO Lana Vukovljak, American Diabetes Educators Association presented respectively on their adoption of the 7 Steps and how the American Association is now basing credentialling of its members on this system. ADEA outgoing President Jan Giles presentation that 'Behaviour Change, The Next Step in the Diabetes Education Outcomes Continuum' announced that Credentialling and Recredentialling in Australia of Diabetes Educators would be directly linked to the production of 7 key performance outcomes of patient behaviour change. Diabetes Education therefore must demonstrate patient care assessment, patient care planning and (re) evaluation of patient care plans– healthy eating, being active, monitoring, taking medication, problem solving, healthy coping and reducing risks. Raising community awareness of Credentialled Diabetes Educators role appears to be the initial vehicle for ADEA to commence introduction of the new system.

Carbohydrate Counting
Dietitians Liz Mount, Monash Medical Centre, and Kerryn Roem, Private Practice Melbourne made an excellent presentation of the argument for the introduction of both basic and advanced carbohydrate counting for all clients with type 1, 2 and gestational diabetes. Practical examples were provided. They recommended professional advice, referral to a carbohydrate counter, providing websites that possess CHO counters such as www.food.com.au or www.calorieking.com.au. Discussion of CHO Counting Programs of choice such as the DAV taught program DAFNE and intimate e.g. 1grm used by Monash Medical Centre rather than 10grm per unit as taught by DAFNE/DAV. They also discussed the advantages and cautions to take re: CHO counting in both advanced and basic counting scenarios. The GI Index is not abandoned by a complementary tool in the overall support/dietary management of people with diabetes. At Monash Medical Centre Diabetes Ambulatory Support Unit parents are taught to calculate CHOs of recipes. These are checked by the dietitian and then shared with other parents. Also stressed was the importance of telephone coaching to support clients in the long term, decreasing stress and burnout, and delaying relapse.

Januvia
Brett Fenton (CDE PDH Judy Fenton's son) CDE/Deputy Manager International Diabetes Institute, Caulfield and Diabetologist Leon Chapman Presented on 'Januvia' (Sitagliptin) gave an excellent insight into their clinical experience using this oral medication therapy to enhance endogenous Incretin action. Although not a first line treatment Brett presented a case study where exception to the rule was applied by the team at IDI to ensure that a deep sea dive instructor could retain his licence to practice rather than having to commence insulin therapy and also resulting in little or no weight gain therefore having positive impact on quality of life. Incretins are made by the GI tract to decrease gastric motility and stimulation of beta cells resulting in an increase in insulin production only when the BGL level is increased and turns off when serum BGL decreases and decrease in production of Glucagon resulting in glucohomeostatis. Januvia is prescribed to people over 18 years old, failed diet, physical activity. There Hba1c > 8.7% Metformin or sulphonylureas or Thiazlonedione that ensures PBS Reimbursement otherwise private script. Brett conducted a clinical audit of 246 people on Januvia with 194 having had a pre/post Hba1C that demonstrated a 0.8% decrease in Hba1C over a 3-month period. Dr. Chapman relayed his experience of *Januvia* to practitioners that it is not

indicated with a basal insulin, recommends trying traditional oral medications first, but if need to break the cycle, the oral therapy will require a patient's pancreas that is responsive and therefore recommended reasonable use of this therapy early in diagnosis. There is no data yet to demonstrate the drop off effect of the drug – predictions could be 2-3 years. Cost of *Januvia* is $80 per month.

Diabetes Australia Victoria
DAV have updated their website content and Catherine Prochilo, Team Leader DAV, CDE presented on the updated version of patient recommendations for travel overseas. Last year I contacted Catherine who was Acting Nurse Manager – Diabetes Education at DAV re: concerns expressed across the South West re: currency of patient information on the DAV Website. She reassured me that action had commenced at forming an expert review panel to update the website which is now completed. For further information re: travel see website: www.dav.com.au.

Feet:
Professor Dennis Yue, Endocrinologist Royal Prince Alfred Hospital NSW presented on '*Establishing a sustainable and functional multidisciplinary diabetes high risk foot clinic in the urban setting'.*

Dennis is internationally known for is expertise in implementation of the clinic at RPAH – patients must have a high-risk active foot lesion to be admitted to the clinic. The clinic has 3.0 EFT, .8 EFT Nurse Coordinator, 0.4 Endocrinology with 100% cover, one day/month a pathologist, and 0.1 EFT Vascular Surgeon and Orthopaedic Surgeon. They manage approximately 2,500 patient episodes per annum. Dennis reported that the patient treatment plan is typically established prior to admission based on the referral which argued is important in producing positive outcome. (Editor's note – Dennis maybe referring to a Clinical Pathway based on diagnosis e.g. Charcot's foot, plantar abscess +/- osteomyelitis). Investigation and treatment vascular insufficient, with the need to initiate and supervise wound management. Morbidity is reduced through the clinic for e.g. distal treatment may result in a below knee amputation rather than an above knee amputation. Ref: Krishnan et al. Diabetes Care, 2008 – data expressed per 100,000 general population.
Before commencing a High Risk Foot Clinic Professor Yue recommended that you must have" a multidisciplinary team that is integrated co-located and stable". At RPAH they have one large room with multiple chair, training is available for additional podiatrists, nurses and doctors and any interested specialists e.g. physician. Professor Yue recommended that senior doctors need to be in charge and not to delegate to junior staff but they should also not sitting at the clinic all the time! A coordinator who knows all of the cases is the Diabetes Nurse Educator at 0.8 EFT. Professor Yue said that they took "…a French Bollinger Champagne Approach to Staffing". Running a high risk clinic with only one podiatrist would ensure that the clinic would eventually collapse due to annual leave, natural staff attrition and turnover, and the need to train another podiatrist. Staff need to be also available every working day therefore handover to a patient's GP on call over weekend at RPAH is required. Documentation and treatment changes and communication must be expediated and recommends IT to ensure that this occurs and reaches the GP. Potential for several foot ulcers to be active e.g. 1-3 per patient so they use colour coded charts. Network of footwear and other Health Professionals required such as Community Nurses and Community Podiatrists. He stressed the importance of this to ensure a continuum of care rather than a stand-alone clinic.

Further recommendations: a Doppler hand held to undertake ABIs although they now have vascular radiology medicine located next door at RPAH, however, good staff rather than technology is paramount. Income for the clinic is acquired through clinical trials, clinical outcomes, telemedicine projects and training courses. Resources have to be diverted into the foot clinic from diabetes education and general podiatry services. Rome was not built in a day – what do you in the meantime to sustain a clinic! The cost to treat one active high-risk foot lesion costs $3500 in staff salary versus $500 to consult with a general patient according to Professor Yue. There has to be a change in attitude and "official network between large tertiary centres with rural areas". A successful clinic that will be sustainable involves district nursing or Hospital In The Home to ensure that parental Antibiotics maybe administered at home. Recurrent admissions are approximately 50% at RPAH, which reflects world trends with one in eight patients having experienced an ulcer or amputation previously. Fail To Attend rate is approximately 3%, which aligns with other clinics. The GP always receives a letter to notify them of management or if the fails to attend.

Editors Note: How else could they mind the gap in this context? Follow up phone call to the patient/client to establish why they failed to attend the clinic by the Clinic Coordinator. Opportunity to reschedule the appointment if motivation and clear understanding as to the rationale for attendance, and addressing barriers to attendance to such a clinic such as transport etc.

Gestational Diabetes

Dr. Caroline Allen, Endocrinologist, Head of Monash Medical Centre's Diabetes & Pregnancy Outpatient Clinic re-emphasised the need for postnatal follow-up for the 5-10% of women with GDM pregnancies at 6 weeks postpartum and then 2 yearly following due to the risk of women. She reminds women to undertake an Oral Glucose Tolerance Test and Blood Pressure check with their GP when they have their pap smear. Women who have had GDM are at increased risk of developing type 2 diabetes later in life. This risk of GDM increases ten fold the second time round! Management of women with GDM has been proven through the Hyperglycaemia & Pregnancy Outcomes Study (HAPO, BJM, 358(19) 1991, 2008) with GDM occurring between 20&33 weeks. The Australasian Diabetes In Pregnancy Guidelines are presently under review with the advent of such therapies as metformin and sulphonylureas 'Glibenclamide' in GDM are found to be safe, and the avoidance of certain more recent insulin therapies due to lack of clinical research data such as long acting analogues.