Bands v Bypass and their management in primary care.

The link between obesity and type 2 diabetes is well recognised however current medical therapy aimed at obesity has only limited success and some argue the same is true for treatment of type 2 diabetes. For increasing numbers of severely obese patients with type 2 diabetes bariatric surgery offers significant weight loss coupled with the improvement or remission of weight related co morbidities. The benefits of bariatric surgery have been recognised by NICE (CG43; wwwnice.org.uk) who recommend surgery for those with diabetes or other complications over a BMI of 35. Local guidelines, however, restrict surgery to those with a BMI of 45 with complications and 60 without.

Access to bariatric surgery for patients in Portsmouth City PCT is via the newly commissioned Tier 3 service known as Lifemorph which aims to promote weight loss through lifestyle changes. The service is also able to assess suitability for surgery and begin the behaviour changes which are crucial in ensuring success. The referral criteria to Lifemorph are those with a BMI of 35 with co morbidities, and 40 without. After assessment the clients enter a 12 week programme of supported lifestyle changes after which point they are re-assessed and can complete a further 12 week programme. Support is available from dieticians, health promoters, psychologists and bariatric physicians. Patients suitable for surgery must engage with the service for 12 weeks and be assessed by the bariatric physician before funding can be requested. Hampshire PCT has commissioned a similar service, however currently access is via application to the South Central Specialised Commissioning Group.

After funding has been agreed patients can choose their surgical provider from the approved provider list. Current local providers include Portsmouth Hospitals NHS Trust (from September 2011), Spire Southampton, John Radcliffe in Oxford, as well as providers further afield.

Most providers will assess suitability for surgery with a multidisciplinary team format.

The Laparoscopic Adjustable Gastric band (LAGB)

Well known to patients from the media. Simple to insert, it needs one night in hospital. A silastic band is placed which is inflated with saline 2 weeks after surgery leading to early fullness with a modest reduction in appetite. The band can deliver approximately 50% excess weight loss with about a 60-70% chance of resolution of diabetes.
Those with longstanding diabetes or needing large doses of insulin are less likely to resolve. It can be difficult to predict which patients will do well with a band. It is said that those who graze and who enjoy sweet foods are less likely to do well, but this is not borne out by the literature. Patients need to be highly motivated to make a band work, and will need between 8 and 10 visits to the unit in the first year, with about 3-5 band fills. Also, there is a number of patients in whom revision surgery is required, either due to complications (slippage of the band, port infection or kinking etc) or due to a slow rate of weight loss. Overall about 15% of bands need revision or removal.

Other specific complications are thiamine deficiency due to protracted vomiting and absolute obstruction. Although rare these need immediate referral for treatment. Band placement is relatively non invasive procedure as compared to other surgical alternatives, can be done in relatively quickly and can deliver a significant weight loss. It is also reversible should the patient not be able to tolerate it for whatever reason. Additionally, as there is no anatomical insult, further bar iatric surgery is not precluded and there is no need for lifelong supplementation with vitamins/minerals.

A Roux en Y Bypass

Is a more invasive procedure which should be thought of as irreversible. It is a combined restrictive and malabsorptive procedure although it is likely that the major effects are achieved by modulation of the neuroendocrine systems in the GI tract. The patients are left with a gastric pouch the size of a plum, with the majority of the stomach and duodenum effectively bypassed causing an element of malabsorption. (See diagram)

Discharge home is usually on the third day after a laparoscopic procedure. Driving and work should be avoided for a further 2 weeks. Patients can expect around a 70% excess weight loss with about 80% experiencing resolution of diabetes. Additionally other co morbidities such as sleep apnoea, hypertension and hypercholesterolemia are improved or resolved.

Although dietary advice and follow up is important, patients do not tend to require as many follow up visits as those with a band. Patients experience fullness after small meals and may experience Dumping if they eat high carbohydrate foods (chocolate, ice cream etc). Dumping is felt as sweating, shaking and nausea after eating and is managed by avoiding triggering foods. Patients need vitamin and mineral supplements plus additional vitamin D and calcium or life. Patients will need blood tests at 6 months post surgery and then annually and may need additional Iron, B12 and Folate dependent on results.

What you need to know – long term issues for both procedures.

Medication
- Dispersible or liquid medications may be better tolerated than tablets.
- Long acting drugs may problematic, consider short acting/ or PR preparations, especially for analgesics.
- Diuretics during the first 4 weeks post operatively may precipitate dehydration.

Vomiting
- Most patients vomit initially as they learn what they can and can’t eat.
- Repeated daily vomiting is abnormal and may be due to pouch outlet problems or an overly tight band. Seek help from the bariatric unit.

Protracted vomiting with confusion or decrease in consciousness could be a sign of thiamine deficiency and needs URGEnt assessment. Admit to the nearest acute unit for IV thiamine supplementation to avoid Wernicke’s encephalopathy.

Constipation
- Common early complaint, often due to low fluid intake.
- Advise2 litres of water a day in addition to other drinks.
- Lactulose, magnesium hydroxide or diluted fruit juice are better than fybogel or senna.

Hair Loss
- Hair loss/thinning is normal due to rapid weight loss.
- This will slow as rapid weight loss also slows.
- Zinc supplementation is unlikely to help.
- If hair loss occurs after the period of rapid weight loss consider other causes such as thyrotoxicosis, alopecia, etc.

Weight Regain
- Patients may regain some weight at 1-2 years post surgery. This is NORMAL
- It often due to a resetting of the anatomy and physiology rather than surgical failure of dietary indiscretion
- Seek specialist dietetic advice rather than suggesting further surgical intervention in the first instance.

Alcohol
- Alcohol absorption may be more rapid post surgery.
- Patients get drunk more quickly.
- They may change away from beer to smaller volume drinks containing more alcohol such as wine and spirits.
**Eating Disorders/Transfer addictions**
- Rarely patients fear weight regain to such a level that they become almost to the point of anorexia nervosa.
- A loss to a level of BMI <23 needs referral to an experienced dietician or to a bariatric physician.
- Patients with an addictive personality may transfer their addiction from food to alcohol, gambling and occasionally promiscuity. Specialist counselling is needed.

**Pregnancy**
- Women should avoid pregnancy in the first year following surgery.
- There may be nutritional challenges and weight loss may be halted.
- Patients with PCOS may become fertile and contraception will be required.
- If a patient becomes pregnant they should switch their multivitamin/minerals to one suitable for pregnancy immediately.

**Specific complications in bypass patients**

**Multivitamins and Supplements needed for life.**
- Bypass patients need an OTC multivitamin and mineral tablet from two weeks post discharge, breaking them in half to aid absorption.
- Options for vitamins/minerals: Sanatogen A – Z, Centrum, Seven Seas and Forceval Options for Vitamin D/Calcium: Calcichew D3 forte or Adcal

**Iron deficiency anaemia**
- A problem in those who stop their vitamins/minerals, especially in menstruating women.
- Ferrous gluconate is better than sulphate due to its bioavailability.
- Occasionally parenteral iron may be needed to correct severe deficiency.

**Osteomalacia/osteoporosis**
- Symptoms of bone pain and weakness some years post surgery may be due to osteomalacia.
- This should be investigated and treated.
- DEXA scans useful for those most at risk of bone loss, i.e. positive family history, early menopause or early bilateral oophorectomy.

**Hypoglycaemic symptoms**
- Rarely patients may experience hypoglycaemic symptoms to the point of collapse.
- This can occur in the absence of pre surgical diabetes and is commonest about 2 years post op.
- Use home blood glucose monitoring to document hypoglycaemia.
- Manage with small regular meals (6 times a day) containing complex carbohydrates.

**The Bariatric Service at PHT**
The newly opened bariatric unit at PHT offers integrated assessment and treatment of patients who meet the criteria for surgery with a dedicated specially equipped bariatric ward. The multidisciplinary team offer a high level of expertise in bariatric medicine, dietetics and surgery.

**Dr Lorraine Albon**
Is a diabetologist with an interest and experience in this area. She is the bariatric physician working with the Lifemorph team. She will assess complex patients in the community to assess medical issues and with the team assess suitability for surgery. She can also offer help and advice for patients with issues longer term post surgery such as a re-emergence of diabetes, hypoglycaemia and weight regain. Patients should be referred to her at the Diabetes Centre, Queen Alexandra Hospital.
Injection Technique Recommendations and Needle Length - Information for Patients and Health Care Professionals

Injection Sites
Insulin is a sub-cutaneous injection and can be injected into arms, buttocks, thighs and abdomen. Within these areas site rotation must also take place to help reduce the risks of lipohypertrophy, inflammation, oedema or infection. An inspection of injection sites is recommended by the healthcare professional regularly and especially if there are issues around variable glycaemic control. Absorption of insulin will also vary dependent upon the injection sites.

- The thighs and buttocks are the preferred injection sites when using NPH (intermediate acting) insulin’s such as Humulin I and Insulatard as the basal insulin is absorption is slowest from these sites.
- The abdomen is the preferred site for soluble human insulin (Humulin s, Actrapid) as absorption is fastest from these sites.
- Premixed insulin’s (human or analogue) should be given in the abdomen in the morning to increase speed of absorption of the short acting insulin in order to cover the post breakfast glycaemic excursions. This can then be given in the thigh or buttock in the evening to reduce the absorption rate and decrease the risk of hypos.
- Rapid acting insulin analogues may be given at any of the injection sites as absorption rates do not appear to be site specific.
- Long acting insulin analogues may be given at any of the injection sites as absorption rates do not appear to be site specific.

Massaging of the sites is not recommended since this will increase the absorption rate. It must also be remembered that absorption will be increased in the thighs and buttocks with increased physical activity of the legs and also heat will also increase absorption.

Needles - Length

Children and Adolescents
There is no clinical reason to recommend needles longer than 6mm for children and adolescents. It is recommended that when using 5/6mm needles that the skin lift technique is used. 4mm needles can be used without the skin lift. Arms should only be used as a site for a 3rd party and the skin lift technique should be used.

Adults
There is no clinical reason to recommend using needles longer that 8mm. The subcutaneous fat layer is no different dependent upon BMI and therefore 4/5/6mm needles are recommended at a 90 degree angle without any skin lifting. If in doubt about the possibility of an IM injection then a skin lift technique should be used. These recommendations are to ensure that insulin is delivered into the subcutaneous fat layer when it is absorbed to give the best insulin profile. It is recommended that a new needle be used for each injection thus helping to reduce any damage to injection sites and reducing lipohypertrophy.

Skin lift technique.
Although with the introduction of the shorter needles skin lift should not be needed it may be advisable to teach this to everyone so that it can be used if injecting in slim limbs and the skin lift can be used for pregnant women when injecting in their abdomen. All people with diabetes should be taught the correct technique:
1) Lift skin
2) Insert needle into skin at 90° angle
3) Administer insulin
4) Leave needle in the skin for at least 10 seconds after the full dose of insulin has been given
5) Withdraw needle from skin
6) Release lifted skin fold
7) Dispose of used needle.

Pregnancy
Pregnant women can continue to inject in the abdomen but should use the raised skin lift technique. Other sites can continue to be used.

Bleeding and Bruising
Bleeding and bruising does not have an adverse clinical effect on the absorption or action of insulin. If this occurs then it is recommended to review injection technique and needle length.
When the provision of education for people with diabetes has been a fundamental part of our role for a combined total of 31 years of our careers, it is sometimes easy to forget that this very common sense aspect has faced (and continues to face) questions around its clinical and cost effectiveness. When we consider that 80-90% of an individual's diabetes care is performed by themselves or their families, it is hard to imagine why we would not provide them with information about their condition and help them reflect on the impact of their self-management behaviours.

However, funding issues, changes in service commissioning and delivery and the emphasis on evidence-based care have at times resulted in challenges to these parts of our service. It is reassuring then that evidence is growing around the value of this intervention and that its place in diabetes services is firmly endorsed by the NSF for diabetes and NICE guidance. Both of these support the use of structured education at diagnosis and as required on an ongoing basis following an individual needs assessment, recognising that needs change over time. What constitutes structured education is covered in depth by some of the documents on the subject, but briefly there is recognition that an effective education programme is:

- Patient-centred
- Comprehensive (covering technical, psychological and self-management aspects)
- Dynamic and flexible (reflecting patient/group clinical needs, cultural and education background and so on)
- Clear in its link with adult education theory
- Run by multi-disciplinary teams with trained educators
- Provided in a group setting wherever this is appropriate
- Accessible and
- Evidence-based

NICE has provided a framework against which programmes can be reviewed to ensure that they meet essential criteria and suggest that a structured programme should have an underpinning philosophy, have a structured curriculum implemented by trained educators and that the programme be quality assured and outcomes audited. In order to ensure that we meet NICE criteria, we have been working to ensure that each of our programmes meets the essential criteria. We have a common philosophy and use four adult learning theories to guide our programmes.

Each of our educational groups has a curriculum and are run by diabetes specialists (nursing, dietetic and medical), some of whom have attended national training programmes such as DESMOND. One of the benefits to working in a team is the transfer and sharing of such skills. We are starting to perform peer review and are currently working on ensuring consistency with our approach to quality assurance and audit.

Some of the structured group education programmes we currently run are:

<table>
<thead>
<tr>
<th>Name</th>
<th>Brief Description</th>
<th>Programme (P) or 1 off Session (1)</th>
<th>Type 1</th>
<th>Type 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>DESMOND</td>
<td>Whole day education and goal setting for those newly diagnosed with Type 2 diabetes</td>
<td></td>
<td>1</td>
<td>✔</td>
</tr>
<tr>
<td>BBC (Basal Bolus Conversion)</td>
<td>Aimed at providing those converting to this insulin regimen with the information and problem solving skills to use it effectively.</td>
<td>P</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>SIG (Starting Insulin Group)</td>
<td>For those with Type 2 diabetes needing to start insulin.</td>
<td>P</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Carbohydrate Awareness</td>
<td>To help participants understand the role of carbohydrates in diabetes management.</td>
<td>1</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>JIGSAW (Juggling Insulin Goals for Success and Wellbeing)</td>
<td>Skills-based programme again emphasising the development of problem solving skills for those wishing to intensify their diabetes management</td>
<td>P</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Diet &amp; Gestational Diabetes</td>
<td>To help participants understand the role of diet in managing diabetes at this time.</td>
<td>1</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Hydrocortisone and Illness</td>
<td>To help participants using oral steroid replament therapy to understand how and when to adjust their oral doses or administer injected therapy if required.oral</td>
<td>1</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Neuropathy Groups</td>
<td>To help participants understand and explore options for the management of diabetes</td>
<td>1</td>
<td>✔</td>
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Under review or further development

| Type 1 | For those newly diagnosed with Type 1 diabetes to help understand the management of their condition and ongoing care requirements | P | ✔     |
| Insulin Pump Therapy      | To help participants understand the principles and management of glycaemic issues using a continuous sub-cutaneous insulin infusion (CSII) | P | ✔     |

To discuss any of these programmes or any aspect of running structured education programme, please contact us at the centre. Sarah Moutter and Lisa Skinner.
LOW-CALORIE DIET OFFERS HOPE OF CURE FOR TYPE 2 DIABETES

Many of you will have recently seen these headlines and a number of our patients at the Diabetes Centre have asked if it is true! The above statement comes from a study carried out by scientists at Newcastle University which was funded by Diabetes UK.

11 men & women with Type 2 Diabetes (diagnosed in the past four years) followed a diet for two months of just 600 calories a day, consisting of diet drinks and non-starchy vegetables. 600 calories is the amount of calories many people would eat at lunch alone!

The volunteers were closely supervised by a medical team and matched with the same number of volunteers with diabetes who did not get the special diet.

One week into the study the pre-breakfast blood sugar levels had returned to normal. MRI scans showed that the fat levels in the pancreas had returned to normal and it regained its ability to make insulin. Researchers believe that a strict diet melts away fat clogging up the pancreas, allowing it to operate normally. After the trial the volunteers returned to normal eating but had advice on healthy foods and portion size. Ten of the group were retested and seven had stayed free of diabetes.

18 months later four volunteers were still free of diabetes, this appeared to be dependant on how susceptible a person was to diabetes.

In summary we think the ‘Jury is out’ on the long term results of this research and the following factors and statements need to be considered:

• A temporary alleviation of symptoms does not constitute a “cure”.
• Foods contain nutrients and anti-oxidants which can help prevent other health diseases. The department of health still recommends 5 portions of fruit and vegetables a day, this and adequate intakes of important nutrients could not be achieved when restricting people to 600 calories a day.
• Having 600 calories a day is nearly impossible to follow long term 1200 calories is difficult enough.
• Prof Roy Taylor is not suggesting that people should follow the diet - “This diet was only used to test the hypothesis that if people lose substantial weight they will lose their diabetes”.
• Catching people with pre-diabetes or diabetes in it’s early stages while beta cells are still functioning can enable preservation of beta cell function and delay progression by years.
• More research is needed to see whether the “reversal” is permanent.

The majority of people are aware of the impact of dietary manipulation in the management of Type 2 Diabetes, however if anyone is considering following such a low calorie diet they should seek medical advice first.

PATIENT CONFERENCE - ANNUAL DIABETES PATIENT CONFERENCE

Each autumn with the invaluable help of the local diabetes groups, we organise a Patient Conference held in the large entertainments hall at St James’ Hospital. This is a popular event for all those who regularly attend and we would like to make sure that all people with diabetes have this opportunity.

The purpose of the conference is to provide lay people with an interest in diabetes to meet others and exchange experiences and stories whilst having the opportunity to gain more national and local diabetic related knowledge and information.

The content of the conference is planned around feedback from last year. This year we will include ‘speed dating (questioning) drawing on the experience of Consultants, GP’s, Diabetes Specialist Nurses, Podiatrists and Dietitians. We have invited Partha Kar, Diabetologist to discuss the current changes to the NHS and new treatments. We have experienced dietitians who are able to provide the latest information on diet, an update on neuropathy from Jane Rowney, Specialist DSN plus much more.

Professor Ken Shaw has always been a wholehearted supporter of this event and is joining us again to meet popular demand. This year’s Diabetes Patient Conference will be held on Friday November 25th at St James Hospital in the Entertainments Hall.

We are dependant on you as Health care Professionals to promote and advertise this event within your surgeries and Health Centres. We will be sending you posters (with details of how to book a place) to display within your waiting areas.

Sarah Moutter DSN Diabetes Specialist Nurse PHT
Jane Egerton DSN Diabetes Specialist Nurse Southern Health Care
Debbie Fishwick DSN Diabetes Specialist Nurse Southern Health Care
“The House believes that analogue insulin is more effective and clinically appropriate than human insulin”

For: Professor Richard Holt, Southampton General Hospital, Southampton
Against: Iain Cranston, Queen Alexandra Hospital, Portsmouth

“Abnormal Liver function tests in type 2 diabetes: a red herring or a worry?”

Professor Christopher Byrne, Southampton General Hospital, Southampton

Workshops

1. Case based discussions: “Complex” diabetes
2. Blood sugar monitoring: tools and needs
3. Diabetes- foreign travel and sick days
4. Low sodium levels / steroid issues: some case based discussions
5. Who needs a pump?
6. Cardiovascular risk factors: what about the pulse?
7. Renal disease and diabetes drugs
8. Eat and be merry- its only diabetes

Facilitators for workshops

Dr. D Meeking  Dr. Paul Kalra  Dr. Mayank Patel
DSN Lisa Skinner  DSN Anita Thynne  DSN Jane Rowney
DSN Sharon Allard  DSN Jo Buchanan  DNS Amanda Morcombe
ENS Jean Munday  DSN Sarah Moutter  Sue Beaden
Jeanette Head

Gold sponsors

Novo Nordisk and Eli Lilly

Silver sponsor

Sanofi- Aventis

Co-Sponsors

Boehringer- Ingelheim
Roche
BMS /Astra Zeneca
Merck Sharp and Dohme
Novartis
Otsuka
Servier
Life Scan
Ibsen
Pfizer
Abbott
Bayer/Medtronic

The pharmaceutical companies named above have paid for stand space but have had no influence over the agenda.
The Diabetes Specialist Consultants are aiming to hold a whole day conference aimed at primary care-focussing on areas dealing with diabetes management.

The conference will consist of a variety of lectures/discussions and workshop sessions based firmly upon the practical management of patients with diabetes and common endocrine conditions, as per the attached provisional programme.

If you would like to attend the conference, please fill out the form below, with the necessary details and send it, with a cheque made payable to:

**Southern Diabetes Medical Services**

Addressed to:
Dr. Partha Kar, Consultant Physician
Diabetes Centre, Queen Alexandra Hospital, Portsmouth PO6 3LY

*(Please note monies are non-refundable if you cancel within one month of the conference)*

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**TO ATTEND CONFERENCE**

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Contact Number</td>
<td>[ ]</td>
</tr>
<tr>
<td>Job Title</td>
<td>[ ]</td>
</tr>
<tr>
<td>Practice / Area of work</td>
<td>[ ]</td>
</tr>
<tr>
<td>Any specific dietary requirement?</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

Workshop choices: (Allocated on first come, first serve basis)

1. Option 1: [ ]
2. Option 2: [ ]

**Registration Fees**

GP / Consultant: £50
GP trainee / Specialist trainee: £40
Practice Nurse / Hospital / Specialist Nurse / Other Healthcare professional: £35

Any queries, please email drparthakar@gmail.com
PROGRAMME OF FREE PROFESSIONAL EDUCATION AND TRAINING OPPORTUNITIES 2011/12
(SUPPORTED BY: NHS EDUCATION SOUTH CENTRAL)

VENUE: REES HALL, SOUTHSEA TERRACE, SOUTHSEA, PO5 3AP

10TH OCTOBER 2011
DIABETES FOR THE NON-REGISTERED HEALTHCARE PROFESSIONAL
0900 - 1300

17TH NOVEMBER 2011
DIABETES CARE FOR THE HOUSEBOUND, RESIDENTIAL + CARE HOMES
0930 – 1630

13TH SEPTEMBER 2011
DIABETES PHARMACOLOGY
0900 - 1300

6TH & 7TH OCTOBER 2011
LIVING WITH DIABETES
0900-1700 & 0900-1300
(ATTENDANCE REQUIRED AT BOTH SESSIONS)

20TH OCTOBER 2011
CARBOHYDRATE IN PRACTICE
0900-1300

TO BE CONFIRMED
DIABETES IN INPATIENTS
(ATTENDANCE REQUIRED AT BOTH SESSIONS)

6TH & 7TH DECEMBER 2011
CHRONIC DIABETIC COMPLICATIONS
0900 - 1800 & 0900 - 1300
(ATTENDANCE REQUIRED AT ALL SESSIONS)

29TH NOVEMBER 1400 - 1700
6TH DECEMBER 1300 – 1800
15TH DECEMBER 1300 – 1700
DIAGNOSIS, COMPLICATION, PREVENTION & SCREENING
EDUCATION CENTRE QAH

8TH + 22ND NOVEMBER 2011
LIFESTYLE & BEHAVIOUR CHANGE
0900 – 1800
(ATTENDANCE REQUIRED AT BOTH SESSIONS)

SUSPENDED
SELF MANAGEMENT & GROUP EDUCATION
0900 – 1700
(ATTENDANCE REQUIRED AT BOTH SESSIONS)

9TH FEBRUARY 2012
DIABETES IN YOUNG PEOPLE
0900 - 1300

TO BE CONFIRMED
INJECTABLES
0900 – 1700
(ATTENDANCE REQUIRED AT BOTH SESSIONS)

27TH JANUARY 2012
DIABETES IN PREGNANCY
1400 - 1700

TO BE CONFIRMED
INTENSIVE INSULIN MANAGEMENT
(INC. INSULIN PUMPS)
0900 – 1630
(ATTENDANCE REQUIRED AT BOTH SESSIONS)

FOR COURSE DETAILS AND A REGISTRATION FORM, CONTACT:
Diabetic.ProfessionalEducation@porthosp.nhs.uk
or
visit our website:
www.portsmouthdiabetes.com
Direct GP access to the following services is available. Emergency referrals we will aim to see within 24 hours and routine referrals will be seen within 4-6 weeks. These services are provided in addition to the traditional diabetes clinics operating at QAH, GWM and Petersfield Hospital. Referrals may be made through a conventional letter/fax or Choose and Book unless otherwise stated.

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>COMMENT</th>
<th>SERVICE PROVIDED BY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rapid Access (URGENT)</td>
<td>Urgent cases eg new onset type 1 diabetes, mild DKA may be discussed with any member of the diabetes team 92 286260 to decide the best course of action.</td>
<td>Rotational basis via specialty DSN team</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Usually seen within one week of referral. Please refer ASAP 9228 6000 x4553 or 4584 since early review is essential. The service also provides pre-pregnancy counselling for all diabetic women of child bearing age.</td>
<td>Mike Cummings Sarah Moutter Anita Thynne Jeannette Head</td>
</tr>
<tr>
<td>Cardiovascular Clinics</td>
<td>For diabetic patients with established CVS disease or who are at high CVS risk who require specialist advice (including patients with microalbuminuria)</td>
<td>Mike Cummings</td>
</tr>
<tr>
<td>Foot Clinic</td>
<td>Patients can be referred by any member of the community diabetes team, usually via podiatry. Urgent slots will be kept for urgent cases.</td>
<td>Darryl Meeking Sharon Tuck</td>
</tr>
<tr>
<td>Erectile Dysfunction Clinic</td>
<td>For any diabetic patient that has not responded to oral therapy.</td>
<td>Mike Cummings Sarah Moutter</td>
</tr>
<tr>
<td>Type 1 Diabetes Intensified Insulin Education Service (JIGSAW)</td>
<td>Goals-based 22-hour intensive insulin education package open for patients with type 1 diabetes using multiple daily dose insulin therapy, but who are unhappy with their achieved control. Access either by DSN referral or patient self referral (both by proforma to Caroline Parnell).</td>
<td>Iain Cranston Lisa Skinner Sue Beaden</td>
</tr>
<tr>
<td>Insulin Pump Service</td>
<td>Assessment / initiation and follow up service (as per NICE guidelines) for patients wishing to consider pump therapy (after education through the JIGSAW service).</td>
<td>Iain Cranston Lisa Skinner Sue Beaden</td>
</tr>
<tr>
<td>Low Renal Clearance Clinic</td>
<td>Assessment and follow-up for optimised metabolic management of patients with diabetes and renal impairment (eGFR 20-40) with liaison to renal services in-clinic.</td>
<td>Iain Cranston Joanne Buchanan</td>
</tr>
<tr>
<td>Painful Peripheral Neuropathy Groups</td>
<td>One off group sessions examining the causes of and available treatments for painful peripheral neuropathy. Focus also on foot care and risks associated with sensory loss.</td>
<td>Jane Rowney</td>
</tr>
<tr>
<td>Desmond (Type 2) Education Sessions</td>
<td>Whole day group education sessions for people newly diagnosed with type 2 diabetes. Booked through the Diabetes Centre: 02392 286260 Portsmouth City, Tuesday – Friday. 01329 229422 Fareham &amp; Gosport, &amp; East Hampshire. Sarah Stiles</td>
<td>DSN Team</td>
</tr>
<tr>
<td>Exenatide Initiation Service</td>
<td>Medical assessment and then education in the use of Exenatide. Follow up for 6 months to ensure efficacy.</td>
<td>Iain Cranston Sharon Allard Sarah Moutter</td>
</tr>
</tbody>
</table>

**THE FOLLOWING SERVICES ARE ALSO AVAILABLE FOLLOWING INITIAL ASSESSMENT / REVIEW BY THE SPECIALIST NURSING TEAM**

<table>
<thead>
<tr>
<th>SERVICE</th>
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<th>SERVICE PROVIDED BY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Insulin Groups</td>
<td>Insulin starts for patients with type 2 diabetes.</td>
<td>Rotational basis via specialty DSN team</td>
</tr>
<tr>
<td>Basal Bolus Insulin Conversion Groups</td>
<td>For people with type 1 and type 2 diabetes who wish to change their insulin to a basal bolus regimen. Goals based programme with dietetic and nursing input focussing on carbohydrate counting. Accessed by proforma.</td>
<td>Anita Thynne Sarah Moutter Jeanette Head</td>
</tr>
</tbody>
</table>