ROYAL COLLEGE of PHYSICIANS of EDINBURGH

RCPE Diabetes and Endocrinology Symposium
6 October 2022

Professor Graham Leese, Professor of Endocrinology and Diabetes, Ninewells Hospital and Medical School

Question: What ulcer risk score do you recommend?

Answer: Overall I think SINBAD is probably best just now although I have not used in in a clinic

Question: Do you think significant soft tissue infection with Diabetic Foot ulcer anaerobic cover is also required?

Answer: We use metronidazole if the wound is odourous - reflecting anaerobic infection

Question: Do you worry about Tetanus (e.g. immigrants with diabetes foot ulcers)?

Answer: Only if the ulcer was caused by some penetrating injury

Question: There is literature to suggest role of PCT in bacterial infection is less helpful than previously thought... trying to find meta analysis paper surrounding this.

Answer: Not sure I know what you mean by PCT

Question: Antibiotic resistance is a major issue that you mentioned - how do you think this might affect our ability to treat what are already difficult ulcers in 20 years' time?

Answer: Increasing resistance will make wounds more difficult to treat and may result in increased amputaion

Professor Richard Ross, Professor of Endocrinology, University of Sheffield

Question: Salivary tests have been around for a while - why haven't they been shown to be so reliable before or has previous research not shown it to be as reliable as these studies?

Answer: Previous studies have measured salivary cortisol mainly using immunoassay and as levels are low salivary cortisol is often undetectable. We have used LCMS and measure salivary cortisone (reflects free serum cortisol) and done this on waking when serum cortisol levels peak. Doing this we get a much more physiological measure of adrenal function and it is likely that waking salivary cortisone will become a routine screening test for adrenal insufficiency.

Question: If using standard hydrocortisone, are you using normal circadian rythm?

Answer: You cannot mimic the circadian rhythm of cortisol using immediate release hydrocortisone because of its short half-life. You wake in the morning with very low cortisol levels even if you take a dose last thing at night. If you take a dose last thing at night you then get a peak of cortisol when you would normally have low levels. During the day immediate release hydrocortisone gives you peaks and troughs above and below physiological cortisol levels.

Dr Richard Quinton, Endocrine Unit, Royal Victoria Infirmary, Newcastle uponTyne

Question: Do you check for FGFR1 mutations in Kallmann's syndrome?

Answer: I get consent for research genetics to do a full gene panel via the Pitteloud Lab in Lausanne; you can do the same, or ask Prof Faisal Ahmed (Paed Endo Glasgow) to do the same as NHS gene panel

Question: for POI In slightly elderly age like 35 yrs old , do u recommend Femoston or only estradiol?

Answer: If never gone through puberty, I always start with Estradiol monotherapy to get best possible breast development, but otherwise, Femoston 2/10 is a reasonable start point.

Professor Tricia Tan, Professor of Practice in Metabolic Medicine, Diabetes & Endocrinology, Imperial College, London

Question: Why is there increased risk of alcohol and substance abuse? Are we stressing the patients!

Answer: The mechanisms are unclear and is thought not likely to be an 'addicition' transfer. Instead there are some suggestions that this is related to previous alcohol use, smoking, a younger age at surgery and being male.

Question: Is there a standard approach to adjusting insulin regimes/doses for patients about to undergo bariatric surgery to avoid post-op hypoglycaemia?

Answer: This tends to be case by case but being aware of the rapid glucose drop that can occur in these patients should influence the amount and type of insulin used.

Question: Any data on patients established on SGTL2 inhibitors and post-bariatric surgery including glucose dynamics, adverse events?

Answer: We are writing some guidelines on the drugs…or join the SfE talk next week where I will discuss this. Alternatively there will be an ABCD webminar on the 6th of Dec, and I will go through the treatments in more detail: https://abcd.care/events/management-hypoglycaemia-post-bariatric-surgery

Question: Have you seen autonomic neuropathy following significant weight loss? any thoughts about why it could occur / prevention or treatment?

Answer: This does occur and is not well studied.

Question: what is the difference between dumping syndrome and post bariatric hypo? is there difference in treatment between these 2 conditions?

Answer: Yes there is a difference and overlap. Come to the SfE talks or webinar as above.

Question: What is the inclusion criteria for Bariatric Surgery in non-diabetic obese population.

Answer: See NICE guidance: obesity surgery will be offered to adults with a BMI of 40kg/m2 or more, or between 35 kg/m2 and 40kg/m2 or greater in the presence of other significant diseases..

Question: What is your advice about Semaglutide for weight reduction in obesity.

Answer: This is an effective treatment for obesity and the guidance coming out will allow for funding for 2 years only and patients needs to be referred to a specialist weight centre.

Dr Jane Dymott, Consultant in Diabetes & Endocrinology, Aberdeen Cardiovascular & Diabetes Centre, Aberdeen

Question: Are there any discussions within your field of expertise regarding sport - testosterone suppression to 'female norms' has been high profile in athletics? Do you give any advice regarding what 'successful' treatment could be regarded as?

Answer: General approach would be to suppress testosterone to a level that the person is happy with. Often this will be full suppression to female range but some people prefer a higher testosterone. Would discuss effects of lower testosterone in terms of enhanced feminisation, loss of erectile dysfunction, infertility. Evidence for targets in sport is still controversial but if people were given a target then could certainly discuss how to reach this.

Question: How often do you follow-up patients on GAHT? And can/should this follow-up taper over time?

Answer: generally every 4-6months for first 2 years and then annually.

Question: Is there any effect on risks of osteoporosis in the long term with the hormone switch?

Answer: Providing people are on sex hormones no increased risk of osteoporosis. If people are on GnRH analogues alone (sometimes requested if people identify as gender neutral) this would increase risk but would not be an approach we would advise, due to health risks. If people are GNRH alone we would monitor for osteoporosis as per anyone else with sex hormone deficiency.

Question: Have any adverse effects been reported from hormones that have been found from, for example, Amazon, in a way that has been described for sports supplements?

Answer: I assume this refers to self prescribed medication/internet sourced medication. Clearly any medication that is not monitored is potentially dangerous but generally in my experience people who go down this route are quite cautious and try to follow standard guidelines available on the internet.

Question: Doing a young adult diabetes clinic I've had 2 patients in the last year asking about the impact of hormone therapy on their diabetes. How would you advise them?

Answer: Generally there shouldn't be any significant effects, but clearly if there are weight, behaviour changes this would affect diabetes.

Question: How do you approach scenarios whereby hormones pose a higher risk for a particular individual e.g. migraine with aura, or family history?

Answer: We would take the same approach as for anyone else with hypogonadism who needs hormone replacement; for example using topical oestrogen rather than tablets to reduce risk, and discuss risks and benefits with the person so they can make an informed choice.