ROYAL COLLEGE of PHYSICIANS of EDINBURGH

RCPE Symposium: Diabetes and Endocrinology 30 November 2023

Advanced diabetes complications in pregnancy
Professor Helen Murphy

Questions and comments:

Is the GDM audit live? Yes the UK GDM audit is live
Is data entry for primary or secondary care or both? Data entry is entirely electronic (from secondary care maternity and neonatal datasets)
Any data/opinion on people with GDM regarding CGM? Studies are ongoing – but I'm sure as CGM gets cheaper and more accessible it will be used increasingly in GDM pregnancy. The likely GDM targets will be 3.5-6.7mmol/L, aiming for 85-90% time in GDM target range
What can we do to support more women with diabetes to breastfeed? They often have a harder time starting- in part because of NICU involvement- but they are a group whose children stand to benefit particularly. Totally agree – we have local infant feeding team, who offer support to all women with diabetes (T1 and T2D) and as many GDM as possible ~36/40 and again post-partum, esp for those in NICU – the antenatal contact makes a real difference, and they have doubled the numbers of women with diabetes who are successfully breastfeeding at the time of hospital discharge.
If using CGM in T2 do you focus on TiR or the fasting/post-meal glucose targets outlined in NICE guidance? We honestly do not have good data about the TIR targets in T2D – I aim for 80-90% TIR 3.5-7.8mmol/L, and HbA1c <43mmol/mol, with a general mantra of fix fasting first (since we think longer overnight exposure to maternal glucose is more closely associated with fetal growth acceleration, than a short lived 1-2hr post-meal spike)

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Advances in medical management of diabetic retinopathy
Mr Christopher Brand

Questions and comments:

What is the timeline for worsening vision with improved blood glucose control and subsequent improvement? Patients with less-than-ideal blood sugar control may have a reduction in their visual acuity as a result of their blood sugar control regardless of whether there is an improvement in blood sugar control or not. Most patients in who there is an improvement in blood sugar control will not experience any impact on their vision. Although, it is well recognised a rapid improvement in blood sugar control is a risk factor for visual deterioration secondary to macular oedema involving the fovea. I think the timeline for deterioration in visual acuity following rapid blood sugar improvement is within 6 months of the improvement. The timeline for subsequent spontaneous visual improvement would be signs of anatomical improvement in macular oedema within 3-6 months. If you have a patient under your care who informs you their vision is deteriorating. I would recommend checking if they are under the care of the diabetes eye screening programme (DESP) or hospital eye services *HES). If the patient is under care of the DESP, historically they have non-sight threatening retinopathy, the risk of developing significant maculopathy is less, so the recommendation would be to see their local optician for a sight test/glasses check. If the patient is under care of HES for diabetic retinopathy monitoring; the options would be to see their local opticians for a sight test or expedite their HES appointment.
In terms of rapid glycaemic control, in patients with already having advanced retinopathy/maculopathy, what is your onion on the glycaemic targets? do you think there is a place for lowering the glycaemic intensity? In patients with advanced retinopathy/maculopathy; eye treatment will be required over many months/years to improve and stabilise the retinopathy/maculopathy. Also, I don't think it is easy for physicians/GP to predict in any individual patient who will or won't have rapid blood sugar improvement when adjusting patients' diabetes treatment. My request would be for the physician/GP to improve blood sugar control, along with blood pressure control and any other medical condition in all patients in such a way that benefits the patient systemically. As an Ophthalmologist we would continue to treat the patient's eyes accordingly.
Does pregnancy alone increase risk of deteriorating retinopathy or is it spied of improved control? Yes; pregnancy increases the risk of deteriorating diabetic retinopathy. If the patient is under the care of diabetes eye screening programme (DESP), there should be a protocol whereby the DESP is

informed of patients who are pregnant. The pregnant patient under care of DESP is then screened 3 monthly throughout the pregnancy. If the patient is under the care of hospital eye services (HES) for their diabetic retinopathy monitoring we would expedite their appointment hospital appointment and review them 2-3 monthly, unless it was deemed treatment was necessary.

Challenging thyroid function test results
Professor Graham Leese and Professor Mark Gurnel

Questions and comments:

Why do you check FT3 in people with hypothyroidism? It is not strictly necessary but tends to be done by most Labs whenever a fT4 is checked.
Role of total T4 in FDH? Not really any different to fT4 - it has the same problems and tends to read high.
Do you recommend going ahead with genetic testing first or do CRH test or SRL test in possible THR? These days would still do TRH test and SRL test before genetic testing which is still complex and expensive. THat may change in the future.