Comment on: Nathan DM, Buse JB, Davidson MB et al. (2006) Management of hyperglycaemia in type 2 diabetes: a consensus algorithm for the initiation and adjustment of therapy. A consensus statement from the American Diabetes Association and the European Association for the Study of Diabetes. Diabetologia 49:1711–1721

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To the Editor: The American Diabetes Association and European Association for the Study of Diabetes consensus document on the management of hyperglycaemia in type 2 diabetes [1, 2] states that while ‘a lifestyle intervention programme to promote weight loss and increase activity levels should ... be included as part of diabetes management’, ‘the beneficial effects of such programmes are usually seen rapidly, within weeks to months, and often before there has been substantial weight loss’, a statement supported by a 40-year-old reference. The whole section on lifestyle interventions dismisses them as desirable in principle but hardly worth a try because of their ‘limited long-term success ... to maintain glycaemic goals in patients with type 2 diabetes’. There are even suggestions that increased physical activity may lead to ‘potential problems associated with neuropathy, such as foot trauma and ulcers’, a notion unsupported by systematically collected evidence, indeed by no reference at all. They also suggest that ‘the most convincing long-term data that weight loss effectively lowers glycaemia have been generated in the follow-up of type 2 diabetic patients who have had bariatric surgery’, hardly a model of lifestyle intervention in the average person with type 2 diabetes. Hence, the recommendation to start newly diagnosed patients straight on ‘lifestyle intervention+metformin’.

We would like to contend that, contrary to the above position, a growing body of sound literature supports the notion that lifestyle intervention is both feasible in routine practice and effective in achieving and reinforcing the very goals sought by pharmacological means. It is true though that lifestyle intervention is bound to be ineffective in the medium to long term if delivered with the classic prescribing approach [3]. Doctors and their fellow health-care providers, who are mostly trained to treat acute diseases, need to radically shift their attitude and stop thinking of their chronically ill patients as pill-popping automata, ‘non-compliant’ when they fail to ingest 10–15 tablets, walk 30 min and perform a number of other tedious tasks every single day of their life. Adults will learn new concepts and apply them to daily life if these are perceived as reasonable, useful and related to personal experience [4]. No change can be elicited without inducing motivation that goes more than skin-deep, and one way of achieving this is through the reorganisation of working practices, with greater involvement of nurses, dietitians, educators and all the personnel of the diabetes care team [3]. The importance of barrier and strategy identification in developing and implementing realistic self-management plans and the significance of collaborative alliances between patients and operators are never sufficiently stressed.

A number of recent systematic reviews, Cochrane and otherwise, suggest that lifestyle intervention programmes in chronic diseases are particularly effective when implemented in the form of interactive education delivered in groups [3, 5–8]. Groups are far superior to the individual approach because of peer-to-peer relationships, interpersonal

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dynamics and other positive effects that are simply impossible to elicit in classic one-to-one, usually top-down, consultations [5]. This is accompanied by greater satisfaction, not only for patients but also for doctors and all members of the care team.

In our experience, substituting individual with group visits in the routine care of patients with type 2 diabetes achieved long-term (5 years) sustained weight loss, stabilisation of HbA_{1c}, amelioration of other cardiovascular risk factors and reduced prescribed medication [9, 10]. To lower HbA_{1c} by one percentage point cost, over the first 4 years, an additional US\$56.7 per patient treated by group care compared with those on individual care, and US\$2.12 per point gained in the quality of life score [9]. In light of these and other results, it would be desirable that position statements from the main international research associations take into account evidence-based data from recent literature when dealing with such important aspects of diabetes care.

Duality of interest statement: There is no duality of interest.

References

1. Nathan DM, Buse JB, Davidson MB et al (2006) Management of hyperglycaemia in type 2 diabetes: a consensus algorithm for the initiation and adjustment of therapy. A consensus statement from the American Diabetes Association and the European Association for the Study of Diabetes. *Diabetologia* 49:1711–1721
2. Nathan DM, Buse JB, Davidson MB et al (2006) Management of hyperglycaemia in type 2 diabetes: a consensus algorithm for the initiation and adjustment of therapy. *Diabetes Care* 29:1963–1972
3. Norris SL, Engelgau MM, Venkat Narayan KM (2001) Effectiveness of self-management training in type 2 diabetes. A systematic review of randomized controlled trials. *Diabetes Care* 24:561–587
4. Newman P, Peile E (2002) Learning in practice. Valuing learner's experience and supporting further growth: educational models to help experienced adult learners in medicine. *Br Med J* 325:200–202
5. Jaber R, Braksmajer A, Trilling JS (2006) Group visits: a qualitative review of current research. *J Am Board Fam Med* 19:276–290
6. Deakin T, McShane C, Cade JE et al (2005) Group based training for self-management strategies in people with type 2 diabetes mellitus. *Cochrane Database Syst Rev* CD003417
7. Vermeire E, Wens J, Van Royen P et al (2005) Interventions for improving adherence to treatment recommendations in people with type 2 diabetes mellitus. *Cochrane Database Syst Rev* CD003638
8. Norris SL, Zhang X, Avenell A et al (2005) Long-term non-pharmacologic weight loss interventions for adults with type 2 diabetes. *Cochrane Database Syst Rev* CD004095
9. Trento M, Passera P, Bajardi M et al (2002) Lifestyle intervention by group care prevents deterioration of type 2 diabetes: a 4-year randomized controlled clinical trial. *Diabetologia* 45:1231–1239
10. M Trento, P Passera, E Borgo et al (2004) A 5-year randomized controlled study of learning, problem solving ability and quality of life modifications in people with type 2 diabetes managed by group care. *Diabetes Care* 27:670–675