SPECIAL REPORT

Improving the care of elderly diabetic patients: the final report of the St Vincent Joint Task Force for Diabetes

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Introduction

Diabetes mellitus is an important, growing health problem for the elderly population. Hyperglycaemia and hypoglycaemia, microvascular and large vessel complications all adversely affect the quality of life of elderly patients, while placing a heavy demand on limited health care resources [1]. A recently published consensus document on the management of non-insulin-dependent diabetes (the commonest type in elderly subjects) warns us not to 'overtreat' our elderly patients [2], but the authors are unable to define what they mean by 'elderly'. Failure to characterize patients in terms of functional and mental ability may prevent many patients receiving their appropriate level of diabetic care. Older patients require a management approach that differs from that for younger adults because of the presence of co-morbidity, age-related changes in functional ability, the threat of and susceptibility to hypoglycaemia, and the increased role of informal carers.

Representatives of government health departments, patients' organizations, and diabetes experts met, under the aegis of the World Health Organisation for Europe and the International Diabetes Federation, in St Vincent, Italy, in 1989. They unanimously agreed on several general goals. These included a sustained improvement in health and quality of life, as well as the promotion of independence, equity and self-sufficiency for all people with diabetes, including elderly subjects. Five-year targets for the prevention of micro- and macrovascular complications were identified, as was the importance of educating patients and carers in diabetes management (Table 1) [3]. To advise on the implementation of this initiative, the Department of Health and the British Diabetic Association jointly established a Task Force in 1992, which produced a final report in 1995 addressing the goals and targets of the original Declaration [4] (see Table 1).

The report highlighted the importance of achieving uniform standards for diabetes care, with the expectation that improved education would lead to patients taking the lead in managing their disease. Although the report can be criticized for not establishing a specific sub-group for diabetes in older patients, it did recognize old people as having special needs and requiring improvements in care for every aspect of diabetes management, education and research. The importance of multisystem disease in older people was noted. A key recommendation was that local diabetes service advisory groups (LDSAGs) should take a lead in establishing comprehensive healthcare policies for all people with diabetes (irrespective of age) within each health district. These groups should develop a locality-based service, incorporating a diabetes register as a prerequisite for assessing need and attaining St Vincent targets [5].

We feel that the incorporation of a motivated geriatrician into the local diabetes care team is an essential starting point for the development of an integrated district-wide diabetes service between primary and secondary care. This should ensure that older adults with diabetes are included in newly-formed district diabetic healthcare policies. However, geriatricians may be seen as 'generalists' rather than 'specialists' in diabetic care and, whilst their input may be eventually welcomed, they may not be invited to be part of the
Vincent Declaration

grammes for detection and control of diabetes and its complications through an intensification of the research effort

Sustained improvement in health experience and a life approaching normal expectation in quality and quantity

General goals for people with diabetes

Five-year targets

Elaborate, initiate and evaluate comprehensive programmes for detection and control of diabetes and its complications, with self-care and community support as major components

Organize training and teaching in diabetes management and care for people of all ages with diabetes, for their families, friends and working associates and for the health care team

Promote independence, equity and self-sufficiency for all people with diabetes—children, adolescents, people of working age and older people

Implement effective measures for the prevention of costly complications:

- Reduce new blindness due to diabetes by one-third or more
- Reduce the numbers of people entering end-stage diabetic renal failure by at least one-third
- Reduce the rate of limb amputations for diabetic gangrene by half
- Cut morbidity and mortality from coronary heart disease in the diabetic by vigorous programmes of risk-factor reduction

Table I. Diabetes care and research in Europe: the St Vincent Declaration

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<th>General goals for people with diabetes</th>
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<td>Sustained improvement in health experience and a life approaching normal expectation in quality and quantity</td>
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Modified from Krans et al., 1992 [3].

initial disciplinary care team. Their expertise in multi-disciplinary care should allow geriatricians to encourage LDSAGs to network part of their adult services to existing elderly care provision and give weight to the importance of assessments by therapists, socio-economic evaluation and developing support services for dependent patients.

In the UK, collaboration between adult diabetologists and geriatricians is evolving, led by the Diabetes Special Interest Group of the British Geriatrics Society, as general physicians now recognize the special skills of geriatricians in assessing and managing elderly patients whose diabetes is associated with cognitive impairment, age-associated disability and co-morbidity.

An important future objective of the Special Interest Group will be to liaise with the British Diabetic Association and define minimum training requirements in diabetes care for geriatricians. Any model of care for managing the elderly diabetic patient should recognize the important role of the diabetes nurse specialist in educating, assessing and goal-setting, as well as the development of shared care protocols and indications for hospital referral [6].

One major difficulty with the St Vincent 5-year targets for reductions in new blindness, end-stage renal failure, limb amputations and coronary heart disease (angina and myocardial infarction), due to or associated with diabetes, is the lack of hard data available in 1989 to use as a baseline for comparison today. If we are to address the issues in the Declaration, then routine collection of diabetes outcomes, both biomedical and psychological, is a pre-requisite to evaluating the effects of any interventions aimed at achieving the targets. A dataset of mainly biomedical outcomes has been generated for routine use in the clinic, although implementation will depend upon resource and local organization [7]. In addition, further recognition of the multiprofessional educational approach and establishment of joint hospital/primary care audit procedures is necessary for the success of such initiatives.

Older diabetic adults residing in long-term institutions are an important but neglected group which the St Vincent Task Force Group has not considered. Patients in residential and nursing homes have special problems that complicate management [8] and their care should be included within the remit of LDSAGs.

Since 1989, the results of several multicentre trials have clarified the effectiveness of interventions aimed at reducing diabetic micro- and macrovascular disease targets. Although the Diabetes Control and Complications Trial (DCCT) demonstrated clear benefits of tight glycaemic control in preventing or slowing the development of diabetic retinopathy and nephropathy in a young group of insulin-dependent diabetic subjects, there was a high incidence of hypoglycaemia—despite close clinical supervision [9]. The particular risks of hypoglycaemia in elderly people necessitate careful patient selection and supervision when aiming for near-normoglycaemia, especially as many elderly patients do not recognize the symptoms of hypoglycaemia and have not been educated on how to treat it [10]. In addition, the diabetes found in most elderly patients is non-insulin dependent and they are at risk of large vessel disease (with women having a higher risk of coronary artery disease than men), the incidence of which has not yet been shown to be affected by tight glycaemic control.

Perhaps more relevant to older adults with diabetes is the UK Prospective Diabetes Study (UKPDS) which will report in 1998 on the long-term outcomes of specific treatments for some 5,000 newly diagnosed non-insulin-dependent diabetes patients [11]. Although this may confirm that the onset and progression of microangiopathic complications (retinopathy, neuropathy) are directly related to glycaemic control, it is not possible to predict the effect on large vessel endpoints (such as peripheral vascular disease and ischaemic heart disease) which are more important causes of morbidity and mortality in patients with non-
insulin-dependent diabetes. Furthermore, as the upper age for recruitment was set at 65 years, future data on subjects above this age will be limited.

Although maintaining glycaemic control to prevent osmotic symptoms and reduce the risk of developing microvascular disease cannot be overemphasized, achieving normoglycaemia may carry with it an unacceptable potential risk of hypoglycaemia. Rather than aiming for normoglycaemia in all cases, we must focus on lowering blood pressure and blood lipid concentrations, and urge cessation of smoking, these perhaps being safer interventions. There is evidence that treatment of hypertension slows the progression of retinopathy and renal disease, as well as myocardial infarction and stroke [12-13]. The Scandinavian Simvastatin Survival Trial has demonstrated the benefits of lowering blood cholesterol in preventing coronary artery endpoints [14]. Although the mean age of patients in that study was approximately 60 years, improved survival in older subjects was observed, indicating that lipid estimations may become part of routine clinical practice for elderly patients with non-insulin-dependent diabetes.

Screening of the population for diabetes is another option to consider in those aged 60 years and over, but the likelihood of identifying an asymptomatic individual with diabetes in the general population by random screening is small [15]. However, in high-risk groups, the likelihood will be much greater. The development of Community Screening programmes for diabetes may be one initiative that LDSAGs should consider, but there is controversy about the ideal method of screening, referral procedures and further investigations required.

Several important questions still require answers. Does improved glycaemic control lead to benefit in patients aged 70 years and over, either in terms of mortality or developing complications? What is the most cost-effective and beneficial management approach: general practitioner care only or shared care? The importance of education in reducing complications and hypoglycaemia rate also requires further study.

Conclusions

The Task Force emphasizes that models of care and service organization for elderly diabetic patients must evolve, applying the results of recent trials and using the framework of LDSAGs to provide better cost-effective care and optimal management. A commitment to raising local standards of care does, however, include listening to the views of the patients and their carers and recognizing that diabetes specialist nurses have a key role in patient assessment and goal setting, which is different to that for younger patients. Optimum management of elevated blood pressure and lipids, careful selection of glycaemic targets and improved educational strategies, are the cornerstones of treatment for achieving the aims of the St Vincent Declaration. However, diabetes care must also encompass strategies which promote quality of life and well-being, and this is not just a consequence of an increase in care. An improvement in the nature and quality of care is needed and can be achieved only when those responsible for planning and organizing services recognize the very special characteristics of older people with diabetes.

Key points

- Involvement of geriatricians in local diabetes service advisory groups is essential to achieve well organized cost-effective care for elderly diabetic patients.
- The establishment of diabetes registers will facilitate seamless care for elderly patients between primary and secondary sectors.
- Recent trials have demonstrated the relevance of blood pressure control, lipid lowering agents and tight glycaemic control to achieving St Vincent Declaration targets.

References

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