TREATING TYPE 2 DIABETES BY TREATING A PRIMARY CAUSE

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ONE OF THE OLDEST AND BEST established concepts in the history of logical thought is the concept of Cause and Effect. The principle of relationships between events, set down long ago by Aristotle, simply states that if one accepts that "A" causes "B" and if the condition "A" is present, then condition "B" is very likely. Now, if condition "A" is overweight, and condition "B" is type 2 diabetes, it should come as no surprise that, since we are experiencing a world-wide explosion of overweight, there is a parallel increase in diabetes. Logical principles further dictate that if the above relationship is true, and condition "B" is present, then condition "A" must also be; where there is type 2 diabetes, overweight is virtually inevitable. It should not be a difficult logical jump to accept that the first approach to dealing with type 2 diabetic patients should be to help them to reduce their body weight.

There is no shortage of evidence that weight loss has a dramatic effect on diabetes. In fact, rapid weight loss can result in a rapid remission of diabetes (treating condition "A" treats condition "B"). The response is actually so swift that patients are required to stop any diabetic medication before they begin an effective weight loss programme. Simply lowering blood sugar levels with drugs may address some manifestations of diabetes, but it does nothing to assist with the excess weight. In fact drugs often exacerbate the weight problem.

Drugs may very well assist in managing blood sugars, but the mortality from coronary heart disease seems to be unaffected. A report in the New England Journal of Medicine – *Mortality From Coronary Heart Disease in Subjects With Type 2 Diabetes and in NonDiabetic Subjects With And Without Myocardial Infarction* Vol:339 , p229,1998 – found that the seven year incidence rates of myocardial infarction in diabetic subjects without an infarction history was as great as the rates found in subjects without diabetes, but with a previous history of infarction. The difference was quite striking: for non-diabetics, the infarction rate was 3.5% infarction without previous history compared with diabetics at a chilling 20.2%. It is clear that with the detection of type 2 diabetes, reduction of weight should be attempted as soon as possible. Rapid weight loss is important. Real and substantial weight loss (as opposed to the merely cosmetic, or simple shifts in body fluid) is not only possible now, but widely and routinely demonstrable. Pharmacies are leading the way.

In October, 2010, the National Obesity Forum Conference in London heard a presentation by Fin McCaul, one of the pharmacists at Prestwich Pharmacy in Manchester. Mr McCaul (who is also chair of the Independent Pharmacy Federation) was presenting his pharmacy's outstanding results in treating overweight and obesity at the pharmacy. His paper "*Options for the morbidly obese*" was based upon 1148 overweight patients with a median initial BMI of 33.6 kg/m^2 enrolled into the pharmacy's Lipotrim weight management programme. Of these patients, 25% were morbidly obese with a BMI >40 kg/m^2. At the time of audit, during which many patients were still actively dieting, the median BMI had decreased to <30 kg/m^2. 94% of the dieters lost more than 5% of their pre-diet weight, 47% lost more than 10% and 21% of the patients lost more than 20%. His results from the morbidly obese subset were very impressive indeed.

With the advantage of computerised records many of the more than 1500 pharmacies using the same weight management programme have elected to keep their patient weight records online with the "Lipotrim Patient Tracker Software". With this programme even small independent pharmacies can access a continuous audit of their results and demonstrate the value of their service. One

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example of this is a pharmacy who to date has treated not hundreds, but 17 patients. These patients ranged from BMI 26 to BMI 43 when they started the programme. The range of weight loss was between 9 pounds and 5 stone (3.9kg – 31.4kg). The percent of initial weight lost ranged from 5% to 34% with a median of 9%.

Another pharmacist, treating a moderately sized cohort of patients, managed equally impressive results. Here, 318 patients (half of whom were over BMI 32 at the start of their diet and whose BMI's ranged from 25.4 to 56) lost an average of 1 stone 8lbs (10.1 kg) with a range from 1lb to 8 stone (0.4kg – 48.5kg). This population averaged about 11% of initial weight lost. As the number of patients included in the audit was reasonably large, it was possible to get results for a subset of 155 who had lost at least 10% of their pre-diet weight. This group lost an average of 2 stone 5lbs (15kg) reducing their collective average BMI from 34 to 28 at the time of audit. And from that group, 20 of the heaviest patients had started the diet with an average BMI of 43 and at the time of audit had reduced their average BMI to 34.8. The range of weight loss in this subgroup of patients ranged from 1 stone 8lbs to 7 stone 9lbs (10.2kg – 48.5kg) – an average loss of 19% of pre-diet weight.

Given that this programme does not cost the NHS any money, it is hard to justify not encompassing these pharmacys' approach to weight management, especially when weight loss is such a logical option for patients with type 2 diabetes. ■

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