

# Diabetes Nursing Interest Group Newsletter

April 2007

## *DNIG Executive*

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## Message from the Chairs...

### DNIG Leadership: Elections/Appointments

Lillian and Alwyn have been telephoning members to determine interest in the executive positions. The person we thought might take on a co-chair position is no longer able to do that. However, we have had some expressions of interest and will be setting up a face-to-face meeting to discuss the roles and responsibilities of the executive in more depth.

Please review the positions and descriptions. DNIG is a small group, the executive tend to share the responsibilities but it helps to have a contact person for the various positions. If you would like to join the executive, or you know someone who might, please get in touch with Alwyn or Lillian. The past co-chairs are committed to supporting the new executive.

*Diabetes Nursing Interest Group offered three bursaries in 2007 through the Registered Nurses Foundation of Ontario.*

*Ernie "Aieh" Jacobs Memorial Award  
Margaret Myers Diabetes Clinical Practice Bursary  
Mary Ann Murphy Memorial Diabetes Education Bursary*

*The successful applicants will be announced by the middle of April.*

## *Call for Candidates for DNIG positions – to be elected or appointed*

### **Chair / Co-Chair Elect**

Provide leadership of the DNIG  
Act as a link between the DNIG and RNAO  
    Attend Assembly meetings  
    Attend the Interest Group Chairs meeting  
Facilitate formation of the DNIG Executive

### **Secretary** *(Usually the Chair does this.)*

Keep a record of all meetings of DNIG and the Executive Committee  
Send a copy of the minutes to RNAO office  
Ensure notice of meetings and agenda are sent to members for the Annual Meeting  
Address correspondence

### **Policy and Political Action Officer**     *Hilda Swirsky*

Seek opportunities for DNIG to be politically active in issues relevant to the objectives of the organization  
Address issues arising pertaining to policy and/or political action relevant to the DNIG

### **Communications and Public Relations Officer**

Maintain communication with DNIG members:  
    Ensure the DNIG newsletter is published three times per year.  
    Ensure display materials are available for the purpose of promoting DNIG.  
    Ensure DNIG website is kept up-to-date  
Address issues pertaining to communications and public relations related to the DNIG.  
Facilitate links with DES.

### **Membership and Education Officer**

Maintain an up-to-date list of the DNIG membership  
Lead DNIG recruitment and retention initiatives, including welcoming new members  
Ensure DNIG brochures are displayed at relevant conferences  
Provide information to members about educational opportunities, including the DNIG bursaries  
Provide leadership for educational initiatives:  
    Provincial diabetes nursing conference every 1- 2 years  
    Advocate for diabetes certification and education  
Address membership and education issues as they arise

### **Finance Officer**     *Margaret Little/Nancy Benn*

Prepare the annual budget  
Submit a financial statement for every general meeting, or at the request of the Chair  
Maintain the DNIG accounts  
    Issue and sign cheques for payment of authorized expenditures  
    Keep a record of all moneys received and expended  
    Send a financial statement to RNAO office at the end of the year

Submit bookkeeping records to RNAO office for audit when requested  
Address issues arising that pertain to DNIG finances

Student Representative      *Chris Easey*

Promote diabetes nursing among students

## Diabetes Update

### Abdominal obesity: A global epidemic

Prepared by Hilda Swirsky

Sanofi-Aventis invited the Diabetes Nursing Interest Group to participate in a National Stakeholders Educational Forum in Ottawa on March 28<sup>th</sup> and provide feedback and recommendations on how to disseminate current research on abdominal obesity and related health risks.

Keynote speakers Dr. Jean Pierre Despres, Director International Chair on Cardiometabolic Risk, Dr. Milan Gupta, staff cardiologist at William Osler Health Centre, Dr. Rafik Habib, Professor of Family Medicine at the Université de Montreal and Dr. David Lau, practicing endocrinologist and President of Obesity Canada presented compelling research linking abdominal obesity to cardiometabolic risks and diabetes.

The speakers recommended use of waist circumference to measure obesity in addition to the currently used Body Mass Index because it more accurately predicts risk for diabetes, cardiovascular disease and stroke, especially in individuals with traditional risk factors such as metabolic syndrome, high blood lipids LDL and HDL, hypertension, age, male gender, smoking and genetic factors (Depres & Lemieux, 2006, Dagenais, Yi, Mann, Bosch, Pogue & DPhil, 2005).

Suggestions from participants during roundtable discussions included: increasing media focus on abdominal obesity; developing policies to address the socioeconomic determinants of health, and the environment, and community-based educational programs to empower and advocate for multigenerational behavioural changes while remaining sensitive to the fact that some ethnic groups have a higher propensity to cardiovascular disease.

Another valuable resource which addresses this prevalent global concern is RNAO's Best Practice Guideline: Primary Prevention of Childhood Obesity. This BPG recommends preventing obesity by having all nurses promote healthy eating and physical activity throughout the lifespan

while advocating for healthy public policies that promote an environment supportive of healthy lifestyle behaviours.

References:

Dagenais, G. R., Yi, Q., Mann, J.F.E., Bosch, J., Pogue, J., Yusuf, S., DPhil, Prognostic impact of body weight and abdominal obesity in women and men with cardiovascular disease. *American Heart Journal*. 149 (1). 54-60. (2005)

Depres, J. P. & Lemieux. Abdominal obesity and metabolic syndrome. *Nature*. 444, 1-7. (2006).

Registered Nurses Association of Ontario. Best Practice Guideline. Primary prevention of childhood obesity. March 2005. Available at:

[http://www.rnao.org/Storage/12/620\\_BPG\\_childhood\\_obesity.pdf](http://www.rnao.org/Storage/12/620_BPG_childhood_obesity.pdf).

### *Measuring Waist Circumference*

- Have person being measured stand with feet 25–30 cm (10-12 inches) apart
- Locate top of iliac crest (upper hip bone)
- Place measuring tape around the abdomen (ensuring that the tape measure is horizontal). The tape measure should be snug but should not cause compressions on the skin.

Risk increases if the waist circumference is greater than 94cm (37 inches) in men; or 80cm (31 inches) in women. These are the cutoff points for European men and women. Ethnic-specific values are provided in the guidelines.

Canadian Medical Association Journal. (2007). 2006 Canadian clinical practice guidelines on the management and prevention of obesity in adults and children. Retrieved Supplement, 176, from <http://www.cmaj.ca/cgi/data/176/8/S1/DC1/1>

*Read the guidelines, Chapter 3, for a more complete discussion of the importance of measuring BMI and waist circumference and for the need for population-based research to determine clinically sensitive, ethnic-specific cutoff values.*

## **Innovative and emerging therapies in the management of type 1 and type 2 diabetes**

Prepared by Christina Easey, DNIG Student Representative

Diabetes affects the health of many Canadians and there is always a great interest in new and emerging therapies. On March 23, 2007, the University of Toronto, Faculty of Medicine, Banting and Best Diabetes Centre presented Diabetes Update 2007 on this topic at the Metro Toronto Convention Centre.

Daniel Drucker discussed research findings on a new technology for diabetes care. Dr. Drucker is researching *incretins*, the naturally occurring hormones that potentiate nutrient-dependent insulin secretions following ingestion of a meal. The two main incretins are glucose-dependent insulintropic peptides (GIP) and glucagon-like peptide-1 (GLP-1). Dr. Drucker administered a continuous GLP-1 subcutaneous infusion to subjects with 2 diabetes and noted a reduction of blood glucose, body weight, and HbA1c levels. GLP-1 is rapidly degraded by a naturally occurring enzyme, DPP-4, and so an agonist is required to sustain the action.

Clinical trials found that Exenatide administered twice daily, in addition to oral anti-diabetic medications, improved glucose and HbA1c levels by helping to control appetite and improve alpha and beta cell functions of the pancreas, while safely reducing blood glucose levels.

Concurrently, Dr. Drucker is hoping to develop a longer acting Exenatide (Exenatide LAR) that can be administered once a week. Combining DPP-4 inhibitors with GLP-1 may offer a new approach to the management of type 2 diabetes.

For further information on the University of Toronto, Banting and Best Diabetes Centre and an online resource: Approach to the management of diabetes mellitus, visit the website at [www.bbdc.org](http://www.bbdc.org).

Reference:

Drucker, D. (2007, March). *New approaches for the management of type 2 diabetes: The role of incretins*. Paper presented at Diabetes Update 2007: Innovative and emerging therapies in the management of type 1 and type 2 diabetes, Toronto, Ontario.

## Health Council of Canada Report: Why health care renewal matters: Lessons from diabetes

The Health Council of Canada was mandated to monitor the transformation of the Canadian health care system. In the first in a series of reports on health outcomes, the Health Council examines the importance of health system renewal for improving the health and quality of life of Canadians with a chronic health condition such as type 2 diabetes.

The report reviews Canadian and international evidence on the quality of care for people with diabetes and identifies three lessons learned:

- The way we now provide primary health care leaves too many people with diabetes vulnerable to serious health complications that could be avoided. A redesign of the traditional family doctor's practice—to introduce teams, technology and other tools for change—will help achieve better care and keep Canadians healthy.
- Trends in the growth of diabetes including disturbing inequalities for some groups of Canadians. These inequalities could worsen unless we invest in greater preventive care for people at high risk of developing diabetes.
- We have tremendous untapped potential to prevent chronic health conditions in Canada. To reduce smoking, it has taken over a generation for us to see real change. We can do the same for healthy eating and exercise, but it will take sustained action within and beyond the traditional boundaries of health care.

Reference:

Health Council of Canada (March 2007). Why health care renewal matters: Lessons from Diabetes. [http://www.healthcouncilcanada.ca/docs/rpts/2007/HCC\\_DiabetesRpt.pdf](http://www.healthcouncilcanada.ca/docs/rpts/2007/HCC_DiabetesRpt.pdf)

## Best Practices

Delmas, L. (2006). Best practice in the assessment and management of diabetic foot ulcers. *Rehabilitation Nursing*, 31(6), 228-233.

**Abstract:**

Diabetes is an increasingly serious health issue in the rehabilitation population. Foot ulcers develop in approximately 15% of people with diabetes and are a preceding factor in approximately 85% of lower limb amputations. Nurses have significant opportunity to positively influence client outcomes and quality of life by promoting maintenance of healthy feet, identifying emerging problems, and supporting evidence-based self-care and interdisciplinary intervention. Best Practice guidelines (BPG), such as those developed by the Registered Nurses Association of Ontario, provide

a framework to enhance nursing practice and promote excellence in client care. This article highlights key evidence from the BPG, "Assessment and Management of Foot Ulcers for People with Diabetes", and other relevant diabetes literature. This information better equips rehabilitation nurses to promote ulcer prevention strategies; identifies key factors in ulcer risk; and utilizes current, best evidence for ulcer assessment, management, and evaluation.

## Nursing Best Practice Research Unit (NBPRU) Guidelines

The unit has developed several user guides related to the evaluation and implementation of Best Practice Guidelines. Nurses working in diabetes care may be interested in a new resource: **The confidence in administering insulin and managing diet scale (CAIMDS)**.

This user guide describes a self-efficacy scale for insulin self-administration, monitoring of blood glucose levels and managing one's diet. CAI-MDS can be used by nurses who wish to evaluate the effectiveness of diabetes-related education, as a result of implementing the RNAO BPG on Subcutaneous Administration of Insulin for Adults with type 2 Diabetes. CAIMDS is available at: [http://www.rnao.org/researchunit/Storage/24/1850\\_CAI\\_MDS\\_Insulin\\_User\\_Guide\\_FINAL\\_Nov2006.pdf](http://www.rnao.org/researchunit/Storage/24/1850_CAI_MDS_Insulin_User_Guide_FINAL_Nov2006.pdf)

## Institute for Clinical Evaluative Sciences (ICES) Media Releases

### *1. InTool*

Developed by ICES to support evidence-based decision-making, InTool provides instant information through an easy to use, interactive, web-based application.

- You can select one of three health topics: Access to health services, Primary care; Cancer. *Diabetes* will be added to the topic list soon.
- On the same web page: 1) you can download slides for use in presentations from published diabetes reports and 2) link to information on ICES 'Work in Progress' on diabetes.

### *2. Prevalence of Diabetes in Ontario exceeds global rate projected for 2030*

A new ICES study\* reports the prevalence of diabetes in Ontario rose to nearly nine per cent by 2005, thereby surpassing the global rate of 6.4%, which the World Health Organization (WHO) to predicted for 2030.

- Diabetes prevalence has increased 69%: from 5.2% in 1995 to 8.8% in 2005.
- Prevalence rates have remained higher among persons aged 50 years and older compared to

persons aged 20 to 49 years, but the rates increased to a greater extent in the younger population (94% for those 20 to 49 years vs. 63% for those aged 50 and older).

- 31% increase in annual incidence, from 6.6 per 1,000 persons in 1997 to 8.2 per 1,000 persons in 2003.
- The mortality rate among persons with diabetes declined by 25% between 1995 and 2005.

Dr. Lorraine Lipscombe, ICES Research Fellow and lead author of the study attributes the steady increase in prevalence to “the rising number of new cases of diabetes, coupled with declining mortality rates due to people living longer with the disease”. Dr Lipscombe speculates that one important cause of this dramatic growth in diabetes may be the rising rates of obesity, especially in the under 50 population, suggesting that effective public health interventions to manage and prevent obesity are greatly needed.

Dr. Lipscombe stresses that the study’s results are important for policy makers to adequately prepare for the rising burden of diabetes on health care resources.

\*Trends in diabetes prevalence, incidence and mortality in Ontario, Canada 1995-2005: a population-based study”, is in the March 3, 2007 issue of *The Lancet*.

### *3. Diabetes increases hip fracture risk by 20% in the elderly*

The investigators identified more than 197,000 Ontario residents, who were 66 years of age and older with diabetes between 1994 and 1995, and tracked those admitted to hospital for a first hip fracture until March 31, 2003. Hip fracture rates were compared to those of over 400,000 age-matched Ontario residents without diabetes.

“Diabetes was found to increase the risk of hip fracture by about 20% in both men and women. In addition, persons with diabetes were more likely to reside in the lowest income neighbourhoods, and were more likely to be prescribed at least one drug that increases falls or decreases bone mineral density (BMD). Individuals with diabetes were also more likely to have other illnesses and more physician visits, but were less likely to have had a BMD test compared to those without diabetes.”

Dr. Lipscombe and her fellow investigators, caution that: “until there is further understanding of the mechanisms of diabetes and fractures, broad fracture risk assessment of all diabetes patients and enhanced prevention strategies in this population are warranted.”

*To read these reports, go to the ICES web site: <http://www.ices.on.ca/> and follow the link under ‘ICES in the news’*

*You can also sign up for the ICES Alert on the same page and receive an email when new information on your chosen topic becomes available.*

## *Conference Corner*

### *8th Annual Options for Diabetes Conference*

Dates: Friday, April 13th, & Saturday, April 14<sup>th</sup> 2007  
Location: Holiday Inn, Kingston

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### *Diabetes 2007: Rideau Valley Diabetes Services 6<sup>th</sup> Annual Health Care Professional Conference*

Topic: What is the evidence to reduce cardiovascular morbidity in dysglycemia?  
Dates: Wednesday, May 16<sup>th</sup> 2007, 8:00 a.m. to 4:15 p.m.  
Location: Merrywood Easter Seals Camp, R. R. #5, Perth, ON.

### *Remember to send us your email address!*

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