COMMENTS AND RESPONSES

Comment on: Draznin et al. Pathways to Quality Inpatient Management of Hyperglycemia and Diabetes: A Call to Action. Diabetes Care 2013;36:1807–1814

The initiative taken by the PRIDE investigators is to be commended and fully supported (1). They correctly identify gaps in the knowledge of how to manage inpatient dysglycemia, in particular hyperglycemia. However, as discussed recently by one of us, while there is plenty of evidence to show that hyperglycemia is associated with poor outcomes in hospitalized patients, there is almost no data to show that correcting the hyperglycemia is beneficial (2). The data that do exist are limited to cardiac surgery, which represent a small minority of hospitalized patients, while the data from the intensive care population are inconclusive.

In the U.K., three major organizations, the Association of British Clinical Diabetologists, the Diabetes Inpatient Specialist Nurse UK Group, and Diabetes UK, commissioned—through National Health Services Diabetes—the development of a series of national guidelines on the management of inpatient diabetes through a joint working group, the Joint British Diabetes Societies Inpatient Care Group (JBDS-IP). Wherever possible, these guidelines collated the most up-to-date published evidence or, where evidence was not available, used expert consensus to develop the management pathways. The JBDS-IP has now produced guidelines used very widely across the majority of U.K. hospitals, ensuring standardization of care. The documents include the management of diabetic ketoacidosis, hyperosmolar hyperglycemic syndrome, hypoglycemia, self-management of diabetes while in hospital, the management of parenterally fed patients, and the perioperative management of patients with diabetes undergoing surgery or procedures. These are all freely available for download at http://www.diabetologists-abcd.org.uk/JBDS/JBDS.htm. A recent survey of their use, presented at Diabetes UK in March 2013, showed very high levels of awareness among diabetes teams across the U.K. and a very high level of uptake and adoption (or adaption) of the guidelines, with the vast majority of teams finding them very valuable or valuable to the care of the patients under their charge.

The guidelines deal with many of the issues raised by Draznin et al. (1), and our previous work has shown the economic cost of diabetes in the U.K. looking at discharge data for over 4 million adults across a number of medical and surgical specialties (3) and the impact of an inpatient diabetes specialist nurse service (4). Several of the JBDS-IP guidelines have audit standards that set out to benchmark good practice. These guidelines have also deliberately not referred to the ambiguous term "sliding scale," in line with the suggestions of Draznin et al., but refer only to fixed rate intravenous insulin infusions (used for treating diabetic ketoacidosis) or variable rate intravenous insulin infusions. The effects of glucocorticoids have also been discussed elsewhere by one of the authors of the JBDS-IP guidelines (5). Draznin et al. (1) also may wish to consider looking at developing management pathways where the patient is engaged and involved in the decisions made while they are inpatients, for which JBDS-IP has a guideline.

In summary, we wholeheartedly welcome the focus on inpatient diabetes and hope the PRIDE investigators may find some of these materials and this approach helpful.

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