(See page 40)

Part one

Q1 (a), (b), (d), (e). The diagnosis of type 2 diabetes is not always straight forward. A fasting or random blood glucose are reasonable initial tests; though it is important to know whether your laboratory measures blood (BG) or plasma glucose (PG) levels. In western countries plasma is almost always used, and this is increasingly happening in Africa. Blood glucose meters usually give a plasma equivalent result (though ideally such meters should not be used for diagnosis). If classical osmotic symptoms are present, a fasting PG of >7.0 mmol/l or random PG >11.1 is diagnostic. A repeat test is needed if there are no symptoms present. A post-prandial glucose is not a standardised test as it depends on the time and carbohydrate composition of the preceding meal. The oral GTT should only occasionally be needed in doubtful cases. Glycated haemoglobin (HbA1c) is still not widely available in Africa, largely due to its expense, but it is useful in diagnosing as well as monitoring diabetes. An HbA1c > 6.5% is diagnostic, though again a repeat positive test is needed if the patient is asymptomatic. HbA1c should not be used for the diagnosis of type 1 diabetes or gestational diabetes.

Part two

Q2 (a), (c), and possibly (e). All patients with newly diagnosed type 2 diabetes should receive lifestyle advice, followed usually later by oral agents if necessary. However, markedly hyperglycaemic patients (such as here) may need oral agents at diagnosis. Metformin is the drug of choice – particularly in the overweight or obese. There may be a case with this particular patient in giving a small amount of short-term sulphonylurea treatment (e.g. glibenclamide or gliclazide) in addition to metformin, to achieve more rapid blood glucose lowering. Insulin is not needed as the patient is well and not ketonuric.

Part three

Q3 (a), (b), (c). With longstanding diabetes, retinopathy, and persisting dipstick proteinuria; this patient is likely to have diabetic nephropathy. A strongly evidence-based management to slow progression is strict blood pressure (BP) control, with target levels of below 130/80. If available, an ACE inhibitor should be used, with other drugs added as necessary. However, if unavailable, any anti-hypertensive can be used, still with considerable benefit. Lifestyle advice such as weight loss and salt restriction should always be given.

Advertisement Enquiries

Please find below the websites of our advertisers

Advertiser	Page	Email address/website
Erongomed	IBC	www.who.int/hiv/pub/guidelines/arv2013/en
Focus & Rulz	6	www.focusandrulz.com
Hemocue	4	www.hemocue.com
Hindustan Syringes & Medical Devices (HMD)	6	www.hmdhealthcare.com
LINET	IFC	www.linet.ae
MMV (Medicines for Malaria Venture)	BC	www.mmv.org
NEPAD Medicines Harmonisation Conference	2	www.nepad.org/scientificconference