

PROUD

Professionals United by Diabetes

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A DUAL PERSPECTIVE ON DIABETES: RECONCILING RULES WITH REALITY

Miriam E. Tucker is a US-based medical reporter/health writer specialising in diabetes. She has had Type 1 diabetes for 31 years. Some might find her views a little controversial but, based on her own experiences, she explains why she believes that managing the condition must involve compromises between rules and reality. She invites readers to feel free to email her with any comments, (including criticisms!) of her Narrative at miriametucker@aol.com.

I'm sure you can think of many examples in which the ways you deal daily with diabetes aren't exactly what the doctor ordered - even if you are one yourself. Here are three of mine.

Pump vs. injections

The debate continues, especially now that glargine has leveled the playing field. From a purely medical perspective, insulin pumps come out ahead. By allowing the user to precisely calibrate basal as well as bolus infusions - which multiple injections do not - pumps are currently the most physiologic replication of the healthy human pancreas that money can buy. In my work, I write very positively about the benefits of insulin pumps.

But for me personally, it's a different story. I have a particular sensitivity to physical irritations - if my clothing is tight, for example, I get a sick headache that ruins my day. A pump on my tummy? No way!

I've actually been on a flexible basal/bolus regimen for nearly two decades now, first with Ultralente and regular, now with glargine plus lispro. Before glargine, my endocrinologist would always urge me to go on the pump whenever my HbA1c went too high. The pump “threat” actually worked as an incentive to improve my control!

Glargine has changed things. I have seen more healthcare professionals - my own included - more willing to work with the shot regimen. Still, though, I see many people taking sides. In my view, it is absolutely imperative that practitioners offer patients the choice, withholding all personal bias.

My last HbA1c was 6.8%, but I still get a lot of highs and lows. I readily admit that I'd probably do better, blood-sugar-wise, on a pump. And maybe I'll switch one day. But for now, no. And that's my precious choice to make.

Re-using syringes/pen needles

I usually re-use my syringes (for glargine) until I bleed, they bend, or the numbers fade so much I can no longer read them. And I only change the needle on my lispro pen when I change insulin cartridges. According to the package label, my behavior is putting me at risk for the most dire of consequences, including:

“The tip of a reused needle can be weakened to the point where it breaks off and gets stuck under your skin” (has never happened to me).

“Studies have shown that there's a link between needle re-use and the appearance of lumps of fatty tissue that can form at an injection site” (not that I've noticed).

“A reused needle doesn't inject as easily or as cleanly as a new one and can cause pain, bleeding, and bruising” (OK, that's happened).

With regard to the pen needles, my bottom line is convenience - I can grab the pen from my purse in a restaurant, inject quickly, re-cap it, and put it back. If I had to worry about unscrewing the used needle and screwing on a new one each time, the whole point of using the pen would be utterly erased. To me, this isn't trivial. I also re-use finger lancets and I haven't swabbed an injection site with alcohol since the late 80's. Amazing I'm still alive!

Alcohol

As we know, alcohol is a tricky subject for people with diabetes. For us, it has two opposite effects. Like any other carb, it raises glucose in the short-term. But in the long term (i.e., overnight), it suppresses the liver's ability to release glucose, thereby potentially causing hypoglycemia. That's why we are either told not to drink at all, or to eat something if we do. I believe this advice is insufficient.

If your bedtime glucose is normal after an evening of moderate drinking, there's a problem: your overnight basal insulin dose has been calculated to overcome the usual 3:00 am glucose surge from the liver. Therefore - and this should be obvious - you have to cut back on your overnight insulin dose to avoid dropping low while you're asleep.

But you'll rarely hear a physician, nurse or educator give that advice - especially here in the U.S. My endocrinologist basically told me that I shouldn't drink, period. So now I simply don't discuss my moderate social drinking with her.

Although this frustrates me, I do understand it. Very few studies have been done in this area, and, unless the alcohol lobby pays for one, it's unlikely there will be. Aside from the obvious concerns about alcohol abuse, the practice of adjusting insulin based on alcohol consumption is fraught with error. The degree of adjustment would depend on the type of basal insulin being used, the type and amount of alcohol consumed, and factors relating to individual metabolism that are far too complicated to allow for an easy algorithm.

Basically, I've had to come up with my own formula, which doesn't always work. I make sure, however, that when I err it's on the side of ending up with high blood sugar rather than low.

What I find disturbing is the head-in-the-sand attitude of practitioners who simply tell patients not to drink, then are surprised when they end up in the emergency room. Patients WILL drink. It's incumbent upon healthcare providers to educate them on how to deal with it.

I applaud the Diabetes Federation of Ireland, whose website offers this advice: You may need to reduce your insulin dose at bedtime after you have been drinking. If you have a hangover the next day, you may have to adjust your morning insulin dose, too. Thank you, DFI, for understanding that we are human beings too.

KEY MESSAGE: Sometimes, the medical rules we know and the reality we live don't add up. That's because we are human beings, not just diabetic bodies.

Note. Opinions expressed in Diabetes Narratives are those of the individual Narrators and are not necessarily endorsed by PROUD.

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