QJM has published scores of papers on the subject of diabetes mellitus over the last five years. The pilot study in this month’s issue by Kerr and colleagues from Portsmouth considers an aspect of diabetes management that has not received much attention to date in the journal i.e. the implications of excessive alcohol consumption on glycaemic control. To be honest, there is much information already available about the benefits or otherwise of alcohol consumption in general – much of this is confusing and contradictory (even for physicians). Curious about what advice we should give to our diabetic patients, I consulted the Diabetes UK website. It gave what would on the face of it appear to be sensible advice and while urging caution, it reassured diabetics, that when glycaemic control was good, a moderate consumption of alcohol within the UK daily recommended limits should do no harm. However, a variety of views were found on searching the same topic in PubMed. Several papers urged caution for type 1 diabetics with respect to drinking even small amounts of wine with an evening meal. A risk of hypoglycaemia was described that could occur the morning after, possibly as a result of impaired nocturnal growth hormone secretion. Similar conclusions have been found in studies involving moderate drinking in type 2 diabetics. The paper from Kerr et al considers the influence of liberal or excessive alcohol consumption on glucose metabolism in patients with type 1 diabetes. It was found that drinking between 6-8 units of wine with lunch in a carefully regulated environment resulted in a rise in ketones. The authors make the point that patients with diabetes are at an increased risk of developing ketoacidosis if they binge drink, especially if they neglect their regular insulin administration regime (which could happen as a result of intoxication). There are clear safety messages from this study for all diabetic patients. However, the overall subject of alcohol consumption and diabetes is one that needs greater clarity so that we give consistent advice to patients. The accompanying commentary by Song explores this topic in more detail.

It is accepted that hyponatraemia is the most frequently encountered electrolyte abnormality. Its prevalence will of necessity vary according to clinical setting and population. An expert panel in the US attempted to determine the health care burden of hyponatraemia (http://www.resource-allocation.com/content/4/1/10). It was estimated that hyponatraemia effected between 3.2 million to 6.1 million persons in the U.S. per year and the health care costs of dealing with it was of the order of $1-3 billion. In a recent issue of QJM we published a paper that have described an increased risk for fracture associated falls in the elderly who have mild hyponatraemia. Other papers have discussed the association of hyponatraemia with meningitis, pneumonia and myocardial infarction. Whelan and colleagues from Dublin determined the independent predictive value of serum sodium (both high and low) with respect to the mortality of over 14,000 inpatients. Highest rates of mortality were found in those patients whose sodium was either <125 µmol/L or >140 µmol/L. They re-affirm the important prognostic significance of serum sodium in medical inpatient admissions for whatever cause. In addition, it was found that the observed increased mortality in patients with hyponatraemia was independent of other clinical variables.

While the prevalence and outcomes for cardiovascular disease (CVD) risk factors have been well studied in developed countries, this is certainly not the case elsewhere, particularly in sub-Saharan Africa (SSA). Until relatively recently, it has been thought that low levels of CVD existed in that part of the world. However, there has been growing concern that both risk factors and CVD itself have been increasing over the last two decades in SSA. Estimating the burden of CVD in SSA represents a
challenge for a number of reasons including lack of diagnostic facilities and the feasibility of comprehensive epidemiological studies. Kengne and Awah describe a 9 year prospective study where they attempted to determine the outcome for a set of known CVD risk factors in a rural population in Cameroon. Male gender, smoking, elevated fasting capillary glucose, raised blood pressure and age above 50 years were found to be potential determinants of death due to CVD. While this represents a small study confined to just one area of SSA it does add to our knowledge of what would appear to be a growing public health challenge in developing countries.

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