Diabetes and cancer

One of the reviews in this month’s issue documents an observed association between two common disease entities: diabetes and cancer. This phenomenon has been documented for some time with emerging evidence to suggest that the risk of developing some forms of malignancy may be associated with diabetes. For example, there have been reports of increased prevalence in colonic cancers in males with type 2 diabetes mellitus and epidemiological studies from Japan have reported an apparent association between diabetes and a variety of cancers. Why should this be so? The review by Chowdhury considers a number of hypotheses. It would seem logical that both diabetes and some cancers should share a number of risk factors that include advancing age, adverse life style and obesity. The development of certain tumours in diabetic patients raises other possibilities as yet not understood. Finally, it is possible that some treatment regimes may predispose the diabetic patient to an increased risk of malignant disease. It should be noted that the European Association for the Study of Diabetes has called for an urgent investigation into apparent links between the use glargine insulin and cancer. This of course is of concern and the review concludes by recommending further research in this area.

Carbon footprints and clinical services

I draw your attention to a paper that covers a subject that has not previously received much attention within this journal i.e. reduction of carbon footprint. I remember attending an international conference two years ago where the key note speaker was asked to identify the most significant development that would influence healthcare over the next decade. His chosen area was that of the human genome and he eloquently justified his preference. However, at the end of his talk he said that, on reflection, he would have chosen the more challenging area of climate change and its impact on health. (I wonder if he would have added the implications of the financial downturn were he to give his talk more recently). It is acknowledged that climate change can result in a spectrum of morbidity and mortality including deaths caused by exposure by vulnerable people to extremes of heat or cold, flooding, drought and poor air quality. For a discussion of these please refer to Health effects of climate change in the UK.1 The paper by Connor in this month’s issue considers another dimension of the relationship between health and climate change. Ironically provision of health care may of itself be associated with significant adverse environmental impact. This study describes an assessment of the carbon footprint associated with a district renal service. Using component analysis techniques with collection of activity data, the results showed that with respect to total CO2 emissions associated with this renal service, 72% resulted from procurement (pharmaceuticals, equipment) 15% from travel and 13% from building use. It was suggested that the greatest benefits with respect to carbon reduction might result from looking at procurement and supply issues. If the findings from this small study were extrapolated to the NHS as a whole, then a really meaningful reduction in CO2 emissions could be achieved. Thinking of considering the carbon footprint of your own clinical service? I refer you to the Carbon Trust website which has access to a number of tools that may be used in this context.2

Association of Physicians 104th Annual General Meeting

The abstracts from this year’s Association of Physician’s Meeting which was held in Dundee are available this month. Despite the problems
caused by volcanic ash, it was a successful event. The abstracts as in previous years were of exceptional high standard. It was particularly encouraging to hear presentations by researchers in the early years of their academic careers. It is our intention to focus more attention on the output of young clinical academics over the next year.

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References