Correspondence

Microalbuminuria screen in patients on an ACE

Dear Editor,

Thank you for the informative collation of lab tests in diabetes – I read it with interest.

Can I question you over the suggestion of doing at least one microalbuminuria screen on each patient with diabetes each year in the pamphlet?

My understanding is that if the patient is either already on an ACE inhibitor (as this is the treatment if microalbumin +) or they have established microalbuminuria they do not need to be screened.

Can you verify this for me please as that has been my practice to date?

Thank you
David Zarifeh

Dr Rick Cutfield Diabetologist, responds...

I recommend annual screening of microalbumin despite use of an ACE inhibitor. Worsening microalbuminuria will trigger a response to watch blood pressure and glucose control more closely, perhaps adjusting the BP target downwards eg <120/80. It may also trigger a response to emphasise drug compliance.

It is also helpful to see stability or improvement of microalbumin levels while on treatment – to patient and doctors.

Microalbuminuria that steadily progresses to proteinuria should prompt consideration of a referral to diabetes or renal specialist.

Please note: If patients have microalbuminuria - aspirin and statins are mandatory to reduce cardiovascular risk.

Paracetamol in infants less than 2 months of age

Dear Editor,

I have not previously seen recommendations to avoid paracetamol use in infants under 2 months of age as stated in this review (BPJ 5 p24 "Safe Use of Paracetamol In Children"). Considering the relatively wide-spread use of paracetamol for infants receiving immunisations at 6 weeks, and extensive dosing information for infants under 2 months of age, could you please clarify why is such use "best avoided"?

My understanding was that glutathione conjugation is only one pathway for paracetamol clearance (besides the "toxic pathway") and there is apparently a greater degree of sulphation in children. It would seem a shame to unnecessarily avoid paracetamol use in infants having their "jabs" at 6-weeks.

Yours sincerely,
Robert Buckham
Christchurch Drug Information Service

Dr David Reith Paediatrician, reponds...

Paracetamol can be used for the treatment of pain and fever in infants less than 2 months of age. Although in the past paracetamol was used guardedly in this age group, there is recent data on pharmacokinetics, efficacy and safety in the neonatal age group.[1,2] Glucuronidation of paracetamol, the major pathway of elimination in older children and adults, appears to be reduced in neonates resulting in reduced clearance in this age group. This means that doses need to be given less frequently for the same effect, and also to avoid toxicity. Paracetamol toxicity has been described in neonates following excessive dosing and it is important to communicate dosing instructions clearly to parents and caregivers.[3] The BNF for children advises oral doses for term neonates of 20 mg/kg as a single dose, then 15–20 mg/kg every 6 to 8 hours as necessary, up to a maximum daily dose of 60 mg/kg.[4] Over 3 months of age, divided doses of up to 90 mg/kg/day may be given in otherwise healthy children.

1. Anderson BJ, Pons G, Autret-Leca E, et al. Pediatric intravenous paracetamol (propacetamol) pharmacokinetics: a population analysis. Paediatr Anaesth. 2005 Apr;15(4):282–92.
2. Allegaert K, de Hoon J, Verbesselt R, et al. Intra- and interindividual variability of glucuronidation of paracetamol during repeated administration of propacetamol in neonates. Acta Paediatr. 2005 Sep;94(9):1273–9.
3. Walls L, Baker CF, Sarkar S. Acetaminophen-induced hepatic failure with encephalopathy in a newborn. J Perinatol. 2007 Feb;27(2):133–5.
4. BNF for Children 2005. BMJ Publishing Group, Royal Pharmaceutical Society of Great Britain, RCPCH Publications Ltd.

Frequency of testing in patients with diabetes

Dear Editor,

I was interested to get bpac report re. diabetes testing. Many of my diabetic patients are enrolled in a chronic care management scheme with the Counties Manukau DHB. They have minimal requirements for lab testing – these include;

- HbA1c at least every 3 months
- Lipids profile at least every 3 months
- Serum glucose at least every 3 months

These criteria (amongst many others) need to be met if we are to receive payment for managing these patients. If you think these tests are too frequent, I suggest you contact the DHB rather than the GP's who are obliged to order them.

Yours faithfully,
Dr John Allen

Dr Gary Sinclair (Clinical Director Primary Care and Chronic Care Management, Counties Manukau DHB) responds...

The Diabetes CCM programme was initially developed in 2001 based on an expanded version of the Chronic Care Model developed by Ed Wagner, using a Kaiser approach to delivery of service. As part of the delivery system redesign, information systems and decision support, CMDHB developed "templates" in locally used patient management systems for collection of the disease specific dataset for communication to a central "integrated care" server which collects data for decision support, exception reporting and general programme management.

At that time the national guidelines for diabetes and cardiovascular disease were in development, and so the clinical dataset (including required laboratory investigations) was derived on advice from a local programme disease specific advisory group (DSAG) which included physicians from both primary and secondary care in CMDHB.
Given that the CCM programme is targeted at high acuity patients (all patients have to satisfy entry criteria demonstrating poor control of clinical management indicators or signs of advanced end organ damage), and to facilitate ease of programme implementation, the DSAG advised on regular three monthly testing for HbA1c, serum creatinine and albumin-creatinine ratio, lipids being tested every six months.

With the release of national guidelines for the management of diabetes and cardiovascular disease, we noted some variance between guideline based "best practice" and the CCM programme requirements for some of our enrolled patients.

We are currently engaged in the process of integrating the CCM programmes for diabetes and cardiovascular disease, based on the current national guidelines and incorporating requirements for the "Get Checked 2" dataset. At this stage we anticipate migrating to the new platform early in 2008. The new programme will have the IT capability to advise on different management for different individuals (including laboratory investigations) based on individual patient scenarios.

The DSAG has discussed the present laboratory testing protocols, and support the best practice guidelines articulated by bpac[nz]. However in the interests of maintaining programme integrity, DSAG have advised that we continue collecting lab data at the afore mentioned intervals relying on the judgement of our clinicians regarding actual testing intervals until the decision support platform is deployed.

Send your letters to...

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