



The Royal Australasian
College of Physicians

This submission was formulated to give feedback on the draft National Evidence-Based Guideline on Secondary Prevention of Vascular Disease in Type 2 Diabetes, which updated and replaced three sections of the guidelines for the management of type 2 diabetes.



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College of Physicians

From the President

7 July 2015

[REDACTED]
Baker IDI Heart & Diabetes
Institute Level 3
195 North Terrace
Adelaide SA 5000

Via Email: [REDACTED]

Dear [REDACTED]

Secondary Prevention of Vascular Disease in type 2 diabetes guideline

The Royal Australasian College of Physicians (RACP) thanks the Baker IDI Heart & Diabetes Institute for the opportunity to provide feedback on the draft National Evidence-Based Guideline on Secondary Prevention of Vascular Disease in Type 2 Diabetes.

The prevalence of type 2 diabetes is increasing in Australia, and most people with diabetes are at risk of developing various vascular complications such as cardiovascular disease and stroke. These complications, which represent the major cause of morbidity and mortality in diabetic patients, can have a significant impact on their quality of life and decrease life expectancy. It is vital that clinicians are aware of effective interventions for secondary prevention for these complications.

The RACP considers a national, evidence-based guideline as a useful resource for our members, as it would be a therapeutic standard for secondary prevention of vascular disease in type 2 diabetes once endorsed by the National Health and Medical Research Council (NHMRC). A clinical-practice Guideline would support clinicians in their decision-making on optimal treatments for their patients with type 2 diabetes.

The College's submission draws from consultation with our Fellows. Our main points of concern for consideration are:

Recommendation of EBR1 - blood pressure management

The RACP regards that setting a blood pressure target at 110/70 mmHg in all adults with type 2 diabetes and known prior cardiovascular disease as unsuitable, discordant with the literature of the past several years, and potentially dangerous for patients over the age of 50. It is also out of step with contemporary evidence-based guidelines for the management of high blood pressure in adults around the globe.

Some clinical evidence such as the ADVANCE and the ACOORD BP studies do not support this recommendation. A revision on this recommendation is needed, given that the evidence on this target is lacking. It is critically important that blood pressure targets and management recommendations in the Guideline are based on clinical evidence of patients with type 2 diabetes, rather than clinical trials of cardiovascular disease specifically. Otherwise, unnecessary harm may be caused to a patient.

Recommendation of EBR 8 - lipid control

The Guideline advocates the use of the maximum tolerated doses of a statin, which is misleading, as it can be interpreted as stating that 80mg atorvastatin is the most desirable dose for most patients with type 2 diabetes. Clarification is needed to prevent misinterpretation. Moreover, this recommendation fails to acknowledge the risk of dose-dependent drug interactions between statins and commonly prescribed medicines such as diltiazem and clarithromycin. Furthermore, Aboriginal and Torres Strait Islander patients are highly sensitive to statins and often experience severe myositis on usual recommended doses.ⁱ

To ensure appropriate decisions are made about drug combination therapy by clinicians, the RACP proposes that this recommendation should come with a note that higher doses of statins can potentially induce more pronounced drug interactions and adverse effects. This will help clinicians better anticipate the adverse outcomes of drug combination therapy.

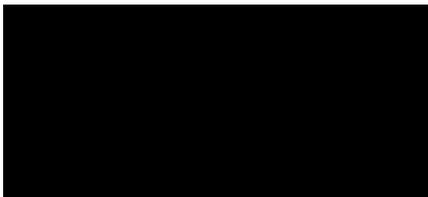
Overuse of medications

If the Guideline is followed completely, the RACP is concerned that patients with type 2 diabetes would be on too many medications, elderly patients particularly. The issue of polypharmacy in the elderly is a growing problem. It is well recognised that there are a number of clinical problems associated with polypharmacy, including decreased physical and social functioning, increased risk of falls, delirium, hospital admissions and death.ⁱⁱ

The Guideline should improve the quality of patients' care and health outcomes, and avoid promoting over-prescribing of medicines, which can lead to reduced compliance, and increase the risk of adverse drug effects and poor medication outcomes.

The College would like to see the next revision of the draft Guideline with consideration of the evidence presented in our feedback. Should you require any further information regarding this response, please contact [REDACTED], Policy Officer at [REDACTED]

Yours sincerely



Laureate Professor Nicholas J Talley

ⁱ L Haysom .Statin-associated myotoxicity in an incarcerated Indigenous youth - the perfect storm. Med J Aust 2015; 202 (7): 381-382.

ⁱⁱ Time to start deprescribing. https://www.mja.com.au/insight/2014/35/time-start-deprescribing?0=ip_login_no_cache%3De00165d7112eef07fd0ce3dfc2edc11f