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Brief report

Therapeutic inertia amongst general practitioners with interest in diabetes

Samuel Seidu^{a,*}, Tun Than^a, Deb Kar^a, Amrit Lamba^b, Pam Brown^c, Azhar Zafar^a, Rizwan Hussain^d, Ahmed Amjad^e, Mathew Capehorn^f, Elizabeth Martin^g, Kevin Fernando^h, Jim McMoranⁱ, David Millar-Jones^j, Shahzada Kahn^k, Nigel Campbell^l, Richard Brice^m, Rahul Mohanⁿ, Mukesh Mistryⁱ, Naresh Kanumilli^q, Joan St. John^o, Richard Quigley^p, Colin Kenny^r, Kamlesh Khunti^a

^a Diabetes Research Centre, Gwendolen Road, Leicester General Hospital, Leicester LE5 4WP, United Kingdom

^b Colindale Medical Centre, 61 Colindeep Lane, Colindale, London, NW9 6DJ, United Kingdom

^c Kings Road Surgery, Mumbles, Swansea, United Kingdom

^d Avicenna Medical Centre, United Kingdom

^e Cheetham Hill Primary Care Centre, 244 Cheetham Hill Road, Manchester, Greater Manchester, M8 8UP, United Kingdom

^f Clifton Medical Centre, Rotherham, United Kingdom

^g Diabetes Department, St. James Teaching Hospital, United Kingdom

^h North Berwick Health Centre, North Berwick Group Practice, 54 St. Baldred's Road, North Berwick, EH39 4PU, United Kingdom

ⁱ The Community Diabetes and Cardiovascular Risk Clinic service is based on the first floor Spires Suite of City of Coventry Health Centre, 2 Stoney Stanton Road, Coventry CV1 4FS, United Kingdom

^j Oak Street, Cwmbran, Gwent, NP44 3LT, United Kingdom

^k Vicarage Lane Health Centre, 10 Vicarage Lane, Stratford, London, Greater London, E15 4ES, United Kingdom

^l Lisburn Health Centre, Linenhall Street, Lisburn, BT28 1LU, United Kingdom

^m Estuary View Medical Centre, Boorman Way, Whitstable, CT5 3SE, United Kingdom

ⁿ Church House Surgery, Shaw Street, NG11 6HF Ruddington, United Kingdom

^o Law Medical Group Practice, Wembley and Willesden, United Kingdom

^p Thornliebank Health Centre, 20 Kennishead Road, Glasgow, G46 8NY, United Kingdom

^q Northenden Group Practice, Stockport, Manchester, M22 4DH, UK

^r Retired GP, Dromore, Co Down, UK

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* Corresponding author.

E-mail address: sis11@le.ac.uk (S. Seidu).

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ABSTRACT

Introduction: As the therapeutic options in the management of type 2 diabetes increase, there is an increase confusion among health care professionals, thus leading to the phenomenon of therapeutic inertia. This is the failure to escalate or de-escalate treatment when the clinical need for this is required. It has been studied extensively in various settings, however, it has never been reported in any studies focusing solely on primary care physicians with

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an interest in diabetes. This group is increasingly becoming the focus of managing complex diabetes care in the community, albeit with the support from specialists.

Methods: In this retrospective audit, we assessed the prevalence of the phenomenon of therapeutic inertia amongst primary care physicians with an interest in diabetes in UK. We also assessed the predictive abilities of various patient level characteristics on therapeutic inertia amongst this group of clinicians.

Results: Out of the 240 patients reported on, therapeutic inertia was judged to have occurred in 53 (22.1%) of patients. The full model containing all the selected variables was not statistically significant, $p=0.59$. So the model was not able to distinguish between situations in which therapeutic inertia occurred and when it did not occur. None of the patient level characteristics on its own was predictive of therapeutic inertia.

Conclusion: Therapeutic inertia was present only in about a fifth of patient patients with diabetes being managed by primary care physicians with an interest in diabetes.

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1. Introduction

As the armamentarium of therapeutic options in management of type 2 diabetes increases, there is an increasingly complex range of options which can create confusion among health care professionals leading to the phenomenon of therapeutic inertia. Therapeutic inertia is defined as the failure of healthcare professionals to initiate or intensify or de-intensify therapy when indicated [1,2]. Early in the disease, there are clear guidelines about diet and lifestyle modifications and the use of oral hyperglycaemic agents (OHAs) [3]. As the disease progresses and there are increasing comorbidities such as renal and cardiovascular disease, a more individualised approach to treatment is required. For example, in older patients [4], quality of life becomes a more important factor. Therapeutic inertia could be due to a lack of training or knowledge, difficulty accessing specialist care advice in a timely manner or deviation from clinical guidelines [5]. There are also wider system level factors in therapeutic inertia such as the high cost of newer agents [6].

Therapeutic inertia is present at all levels of treatment, although, it manifests at a higher level when injectable therapies are indicated. Studies in the UK have shown there was a delay in intensification for patients on one OHA with an HbA1c $>7\%$ (>53 mmol/mol) of 1.6 years, compared with >6.9 years for those taking two OHAs [7]. The median time to intensification with insulin was >7.1 , >6.1 , or 6.0 years for those taking one, two, or three OADs [7].

The delay in intensification leaves a hyperglycaemic legacy which accounts for the complications later in the disease [8]. Therapeutic inertia has been shown to lead to an increase risk of myocardial infarction by 67% (CI 39–101%), stroke by 51% (CI 25–83%), heart failure by 64% (CI 40–91%) and with a composite cardiovascular events by 62% (CI 46–80%) in people with type 2 diabetes with a HbA1c of $>7\%$ and not receiving treatment intensification within 1 year [8].

Since therapeutic inertia has been blamed on the lack of training or knowledge and the difficulty in accessing specialist care advice in a timely manner, it is worth up skilling the primary care base to prevent the phenomenon. This will bring not only clinical benefits to the patients, but also financial ben-

efits to the health system and the providers. To our knowledge, therapeutic inertia has never been reported in any studies focusing solely on primary care physicians with an interest in diabetes, however, this group is increasingly becoming the focus of managing complex diabetes care in the community, albeit with the support from specialists [9–13].

Therefore, in this study, we sought to assess the prevalence of the phenomenon of therapeutic inertia amongst primary care physicians with interest in diabetes in the UK. We also assessed the predictive abilities of various patient level characteristics on therapeutic inertia amongst this group of clinicians. When there has not been intensification of treatment, we assessed if this was due to the knowledge of the clinical context of the patient by the clinician.

In this study, we defined intensification or de-intensification as the change of a therapeutic dose of existing glucose lowering drug or addition or withdrawal of another glucose lowering drug. This may not always occur, but that is not always therapeutic inertia, as there may be other clinical reasons such as the patient being stated to be within an individualised acceptable target of glycaemic control. Therapeutic inertia is failure to intensify or de-intensify treatment when there is a clinical justification for this to occur. Broadly, “Intensification” refers to situations when the patient is less than 65 years and HbA1c has remain more than 53 mmol/mol (7%) for more than twelve months when there is no risk of hypoglycaemia — *this represents those who are younger, and may require tightening of treatment to achieve recommended HbA1c control.* “De-intensification” refers to those over 65 years and have risk of hypoglycaemia but have HbA1c less than 53 mmol/mol (7%) yet no treatment change occurred in past 12 months — *this group represents those who clinically may need a higher HbA1c targets and may be candidates for treatment relaxation.*

2. Methods

Primary care physicians with interest in diabetes across the UK were invited for this quality assurance programme. These clinicians were identified through the Primary Care Academy of Diabetes Specialists (PCADS). At the time of the study,

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