

# Deaths from diabetes

Thabo Mbeki, in commenting on the state of the South African nation, recently observed that the major health threats to his country were "tuberculosis, AIDS, malaria, hypertension and diabetes". Mbeki is ahead of many political leaders around the world in recognizing that the emotional impact of infectious and other invasive diseases (including cancer) can lead to neglect of a similar or larger health impact arising from non-communicable disease. After all, in many countries cardiovascular diseases are not just the largest single cause of death, but also the most important cause of early death, perhaps best thought of in terms of life-years lost.

For this reason, malaria remains perhaps of most concern amongst this quintet, killing as it does principally young children, and AIDS and TB are similarly of concern for their impact on adults in the working age group. As I have noted previously in this column, diabetes can also have a particularly large impact in less-developed nations through its damage to the economic and professional elite in those countries, while in the more prosperous and rapidly industrializing countries it is the sheer rate of increase in incidence of the condition in ever-younger age groups that is of concern.

Perhaps not surprisingly, as the diabetes prevalence increases in a country it comes to account for more and more of the adverse cardiovascular events that afflict the population, and in particular the cardiac and cerebral (stroke) events which lead to premature death. At this point, confusion still arises between 'diabetes' and 'hyperglycaemia' (high blood glucose levels). While the latter is a significant cardiovascular risk factor in itself, it is the constellation of a number of other such risk factors in people with diabetes that lead to the greatly enhanced risk of a vascular catastrophe.

These multiple risk factors mean it is important that diabetes care is seen as management of a broad spectrum of metabolic abnormalities and late complications, and not just 'treatment' of hyperglycaemia. Unfortunately, the importance of this misunderstanding is often missed by those advocates of the importance of diabetes to national and global health,

though the issue is not lost within IDF with its 'Time to Act' cardiovascular protection initiative, nor in such groups as American cardiologists who see the results of its neglect for themselves.

In this issue of *Diabetes Voice* (see articles by Nigel Unwin and Amanda Marlin and by Kaushik Ramaiya), we hear of welcome new joint initiatives of WHO and IDF, driven by many of these concerns, and designed to further raise awareness of the significance of the problem, particularly in low- and middle-income countries where health-care reporting may lead to significant under-appreciation of the extent of the problem (see article by Kaushik Ramaiya).



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Indeed, the article by Nigel Unwin and Amanda Marlin itself illustrates that last problem. While it correctly quotes 3.2 million deaths per annum as being measurably attributable to diabetes, such a figure will miss many if not most of cardiovascular deaths, as for these it is usual to fail to record the underlying cause of death. Indeed this figure is quite incompatible (far too low) with the current estimates of approaching 200 million people with diabetes worldwide, and our understanding that over half will die of a diabetes-related cause in on average 10 years from diagnosis, while losing 6 years of life. Such understanding points to a true global death rate from diabetes of around 10-20 million per annum (about 1 every 2 seconds) – a sobering thought that should be at the forefront of every President's mind.