Editorial

TIME TO DECLARE WAR ON DIABETES

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It is now well established that diabetes mellitus is an extremely common disorder in Saudi Arabia. Recently published surveys indicate that nearly one Saudi Arabian in five beyond the age of 30 has diabetes mellitus.[1,2] Diabetes is present in epidemic proportions throughout the country with exceedingly high rates concentrated in urban areas.[2] The diabetes epidemic, however, is not unique to the local Saudi population, but has also struck the rest of the Gulf community[3-5] and Arab world. Indeed, emerging figures from neighboring Arab countries such as Egypt[6] and Jordan[7] reveal the same alarming trend. Given that diabetes is a chronic burdensome disease of largely middle-aged and elderly people, with close ties to such menacing complications as strokes and heart attacks, it is a grim prospect to forecast what the future might hold for us as our relatively young population begins to age. In essence, what we are seeing today is only the tip of the iceberg of the diabetes epidemic. So, with this background in mind, what should we all be doing both as clinicians and scientists, to face up to the challenge of diabetes and curtail the scale of its devastation?

First, the entire medical community has an obligation and a binding duty towards the care of diabetic patients, for the clinical burden of diabetes is too large to be shouldered by diabetologists alone. By its nature, diabetes is a multisystem disease with wide-ranging complications that span nearly all regions of the body. Thus physicians, regardless of their specialty, are obliged to learn to deal, if not in a professional then in a personal capacity, with diabetic patients and respond to their medical needs. However, because hyperglycemia is typically asymptomatic in Arab patients (even in the face of significantly elevated blood glucose),[8] its clinical importance may, unfortunately, be overlooked. Indeed, as is often the case in diabetic patients with multiple medical problems, the presence of a "high profile" medical condition tends to overshadow the significance of glycemic control as diabetes is somehow dismissed as a harmless companion, unwarranted of comparable care and attention. Such attitudes, widely held, must change, especially as we now know beyond any questionable doubt that high blood sugar means serious complications.[9] Diabetes must therefore be respected and taken seriously by all. Another commonly encountered misconception relates to the treatment of diabetes: it is not often realized that modern treatment of diabetes does not necessarily lie in the provision of pancreatic transplant services or availability of sophisticated insulin devices and pumps; patient education, not technology, remains the heart and soul of diabetes care. Education of the patient and his/her family, whether in relation to diet, exercise, foot care, etc., forms the best and most effective, albeit unglamorous, way to treat diabetes and prevent long-term diabetic complications. Indeed, with no magic cure for diabetes in sight, we should consider investing heavily and in a long-term fashion in patient education as the best prescription for diabetes. Unfortunately, isolated efforts made by an enthusiastic doctor or a dedicated diabetic nurse alone are not the answer to providing adequate care, as there are always too many diabetic patients to treat and educate. Diabetes education must therefore become a national objective and a public priority mediated through the concerted efforts of everyone concerned: the medical community, the general public, even the media, all contributing in their own way to raising public awareness of the disease and its complications. In addition, we should create a national body made up of leading experts and respected public figures both to monitor the disease and to campaign and lobby on behalf of the people with diabetes. Finally, we should generate dynamic social organizations with branches extending countrywide as places where diabetic people come to seek general support, information and literature and meet and interact with professional staff and fellow patients. These objectives are not far-fetched dreams impossible to implement in our country; on the contrary, as a nation we have been blessed with an unusual blend of abundant resources and an exceptionally charitable public, all ready to be tested to respond to the needs of the ever-growing local diabetic population.

What about the local scientific community, what are they supposed to do? For one thing, local scientists and diabetes researchers should join forces with one another in the common fight against diabetes; as always in life, fragmented efforts achieve very little. Thus, individual skills should be cultivated and common resources pooled together, perhaps with the aim of establishing a regional institute for the study of diabetes, where national scientific activities and those from across the Arab world (and beyond) could be coordinated and where ambitious scientific projects on diabetes could be conceived and undertaken. The local scientific community is to be

congratulated for having thus far successfully achieved its first target, that of piecing together the epidemiological picture of diabetes in Saudi Arabia and elsewhere in the Arab world. It must now turn its attention to a new challenge, namely to define the cause(s) and pathophysiological processes (e.g., insulin resistance vs. insulin deficiency) responsible for initiating the diabetic syndrome in our native population, a topic of which we currently know very little. The underlying etiology of diabetes and its complications should therefore be actively sought and delineated at the clinical, laboratory and molecular levels. Exploring the Arabian brand of diabetes could uncover valuable scientific information of potential benefit to all. In this context, it is relevant to remind everyone of the remarkable advances made recently in the field of diabetes as a result of studies undertaken on a small and isolated tribe of Native Americans (Pima Indians) known for its high incidence of diabetes. With so much diabetes around us to explore, it is high time that Arab scientists and clinicians rose to the occasion and taught the world something new on diabetes.

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References

1. El-Hazmi MAF, Warsy AS, Al-Swailem AM, Sulaimani R, Al-Meshari A. Diabetes mellitus and impaired glucose tolerance in Saudi Arabia. Ann Saudi Med 1996;4:381-5.
2. Al-Nuaim AR, Al-Rubean K, Al-Mazrou Y, Khoja T, Al-Attas O, Al-Daghri. Prevalence of diabetes mellitus, obesity and hypercholesterolemia in Saudi Arabia: national chronic disease survey. Riyadh: Ministry of Health and King Saud University; 1995. ISBN: 9960-603-01-6.
3. Abdella N, Khogali M, Al-Ali S, Gumaa K, Bajaj J. Known type 2 diabetes mellitus among the Kuwaiti population. A prevalence study. Acta Diabetologica 1996;33:145-50.
4. Asfour M, Lambourne A, Soliman A, et al. High prevalence of diabetes mellitus and impaired glucose tolerance in the Sultanate of Oman. Diabetic Med 1995;12:1122-5.
5. Zurba FI, Al-Garf A. Prevalence of diabetes mellitus in Bahrain. Bahrain Med Bull 1996;18:44-51.
6. Ajluni KM, Jadoua HY, Batiehah AM. Prevalence of diabetes mellitus and impaired glucose intolerance in Jordan [abstract]. First International Medical Congress; May 1996; Amman, Jordan.
7. Herman WH, Ali MA, Aubert RE, et al. Diabetes mellitus in Egypt: risk factors and prevalence. Diabetic Med 1995;12:1126-31.
8. Kingston M, Skoog WC. Diabetes in Saudi Arabia. Saudi Med J 1986;7:130-42.
9. The Diabetes Control and Complications Trial Research Group. The effect of intensive treatment of diabetes on the development and progression of long-term complications in insulin-dependent diabetes mellitus. N Engl J Med 1993;329:987-97.