



GADE NEWS

AN OFFICIAL CHAPTER OF THE



American Association
of Diabetes Educators



Newsletter of the Greater Augusta Diabetes Educators

September 2009



President's Message

Wow! I can't believe this summer is almost over and fall is rapidly approaching. I hope all of you had a safe and enjoyable summer. Thank you to GADE member and speaker at our May meeting, Dr. Deborah Lee Young-Hyman, who did an excellent presentation on "Disordered Eating Habits in Patients with Diabetes".

While some of us were working or vacationing, others attended the 2009 International Diabetes Educators Conference in Atlanta, GA, on August 5th- 9th. If you didn't have an opportunity to go, don't worry. As part of our September general meeting, "The Pearls of Wisdom" will enlighten you with some of the highlights from the conference. You don't want to miss this! Come join us for dinner and an evening of sharing information while you earn CEU's.

Just to remind members, they are welcome to attend our board meetings. Our next meeting will be held on October 13, 2009, at University Hospital. Check with any board member prior to coming because time and place are subject to change.

Tina Moore, get well soon, the board misses you.



Just a reminder! Don't forget to bring your can goods and/or money for the Golden Harvest food bank. This project will continue throughout this year.



Hope to see you at our meeting on Thursday, September 17th.

Aaron Newberry
2009 GADE President



RSVP by Wednesday, September 16th to Robin Petry

Phone: 706-836-3027 or email: rpetry@uh.org



Mark Your Calendars

GADE Meeting Schedule
5:30pm Social
6pm Dinner and Business
6:30pm Program

2009 GADE Meeting Dates
September 17, 2009
December 8, 2009



GADE Board Meeting: Oct 13th

Board meetings are open to all members. Meetings are subject to change based on board member schedules. Meetings are at 5:30pm and to be held in Dining Room 6 at University Hospital. Closer to date of event, please call one of the board or officers to confirm the place and time.



Start planning now!

Call for Nominations for GADE 2010 Officers



- President-Elect
- Secretary
- Treasurer

● You may nominate yourself or with their permission someone else. Contact Samee Ellerbee at the numbers listed in the Officer/Board contact list by October 15, 2009.



2009 Officers and Board Members

Officers:

President **Aaron Newberry, LD, RD**
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President Elect **Hilda Sullivan**
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Treasurer **Victor Yu, MPH, CDE, RD, LD**
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armydietitian@yahoo.com

Committee Chairs:

Legislation **Volunteer needed**

Membership **Karen Cota, RD, CSP, LD**
706-733-0188, Ext 6963
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Newsletter **Robin Petry, RN, CDE**
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Nominating **Samee Ellerbee, RPh, CDM, CDE**
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Project GOOD **Robin Petry, as above**

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September GADE Meeting

Greater Augusta Diabetes Educators



Webcast: Managing Hypertension in Adults with Diabetes

Followed by

**GADE members who attended the AADE national meeting
“Pearls of Wisdom” from sessions they attended**

Thursday, September 17, 2009
University Hospital
Augusta GA
Dining Rooms 1,2,3

5:30pm Social; 5:45pm Business meeting;
6pm Dinner; 6:30pm to 8pm Speaker Presentation

The **Managing Hypertension in Adults with Diabetes Webcast** examined clinical trials of hypertension treatment in patients with diabetes. Management strategies were presented, which will help health care professionals better treat their patients with diabetes.

At the end of this seminar, participants will be able to:

- Discuss the pathophysiology of hypertension in diabetes.
- Examine clinical trials of hypertension treatment in patients with diabetes and the impact of these trials on guidelines.
- Identify management strategies for patients with diabetes and hypertension.

CEU's approved for physicians, physician assistants, nurses, nurse practitioners, pharmacists, dietitians, certified diabetes educators

This activity is supported by an unrestricted educational grant from Merck & Co.

Cost: No charge

To register: Contact Robin Petry on or before Wednesday
September 16, 2009



Phone: 706-836-3027 or Email: rpetry@uh.org



Accreditation

Physicians: The American Diabetes Association is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The American Diabetes Association designates this education activity for a maximum of 1.5 AMA PRA Category 1 credit™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Family Physicians: This activity has been reviewed and is acceptable for up to 1.5 elective credit(s) by the American Academy of Family Physicians.

Doctors of Osteopathy: This activity is approved for Category 2 CME credit through the American Osteopathic Association.

Physician Assistants: AAPA accepts category 1 credit™ from AOACCME, prescribed credit from AAFP, and AMA PRA Category 1 credit™ from organizations accredited by ACCME. ADA is an accredited provider through the ACCME.

Nurses: The American Diabetes Association is approved as a provider of continuing education in nursing by the Virginia Nurses Association (VNA) which is accredited as an approver of continuing education in nursing by the American Nurses' Credentialing Center's Commission on Accreditation. The American Diabetes Association is located at 1701 North Beauregard Street, Alexandria, VA 22311. VNA-CEA Provider Number: 07-03-02.

This educational activity is approved by the Virginia Nurses Association (VNA) which is accredited by the American Nurses Credentialing Center's Commission on Accreditation as an approver of Continuing Education in Nursing for a maximum of 1.8 VNA Contact Hour. The VNA is located at 7113 Three Chopt Road, Suite 204, Richmond, VA 23226. The American Diabetes Association is also a provider approved by the California Board of Registered Nursing, Provider No. CEP-12196, for 1.5 contact hours.

Nurse Practitioners: This program has been approved for up to 1.8 contact hour(s) of continuing education by the American Academy of Nurse Practitioners. Program ID 0605204.



Pharmacists: The American Diabetes Association is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education. This activity provides up to 1.5 contact hours of continuing pharmacy education credit. The ACPE program number is 239-000-06-007-C01. Each pharmacist should claim only those hours of credit that he/she spent in the education activity.

Dietitians: The American Diabetes Association is a Continuing Professional Education (CPE) Accredited Provider with the Commission on Dietetic Registration (CDR). Registered dietitians (RDs) and dietetic technicians, registered (DTRs) will receive 1.5 continuing professional education units (CPEUs) for completion of this program/material.



Certified Diabetes Educators: To satisfy the requirement for renewal of certification by continuing education for the National Certification Board for Diabetes Educators (NCBDE), continuing education activities must be diabetes related and approved by a provider on the [NCBDE List of Approved Providers](#). NCBDE does not approve continuing education. The American Diabetes Association is on the NCBDE List of Approved

Providers.

Planning Committee

George L. Bakris, MD

Vice Chairman, Department of Preventive Medicine
Rush-Presbyterian-St. Luke's Medical Center
Professor of Preventive Medicine and Internal Medicine
Rush Medical College Chicago, IL

Dr. Vivian A. Fonseca, MD

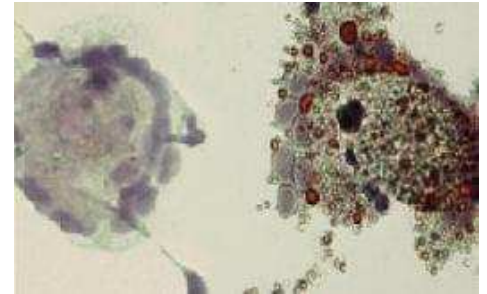
Professor of Medicine, Tullis-Tulane Chair in
Diabetes
Tulane University Health Sciences Center
New Orleans, LA

Research Shows Why Low Vitamin D Raises Heart Disease Risks in Diabetics

Newswise — Low levels of vitamin D are known to nearly double the risk of cardiovascular disease in patients with diabetes, and researchers at Washington University School of Medicine in St. Louis now think they know why.

They have found that diabetics deficient in vitamin D can't process cholesterol normally, so it builds up in their blood vessels, increasing the risk of heart attack and stroke. The new research has identified a mechanism linking low vitamin D levels to heart disease risk and may lead to ways to fix the problem, simply by increasing levels of vitamin D.

On the left is a healthy macrophage cell with sufficient vitamin D. On the right is a macrophage with inadequate vitamin D has become clogged with cholesterol, an early marker of atherosclerosis. Credit: Washington University School of Medicine



"Vitamin D inhibits the uptake of cholesterol by cells called macrophages," says principal investigator Carlos Bernal-Mizrachi, M.D., a Washington University endocrinologist at Barnes-Jewish Hospital. "When people are deficient in vitamin D, the macrophage cells eat more cholesterol, and they can't get rid of it. The macrophages get clogged with cholesterol and become what scientists call foam cells, which are one of the earliest markers of atherosclerosis."

More information: Oh J, Weng S, Felton SK, Bhandare S, Riek A, Butler B, Proctor BM, Petty M, Chen Z, Schechtman KB, Bernal-Mizrachi L, Bernal-Mizrachi C. 1,25 (OH) vitamin D inhibits foam cell formation and suppresses macrophage [cholesterol](#) uptake in patients with type 2 diabetes mellitus. *Circulation*, vol. 120(8);pp. 687-698. Aug. 25. 2009. Published online August 10, 2009 [doi:10.1161/CIRCULATIONAHA.109.856070](https://doi.org/10.1161/CIRCULATIONAHA.109.856070)

Source: Washington University School of Medicine ([news](#) : [web](#))



FDA NEWS RELEASE: **For Immediate Release:** July 31, 2009

The U.S. Food and Drug Administration today approved Onglyza (saxagliptin), a once-daily tablet to treat Type 2 diabetes in adults. The medication is intended to be used with diet and exercise to control high blood sugar levels.



The hormone insulin keeps blood sugar (glucose) levels within a narrow range in people who don't have diabetes. People with Type 2 diabetes are either resistant to insulin or do not produce enough insulin to maintain normal blood sugar levels.

Onglyza is in a class of drugs known as dipeptidyl peptidase-4 (DPP-4) inhibitors which stimulate the pancreas to make more insulin after eating a meal.

The most common side effects observed with Onglyza are upper respiratory tract infection, urinary tract infection, and headache. Other side effects include allergic-like reactions such as rash and hives.

Approval of Onglyza was primarily based on the results of eight clinical trials. The application seeking FDA approval was submitted before December 2008 when the agency recommended that manufacturers of new diabetes drugs carefully design and evaluate their clinical trials for cardiovascular safety. Although Onglyza was not associated with an increased risk for cardiovascular events in patients who were mainly at low risk for these events, the FDA is requiring a postmarket study that will specifically evaluate cardiovascular safety in a higher risk population.

Onglyza is manufactured by Bristol-Myers Squibb Co. of Princeton, N.J., and marketed by Bristol-Myers and AstraZeneca Pharmaceuticals LP, of Wilmington, Del.

Diabetes Advance: Researchers Find Gene That Causes Resistance To Insulin



A breakthrough by an international team of researchers in Canada, France, the UK and Denmark has uncovered a new gene that could lead to better treatment of type 2 [diabetes](#), as well as a better understanding of how this widespread disease develops.

Unlike most of the genes that have been shown to cause diabetes, the new gene, called Insulin Receptor Substrate 1 (IRS1), doesn't affect how insulin is created in the pancreas, but rather, how the body responds to insulin already in the bloodstream, say the researchers, whose work was published in *Nature Genetics* Sept. 6.

"Most of the genes that we've identified as diabetes risk genes to date reduce the function of the pancreas, specifically of beta cells in the pancreas that make insulin," explained Dr. Robert Sladek of McGill University and the Génome Québec Innovation Centre in Montreal, a corresponding author of the paper. "IRS1 has to do with the function of the other tissues in the body. Rather than reduce production of insulin, this gene reduces the effect of insulin in muscles, liver and fat, a process called insulin resistance."

"IRS1 is the first inside the cell that gets activated by insulin," Sladek continued. "It basically tells the rest of the cell, 'hey, insulin is here, start taking in glucose from the blood!' If IRS1 doesn't work, the whole process is disrupted."

This study, which used genetic material drawn from more than 6,000 French participants divided into two separate groups, represents the final step in a series of collaborations between these researchers that has redrawn our understanding of diabetes genetics. In this instance, not only did the researchers pinpoint a new diabetes-linked gene, they found the genetic trigger, which leads to malfunction, in a totally unexpected place.

"It's a single-nucleotide polymorphism (SNP, pronounced 'snip'), a single letter change in your DNA," said Sladek. "What's interesting about this particular SNP is that it's not linked genetically to the IRS1 gene in any way; it's about half-a-million base-pairs away, in the middle of a genetic desert with no known genes nearby. In genetic terms, it's halfway from Montreal to Halifax. And yet we can see that it causes a 40-per-cent reduction in the IRS1 gene, and even more important, a 40-per-cent reduction in its activity. Which means that even if insulin is present, it won't work."

Sladek hopes this discovery may lead to new therapeutic lines of attack in the future.

Rung et al. **Genetic variant near IRS1 is associated with type 2 diabetes, insulin resistance and hyperinsulinemia.** *Nature Genetics*, 2009; DOI: [10.1038/ng.443](https://doi.org/10.1038/ng.443)



University Hospital 23rd Annual Diabetes Expo

Saturday, November 14, 2009

12p-5p

Warren Baptist Church

2303 Washington Rd. Corner of Washington Road and Fury's Ferry Road)

Diabetes Expo is a FREE, fun-filled, educational afternoon of exhibits and classes offering the latest information related to diabetes care and management.

Diabetes Expo is sponsored by University Health Care System

Pre-registration is not required

Mediterranean Diet Helps Control Diabetes

In the study, researchers randomly assigned 215 [overweight](#) people recently diagnosed with type 2 diabetes who had never been treated with diabetes medications to either a Mediterranean-style diet or a low-fat diet.

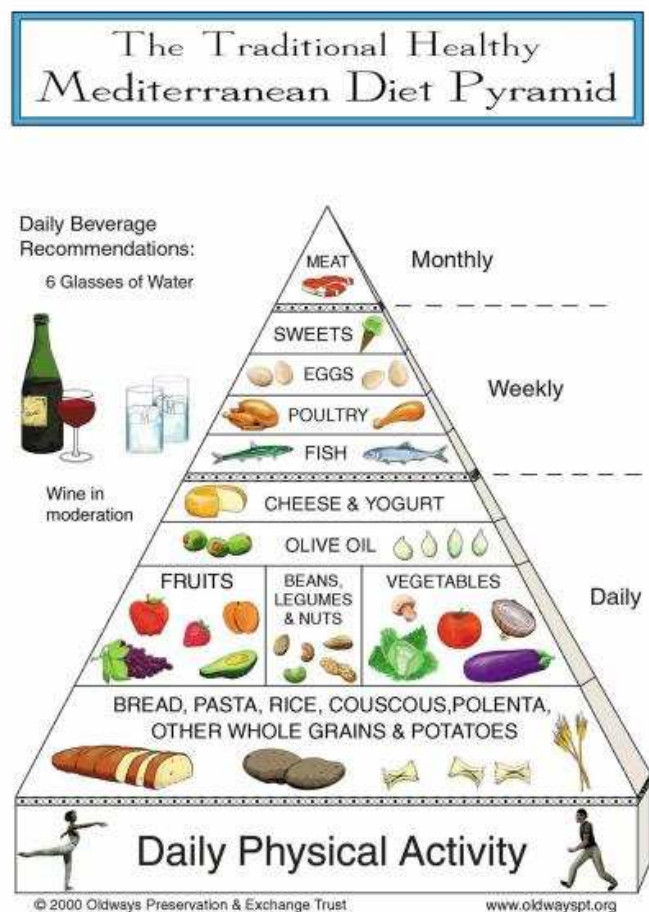
The Mediterranean diet was rich in vegetables and whole grains and low in red meat, which was replaced with fish or poultry. Overall, the diet consisted of no more than 50% of daily calories from [carbohydrates](#) and no less than 30% of calories from fat.

The low-fat diet was based on American Heart Association guidelines and was rich in whole grains and limited in sweets with no more than 30% of calories from fat and 10% from saturated [fats](#), such as animal fats.

After four years, researchers found that 44% of people on the Mediterranean diet ended up requiring diabetes medications to control their blood sugars compared with 70% of those who followed the low-fat diet.

In addition, people who followed the Mediterranean diet group also experienced improvement in other [heart disease](#) risk factors. Interestingly, [weight loss](#) was relatively comparable between the two groups by the end of the trial, suggesting that attributes of the Mediterranean diet beyond weight loss affect blood sugar control.

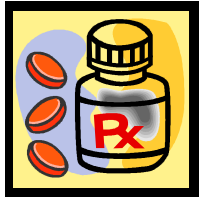
SOURCES: Esposito, K. *Annals of Internal Medicine*, Sept. 1, 2009; vol 151: pp 306-315. News release, American College of Physicians.



Mediterranean diet: A diet traditionally followed in Greece, Crete, southern France, and parts of Italy that emphasizes fruits and vegetables, nuts, grains, olive oil (as opposed to butter) and grilled or steamed chicken and seafood (as opposed to red meat). Plus a glass or two of red wine.

To be exact, there is not merely one Mediterranean diet. What is eaten varies significantly from one Mediterranean country to another. There also are major differences in diet between some regions within a country, as in Italy. However, the shared features of what is usually spoken of as the Mediterranean-style diet are as follows:

- High consumption of fruits, vegetables, bread and other cereals, potatoes, beans, nuts and seeds;
- Olive oil is the key monounsaturated [fat](#) source;
- Dairy products, fish and poultry are consumed in low to moderate amounts;
- Little red meat is eaten;
- Eggs are eaten zero to four times a week; and
- Wine is drunk in moderate (or low) amounts.



21st Century Medicine Today

By
Dr. Ian Herskowitz



A recent paper published in *Diabetologia* raised some concern about the risk of cancer associated with the use of insulin glargine in diabetes therapy. A total of 4 studies were included in the analysis.

The first study from Germany included 127000 insulin treated patients with diabetes. These patients had no prior history of malignancy. They received conventional human insulin, lispro, aspart, or glargine. The unadjusted risk for developing a malignancy was lower in the analogue insulin patients but since the patients on glargine were on much lower doses than those on human insulin, when the adjustment was made based on daily dose of insulin the study the risk of malignancy was higher with the glargine treated group.

The second study from Sweden followed 114000 patients from ages 35-84 on insulin for diabetes. After adjusting for age and sex the rate of malignancy was not elevated for glargine monotherapy compared with other insulin. However when women on glargine were examined there was a higher rate of breast cancer in that group compared to women on other insulin types (relative risk 1.97).

A third study from Scotland examined 36000 patients on insulin over a 4 month period from a database that included almost everyone in the country with diabetes. In a 4 year follow up of 3959 patients using glargine, the incidence of cancer was the same as in those not on glargine. However, in a subset of 447 patients who used glargine as their sole insulin, they noted a higher rate of cancer than did the 32000 using other insulin therapy. No higher rate of breast cancer was seen in this population. The authors in this study noted some differences in the glargine only group including being older 68 yrs vs. 41 yrs, being more over weight, more hypertensive and more likely to be on oral hypoglycemics.

The fourth and final study from Wales, looked at 62000 patients. These individuals were over age 40 and on insulin or oral agents since 2000. The groups were subdivided by oral agent type and insulin type in the analysis. Metformin monotherapy had the lowest risk of cancer in the study. Insulin regimens had the highest rate of cancer a 1.42 relative risk. Adding metformin to insulin lowered the risk of cancer in this analysis. Insulin therapy was associated with a higher rate of colorectal cancer and pancreatic cancer.

Overall there is some suggestion of increased cancer risk in these studies. However the numbers in the study are relatively small compared to the number of people studied in the total group. We do know from past studies with diabetes that there is a higher risk of cancer in Type 2 Diabetes. There is some suggestion that insulin may be associated with some increased risk of cancer but this is still not definite. New data on this issue will be presented in September at the EASD (European Association for the Study of Diabetes) meeting in Vienna. The FDA may also request additional safety data from Sanofi Aventis after completion of its review of insulin glargine.