

EDITORIAL

Educate is a word that was first used in the 16th century and derives from the Latin word *educatus* (to rear) and *educere* (to lead forth). In modern language, education refers to training of the mind, with acquisition of new knowledge and skills. In South Africa, education is a hot topic with important unresolved issues in basic and postgraduate education. People with diabetes require ongoing education as an integral part of their management. Knowledge acquired on the nature of the condition, factors that influence glycaemic control and the medication used is crucial to ensuring successful overall management. However, in busy clinics and resource-starved centres of health delivery, this aspect of care may easily be overlooked. Many diabetes clinics operate without the services of an educator and this is clearly not an optimal situation, if efforts to limit the morbidity and mortality associated with poor glycaemic control are serious. The dire situation with regard to diabetes education has been highlighted in a recent study on the status of programmes for diabetes education in both the private and the public sectors in South Africa.¹ This survey reported that of 27 respondents, only 5 (18.5%) offered a structured programme for patients with diabetes and that most diabetes education was provided on an opportunistic *ad hoc* basis.¹ The situation is made even more challenging by varying rates of literacy and cultural values and beliefs. Against this backdrop, it is encouraging to see studies on diabetes education in South Africa.

In the current issue of JEMDSA, Muchiri and colleagues report on a study where diabetes education was evaluated over a 12-month period in the North West Province. Although the intervention was weighted toward nutritional education, other aspects of diabetes were covered, and at 12 months diabetes knowledge was significantly better in the intervention group as compared to the control group. It is clear that many more studies relating to diabetes education and the optimal means of empowering people with diabetes to acquire effective self-management skills in our setting are required.

Also in this issue, Ramkisson and colleagues report on levels of distress in patients attending both private and public health care facilities in KwaZulu-Natal. Any chronic disease may be associated with distress related to altered quality of life and disease-specific factors. Diabetes may be associated with many factors that induce distress, including the ongoing need for self-discipline in management, diet, adherence to exercise and anxiety regarding hypoglycaemia and chronic complications. Levels of distress may not be perceived when patients attend busy clinics, where high throughput of numbers may, of necessity, take precedence over quality holistic patient care. Ramkisson and colleagues found moderate to high levels of distress in 44% of the study sample and identified a number of factors associated with increased levels of distress. Identifying psychologic impediments

to improved overall patient care is important and this study has identified factors that may be focused on in specific patient groups.

Contemporary society abounds with technology and if this technology can be employed in a cost-effective manner to improve health outcomes, it should be made available on a wide scale. Glucose meters capable of accurate and reproducible ambulatory glucose measurement are one such technology and while it is generally accepted that self-monitoring of blood glucose (SMBG) is of clinical benefit in subjects with type 1 diabetes and those with type 2 diabetes treated with insulin, the benefit in patients treated only with oral anti-hyperglycaemic therapy is less clear. A Cochrane analysis concluded that SMBG in patients with diabetes treated with oral agents provided a small benefit,² whereas the PRISMA study showed overall benefit of SMBG.³ Pillay and Aldous report on the introduction of structured SMBG accompanied by education in a busy regional hospital in KwaZulu-Natal. Although the study sample was heterogeneous and included subjects with both type 1 and type 2 diabetes, at 12 months, structured SMBG accompanied by education led to improvement in both groups and affirms the need for widespread access to meters and strips, particularly in insulin-treated patients.

Finally, in the current issue of JEMDSA, Coetzee and colleagues describe three patients with cardiac tamponade associated with hypothyroidism. In South Africa, pericardial effusion is invariably equated with *Mycobacterium tuberculosis* infection and these cases illustrate the need to maintain vigilance for other diagnoses. The specific factors leading to such extensive pericardial fluid accumulation are intriguing as it is not uncommon to encounter patients with thyrotropin levels much higher than those reported in the 3 patients, yet without symptoms of pericardial disease. As the authors speculate, subclinical effusions are probably common and spontaneously resolve as the condition improves.

It is hoped that the readers enjoy this issue of JEMDSA and the reports provide a stimulus to extend the findings in other studies.

Dr F J Pirie, guest editor

References

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