
EDITORIAL

In the Journal's editorial of March 2019, I alluded to the pressing and broad (no pun intended) issue of gender inequality in the domain of leadership representation in Endocrinology. It would seem that poor representation is also prevalent in the value which allied disciplines offer and the integrated and multidisciplinary approach to patient care is often overlooked. While the Journal continues to strive to attract "cutting edge" submissions, it should also offer wider comment appropriate to (usually lack of) involvement and from (more assertive input) allied disciplines. This is especially relevant in the context of healthcare delivery in developing countries where both doctor shortage and concomitant task shifting amongst healthcare personnel is often the norm.

As such, Manickum P *et al* remind us (sadly enough) that patients with diabetes mellitus account for half the lower limb amputations in South Africa and with a five-year audit, less than 20% of amputees were referred for rehabilitation (even more sadly) – this is a crippling (again no pun intended) lapse of treatment.

Kaplan H *et al* provide very comprehensive data on hypoglycaemia in 445 treated patients with T1 and T2 diabetes. The high frequency of hypoglycaemic episodes (77% in T1 and 18% in T2 patients) and the frequency of severe hypoglycaemia (22% in T1 and 5% in T2 patients) over a three-month period are noteworthy. Reference is made to the doctor team (29 GPs and nine specialists) involved but perhaps too little emphasis was placed on allied team involvement (nurse educators and pharmacists) in regards to patient education (especially relevant with insulin and sulphonylurea medications).

Magnesium deficiency is known to correlate with diabetes. Jansen van Vuuren J *et al* offer a viewpoint on their observed correlation between serum magnesium and lipid subsets in

a cohort of South Africans with diabetes. It would seem that magnesium supplementation may potentially impact adversely on lipid fractions in certain ethnic (vulnerable) groups and as such, supplementation should be utilised with caution.

Lifestyle change remains a cornerstone of therapy in patients with diabetes. This is especially relevant in overweight/obese patients with T2 disease, where an appropriate exercise programme may reduce insulin resistance significantly. Thaane T *et al* review the specific mechanisms and benefits of supervised resistance exercise training programmes. It would suggest that such patients with diabetes may deserve the long-term input of a biokinetic team.

Pharmacovigilance is certainly useful and du Plessis J *et al* indicate that testosterone replacement therapy is associated with new-onset and significant polycythaemia. This is more apparent when therapeutic serum levels of testosterone are achieved. These observational data while, not clarifying the relationship(s) between testosterone treatment and more or fewer cardiovascular events, certainly alerts clinicians to monitor this adverse effect especially in a patient at risk for thrombotic events.

There is important and frequent interplay between body composition (lean and fat mass), bone mineral density and osteopenia-osteoporosis in HIV-treated patients. Ellis C *et al*, in their secondary analysis, indicate these associations. Thus, apart from inflammation (bad for bones) and anti-viral medications (good and bad for bones) other factors, especially age of the patient, emerge as important risk factor(s) in this dynamic.

Happy reading,

Jeff Wing