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Editorial

Glycaemic targets in diabetes

A major issue of controversy in diabetes management globally — but especially in Africa — is glycaemic targets. What levels of blood glucose should we be planning to achieve in our diabetic patients? There are two issues here — the research evidence, and what is practically achievable.

The evidence for type 1 diabetes (T1DM) suggests that the nearer to normoglycaemia the better — equivalent to an HbA1c <6.5%. The problem of this degree of 'tight' control is of course the risk of hypoglycaemia. In type 2 diabetes (T2DM) the situation is less clear, as there is evidence that over-tight control may be associated with excess mortality, particularly in those with cardiovascular risk factors.

All the studies which examine the benefits or otherwise of glycaemic control have been in European or North American populations. Their results are probably broadly applicable to Africa. However, the real problem is that in many African environments patients with diabetes may have no facilities for home glucose monitoring, regular HbA1c testing, diabetes team support etc. In situations like this, targets may have to be relaxed and individualised; and even become qualitative rather than quantitative. For example, some African intervention programmes have used symptom control and lack of hypoglycaemia as their primary aims. In T2DM, lack of nocturia¹, or a random clinic blood glucose of <14.0 mmol/l² may equate to reasonable HbA1c levels.

Simple protocols which are not based on HbA1c levels can be effective in leading to glycaemic improvements in T2DM.³ Once again, this demonstrates that diabetes practice in Africa can be effective despite a lack of laboratory and other technical support.

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Front cover: Bwindi impenetrable forest, Uganda.