Ten years ago, the diabetologist’s dream was to reduce the nephrologist’s workload enormously, at least as far as diabetic patients are concerned. This dream has now become a nightmare. Developed and affluent countries throughout the world are experiencing a dramatic increase in the incidence of end-stage renal failure (ESRF) in patients with Type 2 diabetes. During the period 1989-1995 in mainland France, the prevalence and incidence of diabetes reached 15.7%, whereas in French overseas territories the prevalence and incidence were 25.7% and 35.6% respectively. In such patients, the development of ESRF competes with premature deaths from ischaemic cardiovascular diseases, mainly coronary heart disease.

Elderly Type 2 diabetic patients are currently the major and rapidly growing component on RTT, starting dialysis “in emergency conditions.”

During the last ten years, in an attempt to prevent clinical nephropathy and slow the decline in the glomerular filtration rate, numerous concordant and well-designed prospective studies have shown that different interventions (mainly improved blood glucose and blood pressure control) are highly effective, at least for those diabetic patients included in protocols!

In daily care, the application of the findings in these studies would lead to a dramatic increase in the annual cost of drugs used by diabetic patients in France, while the increase of RRT incidence in diabetic patients would be dramatic as well.

In France, 90% of Type 2 diabetic patients are treated exclusively by general practitioners, at least until a severe complication occurs. Thus, the majority of Type 2 diabetic patients with renal failure are referred to nephrologists by GPs. At the time of referral, the clinical presentation is very informative: about 50% of the diabetic patients have a creatinine clearance lower than 10 ml/min. Poor blood glucose and blood pressure control are observed in nearly 90% of these patients. The care of Type 2 diabetic patients by GPs must be changed radically. Extensive co-operation between diabetologists and nephrologists is urgently needed to improve the knowledge of GPs about diabetes and kidney disease.

However, for a GP in charge of a small number of diabetic patients, it may be impossible to integrate the very rapid changes in knowledge within the field of diabetes, hypertension, and dyslipidaemia, since he or she must also explore molecular biology, new antibiotics, AIDS therapy, etc.

To improve patient compliance and the knowledge and expertise of physicians, diabetologists and nephrologists need to be more imaginative and design more effective educational programmes than those currently in use.

In this context, guidelines such as those recently issued by the AFDÉDIAM and the French Society of Nephrology on the care of diabetic patients with renal insufficiency are most welcome. However, they need to be disseminated to the medical community in a short presentation and explained.

Experts who are not in 100% agreement with these guidelines should refrain from expressing personal opinions and concerns which may be relevant but would reduce the impact of the message to non-specialist physicians. To improve communication to all health-care providers, there is an urgent need to develop common lines of thought and co-operation between diabetologists and nephrologists on matters of diabetic kidney disease.

The joint meeting on Kidney and Diabetes held in Paris on December 3, 1999, and attended by more than 300 diabetologists and nephrologists, should be the starter for close and prolonged co-operation intended to produce a significant reduction in the number of diabetic patients who must undergo three dialysis sessions each week in order to survive.

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