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Letter to the Editor

Indian Diabetes Risk Score: Use beyond population screening for diabetes

I read with interest the article titled “Performance of Indian Diabetes Risk Score (IDRS) as screening tool for diabetes in an urban slum” by Dudeja et al. published in *Med J Armed Forces India* 2017 April 30;73(2):123–128¹ and would like to compliment the authors for validating a cost effective and non-invasive screening tool for diabetes. As per WHO report, over 19% of the world's diabetic population resides in India. This means that currently India has 35 million diabetic subjects, the number of which is projected to rise to 80 million by the year 2030. The problem becomes grave with the fact that more than half of the individuals with diabetes in India remain undiagnosed and hence are at increased risk of developing diabetic complications. Thus, timely screening and appropriate intervention is the need of the hour.

Opportunistic screening for diabetes is recommended by ADA in routine clinical practice. There is evidence supporting cost effectiveness and validity for the use of diabetes risk score as an alternative to fasting blood sugar for initial screening for diabetes in clinical practice.² In health care settings, the high-risk individuals can be identified using IDRS and be targeted for annual screening for diabetes. Also, by systematic counselling and intervention, it can be used as an efficient tool to reduce the risk in diabetics. The results of a study favoured the Madras Diabetes Research Foundation (MDRS)-IDRS for efficiency and cost effectiveness in comparison to genotyping or OGTT for initial screening for diabetes when used on the whole population.³

Madras Diabetes Research Foundation, Chennai came up with IDRS as a simple and non-invasive tool to help in preliminary screening for Type 2 Diabetes Mellitus (T2DM) in the community. The developers of IDRS have explored its use in many other clinical and epidemiological settings.³ Presently, normoglycemic individuals with a high IDRS score are likely to develop pre-diabetes or diabetes in future. However, among the symptomatic individuals a high IDRS score (>60) can be taken as an indication towards T2DM whereas a low-risk score will favour the diagnosis of other forms of diabetes (other than

T2DM). Subjects with IDRS > 60 are at a high risk for development of metabolic syndrome, non-alcoholic fatty liver disease and diabetic complications in the form of coronary artery disease and peripheral vascular disease.

Thus, in current national scenario it is worthwhile to incorporate IDRS for population screening as well as opportunistic screening at clinical practice for getting a lead time in diagnosis of diabetes as well as its complications and metabolic syndrome.

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Reply

Dear Editor,

We are grateful to the author for an encouraging reply. IDRS has been performing consistently and should be used as a screening tool in community settings by peripheral health care/auxiliary workers. This will not only aid in early identification of patients and hence early diagnosis but also will go a long way in decreasing health burden due to better prognosis. As a screening instrument, it can be used in health care establishments for opportunistic screening. However, patients with high scores should be advised blood sugar level as well as other tests to rule out target organ damages as they remain to be recommended protocol for diagnosis and treatment of Diabetes. Further, IDRS has been used in some studies as prognostic marker in diabetes management. Though research has proved it to be a useful tool, its application in various settings by health care professionals can only reap its true benefits.

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Letter to the Editor

Accreditation of service hospitals: Time to move towards state of readiness

Dear Editor

We read with extreme interest the editorial titled 'Accreditation of Armed Forces hospitals: An imperative now' by Chatterjee published in Med J Armed Forces India 2017;73:213–215.¹ We compliment the author's effort in highlighting the salient issues for every one of us to realize and ponder.

We partly agree with the author's argument that the service hospitals are not uniform in their practice and standardization of care processes have become diluted over several decades. This may be perceived dilution whereas reality may be different. We have service set ups all across the country. Some are smaller hospitals and few are big enough to cater for few basic specialities. There are quite a few set ups with tertiary care capability too. One of the important components of standardized system is the continuity of care. The hospital administrators have to struggle many times to get a suitable relief during leave of specialists posted. Basic speciality service providers have to leave for training and temporary duty commitments without ensuring continuity of care in their absence due to either partial or no relief at all. Though the provision exists for hiring the services of civil experts, busy clinic and other commitments of these specialists does not allow arrangement of mutually convenient timing and venue. Clientele may prefer to go to nearby private set ups just for the sake of convenience, not because of distrust or personal choice to avoid service hospitals. Unless we

ensure complete continuity of care in all our hospitals, implementation of other standards becomes less practical. The base of the care pyramid has to be strong enough. As we agree with the author that there is requirement of integration of multiple specialities and subspecialities, such modernization can only sit on top of a strong and stable base. Too much of sub-speciality oriented approach makes such care availability skewed towards command hospitals or metro cities. Those men and families posted in smaller places are not to be ignored and clear policy to ensure continuity of care should be implemented at all such places. There is a need to change the mindset that 'cannot leave subspeciality centre unmanned' to 'cannot deprive the provision of basic speciality care' at every service establishment with significant clientele load. This step alone can result in much better patient outcome and improved clientele satisfaction.

Issues surrounding the human resource deployment hinder our efforts to seek full accreditation process. Services are unique with medical and paramedicals trained to work with man power constraints. We are tuned to deliver well even when doctor/patient/nurse ratio being skewed. Our hospitals ensure outcomes comparable to best of the centres in the country, if not more, even with these man power limitations. Unfortunately accreditation agencies do not accept this rationale. Management of medications is another sore area.