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# EDITORIAL

## THE ST VINCENT DECLARATION: A NEW CHARTER?

The resonance of the name recalls important landmarks in human history such as the Universal Declaration of Human Rights (1948) or the Helsinki Final Act (1975). So it is for diabetics, who number more than 10 million in Europe – and the number is on the increase worldwide. In October 1989, at St Vincent, a resort in northern Italy, representatives from various European government agencies and patients' organisations met with experts in various fields of diabetes care and research. They formulated a set of aims which they thought were achievable, to try to reduce the complications of diabetes and improve quality of life for patients. A programme of action has been published by the WHO and is a document which deserves to be read in full.<sup>1</sup>

One of the principal aims was 'to reduce new blindness by one third or more', topping a list which included prevention of renal failure, gangrene, coronary artery disease and pregnancy complications.

The British Diabetic Association together with the UK Department of Health responded by setting up a Task Force to look at ways of implementing the St Vincent declaration and has since published its recommendations.<sup>2</sup>

It is a seeming paradox that almost two decades after the efficacy of photocoagulation has been proved by randomised controlled trials,<sup>3,4</sup> blindness from diabetic retinopathy should still assume such prominence. According to available data diabetic retinopathy is still the commonest cause of newly registered blindness amongst the working age group.<sup>5,6</sup> The number of possible causes include (1) treatment not being delivered, either because the patient is not being identified or identified soon enough; (2) treatment not being applied appropriately in time or manner; or (3) treatment being less effective than previously thought.

There is no disagreement that the St Vincent targets are desirable, but whether they can be met depends on knowing where we are on the rectilinear curve of efficiency. At present there are too many

unknowns, for not only is the diabetic population imprecisely defined, but there is a suggestion that the registration of visual impairment considerably underestimates the true size of the problem, especially amongst the elderly.<sup>7</sup> Some kind of database, perhaps district based, of all known diabetics seems desirable and would provide much of the information needed to assess present status, monitor profiles of care and measure future performance. This is a priority that is recognised by the Task Force.

The first aim of eye care must be to institute regular screening according to an agreed protocol. While it is the responsibility of the physician or general practitioner (GP) to arrange an annual or regular check for the patient, the ophthalmologist should ensure that the screening modality is acceptable in sensitivity and specificity. Conditions differ in districts and no one strategy is applicable to all. Some may use photography but others personnel. The performance of screeners improves on training,<sup>8</sup> and without this improvement the sensitivity may not be acceptable.<sup>9</sup> This is an important role for the ophthalmologist who, in addition to setting a threshold for referral, must also ensure that there is ready access for those screened positive. In some districts this may mean additional manpower, but the case will have to be proved. In addition, the quality issue needs to be addressed by accreditation of screeners and continuing audit, for which a central database will be the key.

The timely delivery of appropriate photocoagulation treatment is critical for success and this process needs continuous monitoring. One needs to audit both the process and the outcome, which is an activity perhaps better done at the district level and will provide indicators of performance for individual units. Until more reliable data can be collected on blindness rate, surrogate measures such as vitrectomy rates will also provide a pointer to the effectiveness of both screening and treatment. A national audit on treatment is currently being

conducted by the Royal College of Ophthalmologists; its outcome is keenly awaited.

What of the current modes of treatment and their true efficacy? While there is good evidence that in proliferative disease early and adequate treatment will prevent up to 90% of patients from developing blindness, the evidence is less convincing in maculopathy, which is unfortunately a greater problem numerically. While both the ETDRS<sup>10</sup> and the British Multicentre Study<sup>11</sup> have proved beyond doubt that treatment is better than no treatment, the result is not a statement of the level of efficacy. Lest we should become complacent we need to be reminded that, in both studies, the treated eyes also deteriorated but more slowly. This is hardly surprising, as the way photocoagulation benefits macular oedema has never been fully explained. The problem is further compounded by the nature of non-insulin-dependent diabetes (NIDDM), which may escape detection until tissue damage has occurred.

Perhaps we will need to re-consider the role of glucose control; this has already been shown to benefit retinopathy in insulin-dependent diabetes<sup>12</sup> and it is not unreasonable to assume a parallel effect in NIDDM, in which case the role of the physician (usually GPs, who currently treat the majority of NIDDM cases) will have to be enlarged to share in the management of maculopathy. The role of glucose control in NIDDM is being evaluated by the UKPDS<sup>13</sup> and the outcome of the study is eagerly awaited.

While one needs to be critical in interpreting the results of studies on treatment, the present methods are still the best we have and have been proven by randomised controlled trials. Whatever new measures we may adopt in treating retinopathy it makes sense to maximise the effectiveness of those we have, and that consists of early detection, timely intervention and correct techniques of application. These and other wide-ranging issues were considered by the Visual Impairment Subgroup of the Task Force and their report, including a list of recommendations, is being published along with other subgroup reports in a special issue of *Diabetes Medicine*.

Of equal importance is the provision of support, education and retraining for the visually handi-

capped, and the report of the Task Force highlights these aspects as a priority.

The noble aims and lofty aspirations of the St Vincent Declaration pose a challenge to the profession. To approach its goal will require a collaborative effort which involves a contribution not only from the ophthalmologist but from all those interested in diabetes care, ranging from the GP to the epidemiologist, if the target of reducing blindness by a third or more is to be reached.

H. CHENG

### References

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