The Diabetes Clinic and Internal Medicine

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Can internists be diabetologists? Surely they can. Should the diabetologist be an internist? Preferably yes.

The multidisciplinary nature of the diabetes clinic, only included in Internal Medicine, places the Internist in an especially good stand to practice it. All sorts of problems will confront him, without exception, Internal Medicine problems and its subspecialties. From the differential diagnosis of its acute complications, passing through the therapy of such complications in the Emergency service of any hospital in the country – where almost always it is the Internist, the most differentiated professional – until the early diagnosis and the therapy of its endless chronic complications, it is to the internist to play the main role.

A long term diabetic, with progressive microalbuminuria, moderate hypertension, incipient proliferative retinopathy and/or intermittent claudication, silent angor and/or "restless feet" , plantar paresthesia with hypoesthesia in half, cystoparesis, retrograde ejaculation and/or gastroparesis and nocturnal diarrhea and/or flat feet, painful shoulder, Dupuytren hand, hyperostotic spondylosis, so on and so forth, this diabetic must be studied or even assisted by a nephrologist and/or ophthalmologist, and/or cardiologist, and/or neurologist, and/or urologist and/or gastroenterologist and/or rheumatologist, so on and so forth.

Only an Internist may well integrate the information, talk with every one and all specialists, to conciliate the different therapy programs, and this way, to be the very own patient's assistant physician.

Of course that all consultants called to study or even to treat the diabetic patient must also know well the condition to come up with the appropriate therapy program to the patient's needs and, mainly, to be able to talk productively with his/her assistant physician. This is the way for the cardiologist scheduling the anti-hypertensive therapy while searching for the eventual presence of a diabetic cardiomyopathy or silent angor. This is also the way for the rheumatologist that, before a painful shoulder, will make a differential diagnosis with retractile capsulitis and will look for the eventual presence of hyperostotic spondylosis or a flat foot needing correction for a prophylactic plantar of the causing callosity of a perforating condition.

Obviously that apart of the Internist, also the endocrinologist can and should treat diabetic patients. However that, due to pressure by the Clinic, or by their natural vocation to go from General Endocrinology to "full time" Diabetology , he/she will feel at once and will look to correct his/her Internal Medicine weaknesses, becoming through a self-learning process, into an internist and soon will forget Endocrinology special skills, as never or almost never will have the opportunity of practicing them.

In the Diabetes clinic, endocrinopathies are rare. Although I will accept well that in Endocrinology appointments there are a significant percentage of diabetic patients with endocrinopathy symptoms, in diabetic appointments they are an extreme rarity.

In hundreds of diabetic patients that, in these three decades of our existence look for us in the Diabetes and Nutrition Clinic at Santa Maria Hospital and one can count in our fingertips the number of acromegalies and Cushing diseases. Surely in a much smaller percentage than that in which diabetes presents itself as "second disease" in a cardiology or ophthalmology clinic or Vascular Surgery. There is a diabetes prevalence much higher in cardiovascular diseases than among endocrinology diseases, excepting Acromegaly and Cushing.

It is wrong the simplistic vision that being insulin a hormone, it makes diabetes an endocrinologist matter and the endocrinologist alone. It derides from a Clinic etiopathogenesis definition when this should be defined by its clinic correlations and not etiopathogenic. Taken to extreme, this vision should also deliver to the immunologist Type I Diabetes and along with it,

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thyroiditis, pernicious anemia, rheumatoid arthritis, multiple sclerosis and all diseases in which the etiopathogenesis was immune self-aggression.

And if this is the way it is, and has been since the beginning. Long before Endocrinology existed, there were diabetologists as Bouchardat – from all, in time, the first authentic – Von Noorden, and already in this century, were and are the internists in North American, Frederick Allen, Joslin and all from their School, (in Joslin Clinic, the deservedly most famous diabetes clinic of the world, there have never been endocrinologists. The kind of consultants there are there are internists/diabetologists, ophthalmologists, etc…) and Banting was an orthopedist….

In Europe, it is internist Lawrence – the greatest of all British diabetologists – are internists the "Hotel Dieu" (the deservedly most famous French Diabetology school) diabetologists, from the internist/nephrologist/diabetologist Dérot to his successor Tchobroutsky and to the latter successor, Slama. The diabetologists are the gastroenterologist/diabetologist Creutzfeldt (who was a president of our "European Association for the Study of Diabetes"…), Pfeiffer and, at present, in Spain, Serrano Rios, an Internal Medicine Lecturer in the most prestigious Academic Seat of the country, previously taken by Gimenez Diaz, so on and so forth.

Also among us, the relationship of the diabetologist with Internal Medicine is narrow and preceded Endocrinology by a number of years. Roma became a diabetologist in 1992 when he saw in Boston the beginning of insulin therapy. His pupils, that I am proud to be included in, are we the internists. Even in the next generation, we the "founders" of Clinic Endocrinology (not the science endocrinology, as this was practiced with distinction by a man of Roma generation: Celestino da Costa, embryologist and histologist of the endocrine system, internationally reknown…), I was saying, the clinician who first dedicated themselves to Endocrinology and can be considered the "founders" among us, Iriarte Peixoto, Eurico Pais e Ludgero Pinto Basto, all of them were and continued proudly being internists. Iriarte Peixoto and Ludgero Pinto Basto were actually Civil Hospitals internists in a place achieved in the hardest contests of public tests ever made in our country. When the HCL (Lisbon Civil Hospitals) set up the Endocrinology department, both refused to make part of it, remaining as internists/endocrinologists and offering two extra vacancies to the next generation.

In Coimbra, the first Diabetes services in the HUC (Coimbra University Hospitals) by the internist Armando Porto and if nowadays, in these hospitals, a distinguished school of Endocrinology/Diabetology is blossoming, created and driven by Almeida Ruas, already in the CHC and he is a Armando Porto disciple, our Chairman Santana Maia, who created a diabetic school for internists.

Also in Oporto, if Salcedo soon distinguished himself as endocrinologist/diabetologist, creating his clinic within Santo António Hospital, I think Hargreaves never gave up his internist status of Internal Medicine Lecturer, whilst creating Endocrinology in the University Hospital.

And then we have the District hospitals with internists practicing Clinic Diabetology, first in Beja and then in Portalegre, Caldas da Rainha, Almada, Faro, Santarém so on and so forth. Even in Macau for many years it has been created a "metastasis" of our HSM Clinic.

Therefore, we, the internists "we defend our Princess", Diabetes, and we do not mind to share it with endocrinologists. However, it must be said, if she is our Princess, and if for late complications, it is us, the hospital clinic internists, the assistants, it must be acknowledged, I say the mandatory role, absolutely crucial of the family doctor. And if he/she feels such vocation and he/she has the opportunity to acquire the special skill, it must be acknowledged that also he/she, a primary care diabetologist, has a crucial importance to treat Diabetes.

For Type I Diabetes I think it is imperative the assistance from the very diagnosis, of the diabetologist whether the internist or endocrinologist. But even in such cases, it will be helpful a harmonious cooperation and productive assistance with the Family Doctor, who if actually is it, by personal merit and family choice, he will always be the adviser/friend in whom the patient and his/her family will trust.

After all this, who is and how one becomes a diabetologist?

It is not the reading, the study of treaties and the participation in Congresses which "makes" the diabetologist. That is an important previous condition *but* it is not a Diabetology background.

This is acquired belonging to a School and experiencing a clinic. I have met some practitioners with a wide diabetic assisted population who I never ack-

nowledged as Consultants for lack of School. And I have met an even greater number of colleagues "with School" but without clinical experience who I do not acknowledge as clinical diabetologists. They might be diabetologists/researchers, scientists even with deserved reputation but they are not clinicians. They are unskilled to assist diabetic patients.

I recall one day, taking to the hotel in my car, Albert Renold, a reknown diabetologist/scientist, founder of EASD someone I was a friend with and after listening to another brilliant conference I said "You are fantastic, but I treat diabetic patients better…" and he replied "Sure you do! I have not practiced clinic for years and I was stressed doing it in the later stages…".

A clinic practice with a tutorial by a good School will produce diabetologists whether endocrinologists, family doctors or internists. But surely it will be the internists, who will feel better and will practice Diabetology Clinic more easily. ■