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**Analysis** Too Much Medicine

# The epidemic of pre-diabetes: the medicine and the politics

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## Prediabetes as a clinical entity

Prediabetes as a clinical entity

Prediabetes, like prehypertension, and pre-obesity/overweight are construed as intermediate health states, between ideal health and clinically-diagnosed conditions indicating elevated risks to health. They are increasingly recognized as major risk factors for some of the leading causes of mortality among high-income and middle-income economies and are advocated as clinical entities deserving targeted identification and clinical intervention.<sup>1-2</sup> Their recognition as clinical entities is valuable to the extent that the “diagnosis” alerts individuals to act in order to prevent the worsening of risks and onset of disease. While health information alone is no guarantee for the promotion of health, health-related behavioral changes, it should be noted, are contingent on health information and the understanding of such.

Far from turning healthy individuals into or labeling them “patients” and pathologizing their health status, prediseases ought to be seen in the context of disease prevention. Being aware that one’s glycaemic level increases his/her risk of developing diabetes and perhaps arterial disease makes more salient the need to make healthier choices. Making the healthy choice, as we know, is difficult due to our bounded rationality and bounded will-power.<sup>3</sup> However, prompts make it easier to make a healthier choice – be it strictly adhering to treatment regimen or reducing sedentary behaviors. Granted that there is value in the recognition of prehypertension, prediabetes and pre-obesity as clinical entities is clinical intervention warranted in the control and management of prediseases?

On the surface the proposition that clinical intervention is neither sufficient nor necessary in the control and management of prediseases, given that they are recognized as clinical entities, appears incongruous. However, the control and management of prehypertension, prediabetes and pre-obesity are, as with the primary prevention of hypertension, diabetes and obesity, behavioral and non-pharmacologic. The non-pharmacological and non-clinic management of individuals with prediseases is critical to avoid the repeat of the (increasing) capture of (primary and secondary) prevention efforts at present by the interests of pharmaceutical and medical devices industries with the (indirect and unintended while in some cases direct and unambiguous) support of practitioners.<sup>4</sup>

Studies of interventions in primary prevention have shown the superiority of lifestyle interventions over drug-based treatment with a review of pharmacotherapy for mild hypertension among healthy adults finding no reduction in mortality or morbidity in randomized clinical trials.<sup>5</sup> Meanwhile, clinic-based, preventative

interventions have shown mixed results with regards to their effectiveness. Indeed, disease prevention and health promotion are activities that need not, cannot and should not be locked in within the confines of the health care system.<sup>6</sup> The workplace, school and home are, most likely, the best candidates for carrying out these activities and by implication controlling and managing prediseases. Disease prevention and health promotion are activities that need not, cannot and should not be locked in within the confines of the healthcare system.<sup>3,7</sup> This is not just a matter of health costs but a matter of health outcomes.

## References

- 1 Tsai SP, Wen CP, Chan HT, Chiang PH, Tsai MK, Cheng TY. The effects of pre-disease risk factors within metabolic syndrome on all-cause and cardiovascular disease mortality. *Diabetes Res Clin Pract* 2008;82(1):148-56.
2. Tabák AG, Herder C, Rathmann W, Brunner EJ, Kivimäki M. Prediabetes: a high-risk state for diabetes development. *Lancet*. 2012;379(9833):2279-90.
3. Carrera PM. The difficulty of making healthy choices and “health in all policies”. *Bull World Health Organ*. 2014 Mar 1;92(3):154.
4. Glauser W. Seniors overmedicalized, experts say. *CMAJ*. 2011; 183(11): E701–E702.
5. Diao D, Wright JM, Cundiff DK, Gueyffier F. Pharmacotherapy for mild hypertension. *Cochrane Database Syst Rev* 2012;8:CD006742.
6. Krogsbøll LT, Jørgensen KJ, Grønhøj Larsen C, Gøtzsche PC. General health checks in adults for reducing morbidity and mortality from disease: Cochrane systematic review and meta-analysis. *BMJ* 2012;345:e7191.
7. Weintraub WS, Daniels SR, Burke LE, Franklin BA, Goff DC Jr, Hayman LL, et al. Value of primordial and primary prevention for cardiovascular disease a policy statement from the American Heart Association. *Circulation* 2011;124(8):967-90.

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