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LETTER TO THE EDITOR

Clinical inertia in insulin initiation in type 2 diabetes across Central and Southeastern Europe

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We read with interest the article by Campbell et al. [1]: "High level of clinical inertia in insulin initiation in type 2 diabetes across Central and South-Eastern Europe: insights from SITIP study" that has recently been published online in Acta Diabetologica. The authors investigated the level of clinical inertia in insulin initiation in type 2 diabetes mellitus in the region. The most important findings were that only 9.4% (20 of out of 211 respondents) of healthcare professionals would initiate insulin therapy in T2D patients at the recommended HbA1c threshold of 7–7.9% (53–63 mmol/mol), with psychological distress being recorded as the major barrier to insulin initiation. The authors concluded that despite the large regional variation, there is a widespread delay of insulin initiation from specialist diabetes healthcare professionals in Central and Southeastern Europe.

This conclusion is indirectly supported by the results of our recently published observational cross-sectional study conducted in the Czech Republic (a country within the region of interest), focused on insulin initiation in type 2 diabetes patients in routine clinical practice. This study showed that the mean HbA1c value at the time of insulin initiation was 9.2% (77.2) mmol/mol [2]. Thus, although the Czech Republic was not represented in the SITIP study, we may speculate that we could obtain very similar results regarding clinical inertia on the topic of the SITIP study's focus.

The authors of the SITIP study should be congratulated on their efforts to collect and analyze such a large amount of data, while attempting to correct for important covariables, leading to an interesting debate and highlighting this very important topic.

Although we agree with most of their conclusions, we would like to make three comments. We hope that this may contribute a further insight to the research area of clinical inertia in type 2 diabetes.

The authors correctly noted that countries in Central and Southeastern Europe compare rather poorly to countries in northern Europe due to a number of factors including different healthcare systems, treatment availability, and clinical training. Some of these factors (for example, lack of physicians) may influence the amount of time a physician is able to spend with patients. Insulin initiation, as well as the subsequent care, needs considerably more time than is allowed by a routine checkup. Thus, the number of patients seen per day, or the number of patients registered with one particular physician, could be an important factor which might influence his or her ability to introduce insulin into the type 2 diabetes therapy, and indirectly modify the compliance with actual recommendations. It would also be interesting to see if there is any difference between physicians from specialized centers, hospitals, and private clinics, as we might expect those from the specialized centers to be better qualified and more experienced.

The authors also provided readers with a useful overview of the literature concerned with clinical inertia in type 2 diabetes therapy. They found only one study focused on this area in Central and Southeastern Europe, which was conducted in Croatia. Thus, we would like to draw their attention to our international cross-sectional study published in 2018 [3], which described a high level of clinical inertia in type 2 diabetes patients treated with insulin in the Czech Republic and the Slovak Republic.

We suggest taking these points into account especially when planning a follow-up study.

Managed by Massimo Porta.

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Compliance with ethical standards

Conflict of interest The authors do not have any conflicts of interest to declare.

Statement of human and animal rights This article does not contain any studies with human or animal subjects performed by any of the authors.

Informed consent For this type of study formal consent is not required.

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