

## **Airing Pain Programme 124: Diabetic Neuropathy**

### ***Managing neuropathic pain related to diabetes, and how to adapt diet to treat the disease***

*This edition of **Airing Pain** has been supported by a grant from The Champ Trust and Foundation Scotland.*

*According to the most recent Scottish Diabetes Survey in 2018, there are an estimated 304,000 people living with a diagnosis of diabetes in Scotland, around 5% of the population. A long-term effect of diabetes can be the development of diabetic neuropathy. This edition of **Airing Pain** focuses on neuropathic pain in people with diabetes, and how the X-PERT diabetes course helps people to deal with the complications that arise when living with diabetes.*

*First up, Paul Evans speaks to David Bennett, Professor of Neurology at the University of Oxford, who outlines the differences between type 1 and type 2 diabetes and how the initial treatment plan differs between the types. Professor Bennett then goes on to describe how neuropathy develops in people living with diabetes and how neuropathic pain manifests.*

*Paul then talks with Steve Sims, who lives with diabetic neuropathy as a result of type 2 diabetes. Paul and Steve discuss how they have adjusted their diets to deal with type 2 diabetes and how the X-PERT diabetes course has helped them to adjust to living with diabetes.*

***Issues covered in this programme include: Diabetes, the differences between type one and type two diabetes, diabetic neuropathy, diabetic retinopathy, nutrition, diet, insulin levels, glycemic control, risk factors of diabetes, peripheral vascular disease, foot pain, burning pain, gabapentinoids, and support groups.***

**Paul Evans:** This is **Airing Pain**, a programme brought to you by Pain Concern. The UK charity providing information and support for those of us living with pain, and for those who care for us. I'm Paul Evans. And this edition of **Airing Pain** has been funded by a grant from the Champ Trust and Foundation Scotland.

2020 has been designated the Global Year for the Prevention of Pain by the International Association for the Study of Pain. Their campaign is focusing on protecting against the onset of pain, preventing pain from becoming chronic or recurring, and reducing the long-term consequences of pain. Well, in this edition of **Airing Pain**, we'll be looking at all three of

those tiers, through one condition that we're all, young and old, susceptible to getting: diabetes.

**Dave Bennett:** There is a kind of paradox, and patients of mine ask me, 'Doctor, I don't understand. My feet are numb. So I touched them and I can't feel anything, but they are continuously painful'.

**Evans:** And regardless of what causes your chronic pain, we look at the benefits of sharing experience with like-minded people

**Steve Sims:** Particularly if you're newly diagnosed or you've got a problem which you've not had before. The chances are when you come into the group, somebody will have experience of it.

**Evans:** The Scottish Diabetes Survey in 2018 estimated that there were over 304,000 people with a diagnosis of diabetes in Scotland. That's over 5% of the population. Between 10 and 15% of those have type one diabetes, with type two accounting for the remainder. Chronic complications arising from diabetes are numerous, but include eyesight problems, kidney function, nerve damage or neuropathy, and more. But before we get to that – the two types of diabetes, type one and type two, why the distinction? Professor Dave Bennett is Professor of Neurology at the University of Oxford. He's also Consultant in Neurology at Oxford University Hospitals Foundation Trust.

**Bennett:** Type one diabetes usually is a type of diabetes that comes on in children or young adults. It's probably triggered by the immune system, and it's direct damage to the pancreas, which is the part of the body that produces insulin, so that you get virtually no insulin being produced. And the issue there is that people with type one diabetes, they really need to be treated with insulin, certainly that's key to their survival, and they would get very high blood glucoses without insulin.

Type two diabetes, not exclusively, but it tends to have a later age of onset, the underlying basis of the disease is different. It's probably a combination of producing maybe less insulin, not the kind of complete lack of insulin production that you see in type one, but less, and also the body being less responsive to the insulin, [which is] something called insulin resistance. So particularly, the muscles are very important in the way you respond to insulin. And it's that generic general resistance to insulin, that is the source of the problem. And type two diabetes – certainly when it's initially diagnosed – you don't have to be treated with insulin, because you've got some basal insulin being produced. It's often initially treated with oral medication, and with diet. And then some people, if they have particular difficulties with

glucose control, may ultimately be treated with insulin, but it's not an absolutely essential part of the treatment from the beginning.

**Evans:** Well, Steve Sims who lives in Cardiff has type two diabetes, and he does take insulin.

**Sims:** The major effect from diabetes is having to take more note of what I eat. The fact that in restaurants, for instance, they won't tell you quite often what's in it. So it makes it difficult to judge them, what you can eat and can't eat.

**Evans:** It's carbohydrates that you have to be careful of, isn't it?

**Sims:** I wouldn't say you've got to be careful of [it]. Again, obviously, you've got to be aware of what the carbohydrate content of a meal is.

**Evans:** Well, I'm type two diabetes, as well, a fairly new type two diabetes. And my GP sent me on an expert programme. It's called the X-PERT Programme. And the biggest shock to me when I started this programme was we walked into the room – [there was] about fifteen of us – it was taken by a diabetes specialist nurse and a nutritionist. The biggest shock was the packet of biscuits on the table in front of me. You go in and you think that this, this is going to be a 'thou shalt not' course.

**Sims:** Well, we all need carbohydrates, because we convert that into glucose, and that's what gives us the energy for our muscles, etc. So we've got to have so much. The problem is that with, I would say the British diet or Western diets, perhaps, it does have a tendency to be carbohydrate-loaded. You've only got to think of a pub meal. What you would eat at home, perhaps might contain thirty or forty grams of carbs. Most pub meals are eighty or ninety grams of carbs. For some reason or other within our culture, we've had a tendency to [eat a lot of] carbohydrates, possibly, because in the past, I suppose we were all involved in a lot more manual labour than we are now, so we actually burned it off, which is point of eating it. But we've still got that habit, you know, the nice roast dinner and all the rest of it. You know, I've known people who have a treat every day, and then wonder why their diabetes is out of control, or why their weight's going up as well. No, you don't have a treat every day, you have a reasonable diet, and as any dietitian will tell you, you just stick to a reasonably low-fat, high-fibre diet.

When I did my X-PERT course, that's one thing that surprised me with the dietitians and the diabetes specialist nurses that we had there. [They] were a lot more open minded. So if you said to them, you know, 'I have problems walking any distance because of problems with my legs'. Their attitude was, 'Yeah, okay, fine. Let's look at what problems that's causing, [because] we've got to be able to do it'. So they say, 'Well, alright, don't walk very far. So

walk a little bit and stop, walk a little bit and stop.'. Which is, if I'm open about it, what I have a tendency to do, or I use a walking stick or something to help take the weight off. But they were willing to look at that, and incorporate that into what they said. You have to look at the whole human being not just our condition.

**Evans:** We talked about the X-PERT programme. The education programme [that] we've both done, presumably – you like me – at the start of your diabetes journey?

**Sims:** I did one recently as well. They brought out a new one, which is specifically for people on insulin. And that was a real eye-opener, it's totally changed how I treat my diabetes now. I was injecting twice a day, I now inject five times a day, but I inject [in response] to what I eat. And that was the difference on that course.

**Evans:** Explain that to me.

**Sims:** I use an app on the phone – that dreaded technology comes in again – and I can work out the carbohydrate within a meal. I've got it set up so that I can then use that information, I check my blood glucose levels, I will then put that information in on the app, it will then tell me with the carbohydrate, how much insulin I need for that meal. So I can then adjust with fast-acting insulin for that meal.

**Evans:** I don't take insulin. I'm just wondering, does that give the sort of permission to do whatever you like, to eat whatever you like? Or is there an education side with that, like, 'Hang on, you still have to be careful'.

**Sims:** You can fall into the trap of just working out what's in there, and as I say, take as much insulin as you want. You can do that on the odd occasion, obviously, but no, part and parcel of the course [is that] you still need to look at what you're eating. But it appreciates the fact that, for instance, if you go out for a meal, you haven't got a lot of control over what actually ends up on your plate. There's a psychological element in it as well, as it's giving me more control over my own life. So rather than the diabetes, controlling what's going on, I have some control over the diabetes. So I can recommend the X-PERT course, to be honest, anybody with diabetes should get on it.

**Evans:** Well, this is something I'm learning too. There are actually three versions of the X-PERT course and 'expert' is spelled X-PERT, not to be confused with the expert patient programme. So, one course is for the prevention of diabetes. It's an intensive lifestyle programme aimed at reducing risk of developing type two diabetes for people at higher risk. The next course is for people who have type one or type two diabetes. That's the one both I and Steve went on, and I can thoroughly recommend it. And then there's the course that

Steve mentioned and recommends for people with type one or type two diabetes, and who are treated with insulin.

Ask your GP or practice nurse for more details, or go to the website [diabetes.co.uk/education](https://diabetes.co.uk/education) for more details of the X-PERT course and other diabetes management programmes. Well, of the complications that can occur with diabetes, that I mentioned earlier, it's neuropathy and the pain that comes with it that I want to focus on. Professor Dave Bennett.

**Bennett:** Neuropathy generally relates to the peripheral nervous system, and the way you can think about that is your peripheral nervous system connects motor neurons which are going to drive your muscles from the spinal cord to the muscle. So that they provide the signal that makes your muscle contract and so that you can move, and the peripheral nerves also carry information back from your sensory nerve fibres that respond to sensory stimuli such as brushing the skin or putting the skin on something hot, and they carry the information back again via the nerves, back to the spinal cord. It's a way of connecting, ultimately, your brain and spinal cord to the body.

**Evans:** So peripheral being, I presume, the peripheries?

**Bennett:** The periphery is actually anything outside the brain and the spinal cord, because your central nervous system refers to the brain and the spinal cord.

**Evans:** Now, how does diabetes cause neuropathy?

**Bennett:** So that's a good question, actually. And I wish I could sit here and give you one very clear answer. Understanding of their mechanisms is still somewhat debated. We know certain things about it. So diabetes is a problem relating to control of your blood glucose. And if you have diabetes, then you either produce less of a hormone called insulin, which is needed to lower blood glucose, or your body's resistant to the effects of insulin. And the end result of that is – you have an average [of glucose] over the course of a day – someone with diabetes, their blood glucose is higher than the general population.

And we know that there is a relationship between how high that blood glucose is and your risk of getting neuropathy. So partly, the risk of neuropathy is related to what we call glycemic control, which is the medical word for what your blood glucose is, on average. But there are other factors as well. So we also know that if you have particularly high levels of lipids, by which I mean things like cholesterol, that is also a risk factor for diabetic neuropathy. So we know something about the risk factors, what we don't really know is the exact mechanisms of the disease. Now, there's theories. So one of the theories is actually one of the kind of generic issues with diabetes – is that the small blood vessels don't

function as well as they should. So a good example of that is some people with diabetes get diabetic retinopathy. And that is a problem, essentially, of the blood vessels within the retina in the eye. And that's why people with diabetes need regular eye checks.

Well, the nerve, like any other tissue in the body, has blood vessels in it. And the health of the nerve is dependent on how good that blood supply by those blood vessels is. So one likely problem in diabetes is an issue with the blood supply to the nerves. But there are other factors. So the fact that you have this high glucose, that can then give rise to modifications of proteins in your body and change in the metabolism, that particularly impact on the way that nerves work. And so for instance, an analogy would be, [if] we were sitting in an auditorium today that was about forty metres long. And if your peripheral neuron – like your sensory neuron – if you were to say that that is the size of that auditorium, [then] what we call the axon, which is the bit that carries the electrical signals, which connects to, for instance, the skin or the muscle, [and] the analogous situation would be the axon goes all the way to Paris.

Now, that is a big challenge for something to get cargos – such as everything you need to keep your nerve healthy – [across] all that distance. And one of the things that that can happen in diabetes is that the support of those axons begins to fail, because of the changes in metabolism and the altered blood supply. And that is one of the key events that causes diabetic neuropathy.

**Evans:** So explain how it develops, and what it feels like.

**Bennett:** The symptoms of diabetic neuropathy – usually, the symptoms that patients notice – are to do with sensation, and the typical features that they might have [are] ... because of this challenge, which we did speak about nerves – one of the things they need to do is get the kind of the nutritive functions, the transport of all the things those nerves need to survive, needs to go over a really long distance. That then makes sense, actually, as it is the longest nerves in diabetes that are affected first. So in fact, the place that most people with diabetes first noted problems is their feet. And what they would notice, for instance, is that their feet may feel numb. And that numbness may very gradually, over months or years, kind of spread up towards the ankles, or if it was severe, up towards the knees, they may notice pins and needles. So that sensation if you've crossed your leg for a period of time, which is quite unpleasant, actually, and they may not, of course, crossed the leg and they may just notice that spontaneously. And also pain, which is again, usually most commonly in the feet, it can have a nasty kind of burning quality to it. Usually it's more severe at night than it is during the day. If the neuropathy progresses, they might notice problems in other parts of the

body, such as the hands, which again, are relatively long nerves, but usually it's the feet where we see the first problem.

**Evans:** Professor Dave Bennett. Steve Sims has diabetic neuropathy.

**Sims:** It's not just pain, you also have the other effect, which is [that] I have very little feeling in my feet. I'm not getting the sensations from my feet that tell me that I'm balanced. So that was the first effect I had with it. So this is why I've got handrails, put here on these steps, and on the steps in the front, so that at least I can maintain my balance.

Again, if I'm walking, I have a tendency, you know, for walking any distance I use a walking stick, mainly because it gives me another point of reference. That was the first effect I found with neuropathy, the pain came later. It's a difficult pain to explain. Because it's random. It always hits the same areas, but it doesn't always feel the same. Sometimes it can be just as sort of a minor niggle. Other times, it can be that strong, it will bring tears to your eyes. And it might last anything from a couple of seconds to three, four or five hours. But then it'll suddenly stop and it will just turn itself off. That is probably one of the most difficult things to deal with.

It's not too bad during the day when you're up and about. Because changing your weight around, moving around, can ease it. Most of mine is in the feet, [but] you can get in the hands as well – most of the periphery nerves. But it's at night it's the worst. Whether or not having weight on your feet actually makes any difference [to] the pain, or whether it's if it's a distraction from the pain. You can take painkillers, as I do, at night, sometimes if it's really playing me up. The trouble is that they will only dull it, they won't get rid of it. They'll just dull it off. Mind you, sometimes you can, as I normally do, take paracetamol – I can take two paracetamol and the more that I take them, it switches itself off – it is that random. It's really difficult, you know. I've had other cases where I probably had about half an hour sleep through the night, because what will happen is it will suddenly calm down, so you drift off to sleep, [then] ten minutes later, it starts back up again.

I end up with a few different types of pain, as well. On my left foot, it's as if somebody is driving a spike up between my little toe and the toe next to it. Literally, driving it into my foot between the toes. And then that pain will grow until it grows down the side of my foot. When I spoke to one of the nurses about it, she said well, what it's doing is it's following the track of the nerve.

On my right foot, I end up with two or three different effects. Sometimes it's like a prickling across the top of my foot. And again, that pain will grow. I also get, on the side of that foot, like a friction burn. Sometimes if I turn over, so I take pressure off that foot, that [pain] will go.

That's one of the problems with it: it's random. And I found out something else about it some time ago – I actually passed out while I was giving blood, and they thought I might have had a heart attack, because many years ago I did have a heart attack, so my ECG is a bit weird. Talking to one of the doctors afterwards – as it was I just passed out, it was warm and I just keeled over – but he said the thing they were worried about is because of the neuropathy, you may not suffer with pain from a heart attack. It can affect the nerves around the heart as well, that I wasn't aware of until he said. To some extent I wish he hadn't told me. You know, 'yes, it's nice to have the information, but can you tone it down a bit on occasion?'

**Bennett:** Because one of the difficult issues of diabetes – at the same time as you may have a diabetic neuropathy – is that some patients with diabetes have problems with the blood supply to the legs. And you can have this combination of where there's not enough blood going to the feet, and at the same time, you've got loss of sensation in the feet. And that's why you might hear this term the 'diabetic foot'. That's why you will hear the doctors say it's very important that you look after your feet, because, number one, you could injure the feet and not feel it. Someone that doesn't have diabetic neuropathy might walk along the floor and might just stub their toe or might stand on something sharp, you know, [and] they would know that there was a problem there, [but] someone with diabetes might have something in their shoe rubbing them, and get a nasty blister, and they they're completely unaware of it. And then the second thing is, at the same time as getting these injuries, their body's less good at healing itself, particularly because the blood supply to the feet is not as good. So you're more likely to get infections or ulcers on the feet. And that's why it can be this difficult combination of both neuropathy and what we call peripheral vascular disease and diabetes, that [means that] people really need to look after their feet.

**Evans:** I guess this is why, in my annual diabetes check-up, the diabetes nurse tickles my feet, and puts a tuning fork on it, and says, 'Can you feel it?'

**Bennett:** Yes, the tickle of the feet is probably not a tickle with her fingers, it's probably a little monofilament. So it's a little filament. And she touches that filament to the skin and says, 'Can you feel that?' So then she's checking for sensation. So that's seeing that the sensory nerve fibres can carry that information. If you think about it, they're carrying transmitting information from the skin, to the spinal cord and then ultimately up to the brain. She's testing two different types of nerve fibres. So you have a kind of nerve fibres that will carry information about touch and then there's also nerve fibres that can detect rapidly changing vibrations, [and] that's what the tuning fork is doing, it's causing that vibration, and she's checking that you can feel the vibration on the toe as well.

So it's great that she's doing that and the idea is she's screening for diabetic neuropathy. And obviously, the measures you would take if someone had diabetic neuropathy, is [that] you may look again at how can we optimise what we call your glycemic control – the blood sugar control. And also measures to really looking after the feet, making sure that your shoes are... [that] you're checking the feet at the end of the day, that you might need to go and see a podiatrist – to keep an eye on the feet, those kinds of measures.

**Evans:** So having established what diabetic neuropathy is, how do you treat it?

**Bennett:** I would love to sit here and say to you, 'If someone has diabetic neuropathy, we've invented a tablet, you take that tablet, and it's going to make your nerves regrow'. But I can't, [because] that has not been invented yet. So there is research into that, and some of that we've discussed at this conference, but we don't have anything yet that makes nerves regrow. There have been clinical trials of tablets to try and help diabetic neuropathy and unfortunately, so far, all of those clinical trials of tablets for diabetic neuropathy have essentially failed. So trials that optimise glycemic control have worked, particularly for type one diabetes, but trials [that] have tried to take a new tablet to prevent diabetic neuropathy have not worked.

But trials of weight loss and exercise are showing signals of success. There's really quite a good evidence base that keeping fit and doing exercise is incredibly good for your nerves. I mean, it kind of makes sense, but there is actually some scientific evidence for that. And actually, they literally counted the number of nerve fibres in the skin, then got some sort of exercise programme, lose weight and, three months later, the number of nerve fibres in skin has increased. And so people need to take that on board – that probably the worst thing you can do is stop exercising, have a sedentary lifestyle, [because] that is not good for your nerve function.

**Evans:** We're not talking about reversing?

**Bennett:** No, I am. In terms of exercise, I am. I'm saying [that] you're taking people that have a low nerve count, and then you're getting them to exercise, and the nerve count increases.

**Evans:** For both forms of diabetes?

**Bennett:** Most of that data is on type two diabetes, as far as I'm aware.

**Evans:** If somebody does have pain as a result of their diabetes – or perhaps they don't know it's as a result of their diabetes – if somebody has pain, and they are diabetic, what should they do?

**Bennett:** It's worth going to see your GP about that. I mean, there are a number of causes of pain in diabetes that [are] not always related to peripheral neuropathy. So sometimes people get pain because they're not getting enough blood supply to the feet. Sometimes you're at higher risk of getting an ulcer infection. But let's assume that someone has diabetic neuropathy, and as a consequence of that they've developed pain. Typically, the pain would be in the feet, and usually both feet. And people often describe it as – not always – but they often describe it as a burning pain. And it may be accompanied by other sensory symptoms. There is a kind of paradox, and patients of mine ask me, 'Doctor, I don't understand. My feet are numb. So I touched them and I can't feel anything, but they are continuously painful'.

The reason for that paradox is that the feet are numb because the nerve fibres have, as it were, degenerated back from the skin. So they're no longer connecting where they should be to the skin. And this is something damaging the body; your pain fibres are completely silent. But when they're not connected to where they should be, they just start firing all the time. And that is almost like an illusion to the brain. So you can't feel things because they're not connected to the skin. But the brain is getting this input all the time, so you're getting this feeling of continuous pain. So that's a source of that paradox. If people are getting those kinds of symptoms – well number one, obviously, if they're not already been diagnosed with diabetic neuropathy, it's worth them being examined by the doctor and looking for clinical signs of diabetic neuropathy. And we've discussed about the general issues about diet and blood glucose control. Then also there are tablets that we can use – medications to try and damp down that pain.

So that pain is what we call neuropathic pain. And all that means is it's pain that's due to damage of the nervous system, sensory nervous system. That's all that neuropathic pain means. But with most of those tablets, what we're trying to do ... If you think about it, you've got too much electrical traffic in the sensory nervous system. And essentially, tablets are trying to damp down that electrical traffic. That's a way of thinking about it. And so, there's an array of medications that can be used and they can be prescribed by your GP. To give you some examples, there are tablets that are generically called gabapentinoids, [they] are one group. And there's another group of tablets that were actually initially developed as antidepressants, but not only are they antidepressants, they are actually analgesics, they clearly reduce pain as well. Sometimes a kind of misconception of patients is, 'I went to the doctor, I've got this pain in my feet and my doctor just thinks I'm depressed and he just fobbed me off with an antidepressant'. That is not the case. What I'm trying to explain is that these tablets – although, kind of, if you were to look them up in the medical text, they say would say that they're antidepressants – there is good evidence that they're also painkillers,

[that are] particularly effective for neuropathic pain, and that's why your doctor's prescribing them.

**Evans:** What I do know – what I have been told is, yes, control it by diet, which is what I do, or you go on to medication. But if you ignore diabetes, it is very, very serious, you cannot ignore it.

**Bennett:** I think that's a very good point. It's difficult because it's to do with human nature. And the issue is that you may not feel particularly unwell, your doctor may tell you that you've got diabetes, but actually [you] say, 'Well, in myself, you know, I'm getting around, I'm going to work, I'm not really seeing lots of problems, what is the problem?' And of course, the issue is, is you're storing up lots of problems for the future. So diabetic neuropathy, which, you know, in its initial phases may be very subtle, and you might have a very mild diabetic neuropathy and virtually not know it's there. But of course, that may then progress so that you'd have numbness or the feet [or] severe pain in the feet. And some patients have trouble with what's called the autonomic system, which is needed to control your blood pressure and the way you handle food.

Some people may get problems with their eyes. And again, initially, there will be a, kind of, very trained doctor looking at the back of the eye [who] might say, 'Well, I can see some subtle changes there,' and the patient says, 'I don't notice any problems at all.' But in five years' time, they could have threat, then, to their sight, to their vision, because of the problem with diabetes. Same thing with the kidneys. And again, initially, you might not notice any problem, but if this was left untreated, you might have complete kidney failure and need to go on dialysis or have what's called a renal transplant. So it's difficult because you're saying to people at the early stages, you need to take this seriously and try and address it, as [much as] you can, [because] you want to prevent all these problems in the future. Whilst, of course, human nature say, 'Well, I feel fine now, do I really need to worry about it?'

It's such a simple thing to test for. Definitely be aware if people have symptoms, if they're finding that they're passing urine a lot, if they're having to drink a lot, they're always thirsty. Maybe people are getting lots of infections, skin infections that they wouldn't normally get. Particularly if there's a family history of diabetes, particularly if there are some issues with some weight gain, say over the last few years. It's worth getting tested for diabetes, because we are in an epidemic; the rates of diabetes are going up and up and up. And you can make these early changes to your health, that in the long run are going to make a massive difference.

I'll be blunt, the biggest risk factor – the reason that we have a diabetes epidemic is obesity and weight gain. So people can take measures to try and eat a healthy diet, keep to a

healthy – what we call body mass index. You can use simple calculators online, actually, where you can calculate your own BMI, and it will tell you whether you're in the kind of optimal range, whether you're underweight, whether you're overweight, whether you're obese and what your risk is. And you know, it's really worth thinking about that because then you could entirely prevent the problem. I'm not saying that all diabetes is due to obesity. That's not the case. There are a number of causes. But it is one of the risk factors that people can do something about. We can't fight our genetics; our genetics are given to us by our parents. And there's nothing we can do about that. But I'm just talking about things that people can do, that can make a difference, and that is to have a healthy lifestyle.

**Evans:** Professor Dave Bennett of the University of Oxford. As always, I'll just remind you that whilst we, in Pain Concern, believe the information and opinions on ***Airing Pain*** are accurate and sound based on the best judgments available, you should always consult your health professional on any matter relating to your health and wellbeing. He or she's the only person who knows you and your circumstances and therefore the appropriate action to take on your behalf.

You can find all the resources to support the management of chronic pain, including details of Pain Concern's videos, leaflets, all editions of these ***Airing Pain*** programmes and ***Pain Matters*** magazine at [painconcern.org.uk](http://painconcern.org.uk). So another reminder, at the end of this edition of ***Airing Pain***, is to say that help and support to manage any chronic pain condition is available from many quarters, not just from healthcare professionals, but [also] in patient support groups. You can find the diabetes support group in your area at the Diabetes UK website, which is [diabetes.org.uk](http://diabetes.org.uk). And Steve Sims is Secretary of the Cardiff diabetes group.

**Sims:** By going to a support group, you will find people there with experience of the condition. Particularly if you're newly diagnosed or you've got a problem which you've not had before, the chances are, when you come to the group, [that] somebody will have experience of it. They won't give you medical advice, that's the last thing that we're there for. But we might tell you to get back in touch with your diabetes care team, [because] you need to talk this out with them. Or in some cases, it's a matter of, 'Yeah, well I'm afraid that comes with the territory'. We also have the carers come to the group as well. Without my wife I wouldn't be anywhere, yet they're forgotten. With any chronic condition, your carers are one of the most important parts of your treatment, your support. They're vital.

#### **Contributors:**

- Professor Dave Bennett, Professor of Neurology, Nuffield Department of Clinical Neurosciences, University of Oxford
- Steve Sims, Secretary, Cardiff Diabetes Group.

**More information:**

- The X-PERT diabetes courses – [diabetes.co.uk/education/x-pert.html](https://diabetes.co.uk/education/x-pert.html)
- IASP Global Year for the Prevention of Pain 2020 – [iasp-pain.org/GlobalYear](https://iasp-pain.org/GlobalYear)
- Pain Concern's [Neuropathic Pain](#) leaflet
- Pain Concern's [Diet and Pain](#) leaflet.

**With thanks to:**

- The British Pain Society (BPS), who facilitated the interviews at their Annual Scientific Meeting in 2019 – [britishpainsociety.org](https://britishpainsociety.org)
- The International Association for the Study of Pain (IASP) – [iasp-pain.org](https://iasp-pain.org)
- Diabetes UK, a leading UK charity that involves sharing knowledge on diabetes – [diabetes.org.uk/](https://diabetes.org.uk/).

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