Prossimità e organizzazione delle cure: la medicina generale di domani tra demografia e cronicità

IL MODELLO DELLA GESTIONE DEL DIABETE E IL RISCHIO RESIDUO

AGOSTINO CONSOLI

DMSI & CeSI-MeT Università d'Annunzio – CHIETI

ITALY

76° CONGRESSO NAZIONALE | 7-12 ottobre 2019 | Tanka Village - Villasimius (CA)

Ai sensi dell'art. 76 del Regolamento applicativo dell'Accordo Stato-Regioni 02.02.2017, dichiaro che negli ultimi due anni ho avuto i seguenti rapporti anche di finanziamento con i seguenti soggetti portatori di interessi commerciali in campo sanitario:

Abbot, Astra Zeneca, Boheringer Ingelhaim , Eli Lilly, Merck Sharp & Dhome , Menarini Diagnostici, Novo-Nordisk, Sanofi-Aventis, Sigma-Tau, Takeda.
(Speaker)

Astra Zeneca, Boheringer Ingelhaim, Eli Lilly, Janssen Farmaceutici, Merck Sharp & Dhome, Novo-Nordisk, Sanofi-Aventis.
(Advisory Board)

Astra Zeneca , Novo-Nordisk
(Consultant)

Astra Zeneca, Eli Lilly, Novo-Nordisk
(Research Grant)

In fede, *AGOSTINO CONSOLI*

The NEW ENGLAND JOURNAL of MEDICINE

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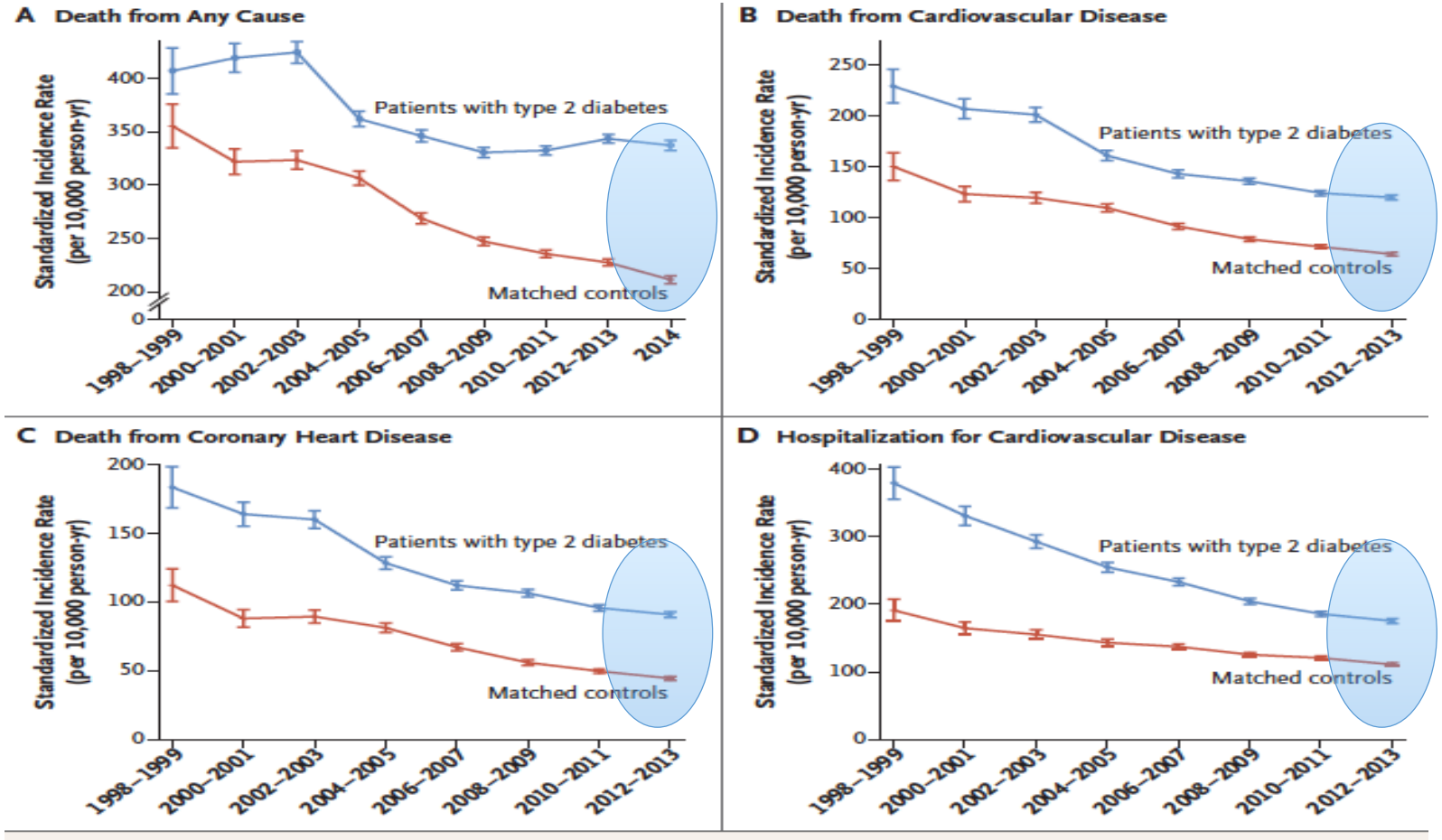
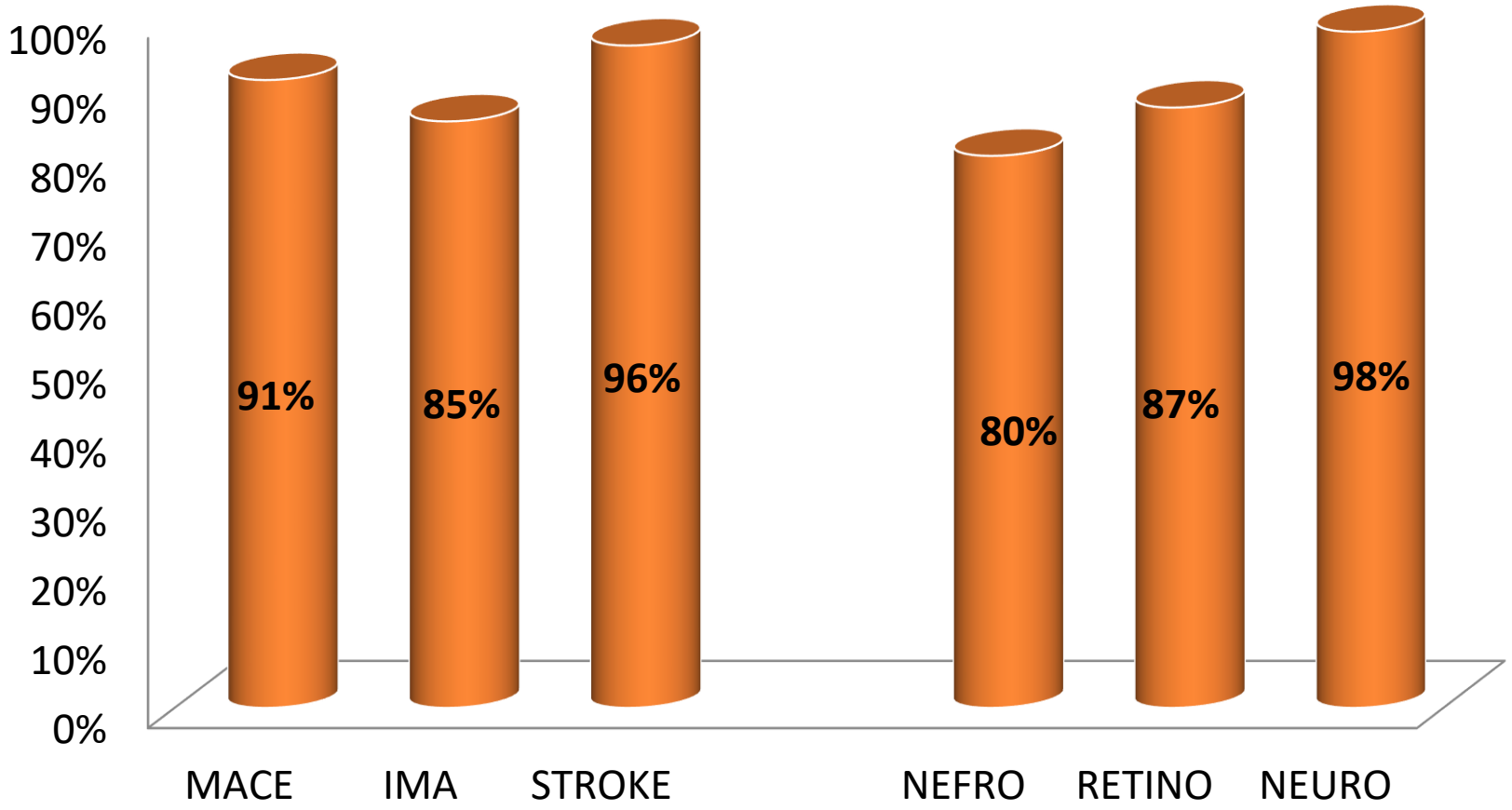
Mortality and Cardiovascular Disease in Type 1 and Type 2 Diabetes

Aidin Rawshani, M.D., Araz Rawshani, M.D., Ph.D., Stefan Franzén, Ph.D., Björn Eliasson, M.D., Ph.D., Ann-Marie Svensson, Ph.D., Mervete Miftaraj, M.Sc., Darren K. McGuire, M.D., M.H.Sc., Naveed Sattar, M.D., Ph.D., Annika Rosengren, M.D., Ph.D., and Soffia Gudbjörnsdottir, M.D., Ph.D.



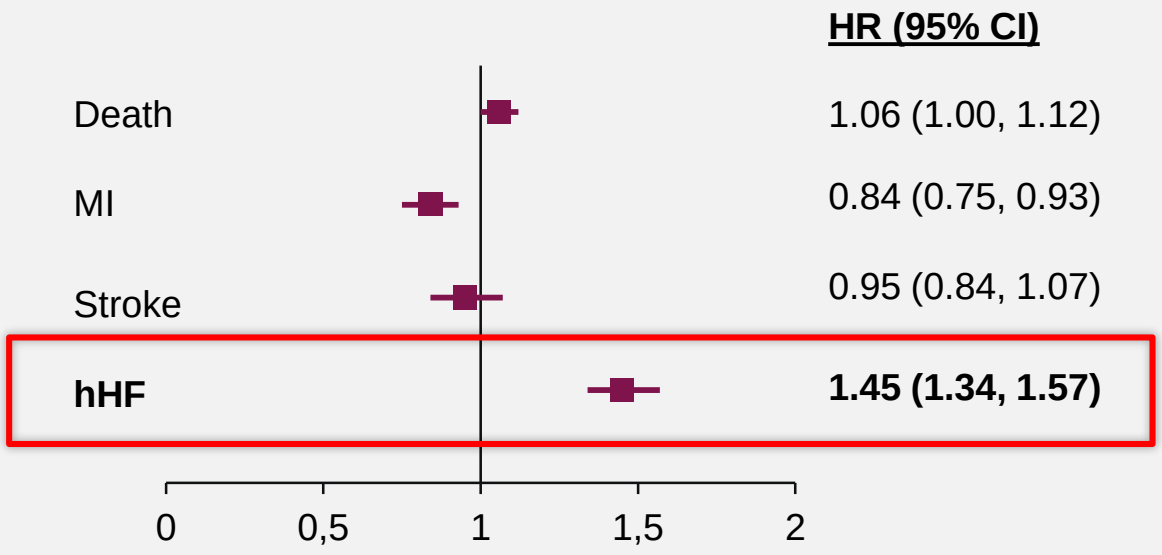
«Residual» macro- and micro- vascular Risk in DM2 subjects in «standard» treatment



Giugliano D et al. Endocrine 2018

Despite control of known CV risk factors, patients with T2D remain at elevated risk of developing HF

Risk of event in patients with T2D and no risk factors out of target range compared to patients without diabetes



- In this analysis the risk of hHF in patients with T2D (n=271,174) was compared to those without T2D (n=1,355,870)
- The following risk factors were either not present or within guideline range: elevated HbA1c, systolic/diastolic BP, or LDL-C, or albuminuria or tobacco use
- A substantial risk for hHF remained among patients who had all the variables within target range

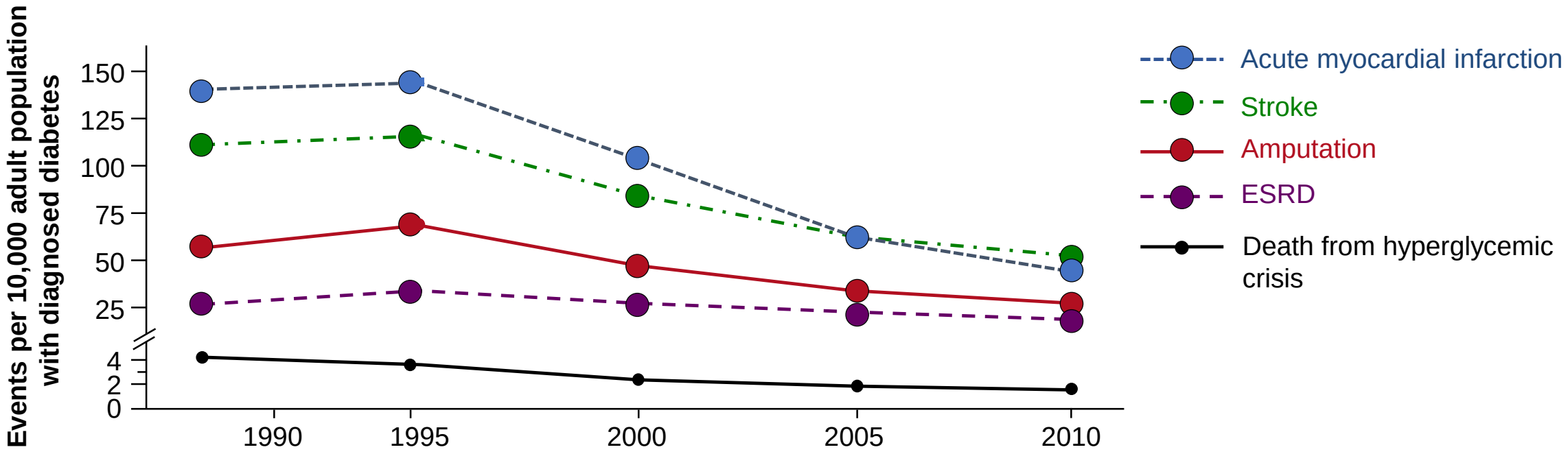
On average, the patients with T2D had a 45% increase in the risk of hHF, despite other major risk factors in guideline recommended range or absent

BP = blood pressure; CV = cardiovascular; HbA1c = glycated hemoglobin; HF = heart failure; hHF = hospitalization for heart failure; HR = hazard ratio; LDL-C = low density–lipoprotein cholesterol; MI = myocardial infarction; T2D = type 2 diabetes.

Rawshani A et al. *N Engl J Med.* 2018;379:633-644.

Diabetes-related complications in the US 1990–2010

- Ischemic complications such as MI and stroke are declining
- Reductions in rates were smallest for ESRD



CHF, chronic heart failure; ESRD, end-stage renal disease; MI, myocardial infarction

Gregg EW *et al. N Engl J Med* 2014;370:1514;

Prevalence and co-prevalence of comorbidities among patients with type 2 diabetes mellitus

The vast majority of patients with T2DM have multiple comorbidities

97.5% of patients had at least one comorbid condition in addition to T2DM

88.5% of them had at least two.

The comorbidity burden tended to increase in older age groups and was higher in men than women.

Iglay et al. Current Medical Research and Opinion, 32:7, 1243-1252, 2016.

Prevalence of comorbidities in type 2 DM patients according to age and gender

	Overall		Age Groups‡					
			<65 Years		65 to 74 Years		75+ Years	
	N	Median (IQR) or %	*N*	Median (IQR) or %	*N*	Median (IQR) or %	*N*	Median (IQR) or %
Comorbidities								
T2DM only	34,773	2.5	21,952	3.3	6026	1.6	6795	2.0
1 Comorbidity	125,048	9.0	79,735	11.9	22,348	5.9	22,965	6.8
2 Comorbidities	275,415	19.8	157,257	23.4	63,115	16.7	55,043	16.3
3 Comorbidities	459,189	33.1	242,810	36.2	126,932	33.5	89,447	26.4
4+ Comorbidities	494,591	35.6	169,609	25.3	160,594	42.4	164,388	48.5

	Gender§			
	Male		Female	
	N	Median (IQR) or %	*N*	Median (IQR) or %
Comorbidities				
T2DM only	13,773	2.1	20,978	2.8
1 Comorbidity	46,796	7.2	78,208	10.6
2 Comorbidities	118,829	18.3	156,514	21.1
3 Comorbidities	220,969	34.1	238,178	32.2
4+ Comorbidities	248,057	38.3	246,508	33.3

Iglay et al. Current Medical Research and Opinion, 32:7, 1243-1252, 2016.

Patients with Type 2 diabetes often have multiple comorbidities that contribute to increased CV risk

71% have high BP[1]

65% have dyslipidaemia[2]

85% are overweight[1]

Patients with Type 2 diabetes have up to **2x greater risk of CVD** than those without diabetes[3]

Sustained reductions in **HbA_{1c}** and other parameters including **weight**, **BP** and **lipids** can benefit the health of patients with Type 2 diabetes[4–8]

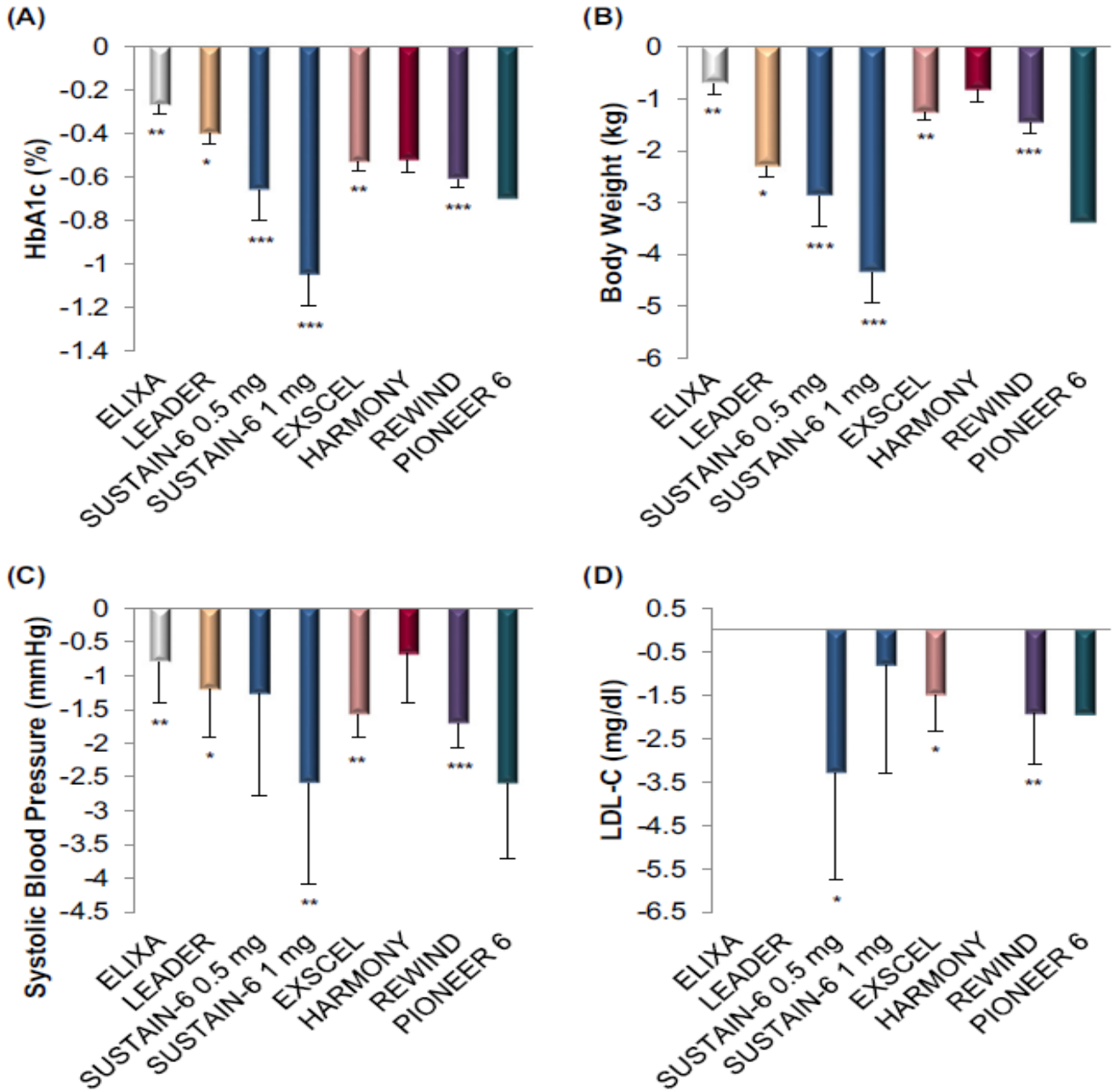
BP, blood pressure; CVD cardiovascular disease.

1. CDC. National Diabetes Statistics Report, 2014. Available at: http://www.cdc.gov/diabetes/data/statistics/2014StatisticsReport.html. Last accessed September 2015; 2. CDC. Available at: http://www.cdc.gov/diabetes/statistics/comp/fig7_overweight.htm. Last accessed September 2015; 3. Gregg EW, *et al. N Engl J Med* 2014;**370**:1514–23;
4. Stratton IM, *et al. BMJ* 2000;**321**:405–12; 5. Pi-Sunyer FX. *Postgrad Med* 2009;**121**:94–107; 6. Williamson DF, *et al. Diabetes Care* 2000;**23**:1499–504;
7. Patel A, ADVANCE Collaborative Group. *Lancet* 2007;**370**:829–40; 8. Pyörälä K, *et al. Diabetes Care* 1997;**20**:614–20.

Key factors affecting adherence

- **Complexity of medication regimen (number of doses, number of concurrent medications)**
- Treatment requires mastery of certain techniques (injection, inhaler)
- Duration of therapy
- Frequent changes in medication regimen
- Lack of immediate therapeutic benefit
- Medications with associated social stigma
- Actual/perceived unpleasant side effects
- Treatment interferes with lifestyle/requires significant behavioural change

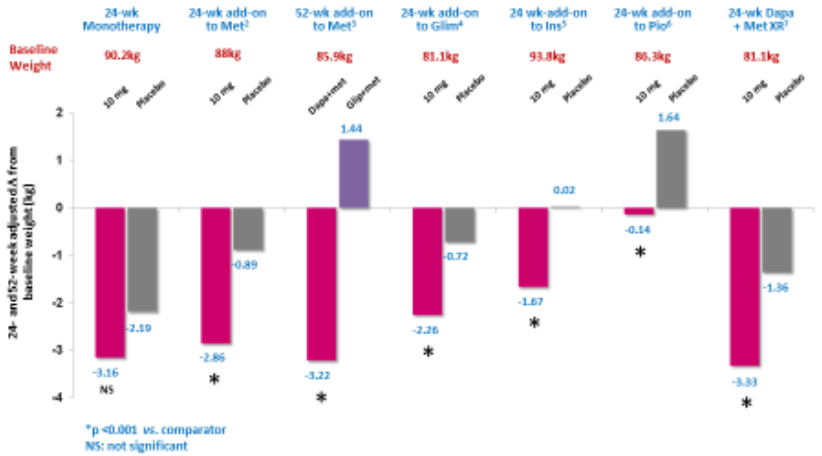
GLP-1 RAs improve several parameters



Caruso I et al., *Trends Endocrinol Metab* 2019

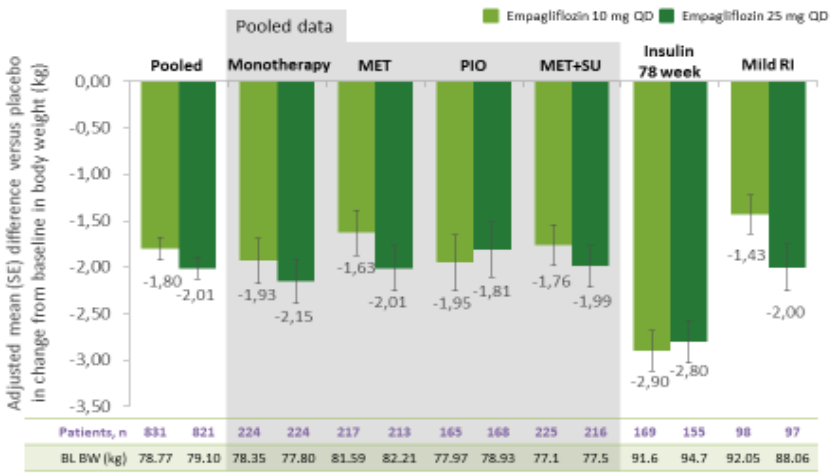
SGLT2 Inhibitors: Effects on weight

Body weight changes with dapagliflozin



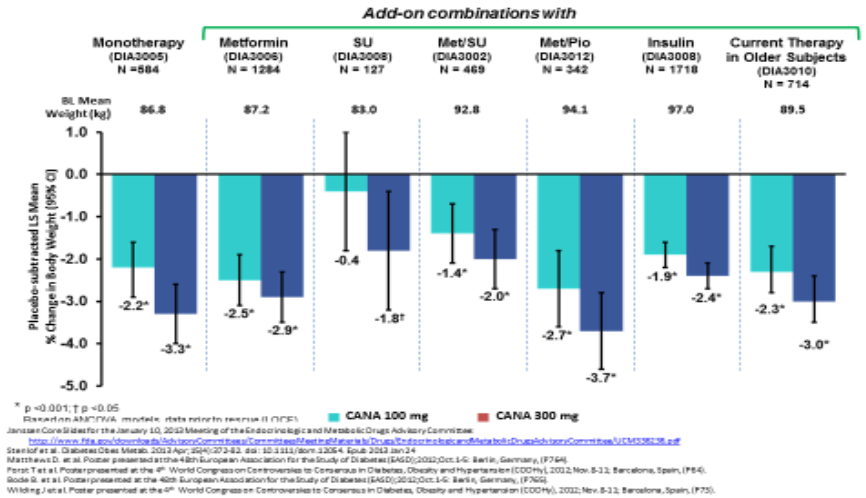
[1]Ferrannini E, et al. *Diabetes Care* 2010;33:2217–2224; [2]Bailey CJ, et al. *Lancet* 2010;375:2223–2233; [3]Nauck MA, et al. *Diabetes Care* 2011;34:2015–2022; [4]Strojek K, et al. *Diabetes Obes Metab* 2011;13:928–938 [5]Wilding J, et al. *Diabetes* 2010;59 (Suppl 1):A21–A22 (Abstract 0078-OR); [6]Rosenstock J, et al. 71st *ADA Scientific Sessions*, San Diego, 24–28 June, 2011 (Abstract 0986-P); [7]Henry R, et al. 71st *ADA Scientific Sessions*, San Diego, 24–28 June, 2011 Abstract 307-OR.

Body weight changes with empagliflozin



BL, baseline; BW, body weight; MET, metformin; PIO, pioglitazone; QD, once daily; RI, renal impairment; SE, standard error; SU, sulphonylurea.
*All statistically significant unless otherwise marked.

Body weight changes with canagliflozin

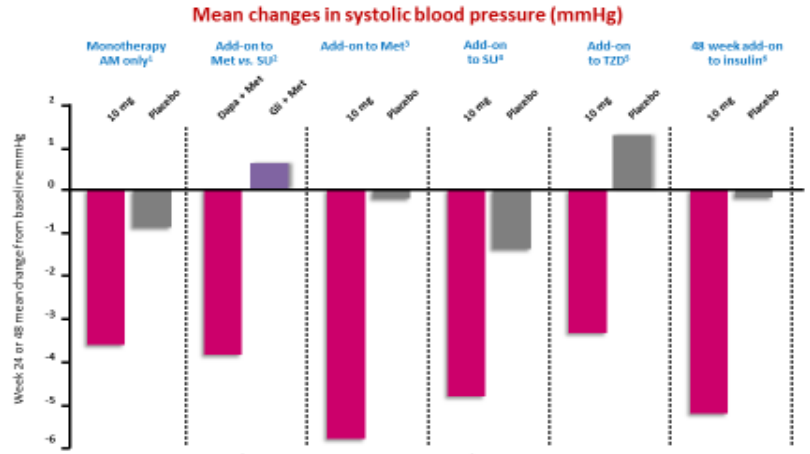


* p <0.001; † p <0.05
Based on ANCOVA models, data prior to rescue (LOCF)

Janssen Core Slides for the January 10, 2012 Meeting of the Endocrinologic and Metabolic Drugs Advisory Committee
Stenlof et al. *Diabetes Obes Metab.* 2013 Apr; 15(4):372-82. doi: 10.1111/dom.12054. Epub 2013 Jan 24
Matthews D. et al. Poster presented at the 48th European Association for the Study of Diabetes (EASD);2012;Oct.1-5; Berlin, Germany, (F764).
Foroi T et al. Poster presented at the 4th World Congress on Controversies to Consensus in Diabetes, Obesity and Hypertension (CODHy), 2012; Nov. 8-11; Barcelona, Spain, (P84).
Rodbard D. et al. Poster presented at the 48th European Association for the Study of Diabetes (EASD);2012;Oct.1-5; Berlin, Germany, (F765).
Wilding J et al. Poster presented at the 4th World Congress on Controversies to Consensus in Diabetes, Obesity and Hypertension (CODHy), 2012; Nov. 8-11; Barcelona, Spain, (F75).

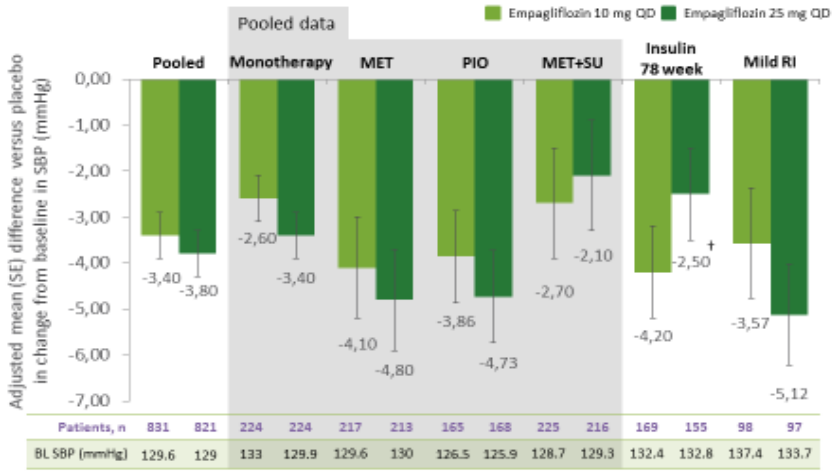
SGLT2 Inhibitors: Effects on Blood Pressure

Blood pressure reductions consistently observed with dapagliflozin in phase III studies



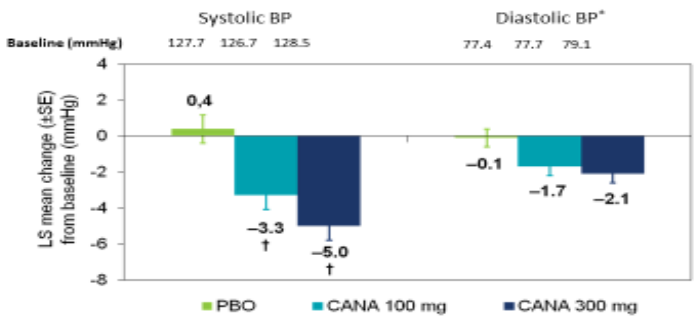
[1]Ferrannini E, et al. *Diabetes Care* 2010;33:2217-2224; [2]Nauck MA, et al. *Diabetes Care* 2011;34:2015-22; [3]Bailey CJ, et al. *Lancet* 2010;375:2225-35; [4]Strojek K, et al. *Diabetes Obes Metab* 2011;13:928-38; [5]Rosenstock J, et al. 71st ADA Scientific Sessions, San Diego, 24-28 June, 2011 [Abstract 0986-P]; [6]Wilding J, et al. *Diabetes* 2010;59 (Suppl 1):A21-A22 [Abstract 0078-OR].

Blood pressure reductions observed with empagliflozin in phase III studies



BL, baseline ; MET, metformin; PIO, pioglitazone; QD, once daily; RI, renal impairment; SBP, systolic blood pressure; SE, standard error; SU, sulphonylurea.
*All statistically significant unless otherwise marked. †Not statistically significant.
Hach T, et al., Häring H-U, et al., Rosenstock J, et al., Barnett A, et al. *Diabetes*. 2013;(Suppl 1):[P654.B, P3092, P3102, P3104, respectively];
Kovacs C, et al. *Diabetes Obes Metab*. 2013 Aug 1. doi: 10.1111/dom.12188; Häring H-U, et al. *Diabetes Care*. 2014. doi:10.2337/dc12-2673.
Barnett A, et al. Lancet Diabetes Endocrinol. 2014 May;2(5):369-84. doi: 10.1016/S2213-8587(13)70209-0
Rosenstock J, et al Poster: 551, 49th Annual Meeting of the European Association for the Study of Diabetes, 23–27 September 2013

Reduction in Blood Pressure with canaglifozin treatment at Week 26

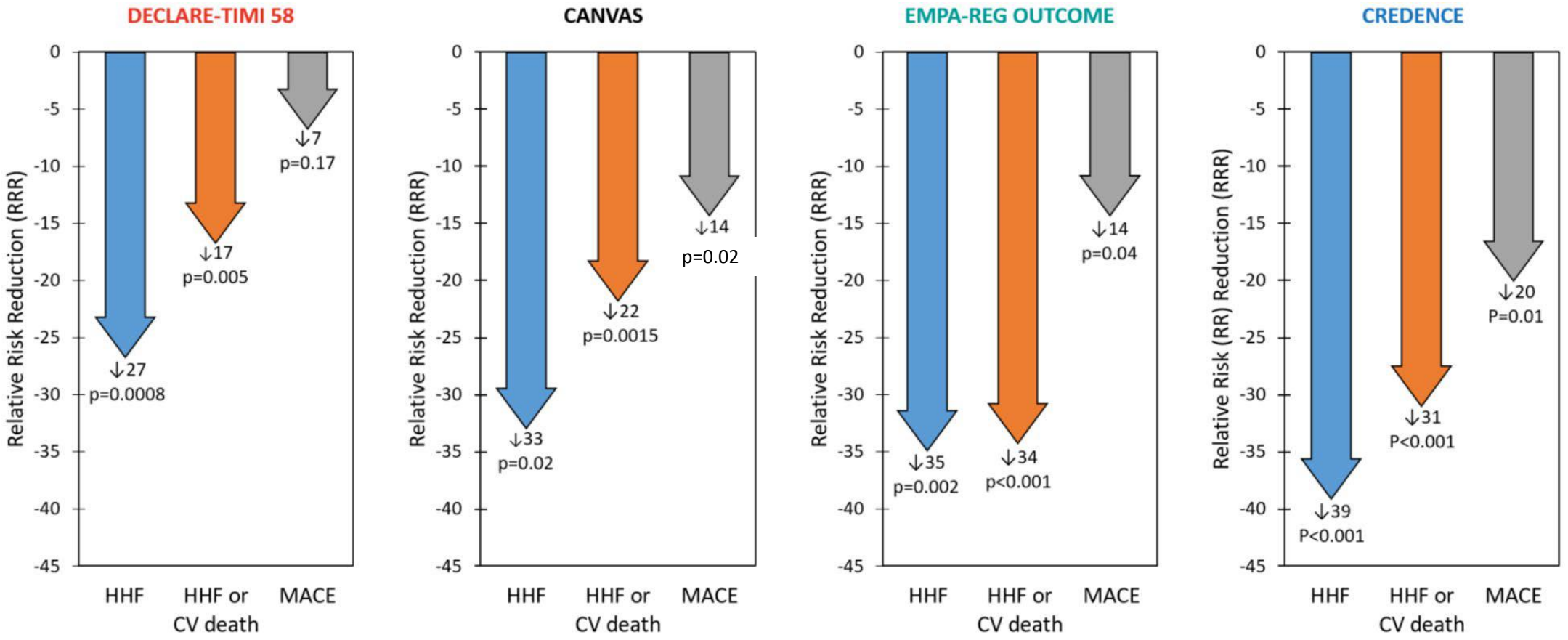


*P <0.001 vs placebo; †Statistical comparison for Canagliflozin 100 and 300 mg vs placebo not performed (not pre-specified).
BP, blood pressure; LS, least squares; SE, standard error; PBO, placebo; CANA, canagliflozin; mITT, modified intent-to-treat; LOCF, last observation carried forward.

•Minimal changes in pulse rate were observed with canagliflozin 100 and 300 mg compared with placebo (−1.6, −0.5 and 1.4 beats per min, respectively).

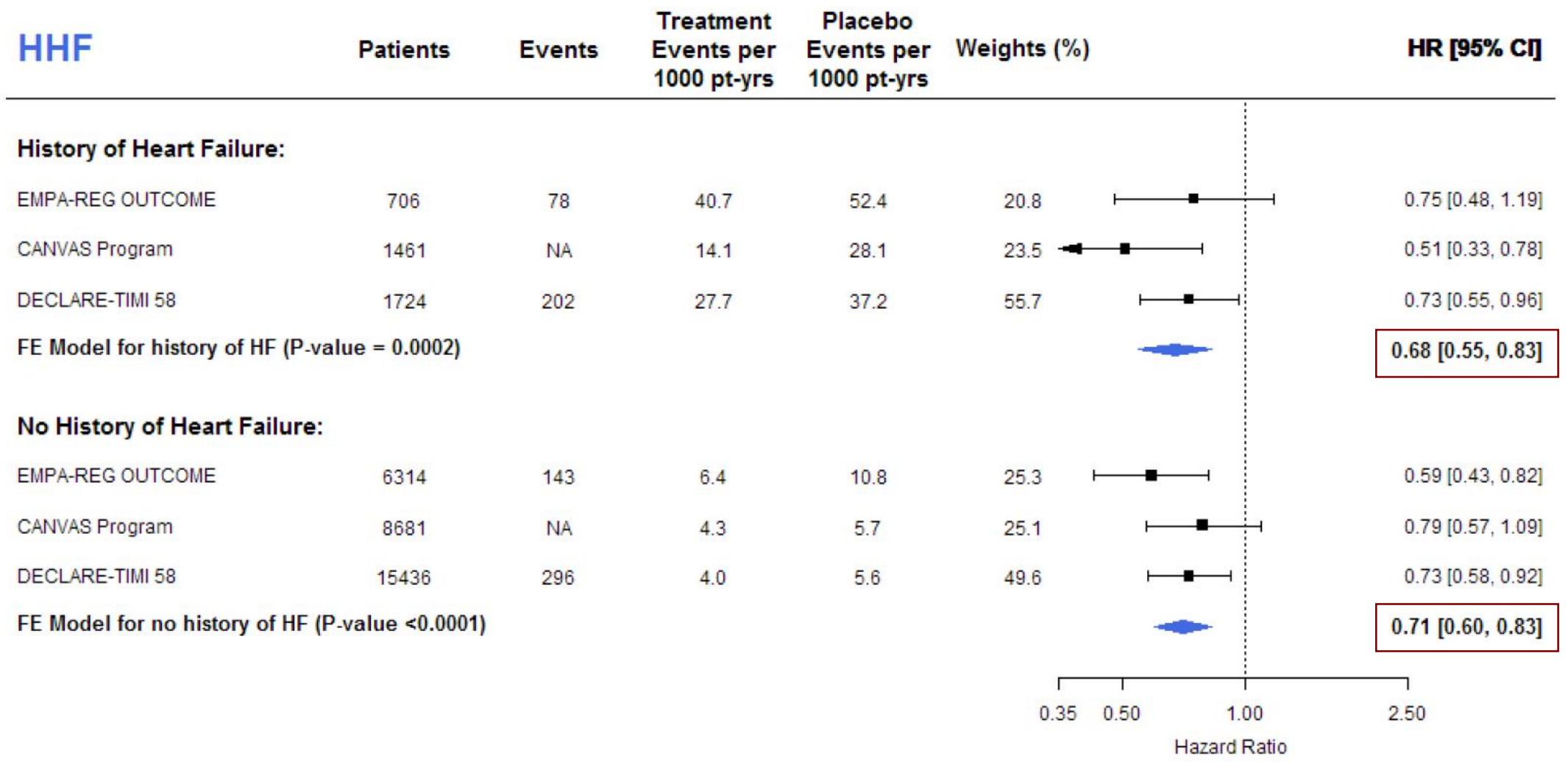
Stenlof et al. Diabetes Obes Metab. 2013 Apr;15(4):372-82. doi: 10.1111/dom.12054. Epub 2013 Jan 24

Heart failure hospitalization (HHF), HHF and CV death, and MACE relative risk reductions (RRRs) in SGLT2 inhibitors CVOTs



Kluger et al. Cardiovasc Diabetol 18:99, 2019

SGLT2 inhibitors CVOT: meta-analysis of hospitalization for heart failure stratified by history of heart failure

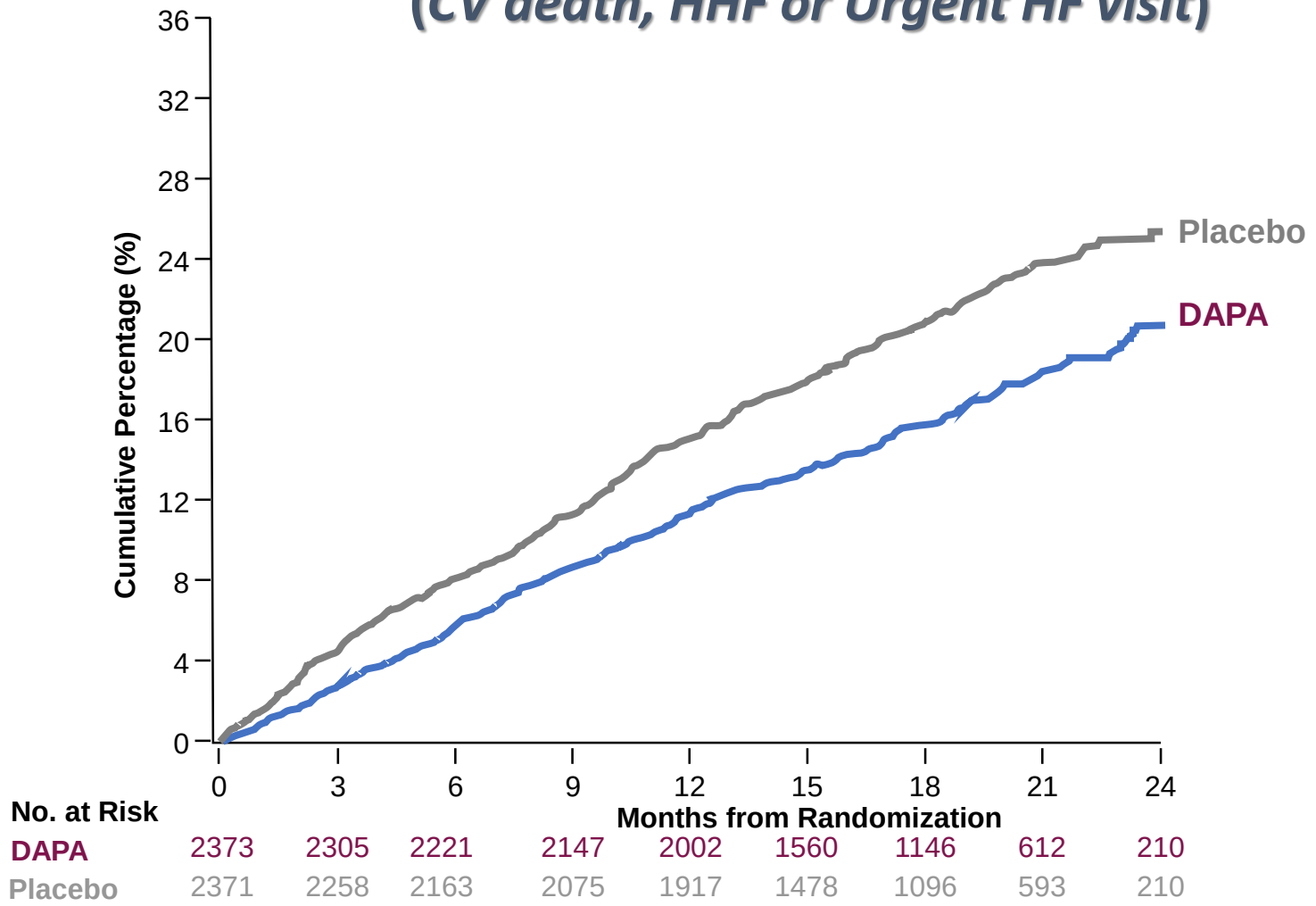


Zelniker TA et al. Lancet 5;393(10166):31-39, 2019

DAPA-HF STUDY

Cumulative Occurrence of PRIMARY COMPOSITE ENDPOINT

(*CV death, HHF or Urgent HF visit*)



26% RRR

HR 0.74 (0.65, 0.85)
p=0.00001

NNT = 21

4744 patients

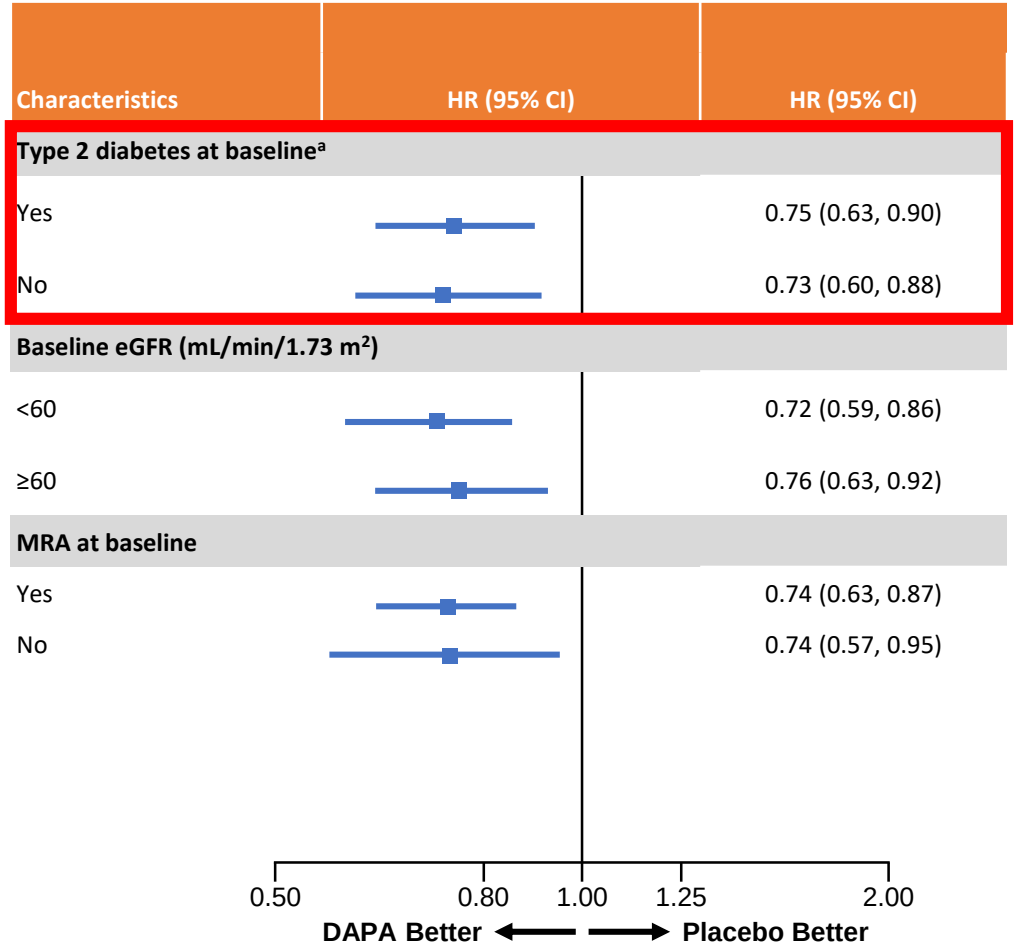
- **≥18 years of age**
- **With or without T2D**
- **Diagnosis of symptomatic HFrEF (NYHA class II-IV) for ≥ 2 months**
- **LVEF ≤40% within last 12 months**
- **Elevated NT-proBNP**
- **eGFR ≥30 ml/min/1.73 m²**
- **Stable SoC HFrEF treatment**

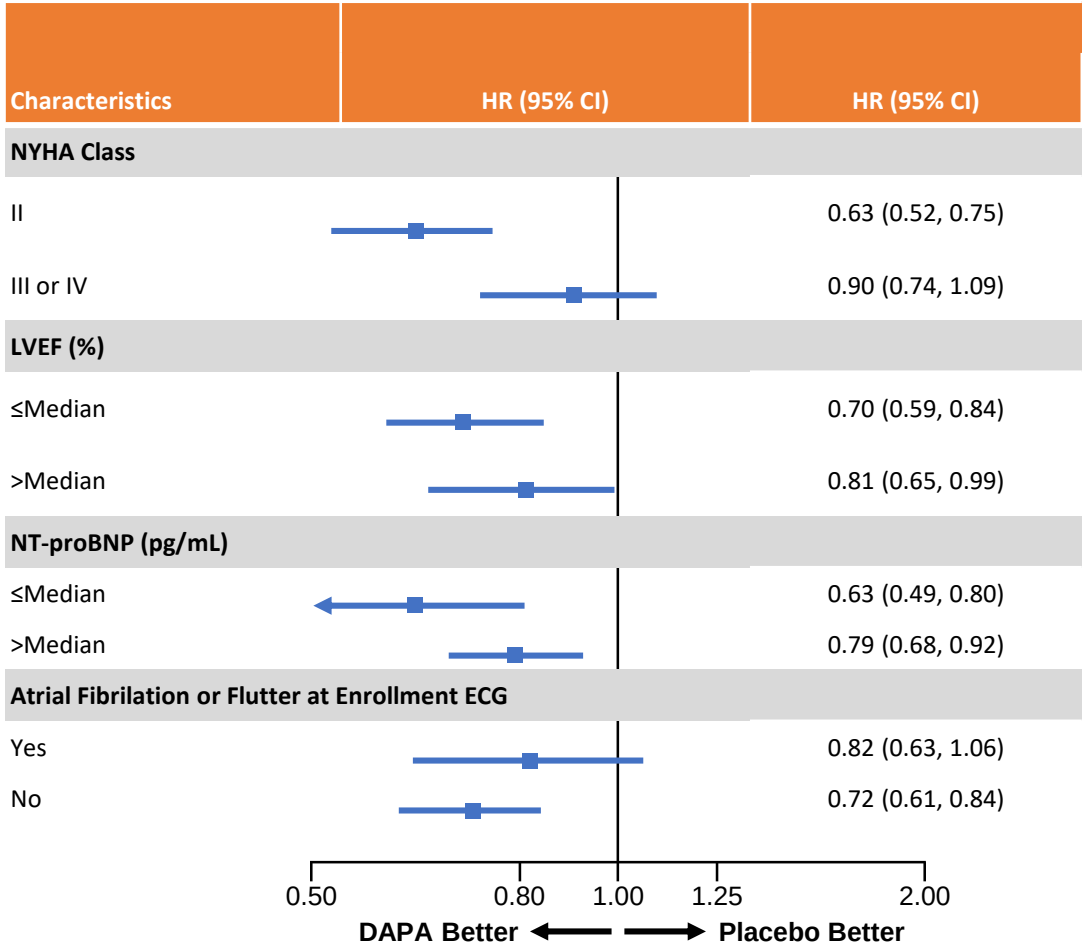
DAPA = dapagliflozin; HF = heart failure; hHF = hospitalization for heart failure; HR = hazard ratio; NNT = number needed to treat.

McMurray J. et al. N Engl J Med 2019, Epub Sept 19

DAPA-HF STUDY

PRIMARY COMPOSITE ENDPOINT in pre-specified sub-groups

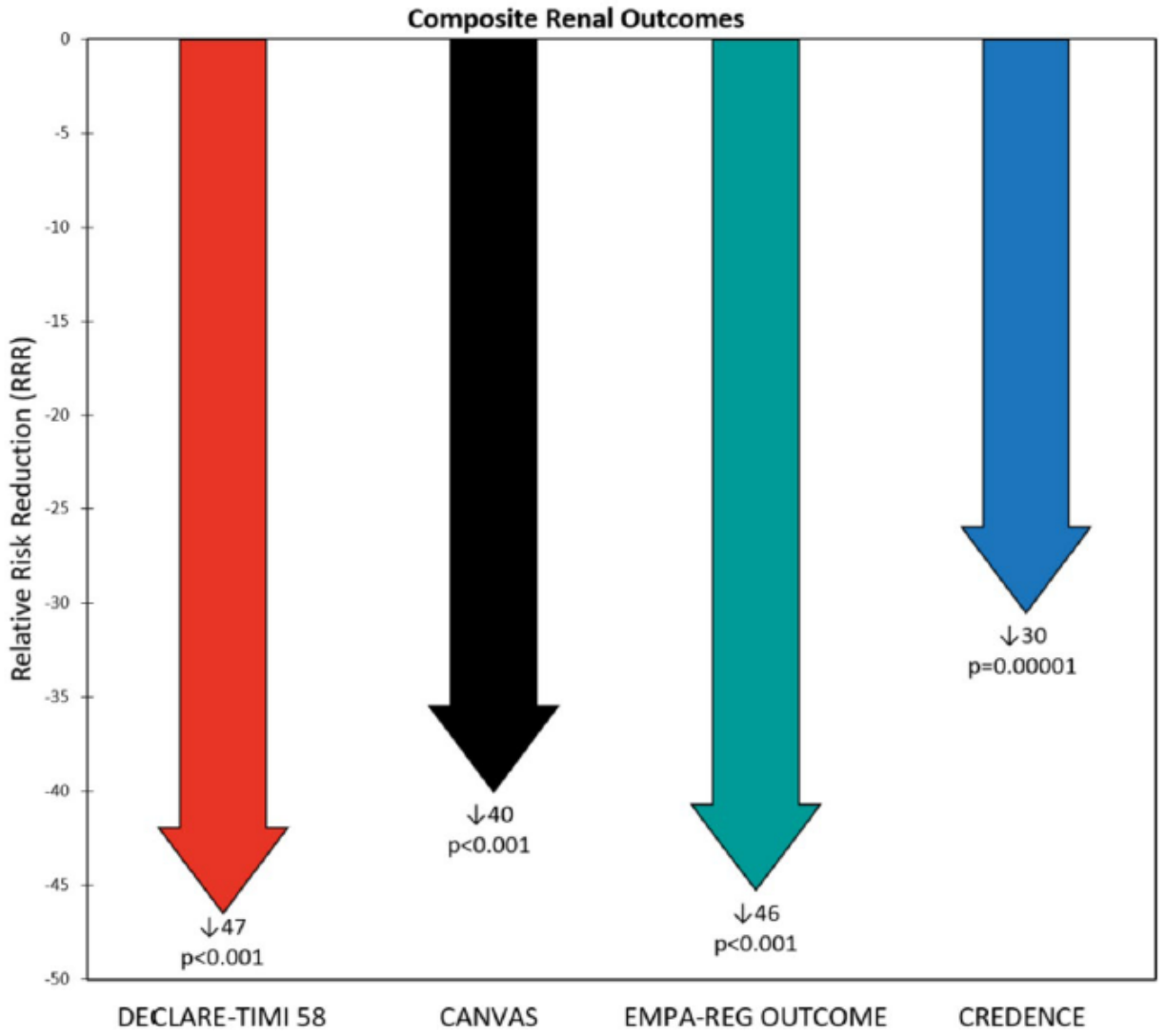




[a]Defined as history of T2DM or HbA1c ≥6.5% at both enrollment and randomization visits.

McMurray J. et al. N Engl J Med 2019, Epub Sept 19

Composite renal outcome relative risk reductions (RRRs) in SGLT2i Outcome Trials

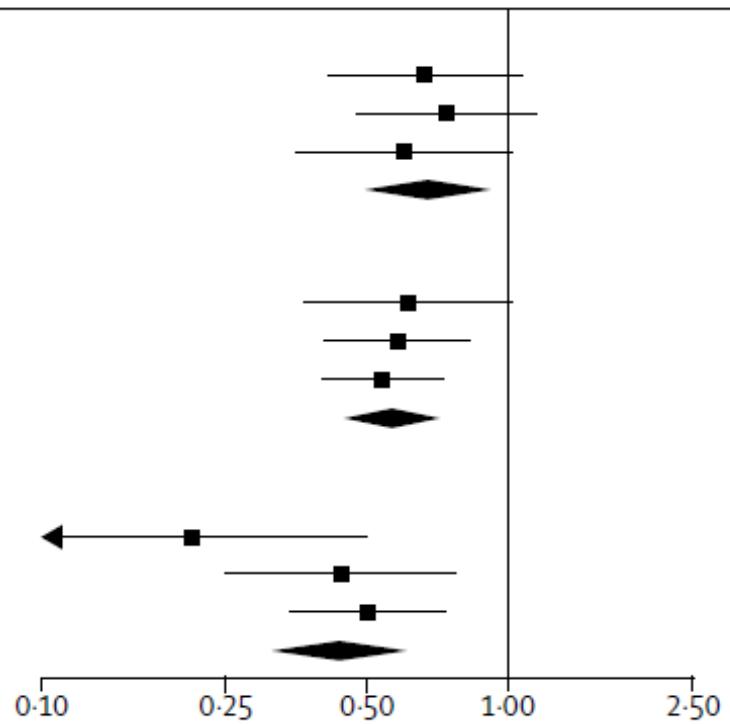


Kluger et al. Cardiovasc Diabetol 18:99, 2019

SGLT2 inhibitors for primary and secondary prevention of cardiovascular and renal outcomes in type 2 diabetes: a systematic review and meta-analysis of cardiovascular outcome trials

Renal Endpoint

	Patients		Events	Events per 1000 patient-years		Weight (%)	HR	HR (95% CI)
	Treatment (n)	Placebo (n)		Treatment	Placebo			
eGFR <60 mL/min per m²								
EMPA-REG OUTCOME	1196	605	NA	NA	NA	33·5		0·66 (0·41–1·07)
CANVAS Program	NA	NA	83	11·4	15·1	39·6		0·74 (0·48–1·15)
DECLARE-TIMI 58	606	659	59	8·9	15·2	27·0		0·60 (0·35–1·02)
Fixed effects model for eGFR <60 (p=0·0054)								**0·67 (0·51–0·89)**
eGFR 60 to <90 mL/min per m²								
EMPA-REG OUTCOME	2406	1232	NA	NA	NA	16·8		0·61 (0·37–1·03)
CANVAS Program	NA	NA	118	4·6	7·4	34·4		0·58 (0·41–0·84)
DECLARE-TIMI 58	3838	3894	186	4·2	7·8	48·9		0·54 (0·40–0·73)
Fixed effects model for eGFR 60 to <90 (p<0·0001)								**0·56 (0·46–0·70)**
eGFR ≥90 mL/min per m²								
EMPA-REG OUTCOME	1043	486	NA	NA	NA	11·7		0·21 (0·09–0·53)
CANVAS Program	NA	NA	48	3·8	8·1	27·5		0·44 (0·25–0·78)
DECLARE-TIMI 58	4137	4025	120	2·5	4·9	60·8		0·50 (0·34–0·73)
Fixed effects model for eGFR ≥90 (p<0·0001)								**0·44 (0·32–0·59)**



Use on innovative treatment strategies in T2DM can reduce:

- **Medication Burden**
- **Advers drugs events**
- **Hypoglycemia**
- **Treatment Adherence**
- **RESIDUAL RISK**

Onoviran OF et al. Ther Adv Chronic Dis. 2019, Vol. 10: 1–23.

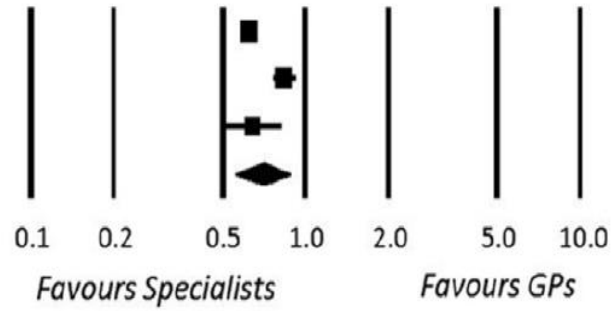
Diabete Mellito: il fattore C

- **COMUNE:** *una persona su 15 in Italia ha diabete noto*
- **CRESCENTE:** *2 milioni di Italiani 30 aa fa, 4 milioni oggi*
- **CRONICO:** *decadi di vita con la malattia*
- **COINVOLGENTE:** *ogni apparato, organo, cellula soffre per l'iperglicemia*
- **CALEIDOSCOPICO:** *il quadro clinico cambia nel tempo*
- **CONDIZIONANTE:** *impone fino a 500 mila «azioni» nel corso della vita*
- ***Non* CURABILE:** *non si guarisce dal diabete*
- **CATTIVO:** *può comportare grave disabilità e premorienza*
- **COSTOSISSIMO:** *molti miliardi di euro*

Attending Diabetes Clinics is associated with a lower all-cause mortality. A meta-analysis of observational studies performed in Italy

Unadjusted analysis

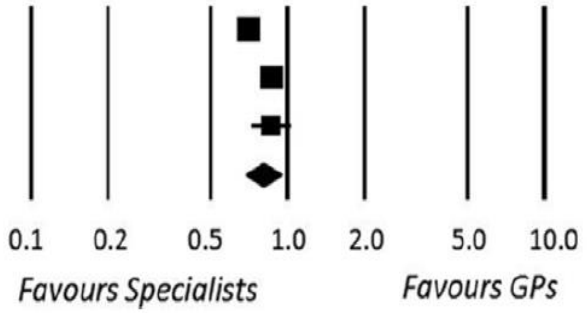
Study (reference)	Statistics for each study *MH odds ratio (95%, CI)*	p	Relative weight
Baviera M 2017 (19)	0.62[0.59-0.66]	<0.001	37.7
Zoppini G 1999 (18)	0.84[0.76-0.92]	<0.001	36.1
Bruno G 2005 (17)	0.64[0.49-0.82]	<0.001	26.2
Overall MH-OR	**0.70[0.55-0.88]**	**0.002**	**100.0**



Adjusted analysis*

Panel B

Study (reference)	Statistics for each study *Adj. odds ratio (95%, CI)*	p	Relative weight
Baviera M 2017 (19)	0.71[0.67-0.75]	<0.001	37.4
Zoppini G 1999 (18)	0.87[0.81-0.94]	<0.001	36.1
Bruno G 2005 (17)	0.87[0.73-1.04]	0.12	26.5
Overall MH-OR	**0.81[0.69-0.95]**	**0.009**	**100.0**



***Variables used for adjustment in individual studies always included gender and age; the other confounders were insulin therapy and place of residence in the study of Zoppini et al., and duration of diabetes in the study of Bruno et al.**

Bonora E et al. Nutr Metab Cardiovasc Dis 28: 431-435, 2018

Per ottenere i migliori risultati possibili nella cura delle persone con diabete, attraverso la forte integrazione tra i diversi punti di erogazione dell'assistenza, è necessaria **una più precisa definizione organizzativa istituzionalizzata delle attività e dei ruoli delle Strutture Diabetologiche e della Medicina Generale.**

Il programma di cura della persona con diabete non può prescindere da una Gestione Integrata della patologia che veda al centro il paziente stesso e preveda la sinergia tra il Medico di Medicina Generale (MMG) e il Team Diabetologico.

Per una corretta gestione integrata nell'assistenza del paziente diabetico sono necessari:

1. un percorso diagnostico terapeutico e assistenziale (PDTA) condiviso;
2. un modulo di informazione e consenso sottoscritto dal paziente che aderisce alla gestione integrata, così come previsto dal PDTA;
3. l'utilizzo della cartella clinica informatizzata;
4. l'attivazione di strumenti di comunicazione diretta, on-line, attraverso l'integrazione delle cartelle cliniche dei MMG e dei Team Diabetologici;
5. la formazione continua dei professionisti;
6. la raccolta dati e la valutazione periodica della Gestione Integrata, attraverso l'utilizzo di indicatori di struttura, di processo e di esito e l'avvio di percorsi di self-audit, audit di gruppo e di Associazioni Funzionali Territoriali e Unità Complessa di Cure Primarie.

Allegato al Decreto del Commissario ad ACTA
n. 75/2016 del 05 LUG. 2016

All. A)

ASR ABRUZZO
AGENZIA SANITARIA REGIONALE

PDTA DEL DIABETE

Il programma di cura della persona con diabete non può prescindere da una Gestione Integrata della patologia che veda al centro il paziente stesso e preveda la sinergia tra il Medico di Medicina Generale (MMG) e il Team Diabetologico

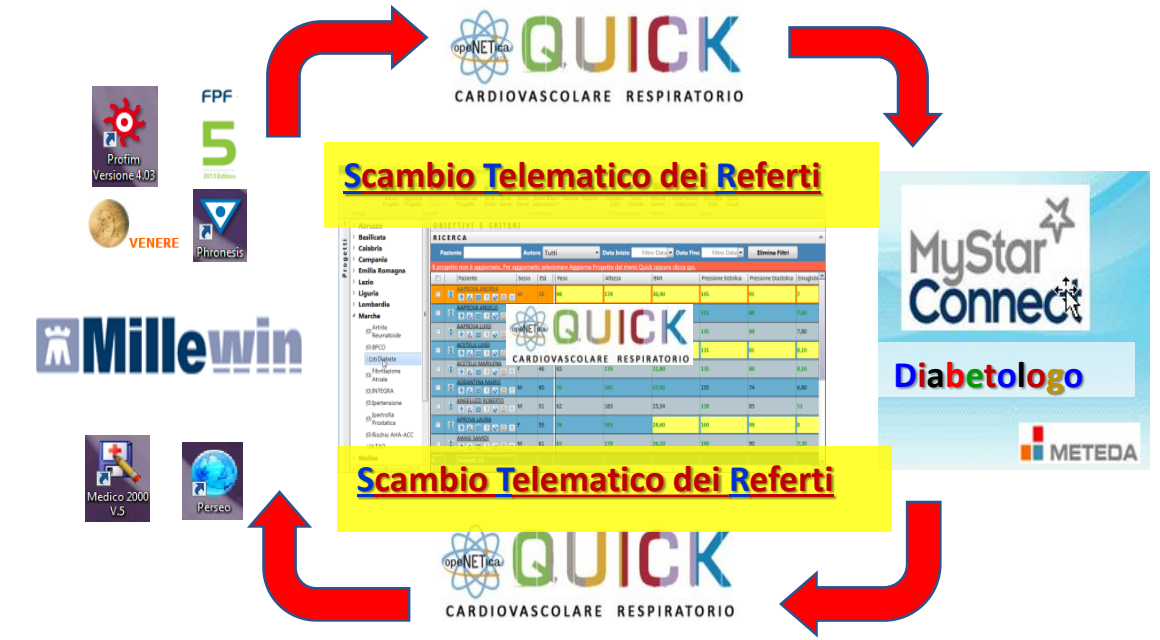
In tutte le fasi del percorso è necessaria comunque una stretta interazione tra il Team Diabetologico, il MMG e gli altri specialisti, da realizzarsi attraverso l'uso di supporti informatici.

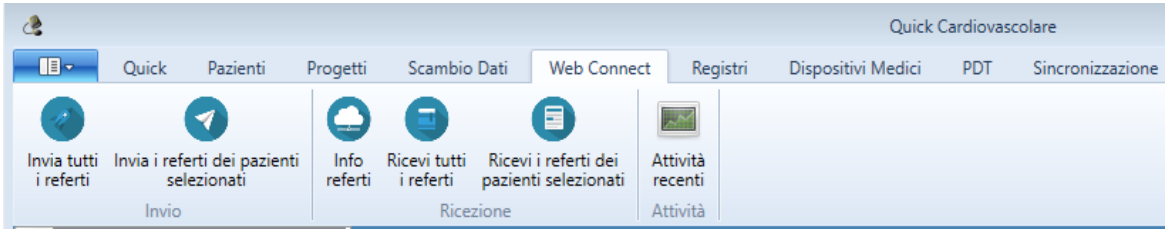
INTEGRAZIONE GESTIONE ASSISTENZA

UNA SOLUZIONE POSSIBILE

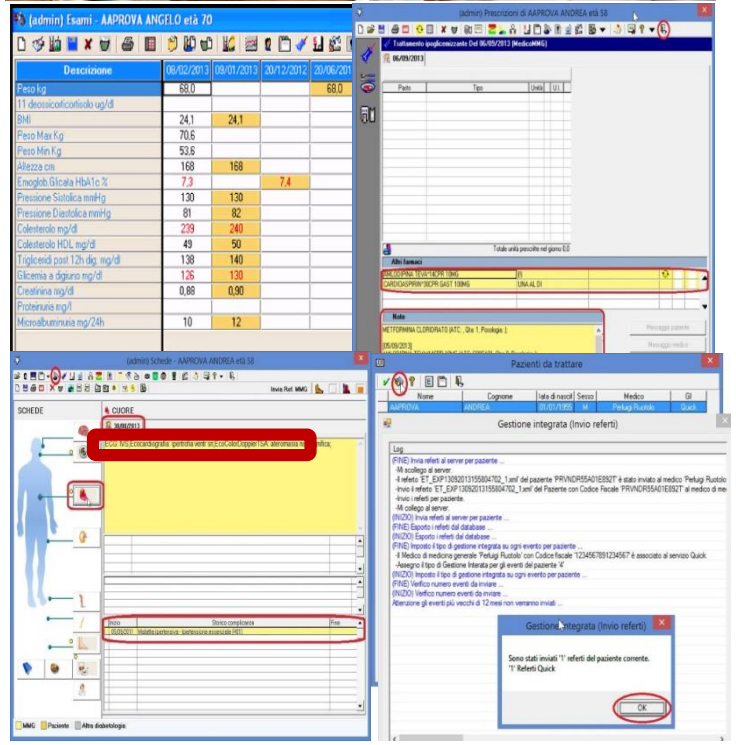
Cartelle Cliniche MMG / Quick Connect / My Star Connect Diabetologo

Cartelle Cliniche MMG

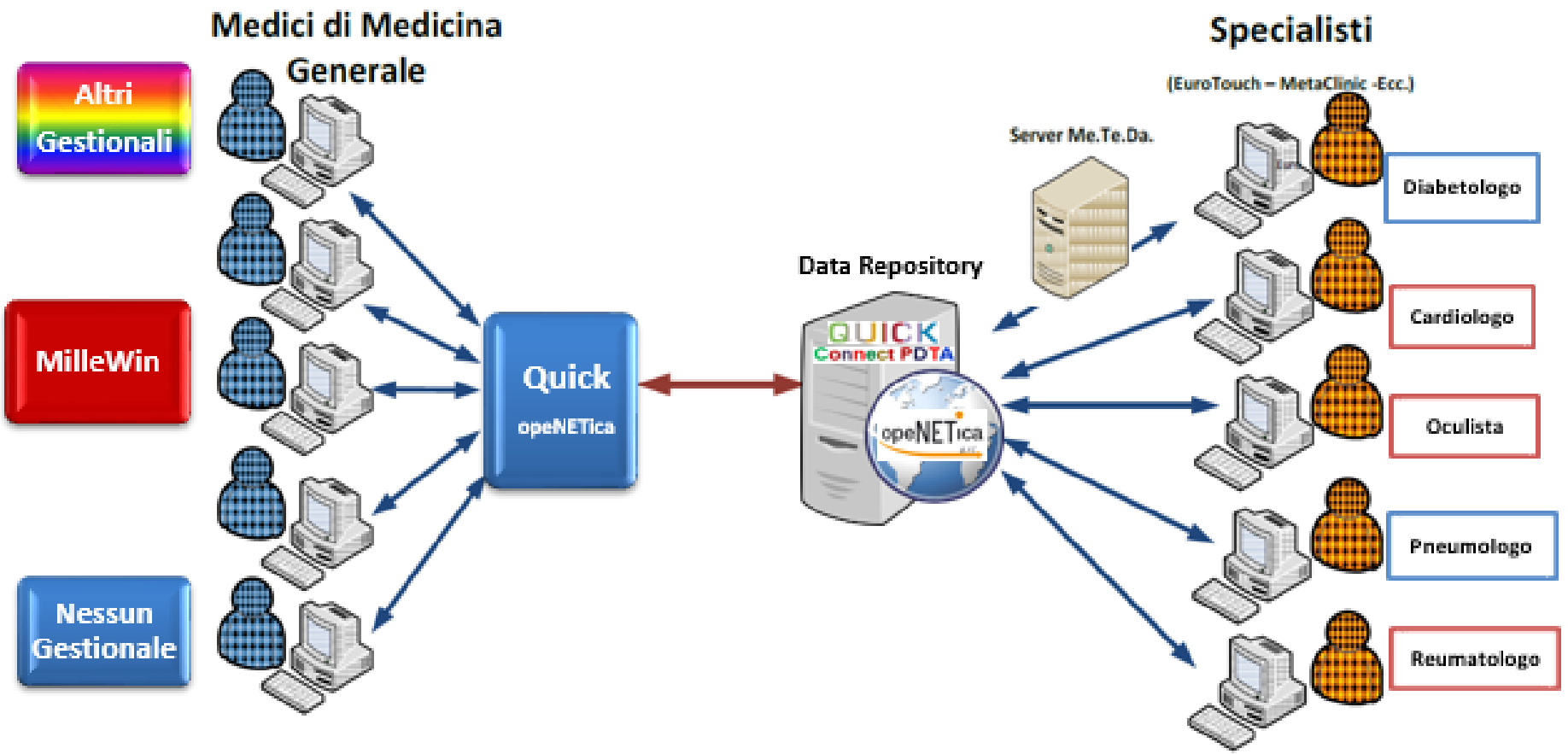




Cartella Clinica Diabetologo



UNA SOLUZIONE POSSIBILE



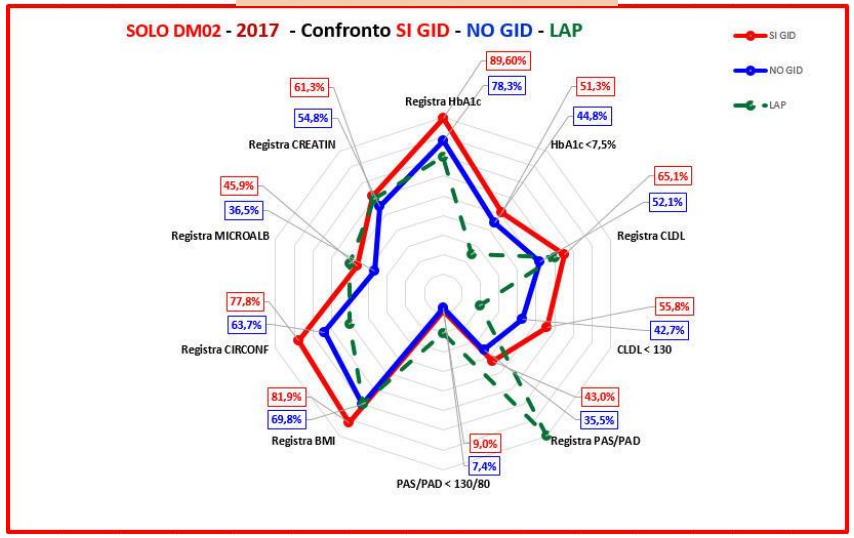
LA GESTIONE INTEGRATA DEL DIABETE NELLA AUSL DI PESCARA

RISULTATI PRELIMINARI

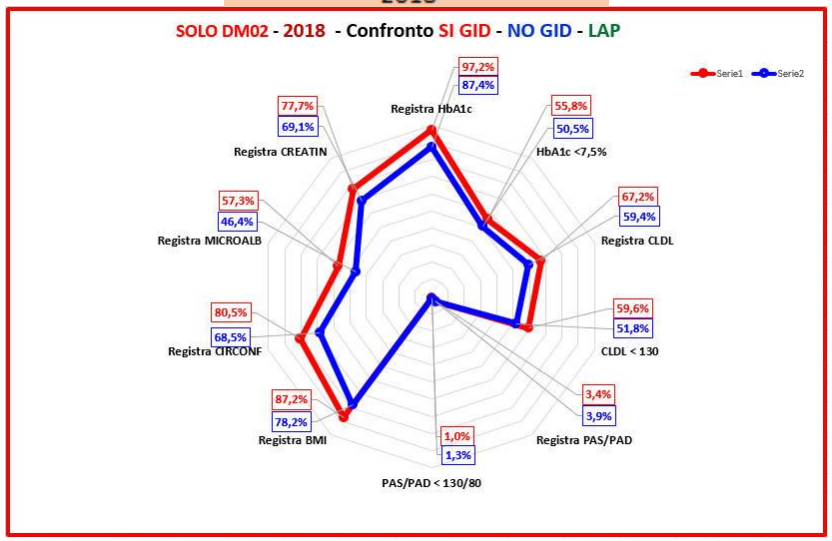
	2017			diff %
TOTALE				
	SI GID	NO GID		
DIABETICI SI GID NO GID	1943	4085		
% DIAB SI GID NO GID	32,22%	67,78%	3%	
DIABETOLOGIA PESCARA	SI GID	NO GID	LAP	
Registra HbA1c	89,60%	78,3%	70%	12,61
HbA1c <7,5%	51,3%	44,8%	25%	12,67
Registra CLDL	65,1%	52,1%	60%	19,97
CLDL < 130	55,8%	42,7%	20%	23,48
Registra PAS/PAD	43,0%	35,5%	90%	17,44
PAS/PAD < 130/80	9,0%	7,4%	20%	17,78
Registra BMI	81,9%	69,8%	70%	14,77
Registra CIRCONF	77,8%	63,7%	50%	18,12
Registra MICROALB	45,9%	36,5%	50%	20,48
Registra CREATIN	61,3%	54,8%	60%	10,60

	2018			diff %
TOTALE				
	SI GID	NO GID		
DIABETICI SI GID NO GID	1465	2699		
% DIAB SI GID NO GID	35,2%	64,8%	3%	
DIABETOLOGIA PESCARA	SI GID	NO GID	LAP	
Registra HbA1c	97,2%	87,4%	70%	10,08
HbA1c <7,5%	55,8%	50,5%	25%	9,50
Registra CLDL	67,2%	59,4%	60%	20,07
CLDL < 130	59,6%	51,8%	20%	20,86
Registra PAS/PAD	3,4%	3,9%	90%	18,35
PAS/PAD < 130/80	1,0%	1,3%	20%	13,04
Registra BMI	87,2%	78,2%	70%	18,59
Registra CIRCONF	80,5%	68,5%	50%	20,99
Registra MICROALB	57,3%	46,4%	50%	25,37
Registra CREATIN	77,7%	69,1%	60%	18,09

2017



2018



http://www.siditalia.it/pdf/Diabetologi%20per%20curare%20e%20diabetologi%20per%20risparmiare.pdf

	AREA D'INTERVENTO	RISPARMIO ASL PESCARA euro/anno	RISPARMIO ASL TERAMO euro/anno	RISPARMIO ASL L'AQUILA euro/anno	RISPARMIO ASL CHIETI euro/anno	RISPARMIO REGIONALE euro/anno	RISPARMIO NAZIONALE euro/anno
1	"Strisce appropriate" Ottimizzazione dell'autocontrollo glicemico domiciliare;	€ 241.298,84	€ 232.726,66	€ 230.524,52	€ 295.449,98	€ 1.000.000,00	€ 30.000.000,00
2	"L'esame serve davvero?" Appropriatezza nella prescrizione di esami di laboratorio e strumentali (propria e indotta);	€ 482.597,67	€ 465.453,33	€ 461.049,03	€ 590.899,97	€ 2.000.000,00	€ 60.000.000,00
3	"No ipoglicemia" Prevenzione delle ipoglicemie con una scelta oculata dei farmaci anti-diabetici;	€ 313.688,49	€ 302.544,66	€ 299.681,87	€ 384.084,98	€ 1.300.000,00	€ 41.000.000,00
4	"Guarda la convenienza" Uso efficace delle varie opportunità offerte dal ricco armamentario terapeutico;	€ 289.558,60	€ 279.272,00	€ 276.629,42	€ 354.539,98	€ 1.200.000,00	€ 35.000.000,00
5	"Un click solo" Corretta istruzione dell'esecuzione della terapia insulinica per evitare spreco di insulina con la dose test che precede l'iniezione;	€ 144.779,30	€ 139.636,00	€ 138.314,71	€ 177.269,99	€ 600.000,00	€ 19.000.000,00
6	"Cerca la bozza" Prevenzione delle lipodistrofie nei pazienti insulino-trattati;	€ 168.909,19	€ 162.908,67	€ 161.367,16	€ 206.814,99	€ 700.000,00	€ 21.000.000,00
7	"Guarda prima i piedi" Prevenzione del 'piede diabetico';	€ 386.078,14	€ 372.362,66	€ 368.839,23	€ 472.719,97	€ 1.600.000,00	€ 50.000.000,00
	TOTALE PRIMI SETTE INTERVENTI	€ 2.026.910,23	€ 1.954.903,98	€ 1.936.405,93	€ 2.481.779,86	€ 8.400.000,00	€ 256.000.000,00
8							

CONTINUARE AD IGNORARE I VANTAGGI CLINICI ED ECONOMICI DELLA GESTIONE INTEGRATA PRIVA LE PERSONE CON DIABETE DELL'OPPORTUNITA' DI UNA CURA MIGLIORE ED IMPEDISCE UNA CORRETTA RAZIONALIZZAZIONE DELLE RISORSE

Grazie per l'attenzione