**Tackling diabetes mellitus and tuberculosis: a new Union guide on the management of diabetes-tuberculosis**

**“Editorial”**

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One of the ambitious goals of the World Health Organization (WHO) End Tuberculosis (TB) Strategy is an 80% reduction in TB incidence by 2030 compared with 2015 and no TB-affected families facing catastrophic financial costs1 The rapidly growing epidemic of diabetes mellitus (DM) in low- and middle- income countries may hamper TB control efforts and derail progress made towards achieving these targets. If the current DM epidemic continues to increase as predicted, it is estimated that TB incidence will decrease by less than 10% in the next 15 years in 13 TB high burden countries.2 People living with DM have about a three times higher risk of developing TB3. TB patients with DM also have a poor treatment response, higher risk of unsuccessful treatment outcome and relapse after completion of anti-TB treatment.

To address these co-epidemics, WHO and International Union Against Tuberculosis and Lung Disease (The Union) launched a Collaborative Framework for Care and Control Tuberculosis and Diabetes in 2011,4 but this had no technical guidance for health facilities describing how to undertake bidirectional TB and DM screening or care for patients affected by both diseases in resource-limited settings.

Therefore The Union, in partnership with the World Diabetes Foundation, developed technical guidelines in 2019: “Management of Diabetes Mellitus-tuberculosis”.5 This guide is aimed at frontline health workers. The main recommendations about screening include: all TB patients should be screened for DM; in settings with TB prevalence rates greater than 100/100,000, systematic screening for active TB disease should be offered to persons newly diagnosed with DM; persons with established DM should be followed-up vigilantly with careful assessments according to local circumstances. To prevent transmission of *Mycobacterium tuberculosis* in DM clinics, it is emphasised that patients with both DM and infectious TB should be treated in TB clinic for at least the first two weeks and preferably the first two months, and visits to DM clinics avoided if possible. Complicated cases require consultation with DM experts.

Management of persons with DM and TB requires a comprehensive approach that includes life style changes, smoking cessation and appropriate anti-DM treatment. Metformin is the first choice oral DM drug. Insulin may have to be considered if blood glucose levels are not adequately controlled with oral hypoglycaemic drugs. Low dose aspirin and a statin may be used for patients with a history of previous cardiovascular disease. There must be structured follow-up of patients, as treatment failure and recurrent TB are more common compared with TB patients without DM and the tools for conducting such monitoring are clearly laid out in the guide.

Finally, in line with the “Framework”,4 a national joint coordinating mechanism is proposed for joint collaborative activities.

We hope this guide will serve as a useful tool for health workers in the field, such as clinicians, nurses, public health workers and programme managers, who are involved in the fight against both conditions. We especially hope they will be useful for those working at the primary health care level where services may be more integrated.

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