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Letter to the editor: Metabolic syndrome in rural Australia: An opportunity for primary health care. Jancey et al., DOI: 10.1111/ajr.12500

We agree with the authors that metabolic syndrome is a major contributor to diabetes and cardiovascular disease.¹ Unfortunately, metabolic syndrome is not an easily marketable concept, which is why these types of interventions are typically described internationally as diabetes prevention. Usually these programs are evaluated by imputed reduction in risk of diabetes based on reduction in weight and waist circumference, and reduction in absolute cardiovascular risk.

In 2007, the Greater Green Triangle Diabetes Prevention Project (GGT DPP), undertaken as part of the Council of Australian Governments diabetes prevention initiative, reported significant changes in all but one of the components of the metabolic syndrome.² For example, weight change was -2.38 kg and -2.52 kg at 3 and 12 months respectively,² compared with Blackford and colleagues -0.7 kg at 6 months.³ More broadly, A meta-analysis of 22 studies reviewing evidence on effectiveness of translational diabetes prevention reported a mean weight loss in lifestyle interventions of 2.32 kg.⁴ In addition to guidelines for diet and physical activity, Dunkley and colleagues highlight the importance of adhering to comprehensive guidelines for diabetes prevention such as NICE or EU IMAGE – they found a significant association between guideline adherence and greater weight loss (an increase of 0.4 kg per point increase on a 12-point guideline-adherence scale).⁴ We

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encourage all those designing diabetes prevention interventions to follow their recommendations.

One of the challenges the authors mention is the implementation of chronic disease interventions on a broader scale. In 2007, the GGT DPP was scaled-up across the whole of the State of Victoria and is currently the largest diabetes prevention program underway in Australia. Diabetes Victoria has been funded by the Department of Health and Human Services to deliver the *Life!* program. To reflect the higher rural prevalence of diabetes, a disproportionately higher number of facilitators from rural areas were trained. Over 60,000 Victorians have been referred to the program, and over 36,400 have commenced the structured group courses or telephone health coaching designed to prevent diabetes, heart disease and stroke. Many of the referrals to the program come from General Practitioners. Due to a rigorous approach to implementation at scale, the outcomes of the program are only slightly less than the original GGT DPP.⁵

Finally, we commend the authors on the screening method used to recruit to the study.³ A relevant blood test post AUSDRISK is certainly a worthwhile step when recruiting to lifestyle interventions.⁶

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