EURADIA
Alliance for European Diabetes Research

Quarterly Newsletter
No 7 November 2007

Letter

From the Chair

Dear Members and Friends,

The last couple of months have been particularly busy. EURADIA members have held major meetings and I am delighted to report that attendance has beaten all records with a parallel increase in the number and quality of presentations. I was also pleased to note that the European Commission has been involved in some of these meetings, reflecting a continuing and growing interest in diabetes.

In October, EURADIA and other members of the Alliance co-hosted a diabetes session at the European Health Forum Gastein. EURADIA was responsible for the research component of this session and you will find a summary of the presentations in this Newsletter. The "Diabetes Matters" session was a success at many levels: it allowed diabetes to feature on the main programme of this important event; the session covered diverse aspects of the diabetes "space", from research to patient education, as well as societal and political issues; the "diabetes family" presented a common front setting a great example for the future. I should like to thank Tony O'Sullivan, immediate past Chairman of IDF-Europe, for his visionary leadership in making this "family" function without sibling rivalry! Special thanks also to Lex Herrebrugh for all his help with the organisation of Diabetes Matters at EHFG Gastein 2007.

EURADIA continues to be active and visible in the European diabetes research arena. We are committed to the Innovative Medicines Initiative (IMI) and have expressed our strong support through our contact with the European Commission and Parliament.

A most exciting development is the "invitation to negotiate a contract" from the European Commission DG Research in response to EURADIA's FP7 DIAMAP project. In common English, this means that our project to prepare a roadmap for diabetes research in Europe was considered competitive and approved for funding subject to suitable revision and negotiation of a contract. We anticipate a start date of March 2008 and the project will run for 2 years with funding (if approved…) of around €500,000. Sarah Hills deserves a huge round of applause for writing this successful application for FP7 funding: this is no mean task! DIAMAP is an extremely important project in itself and it will offer yet greater credibility and visibility to EURADIA, allowing us to lobby to even greater effect for increased support and improved coordination of diabetes research in Europe.

Philippe Halban
Chair EURADIA

Coordinating Research in Europe: a strategic role for the European Union

Manuel Hallen, MD: Head of Medical and Public Health Research, Health Directorate, Directorate General Research, European Commission

The evolution of support for medical and health research in the EU was presented in this session. European research programmes have provided many opportunities to enable scientists to learn how to collaborate across national borders to produce top quality results with European added value. The presentation recalled the origins of European research programmes; provided an overview of what the European Commission does now in terms of diabetes research, and the new 7th Framework Programme for research and technological development (RTD).

History and context of research at EU level

March 2007 was the 50th anniversary of the European Union based on the signature of the Treaty of Rome in 1957, which established the European Economic Community. This first treaty provided no legal basis for research activities in science, medicine, and health; therefore, such activities were carried out on a sector-by-sector basis such as 'nuclear energy', 'biology and health protection' and 'agricultural research'.

Ten years later in 1967 the Council of Ministers established a committee for science and technology research, which acts as an advisor both to the European Commission and to the Council. This advisory committee established among others a sub-committee for medical and public health research, which launched a series of exploratory and preparatory activities.

In 1978 the Council of Ministers adopted a first medical and public health research programme authorising the European Community to promote coordination of research projects in the Member States in limited and strictly defined areas of common interest. The entire research programme included in total ECU 1 million over 3 years for three concerted actions.

Research at EU Level: how the research programmes function

The European Commission (EC) *proposes* a programme for co-decision by the Council of Ministers and the European Parliament. A Framework Programme plus a Specific Programme for RTD is eventually adopted, specifying general broad themes and level of funding.

Work programmes/calls for proposals are published by the Commission (the executive body) after consultation with a 'Health' Research Advisory Group [1] and following positive opinion by the 'Health' Programme Committee.

The main drivers of European research policy are the Council of Ministers, the European Parliament and the European Commission – in particular DG Research (RTD) and DG Health and Consumer Protection (SANCO). The European Research Area (ERA) consists of 37 countries participating in a 'Single Market for Research'. The 37 participants are the 27 EU Member States and the Enlargement Countries (Croatia, FYR of Macedonia, Montenegro, Serbia and Turkey) and the countries associated with FP7 Iceland, Israel, Liechtenstein, Norway and Switzerland).

7th Framework Programme

In December 2006 the 7th Framework Programme for RTD was launched (2007-2014) with a budget of € 6.1 billion over 7 years for Health Research.

Activities are funded in three main areas of collaborative research

- *Biotechnology, generic tools and technologies for human health*
- *Translating research for human health:* cancer, cardiovascular disease, diabetes and obesity, rare diseases, and other chronic diseases
- *Optimising the delivery of healthcare to citizens*: enhanced health promotion and disease prevention providing evidence of best public health measures – lifestyles, interventions, special focus on mental health, etc.

Future calls: Translating research for health

Two Calls for Proposals were published in 2007 (now closed) of €637 million and €553 million. The third and fourth Call work programmes are currently being discussed by the Scientific Advisory Group/Programme Committee (3rd Call publication scheduled May-June 2008). Information on Calls and the funding tools in the 'Health' theme can be found on (http://cordis.europa.eu/fp7).

Focus upon diabetes research

With some 27 million people affected in the EU (27), research into diabetes and obesity has always been one of the research priorities in the Framework Programmes. In Framework Programmes 5 and 6 (since 1998) € 240 million of EC funding has been provided for research into diabetes and obesity, approximately 5-10% of all related funding in Europe that was earmarked for this purpose.

Research into diabetes and obesity is again a priority area and the focus will be on aetiologies of the different types of diabetes and their related prevention and treatment. For obesity the focus will be on multidisciplinary approaches including genetics, lifestyle and epidemiology. For both diabetes and obesity special attention will be given to juvenile disease and factors operating in childhood.

This approach will contribute not only to research breakthroughs in treatment of diabetes/obesity but also in prevention and treatment of related complications. Considering the heavy toll taken on life expectancy by these diseases particular attention should be given to childhood aspects where possible.

There is a lack of coherent information on diabetes research in EU Member States and the diabetes epidemic requires a pooling of efforts in order to create synergies. The response to this was the first call of FP7 asking for a 'Road Map' for diabetes research. In response the Alliance for European Diabetes Research (EURADIA) submitted the DIAMAP proposal, which is retained for funding (contract pending).

This text is a summary of the presentation by Dr Hallen during: 'Diabetes Matters' at the European Health Forum Gastein, 5 October 2007.

You can listen to a web cast of Dr Hallen speaking at the Opening Ceremony of the EASD meeting, Amsterdam, 18 September 2008 [2].

Keep in touch with DG Research!

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1. Health Research Advisory Group, FP7 http//ec.europa.eu/research/fp7/index_en.cfm?pg=eag

2. EASD webcasts
www.easd-lectures.org/amsterdam/index.php?menu=view&id=198

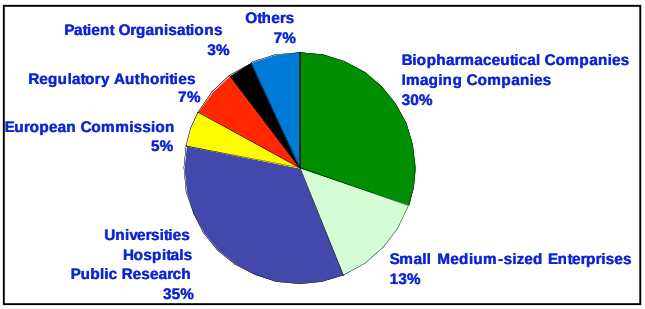
Streamlining Progress from Innovation to Implementation

Veikko Koivisto, MD: Chair, Innovative Medicines Initiative, Diabetes Group

Recent science and technology advances have provided significant new opportunities. Our understanding of human physiology has been greatly improved due to novel technology such as various 'omics, imaging, and information technologies. In order to maximise these and other opportunities, we need both public and private investment. With this support, various stakeholders, such as pharmaceutical industry, biotech companies, academic investigators and patient groups can initiate collaborative research. To avoid major intellectual property issues this should be done at a pre-competitive stage. Such a collaboration would improve our understanding of human pathophysiology, reveal novel targets for therapies and offer more effective drug discovery and development programs. These in turn will lead to better medicines and improved health, and achieve them earlier than with the current processes.

Broad consultation to develop the IMI Strategic Research Agenda

The Innovative Medicine Initiative (IMI) is a program with the objective of enhancing European competitiveness. This objective will be achieved by increasing cooperation between stakeholders to improve the R and D process. The IMI program was developed by utilising the expertise of 350 respondents, representing pharma- and imaging companies, small-medium enterprises (SMEs), academic research, regulatory authorities, patient organisations and the European Commission.



Representation of expertise utilized to develop the IMI.

IMI Strategic Research Agenda (http://www.imi-europe.org). The IMI strategic research agenda (SRA) *focuses* on five therapeutic areas: cancer, brain disorders, inflammatory diseases, metabolic disease, infectious diseases. The SRA *addresses* disease-specific efficacy challenges of predictive pharmacology, predictive toxicology, identification and validation of biomarkers, patient recruitment, and benefit/risk assessment.

The aim of the SRA is to identify pre-competitive bottlenecks in the research and development process for the above conditions, propose recommendations to address these bottlenecks and to propose new models of public/private partnership to implement those recommendations. The IMI governance is designed to foster scientific excellence, a collaborative environment, lean and efficient processes and transparency.

In the short-term a number of collaborative projects addressing the bottlenecks in the research and development process will be funded. In the long-term the research results will be applied to concrete development projects in agreement with the regulatory authorities to ensure fast access to patients.

Funding issues in IMI

For the IMI projects selected the European Commission will provide funding in cash, companies will provide support in kind (for example personnel, laboratory space) and regulators will give their expertise. Funding will be given to other IMI project participants such as academia, SMEs and patient groups. The increased collaboration will be beneficial for all stakeholders.

It will provide access to pre-competitive knowledge that has up to now been out of reach, will stimulate creativity, help to achieve critical mass, share risks of failure and enhance the learning experience, which together will generate more innovation.

IMI will help support European competitiveness
There will be an increased knowledge about diseases and biomedical tools along with more education and training in the biomedical arena. Small and medium sized enterprises will be fostered in the European environment. More R and D jobs in the EU in the public and private sectors will be created and existing talent will be retained within the EU.

Metabolic disease track: diabetes
The IMI track in metabolic diseases is focussing on diabetes as this was considered such an important and common disease. The priorities in diabetes research are:
- More predictable *in vitro*, *in vivo* an *in silico* models for diabetes and its complications
- Novel targets for the treatment of diabetes and its complications
- Novel targets for the treatment of diabetes and its complications
- Biomarkers for beta cell function and mass, insulin resistance and complications
- Genomic studies to identify responders and non-responders (tailored medicine)
- Quality of life and outcome metrics to measure benefits of new therapies

The ultimate beneficiaries of the IMI being the patients.

This text is a summary of the presentation by Dr Koivisto during: 'Diabetes Matters' at the European Health Forum Gastein, 5 October 2007.

Added for this Newsletter: Update on progress with the IMI implementation.
On the 5th November 2007, members from the Committee on Industry, Research and Energy (ITRE) discussed the "Joint Technology Initiatives" (JTIs) and "Innovative Medicines Initiative" (IMI). A global and general approach was undertaken during discussions and focus was given to the *procedures* of the JTIs rather than the *content*. The main concern was that the timing of the European Parliament and the European Commission on the implementation of JTIs does not necessarily coincide. Furthermore, the Parliament still needs answers from the EC regarding issues on staffing, discharge procedures, budgetary control and accounting/auditing, monitoring and intellectual property rights.
12 November 2007: ITRE vote on the IMI proposal.
12 December 2007: Parliament will discuss the IMI Proposal in plenary.
January/February 2008: approval by the Council of the EU and publication of the First Call topics.
End 2008: Start of research projects

Record numbers of participants at international diabetes meetings of EURADIA Partners

Attendance at the annual meeting of the European Association for the Study of Diabetes (EASD) held in Amsterdam in September reached a new peak of 14656 participants. The country totals for the meeting can be accessed on the EASD website (www.EASD.org). It is also possible to access webcasts for the lectures from this meeting.

The Federation of Nurses in Diabetes (FEND) was held immediately prior to the EASD meeting also in Amsterdam and also attracted a high level of participation. Webcasts from the presentations can be accessed on the FEND website (www.fend.org).

Pharmacogenomics: the new frontier in combating complex diseases

breakthroughs toward personalized therapies for type 2 diabetes

Philippe Froguel, MD, PhD: Chair in Genomic Medicine, Division of Medicine, Imperial College London, UK

Genomics has the potential to be extremely useful in diabetes. The hope for people with the disease from pharmacogenomics arises from an increased molecular understanding of the basis of disease (basic research) to better prevention and therapy (for clinical application and therefore directly of importance for the patient). The focus of this session was the increased molecular understanding through to improved disease classification and eventually to individualised treatment.

Approximately 5% of all people with type 2 diabetes have a monogenic form of the disease, and in the past 15 years approximately 80% of these monogenic forms have been elucidated. One of the most important of these monogenic forms is a mutation in the potassium channel and regulatory sub unit of the sulphonylurea receptor of the beta cell. The potassium channel is crucially important for diabetes because if the channel does not close in response to glucose then insulin is not secreted [1].

The example was given of Martin, a young boy with type 2 diabetes. Martin was born in 2001 and at age 18 days of life he was investigated by his family doctor for prolonged neonatal jaundice and was found to be mildly hyperglycaemic (high blood glucose). Upon re-investigation at 2.5 months, his blood glucose was very high so he was admitted to hospital and treated by insulin in 3 daily doses. At the time it was thought that this would be the treatment for the rest of his life. However, a diagnosis was made of 'permanent neonatal diabetes' due to an activating mutation in the gene encoding a subunit in the ATP-sensitive potassium channel, Kir6.2. Molecular genetic analysis of the gene (*KCNJ11*) encoding the ATP sensitive potassium channel subunit Kir6.2 showed a heterozygous missense mutation: R201H. This led in September 2004 to a change in treatment from insulin injections to glibenclamide (sulphonylurea). One week later, insulin therapy could be stopped. Martin now takes glibenclamide 1.75 mg/day and has perfectly normal blood test results and an optimal blood glucose profile.

In 2006 an EU-funded consortium studied diabetic patients with mutations in the K channel due to Kir6.2 mutations who were switched from insulin to oral sulphonylurea therapy with the result of greatly improved glucose control (HbA_{1c}: ~8% before the switch decreased to 6.4% after 12 weeks, $p<0.001$) [2]. Another example is maturity onset diabetes of the young (MODY), which is the most prevalent form of monogenic diabetes, it has an autosomal dominant mode of inheritance and age of diagnosis is often before 25 years and impaired insulin secretion is a major phenotypic trait. When comparing the response of MODY patients to metformin or sulphonylureas, HNF-1a MODY3 patients are very much more sensitive to treatment with sulphonylureas. The consequence being that sulphonylurea is probably the treatment of choice, although there is a risk of hypoglycaemia. Therefore, this genetic information has direct consequences for the treatment of the patient.

For the remaining 95% of people with type 2 diabetes the situation is different. Type 2 diabetes is a complex multifactorial polygenic disease, there is an environmental component and nature (lifestyle) plays a large role (in the development of obesity and metabolic syndrome). It has been extremely difficult to find the genes for type 2 diabetes.

There is a strong association with environmental influences: progressing from healthy overweight to severe insulin resistance and inflammation and to eventual type 2 diabetes. However, for diabetes to develop there must also be a defect in the pancreatic islets and secretion of insulin. In 2006 a significant finding was made with the gene *TCF7L2* considered to be a major gene for type 2 diabetes. When studied in different populations the gene was found to increase by 50% the risk of developing type 2 diabetes. Although the prevalence of this gene is different between each population [3].

Pharmacogenomics has also improved the understanding of environmental factors and

individual genetic prediction leading to the possibility of better prevention and early diagnosis; thus, to individualised treatment. It was shown in the Diabetes Prevention Program [4] that in patients with *TCF7L2* the progression to type 2 diabetes increased over 4 years. However, lifestyle intervention (by exercising more and eating less) was very effective and the genetic effect can be suppressed; it is possible to overcome the risk conferred by genetics.

A recent paper [5] also shows that the gene variant *TCF7L2* influences therapeutic response to drug treatment in this case to sulphonylureas but not to metformin. *TCF7L2* was genotyped and studied to see if there was a failure to reach target therapeutic response and it was found that the number reaching the goal was lower in patients with TT than the other patients (no difference with metformin). Recently, Shu Y et al. [6] showed for the first time in 40 years how metformin works. The organic cation transporter 1 (OCT1) regulates hepatic uptake of metformin. A common genetic variation in the organic cation transporter 1 (OCT1) modulates the ability of metformin to lower plasma glucose. Hence, there is a huge effect and thus it might be important to test for the gene before a patient starts on metformin treatment. Metformin is the first drug of choice in type 2 diabetes and early treatment of diabetes is extremely important for the course of the disease. Therefore, another step towards personalised medicine [7].

From these recent findings there is a need to understand better the two types of genes:
- those genes involved in *the drug mechanism of action* (OCT1, others?)
- those genes involved in *the mechanism of disease sub types* (K channel genes, *TCF7L2*, others?). There is a need to understand both kinds of genes, not only for the response to treatment but also for the development of diabetes complications. A major challenge is to have better access to data from phase 3 or 4 pharmaceutical trials.

There are other genes for type 2 diabetes, and this year has been most important in that Genome Wide Association (GWA) studies have helped to provide a genetic dissection of the disease bringing closer the possibility of '*a genetic ID card for each person with diabetes*' [8]. Such GWA studies can do an incredible amount for medicine [9], for example in the space of 3 months a new generation of genes has been found none of which had been candidate genes, which meant there had been no prior biologic assumption. All of these genes highly expressed in pancreatic beta cell and we assume they are involved in insulin secretion.

This progression towards individual genetic prediction and improved diagnosis is exemplified by work from Denmark with first generation of genes for type 2 diabetes showing that, if a person has five or six genetic mutations the risk for type 2 diabetes is multiplied by four. With the new generation of type 2 diabetes genes the risk is multiplied by 8 to 10. Preliminary analysis shows that it will be possible to achieve a good assessment of risk by genetics and this has great clinical implications for treatment of people with diabetes.

This text is a summary of the presentation by Prof Froguel during: 'Diabetes Matters' at the European Health Forum Gastein, 5 October 2007.

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8. Sladek R et al. A genome wide association study identifies novel risk loci for type 2 diabetes. *Nature* 2007; 445:881-885
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EU Diabetes working group: health and migration in the EU

The Group met on 11 September 2007 under the Chairmanship of Dr Georgs Andrejevs, MEP. The objective of this meeting was to discuss the challenges related to migration and diabetes and to develop clear recommendations on issue of diabetes and migration in the EU, as a contribution to the Portuguese EU Presidency theme and conference on "Health and Migration in the EU". Presentations were given by Dr Manuel Carballo and Dr José Manuel Boavida.

Diabetes is a serious public health concern affecting more than 31 million adults in the EU, expected to increase to more than 37 million by 2025. If not managed well, diabetes can lead to complications such as cardiovascular disease, stroke, kidney failure, amputation and blindness. Diabetes is one of the costliest health problems in the world, it also represents a major threat to the millions of migrants in Europe who appear to be at greater risk of diabetes than non-migrants. Moreover, if and when migrants do develop diabetes, health outcomes are worse compared to non-migrants, with complex economic and psychosocial implications.

In addition to genetic predisposition, other factors are likely to play an important role with respect to diabetes and migrants: psychological factors; changes in lifestyle and problems of cultural and nutritional adaptation; ways of coping with migration with a negative impact on health. Migrants seem to be at higher risk of developing diabetes in their new country, compared to when they were still in their home country. In the case of migrants, management of diabetes may be hampered by factors such as language and patient professional communication; cultural attitudes to health promotion and protection; costs of care; lack of family care and other support. Migration poses many health challenges and raises questions with respect to e.g. planning of healthcare services, training for healthcare professionals and need for more research. Given the growing prevalence of diabetes, and high rate of diabetes in migrant populations urgent action is needed.

Stimulate research and develop the evidence base: More data are needed on the reasons why migrants seem at greater risk of developing diabetes often leading to serious and costly complications. Research on diabetes and migration and systematic surveillance of migrant health issues should therefore be stimulated at national as well as EU level, through relevant programmes, such as the Programme for Community Action in the field of Health (2007-2013) and the "FP7 Programme for research and technological development 2007-13".

Develop and implement evidence-based policies and programmes: Member States should develop targeted evidence-based policies and programmes aiming to improve prevention, diagnosis and control of diabetes among migrants.

Develop tools for healthcare professionals: Targeted training programmes and other tools for healthcare professionals should be developed in order to ensure appropriate outreach to migrants based on improved communication and taking into account cultural backgrounds and beliefs.

Build partnerships and alliances: Addressing the issue of diabetes and migration will involve many stakeholders. Alliances and partnerships will need to be built between all stakeholder groups involved, such as diabetes associations, representatives of migrant groups, healthcare professionals, and policy and decision-makers.

Recognition of migrants as a vulnerable and specific target group in relevant EU health/diabetes initiatives.

Give concrete follow up to the European Parliament Declaration on diabetes adopted in April 2007: Member States and the EC should respond to the Parliament Declaration on diabetes adopted on 27 April 2006 and work towards an EU diabetes strategy and Council Recommendation for Prevention, Diagnosis and Control. Migrants should be included as a specific target group in these initiatives.

This text is a summary of the original report from the meeting.

An article on the Diabetes Working Group by John Bowis, MEP, appeared in EURADIA Newsletter, May 2007.

News from the EU

EU Directive for Good Clinical Practice in Clinical Trials discussed

A major meeting was held on 3 October in London between the European Commission and the European Medicines Agency (EMEA) with the objective of providing "an overview of the experience to date with the operation of Directives 2001/20/EC and 2005/28/EC and their implementing texts, and to describe problems encountered and offer recommendations for the future."[1] EU Directive 2001/20/EC, adopted on 4 April 2001 [2], concerns "…Good Clinical Practice in the conduct of clinical trials on medicinal products for human use".

Reports following the meeting [3, 4] suggest that the amount of paperwork is having a negative effect on resources and innovation. The overwhelming administration and delays in the system have been causing problems for industry and academia alike. The directive was adopted by EU Member States in 2001 but Member States rejected the EC proposal for an EU system of 'authorisation and control of clinical trials' [3] because of sensitivity over medicines testing resulting in 'persistent complexity.'

'According to research presented on 27 September at a conference in Barcelona organised by the European Cancer Organisation, the number of non-commercial academic clinical trials has fallen by a quarter.' Although the EMEA data showed that in fact they had increased between 2005-6 [4].

1. European Medicines Agency http://www.emea.europa.eu/meetings/conference.htm#
2. Directive 2001/20/EC of the European Parliament and of the Council of 4 April 2001 on the approximation of the laws, regulations and administrative provisions of the Member States relating to the implementation of good clinical practice in the conduct of clinical trials on medicinal products for human use.
3. O'Donnell P, EU directive 'puts people's lives at risk'. *European Voice* vol. 13 No. 37 : 11 October 2007 http://www.europeanvoice.com/archive/article.asp?id=29036
4. Watson R, Doctors disagree about directive on European clinical trials. *BMJ* 2007;335:691 http://www.bmj.com/cgi/content/full/335/7622/691-a

EU Health Strategy 2008-13: research central to health in Europe

On 23 October 2007, the European Commission adopted a new Health Strategy, "Together for Health: A Strategic Approach for the EU 2008 – 2013". Clear goals have been provided to guide future response to a wide range of health challenges along with disease prediction and prevention at the EU level while implementing a system to achieve these goals and partnering with Member States.

The strategy focuses on four principles and three strategic themes for improving health in the EU. These themes include: Fostering Good Health in an Ageing Europe, Protecting Citizens from Health Threats and Dynamic Health Systems and New Technologies. The principles incorporate a value-driven approach while taking into account the links between health and economic prosperity, combining health in all policies and reinforcing the EU's voice in global health. Implementation of the strategy indicates the mechanisms to be developed to identify priorities, define indicators, produce guidelines and recommendations as well as 'fostering exchange of good practice and measuring progress'.

Financial support will come from existing instruments until 2013: the 'Second Programme of Community Action in the Field of Health', 'Safety and Health at Work Strategy 2007-2012' 'The FP7 on Research (including Innovative Medicines Initiative)', and Regional policy programmes.

Research is pivotal to the Health Strategy with reference to new technologies including 'information and communication technologies, innovation in genomics, biotechnology and nanotechnology'. 'Best scientific evidence' must be used as the basis for a health policy 'based on shared values'. The need for more research is recognised as a major tool to support the challenges faced by populations in Europe throughout the life of citizens particularly in chronic disease.

Source: Paper on EU Health Strategy, "Together for Health: A Strategic Approach for the EU 2008-2013" http://ec.europa.eu/health/ph_overview/strategy/health_strategy_en.htm

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World Diabetes Day – Year of the Child – 14th November 2007

The United Nations adopted a resolution on 20th December 2006, following a campaign by the International Diabetes Federation, to recognize diabetes as a chronic, debilitating and costly disease. This resolution designates World Diabetes Day as a United Nations Day to be observed every year, starting with 2007.

With the United Nations' participation, in the reputation and awareness of the government and media participation on there is opportunity for an important boost campaign as well as an increase in or around 14th November 2007.

The theme of this year's World Diabetes Day campaign is Children and Adolescents. Diabetes is one of the most common chronic diseases of childhood. In response to this, the 2007 and 2008 campaigns have set out to challenge this while raising awareness of the warning signs of diabetes, encourage initiatives to reduce diabetic ketoacidosis and distribute material to support these initiatives and promote healthy lifestyles to help prevent type 2 diabetes in children.

The IDF European Region, in partnership with the International Society for Paediatric and Adolescent Diabetes (ISPAD) organized a series of events in and around the European Parliament in Strasbourg to mark World Diabetes Day 2007.

(source: www.worlddiabetesday.org)

EURADIA Partner Profile:

Servier www.servier.com

Servier is the leading independent French pharmaceutical company, established in 140 countries, with reference products for diseases of major importance. The company employs 20 000 people worldwide, including 2 600 in research and development, reflecting the deep involvement of the company in research activities. Annually, it invests 25% of its turnover in research and development. Servier aims to develop innovative drugs that address major public health problems and provide therapeutic benefit. In the space of 30 years, 30 drugs have been registered, all of which were developed by Servier's own research and development. Today, 38 drugs are currently under development (preclinical and clinical) in different research centres, with 13 in preclinical development and, in particular, two in the field of diabetes.

Servier's involvement in diabetes is also reflected by its numerous long-term partnerships with diabetes organizations worldwide. These successful cooperations between medical organizations and Servier have been translated into several grants awarded to encourage research in the field of diabetes, including the Morgagni Prize since 1997, and also a range of educational programs worldwide that enhance the ability of health care professionals to educate their diabetic patients - since 1979, with the Diabetes Education Study Group (DESG) and the Mediterranean Group fo rthe Study of Diabetes (MGSD) since 1985.

Servier is actively helping to raise awareness and diffuse knowledge about diabetes in the ADVANCE study (Action in Diabetes and Vascular Disease: Preterax and Diamicron MR Controlled Evaluation), funded by grants from Servier and the National Health and Medical Research Council of Australia. ADVANCE is designed to examine the benefits of intensive glucose and blood pressure lowering to reduce the risk of micro- and macrovascular complications in type 2 diabetes, final results are expected in September 2008. Servier is proud of its numerous collaborations, which clearly underline its prolonged commitment to international diabetes research, education, and scientific progress.

Conferences and Events

2007

28 November: Intellectual Property Rights (IPR) Helpdesk - seminar on IP in FP7. Brussels, Belgium. www.ipr-helpdesk.org

30 November: Information day Joint Research Centre (JRC), Lisbon, Portugal. http://ec.europa.eu/dgs/jrc/index.cfm?id=3930&lang=en

30 November-1 December: Ethics in stem cell research. Ghent, Belgium. www.bioethics.ugent.be/BIGconference

5-7 December: EuroBioForum, Lisbon, Portugal www.esf.org/activities/eurobiofund/eurobioforum-lisbon-2007.html

13-14 December: Genetically modified mouse models. Turku, Finland www.cascadenet.org/

2008

28 February - 2 March: Advanced Technologies and Treatments for Diabetes, Prague, Czech Republic

5-7 March: Diabetes UK Annual Professional Conference. Glasgow, www.diabetes.org.uk/Professionals/Conferences_and_events/APC2008/

27-29 March: 3rd Amsterdam diabetes Forum Amsterdam, The Netherlands

23-25 April: Dipeptidyl peptidases and related proteins (basic science, inhibitors, clinical applications). Antwerp, Belgium. Details www.congressdpp2008.com

14-17 May: European Congress on Obesity (ECO). Details http://www.eco2008.org/index.htm

16–17 May: European Diabetic Nephropathy Study Group (EDNSG), Hannover, Germany. Abstract deadline 13 January 2008 (carol.forsblom@hus.fi)

1 - 4 June: 5th World Congress on Prevention of Diabetes and its Complications. Helsinki, Finland

6-10 June: 68th Scientific Sessions of the ADA, San Francisco CA. Abstract deadline 7 January. http://scientificsessions.diabetes.org

3 - 6 July: Controversies in Cardiovascular Diseases. Berlin, Germany

13 - 16 August: International Society for Paediatric and Adolescent Diabetes (ISPAD). Durban, KwaZulu-Natal, South Africa

5-6 September: 13th FEND Annual Conference. Rome, Italy www.fend.org/conf2008/conf08.html

7-11 September: 44th Annual Meeting of the EASD. Rome Italy, http://www.easd.org/

1 - 4 October: Endocrino 2008. Lille, France

30 October - 2 November: Controversies in Diabetes, Obesity and Hypertension. Barcelona, Spain http://www.codhy.com/