The Princess Alexandra Hospital NHS Trust

NHS West Essex Clinical Commissioning Group

Diabetes FAQ

With Thanks to Dr Devesh Sennik, consultant endocrinologist at Princess Alexandra Hospital

Questions	Answers
GPs find it difficult to stop GLP1s when they do not get a reduction in HbA1c by at least 11 mmol/mol [1.0%] but do achieve the weight loss. How would you recommend they deal with this scenario?	Failure to achieve the NICE recommended targets has been recognised in the literature and the full improvement in Hba1c and weight occurs in only 60% of cases (see reference below). Patients not meeting the NICE guidelines for improvement will then need to be reviewed and will have to switch to an alternative agent in line with the NICE Type 2 guidelines (examples could include insulin or an SGLT2 agent). Some patients will have relative or serious contraindications to the other agents and a discussion about the benefits and risks of the alternative agents will have to be undertaken. Feel free to ask for advice from your local diabetologist in uncertain cases.All pateints should have a review of lifestyle factors (diet, exercise) as this can be very effective. **References:** ▪ http://www.bjd-abcd.com/index.php/bjd/article/view/15 ▪ GLP-1 receptor agonists in type 2 diabetes - NICE guidelines versus clinical practice; The British Journal of Diabetes Vol 14, No. 2 ▪ *Ken y Thong, Piya S Gupta, Melissa L Cull, Karen A Adamson, David S Dove, Susannah V Rowles, Stephanie Tarpey, Catriona Duncan, John Chalmers, Roy Harper, Paula Mcdonald, Ursula Brennan, Chris Walton, Robert EJ Ryder*
GLP1s use in combination with insulin – which patients are suitable for this combination and how should it be monitored?	Patients who do not meet treatment targets on either agent alone can be considered for the combination in line with NICE guidance. Certainly patients with insulin resistance who are on high insulin doses are a possible cohort that would benefit.
What are your views on the biosimilar glargine? Should we be switching patients?	The biosimilar glargine is appropriate to use when clinicians would otherwise use glargine. Remember that NICE guidance advises to use non-insulin analogue basal insulin in the first instance. If there are problems e.g. hypoglycaemia or nocturnal hypos then an insulin analogue should be used instead. It is always difficult to switch patients who are getting on well with insulin and I would suggest not doing this routinely but only after discussion and agreement from individual patients.
Which patients are suitable for the flozins and how should these be monitored?	The SGLT-2 inhibitors or flozins have had favourable NICE guidance advising that they can be used where type 2 diabetes is inadequately controlled. Patients will usually have tried the other oral medications such as metformin and sulphonylureas and either this strategy will have not worked or they will have had side effects/ contraindications to these agents. You should also consider these agents in circumstances related to e.g. occupation when you wish to avoid the side effects of weight gain and hypoglycaemia. The NICE guidance states that there are no additional monitoring requirements required for these agents. Patients will therefore be on annual monitoring and you should recheck an HBA1c at 3 months to assess response.

Questions	Answers
Which cohorts of patients should not be on sulphonylureas and which ones are better to use?	Please advise all patients on sulphonylureas of the dangers of hypos and how to effectively treat them. Warn drivers of their obligations under DVLA rules and offer them glucometer testing to help reduce their risk of hypos whilst driving. Patients may be at additional risk from hypos because of occupation (working from height, Group 2 driving), personal or mobility issues (eg infirm/elderly, neurological/ muscle disease or mobility problems), or the possible severity of a hypo (history of ischaemic heart disease or cardiac arrhythmia). Always consider social support networks and consider how a patient might cope with a severe hypoglycaemia event. You should consider these factors on prescribing these agents. In those at additional risk from a hypo you may wish to use an alternative agent with a reduced hypo risk and this is in line with NICE guidance. Other agents with reduced hypo risk are metformin, the DPP-4 inhibitors, SGLT-2 inhibitors and GLP-1 receptor agonists.
How do we prepare patients to start insulin sooner?	70% of patients with diabetes will go on to require insulin due to ongoing pancreatic beta cell decline. Patients should be advised of this at an early stage and this should not be seen as a failing on the patient's part (or healthcare team). Ongoing advice from a trusted HCP can be very beneficial and the motivational interviewing technique very helpful in addressing patient's concerns directly. If patients have any questions it is always useful to organise a session with a suitably trained diabetes specialist nurse or practice nurse. They can then get some insight and introduction into the needles (4-6 mm) and modern pen devices used. Patients should be advised as to the complications that occur with sub-optimally controlled diabetes and all should be offered a diabetes structured education programme (such as X-PERT) to help improve their knowledge of diabetes. Knowledge of how to recognise the carbohydrate content of food is a useful step before starting insulin and this can be done via a trained dietician or the diabetes uk website.