



2018 Diabetes Summit

Managing Diabetes: An Art and a Science

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Disclosures

- No relevant conflict of interest to report



Upon completion of this program the participant will be able to:

- ▶ Apply guidelines for management of diabetic patients' medications
 - ▶ Discuss approaches for insulin titration in diabetic patients
 - ▶ Utilize correction factors for insulin medication management
 - ▶ Discuss carbohydrate counting in regards to diabetic medication management
- 



Guiding Principles of Selecting Therapy

- ▶ Tailor to individual patient preferences (including cost), prognoses and comorbidities
 - ▶ type of diabetes
 - ▶ age
 - ▶ eating patterns
 - ▶ weight
 - ▶ physical activity habits
 - ▶ oral vs injectable
 - ▶ etc



Abbreviations

- ▶ Dipeptyl peptidase-4 inhibitors (DPP-4i)
- ▶ CrCl: Creatinine Clearance
- ▶ eGFR: estimated glomerular filtration rate
- ▶ GI: Gastrointestinal
- ▶ Glucagon Like Peptide-1 agonists (GLP-1a)
- ▶ MOA: Mechanism of Action
- ▶ MI: Myocardial Infarction
- ▶ ROA: Route of Administration
- ▶ SCr: Serum Creatinine
- ▶ SU: Sulfonylurea
- ▶ TZD: Thiazolidinediones



Egregious Eleven





AACE/ACE guidelines

- ▶ <https://www.aace.com/publications/algorithm>



Metformin

- ▶ The Gold Standard
 - ▶ preferred initial pharmacological agent for type 2 diabetes
 - ▶ if not contraindicated and if tolerated
- ▶ Given Orally
- ▶ MOA
 - ▶ Decreases hepatic glucose production
 - ▶ Improves insulin by increasing peripheral glucose uptake and utilization
- ▶ Decreases both post-prandial and FPG level
- ▶ Insulin secretion does not change = **no hypoglycemia**



Metformin

➤ DOSING

- Clinical efficacy generally not seen with doses <1500mg/day (monotherapy)
- Titrate dose up (GI side effects)
 - Start at a low dose, titrate slowly, take with food
 - Generally start at 500mg/day or 500mg BID then increase by 500mg per week if tolerated until 2000mg/day
 - Max dose 2500mg/day
 - Not much benefit after >2000mg/day
 - Most benefit = 1500-2000mg per day



Metformin

- ▶ BLACK BOX WARNING

- ▶ Lactic Acidosis

- ▶ Rare, but serious that can occur due to metformin accumulation during treatment
 - ▶ The risk of lactic acidosis increases with the degree of renal dysfunction and the patients age
 - ▶ Risk can be greatly decreased with regular monitoring of renal function and by the use of minimum effective dose



Metformin

- Contraindications

- Renal disease/dysfunction

- Excretion through the kidneys

- CHF requiring pharmacologic treatment

- In patients with stable CHF, metformin may be used if renal function is normal but should be avoided in unstable or hospitalized patients with CHF

- Known hypersensitivity to metformin HCl

- Acute or chronic metabolic acidosis, including diabetic ketoacidosis, with or without coma

Metformin

eGFR Level (mL/min per 1.73 m ²)	Action
≥ 60	No renal contraindication to Metformin Monitor renal function annually
45 – 59	Continue use Increase monitoring of renal function every 3-6 months
30 – 44	Prescribe Metformin with caution Use lower dose 50% or half of maximum dose Closely monitor renal function every 3 months Do not start new patients on Metformin
< 30	Stop Metformin

Lipska KJ, Bailey CJ, Inzucchi SE. Use of Metformin in the Setting of Mild to Moderate Renal Insufficiency. *Diabetes Care* 2011; 34: 1431-1437



Case

- ▶ AW is a 57 year old female newly diagnosed with diabetes. A1c = 8.2%. SCr 0.7 mg/dL and eGFR >60ml/min.
- ▶ What is the best therapy option based on the information given?
 - ▶ A Sitagliptin
 - ▶ B Metformin
 - ▶ C Canagliflozin
 - ▶ D Rosiglitazone



Sulfonylureas (SU)

➤ Oral medications

- Glyburide (Diabeta®, Micronase®)
 - Micronized Glyburide (Glynase®; Prestab®)
 - Glipizide (Glucotrol®, Glucotrol XL®)
 - Glimepiride (Amaryl®)
-
- MOA for all SU: Stimulate insulin secretion from the beta cells of in the pancreas



Sulfonylureas (SU)

- Contraindications
 - Renal insufficiency
 - Hepatic insufficiency
 - Type 1 Diabetes
 - Sulfonamide Allergy
 - Major Surgery
 - Severe infections/stress/trauma
 - Lactation
- High Risk Patients
 - Elderly (>60 years) whose diet is marginal, Binge drinkers, impaired hepatic or renal function



Case

- ▶ DP is an 88 year old female on metformin. Her provider wants to start a sulfonylurea.
- ▶ Which FU would be the best choice for DP?
 - ▶ A Glyburide
 - ▶ B Glipizide IR
 - ▶ C Glipizide ER
 - ▶ D Glimepiride



Thiazolidinediones (TZD)

- Pioglitazone (Actos®)
- Rosiglitazone (Avandia®)

- MOA:
 - Improves insulin sensitivity in muscle and fat tissue
 - Decreases hepatic glucose output (gluconeogenesis)

- ROA: Oral



Thiazolidinediones (TZD)

- ▶ **In patients with symptomatic heart failure, thiazolidinedione treatment should not be used**
 - ▶ Fluid retention leads to or can exacerbate heart failure
 - ▶ Treatment with both agents is not recommended in patients with NYHA (New York Heart Association) Class III or IV cardiac status (CHF)



Thiazolidinediones (TZD)

- ▶ Precaution

- ▶ Hepatotoxicity

- ▶ Avoid treatment with these agents if transaminases are $>2.5x$ the ULN (Upper limit of normal) at baseline or the patient exhibits signs and symptoms of active liver disease
 - ▶ Monitor liver function prior to initiation of therapy, then every 2 months for the first year, and periodically thereafter



Thiazolidinediones (TZD)

- ▶ Pearls

- ▶ Slow onset of action –may take up to 2 to 3 months to see full effect



Incretins

- In the body
 - Glucagon Like Peptide-1 (GLP-1)
 - Produced by GI tract when food stimulates insulin
 - Dipeptyl peptidase-4 (DPP-IV)
 - Metabolizes GLP-1
- Drugs related to natural GLP-1 and DPP-IV
 - Glucagon Like Peptide-1 agonists (GLP-1a)
 - Dipeptyl peptidase-4 inhibitors (DPP-4i)



Glucagon Like Peptide-1 agonists

- ROA: Subcutaneous injection
- MOA:
 - Promotes satiety, reduces appetite
 - Decreases postprandial glucagon secretion
 - Decreased glucagon reduces hepatic glucose output
 - Slows gastric emptying in the stomach
 - Enhances glucose-dependent insulin secretion
 - Resistant to DPP-IV degradation



Glucagon Like Peptide-1 agonists

- Caution
 - Pancreatitis
 - Renal function: in general no dose adjustments
 - Use with rapid insulin
 - Consider decreasing dose of sulfonylurea or basal insulin when used in combination with GLP-1 agonists
- **BLACK BOX WARNING**
 - Thyroid Cancer



Glucagon Like Peptide-1 agonists

- ▶ Products
 - ▶ Exenatide
 - ▶ Byetta (twice daily, renal dosing)
 - ▶ Administer within 60 minutes before morning and evening meals (do not give after meal)
 - ▶ Bydureon (once weekly)
 - ▶ Liraglutide
 - ▶ Victoza (once daily) - - Cardiovascular benefit
 - ▶ Dose titration important
 - ▶ Semaglutide
 - ▶ Ozempic (once weekly)
 - ▶ Dose titration important
 - ▶ Dulaglutide
 - ▶ Trulicity (once weekly)
 - ▶ Albiglutide - - May/June 2018 will no longer be available
 - ▶ Tanzeum (once weekly)
 - ▶ Lixisenatide
 - ▶ Adlyxin (daily)
 - ▶ Administer once daily within one hour before the first meal of the day



Case

- ▶ A provider decides to put a patient on a GLP-1 agonist. The patient wants a once a week medication.
- ▶ Which one of the following GLP-1 agonists is only once a week?
 - ▶ A Exenatide/Byetta
 - ▶ B Exenatide/Bydureon
 - ▶ C Liraglutide/Victoza
 - ▶ D More than one of the above

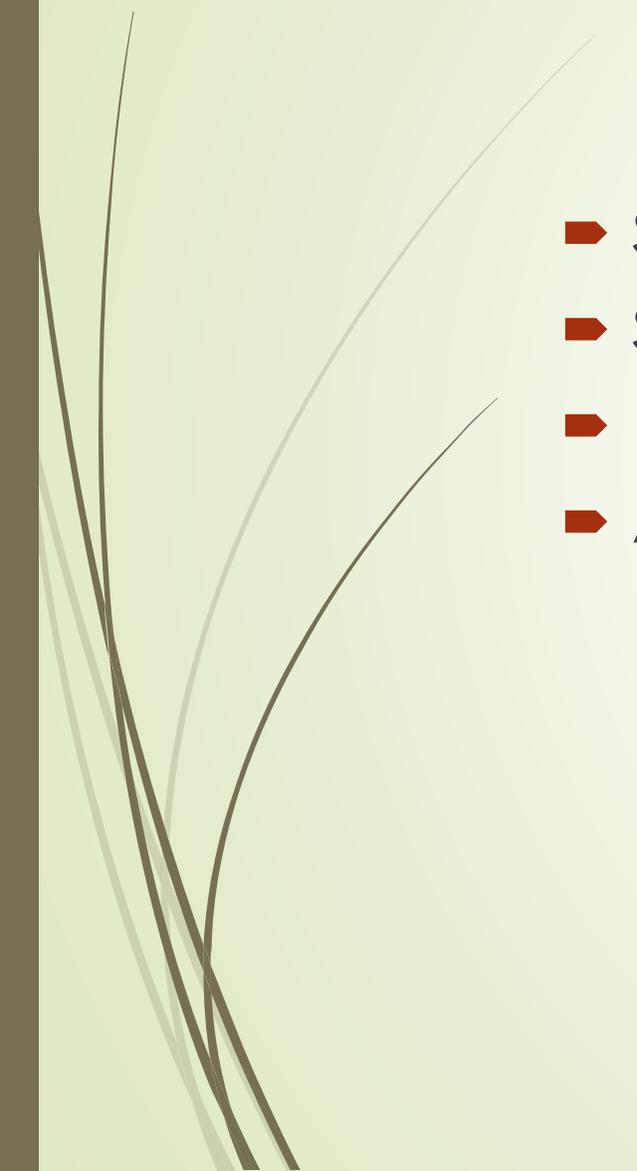


Dipeptyl peptidase-4 inhibitors

- MOA: Inhibit breakdown/metabolism of GLP-1
- ROA: Oral administration
- Administer with or without food
- Weight neutral
- CAUTION: Renal dosing



Dipeptyl peptidase-4 inhibitors

- Sitagliptin (Januvia®)
 - Saxagliptin (Onglyza®)
 - Linagliptin (Tradjenta®)
 - Alogliptin (Nesina®)
- 



Case



- ▶ Remember AW from our first case? We decided to put her on metformin.
- ▶ Five years later AW is still on the metformin.
- ▶ She now needs additional therapy.
- ▶ She is scared of injections and terrified of hypoglycemia.
- ▶ Please pick the best therapy option based on the information given
 - ▶ A Alogliptin
 - ▶ B Glyburide
 - ▶ C Exenatide
 - ▶ D Insulin



Sodium-glucose cotransporter 2 (SGLT-2) inhibitors

- MOA: Lowers renal threshold of glucose
 - insulin-independent glucose lowering by blocking glucose reabsorption in the proximal renal tubule by inhibiting SGLT2
- ROA: Oral
- Caution: Renal Dosing
- Products
 - Canagliflozin (Invokana®)
 - Dapagliflozin (Farxiga®)
 - Empagliflozin (Jardiance®) - - Cardiovascular benefit
 - Ertugliflozin (Steglatro®)



Sodium-glucose cotransporter 2 (SGLT-2) inhibitors

- Adverse Drug Effects
 - Urinary Tract Infections
 - Yeast infections
 - Hypovolemia/Decreased blood pressure
 - Hyperkalemia
 - Increased LDL cholesterol
 - Hypoglycemia with Empagliflozin
 - FDA Safety Announcement: may lead to ketoacidosis (05-15-2015)



Case

- ▶ UG is a 69 year old male who is on metformin 2000mg XR once daily by mouth and dulaglutide. His BP is 110/72. SCr ~1. His provider thinks UG needs another agent added to therapy.
- ▶ Given the following options, which would be the best choice for UG?
 - ▶ A Sitagliptin
 - ▶ B Exenatide
 - ▶ C Dapagliflozin
 - ▶ D Glipizide



Case

- ▶ LL is a patient with a high copay for brand name medications. He is already on metformin 850mg three times daily.
- ▶ Which of the following classes would be the cheapest option for LL?
 - ▶ A SGLT-2 inhibitor
 - ▶ B DPP4 inhibitor
 - ▶ C Sulfonylurea
 - ▶ D GLP-1 agonist

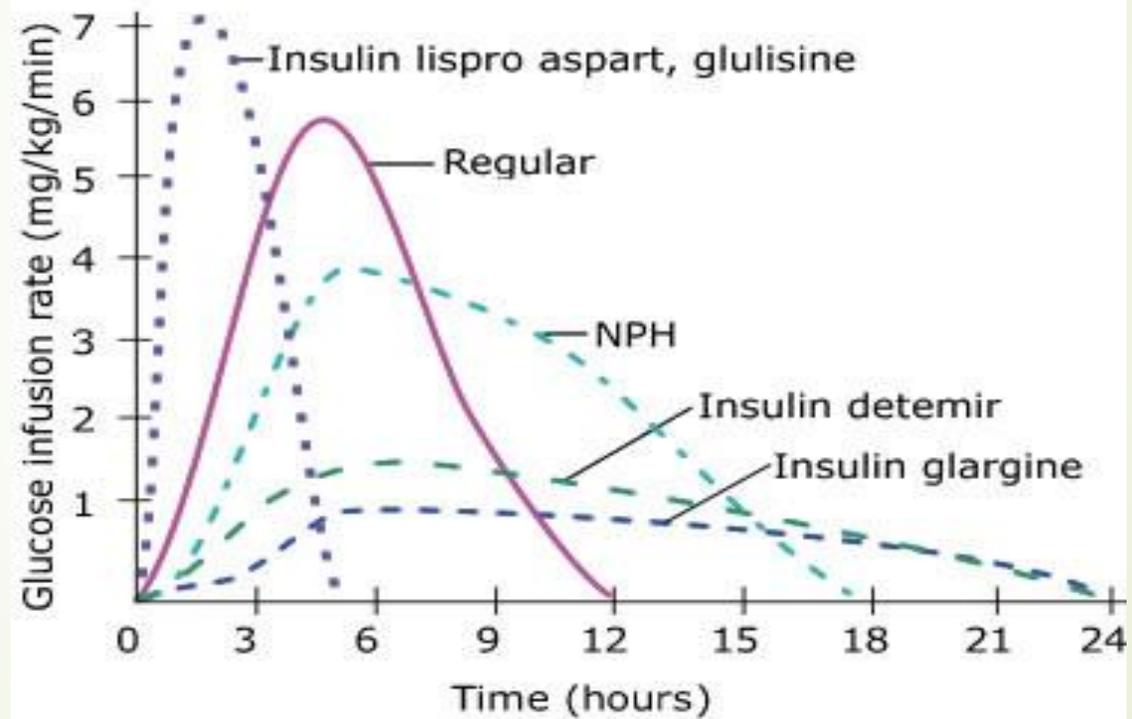


Insulin

- ▶ MOA: exogenous source of insulin
- ▶ ROA: Insulin is destroyed by stomach acid so it cannot be taken orally.
 - ▶ Subcutaneous Injection, Inhalation, intravenous (special situations)
 - ▶ Sites for injection: Abdomen, arms, thighs, buttocks
 - ▶ rotate within one area systematically
 - ▶ do not mix with GLP-1 agonists or inject in same spot
- ▶ Goal of insulin therapy: achieve tight control while avoiding hypoglycemia
- ▶ Side effects: weight gain, hypoglycemia
- ▶ Fear of needles

Insulin

Activity Profiles of Different Types of Insulin





Long Acting (Basal) Insulin

- ▶ Insulin glargine (Lantus 100 units/mL) (Toujeo 300 units/mL) (Basaglar 100 units/ml)
 - ▶ pH ~4
 - ▶ may cause more pain at injection site
 - ▶ Per package insert “higher doses of Toujeo were required to achieve similar levels of glucose control compared to Lantus in clinical trials”
 - ▶ Pregnancy Category C
- ▶ Insulin detemir (Levemir 100 units/mL)
 - ▶ pH ~7.4
 - ▶ Pregnancy Category B
- ▶ Insulin degludec (Tresiba 100 units/mL or 200 units/mL)
 - ▶ pH ~7.4
 - ▶ Pregnancy Category C
 - ▶ Less nocturnal hypoglycemia in studies



Long Acting (Basal) Insulin

- ▶ Do not mix or dilute with any other insulin or solution
- ▶ Insulin degludec
 - ▶ Once daily dosing
- ▶ Insulins glargine and detemir
 - ▶ Once (Or twice) daily dosing



Intermediate acting insulin

- ▶ Humulin N
- ▶ Novolin N

- ▶ Humulin N: May be mixed with regular or insulin lispro before injection. Regular or insulin lispro should be drawn into the syringe first, with injection occurring immediately after mixing.
- ▶ Novolin N may be mixed with regular insulin in the same syringe.



Short Acting Insulin

- ▶ Humulin R
- ▶ Novolin R

- ▶ Give 30-60 minutes before a meal
- ▶ May be mixed with longer-acting insulin (excluding regular insulin[concentrated]); regular insulin must be drawn into the syringe first.

- ▶ Generally 100 units/ml



Short Acting Insulin

- ▶ Humulin R available as a prefilled pen device or vial containing U-500 strength insulin (500 units/mL) for patients who require more than 200 units per day
 - ▶ The safety and efficacy of Humulin R U-500 used in combination with other insulins has not been determined.
 - ▶ Dosing errors have occurred when Humulin R U-500 was administered with syringes other than a U-500 insulin syringe. Patients should be prescribed U-500 syringes for use with Humulin R U-500 vials. The dose of Humulin R U-500 should always be expressed in units of insulin.



Rapid Acting Insulin

- ▶ When compared with regular insulin, rapid acting insulin has a more rapid onset and shorter duration of activity
- ▶ Used to control post-prandial sugars
- ▶ Should be administered within 15 minutes before or immediately after a meal
- ▶ -100 units/mL

- ▶ Insulin aspart (Novolog)
 - ▶ Pregnancy Category B
 - ▶ Also available as Ultra Rapid Acting (Fiasp)
- ▶ Insulin lispro (Humalog)
 - ▶ Pregnancy Category B
 - ▶ Also available 200 units/ml
- ▶ Insulin glulisine (Apidra)
 - ▶ Pregnancy Category C



Combination Products

- ▶ Insulin Mixes

- ▶ Insulin 70/30 (70% NPH 30% Regular)
- ▶ Mixtard 70/30, Novalin 70/30, Humulin 70/30
- ▶ Humulin 50/50 (50% NPH 50% Regular)
- ▶ Humalog 75/25 (75% insulin lispro protamine and 25% insulin lispro)
- ▶ NovologMix 70/30 (70% insulin aspart protamine and 30% insulin aspart)
- ▶ Twice daily dosing generally

- ▶ GLP-1/basal insulin

- ▶ Soliqua 100/33: combination of insulin glargine and lixisenatide injection
- ▶ Xultrophy 100/3.6: combination of insulin degludec and liraglutide



GLP-1 /basal insulin combination

- ▶ Soliqua 100/33: combination of insulin glargine and lixisenatide injection
 - ▶ In patients inadequately controlled on less than 30 units of basal insulin or on lixisenatide, the starting dosage is 15 units (15 units insulin glargine/5 mcg lixisenatide) given subcutaneously once daily.
 - ▶ In patients inadequately controlled on 30 to 60 units of basal insulin, the starting dosage is 30 units (30 units insulin glargine/10 mcg lixisenatide) given subcutaneously once daily
 - ▶ *Inject once a day within the hour prior to the first meal of the day*
 - ▶ *Max dose 60 units per day*
- ▶ Xultrophy 100/3.6: combination of insulin degludec and liraglutide
 - ▶ Recommended starting dosage is 16 units (16 units of insulin degludec and 0.58 mg of liraglutide) given subcutaneously once daily
 - ▶ *Administer once daily at same time each day with or without food*
 - ▶ *Max dose 50 units per day*

Summary Table

Antihyperglycemic Therapy	<i>Metformin</i>	<i>Sulfonylureas</i>	<i>TZDs</i>	<i>DPP4-i</i>	<i>SGLT2-i</i>	<i>GLP-1</i>	<i>Insulin (basal)</i>
Route	Oral	Oral	Oral	Oral	Oral	Inject	Inject
Hypoglycemia risk	Low	Moderate	Low	Low	Low	Low	HIGH
Weight	Neutral/Loss	Gain	Gain	Neutral	Loss	Loss	Gain
Adverse effects	GI	Hypoglycemia	Edema	Rare	Genital urinary infections, dehydration	GI	Hypoglycemia
Costs	Low	Low	Low	High	High	High	Variable
Efficacy (A1c lowering)	High (1-1.5%)	High (1-1.5%)	High (1-1.5%)	Intermediate (0.5-1%)	Intermediate (0.5-1%)	High (0.8-1.8%)	Highest (1.5-3.5%)



Case

- OP is a 49 year old male newly diagnosed with diabetes. A1c 12.4%, SCr 0.8. He only wants to be on one medication.
- Which ONE medication would be best for OP
 - A Sitagliptin
 - B Metformin
 - C Dapagliflozin
 - D Insulin



Insulin

- ▶ There are different regimens used for dosing insulin in those who use basal/bolus insulin:
 - ▶ Fixed dose (with or without correction scale)
 - ▶ Sliding Scale
 - ▶ Matching insulin to carbohydrate
- ▶ Follow up for titration can include
 - ▶ Self titration by patient
 - ▶ Diabetic educators
 - ▶ Pharmacists
 - ▶ RNs
 - ▶ Others
- ▶ Methods
 - ▶ Self- titration
 - ▶ Phone
 - ▶ Office visit
 - ▶ Electronic messaging



Dosing insulin: Fixed dose insulin

- ▶ Set amount of insulin is given at each meal (can be the same for each meal or vary)
- ▶ Very rigid regimen
 - ▶ Based on the assumption that all meals eaten will contain the same amount of carbohydrates
- ▶ Good for those who eat the same type and quantity of food on a day-to-day basis or need an easy to use method



Starting Insulin

- ▶ Start with bedtime intermediate acting insulin OR bedtime or morning long acting insulin
 - ▶ Start with 10 units (non weight based dosing)
 - ▶ ~0.2 units/kg (weight based dosing)



Meal time insulin

- ▶ If patient's basal insulin has been optimized but further control is still needed
- ▶ Start one injection of meal time insulin to either breakfast or main meal of the day
 - ▶ Can use TDD (see below) or start at 2-6 units and titrate up based on blood sugars
- ▶ Or if you want to start both basal and bolus at once:
- ▶ If patient needs to be on basal and prandial then use 0.3-0.5 units/kilogram for an estimate. (Note: some sources will also say 0.2-0.4 units/kg) (50% long acting 50% prandial) (The 50% of prandial would be split between the number of doses per day. For example if the patient's insulin requirement was 60 units, 30 units would be for prandial divided into 3 meals would be 10 units with breakfast, 10 units with lunch, 10 units with supper
 - ▶ Keep in mind, patient may not need prandial insulin with every meal depending on blood sugars



Adjusting insulin

- ▶ Look for patterns
 - ▶ Running high or low
 - ▶ Reasons for high or low values out of the ordinary
 - ▶ Adherence
 - ▶ Look at average and range
- ▶ Can titrate every ~3 days until glycemic goal is reached
- ▶ Example:
 - ▶ FBG average >180 mg/dL Add 4 units basal
 - ▶ FBG average 140-180 mg/dL Add 2 units basal
 - ▶ FBG average 110-139 mg/dL Add 1 unit basal
 - ▶ If Blood glucose <70 mg/dL reduce total dose by 10-20%
 - ▶ If Blood glucose <40 mg/dL reduce total dose by 20-40%
 - ▶ If post prandial not <140-<180: increase prandial insulin by ~ 10%
- ▶ Self titration – many examples
 - ▶ 1 unit per day until fastings <130 mg/dL



Dosing insulin: matching insulin to carbohydrates

- ▶ Insulin is based on two factors: amount of carbohydrates eaten and the difference between actual blood glucose and target blood glucose
 - ▶ Insulin to carbohydrate ratio: indicates how many carbohydrates 1 unit of insulin will cover
 - ▶ Correction factor: indicates the glucose lowering power of 1 unit of insulin
- ▶ EX: if an individual had an insulin to carb ratio of 15 and a correction factor of 50, it would mean that they would take 1 unit of insulin for every 15 grams of carbohydrates eaten and 1 unit of insulin would lower their blood glucose by 50
- ▶ More flexible than other methods as it allows for differences in carbohydrate intake and pre-meal glucose levels
- ▶ More involved than other methods and only for those willing to put in the extra time



Dosing insulin: sliding scale

- ▶ Varies the dose of insulin based on the blood glucose level
 - ▶ The higher the blood glucose, the higher the insulin dose
- ▶ Must monitor blood sugars before meals to get an accurate reading
- ▶ Works well for those who want more control over blood glucose and willing to do the extra monitoring



Sliding Scale Pros/Cons

➤ Pros

- Fewer calculations for patients than CHO counting
- Fairly convenient for patients

➤ Cons

- Does not prevent hyperglycemia
- More frequent glucose checks & nursing time for those in SNF/LTC
- Cannot be personalized
 - Does not take into effect the diet, weight or insulin history

Sliding Scale Examples

▶ Very low schedule (Insulin-sensitive)

- ▶ BG 150-199: 0.5 unit Bolus Insulin (regular or rapid-acting)
- ▶ BG 200-249: 1 units Bolus Insulin
- ▶ BG 250-299: 1.5 units Bolus Insulin
- ▶ BG 300-349: 2 units Bolus Insulin
- ▶ BG Over 350: 2.5 units Bolus Insulin

▶ Low schedule

- ▶ BG 150-199: 1 unit Bolus Insulin (regular or rapid-acting)
- ▶ BG 200-249: 2 units Bolus Insulin
- ▶ BG 250-299: 3 units Bolus Insulin
- ▶ BG 300-349: 4 units Bolus Insulin
- ▶ BG Over 350: 5 units Bolus Insulin

▶ Medium schedule

- ▶ BG 150-199: 1 unit Bolus Insulin (regular or rapid-acting)
- ▶ BG 200-249: 3 units Bolus Insulin
- ▶ BG 250-299: 5 units Bolus Insulin
- ▶ BG 300-349: 7 units Bolus Insulin
- ▶ BG Over 350: 8 units Bolus Insulin

▶ High schedule (Insulin-resistant)

- ▶ BG 150-199: 2 unit Bolus Insulin (regular or rapid-acting)
- ▶ BG 200-249: 4 units Bolus Insulin
- ▶ BG 250-299: 7 units Bolus Insulin
- ▶ BG 300-349: 10 units Bolus Insulin
- ▶ BG Over 350: 12 units Bolus Insulin



Sliding Scale

- ▶ Not continually recommended
 - ▶ ADA, CMS and AMDA all say not to use
 - ▶ ADA: avoid the sole use of SSI, it was recently added to the Beers Criteria for potentially inappropriate medication use in older adults.
 - ▶ Leads to wide glucose excursions and is a burden for patients



Correction Factor Insulin

- ▶ Correction factor: the mg/dL drop in blood glucose caused by 1 unit of insulin
- ▶ Used to make insulin adjustments to keep blood glucose levels within target
- ▶ Useful when:
 - ▶ More insulin is needed at a mealtime to correct for a high glucose level
 - ▶ Correct a high blood glucose level outside of a meal time
- ▶ In either case, patient will need to know how many mg/dl one unit of insulin lowers their blood glucose level

Calculating Correction Factor

1. Calculate total amount of insulin per day (basal + bolus)
Ex.) Basal= 15 units, Bolus= 5 units of Novolog three times/day= 15 units
Total Daily Insulin= 15 + 15= 30 units
2. Divide 1800 by Total Daily Insulin if using RAPID-acting insulin = Correction factor
Divide 1500 by Total Daily Insulin if using REGULAR insulin = Correction factor

$$1800/30 = 60$$

Correction Factor= 60

This means that 1 unit of insulin will lower blood glucose by approximately 60 mg/dL



Using Correction Factor to Calculate Correction DOSE

- ▶ Correction bolus formula:
 - ▶ $(\text{Current BG} - \text{Target BG}) / (\text{Correction Factor})$
- Ex: Current BG= 220 mg/dL
Target BG= 100 mg/dL
Correction factor= 60
- ▶ $(220 - 100) / (60) = 120 / 60 = 2$
- ▶ Correction dose = 2 units of insulin
- ▶ A correction dose of insulin would be added to the normal dose that would be taken with a meal
 - ▶ This ensures that the patient will reach his or her glycemic target after a meal



Take Home Points

- ▶ Personalize diabetes medications and goals based on patient factors
- ▶ There are many approaches to adjusting insulin. One person may be more conservative, one more aggressive
 - ▶ Protocols to follow in many cases
 - ▶ We develop our own “style”
- ▶ The best medication is the one that the patient will take correctly
- ▶ Always encourage lifestyle changes
- ▶ If a patient is not at goal, look to increase dose or add on another medication

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THANK YOU!!

- ▶ Any questions??

- ▶ Contact info:

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