National Institute for Health and Clinical Excellence

Type 2 Diabetes in Adults
Scope Consultation Table
04.07.2012 - 29.08.2012

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
SH	Abbott Diabetes Care	1	4.3.1 (a)	The scope extends to the pharmacological management of blood glucose levels and therefore we would propose recommendation specifically on intensification of insulin in type 2 diabetes. □ Lasserson, D. S., P. Glasziou, et al. (2009). "Optimal insulin regimens in type 2 diabetes mellitus: systematic review and meta-analyses." Diabetologia 52(10): 1990-2000.	Thank you for your comment. The review question relating to pharmacological management of blood glucose levels aims to cover the use of insulin treatment in type 2 diabetes, including intensification of insulin therapy where appropriate.
SH	Abbott Diabetes Care	2	4.3.1 (b)	We propose that the recommended target for blood glucose control in adults be consistent with targets recommended by EASD and ADA: HbA1C 7.0% Preprandial capillary plasma glucose 70–130 mg/dL(3.9–7.2 mmol/L) Peak postprandial capillary plasma glucose < 180 mg/dL(< 10.0 mmol/L) □ Standards of Medical Care in Diabetes - 2012, Diabetes Care. 2012;35: S11-63.	Thank you for your comment. Target levels for Hba1c levels will be addressed within a specific review question. A systematic review of the literature will be carried out and the guideline development group will make recommendations based on the included evidence. For this section, the group may also discuss the evidence that the European Asociation for the Study of Diabetes (EASD) and the American Diabetes Association (ADA) guidelines are based on but the final guidance will not specifically refer to EASD and ADA guidelines.
SH	Abbott Diabetes Care	3	4.3.1 (c)	When making recommendations on self-monitoring of blood glucose for people with type 2 diabetes, we recommend that DVLA guidance be considered in order to address issues around self-monitoring of blood glucose and people with type 2 diabetes on oral medications. There are a number of legal cases that describe the consequences of hypoglycaemia at the wheel of a vehicle.	Thank you for your comment. We recognise that self-monitoring of blood glucose is an important area. A systematic review of the clinical evidence around self-monitoring of

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				□ http://www.dft.gov.uk/dvla/medical/ataglance.aspx □ R v. Clarke [2010] 1 Cr App R (S) 26 □ R v. JG [2006] EWCA Crim 3276	blood glucose will be carried out and the guideline development group will make recommendations based on this evidence. The guideline development group will also take into consideration the safety of medications on the person's activities of daily living, including driving throughout the development of the guideline. Specifically, all definitions of hypoglycaemia will be included as part of the evidence review and appropriate guidance from the DVLA will be discussed.
SH	Abbott Diabetes Care	4	4.3.1 (c)	We suggest that it is important within the scope of effectiveness of self-monitoring for blood glucose that guidelines be specific and deliver targeted recommendations for patient groups dependent on the type of therapy.	Thank you for your comment. The review question on self-monitoring will address whether self-monitoring should be used to manage blood glucose levels in adults with type 2 diabetes. Section 4.3.1 (c) has been updated to clarify that targets, frequency of monitoring, timing and site of testing in relation to self-monitoring will all be looked at as part of this clinical area. This question will also look at the use of self- monitoring for people who use blood glucose lowering therapies (oral medication and insulin) and those who do not use blood glucose lowering therapies (i.e. those who may be treated with lifestyle interventions alone). The specific comparisons that will be included

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					within this review question will be discussed and agreed with the guideline development group during the development of the guideline. The recommendations will be based on a systematic review of the evidence and the clinical expertise of the guideline development group. However, the included evidence may limit the level of detail that may be provided in the recommendations.
ts SH	Merck Sharp & Dohme	1	3.2.a	The draft scope states that "*The NICE-recommended target for blood glucose control is haemoglobin A1c (HbA1c) of 59 mmol/mol or lower, or below 7.5%. However specific targets may be individualised to meet people's needs, taking into consideration their risk of hypoglycaemia, cardiovascular risk and comorbidities*". We believe this requires clarification, as it is at odds with recommendation 1.3.1 of CG87: "*involve the person in decisions about their individual HbA1c target level, which may be above that of 6.5% set for people with type 2 diabetes in general*" (Ref 1). Additionally, the quick reference guide produced to support CG87 (Ref 2) includes an algorithm for appropriate use of blood glucose lowering therapy. This states that if HbA_{1c} is ≥ 6.5% when following lifestyle interventions or metformin first-line therapy, it is appropriate to consider (additional) pharmacological treatment. Whilst a threshold of 7.5% is referred to in the context of stepping-up to triple therapy (after dual-therapy no longer provides adequate control of HbA_{1c}), referring to this as the "NICE-recommended target" is misleading. Ref 1: NICE clinical guideline 87: Type 2 diabetes – the management of type 2 diabetes – May 209. Available at: http://guidance.nice.org.uk/CG87 (accessed 20 August 2012) Ref 2: NICE Quick Reference Guide – Type 2 Diabetes – The management of type 2	Thank you for your comment. Section 3.2 (a) has been updated to reflect the current recommended target.

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				diabetes – May 2009. Available at: http://www.nice.org.uk/nicemedia/live/12165/44322/44322.pdf (accessed 20 August 2012)	
SH	Merck Sharp & Dohme	2	4.3.1.a	MSD support the inclusion of sulphoylureas in the list of glucose-control therapies, which are to be reviewed within the context of the subject of pharmacological management of blood glucose.	Thank you for your comment.
SH	Merck Sharp & Dohme	3	4.3.1.a	We would like to draw to NICE's attention that since publication of CG87, the following indications have been approved for sitagliptin, and are detailed in the product SmPC (Ref 3): • For adult patients with type 2 diabetes mellitus, sitagliptin is indicated to improve glycaemic control as triple oral therapy in combination with a PPARγ agonist and metformin when use of a PPARγ agonist is appropriate and when diet and exercise plus dual therapy with these medicinal products do not provide adequate glycaemic control. (Approved in June 2009) • For adult patients with type 2 diabetes mellitus, sitagliptin is indicated to improve glycaemic control as monotherapy in patients inadequately controlled by diet and exercise alone and for whom metformin is inappropriate due to contraindications or intolerance. (Approved in August 2009) • Sitagliptin is also indicated as an add-on to insulin (with or without metformin) when diet and exercise plus stable dose of insulin do not provide adequate glycaemic control. (Approved in November 2009) Sitagliptin may now also be used in patients with moderate and severe renal impairment (CrCl < 30 mL/min), or with end-stage renal disease requiring haemodialysis or peritoneal dialysis. Ref 3: SmPC for Januvia ® ▼25 mg film-coated tablets; 50 mg film-coated tablets; 100 mg	Thank you for your comment. The new licensed indications for all pharmacological agents listed in section 4.3.1 (a) will be updated following CG87 so that they are in line with current Summary Product Characteristics (SmPCs) and will be included as part of the evidence review. The specific drug comparisons that will be included within this review question will be discussed and agreed with the guideline development group during the development of the guideline.

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				film-coated tablets. Available at: http://www.medicines.org.uk (accessed 20 August 2012)	
SH	Merck Sharp & Dohme	4	4.3.2.d	We note that, whilst the draft scope proposes that recommendations for liraglutide (TA203) and exenatide (prolonged release; TA248) will not be updated in the guideline, the Guidance Executive (GE) document for these TAs (under a parallel consultation) recommends that both should be reviewed within the on-going update of CG87 (Ref 4). The GE proposal states that it is unfair to preserve the funding direction for two products in the GLP-1 class, when it does not apply to others. The proposal also states that consideration of the most clinically and cost effective positions for these treatments is best considered in the context of the entire treatment pathway, and this can only be assessed in the context of a clinical guideline. With the GE proposal in mind, we question the rationale for excluding SGLT-2 inhibitors in the draft scope, which states that these drugs will be covered by separate technology appraisals. This is at odds with the GE's rationale for TA 203 and TA 248, as well as NICE's position on DPP-4 inhibitors, none of which have been reviewed by the TA route (including those licensed after publication of CG87). Ref 4: Guidance Executive - TA203 Diabetes (type 2) - liraglutide: appendix B proposal paper "Review of TA203; Liraglutide for the treatment of type 2 diabetes mellitus, and TA248; Exenatide prolonged release suspension for injection in combination with oral antidiabetic therapy for the treatment of type 2 diabetes" – August 2012. Available at: http://guidance.nice.org.uk/TA203/ReviewProposal (accessed 20 August 2012)	Thank you for your comment. Technology appraisals (TA) TA203 (liraglutide) and 248 (prolonged-release exenatide) were based on recommendations from clinical guideline (CG) 87. Because the update of the clinical guideline CG87 and clinical guideline CG66 is scheduled to consider exenatide, this could result in a change to the recommendations in TA203 and TA248. In August 2012 the Centre for Technology Evaluation (CHTE) at NICE therefore consulted on a proposal for TA203 and TA248 to be updated in the update of clinical guidelines CG66 and CG87. After consultation NICE agreed to update TA203 and TA248 within the update of the clinical guidelines CG66 and CG87. Once the guideline is published the technology appraisals will be withdrawn. The Centre for Technology Evaluation (CHTE) at NICE are currently developing guidance on the SGLT-2 inhibitors Dapagliflozin in combination therapy for the treatment of type 2 diabetes (ID427) and Canagliflozin for type 2 diabetes

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					mellitus (ID554). The update of clinical guideline CG87 and clinical guideline CG66 will incorporate this guidance subject to a technology appraisal review proposal agreement
SH	ELCENA JEFFERS FOUNDATION	1	'general'	Commenting on the whole document. EJF members, agree with the NICE guidelines on diabetes, and wishes to use the information to inprove their quality of life as persons who lives with diabetes and to share information with professionals.	Thank you for your comment.
SH	The University of Glamorgan	1	1	Our comments are as follows: the title is: Type 2 Diabetes: management of type 2 diabetes, yet the guidance for 'Type 1 Diabetes' and 'diabetes in children' includes diagnosis. Our view is that accurate diagnosis is essential to appropriate treatment and should be included and that the guidelines should have a consistent approach	Thank you for your comment. Although we recognise the importance of diagnosing type 2 diabetes, this clinical issue was not prioritised for update during the scoping process for type 2 diabetes clinical guideline. However, as diagnosis and differentiation between type 1 and type 2 diabetes are being covered in the type 1 diabetes guideline, we will be able to cross-refer to appropriate recommendations made for diagnosis within this guideline. There will not be a separate evidence review focusing on diagnosis in the type 2 diabetes update.
SH	Department of Health	7	3.1	Mention of hypoglycaemia and that acute severe hypoglycaemia is a life threatening emergency.	Thank you for your comment. Hypoglycaemia has been specifically considered in section 3. 1 (d)
SH	Department of Health	8	3.1	Mention of the importance of early diagnosis as UKPDS showed that 50% have complications at diagnosis.	Thank you for your comment. This has been incorporated into section 3.1 (c)

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SH	Royal College of Pathologists	1	3.1 c)	This paragraph conveys the impression that the complications of diabetes are due solely to hyperglycaemia. Type 2 diabetes results in, or is part of, a constellation of metabolic disturbances together termed the Metabolic Syndrome, and importantly including dyslipidaemia. Although reference is made later to the NICE Guideline on lipid modification, the importance of dyslipidaemia and its control in type 2 diabetes in order to prevent cardiovascular disease, should be given more prominence at this point.	Thank you for your comment. We recognise dyslipidaemia is an important issue within the adult population with type 2 diabetes. However, section 3.1 (c) is only intended to provide a brief overview of some of the complications that can occur in people with type 2 diabetes
SH	Diabetes UK	1	3.1.(b)	NICE Public Health Guidance *Preventing Type 2 Diabetes: Risk identification and interventions for individuals at high risk* includes people of Chinese family origin as a group in which type 2 diabetes is more prevalent (p.44): "In the UK, type 2 diabetes is more prevalent among people of South Asian, Chinese, African–Caribbean and black African descent than among the white population. People in these groups tend to develop it at a younger age (DH 2006). They also tend to progress from impaired glucose tolerance to diabetes much more quickly (more than twice the rate of white populations) (Webb et al. 2011)."	Thank you for your comment. Section 3.1 (b) has been amended to include people of Chinese family origin.
SH	Diabetes Trials Unit	1	3.1.a	First sentence: Replace "…initially and insulin-resistant state" with "a condition of insufficient insulin often exacerbated by insulin resistance…" Second sentence: Replace "…may be needed because of the continuing failure of insulin secretion." with "…will be needed by the majority of people as their insulin secretion declines over time."	Thank you for your comment. Section 3.1 (a) has been updated and reads as follows: "Type 2 diabetes is a condition of insufficient insulin often exacerbated by insulin resistance …insulin therapy may eventually be needed by the majority of people as their insulin secretion declines."
SH	Department of Health	9	3.1c	Should there not be a distinction between acute and chronic hyperglycaemia and their effects?	Thank you for your comment. We recognise this distinction but ordinarily do not include this level of detail in the scope. When developing the guideline we will consider the effects of acute and chronic hyperglycaemia as part of the evidence review.

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SH	Novartis Pharmaceuticals Ltd	1	3.2 (a)	Will there be a review of the evidence of whether or not this is still the most appropriate HbA_{1c} target level?	Thank you for your comment. Optimum target levels for Hba1c will be addressed within a specific review question. A systematic review of the literature will be carried out and the guideline development group will make recommendations based on the included evidence.
SH	Novo Nordisk Ltd	1	3.2 (d)	We note that this paragraph outlines that there are new members of the dipeptidyl peptidase 4 (DPP-4) inhibitor class available. We would like to point out that liraglutide, a GLP-1 mimetic, is also available, although this was not included in the previous version of the clinical guidelines, but indeed was given a positive Single Technology Appraisal (STA) by NICE.	Thank you for your comment. Technology appraisals (TA) TA203 (liraglutide) and 248 (prolonged-release exenatide) were based on recommendations from clinical guideline (CG) 87. Because the update of the clinical guideline CG87 and clinical guideline CG66 is scheduled to consider exenatide, this could result in a change to the recommendations in TA203 and TA248. In August 2012 the Centre for Technology Evaluation (CHTE) at NICE therefore consulted on a proposal for TA203 and TA248 to be updated in the update of clinical guidelines CG66 and CG87. After consultation NICE agreed to update TA203 and TA248 within the update of the clinical guidelines CG66 and CG87. Once the guideline is published the technology appraisals will be withdrawn. The Centre for Technology

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					Evaluation (CHTE) at NICE are currently developing guidance on the SGLT-2 inhibitors Dapagliflozin in combination therapy for the treatment of type 2 diabetes (ID427) and Canagliflozin for type 2 diabetes mellitus (ID554). The update of clinical guideline CG87 and clinical guideline CG66 will incorporate this guidance subject to a technology appraisal review proposal agreement.
SH	Royal College of Pathologists	2	3.2 a)	'Many people start on metformin therapy, but some may also need insulin....'. Reference to use combination oral hypoglycaemic therapy could be made at this point, although it is well covered elsewhere.	Thank you for your comment. Section 3.2(a) has been updated to include reference to additional or alternative blood glucose lowering agents.
SH	Diabetes UK	2	3.2.(a)	Should this paragraph include other glucose-control therapies?	Thank you for your comment. Section 3.2(a) has been updated to include reference to additional or alternative blood glucose lowering agents.
SH	Diabetes Trials Unit	2	3.2.a	Replace first two sentences with "Initial management of type 2 diabetes typically involves lifestyle interventions together with metformin, although as the condition progresses other oral glucose-lowering agents may be needed to control blood glucose levels. Many people will progress to needing insulin therapy as their insulin secretion declines over time. Fourth sentence: Replace "59 mmol/mol" with "58 mmol/l"	Thank you for your comment. Section 3.2 (a) has been updated to include reference to additional or alternative blood glucose lowering agents. Blood glucose target levels have also been updated to reflect the current recommendations.
SH	Department of Health	11	3.2b	Recognition of the fact that many people will need insulin eventually due to complete failure of the pancreatic beta cells to produce insulin.	Thank you for your comment. We have made reference to the point that many people may eventually

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					need insulin in section 3.2 (a).
SH	Department of Health	10	3.2c	I found this paragraph a bit of a muddle; I think it should mention that there are newer classes of agents for lowering blood glucose. That safety concerns apply to specific classes of agents and that it is lipid lowering agents that have come off patent.	Thank you for your comment. Section 3.2 (c) has been re-worded to ensure these points are clarified.
SH	Department of Health	12	3.2d	This could be incorporated into 3.2 c.	Thank you for your comment. The points made in 3.2 (d) have now been incorporated into 3.2 (c).
SH	The University of Glamorgan	2	4,1,1 (b)	If you are specifying sub-groups consideration should be given to end of life/palliative care	Thank you for your comment. Section 4.1.1 sets out example sub-groups of the population where the management of type 2 diabetes may differ, however this list is not exhaustive. The guideline development group may make specific recommendations for sub-groups of the population based on the evidence reviewed and the clinical expertise of the group. For instance, if the included evidence provides specific information relating to end of life/palliative care, this information will be considered by the guideline development group when making recommendations.
SH	Janssen – Cilag Ltd	1	4.1 population	The scope would beneficiate from the proposed population subgroups to be more precisely defined e.g. the current draft scope list "older adults" as being a sub-group of interest, but determining an age threshold would be needed to define this sub-group.	Thank you for your comment. This has now been amended in the scope within section 4.1.1 to say 'adults aged 65 years and older'.
SH	Eli Lilly and Company Limited	1	4.1.1	Lilly suggests that the patient subgroup "people with renal impairment" is divided further according to levels of severity, as drug choice and/or dose of treatments may differ depending on the stage of impairment. We suggest the classification adopted by the Renal National Service Framework. This classification divides CKD into five stages defined by	Thank you for your comment. The guideline development group may make specific recommendations for sub-groups of the population based on the evidence reviewed and the

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				evidence of kidney damage and level of renal function as measured by glomerular filtration rate (GFR) : 1. Kidney damage with normal or increased GFR [GFR ≥ 90 mL/min/1.73m^2], 2. Kidney damage with mild reduction in GFR [60 ≤ GFR ≤ 89 mL/min/1.73m^2], 3. Moderate reduction in GFR [30 ≤ GFR ≤ 59 mL/min/1.73m^2], 4. Severe reduction in GFR [15 ≤ GFR ≤ 29 mL/min/1.73m^2], 5. Kidney failure [GFR <15 mL/min/1.73m^2 (or dialysis)] (Reference: NICE Clinical Guideline 73, pp. 18-19. Accessed at http://www.nice.org.uk/nicemedia/live/12069/42116/42116.pdf).	clinical expertise of the group. Further division of categories of renal impairment will be discussed during the development of the guideline and will be agreed with the guideline development group. NICE clinical guideline 73 for chronic kidney disease is currently being updated and it is anticipated that definitions will be consistent with this update.
SH	Novartis Pharmaceuticals Ltd	2	4.1.1	It is important to investigate sub-groups, for example, diabetes patients who fast during Ramadan	Thank you for your comment. Section 4.1.1 sets out example sub-groups of the population where the management of type 2 diabetes may differ, however this list is not exhaustive. The guideline development group may make specific recommendations for sub groups based on the evidence reviewed and the clinical expertise of the group. For instance, if the included evidence provides specific information relating to people who are fasting, this information will be considered by the guideline development group when making recommendations
SH	Novo Nordisk Ltd	2	4.1.1 (b)	This section outlines the specific patient sub-groups for whom the management of type 2 diabetes may vary. Diabetes is strongly linked with obesity and for these people, weight gain associated with treatment, is a key concern. We would recommend the inclusion of people who are obese as a distinct subgroup.	Thank you for your comment. Section 4.1.1 sets out example sub-groups of the population where the management of type 2 diabetes may differ, however this list is not exhaustive. It is anticipated that specific recommendations may be

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					made for people with obesity based on the evidence reviewed and clinical expertise of the guideline development group.
SH	Rethink Mental Illness	1	4.1.1 (b)	People affected by mental illness die, on average, 15-20 years earlier than the general population as a result of preventable physical illness. The increased prevalence of diabetes among this group is well documented – figures suggest that it is two to four times the general population.[1] This group is also at an increased cardiovascular risk due to the impact of antipsychotic medication side effects, particularly rapid weight gain.[2] We would therefore recommend that people affected by severe mental illness are treated as a discrete specific patient sub-group for whom the management of type 2 diabetes may vary under this section. There is often a lack of clarity around who is responsible for monitoring and managing the physical health of people affected by mental illness, so practice guidelines are particularly important for this group. This is something Rethink Mental Illness has been doing work on through our '20 Years Too Soon' campaign and more information can be found at www.rethink.org/phc	Thank you for your comment. Section 4.1.1 sets out example sub-groups of the population where the management of type 2 diabetes may differ, however this list is not exhaustive. The guideline development group may make specific recommendations for sub-groups of the population based on the evidence reviewed and the clinical expertise of the group.
SH	Kidney Alliance	1	4.1.1 b)	We agree that this scope should include people with renal impairment – but ask whether this should specify 'all stages' for clarity	Thank you for your comment. Section 4.1.1 sets out example sub-groups of the population where the management of type 2 diabetes may differ, however this list is not exhaustive. The guideline development group may make specific recommendations for sub-groups of the population based on the evidence reviewed and the clinical expertise of the group. Further division of categories of renal impairment will be led by the

[1] Expert Group. '*Schizophrenia and diabetes 2003*'. Expert Consensus Meeting, Dublin 3–4 October 2003: consensus summary. Br J Psychiatry 2004; 184 (suppl 47): s112– 4.
[2] Casey, Daniel E et al., *Antipsychotic-Induced Weight Gain and Metabolic Abnormalities: Implications for Increased Mortality in Patients With Schizophrenia* Journal of Clinical Psychiatry, Vol 65(Suppl7), 2004, 4-18

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					evidence and discussed during the development of the guideline and will be agreed with the guideline development group. NICE clinical guideline 73 for chronic kidney disease is currently being updated and it is anticipated that definitions will be consistent with this update.
SH	Diabetes Trials Unit	3	4.1.1.b	Add fifth bullet: "People in nursing homes"	Thank you for your comment. This guideline will cover all settings in which NHS care is received or commissioned.
SH	Department of Health	13	4.1.1b	Other groups to consider would be patients who have had a CVD event, patients with other chronic conditions including dementia and women of reproductive age.	Thank you for your comment. Section 4.1.1 sets out example sub-groups of the population where the management of type 2 diabetes may differ, however this list is not exhaustive. The guideline development group may make specific recommendations for sub-groups of the population. These recommendations will be based on the evidence reviewed and the clinical expertise of the group
SH	Novartis Pharmaceuticals Ltd	4	4.3	Will there be consideration for starting treatment early and more intensive in patients at risk, for example, prescribing two agents straight away?	Thank you for your comment. Issues such as treatment initiation and intensification and the specific drug comparisons and combinations that will be included within the review question addressing pharmacological management will be discussed and agreed with the guideline

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					development group during the development of the guideline.
SH	Community Diabetes Consultants	2	4.3 b and c	For monitoring glycaemic control in people with type 2 DM to discourage home glucose testing in those at risk of hypoglycaemia ie not on a sulphonylurea and insulin but increase access to HbA1c every 2 months on patient demand ?	The review question on self-monitoring will address whether self-monitoring should be used to manage blood glucose levels in adults with type 2 diabetes. Section 4.3.1 (c) has been updated to clarify that targets, frequency of monitoring, timing and site of testing in relation to self-monitoring will all be looked at as part of this clinical area. The specific comparisons that will be included within this review question will be discussed and agreed with the guideline development group during the development of the guideline. The recommendations will be based on a systematic review of the evidence and the clinical expertise of the guideline development group. For more details on the process of guideline development please see the NICE Guidelines manual 2012.
SH	Royal College of Pathologists	4	4.3 m)	Why is diagnosis of type 2 diabetes not being covered? Diagnosis is being covered in the updates of type 1 diabetes and diabetes in pregnancy	Thank you for your comment. Although we recognise the importance of diagnosing type 2 diabetes, this clinical issue was not prioritised for update during the scoping process for type 2 diabetes clinical guideline. However, as diagnosis and differentiation between type 1 and type 2 diabetes are being covered in the type 1 diabetes

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					guideline, we will be able to cross-refer to appropriate recommendations made for diagnosis within this guideline. There will not be a separate evidence review focusing on diagnosis in the type 2 diabetes update.
SH	LifeScan	1	4.3.1 Key Clinical Issues that will be covered C) Areas from the original review that will be updated by an evidence review	We would like to submit the following references for consideration in the evidence review. • McIntosh B, Yu C, Lal A, et al. Efficacy of self-monitoring of blood glucose in patients with type 2 diabetes mellitus managed without insulin: A systematic review and meta-analysis. *Open Medicine*. 2010;4(2):E102. • Murata GH, Duckworth WC, Shah J et al. Blood glucose monitoring is associated with better glycemic control in type 2 diabetes: A database study. *Journal of General Internal Medicine.* 2009 Jan; 24(1):48-52. • Fisher L, Polonsky W, Parkin CG et al. The Impact of Blood Glucose Monitoring on Depression and Distress in Insulin-Naïve Patients with Type 2 Diabetes. Curr Med Res Opin. 2011 Nov;27 Suppl 3:39-46 • Ezenwaka C, Dimgba A, Okali F, et al. Self-monitoring of blood glucose improved glycaemic control and 10-year coronary heart disease risk profile of type 2 diabetic patients. *Chinese Medical Journal.* 2011;124(2):166-171. • Tunis S, Minshall ME. Self-monitoring of blood glucose (SMBG) for type 2 diabetes patients treated with oral anti-diabetes drugs and with a recent history of monitoring: Cost-effectiveness in the US. *Current Medical Research Opinion.* 2010;26(1):151-162. • Neeser K, Weber C. Cost impact of self-measurement of blood glucose on complications of type 2 diabetes: The Spanish perspective. *Diabetes Technology Therapeutics.* 2009;11(8):509-516. • Karter AJ, Ackerson LM, Darbinian JA, et al. Self-monitoring of blood glucose levels and glycemic control: the northern California Kaiser Permanente diabetes registry. *Americal Journal of Medicine* 2001;111:1-9. • Cuddihy R and Reach G .2nd Annual Symposium on Self Monitoring of Blood Glucose (SMBG) Applications and Beyond, May 7–10, 2009, Berlin, Germany.	Thank you for these references. If these references are identified within the systematic searches conducted for each review question (based on the search criteria set out within the review protocol for each evidence review), they will be considered for inclusion or exclusion within the evidence review. For more information on developing clinical guidelines please see the NICE Guidelines manual 2012.

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				DIABETES TECHNOLOGY & THERAPEUTICS. Volume 11, Number 9, 2009. (page 540-541) • Streja D..Optimizing diabetes management through glucose profiling: A case-based approach. Primary Care Diabetes 2008;2:167–173.	
SH	LifeScan	2	4.3.1 Key Clinical Issues that will be covered C) Areas from the original review that will be updated by an evidence review	We would like to submit the following references for consideration in the evidence review. • Pimazoni-Netto A et al. Rapid Improvement of Glycemic Control in Type 2 Diabetes Using Weekly Intensive Multifactorial Interventions: Structured Glucose Monitoring, Patient Education, and Adjustment of Therapy—A Randomized Controlled Trial. DIABETES TECHNOLOGY & THERAPEUTICS Volume 13, Number 10, 2011. • Virdi N et al. The Association of Self-Monitoring of Blood Glucose Use with Medication Adherence and Glycemic Control in Patients with Type 2 Diabetes Initiating Non-Insulin Treatment. DIABETES TECHNOLOGY & THERAPEUTICS Volume 14, Number 9, 2012. • Hirsch I, Bode B, Childs B, Close K, Fisher W, Gavin J, Ginsberg B, Raine C, Verderese C. Self-Monitoring of Blood Glucose (SMBG) in Insulin- and Non–Insulin-Using Adults with Diabetes: Consensus Recommendations for Improving SMBG Accuracy, Utilization, and Research.. DIABETES TECHNOLOGY & THERAPEUTICS Volume 10, Number 6, 2008. • Neeser K, Weber C. Cost Impact of Self-Measurement of Blood Glucose on Complications of Type 2 Diabetes: The Spanish Perspective.. DIABETES TECHNOLOGY & THERAPEUTICS Volume 11, Number 8, 2009. • Kempf K, Kruse J, Martin S. ROSSO-in-Praxi Follow-Up: Long-Term Effects of Self-Monitoring of Blood Glucose on Weight, Hemoglobin A1c, and Quality of Life in Patients with Type 2 Diabetes Mellitus.DIABETES TECHNOLOGY & THERAPEUTICS Volume 14, Number 1, 2012. • Schnell O et al. Economic and Clinical Aspects of Diabetes Regarding Self-Monitoring of Blood Glucose. DIABETES TECHNOLOGY & THERAPEUTICS Volume 10, Supplement 1, 2008.	Thank you for these references. If these references are identified within the systematic searches conducted for each review question (based on the search criteria set out within the review protocol for each evidence review), they will be considered for inclusion or exclusion within the evidence review. For more information on developing clinical guidelines please see the NICE Guidelines manual 2012.
SH	Welsh	3	4.3.1	The use of insulin in combination with GLP 1 agonists is not currently recommended by	Thank you for your comment. The

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	Endocrine and Diabetes Society (WEDS)			NICE. However, this is a combination of therapy which is increasingly used in the UK, will this be specifically reviewed?	new licensed indications for all pharmacological agents listed in section 4.3.1 (a) will be updated following CG87 so that they are in line with current Summary Product Characteristics (SmPCs) and will be included as part of the evidence review. This will include any new licensed indications for GLP-1 agonists, however the specific drug comparisons that will be included within this review question will be discussed and agreed with the guideline development group during the development of the guideline. NICE clinical guideline recommendations will normally fall within licensed indications; exceptionally, and only if clearly supported by evidence, use outside a licensed indication may be recommended. For more information about recommendations on drugs, please see the NICE Guidelines manual 2012.
SH	WOCKHARDT UK	1	4.3.1	Under 4.3.1, Key clinical issues that will be covered, the issue of long-term safety of genetically-modified (GM) insulins should be addressed. The question "What are the long-term safety issues associated with the use of GM insulins?" should be listed under 4.3.1 Key clinical issues that will be covered (Areas not in the original guidelines that will be included in the update).	Thank you for your comment. An evidence review will be carried out to examine long term effects associated with all the pharmacological agents listed in section 4.3.1, this will focus on adverse events and the development of diabetic complications.

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					Recommendations will be based on the evidence reviewed and the clinical expertise of the guideline development group. The specific drug comparisons that will be included within this review question will be discussed and agreed with the guideline development group during the development of the guideline.
SH	Novo Nordisk Ltd	3	4.3.1 (a)	The structure of this section is very confusing; it implies that lixisenatide was included in the previous guideline. Lixisenatide is not marketed or licenced anywhere in the world. However, it is important to note that liraglutide is an alternative GLP-1 mimetic that was launched in the UK in 2009, although it was not included in the previous guideline (CG87), but has a Single Technology Appraisal (STA) by NICE.	Thank you for your comment. The scope has been amended to include a footnote highlighting the pharmacological agents that were not previously included within the evidence review for CG87.
SH	Sanofi	1	4.3.1 (a)	We welcome the inclusion of our new GLP-1 agonist, Lixisenatide. Review of GLP-1 agonists should consider their use in combination with basal insulin. The marketing authorisation application for lixisenatide includes the indication for combination use with basal insulin, and both exenatide and liraglutide already contain or recognise this use within their respective marketing authorisations. The review should consider the appropriateness of the current rules to allow continuation of GLP1 agonist therapy (1% HbA_{1c} reduction and 3% BMI reduction at 6 months). The ABCD audit showed that only 28.6% of exenatide patients, and 24.8% of liraglutide patients met these criteria (Ryder and Thong, DUK 2011). Furthermore, experience from clinical trials shows that when used in combination with basal insulin (later in the disease process, when glycaemic control is more challenging) the impact on weight could be summarised as preventing weight gain rather than supporting weight loss. The stopping rules above are likely to be inappropriate for use in combination with basal insulin: the achievement of weight neutrality, and a smaller HbA_{1c} reduction would be a positive outcome in this patient group and a more realistic target on which to benchmark a	Thank you for your comment. The new licensed indications for all pharmacological agents listed in section 4.3.1 (a) will be updated following CG87 so that they are in line with current Summary Product Characteristics (SmPCs) and will be included as part of the evidence review. The specific drug comparisons that will be included within this review question and the use of starting and stopping rules will be discussed and agreed with the guideline development group during the development of the guideline. The guideline development group will

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				stopping rule. Finally, as development of the guideline progresses NICE will need to take into account the fact that that one or more of the agents under investigation will see publication of pivotal trials which will add significantly to the evidence available. NICE should provide clarity on how emerging evidence can be incorporated – particularly for pivotal studies of the agents under consideration.	also discuss updating literature searches towards the end of guideline development to ensure that trials that may change guideline recommendations are considered. The final re-run of searches will normally be done 6–8 weeks before consultation on the draft guideline begins. For more information about re-running literature searches, please the NICE Guidelines manual 2012.
SH	Sanofi	2	4.3.1 (a)	We welcome the inclusion of insulin in the update. There is significant new evidence on the efficacy and long term outcomes of basal insulins. The longest and largest RCT study of an insulin ever conducted, ORIGIN, was recently published (The ORIGIN Trial Investigators, NEJM, 2012). In contrast to the ACCORD study (Dluhy and McMahon, NEJM, 2008), ORIGIN showed that insulin glargine had a neutral effect on long term CV risk. This showed that insulin glargine was able to maintain HbA_{1c} at a low level ($\leq$6.5%) for a long period (6.2 years median) with a low risk of hypoglycaemia (1 severe hypoglycaemic event per 100 patient years). The study also concluded that there is no association between insulin glargine and mitogenicity. We feel this new evidence warrants a re-examination of the positioning of insulin glargine in the guidelines relative to other basal insulins. Finally, in a recently published Phase 4 trial comparing the safety and efficacy of insulin glargine in comparison with insulin detemir, both used once daily, insulin detemir failed to achieve non-inferiority in comparison to insulin glargine in the primary outcome of HbA1c reduction (EFFICACY, 2011; http://clinicaltrials.gov/ct2/show/NCT00909480). This new evidence raises strong questions over whether insulin glargine and insulin detemir should receive the same positions in an updated guideline.	Thank you for your comment. An evidence review will be carried out to examine long term effects associated with all the pharmacological agents listed in section 4.3.1, this will focus on adverse events and the development of diabetic complications Recommendations will be based on the evidence reviewed and the clinical expertise of the guideline development group. The specific drug comparisons that will be included within this review question about insulin therapy will be discussed and agreed with the guideline development group during the development of the guideline.
SH	Novartis Pharmaceuticals Ltd	3	4.3.1 (b)	Will there be consideration for how to manage patients when their HbA_{1c} does not adequately respond? For example how long is appropriate to wait before switching therapy.	Thank you for your comment. It is anticipated that the updated guideline will produce a treatment algorithm for people with type 2 diabetes. This algorithm will take into

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					account treatment options when people are not reaching target Hba1c levels. It is also anticipated that the guideline development group will discuss starting and stopping rules for glucose-lowering therapies. The guideline will also cover a separate review question relating to target Hba1c levels.
SH	Abbott Diabetes Care	5	4.3.1 (c)	We propose that consideration be given to new emerging tools that support patients in managing their diabetes, especially patients with special challenges such as low numeracy or low literacy skills. These supportive tools include insulin bolus advisors, calculators, insulin logbooks and structured education programmes. Evidence suggests that use of these tools give patients more confidence in caring for their disease, reduces insulin dosing errors, and assists patients to better self-manage their disease. This is not limited to carbohydrate counters but people with type 2 diabetes who adjust their insulin based primarily on a glycaemic result from a blood glucose meter. • Sussman A, et al. Performance of a Glucose Meter with a Built-In Automated Bolus Calculator versus Manual Bolus Calculation in Insulin Using Subjects. Journal of Diabetes Science and Technology. 2012;6:339-44. • Cavanaugh K, et al. Association of numeracy and diabetes control. Annals of Internal Medicine. 2008;148:737-46. • Kerr D. Poor Numeracy: The Elephant in the Diabetes Technology Room. Journal of Diabetes Science and Technology. 2010;4:1284-7	Thank you for your comment. Although we understand that the use of patient support tools may be important, this issue was not considered a priority for updating during the scoping process. This is either because it will be covered by other NICE guidance, there is not enough new evidence available which may impact on the recommendations or it was not considered a clinical priority for updating. For more details on the scoping process please see the NICE Guidelines Manual 2009.
SH	Abbott Diabetes Care	6	4.3.1 (c)	In the clinical monitoring of glucose section we suggest that recommendations be made for healthcare professionals and patients to use data management software programmes for both continuous glucose monitoring and self-monitoring of blood glucose to better identify patterns and trends of hyper or hypoglycemia and to adjust treatment based on these patterns and trends to improve outcomes.	Thank you for your comment. NICE has asked the National Clinical Guideline Centre (NCGC) to develop the guidance for those with type 1 diabetes and the Internal Clinical Guidelines (ICG) Programme at NICE to develop guidance for those with type 2 diabetes. The scopes for

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					those with type 1 and type 2 diabetes both include self-monitoring. Whilst each developer is considering self-monitoring within their own specific population, NICE will ensure consistency across all the guidelines relating to diabetes. The type 2 diabetes guideline will cover self-monitoriing. However, continuous glucose monitoring will not be the focus of this review question and we will not be making recommendations around the use of this for patients with type 2 diabetesbut continuous monitoring may be looked at as a comparator within this review question if this is discussed and agreed by the guideline development group in the development of the guideline.
SH	Novo Nordisk Ltd	4	4.3.1 (e)	Liraglutide was launched in the UK in 2009. It was not included in the previous version of the clinical guideline update (CG87) due to the concurrent development of the Single Technology Appraisal (STA). The STA guidance (TA203) for liraglutide was published in October 2010. This is due for review in October 2012. In February this year Novo Nordisk responded to a request from NICE for information relating to the potential review of the liraglutide STA guidance. Novo Nordisk would recommend that liraglutide is included within the update of the type 2 clinical guidelines. This is because the STA review dates fall within the start of the guideline development process and from a NHS implementation perspective it would be useful to have a treatment algorithm that includes all of the available treatment options, rather than having to refer to several separate pieces of diabetes guidance from NICE.	Thank you for your comment. Technology appraisals (TA) TA203 (liraglutide) and 248 (prolonged-release exenatide) were based on recommendations from clinical guideline (CG) 87. Because the update of the clinical guideline CG87 and clinical guideline CG66 is scheduled to consider exenatide, this could result in a change to the recommendations in TA203 and

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					TA248. In August 2012 the Centre for Technology Evaluation (CHTE) at NICE therefore consulted on a proposal for TA203 and TA248 to be updated in the update of clinical guidelines CG66 and CG87. After consultation NICE agreed to update TA203 and TA248 within the update of the clinical guidelines CG66 and CG87. Once the guideline is published the technology appraisals will be withdrawn. The Centre for Technology Evaluation (CHTE) at NICE are currently developing guidance on the SGLT-2 inhibitors Dapagliflozin in combination therapy for the treatment of type 2 diabetes (ID427) and Canagliflozin for type 2 diabetes mellitus (ID554). The update of clinical guideline CG87 and clinical guideline CG66 will incorporate this guidance subject to a technology appraisal review proposal agreement.
SH	Novo Nordisk Ltd	5	4.3.1 (e)	The scope for the type 1 clinical guidelines update clearly specifies in section 4.3.1 (l) that new insulin formulations, including insulin degludec, insulin degludec/aspart and insulin detemir will be in the update to the type 1 clinical guidelines. As these products will also be licenced for use in people with type 2 diabetes we would recommend that they are also included within the scope of this guideline.	Thank you for your comment. The review question relating to pharmacological management of blood glucose levels will cover the use of insulin treatment in type 2 diabetes. The specific drug comparisons that will be included

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					within this review question will be discussed and agreed with the guideline development group during the development of the guideline.
SH	British Renal Society	1	4.3.1 a	Although the scope will cross link to existing NICE CKD guidance, there has been a range of new oral hypoglycaemic drugs come into use. Therefore, there is a need for top-level guidance regarding the safe use of newer hypoglycaemic agents (notably GLP-1 analogues, DPP-4 inhibitors and meglitinides) in the presence impaired excretory function due to diabetic renal disease. Whilst the danger of metformin is well known, the potential danger of hypoglycaemia and other complications from these other agents is not well delineated. The current CKD NICE guidelines almost certainly not cover this.	Thank you for your comment. People with renal impairment have been included within the scope as a specific subgroup of the population (see section 4.1.1b). It is anticipated that specific recommendations for subgroups of the population will be made based on the evidence reviewed and the clinical expertise of the group. There is also a separate review question assessing the long term safety of all blood glucose-lowering therapies that are mentioned in section 4.3.1 (a) and this would include newer therapies such as GLP-1 analogues and DPP-4 inhibitors.
SH	Royal College of Pathologists	3	4.3.1 b)	Oral glucose tolerance is not generally used as a target for blood glucose control, only as a diagnostic test.	Thank you for your comment. Oral glucose tolerance has now been removed from section 4.3.1 (b) and section 4.5
SH	Bayer plc	3	4.3.1 c)	The effectiveness of self-monitoring of blood-glucose levels for blood-glucose control. It is important that a distinction is made between insulin-treated individuals for whom self-monitoring of blood glucose (SMBG) is an integral aspect of management, and those who are non-insulin treated. For those who are non-insulin treated there is evidence to show that SMBG with appropriate education and clear objectives leads to improvement in blood glucose control.[1,2]	Thank you for your comment. NICE has asked the National Clinical Guideline Centre to develop the guidance for those with type 1 diabetes and the Internal Clinical Guidelines Programme at NICE to develop guidance for those with type

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				Consideration should also be given to the role of SMBG with specific glucose-control therapies e.g. sulphonylureas because of the risk of hypoglycaemia.[2,3] Please note that the current ISO standard for in vitro diagnostic test systems - *Requirements for blood-glucose monitoring systems for self-testing in managing diabetes mellitus* (15197:2003) is undergoing revision.[4] Proposed changes to the ISO standard include stricter criteria for accuracy. These standards should be taken into account when blood glucose monitor recommendations are made. (1) Clar C et al. Self-monitoring of blood glucose in type 2 diabetes: systematic review. *Health Technol Assess* 2010; 14(12):1-140. (2) NHS Diabetes. Self monitoring of blood glucose in non-insulin-treated Type 2 diabetes. 2010. Available from: http://www.diabetes.nhs.uk/document.php?o=238. (Last accessed: 14/8/2012). (3) UK Hypoglycaemia Study Group et al. Risk of hypoglycaemia in types 1 and 2 diabetes: effects of treatment modalities and their duration. *Diabetologia* 2007; 50(6):1140-1147. (4) International Organization for Standardization (ISO). ISO/DIS 15197 - In vitro diagnostic test systems -- Requirements for blood-glucose monitoring systems for self-testing in managing diabetes mellitus. June 2011. Available from: http://www.iso.org/iso/home/store/catalogue_ics/catalogue_detail_ics.htm?csnumber=5497. (Last accessed: 17/8/2012).	2 diabetes. The scopes for those with type 1 and type 2 diabetes both include self-monitoring. Whilst each developer is considering self-monitoring within their own specific population, NICE will ensure consistency across all the guidelines relating to diabetes. The review questions relating to self-monitoring and optimum target levels for Hba1c will involve a systematic review of the literature. Thank you for your comment. NICE has asked the National Clinical Guideline Centre to develop the guidance for those with type 1 diabetes and the Internal Clinical Guidelines Programme at NICE to develop guidance for those with type 2 diabetes. The scopes for those with type 1 **and type 2 diabetes both include self-monitoring. Whilst each developer is considering self-monitoring within their own specific population, NICE will ensure consistency across all the guidelines relating to diabetes.** **The review question relating to self-monitoring will involve a systematic review of the literature. This review question will cover the use of self-monitoring by people**

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					with type 2 diabetes. This will include people who use blood glucose lowering therapies and those who do not use blood glucose lowering therapies (i.e. those who may be treated with lifestyle interventions alone). Section 4.3.1 has been updated to clarify this. The guideline development group for this guideline will make recommendations based on the included evidence and clinical expertise. For more details on the process of guideline development please see the NICE Guidelines manual 2012.
SH	Kidney Alliance	2	4.3.1 c)	We suggest consideration of self-management or peer educator programmes which are aimed specifically at the BME community.	Thank you for your comment. Although we understand that patient education is an important issue, it was not considered a priority for updating during the scoping process. This is either because it will be covered by other NICE guidance, there is not enough new evidence available which may impact on the recommendations or it was not considered a clinical priority for updating. For more details on the scoping process please see the NICE Guidelines Manual 2009. .
SH	Bayer plc	1	4.3.1 e)	Areas not in the original guidelines that will be included in the update.	Thank you for your comment. The treatment of erectile dysfunction with

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				e) The effectiveness of testosterone therapy for the management of erectile dysfunction in men with type 2 diabetes We believe that the proposed wording should be amended to reflect *the role of hypogonadism as a treatable cause of erectile dysfunction in men with type 2 diabetes as well as the effect of testosterone therapy.* Male hypogonadism is independently associated with[1] and is a prevalent condition in men with Type 2 diabetes (T2D). In a UK cross-sectional study of 355 T2D men, overt hypogonadism was seen in 17% of men with total testosterone <8 nmol/l, and a further 25% had symptoms of hypogonadism associated with total testosterone between 8 and 12 nmol/l.[2] Hypogonadism is associated with increased and more severe erectile dysfunction (ED),[3] additionally it has been shown that ED patients with T2DM are at a greater risk of hypogonadism than non-diabetic ED subjects[1] Hypogonadism may also make men less responsive, or even nonresponsive, to phosphodiesterase type 5 (PDE5) inhibitors.[4] Several studies (both RCTs[5,6] and non-RCTs[7-12] and including in men with T2D[10]) have shown that administration of testosterone therapy can improve response in PDE5i non-responders. The British Society for Sexual Medicine (BSSM) guidelines on the management of ED, recommend that all men with erectile dysfunction should have their serum testosterone measured. Also that men with a total serum testosterone that is consistently <12nmol/l might benefit from up to a 6 months trial of testosterone replacement therapy for ED.[4] British and International hypogonadism guidelines recognise the increased prevalence of hypognadism in men with T2D, and recommend that testosterone testing should take place in all men with T2D and symptoms of testosterone deficiency.[13-15] The Association of British Clinical Diabetologists (ABCD) also suggest that all patients with T2D who present with erectile dysfunction, those with clear unequivocal symptoms of hypogonadism or those who are suspected of primary or central hypogonadism due to other clinical conditions should have biochemical tests to confirm hypogonadism.[16] (1) Corona G et al. Type 2 diabetes mellitus and testosterone: a meta-analysis study. *Int J Androl* 2011; 34(6 Pt 1):528-540. (2) Kapoor D et al. Clinical and biochemical assessment of hypogonadism in men with type 2 diabetes: correlations with bioavailable testosterone and visceral adiposity. *Diabetes*	testosterone therapy was prioritised for update during the scoping process. The review question for erectile dysfunction will focus on pharmacological management of erectile dysfunction, which has been considered a specific complication of diabetes. We will raise the issue of hypogonadism as a cause of erectile dysfunction in men with type 2 diabetes with the guideline development group. If the group conclude that we should addressing hypogonadism as a cause of erectile dysfunction in men with type 2 diabetes we will look to expand this particular review question. Section 4.3.1(e) has been amended in the scope to cover drug therapy for erectile dysfunction (PDE-5 inhibitors, testosterone therapy and alprostadil).

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				Care 2007; 30(4):911-917. (3) NHS Diabetes. Factsheet No. 36. Hypogonadism and diabetes - under diagnosed and under treated. March 2012. Available from: http://www.diabetes.nhs.uk/document.php?o=3381. (Last accessed: 20/8/2012). (4) British Society for Sexual Medicine. Guidelines on the management of erectile dysfunction. July 2009. Available from: http://www.bssm.org.uk/downloads/BSSM_ED_Management_Guidelines_2009.pdf. (Last accessed: 15/8/2012). (5) Buvat J et al. Hypogonadal men nonresponders to the PDE5 inhibitor tadalafil benefit from normalization of testosterone levels with a 1% hydroalcoholic testosterone gel in the treatment of erectile dysfunction (TADTEST study). *J Sex Med* 2011; 8(1):284-293. (6) Shabsigh R et al. Randomized study of testosterone gel as adjunctive therapy to sildenafil in hypogonadal men with erectile dysfunction who do not respond to sildenafil alone. *J Urol* 2004; 172(2):658-663. (7) Aversa A et al. Androgens improve cavernous vasodilation and response to sildenafil in patients with erectile dysfunction. *Clin Endocrinol (Oxf)* 2003; 58(5):632-638. (8) Yassin AA et al. Testosterone and erectile function in hypogonadal men unresponsive to tadalafil: results from an open-label uncontrolled study. *Andrologia* 2006; 38(2):61-68. (9) Rosenthal BD et al. Adjunctive use of AndroGel (testosterone gel) with sildenafil to treat erectile dysfunction in men with acquired androgen deficiency syndrome after failure using sildenafil alone. *Urology* 2006; 67(3):571-574. (10) Kalinchenko SY et al. Oral testosterone undecanoate reverses erectile dysfunction associated with diabetes mellitus in patients failing on sildenafil citrate therapy alone. *Aging Male* 2003; 6(2):94-99. (11) Shamloul R et al. Testosterone therapy can enhance erectile function response to sildenafil in patients with PADAM: a pilot study. *J Sex Med* 2005; 2(4):559-564. (12) Hwang TI et al. Combined use of androgen and sildenafil for hypogonadal patients unresponsive to sildenafil alone. *Int J Impot Res* 2006; 18(4):400-404. (13) Wylie K et al. Androgens, health and sexuality in women and men. *Maturitas* 2010; 67(3):275-289. (14) Bhasin S et al. Testosterone therapy in men with androgen deficiency syndromes: an	

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				Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab* 2010; 95(6):2536-2559. (15) Wang C et al. ISA, ISSAM, EAU, EAA and ASA recommendations: investigation, treatment and monitoring of late-onset hypogonadism in males. *Aging Male* 2009; 12(1):5-12. (16) Dhatariya K et al. ABCD position statement on the management of hypogonadal males with type 2 diabetes. *Pract Diab Int* 2010; 27(9):408-412.	
SH	Diabetes UK	3	4.3.1.(a)	Liraglutide and exenatide are missing from this, subject to the proposed update of TA203 and TA248 within this guideline.	. Thank you for your comment. Technology appraisals (TA) TA203 (liraglutide) and 248 (prolonged-release exenatide) were based on recommendations from clinical guideline (CG) 87. Because the update of the clinical guideline CG87 and clinical guideline CG66 is scheduled to consider exenatide, this could result in a change to the recommendations in TA203 and TA248. In August 2012 the Centre for Technology Evaluation (CHTE) at NICE therefore consulted on a proposal for TA203 and TA248 to be updated in the update of clinical guidelines CG66 and CG87. After consultation NICE agreed to update TA203 and TA248 within the update of the clinical guidelines CG66 and CG87. Once the guideline is published the technology appraisals will be withdrawn. The Centre for Technology

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					Evaluation (CHTE) at NICE are currently developing guidance on the SGLT-2 inhibitors Dapagliflozin in combination therapy for the treatment of type 2 diabetes (ID427) and Canagliflozin for type 2 diabetes mellitus (ID554). The update of clinical guideline CG87 and clinical guideline CG66 will incorporate this guidance subject to a technology appraisal review proposal agreement.
SH	Diabetes Trials Unit	4	4.3.1.a	Second bullet: Replace "mimetics" with "receptor agonists" Replace indented text below with "– (exenatide twice daily & once weekly) and liraglutide" Fourth bullet point: Replace "sulphonylureas" with "sulfonylureas"	Thank you for your comment. Section 4.3.1 (a) has been amended to include glucagon-like peptide-1 (GLP-1) receptor agonists and sulfonylureas as these terms are in-line with British National Formulary (BNF). The wording for exenatide has been agreed in order to differentiate between conventional formulas of exenatide and prolonged release exenatide.
SH	GlaxoSmithKline Ltd	1	4.3.1.a)	Is it possible to clarify necessary timings for the inclusion of therapies for which marketing authorisation has not yet been received, e.g. lixisenatide (Marketing Authorisation Application [MAA] filed with the European Medicines Agency [EMA] in Oct 2011), alogliptin (MAA filed with the EMA in May 2012), albiglutide (possible MAA filed with EMA in 2013) and dulaglutide (possible MAA filed with EMA in 2013)	Thank you for your comment. Pharmacological agents used for the treatment of type 2 diabetes that are not listed within section 4.3.1 (a) of the scope will not be considered within the evidence review. Lixisenatide has now received marketing authorisation and will be considered within the development of the guideline rather than a separate technology appraisal.

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					Pharmaceutical therapies which have not received a marketing authorisation by 31 December 2012 will not be included within this guideline update.
SH	Diabetes Trials Unit	5	4.3.1.b	Replace "This" with "These"	Thank you for your comment. Section 4.3.1 (b) has been re-worded.
SH	Association of British Clinical Diabetologists (ABCD)/Royal College of Physicians (RCP)	2	4.3.1.e	The analysis on the use of testosterone replacement should be widened to those who are considered for replacement with low levels. There is considerable literature on the use of testosterone to improve well-being and long term health and a large proportion of these individuals will have T2DM	Thank you for your comment. The treatment of erectile dysfunction with testosterone therapy was prioritised for update during the scoping process. The review question for erectile dysfunction will focus on pharmacological management of erectile dysfunction, which has been considered a specific complication of diabetes. We will raise the issue of hypogonadism as a cause of erectile dysfunction in men with type 2 diabetes with the guideline development group. If the group conclude that we should addressing hypogonadism as a cause of erectile dysfunction in men with type 2 diabetes we will look to expand this particular review question. Section 4.3.1(e) has been amended in the scope to cover drug therapy for erectile dysfunction (PDE-5 inhibitors, testosterone therapy and alprostadil).

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SH	Association of British Clinical Diabetologists (ABCD)/Royal College of Physicians (RCP)	1	4.3.1a	The use of GLP-1 analogues in combination with insulin must be considered. There is a limited licence for this and the practice is widespread.	Thank you for your comment. The new licensed indications for all pharmacological agents listed in section 4.3.1 (a) will be updated following CG87 so that they are in line with current Summary Product Characteristics (SmPCs) and will be included as part of the evidence review. The specific drug comparisons that will be included within this review question will be discussed and agreed with the guideline development group during the development of the guideline. NICE clinical guideline recommendations will normally fall within licensed indications; exceptionally and only if clearly supported by evidence, use outside a licensed indication may be recommended. For more information about recommendations on drugs, please see the NICE Guidelines manual 2012.
SH	Roche Products Ltd.	1	4.3.1a	We recommend that the bullet 'thiazolidinediones' be renamed to 'PPAR agonists'. 'Thiazolidinediones' should then become a sub-bullet under this new heading along with the existing sub-bullet of 'pioglitazone' The reason for this is that the preceding drug classes explain a mechanism of action (DPP4 inhibitors, GLP1 mimetics), so this should ensure consistency	Thank you for your comment. This has been added to section 4.3.1(a).
SH	Swansea NHS Trust (now renamed Abertawe Bro	1	4.3.1a	The DPP-4 inhibitor 'alogliptin' is included in the review but this does not currently have a licence for use in the UK. Is NICE now including un-licenced agents in its reviews?	Thank you for your comment. Alogliptin is now excluded (see section 4.3.2) and will not be considered within the update of this

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	Morgannwg University NHS Trust)				guideline. Pharmaceutical therapies which have not received a marketing authorisation by 31 December 2012 will not be included within this guideline update.
SH	Swansea NHS Trust (now renamed Abertawe Bro Morgannwg University NHS Trust)	2	4.3.1a	Exenatide (conventional formula) and lixisenatide are included in the GLP-1 mimetic review but not liraglutide or extended release exenatide. Does this mean that their respective Single Technology Appraisals (STAs) will continue to apply? What is the rationale for this decision?	Thank you for your comment. Technology appraisals (TA) TA203 (liraglutide) and 248 (prolonged-release exenatide) were based on recommendations from clinical guideline (CG) 87. Because the update of the clinical guideline CG87 and clinical guideline CG66 is scheduled to consider exenatide, this could result in a change to the recommendations in TA203 and TA248. In August 2012 the Centre for Technology Evaluation (CHTE) at NICE therefore consulted on a proposal for TA203 and TA248 to be updated in the update of clinical guidelines CG66 and CG87. After consultation NICE agreed to update TA203 and TA248 within the update of the clinical guidelines CG66 and CG87. Once the guideline is published the technology appraisals will be withdrawn. The Centre for Technology Evaluation (CHTE) at NICE are currently developing guidance on the

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					SGLT-2 inhibitors Dapagliflozin in combination therapy for the treatment of type 2 diabetes (ID427) and Canagliflozin for type 2 diabetes mellitus (ID554). The update of clinical guideline CG87 and clinical guideline CG66 will incorporate this guidance subject to a technology appraisal review proposal agreement.
SH	Swansea NHS Trust (now renamed Abertawe Bro Morgannwg University NHS Trust)	3	4.3.1a	It is unclear whether new insulins will be included in this review. These preparations are specifically mentioned in the Type 1 diabetes scoping document (4.3.1k) but will presumably also be licenced for use in type 2 diabetes.	Thank you for your comment. The review question relating to pharmacological management of blood glucose levels aims to cover the use of insulin treatment in type 2 diabetes. The specific drug comparisons that will be included within this review question will be discussed and agreed with the guideline development group during the development of the guideline.
SH	Department of Health	14	4.3.1b	I am unsure what "oral glucose tolerance" means.	Thank you for your comment. As oral glucose tolerance tests are mainly used for diagnosing diabetes, this has now been removed from section 4.3.1 (b)
SH	Department of Health	15	4.3.1b	Oral glucose tolerance? This is a test for the diagnosis of diabetes, and it is WHO that sets the targets for this! Also note point 7. OCTT should rarely be used now to diagnose diabetes as HbA1c can be used	Thank you for your comment. Oral glucose tolerance has now been removed from section 4.3.1 (b)
SH	Department of Health	16	4.3.1c	Will cost-effectiveness be examined?	Thank you for your comment. It is within the legal framework that establish NICE for it to consider both clinical and cost effectiveness where

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					possible. Prioritisation of questions from the scope for economic evaluation and potential de novo health economic modelling will be undertaken by the guideline development group. Their decisions will be reflected and published in the economic plan for this guideline
SH	British Psychological Society	1	4.3.1c) *(see 4.5 below)*	This question is important since, although self-monitoring of blood glucose (SMBG) is linked with good self-management of diabetes for those using insulin, evidence for its effectiveness in non insulin-treated Type 2 diabetes is mixed (Farmer *et al*., 2007). Despite this, SMBG is becoming increasingly common. In one survey, over 80% of people with Type 2 diabetes were found to carry out some monitoring (Stewart *et al*., 2004). It is worth noting that the costs associated with SMBG are now greater than those of oral hypoglycaemic agents (Reynolds & Strachan, 2004). Several observational studies, carried out in large (heterogeneous) population groups of people with Type 2 diabetes, failed to find evidence for an association between monitoring and improved glycaemic control (e.g. Evans *et al*., 1999; Abdelqadir *et al*., 2006) except within better-educated patient groups (Karter *et al*., 2001). A recent trial found no evidence of improved glycaemic control among non insulin-treated patients who tested regularly, even when structured education was provided (Farmer *et al*., 2007). *References:* Abdelqadir, M., Elbaqir, M., Eltom, M. & Berne, C. (2006). The Influence of Glucose Self-Monitoring on Glycaemic Control in Patients with Diabetes Mellitus in Sudan. *Diabetes Research & Clinical Practice*, *74*, 90-94. Evans, J.M.M., Newton, R.W., Ruta, D.A., MacDonald, T.M., Stevenson, R.J. & Morris, A.D. (1999). Frequency of Blood Glucose Monitoring in Relation to Glycaemic Control. Observational study with diabetes database. *British Medical Journal*, *319*, 83-86. Farmer, A., Wade, A., Goyder, E., Yudkin, P., French, D., Craven, A. *et al*. (2007). Impact of Self Monitoring of Blood Glucose in the Management of Patients with Non-Insulin	Thank you for your comment. NICE has asked the National Clinical Guideline Centre to develop the guidance for those with type 1 diabetes and the Internal Clinical Guidelines Programme at NICE to develop guidance for those with type 2 diabetes. The scopes for those with type 1 and type 2 diabetes both include self-monitoring. Whilst each developer is considering self-monitoring within their own specific population, NICE will ensure consistency across all the guidelines relating to diabetes. The review questions relating to self-monitoring and optimum target levels for Hba1c will involve a systematic review of the literature. Thank you for your comment. NICE has asked the National Clinical Guideline Centre to develop the guidance for those with type 1 diabetes and the Internal Clinical Guidelines Programme at NICE to develop guidance for those

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				Treated Diabetes: Open parallel group randomised trial. *British Medical Journal, 335*,132. Karter, A.J., Ackerson, L.M., Darbinian, J.A., D'Agostino, R.B., Ferrara, A., Liu, J. *et al*. (2001). Self-monitoring of Blood Glucose Levels and Glycemic Control: The Northern California Kaiser Permanente Diabetes Registry. *American Journal of Medicine*, *111,* 1-9. Reynolds, R.M. & Strachan, M.W.J. (2004). Home Blood Glucose Monitoring in Type 2 Diabetes. *British Medical Journal*, *329*, 754-755. Stewart, D., McCaig, D., Davie, A., Juroszek, L., Blackwood, L., Findlay, N. *et al*. (2004). Glucose self-monitoring in primary care: a survey of current practice. *Journal of Clinical Pharmacy & Therapeutics*, *29*, 273-277.	with type 2 diabetes. The scopes for those with type 1 **and type 2 diabetes both include self-monitoring. Whilst each developer is considering self-monitoring within their own specific population, NICE will ensure consistency across all the guidelines relating to diabetes.** **The review question relating to self-monitoring will involve a systematic review of the literature. This review question will cover the use of self-monitoring by people with type 2 diabetes. This will include people who use blood glucose lowering therapies and those who do not use blood glucose lowering therapies (i.e. those who may be treated with lifestyle interventions alone)**. Section 4.3.1 has been updated to clarify this. The guideline development group for this guideline will make recommendations based on the included evidence and clinical expertise. For more details on the process of guideline development please see the NICE Guidelines manual 2012.
SH	Department of Health	17	4.3.1e	Should this be broadened to a discussion of ED as a marker for CVD and also should this not cover hypogonadism in type 2 diabetes and testosterone replacement?	Thank you for your comment. The treatment of erectile dysfunction with

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					testosterone therapy was prioritised for update during the scoping process. The review question for erectile dysfunction will focus on pharmacological management of erectile dysfunction, which has been considered a specific complication of diabetes. We will raise the issue of hypogonadism as a cause of erectile dysfunction in men with type 2 diabetes with the guideline development group. If the group conclude that we should addressing hypogonadism as a cause of erectile dysfunction in men with type 2 diabetes we will look to expand this particular review question. Section 4.3.1(e) has been amended in the scope to cover drug therapy for erectile dysfunction (PDE-5 inhibitors, testosterone therapy and alprostadil).
SH	AstraZeneca / Bristol Myers Squibb	2	4.3.2	Further clarification is required on how the clinical guidelines intend to treat SGLT-2 inhibitors and GLP-1 mimetics. Will the STAs be incorporated into the clinical guideline through cross-referencing the Technology Appraisal Guidance (TAG)? Could further explanation also be given on how the clinical guideline intends to use these drugs as comparators?	Thank you for your comment. Technology appraisals (TA) TA203 (liraglutide) and 248 (prolonged-release exenatide) were based on recommendations from clinical guideline (CG) 87. Because the update of the clinical guideline CG87 and clinical guideline CG66 is scheduled to consider exenatide, this could result in a change to the recommendations in TA203 and

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					TA248. In August 2012 the Centre for Technology Evaluation (CHTE) at NICE therefore consulted on a proposal for TA203 and TA248 to be updated in the update of clinical guidelines CG66 and CG87. After consultation NICE agreed to update TA203 and TA248 within the update of the clinical guidelines CG66 and CG87. Once the guideline is published the technology appraisals will be withdrawn. The Centre for Technology Evaluation (CHTE) at NICE are currently developing guidance on the SGLT-2 inhibitors Dapagliflozin in combination therapy for the treatment of type 2 diabetes (ID427) and Canagliflozin for type 2 diabetes mellitus (ID554). The update of clinical guideline CG87 and clinical guideline CG66 will incorporate this guidance subject to a technology appraisal review proposal agreement.
SH	Department of Health	18	4.3.2	Would not one comprehensive document covering all of these issues not be more appropriate, it seems incongruous to include only glucose lowering therapies when this is only one aspect of the management of type 2 diabetes, if not then should the title not be changed to better reflect the content?	Thank you for your comment. Section 4.3.2 outlines the sections of the previous diabetes guidelines that were not prioritised for update during the scoping process. This is either because it will be covered by other NICE guidance, there is not enough new evidence available which may

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					impact on the recommendations or it was not considered a clinical priority for updating. The final guidance for type 2 diabetes will incorporate recommendations from CG66 and CG87 where a separate evidence review has not been carried out. Therefore a title which encompasses type 2 diabetes was considered appropriate.
SH	Department of Health	19	4.3.2	I would like to see psychological conditions included, I believe depression does not fully capture the significant and varied psychological burden associated with type 2 diabetes.	Thank you for your comment. The issue of wider psychological burden was not agreed as a priority for update during the scoping process. The updated guidance for managing depression in adults (CG90) with chronic physical health problems applies to people with type 2 diabetes. Similarly NICE guidance for common mental health disorders (CG123) may also be relevant.
SH	Eli Lilly and Company Limited	2	4.3.2	Section 4.3.2 states that the clinical guideline intends to use SGLT-2 inhibitors as comparators without making new recommendations on their use. Lilly considers that primary comparators should be licensed. Given that some SGLT-2 inhibitors (canagliflozin and empagliflozin) are not yet licensed, their inclusion as comparators should be conditional on obtaining a license during the guideline development period.	Thank you for your comment. The new licensed indications for all pharmacological agents listed in section 4.3.1 (a) will be updated following CG87 and will be included as part of the evidence review. The specific comparisons that will be included within this review question will be discussed and agreed with the guideline development group during the development of the guideline but will be limited to licensed indications only. The evidence review will be

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					limited to licensed indications only. The Centre for Technology Evaluation (CHTE) at NICE are currently developing guidance on the SGLT-2 inhibitors Dapagliflozin in combination therapy for the treatment of type 2 diabetes (ID427) and Canagliflozin for type 2 diabetes mellitus (ID554). The update of clinical guideline CG87 and clinical guideline CG66 will incorporate this guidance subject to a technology appraisal review proposal agreement.
SH	Menarini Diagnostics	1	4.3.2	The draft scope indicates that ketone testing will not be covered by the update. However the National Diabetes Audit 2009/10 shows that approximately 0.5% of people with type 2 diabetes suffer DKA over a 5 year period (of a population numbering over 2 million). These will be people who use insulin to manage their condition, and HES data shows that their average stay in hospital is twice as long as people with type 1 diabetes when admitted with DKA. Therefore similar guidelines should be recommended for the education and access to blood ketone monitoring for the at risk group of people with type 2 diabetes as will exist for people with type 1 diabetes. People with type2 diabetes (excluding those managed by lifestyle or oral therapy) should receive education and be encouraged to monitor blood ketone levels at appropriate times, i.e. illness and periods of persistently elevated blood glucose, for the short term prevention of DKA. This is due to: 1. potentially life threatening nature of DKA 2. cost burden to NHS due to preventable hospitalisations 3. comparable cost of appropriately used blood ketone sensors is preferential to the cost of hospitalisations	Thank you for your comment. Blood ketone monitoring and the prevention and management of DKA will be covered by the type 1 diabetes update. It is considered that the management of DKA is similar for people with either type 1 or type 2 diabetes. Therefore these issues will not be covered by a separate evidence review within type 2 diabetes.

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				4. lack of efficacy of urine ketone testing	
SH	Menarini Diagnostics	2	4.3.2	With regard to patient education and blood ketone monitoring, the guidelines should be consistent with the following publication: Joint British Diabetes Societies Inpatient Care Group The Management of Diabetic Ketoacidosis in Adults - March 2010 i.e. 1. Improved patient education with increased blood glucose and ketone monitoring has led to partial treatment of DKA prior to admission with consequent lower blood glucose levels at presentation. 2. Patients with diabetes who are admitted with DKA should be counselled about the precipitating cause and early warning symptoms of DKA. Failure to do so is a missed educational opportunity. Things to consider are: • Identification of precipitating factor(s) e.g. infection or omission of insulin injections • Prevention of recurrence e.g. provision of written sick day rules • Insulin ineffective e.g. the patient's own insulin may be expired or denatured. This should be checked prior to reuse • Provision of handheld ketone meters and education on management of ketonaemia 3. The resolution of DKA depends upon the suppression of ketonaemia and measurement of blood ketones now represents best practice in monitoring the response to treatment.	Thank you for your comment. Blood ketone monitoring and the prevention and management of DKA will be covered by the type 1 diabetes update. It is considered that the management of DKA is similar for people with either type 1 or type 2 diabetes. Therefore these issues will not be covered by a separate evidence review within type 2 diabetes.
SH	The University of Glamorgan	3	4.3.2	While we agree that there are no significant new interventions in structured patient education there is now more evaluation evidence available and this could be updated.	Thank you for your comment. Although we understand that patient education may be an important issue, this has not been prioritised for an update during the scoping process. In this case, high level searches of the literature have indicated that new evidence in this area may not have an impact on the

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					existing recommendations. For more information please see the review decision document.
SH	Novo Nordisk Ltd	6	4.3.2 (d)	This section specifies areas from the original guidelines that will not be updated by an evidence review. Liraglutide is listed as a product under this heading. We would like to point out that liraglutide was not in the original guidelines. Furthermore, as outlined in our comment related to section 4.3.1(e) we would recommend the inclusion of liraglutide in this update to the clinical guideline to ensure the NHS have access to a consolidated set of recommendations for all of the available diabetes treatments.	Thank you for your comment. Section 4.3.2 (d) has been amended to show that this agent was not considered during the development of CG87. TA203 (liraglutide) and TA248 (prolonged-release exenatide) were based on recommendations from clinical guideline (CG) 87. Because the update of the clinical guideline 87 is scheduled to cover exenatide, this could result in a change to the recommendations in TA203 and TA248. In August 2012 the Centre for Health Technology Evaluation (CHTE) at NICE consulted on a proposal for TA203 and TA248 to be updated in the update of clinical guidelines CG66 and CG87. After consultation NICE agreed to update TA203 and TA248 within the update of clinical guidelines CG66 and CG87. Once the guideline is published the technology appraisals will be withdrawn. The Centre for Health Technology Evaluation (CHTE) at NICE are currently developing guidance on the SGLT-2 inhibitors Dapagliflozin in

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					combination therapy for the treatment of type 2 diabetes (ID427) and Canagliflozin for type 2 diabetes meelitus (ID554). The update of CG87 and CG66 will incorporate this guidance subject to a technology appraisal review agreement.
SH	Novo Nordisk Ltd	7	4.3.2 (p)	Novo Nordisk strongly supports the inclusion of hypoglycaemia within the guidelines, and suggests that both the 'identification of hypoglycaemia' and the 'appropriate management of hypoglycaemia' are also considered. This is particularly important following the recent changes to the DVLA guidelines for people with diabetes.	Thank you for your comment. Although we understand that the identification and management of hypoglycaemia may be important issues, they have not been prioritised for an update during the scoping process for type 2 diabetes. However, the identification of hypoglycaemia is currently being covered by the type 1 diabetes update and it is considered that this issue would not differ for people with type 2 diabetes. Therefore a full evidence review will not be carried out within the type 2 diabetes update, however the final guidance may cross-refer to the type 1 diabetes guideline where appropriate. The guideline development group will also take into consideration the safety of medications on the person's activities of daily living including driving throughout the development of the guideline. Specifically, all definitions of hypoglycaemia will be included as part of the evidence

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					review and appropriate guidance from the DVLA will be discussed.
SH	British Renal Society	3	4.3.2 a	It is not clear why patient education is not being updated. This area should be reviewed to include patient self care and engagement.	Thank you for your comment. Although we understand that patient education may be considered important, this issue was not considered a priority for updating during the scoping process. This could be because it will be covered by other NICE guidance, there is not enough new evidence available which may impact on the recommendations or it was not considered a clinical priority for updating. For more details on the scoping process please see the NICE Guidelines Manual 2009
SH	GlaxoSmithKline Ltd	2	4.3.2 d)	Is it possible to clarify the rationale for SGLT-2 Inhibitors being covered by TA/s and not included within this guideline update? If they are to be used as comparators within the guideline, that would lead to their positioning in the treatment algorithms in the guideline.	Thank you for your comment. Technology appraisals (TA) TA203 (liraglutide) and 248 (prolonged-release exenatide) were based on recommendations from clinical guideline (CG) 87. Because the update of the clinical guideline CG87 and clinical guideline CG66 is scheduled to consider exenatide, this could result in a change to the recommendations in TA203 and TA248. In August 2012 the Centre for Technology Evaluation (CHTE) at NICE therefore consulted on a proposal for TA203 and TA248 to be updated in the update of clinical guidelines CG66 and CG87. After

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					consultation NICE agreed to update TA203 and TA248 within the update of the clinical guidelines CG66 and CG87. Once the guideline is published the technology appraisals will be withdrawn. The Centre for Technology Evaluation (CHTE) at NICE are currently developing guidance on the SGLT-2 inhibitors Dapagliflozin in combination therapy for the treatment of type 2 diabetes (ID427) and Canagliflozin for type 2 diabetes mellitus (ID554). The update of clinical guideline CG87 and clinical guideline CG66 will incorporate this guidance subject to a technology appraisal review proposal agreement.
SH	GlaxoSmithKline Ltd	3	4.3.2 d)	Please clarify why GLP-1s [liraglutide & exenatide LAR] will not be updated by an evidence review?	Thank you for your comment. Technology appraisals (TA) TA203 (liraglutide) and 248 (prolonged-release exenatide) were based on recommendations from clinical guideline (CG) 87. Because the update of the clinical guideline CG87 and clinical guideline CG66 is scheduled to consider exenatide, this could result in a change to the recommendations in TA203 and TA248. In August 2012 the Centre for Technology Evaluation (CHTE) at

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					NICE therefore consulted on a proposal for TA203 and TA248 to be updated in the update of clinical guidelines CG66 and CG87. After consultation NICE agreed to update TA203 and TA248 within the update of the clinical guidelines CG66 and CG87. Once the guideline is published the technology appraisals will be withdrawn. The Centre for Technology Evaluation (CHTE) at NICE are currently developing guidance on the SGLT-2 inhibitors Dapagliflozin in combination therapy for the treatment of type 2 diabetes (ID427) and Canagliflozin for type 2 diabetes mellitus (ID554). The update of clinical guideline CG87 and clinical guideline CG66 will incorporate this guidance subject to a technology appraisal review proposal agreement.
SH	GlaxoSmithKline Ltd	4	4.3.2 d)	Should the scope also highlight how other therapies which will have received marketing authorisation before the end of the guidelines will be reviewed? e.g albiglutide (possible MAA filed with EMA in 2013) and dulaglutide (possible MAA filed with EMA in 2013)	Thank you for your comment. Pharmacological agents used for the treatment of type 2 diabetes that are not listed within section 4.3.1 (a) of the scope will not be considered within the evidence review. Other blood glucose-lowering therapies that have not received a final licence by final sign off of the scope before development of the guideline will not

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					be included as part of the guideline update.
SH	British Renal Society	2	4.3.2 e	There is a need to ensure that BP targets are consistent across all NICE guidelines, and where there is a discrepancy, guidance as to determining the target values in conflicting situations.	Thank you for your comment. Specific recommendations on blood pressure targets will not be made in the type 2 diabetes update as this issue has not been prioritised for an update. The guideline development group will discuss cross-referring to other NICE guidance during the development of the guideline.
SH	Bayer plc	2	4.3.2 g)	Areas from the original guidelines that will not be updated by an evidence review. g) Cardiovascular risk estimation This section should be updated to reflect recently published evidence in this area. There is evidence to suggest that erectile dysfunction is a marker of underlying asymptomatic coronary artery disease and predicts future cardiovascular events in men with type 2 diabetes[1-4] as well as in otherwise healthy men.[5] Both British and European guidelines include recommendations regarding the evaluation and management of cardiovascular risk factors in men presenting with ED.[6-8] NHS diabetes have stated that "the importance of ED as a symptom of cardiovascular disease is generally poorly recognised by healthcare professions" and recommend that "the annual review offers the opportunity to identify ED as an early sign of atherosclerosis and heralds future cardiovascular events."[9] (1) Batty GD et al. Erectile dysfunction and later cardiovascular disease in men with type 2 diabetes: prospective cohort study based on the ADVANCE (Action in Diabetes and Vascular Disease: Preterax and Diamicron Modified-Release Controlled Evaluation) trial. *J Am Coll Cardiol* 2010; 56(23):1908-1913. (2) Gazzaruso C et al. Relationship between erectile dysfunction and silent myocardial ischemia in apparently uncomplicated type 2 diabetic patients. *Circulation* 2004;	Thank you for your comment. Although the use of erectile dysfunction as a marker for CVD may be considered important, this issue was not considered a priority for update during the scoping process. Cardiovascular risk estimation will be covered as part of the update of lipid modification (CG67). However, the pharmacological treatment of erectile dysfunction will be covered by the type 2 diabetes update.

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				110(1):22-26. (3) Gazzaruso C et al. Erectile dysfunction as a predictor of cardiovascular events and death in diabetic patients with angiographically proven asymptomatic coronary artery disease: a potential protective role for statins and 5-phosphodiesterase inhibitors. *J Am Coll Cardiol* 2008; 51(21):2040-2044. (4) Ma RC et al. Erectile dysfunction predicts coronary heart disease in type 2 diabetes. *J Am Coll Cardiol* 2008; 51(21):2045-2050. (5) Jackson G et al. Erectile dysfunction and coronary artery disease prediction: evidence-based guidance and consensus. *Int J Clin Pract* 2010; 64(7):848-857. (6) Kostis JB et al. Sexual dysfunction and cardiac risk (the Second Princeton Consensus Conference). *Am J Cardiol* 2005; 96(2):313-321. (7) British Society for Sexual Medicine. Guidelines on the management of erectile dysfunction. July 2009. Available from: http://www.bssm.org.uk/downloads/BSSM_ED_Management_Guidelines_2009.pdf. (Last accessed: 15/8/2012). (8) European Guidelines on cardiovascular disease prevention in clinical practice (version 2012): The Fifth Joint Task Force of the European Society of Cardiology and Other Societies on Cardiovascular Disease Prevention in Clinical Practice (constituted by representatives of nine societies and by invited experts). Developed with the special contribution of the European Association for Cardiovascular Prevention & Rehabilitation (EACPR). *Eur J Prev Cardiol* 2012; 19(4):585-667. (9) NHS Diabetes. Factsheet No. 33. Diabetes and Erectile Dysfunction - 'ED is a marker of ill health'. March 2011. Available from: http://www.diabetes.nhs.uk/document.php?o=351. (Last accessed: 14/8/2012).	
SH	Diabetes UK	4	4.3.2.(q)	Can the guideline look at the pathways of treatment for diabetic macular oedema to provide clear recommendations on the use of all of the available treatments for this condition (including licensed and unlicensed treatments)?	Thank you for your comment. Although we understand that diabetic macular oedema may be considered important, this issue was not considered a priority for updating during the scoping process and therefore will not be updated within

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					the update of clinical guideline 66. In this case there is a NICE technology appraisal that is currently in development looking at the use fluocinolone implant for chronic diabetic macular oedema and there is published guidance assessing the use of ranibizumab for the treatment of diabetic macular oedema (TA237). For more details on the scoping process please see the NICE Guidelines Manual 2009
SH	Association of British Clinical Diabetologists (ABCD)/Royal College of Physicians (RCP)	3	4.3.2.d	Guidance will not be complete without cross reference to liraglutide and long-acting exenatide	Thank you for your comment. Technology appraisals (TA) TA203 (liraglutide) and 248 (prolonged-release exenatide) were based on recommendations from clinical guideline (CG) 87. Because the update of the clinical guideline CG87 and clinical guideline CG66 is scheduled to consider exenatide, this could result in a change to the recommendations in TA203 and TA248. In August 2012 the Centre for Technology Evaluation (CHTE) at NICE therefore consulted on a proposal for TA203 and TA248 to be updated in the update of clinical guidelines CG66 and CG87. After consultation NICE agreed to update TA203 and TA248 within the update of the clinical guidelines CG66 and

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					CG87. Once the guideline is published the technology appraisals will be withdrawn. The Centre for Technology Evaluation (CHTE) at NICE are currently developing guidance on the SGLT-2 inhibitors Dapagliflozin in combination therapy for the treatment of type 2 diabetes (ID427) and Canagliflozin for type 2 diabetes mellitus (ID554). The update of clinical guideline CG87 and clinical guideline CG66 will incorporate this guidance subject to a technology appraisal review proposal agreement.
SH	Diabetes Trials Unit	6	4.3.2.d	Second bullet point: Replace "mimetics" with "receptor agonists" Delete indented text below [*Exenatide QW and Liraglutide are in widespread use and guidance should be given. Lixisenatide was only recently submitted to the EMA*]	Thank you for your comment. The terms used to describe the blood glucose-lowering therapies in section 4.3.1(a) have been revised. TA203 (liraglutide) and TA248 (prolonged-release exenatide) were based on recommendations from clinical guideline (CG) 87. Because the update of the clinical guideline 87 is scheduled to cover exenatide, this could result in a change to the recommendations in TA203 and TA248. In August 2012 the Centre for Technology Evaluation (CHTE) at NICE therefore consulted on a proposal for TA203 and TA248 to be

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					updated in the update of clinical guidelines CG66 and CG87. After consultation NICE agreed to update TA203 and TA248 within the update of the clinical guidelines CG66 and CG87. Once the guideline is published the technology appraisals will be withdrawn. Lixisenatide has now received marketing authorisation and will be considered within the development of the guideline. Pharmaceutical therapies which have not received a marketing authorisation by 31 December 2012 will not be included. The evidence review will be limited to licensed indications only so if a full license it not gained, this pharmacological agent will not be considered and specific recommendations will not be made.
SH	Diabetes Trials Unit	7	4.3.2.g	Should advise a type 2 diabetes specific and validated cardiovascular risk calculator here, such as the UKPDS Risk Engine	Thank you for your comment. Section 4.3.2 (g) shows clinical areas that will not be covered by the type 2 diabetes update. In this case, cardiovascular risk estimation will be covered by the NICE update of lipid modification (CG67). It is anticipated that this will include diabetes specific risk estimation tools.
SH	Association of British Clinical Diabetologists	4	4.3.2.m	Diagnosis of T2DM should be considered. WHO and national guidance has been published on the use of HbA1c for diagnosis. Inclusion in the current guideline review would be timely.	Thank you for your comment. Although we recognise the importance of diagnosing type 2

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	(ABCD)/Royal College of Physicians (RCP)				diabetes, this clinical issue was not prioritised for update during the scoping process for type 2 diabetes clinical guideline. However, as diagnosis and differentiation between type 1 and type 2 diabetes are being covered in the type 1 diabetes guideline, we will be able to cross-refer to appropriate recommendations made for diagnosis within this guideline. There will not be a separate evidence review focusing on diagnosis in the type 2 diabetes update.
SH	Department of Health	20	4.3.2a	Lipohypertrophy occurs in insulin-treated Type 2 diabetes Pioglitazone to be stopped in presence of macular oedema	Thank you for your comment. As part of the pharmacological management review question, we will be examining long term effects of pharmacological management of blood glucose control including safety issues, adverse events and the development of diabetic complications. The recommendations will be based on a systematic review of the evidence and the clinical expertise of the guideline development group.
SH	Department of Health	21	4.3.2b	Dietary advice, consider adding carbohydrate counting as this can be effective in type 2 diabetes. Include alcohol as a calorie source	Thank you for your comment. Although we recognise that dietary interventions may be considered important, this issue was not considered a priority for update during the scoping process. This

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					could be because it will be covered by other NICE guidance or there is not enough new evidence available which may impact on the existing recommendations. For more details on the scoping process please see the NICE Guidelines Manual 2009
SH	Department of Health	22	4.3.2d	Use of all these drugs should be updated	Thank you for your comment. TA203 (liraglutide) and TA248 (prolonged-release exenatide) were based on recommendations from clinical guideline (CG) 87. Because the update of the clinical guideline 87 is scheduled to cover exenatide, this could result in a change to the recommendations in TA203 and TA248. The Centre for Technology Evaluation (CHTE) at NICE consulted on a proposal to enable TA203 and TA248 to be updated in the update of clinical guideline 87 in August 2012. Following consultation NICE agreed to update TA203 and TA248 within the update of the clinical guideline 87. There is currently a Technology appraisal on SGLT-2 inhibitors under development and it is anticipated that recommendations from this guidance will be incorporated within the type 2 diabetes update. The specific comparisons that will be included within the review question relating to

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					pharmacological management of blood glucose levels will be discussed and agreed with the guideline development group during the development of the guideline. Section 4.3.1 (a) has been amended to include meglitinides. However, rosiglitazone is no longer licensed so no specific recommendations will be made for this pharmacological agent.
SH	Department of Health	23	4.3.2h	Is diabetes to be included in the new CKD guidance? The most recent diabetes guidance on the use of lab microalbumin:creatinine annually is clear and helpful and it is vital that there is guidance included in the Diabetes guidelines as well as the CKD one – and it should obviously be the same in both! (see point 1)	Thank you for your comment. It is anticipated that people with diabetes will be covered within the updated NICE guideline on chronic kidney disease. For more details on what this guideline will be covering, see the scope on the NICE website (http://www.nice.org.uk)
SH	Department of Health	24	4.3.2j	Paragraph 2 says foot care will be included in this document.	Thank you for your comment. NICE has two pieces of guidance relating to foot care in those with diabetes: CG10 which covers the prevention and management of foot problems in those with type 2 diabetes and CG119 which covers the hospital inpatient management of people with diabetic foot ulcers and infection. NICE will be updating its existing guidance on foot care for those with diabetes and intend to bring both pieces of guidance together in one document. NICE is also considering how to best align all of its guidance

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					which relates to diabetes. Further details will be available on NICE's website in due course (http://www.nice.org.uk)
SH	Roche Products Ltd.	4	4.3.2j/5.1.2	'Prevention and management of diabetic foot problems' is highlighted as an 'area that will not be updated by an evidence review'. CG10 'Type 2 diabetes: prevention and management of foot problems' was published in 2004. The incorporation of CG10 is listed as 'incorporation under discussion'. We would recommend that evidence for CG10 should be reviewed as this guidance will be 10 years old by the time the Type 2 Diabetes CG is published.	Thank you for your comment. NICE has two pieces of guidance relating to foot care in those with diabetes: CG10 which covers the prevention and management of foot problems in those with type 2 diabetes and CG119 which covers the hospital inpatient management of people with diabetic foot ulcers and infection. NICE will be updating its existing guidance on foot care for those with diabetes and intend to bring both pieces of guidance together in one document. NICE is also considering how to best align all of its guidance which relates to diabetes. Further details will be available on NICE's website in due course (http://www.nice.org.uk).
SH	Department of Health	26	4.3.2p	Erratic glucose control and causes, particularly recognition that hypoglycaemia can occur in Type 2 diabetes	Thank you for your comment. Although we understand that the identification and management of hypoglycaemia may be important issues, they have not been prioritised for an update during the scoping process for type 2 diabetes. However, the identification of hypoglycaemia is currently being covered by the type 1 diabetes update and it is considered that this

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					issue would not differ for people with type 2 diabetes. Therefore a full evidence review will not be carried out within the type 2 diabetes update however the final guideline may cross-refer to the type 1 diabetes guideline as appropriate.
SH	Department of Health	27	4.3.2r	Shouldn't PVD be considered as part of the management of the diabetic foot?	Thank you for your comment. NICE has two pieces of guidance relating to foot care in those with diabetes: CG10 which covers the prevention and management of foot problems in those with type 2 diabetes and CG119 which covers the hospital inpatient management of people with diabetic foot ulcers and infection. NICE will be updating its existing guidance on foot care for those with diabetes and intend to bring both pieces of guidance together in one document. NICE is also considering how to best align all of its guidance which relates to diabetes. Further details will be available on NICE's website in due course (http://www.nice.org.uk).
SH	Department of Health	28	4.3.2s	What about specific issues pertaining to bariatric surgery and type 2 diabetes, for example should it be considered at a lower BMI threshold for South Asians?	Thank you for your comment. The use of bariatric surgery will be covered in clinical guideline 43, which includes consideration of people with type 2 diabetes as a subgroup. It is anticipated that the use of bariatric surgery in people with type 2 diabetes will be covered by

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					the update of NICE clinical guideline 43 on obesity. Therefore, the type 2 diabetes update will not cover a specific review question on the use of bariatric surgery and no specific recommendations will be made.
SH	Department of Health	29	4.3.2s	Bariatric surgery in people with diabetes should be included	Thank you for your comment. The use of bariatric surgery will be covered in clinical guideline 43, which includes consideration of people with type 2 diabetes as a subgroup. Therefore, the type 2 diabetes update will not cover a specific review question on the use of bariatric surgery and no specific recommendations will be made.
SH	Department of Health	30	4.4	What about outcomes that matter to patients e.g. ability to work, fewer hospital admissions, reduced hypoglycaemia.	Thank you for your comment. The outcomes that are included in section 4.4 of the scope are the main outcomes that will be searched for in the literature. The specific outcomes for each review question will be discussed and agreed with the guideline development group during the development of the guideline. All outcomes that are listed in this section are considered to be patient important outcomes.
SH	Diabetes Trials Unit	8	4.4	Is any consideration being given to patient oriented outcomes?	Thank you for your comment. The outcomes that are included in section 4.4 of the scope are the main outcomes that will be searched for in the literature. The specific outcomes for each review question will be

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					discussed and agreed with the guideline development group during the development of the guideline. All outcomes that are listed in this section are considered to be patient important outcomes.
SH	Eli Lilly and Company Limited	3	4.4	In addition to Health-Related Quality of Life, Lilly suggests considering additional treatment-specific aspects that impact quality of life. Examples of such aspects include treatment satisfaction, ease of device use and fear of hypoglycaemia	Thank you for your comment. The outcomes that are included in section 4.4 of the scope are the main outcomes that will be searched for in the literature. The specific outcomes for each review question will be discussed and agreed with the guideline development group during the development of the guideline. All outcomes that are listed in this section are considered to be patient important outcomes.
SH	Eli Lilly and Company Limited	4	4.4	In addition to changes in blood glucose levels and weight (or BMI), Lilly suggests including changes in lipids and systolic blood pressure (BP) to the list of main outcomes. The management of cardiovascular risk factors such as lipids and BP constitutes an important component of glycaemic control within a multi-factorial risk reduction framework given the significant benefits of lipid and BP control in terms of reduced cardiovascular complications such as MI and stroke (EASD/ADA Position Statement 2012). (Reference: Inzucchi SE, Bergenstahl RM, Buse JB, et al. Management of hyperglycemia in type 2 diabetes: a patient-centered approach. Diabetes Care. 2012 (35): 1364 – 1379)	Thank you for your comment. Section 4.4 has been revised and changes in lipids levels and blood pressure have now been included.
SH	LifeScan	3	4.4 Main Outcomes	We propose that the resolution of type 2 diabetes post bariatric surgery should be included within the main outcomes section. Within section g) the ability to perform activities of daily living including the ability to drive will contribute towards Health – related quality of life. Consideration must be made towards the	Thank you for your comment. The use of bariatric surgery will be covered in clinical guideline 43, which includes consideration of people with type 2 diabetes as a

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				implementation of the new DVLA guidance advocating appropriate blood glucose monitoring for type 2 diabetics on insulin, Sulphonylureas and Glinides.	subgroup. Therefore, the type 2 diabetes update will not cover a specific review question on the use of bariatric surgery and no specific recommendations will be made. The guideline development group will also take into consideration the safety of medications on the person's activities of daily living including driving throughout the development of the guideline. Specifically, all definitions of hypoglycaemia will be included as part of the evidence review and appropriate guidance from the DVLA will be discussed.
SH	Novo Nordisk Ltd	8	4.4	Novo Nordisk recognises the importance of HbA_{1c} as a diabetes outcome measure. We would also like to highlight the requirements of Treat-to-target (TTT) design for clinical trials as recommended in the FDA and EMA guidance[1]. TTT studies are considered best practice and the most ethical way to assess insulin therapies. In these studies the insulin dose is adjusted for each individual subject with the aim of achieving identical glycaemic targets. In such studies any between treatment differences are therefore detected via other parameters, for example, the rate of hypoglycaemia. A result of the TTT design is that HbA_{1c} differences between treatment groups will most likely not be significantly different, as the primary aim of the study is to bring all patients to the same glycaemic target. The main difference between insulin therapies subject to this design will be seen in terms of safety parameters, for instance, rates of hypoglycaemia. The rationale behind this trial design is that the benefits of glycaemic control should be balanced with associated side effects of a therapy (e.g. risk of hypoglycaemia), that is, a risk-benefit assessment can be made. The TTT design should result in more balanced outcomes than a trial-design that focuses solely on reducing HbA_{1c}. In summary the Treat-to-target design means limited difference and therefore hypoglycaemia becomes the most important outcome. [1] Food and Drug Administration. Guidance for Industry. Diabetes mellitus: Developing drugs	Thank you for your comment. The inclusion and exclusion criteria for studies for each review question will be discussed and agreed with the guideline development group during the development of the guideline. This will include the types of study design which may be considered for pharmacological management of blood glucose levels.

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				and therapeutic biologics for treatment and prevention - Draft Guidance. February 2008. Available at: http://www.fda.gov/downloads/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/ucm071624.pdf. Last accessed 20th Aug 2012.	
SH	Novo Nordisk Ltd	9	4.4	It is important to evaluate HbA_{1c}, hypoglycaemia, lipid lowering effects and weight changes. Additional outcomes should include both minor and major hypoglycaemia. We encourage the evaluation of these outcomes in clinical and cost effectiveness.	Thank you for your comment. Section 4.4 includes the frequency and severity of hypoglycaemic episodes and both minor and major hypoglycaemia will be included as part of this. Section 4.4 has been revised and changes in lipids levels and blood pressure have now been included.
SH	Roche Products Ltd.	2	4.4	We would recommend that patient satisfaction be included as a main outcome measure for consistency with the diabetes in children guideline and because of the importance of this measure and the likely correlation to better treatment adherence.	Thank you for your comment. The outcomes that are included in section 4.4 of the scope are the main outcomes that will be searched for in the literature. The specific outcomes for each review question will be discussed and agreed with the guideline development group during the development of the guideline. All outcomes that are listed in this section are considered to be patient important outcomes.
SH	Roche Products Ltd.	3	4.4	We would recommend that a 'measure of adherence to treatment' be added to the main outcomes. Diabetes is a long term condition and adherence to treatment with multiple drugs, especially injections, is paramount to effective diabetes control and management.	Thank you for your comment. Specific outcomes such as adherence to treatment will be considered for each review question. These will be discussed and agreed with the guideline development group during the development of the guideline.

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SH	British Psychological Society	3	4.4 (general)	It is useful for health professionals delivering care to people with Type 2 diabetes to identify mediators of the relationship between interventions and outcomes. These might include factors such as self-management (Gregg *et al*., 2007), adherence (West *et al*., 2007), and general lifestyle factors such as walking and other forms of exercise (Richardson *et al*., 2007). *References:* Gregg, J.A., Callaghan, G.M., Hayes, S.C. & Glenn-Lawson, J.L. (2007). Improving Diabetes Self-Management Through Acceptance, Mindfulness and Values: A randomised controlled study. *Journal of Consulting & Clinical Psychology*, *75(2)*, 336-43. West, D.S., DeLillo, V., Bursac, Z., Gore, S.A. & Greene, P.G. (2007). Motivational Interviewing Improves Weight Loss in Women with Type 2 Diabetes. *Diabetes Care*, *30(5)*, 1081-87. Richardson, C.R., Mehari, K.S., McIntyre, L.G., Janney, A.W., Fortlage, L.A., Sen, A. *et al*. (2007). A Randomized Trail Comparing Structured and Lifestyle Goals in an Internet-Mediated Walking Program for People with Type 2 Diabetes. *International Journal of Behavioral Nutrition & Physical Activity*, *4*, 59.	Thank you for your comment. A systematic review of the clinical evidence for each review question will be carried out and the guideline development group will make recommendations based on this evidence. The guideline development process also involves critical appraisal of the included evidence and discussion of the evidence with the guideline development group. It is anticipated that the guideline development group will also discuss wider issues including mediators throughout the development of the guideline.
SH	British Psychological Society	2	4.4 g)	The BPS recommends that psychological well-being should be considered as an outcome for people with Type 2 diabetes. Psychological interventions (including motivational interviewing, cognitive behaviour therapy [CBT] and counselling) have been shown to have an impact on well-being and diabetes control (HbA1c) (Ismail *et al*., 2004). *Reference:* Ismail, K., Winkley, K. & Rabe-Hesketh, S. (2004). Systematic Review and Meta-Analysis of Randomised Controlled Trials of Psychological Interventions to Improve Glycaemic Control in Patients with Type 2 Diabetes. *Lancet*, *363(9421)*, 1589-97.	Thank you for your comment. The outcomes that are included in section 4.4 of the scope are the main outcomes that will be searched for in the literature. The specific outcomes for each review question will be discussed and agreed with the guideline development group during the development of the guideline. All outcomes that are listed in this section are considered to be patient important outcomes.
SH	AstraZeneca / Bristol Myers Squibb	3	4.5	It should be noted that the primary function of self-monitoring of plasma glucose is not to control blood glucose itself.	Thank you for your comment. The wording of the review question for self-monitoring in section 4.5 of the

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					scope has now been amended.
SH	Department of Health	31	4.5	In which combinations and in which order? What individual patient factors should be considered e.g. obesity, CKD, hypoglycaemia, CVD. What factors are important to patients e.g. frequency of dosing, mode of administration, adverse effects.	Thank you for your comment. The specific drug comparisons that will be included within the review question addressing pharmacological management will be discussed and agreed with the guideline development group during the development of the guideline. The guideline development group may make specific recommendations for sub groups based on the evidence reviewed and the clinical expertise of the group.
SH	Department of Health	32	4.5	Unsure what "oral glucose tolerance" means.	Thank you for your comment. Oral glucose tolerance has now been removed from section 4.3.1 (b) and section 4.5
SH	Department of Health	33	4.5	Self-monitoring of capillary blood glucose not plasma glucose When should self-monitoring be used? Which patients benefit most? Cost-effectiveness? Considerations when choosing a glucometer e.g. costs of consumables, accuracy.	Thank you for your comment. NICE has asked the National Clinical Guideline Centre to develop the guidance for those with type 1 diabetes and the Internal Clinical Guidelines Programme at NICE to develop guidance for those with type 2 diabetes. The scopes for those with type 1 and type 2 diabetes both include self-monitoring. Whilst each developer is considering self-monitoring within their own specific population, NICE **will ensure consistency across all the guidelines relating to diabetes.**

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					The review question relating to self-monitoring will involve a systematic review of the literature. This review question will cover the use of self-monitoring by people with type 2 diabetes. This will include people who use blood glucose lowering therapies and those who do not use blood glucose lowering therapies (i.e. those who may be treated with lifestyle interventions alone). Section 4.3.1 (c) has been updated to clarify that targets, frequency of monitoring, timing and site of testing in relation to self-monitoring will all be looked at as part of this clinical area. The guideline development group for this guideline will make recommendations based on the included evidence and clinical expertise. For more details on the process of guideline development please see the NICE Guidelines manual 2012.
SH	Department of Health	34	4.5	What are the risks associated with aspirin use in people with type 2 diabetes? There is no mention of the use of aspirin or clopidogrel in the management of secondary prevention of CVD	Thank you for your comment. Currently secondary prevention of cardiovascular disease is outside the scope of this guideline. CG66 focused on primary prevention of cardiovascular disease and this issue has been prioritised for an update with an evidence review. The management of secondary

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					prevention using aspirin and clopidogrel is covered in other NICE guidance such as TA210 on Clopidogrel and modified-release dipyridamole for the prevention of occlusive vascular events and CG48 on MI-secondary prevention. Although there are no specific recommendations for people with diabetes, it is considered that these recommendations would not change for people with cardiovascular disease and type 2 diabetes.
SH	Department of Health	35	4.5	Hypogonadism and testosterone replacement in type 2 diabetes.	Thank you for your comment. The treatment of erectile dysfunction with testosterone therapy was prioritised for update during the scoping process. The review question for erectile dysfunction will focus on pharmacological management of erectile dysfunction, which has been considered a specific complication of diabetes. We will raise the issue of hypogonadism as a cause of erectile dysfunction in men with type 2 diabetes with the guideline development group. If the group conclude that we should addressing hypogonadism as a cause of erectile dysfunction in men with type 2 diabetes we will look to expand this particular review question. Section 4.3.1(e) has been amended in the

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					scope to cover drug therapy for erectile dysfunction (PDE-5 inhibitors, testosterone therapy and alprostadil).
SH	Department of Health	36	4.5	Psychological health: monitoring, referring and managing.	Thank you for your comment. Although we considered updating psychological issues in type 2 diabetes, the updated guidance for managing depression in adults (CG90) with chronic physical health problems would also apply to people with type 2 diabetes. Similarly NICE guidance for common mental health disorders (CG123) may also be relevant. The issue of wider psychological burden was not agreed as a priority for update during the scoping process
SH	LifeScan	4	4.5 Review questions Self monitoring of plasma glucose	Type 2 testing in patients treated with oral antidiabetic agents (OADs) is inconsistent within this population and potentially failing to achieve health related benefits by supporting improvements in glycaemic control. It would therefore be useful for this Guideline to offer guidance to patients and clinicians on the role of self monitoring of blood glucose in subgroups of the type 2 population. We would therefore propose that the question should be expanded to ask if there are any sub groups in the type 2 population treated with OADs that benefit from self monitoring more than others. Examples might include patients being managed with OADs that predispose to hypoglycemia, or patients with coexisting chronic diagnoses that may indicate the need to more specifically avoid hypoglycemia or patients with a known past history of significant hypoglycemia. Also a recommendation as to the minimum frequency of testing in patients with type 2 diabetes which could mitigate the need for progression of therapy and optimize disease	Thank you for your comment. NICE has asked the National Clinical Guideline Centre to develop the guidance for those with type 1 diabetes and the Internal Clinical Guidelines Programme at NICE to develop guidance for those with type 2 diabetes. The scopes for those with type 1 and type 2 diabetes both include self-monitoring. Whilst each developer is considering self-monitoring within their own specific population, NICE will ensure consistency across all **the guidelines relating to diabetes.**

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				management in specific sub groups as mentioned above.	**The review question relating to self-monitoring will involve a systematic review of the literature. This review question will cover the use of self-monitoring by people with type 2 diabetes. This will include people who use blood glucose lowering therapies and those who do not use blood glucose lowering therapies (i.e. those who may be treated with lifestyle interventions alone)**. Section 4.3.1 (c) has been updated to clarify that targets, frequency of monitoring, timing and site of testing in relation to self-monitoring will all be looked at as part of this clinical area. The guideline development group for this guideline will make recommendations based on the included evidence and clinical expertise. For more details on the process of guideline development please see the NICE Guidelines manual 2012.
SH	LifeScan	5	4.5 Review questions Self monitoring of plasma glucose	We would like to submit the following references for consideration in the evidence review. • Schnell O, Alawi H, Battelino T, Ceriello A, Diem P, Felton A, Grzeszczak W, Harno K, Kempler P, Satman I, Verges B. Addressing Schemes of Self-Monitoring of Blood Glucose in Type 2 Diabetes: A European Perspective and Expert Recommendation. *Diabetes Technology and Therapeutics* 2011;13(9):959-965. • Schnell O, Alawi H, Battelino T, et al. Consensus statement on self-monitoring of	Thank you for these references. If these references are identified within the systematic searches conducted for each review question (based on the search criteria set out within the review protocol for each evidence review), they will be considered for inclusion or exclusion within the

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				blood glucose in diabetes. *Diabetes.* 2009(18):285-289. • Russell-Minda E, Jutai J, Speechley M, et al. Health technologies for monitoring and managing diabetes: A systematic review. *Journal of Diabetes Science and Technology.* 2009;3(6):1460-1471. • Khamseh M, Ansari M, Malek M, et al. Effects of a structured self-monitoring of blood glucose method on patient self-management behavior and metabolic outcomes in type 2 diabetes mellitus. *Journal of Diabetes Science and Technology.* 2011;5(2):388-393. • Weber C, Kocher S, Neeser K, et al. Impact of self-measurement of blood glucose on complications of type 2 diabetes: Economic analysis from a Czech perspective. *Current Medical Research Opinion.*2010;26(7):289-296. • Martin S, Schneider B, Heinemann L, et al. Self-monitoring of blood glucose in type 2 diabetes and long-term outcome: an epidemiological cohort study. *Diabetologia.* 2006;49:271-278. • Karter A, Parker MM, Moffet HH, et al. Longitudinal study of new and prevalent use of self-monitoring of blood glucose. *Diabetes Care.* 2006;29:1757-1763. • Pollock R et al. Evaluating the cost-effectiveness of self monitoring of blood glucose in type 2 diabetes patients on oral anti-diabetic agents: A long-term modelling study in Switzerland. Swiss Med Wkly. 2010;140:w13103. • Tunis S et al.Self-monitoring of Blood Glucose in Type 2 Diabetes: Cost-effectiveness in the United States. Am J Manag Care. 2008;14(3):131-140. • Tunis S et al. Self-monitoring of blood glucose (SMBG) in patients with type 2 diabetes on oral anti-diabetes drugs: cost-effectiveness in France, Germany, Italy, and Spain. Current Medical Research & Opinion Vol. 26, No. 1, 2010, 163–175	evidence review. For more information on developing clinical guidelines please see the NICE Guidelines manual 2012.
SH	LifeScan	6	4.5 Review questions Self monitoring of	We would like to submit the following references for consideration in the evidence review. • Parkin C et al. Results that matter: Structured vs. unstructured self-monitoring of blood glucose in type 2 diabetes. Diab Res Clin Pract (2012), doi:10.1016/j.diabres.2012.03.002.	Thank you for these references. If these references are identified within the systematic searches conducted for each review question (based on the search criteria set out within the review protocol for each evidence

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			plasma glucose	• Schnell O , Alawi H, Battelino T, Ceriello A, Diem P, Felton A, Grzeszczak W, Harno K, Kempler P, Satman I and Verge B. Addressing Schemes of Self-Monitoring of Blood Glucose in Type 2 Diabetes: A European Perspective and Expert Recommendation.. DIABETES TECHNOLOGY & THERAPEUTICS Volume 13, Number 9, 2011. • Polonsky W et al. Structured Self-Monitoring of Blood Glucose Significantly Reduces A1C Levels in Poorly Controlled, Noninsulin-Treated Type 2 Diabetes. Diabetes Care 34:262–267, 2011. • Franciosi M, Lucisano G, Pellegrini F, Cantarello A.,Consoli A, Cucco L, Ghidelli R, Sartore G, Sciangula L, Nicolucci A. ROSES: role of self-monitoring of blood glucose and intensive education in patients with Type 2 diabetes not receiving insulin. A pilot randomized clinical trial.. Diabet. Med. 28, 789–796 (2011) • Kempf K, Kruse J, Martin S. ROSSO-in-praxi: A Self-Monitoring of Blood Glucose-Structured 12-Week Lifestyle Intervention Significantly Improves Glucometabolic Control of Patients with Type 2 Diabetes Mellitus.. DIABETES TECHNOLOGY & THERAPEUTICS Volume 12, Number 7, 2010. • Chidum E et al. Self-monitoring of blood glucose improved glycaemic control and 10-year coronary heart disease risk profile of type 2 diabetic patients. Chin Med J 2011;124(2):166-171. • Klonoff D, Blonde L, Cembrowski G, Chacra A, Charpentier G, Colagiuri S, Dailey G, Gabbay R, Heinemann L, Kerr D, Nicolucci A, Polonsky W, Schnell O, Vigersky R and Yale J. Consensus Report: The Current Role of Self-Monitoring of Blood Glucose in Non-Insulin-Treated Type 2 Diabetes. Journal of Diabetes Science and Technology Volume 5, Issue 6, November 2011. • Morgan C L, Griffin A, Chamberlain G, Turkiendorf A, McEwan P, Evans L, Owens D. A Longitudinal Study into the New and Long-Term Use of Self-monitoring Blood Glucose Strips in the UK. Diabetes Ther (2010) 1(1):1-9. • Torre E, García T, Millán C, Pérez J, Fernández R. Recomendaciones 2012 de la Sociedad Espa˜nola de Diabetes sobrela utilización de tiras reactivas para la medición de la glucemia capilar en personas con diabetes. Av Diabetol. 2012;28(1):3---9 •	review), they will be considered for inclusion or exclusion within the evidence review. For more information on developing clinical guidelines please see the NICE Guidelines manual 2012.
SH	Merck Serono	1	4.5	Merck Serono welcome the review of pharmacological management to control blood glucose levels and would like to emphasize the potential tablet burden that patient can endure. In this	Thank you for your comments. We recognise that potential tablet burden

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				perspective, where possible Merck Serono would appreciate specific and explicit recommendation guiding patients to use treatment option increasing adherence and reducing burden of medication.	and adherence may be important issues in the pharmacological management of blood glucose levels in patients with type 2 diabetes. It is anticipated that the guideline development group will discuss issues such as these during the development of the guideline.
SH	Merck Serono	2	4.5	Merck Serono supports the review of self monitoring used to control blood glucose levels in people with type 2 diabetes. Type 2 Diabetes is a rather long-term chronic disease requiring careful and increasing management of blood glucose level from diagnosis as well as constant health professional support. Therefore we believe that in an integrated care NHS, self reported indicators should be facilitated to help patients' in their objective for health improvement and to better control risk factors related to diabetes.	Thank you for your comment.
SH	Novartis Pharmaceuticals Ltd	5	4.5	There should be consideration of the impact of monitoring on diabetes complications in terms of what should be monitored and the frequency, for example, liver and renal function monitoring.	Thank you for your comment. While we recognise the importance of long term monitoring for diabetic complications, this is outside the scope of this guideline. However, the development of both macrovascular and microvascular complications are included as outcomes in section 4.4 of the scope.
SH	Roche Diagnostics Limited	1	4.5	Self-monitoring of blood glucose (SMBG) is a well-established element of therapy management for people with type 1 or type 2 diabetes on insulin therapy. However, there have been controversial views on the question of whether regular SMBG is similarly beneficial for non-insulin treated people with type 2 diabetes. To gain new insights on this subject, the STeP Study was performed: A prospective, cluster-randomised, multi-centre clinical trial, which examined the impact of structured SMBG upon glycemic control in 483 non-insulin treated people with type 2 diabetes who evidenced poor glycemic control (HbA1c > 7.5%) at baseline. The results provided new and significant evidence on its effectiveness. The innovative concept is based on structured 7-point blood glucose profiles (fasting,	Thank you for your comment. NICE has asked the National Clinical Guideline Centre to develop the guidance for those with type 1 diabetes and the Internal Clinical Guidelines Programme at NICE to develop guidance for those with type 2 diabetes. The scopes for those with type 1 and type 2 diabetes both include self-monitoring. Whilst each

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				preprandial and 2 hour postprandial at each meal, and bedtime), collected and documented over 3 consecutive days prior to each scheduled quarterly healthcare professional visit. To document blood glucose values, meal sizes and energy levels, and to comment on their SMBG experiences, STG participants used the Accu-¬Chek® 360° View 3-day profile tool. They discussed the obtained profiles with their caregivers at all medical visits. To familiarise them with the protocol, patients in the STG arm of the study received a standardised training in SMBG and pattern analysis, while their doctors were equally trained and equipped with an algorithm suggesting appropriate medication strategies The innovative concept is based on structured 7-point blood glucose profiles (fasting, preprandial and 2 hour postprandial at each meal, and bedtime), collected and documented over 3 consecutive days prior to each scheduled quarterly healthcare professional visit. To document blood glucose values, meal sizes and energy levels, and to comment on their SMBG experiences, STG participants used the Accu-¬Chek® 360° View 3-day profile tool. They discussed the obtained profiles with their caregivers at all medical visits. To familiarise them with the protocol, patients in the STG arm of the study received a standardised training in SMBG and pattern analysis, while their doctors were equally trained and equipped with an algorithm suggesting appropriate medication strategies. The study demonstrated diabetes management can significantly improve overall glycaemic control and reduce HbA1c values in non-insulin treated type 2 diabetes. *Polonsky WH, Fisher L, Shikman CH, Hinnen DA, Parkin GC, Jelsovsky Z et al. Structured SMBG significantly reduces HbA1c levels in poorly-controlled, non-insulin treated type 2 Diabetes: Results from the STeP Study [NCT00674986].Diabetes Care February 2011 34:262-267; doi:10.2337/dc10-1732.*	developer is considering self-monitoring within their own specific population, NICE will ensure consistency across all the guidelines relating to diabetes. Thank you for your comment. NICE has asked the National Clinical Guideline Centre to develop the guidance for those with type 1 diabetes and the Internal Clinical Guidelines Programme at NICE to develop guidance for those with type 2 diabetes. The scopes for those with type 1 and type 2 diabetes both include self-monitoring. Whilst each developer is considering self-monitoring within **their own specific population, NICE will ensure consistency across all the guidelines relating to diabetes.** **The review question relating to self-monitoring will involve a systematic review of the literature. This review question will cover the use of self-monitoring by people with type 2 diabetes. This will include people who use blood glucose lowering therapies and those who do not use blood glucose lowering therapies (i.e. those who may be treated with lifestyle interventions alone)**.

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					Section 4.3.1 (c) has been updated to clarify that targets, frequency of monitoring, timing and site of testing in relation to self-monitoring will all be looked at as part of this clinical area.. The guideline development group for this guideline will make recommendations based on the included evidence and clinical expertise. For more details on the process of guideline development please see the NICE Guidelines manual 2012.
SH	Royal College of Pathologists	5	4.5	As for 4.2.1 b) oral glucose tolerance is not generally used as a target for glucose control.	Thank you for your comment. Oral glucose tolerance has now been removed from section 4.3.1 (b) and section 4.5
SH	Sanofi	3	4.5	Review question: What pharmacological interventions should be used to control blood glucose levels in people with type 2 diabetes? When should pharmacological interventions be used? This is an important question to address, particularly in light of the fact that one third of patients in the 2009-10 National Diabetes Audit failed to reach the most basic target for HbA_{1c} of 7.5%. Although not yet released, there is no reason to expect any significant difference in the most recent version of the survey. The question is not one of which agents should be used, but one of which process should be adopted to ensure that patients who are not at target are reviewed and brought to their own individual target. In particular it is those patients newly diagnosed who stand to gain the most – minimising an unnecessary exposure to a prolonged period of hyperglycaemia has potential to minimise long term complications and adverse patient outcomes. The guideline should therefore include a focus on the longitudinal pathway that each patient takes and the need to move through this without delay until target glycaemic levels are	Thank you for your comment. It is anticipated that the guideline will produce an updated treatment algorithm for people with type 2 diabetes. This algorithm will take into account treatment options when people are not reaching target Hba1c levels. The guideline will also cover a separate review question relating to target Hba1c levels and it is anticipated that the guideline development group will discuss strategies for controlling blood glucose levels based on the evidence and the clinical expertise of the group.

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				achieved, rather than awaiting failure at each step before progressing. The fact that the average HbA_{1c} for patients with type 2 diabetes when commencing insulin has recently been shown to be 9.3% in the UK, with a 9.9 year duration of diabetes, is testament to this (Rathman *et al.* 2012). In summary, the biggest impact that the updated guideline could make is to ensure that a focus is driven in getting patients to target early, and keeping them at target in the long run. If a specific pharmacological intervention needs to be given greater prominence, basal insulin has been shown to be simple to use, safe and effective in patients with type 2 diabetes – but is being introduced too late in the patient pathway to prevent the long term morbidities that we see today. The long acting analogues are more effective than intermediate action insulin in reaching target levels of HbA_{1c} with acceptable levels of adverse effects – notably hypoglycaemia. The evidence for the effectiveness of basal insulins has evolved since the guidelines were last reviewed and both the clinical and economic impacts of basal insulin should be reviewed in depth.	
SH	Sanofi	4	4.5	Review question: What are the long term safety issues associated with the use of pharmacological interventions to control blood glucose in people with type 2 diabetes? There is new evidence on the long term safety of insulin glargine from the recently published ORIGIN trial. See comment 2 above for more details.	Thank you for your comment.
SH	Sanofi	5	4.5	Review Question: What are the optimal target values for HbA1c, fasting blood glucose, post prandial glucose and oral glucose tolerance in people with type 2 diabetes? This is an important area to be addressed, but more important than defining the absolute value (or range within which individual targets should fall) is to consider how best to ensure patients achieve these targets. Consideration needs to be given to how to enable patients to "get to target and stay at target" – see comment above on "What pharmacological interventions...".	Thank you for your comment. It is anticipated that guideline will produce an updated treatment algorithm for people with type 2 diabetes. This algorithm will take into account treatment options when people are not reaching target Hba1c levels. The guideline will also cover a separate review question relating to target Hba1c levels and it is anticipated that the guideline development group will discuss

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					strategies for controlling blood glucose levels based on the evidence and the clinical expertise of the group
SH	Sanofi	6	4.5	Review Question: Should self-monitoring be used to control blood glucose levels in people with type 2 diabetes? Self-monitoring should be used by patients on insulin therapy. Selection of the appropriate meter should be informed by patient choice. Allowing patients to choose a meter they like will reduce wastage and improve patient compliance.	Thank you for your comment. NICE has asked the National Clinical Guideline Centre to develop the guidance for those with type 1 diabetes and the Internal Clinical Guidelines Programme at NICE to develop guidance for those with type 2 diabetes. The scopes for those with type 1 and type 2 diabetes both include self-monitoring. Whilst each developer is considering self-monitoring within their own specific population, NICE will ensure consistency across all the guidelines relating to diabetes. The review question relating to self-monitoring will involve a systematic review of the literature. This review question will cover the use of self-monitoring by people with type 2 diabetes. This will include people who use blood glucose lowering therapies and those who do not use blood glucose lowering therapies (i.e. those who may be treated with lifestyle interventions alone). Section 4.3.1 (c) has been updated to clarify that targets, frequency of monitoring, timing and site of testing in relation to

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					self-monitoring will all be looked at as part of this clinical area.. The guideline development group for this guideline will make recommendations based on the included evidence and clinical expertise. For more details on the process of guideline development please see the NICE Guidelines manual 2012.
SH	WOCKHARDT UK	2	4.5	Under 4.5 Review Questions, the following item should be included: Long-term safety of genetically-modified (GM) insulins. • What are the long-term safety issues associated with the use of GM insulins?	Thank you for your comment. We will be conducting a separate evidence review covering long term effects associated with all the pharmacological agents listed in section 4.3.1 when used to manage blood glucose levels in type 2 diabetes. This review question will focus on adverse events and the development of diabetic complications. Recommendations will be based on the evidence reviewed and the clinical expertise of the guideline development group. The specific drug comparisons that will be included within this review question will be discussed and agreed with the guideline development group during the development of the guideline.
SH	Diabetes Trials Unit	9	4.5 Antithrombotic	These two bullet points need to be addressed separately for those with and without known cardiovascular disease.	Thank you for your comment. Currently secondary prevention of cardiovascular disease is outside the

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			therapy		scope of this guideline. CG66 focused on primary prevention of cardiovascular disease and this issue has been prioritised for an update with an evidence review. The management of secondary prevention using aspirin and clopidogrel is covered in other NICE guidance such as TA210 on Clopidogrel and modified-release dipyridamole for the prevention of occlusive vascular events and CG48 on MI-secondary prevention. Although there are no specific recommendations for people with diabetes, it is considered that these recommendations would not change for people with cardiovascular disease and type 2 diabetes.
SH	British Psychological Society	4	4.5 Review question on Self-monitoring	The existing question is "*should self-monitoring be used to control blood glucose levels…"* Since it is important to establish what aspects of self-monitoring of blood glucose are related to better self-management of Type 2 diabetes (see 4.3.1 above), we suggest it would be more useful to ask *"what are the psychosocial (psychological, social, demographic) characteristics of patients who do and do not benefit from self-monitoring of blood glucose*".	Thank you for your comment. NICE has asked the National Clinical Guideline Centre to develop the guidance for those with type 1 diabetes and the Internal Clinical Guidelines Programme at NICE to develop guidance for those with type 2 diabetes. The scopes for those with type 1 and type 2 diabetes both include self-monitoring. Whilst each developer is considering self-monitoring within their own specific population, NICE will ensure consistency across all the guidelines relating to diabetes.

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					The review question relating to self-monitoring will involve a systematic review of the literature. This review question will cover the use of self-monitoring by people with type 2 diabetes. This will include people who use blood glucose lowering therapies and those who do not use blood glucose lowering therapies (i.e. those who may be treated with lifestyle interventions alone). Section 4.3.1 (c) has been updated to clarify that targets, frequency of monitoring, timing and site of testing in relation to self-monitoring will all be looked at as part of this clinical area. The guideline development group for this guideline will make recommendations based on the included evidence and clinical expertise. For more details on the process of guideline development please see the NICE Guidelines manual 2012. If the use of self-monitoring is supported by the evidence, the guideline development group will also consider whether specific recommendations should be made for sub-groups of the population.
SH	Sanofi	7	4.6	Economic evaluation of basal insulin analogues needs to consider both unit dosing requirements, and rates of hypoglycaemia seen in real life clinical practice. A Phase 4 trial comparing insulins glargine and detemir (Rosenstock *et al.*2008) in combination with OADs	Thank you for your comment. In line with the NICE Guidelines manual 2012, any economic evaluation will

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				showed that in order to achieve equivalent glycaemic control insulin detemir needed to be administered in considerably higher doses, and 55% of detemir patients required twice daily dosing, while 100% of glargine patients remained on OD dosing. Furthermore, in the recent EFFICACY trial (mentioned in comment 2 above, EFFICACY 2011) when both insulins detemir and glargine were used exclusively once daily insulin detemir failed to achieve non-inferiority vs glargine. These findings have significant cost implications that are typically overlooked in national level economic evaluations, including the acquisition cost of the insulin and also costs relating to additional blood glucose monitoring requirements. The principal benefit of insulin glargine over NPH insulin is lower observed rates of hypoglycaemia (Home *et al.* 2010). However, the rates of hypoglycaemia seen in clinical trials are typically very low due to the controlled and artificial setting. This means that any given proportional reduction in hypoglycaemia translates into a small number of absolute events prevented. Rates of hypoglycaemia seen in real life clinical practice are considerably higher (Leese *et* 2003). If economic modelling were to incorporate these more realistic rates of hypoglycaemia insulin glargine would be considerably more cost effective. Indeed, since its initial appraisal by NICE a number of studies have shown insulin glargine to be a cost effective treatment option in comparison to NPH insulin in T2 Diabetes, both in the UK (McEwan *et al.* 2007) and in other jurisdictions (Hallinen *et al.* 2012).	make use of the best available evidence
SH	Janssen – Cilag Ltd	5	5.1.1 NICE guidance to be updated	The current scope for consultation mentions that the revised guideline might update and replace parts of the Type 2 diabetes: newer agents- NICE clinical guideline 87 (2009) and Type 2 diabetes - NICE clinical guideline 66 (2008). Should these two previous guidelines be merged into one at the end of this consultation?	Thank you for your comment. It is intended that CG87 and CG66 will be merged into one document.
SH	Novo Nordisk Ltd	10	5.1.3	This section should include 'Liraglutide for the treatment of type 2 diabetes mellitus. NICE technology appraisal guidance 203 (2010)' in line with the other guidance presented.	Thank you for your comment. Section 5.1.3 has now been amended to refer to TA 203: Liraglutide for the treatment of type 2 diabetes mellitus.
SH	Roche Products Ltd.	5	5.1.3	We would recommend that the following other clinical guidelines be considered under the 'other related NICE guidance section': 'CG48 MI secondary prevention' and the new CG in development: 'MI with ST segment elevation' because of the link between diabetes and	Thank you for your comment. The related NICE guidance section has now been update in the scope to

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				cardiac complications.	refer to CG48 MI Secondary prevention.
SH	Janssen – Cilag Ltd	6	5.2 Guidance under development	Could some clarifications be given as to why the wording of the STA for dapagliflozin which is mentioned in section 5.2. is not consistent with the draft scope for dapagliflozin STA. The draft scope for dapagliflozin STA indicates that dapagliflozin (in combination with oral anti-diabetic agents and/or insulin) will be appraised, not just its fixed dose combination as mentioned in the consultation scope for the management of type 2 diabetes.	Thank you for your comment. The wording of this guideline has been amended to reflect the draft scope for dapagliflozin. This section now reads 'dapagliflozin in combination therapy for the treatment of type 2 diabetes'
SH	Janssen – Cilag Ltd	3	Areas from the original guidelines that will be updated by an evidence review	Current understanding regarding oral glucose tolerance (OGTT) is that it is a diagnostic measure rather than ongoing measure for blood glucose control. (http://www.patient.co.uk/doctor/Glucose-Tolerance-Tests.htm) Could some clarifications be given as to why OGTT is considered as a relevant target blood glucose control measure for which target values will be evaluated?	Thank you for your comment. Oral glucose tolerance has now been removed from section 4.3.1 (b) and section 4.5.
SH	Janssen– Cilag Ltd	2	Areas from the original guidelines that will be updated by an evidence review	Could some clarifications be given as to why glucagon-like peptide-1 (GLP-1) mimetics are excluded from the list of glucose-control therapies considered as part of the pharmacological management of blood glucose levels to be assessed during this consultation, especially as both NICE guidances regarding exenatide prolonged-release (TA248) and liraglutide (TA203) have been published.	Thank you for your comment. Technology appraisals (TA) TA203 (liraglutide) and 248 (prolonged-release exenatide) were based on recommendations from clinical guideline (CG) 87. Because the update of the clinical guideline CG87 and clinical guideline CG66 is scheduled to consider exenatide, this could result in a change to the recommendations in TA203 and TA248. In August 2012 the Centre for Technology Evaluation (CHTE) at NICE therefore consulted on a

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					proposal for TA203 and TA248 to be updated in the update of clinical guidelines CG66 and CG87. After consultation NICE agreed to update TA203 and TA248 within the update of the clinical guidelines CG66 and CG87. Once the guideline is published the technology appraisals will be withdrawn. The Centre for Technology Evaluation (CHTE) at NICE are currently developing guidance on the SGLT-2 inhibitors Dapagliflozin in combination therapy for the treatment of type 2 diabetes (ID427) and Canagliflozin for type 2 diabetes mellitus (ID554). The update of clinical guideline CG87 and clinical guideline CG66 will incorporate this guidance subject to a technology appraisal review proposal agreement.
SH	Janssen – Cilag Ltd	4	Areas not in the original guidelines that will be included in the update	While testosterone replacement therapy has been reported has having an effect on glycaemic control, it is not the only therapy of erectile dysfunction that could be used my men with type 2 diabetes. Could some clarifications be given as to why phosphodiesterase type 5 (PDE-5) inhibitors are not considered for the management of erectile dysfunction in T2DM men, and why testosterone therapy is the only treatment for the management of erectile dysfunction in men with type 2 diabetes to be included in the update?	Thank you for your comment. The scope has been amended to include the effectiveness of PDE-5 inhibitors and alprostredil for the management of erectile dysfunction.
SH	Department of Health	25	Diagnosis 4.3.2m	HbA1c can now be used to diagnose T2 diabetes and it is ESSENTIAL that this is included (see WHO guidance and NICE)	Thank you for your comment. Although we recognise the

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					importance of diagnosing type 2 diabetes, this clinical issue was not prioritised for update during the scoping process for type 2 diabetes clinical guideline. However, as diagnosis and differentiation between type 1 and type 2 diabetes are being covered in the type 1 diabetes guideline, we will be able to cross-refer to appropriate recommendations made for diagnosis within this guideline. There will not be a separate evidence review focusing on diagnosis in the type 2 diabetes update.
SH	AstraZeneca / Bristol Myers Squibb	1	General	AstraZeneca and Bristol-Myers Squibb welcome the opportunity to comment on the draft scope for the Type 2 Diabetes NICE clinical guideline	Thank you for your comment.
SH	Bayer plc	4	General	Whilst it is clear that the diagnosis and management of diabetic retinopathy is not considered to be an area covered by the guideline, it is not clear from the proposed scope whether the current section on eye damage is planned for an update to make reference to the NHS Diabetic Eye Screening Programme?[1] (1) NHS Diabetic Eye Screening Programme. 2012. Available from: http://diabeticeye.screening.nhs.uk/. (Last accessed: 21/8/2012).	Thank you for your comment. Screening for eye damage has not been prioritised for an updated evidence review. Therefore, screening for diabetic retinopathy has been added to section 4.3.2 of the scope. However, as the final guideline will include recommendations from CG66, it is anticipated that references (including the UK national screening programme) that are out of date will be updated with recent publications.
SH	British Pain Society	1	General	As diabetes is associated with neuropathic pain the guideline is quite correctly cross referenced to the NICE neuropathic pain guideline we feel it should also be cross referenced	Thank you for your comment. The guideline development group will

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				to the NICE TAG 159 on spinal cord stimulation for neuropathic and ischaemic pain	discuss related NICE guidance and will cross-refer to guidance where appropriate. This guidance has been added to section 4.3.2 of the scope which sets out NICE guidance that will be cross-referred to.
SH	Community Diabetes Consultants	1	General	For type 2 scope we should ask for a definite older people section emphasising the different target of HbA1c in this group- phrasing this around individualising care in older people taking account of multiple co-morbidities A key are is target for Hba1c which will need to be adjusted for frailty and expected length of life	Thank you for your comment. Section 4.1.1 sets out examples of subgroups where the management of type 2 diabetes may differ and adults aged 65 and older are included here. The guideline development group may make specific recommendations for sub groups of the population based on the evidence reviewed and the clinical expertise of the group.
SH	Community Diabetes Consultants	3	General	Although outside the scope to revisit diagnosis as a lot of confusion here locally about whether to use the new diagnostic criteria or not	Thank you for your comment. Although we recognise the importance of diagnosing type 2 diabetes, this clinical issue was not prioritised for update during the scoping process for type 2 diabetes clinical guideline. However, as diagnosis and differentiation between type 1 and type 2 diabetes are being covered in the type 1 diabetes guideline, we will be able to cross-refer to appropriate recommendations made for diagnosis within this guideline. There will not be a separate evidence review focusing on diagnosis in the type 2 diabetes update

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SH	Department of Health	1	General	This guidance cannot be considered in isolation from the guidance for Children and young people, Type 1 and pregnancy. There are common issues and these should be linked to ensure consistency of approach and inappropriate duplication. See also CKD guidance.	Thank you for your comments. We agree. NICE has set up a steering committee to oversee the production of these pieces of guidance. The group, which includes guideline development group chairs, staff from all three guidance-producing centres and staff from NICE, will identify and act on any gaps or overlaps across the different guidance topics in order to ensure that the final guidance produced is complementary and consistent.
SH	Department of Health	2	General	Preconception counselling and contraceptive advice should be included – half the women presenting to pregnant diabetic clinics with pre-pregnant diabetes have type 2	Thank you for your comment. Although we recognise preconception counselling and contraceptive advice are important issues, these areas are outside the scope of this guideline. The guideline covering diabetes in pregnancy is due to be updated. Please consult the draft scope of that guideline to identify if these areas have been prioritised for update.
SH	Department of Health	3	General	Include the management of Type 2 diabetes in hospital e.g. access to diabetes specialist team and self care for diabetes treatment (e.g. insulin) and self-monitoring of glucose. See National Diabetes In patient Audit	Thank you for your comment. This guideline will cover the management of type 2 diabetes in all NHS care settings including in hospital. The guideline development group may make specific recommendations for subgroups of the population based on the evidence reviewed and the clinical expertise of the group.

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SH	Department of Health	4	General	People with T2 diabetes may have eating disorders and this should be included	Thank you for your comment. Section 4.1.1 sets out example subgroups within the population where the management of type 2 diabetes may differ, however this list is not exhaustive. The guideline development group may make specific recommendations for sub groups of the population based on the evidence reviewed and the clinical expertise of the group.
SH	Department of Health	5	General	Starting ACE inhibitors and ARBs – more detailed guidance e.g. checking pretreatment renal function and monitoring this	Thank you for your comment. Although we recognise that beginning treatment with ACE inhibitors and ARBs may be an important area, this is outside the scope of this guideline. These issues are considered in more detail in other NICE clinical guideline (e.g. see chronic heart failure CG108 and hypertension CG127).
SH	Department of Health	6	General	Include obstructive sleep apnoea and diabetes	Thank you for your comment. Although we recognise that sleep apnoea in diabetes may be an important area, this is outside the scope of this guideline.
SH	Department of Health (National Clinical Director for diabetes)	37	General	For the first time, all four major NICE clinical guidelines for diabetes care are being updated around the same time. Different guideline committees are responsible for each, sometimes even different organisations. This is an excellent opportunity to update diabetes care. It also presents a high risk for duplication and confusion. Diabetes care is a continuum. The girl with Type 1 diabetes becomes an adult. She may become pregnant, as may a woman with Type 2 diabetes. Most diabetes care is the same whatever the age or type of diabetes.	Thank you for your comments. We agree. NICE has set up a steering committee to oversee the production of these pieces of guidance. The group, which includes guideline development group chairs, staff from all three guidance-producing centres and staff from NICE, will identify and

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				It is essential that these four guidelines are consistent in the advice they provide so that confusion does not arise as the patient moves from one situation to another. It is also essential that duplication and confusion are avoided from the point of view of healthcare professionals, providers and commissioners. It also seems a great waste of time for four committees to duplicate effort over issues communal to all four guidelines. It is therefore absolutely essential that arrangements are made, so that each of the guideline committees is linked to the others to ensure consistency in guidance, and save resource. It is also strongly advisable to agree, before work starts, what areas are communal to all guidelines, and how such work is to be tackled. These areas will include: • Prompt accurate diagnosis; • Emotional and psychological support for patients, family and carers; • Diabetes education; • Care planning; • Initial management – lifestyle and medication; • Nutrition, including weight normalisation; • Exercise; • Patient self monitoring; • Routine clinical monitoring – annual and interim review: identification of risk factors for complications so as to prevent them; detection of complications; detection of common co-morbidities (e.g. depression, thyroid etc) risk stratification; • Risk factor management e.g. glucose control, blood pressure and cholesterol control; • Prevention and management of acute complications (e.g. high and low glucose) (this includes diabetes care in hospital); • Prevention and management of longer term complications; • Integrated multi-disciplinary care; • Audit and outcome measurement.	act on any gaps or overlaps across the different guidance topics in order to ensure that the final guidance produced is complementary and consistent.

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				The main drugs used are largely the same: • Glucose-lowering; Insulins; Oral, non-insulin injectable; • Blood pressure lowering; • Cholesterol lowering; • Renoprotective.	
SH	FACULTY OF DENTAL SURGERY	1	general	The Dental team including Oral medicine specialists play a major role in screening for oral care in adult and paediatric patients with diabetes. Through oral screening, adult and paediatric patients with undiagnosed diabetes presenting with oral signs and symptoms suggestive of diabetes can be referred to the physician for further evaluation.	Thank you for your comment. Although we recognise detecting undiagnosed diabetes through oral signs and symptoms is an important area, diagnosis of type 2diabetes is out of the scope of this guideline.
SH	FACULTY OF DENTAL SURGERY	2	general	Through educating patients on improving oral health and preventing development of oral complications associated with diabetes, they can improve the metabolic control of diabetes.	Thank you for your comment. Although we recognise oral health and preventing oral complications in patients with type 2 diabetes is an important area, this is out of the scope of this guideline.
SH	FACULTY OF DENTAL SURGERY	3	general	Through working with both the physician and the nutritionist, they play an important role in ensuring that the patient's glycaemic control is optimised in order to prevent systemic complications of diabetes.	Thank you for your comment. Although we recognise oral health and preventing oral complications in patients with type 2 diabetes is an important area, this is out of the scope of this guideline.
SH	FACULTY OF DENTAL SURGERY	4	general	They can discuss indications and contraindications of medications for treatment of oral complications in patients with systemic complications associated with diabetes.	Thank you for your comment. Although we recognise oral health and preventing oral complications in patients with type 2 diabetes is an

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					important area, this is out of the scope of this guideline.
SH	FACULTY OF DENTAL SURGERY	5	general	They can also reduce co-morbidity factors resulting from diabetes by supporting patient's in tobacco-use cessation programs.	Thank you for your comment. Although we recognise oral health and preventing oral complications in patients with type 2 diabetes is an important area, this is out of the scope of this guideline.
SH	Faculty of Pharmaceutical Medicine	1	general	Secondary and other causes of diabetes such as cystic fibrosis and MODY/pancreatic disease should be recognised.	Thank you for your comment. Rarer forms of diabetes will not be covered within this update.
SH	Hindu Council UK	1	General	Our comments are as follow: Recognition that in general South Asian, African and African-Caribbean food is healthy, particularly the vegetarian cuisine that many South Asian communities eat. Although Dietary issues will not be updated, from the Hindu Council UK perspective this would be fine as long due regard is given to the equality of opportunity for religions and religious bodies that can help. From the Hindu perspective it is always of interest what the treatment and medication consists of or what it is derived from, the use of vegetable based treatment is preferred as opposed to animal based medication specifically if it is Bovine derived. Muslim and Jewish colleagues would equally be concerned with any porcine derived medication. However in the absence of this information the Hindu perspective would allow any treatment to preserve the sanctity of Human life. The use of temples or indeed the Hindu Council UK in part of your Educational programmes (structured or otherwise) would be beneficial to the Hindu community that mainly derive from South Asia.	Thank you for your comment. All NICE guidance contains a section on patient centred care. This section states that treatment and care should take into account patients' needs and preference. Specifically, treatment and care, and the information patients are given about it, should be culturally appropriate. It is anticipated that healthcare professionals will use the recommendations within the guideline with their clinical judgement to provide appropriate care to people with diabetes that is also culturally appropriate.
	National Diabetes Inpatient Specialist Nurse Group	1	General	Scope for the guideline is fine	Thank you for your comment.
SH	NHS Direct	1	General	NHS Direct welcome this guideline and have no comments on the scope.	Thank you for your comment.
SH	Royal College	6	General	Lipid management and cardiovascular risk estimation are central and crucial to the	Thank you for your comment. The

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	of Pathologists			management of type 2 diabetes. Whilst it is accepted that these are covered by the update of CG 67, they should be clearly referenced, and where relevant quoted, in this update	type 2 diabetes update will refer to other relevant NICE guidance where appropriate.
SH	Welsh Endocrine and Diabetes Society (WEDS)	1	General	The scope document is focused and considers the evidence for established and newer pharmacological agents. The guideline will review the role of these agents in the treatment of type 2 diabetes. This document will compliment other guidelines that are recently published or under review by NICE.	Thank you for your comment.
SH	Welsh Endocrine and Diabetes Society (WEDS)	2	General	In view of the concerns around risk associated with hypoglycaemia. The guideline will review the evidence for the targets recommended for blood glucose control.	Thank you for your comment.
SH	Cambridge University Hospitals NHS Foundation Trust (CUHFT)	1	Not stated	Somewhere there needs to be something about the correct diagnosis ie not labelling later onset T1D as T2D. This should be explicitly covered in both T1 and T2 guidelines and cross referenced.	Thank you for your comment. Although we recognise the importance of diagnosing type 2 diabetes, this clinical issue was not prioritised for update during the scoping process for type 2 diabetes clinical guideline. However, as diagnosis and differentiation between type 1 and type 2 diabetes are being covered in the type 1 diabetes guideline, we will be able to cross-refer to appropriate recommendations made for diagnosis within this guideline. There will not be a separate evidence review focusing on diagnosis in the type 2 diabetes update
SH	Cambridge University	2	Not stated	T2D should have a specific section on identifying hypoglycaemia (as a new area- as has been listed for T1D).	Thank you for your comment. Although we understand that the

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	Hospitals NHS Foundation Trust (CUHFT)				identification and management of hypoglycaemia may be important issues, they have not been prioritised for an update during the scoping process for type 2 diabetes. However, the identification of hypoglycaemia is currently being covered by the type 1 diabetes update and it is considered that this issue would not differ for people with type 2 diabetes. Therefore a full evidence review will not be carried out within the type 2 diabetes update and it is anticipated that cross-references will be made to the type 1 diabetes update as appropriate in the final guideline.
SH	Cambridge University Hospitals NHS Foundation Trust (CUHFT)	3	Not stated	Worthwhile updating diet section, i.e. macronutrient composition, plant sterols and stanols, MUFA's, and Omega 3 fish.	Thank you for your comment. Although we understand that dietary interventions may be considered important, this issue was not considered a priority for updating during the scoping process. This could be because it will be covered by other NICE guidance or there is not enough new evidence available which may impact on the recommendations. For more details on the scoping process please see the NICE Guidelines Manual 2009
SH	Cambridge University Hospitals NHS Foundation	4	Not stated	What to do if HbA1c unreliable eg anaemia/role of fructosamine/other tests	Thank you for your comment. The guideline will produce recommendations for all the included review questions. These

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	Trust (CUHFT)				recommendations should not replace clinical judgement and it is anticipated that healthcare professionals will use the recommendations together with their clinical judgement to treat people with type 2 diabetes appropriately. As there is an existing recommendation in Clinical Guideline 66 relating to the use of alternative tests when Hba1c may be unreliable, it is anticipated that the guideline development group will discuss this issue. Final recommendations will be made based on the best available evidence and the clinical expertise of the guideline development group.
SH	Cambridge University Hospitals NHS Foundation Trust (CUHFT)	5	Not stated	HPC competencies required for type 2 diabetes management	Thank you for your comment. Currently the guideline will not make specific recommendations relating to HPC competencies as there is no specific review question addressing this issue.
SH	Cambridge University Hospitals NHS Foundation Trust (CUHFT)	6	Not stated	Management of diabetes specific psychological issues such as needle phobia, psychological insulin resistance, denial	Thank you for your comment. Although an update of psychological issues in type 2 diabetes was considered, it was also recognised that the updated guidance for managing depression in adults (CG90) with chronic physical health problems would also apply to people with type 2 diabetes. Similarly NICE guidance for common mental health disorders (CG123) may also be

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					relevant. The issue of wider psychological burden in people with type 2 diabetes was not agreed as a priority for update during the scoping process. For more details on the scoping process please see the NICE Guidelines Manual 2009
SH	Cambridge University Hospitals NHS Foundation Trust (CUHFT)	7	Not stated	New drugs like pramlintide	Thank you for your comment. The evidence review will be limited to licensed drugs and licensed indications only.
SH	Cambridge University Hospitals NHS Foundation Trust (CUHFT)	8	Not stated	Include more on physical activity recommendations	Thank you for your comment. Although we understand that lifestyle interventions such as physical activity may be considered important, this issue was not considered a priority for updating during the scoping process. This is either because it will be covered by other NICE guidance, there is not enough new evidence available which may impact on the recommendations or it was not considered a clinical priority for updating. For more details on the scoping process for this guideline please see the NICE Guidelines Manual 2009
SH	Cambridge University Hospitals NHS Foundation Trust	9	Not stated	Discussion about Diagnosis-differentiation from monogenic and other forms of diabetes	Thank you for your comment. Although we recognise the importance of diagnosing type 2 diabetes, this clinical issue was not prioritised for update during the

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	(CUHFT)				scoping process for type 2 diabetes clinical guideline. However, as diagnosis and differentiation between type 1 and type 2 diabetes are being covered in the type 1 diabetes guideline, we may cross-refer to appropriate recommendations made for diagnosis within this guideline. There will not be a separate evidence review focusing on diagnosis in the type 2 diabetes update
SH	Cambridge University Hospitals NHS Foundation Trust (CUHFT)	10	Not stated	Palliative care management of diabetes	Thank you for your comment. Section 4.1.1 sets out example sub-groups of the population where the management of type 2 diabetes may differ, however this list is not exhaustive. The guideline development group may make specific recommendations for sub-groups of the population based on the evidence reviewed and the clinical expertise of the group. For instance, if the included evidence provides specific information relating to end of life/palliative care, this information will be considered by the group when making recommendations.
SH	Cambridge University Hospitals NHS Foundation Trust	11	Not stated	Glycaemia management in severe obesity	Thank you for your comment. Section 4.1.1 sets out example sub-groups of the population where the management of type 2 diabetes may differ, however this list is not

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	(CUHFT)				exhaustive. The guideline development group may make specific recommendations for sub-groups of the population based on the evidence reviewed and the clinical expertise of the group. For instance, if the included evidence provides specific information relating to BMI, this information will be considered by the group when making recommendations.
SH	Deaf Diabetes UK - DDUK	1	Not Stated	Hello This is my first time feedback as a registered Stakeholder + hope this is okay? Not sure if I understand about comments proforma? At short notice I have highlighted similar access+communication issues affecting all 4 consultation areas on behalf of DDUK. First Feedback for NICE's consultations on Diabetes clinical guidelines From Deaf Diabetes UK - DDUK DDUK is Deaf-led + works specifically with Deaf sign language users mainly BSL - British Sign Language First Feedback / comments in Key points format from Deaf BSL users attendees at - 2010 DDUK Conference - 2011 NHS Education Session for Deaf BSL users + Hard of Hearing people (HOH), Carers - and those who contacted DDUK SupportLine relating to * Type 1 Diabetes in Adults * Type 2 Diabetes in Adults * Diabetes in Children	Thank you for this comment which raises many important issues relating to provision of, and access to, services and information. As part of the NICE clinical guideline development process, the guideline development group will be required to consider the need to advance equality and prevent unlawful discrimination for each and every recommendation proposed. This means that the specific needs and preferences of individuals, including those protected by law, will be considered. This includes those who are deaf or hard of hearing. These considerations are documented in an equalities form which will be published on NICE's website. The issues raised affect diabetes care, as illustrated by the examples

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				* Diabetes in Pregnancy - to remove access + communication barriers for Deaf BSL users who have diabetes, Deaf Parents with a Deaf or hearing Child or children who have diabetes + pregnant Deaf mothers who have diabetes / need to be aware of diabetes health condition during pregnancy to NHS Diabetes Care + Services + NHS Information relating to diabetes. Need to know what treatment/services they should be receiving to deal with the diabetes health condition. - unable to access to current NHS Diabetes Support Group in their local NHS area - making an appointment with their GP difficult due to phone system appointment only - some Doctors /Diabetes Nurse/Health Professionals display reluctant attitude to have a RSLI (Registered Sign Language Interpreter) with their Deaf Patient placing Deaf Patient in an uncomfortable environment - NHS's letter offering a hospital appointment omitting information if a RSLI has been booked as requested often leaving Deaf Patient with no choice but to cancel appointment via third party involvement to phone them on their Telephone voice number given in the letter to rearrange an appointment with a RSLI or bring a family member including a child to "interprete" to avoid cancelling the appointment. - some Doctors Surgeries have a Textphone but Deaf Patients making a direct text phone call unanswered + had to use Typetalk Service which Receptionist Staff always answered quickly. Some Surgeries have Textphone Service facility but often unused / out of sight or unplugged. - NHS Information in written English + no BSL Format on information relating to diabetes but available in other written community spoken language. - Deaf people who have diabetes experience lack of communication support / lack of Deaf awareness amongst Doctors/Diabetes Nurse + Reception Staff leaving them feeling not receiving an inadequate consultation / not really clear or knowing much more about their	provided, but relate to quality of care more generally. Specific changes to the guideline scope have not been made in response to these comments, because the population and particular sub-groups to be covered would include people with diabetes who are deaf or hard of hearing. The guideline developers will therefore continue to adhere to the principles outlined above throughout the development of the guideline. The Patient and Public Involvement Programme (PPIP) and the Implementation team at NICE have also been informed of these issues. PPIP will help all the teams at NICE to ensure that these issues are considered during their work. When the diabetes guidelines are published, the Implementation team will help to raise these issues to staff working in the wider National Health Service (NHS).

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				diabetes condition /what are they supposed to do next or even know how to take the medicine prescribed to them / unsure about their ongoing healthcare plans / lack of aftercare support / lots of concern/confusion over altered diet advice advisable / insulin treatment / misunderstandings information relating to diabetes issues. The need for clearer writing from the Doctors on the use of medication in writing in plain English before Deaf Patients leave the surgery NHS Staff who learnt BSL commendable but are not trained to "Interprete" should not be used as "Interpreter" replacing RSLI. NHS BSL users helpful for informal situation like welcoming Deaf Patient on arrival, signposting them to correct department / Refreshment + Toilet facilities, checking if RSL booked arrived yet as good examples. - Deaf Patients struggled + missed their appts with a Tannoy Public Announcement system calling Patients's name at GP's Surgery / NHS Diabetes Care + Services + A&E department despite informing/reminding the Receptionist to alert them when their name called out but Receptionist often forget if busy. Feedback offered solutions that - all GP surgeries/NHS Diabetes Care + Services a) should ask/check Deaf person their communication preference b) should know how to get / book a RSLI (= Registered Sign Language Interpreter) who are registered with the NRCPD = The National Register of Communication Professionals working with Deaf + Deafblind People. NRCPD is supported by Signature. How to find/Book a RSLI? Visit www.signature.org.uk E: enquiries@nrcpd.org.uk / Tel 0191 383 1155 / Text 0191 383 7915 / Fax 0191 383 7914 c) should have a list of RSLI available on hand to save time with good planning ahead with booking a RSLI d) should comply with The Equality Act 2010 to provide RSLI provision for Deaf BSL users who need one.	

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				- all surgeries should have a way for Deaf BSl users to contact them directly to make an appointment with technology aid available (SMS/Email) - all surgeries / NHS Diabetes care + Services plus A&E departments should consider installing a visual patient system. Note more Surgeries are adopting this but should be a national standard practice including NHS Hospitals + A&E departments. - all NHS Staff particularly medical Staff who work directly with Deaf Patients should receive basic Deaf Awareness training including how to get / book a RSLI + how to work with RSLI / be familiar with their role to ensure effective communication with Deaf BSL user. Note Not appropriate to use a Child family member to take on "Interpreter" role. Not acceptable + must be discouraged. Sometimes Deaf BSL user may use an Adult family member / friend or husband/wife/partner not advisable + not to be encouraged as they only give a summary / confidentially an issue / controlling + often Health Professionals engaged with them instead of Deaf Patient. Deaf Patients need to be explained on the importance of using a RSLI to access full information + make an informed choice on their diabetes health condition. RSLI will always relay full account / full access of whats being said by NHS Professionals to Deaf Patient. RSLI to follow the NRCDP's Code of Conduct including confidentially + impartially. - need support for Deaf people with Type 1/2 diabetes / Deaf parents with their child/children with diabetes + pregnant Deaf mothers who have diabetes or need to understand their pregnancy related to diabetes to access information on all aspects of diabetes health condition in Deaf friendly format leaflets / DVD on specific diabetes related issues + via RSLI provision when needed + suitable BSL format for Deaf children too. Currently none available. - DDUK advocate positive working partnerships with NHS Diabetes Care + Services via education, training, research, services accessible, ensuring that the NHServices comply with the Equality Act 2010, understanding of / to improve awareness of Deaf BSL users who have diabetes needs to take control of / to manage their diabetes health condition better, raise	

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				confidence + make informed choice. NOTE Access + Communication issues are the main issues that the NHS needs to address if Deaf people with diabetes are to be provided with a service that truly to meet their needs / what NHS Diabetes Care + Services they should be receiving. Including knowing how to make complaints + understanding how the NHS work. NOTE NHS Services should offer RSLI provision for any Deaf Patient who needs one on ALL health matters affecting them. DDUK - Registered Stakeholder Catherine Forry / Deaf BSL user / Type 2 Diabetes DDUK Founder	
SH	Royal College of Ophthalmologists	1	Not Stated	On behalf of the Royal College of Ophthalmologists, our comment on the draft scope would be to consider the evidence for the use of fibrates on the reduction in the development of retinopathy: in particular the ACCORD eye data published in 2010 (showing significant reduction in progression of diabetic retinopathy in dyslipidaemic patients with type II diabetes, with the addition of fibrate to a statin). It is reasonable not to include specific details pertaining to diabetic retinopathy screening, or treatment of established retinopathy in the draft scope, but the prevention or reduction of progression of retinopathy would in our opinion be an important topic to include.	Thank you for your comment. Although we understand that the use of fibrates to prevent or reduce progression of diabetic retinopathy may be considered important, this issue was not considered a priority for updating during the scoping process. This is either because it will be covered by other NICE guidance, there is not enough new evidence available which may impact on the recommendations or it was not considered a clinical priority for updating. For more details on the scoping process please see the NICE Guidelines Manual 2009

These organisations were approached but did not respond:

Adults Strategy and Commissioning Unit
Advisory Committee for Community Dentistry
African HIV Policy Network
Age UK
Alder Hey Children's NHS Foundation Trust
Alere
Allergan Ltd UK
Allocate Software PLC
AMORE Studies Group
Anglian Community Enterprise
Ark Therapeutics Ltd
Arrowe Park Hospital
Association for Continence Advice
Association for Improvements in the Maternity Services
Association for the Study of Obesity
Association of Anaesthetists of Great Britain and Ireland
Association of British Dispensing
Association of British Healthcare Industries
Association of Children’s Diabetes Clinicians
Association of Clinical Pathologists
Association of Optometrists
B. Braun Medical Ltd
Bard Limited
Barnet Enfield and Haringey Mental Health Trust
Barnsley Hospital NHS Foundation Trust
Barnsley Primary Care Trust

Basildon and Thurrock University Hospitals NHS Foundation Trust

Baxter Healthcare

Bayer HealthCare

Bedfordshire and Hertfordshire Tissue Viability Nurses Forum

Bedfordshire Primary Care Trust

Betsi cadwaladr

Black and Ethnic Minority Diabetes Association

Black Country Partnership Foundation Trust

Blood Pressure Association

Boehringer Ingelheim

Bolton Primary Care Trust

Bradford and Airedale Primary Care Trust

Bradford District Care Trust

Breakspear Medical Group Ltd

Bristol PCT

British and Irish Orthoptic Society

British Association for Counselling and Psychotherapy

British Association of Prosthetists & Orthotists

British Association of Social Workers

British Dietetic Association

British Geriatrics Society

British Heart Foundation

British Hypertension Society

British Infection Association

British Medical Association

British Medical Journal

British National Formulary

British Nuclear Cardiology Society

British Nuclear Medicine Society

British Nutrition Foundation

British Obesity Surgery Society

British Paramedic Association

British Society for Human Genetics

British Society for Paediatric Endocrinology and Diabetes

British Society for Sexual Medicine

British Society of Interventional Radiology

British Society of Periodontology

Buckinghamshire Primary Care Trust

BUPA Foundation

Calderdale Primary Care Trust

Calderstones Partnerships NHS Foundation Trust

Camden Link

Camden Provider Services

Capsulation PPS

Capsulation PPS

Cardiff Research Consortium

Cardiff University

Care Quality Commission (CQC)

Central Lancashire Primary Care Trust

Central London Community Healthcare

Chartered Society of Physiotherapy

Cheshire and Merseyside Cardiac Network

Chester-le-Street Community Hospital

CHKS Ltd

CIS' ters
City and Hackney Teaching Primary Care Trust
Coeliac UK
Commission for Social Care Inspection
Community Practitioners' & Health Visitors Association
Cook Medical Inc.
Countess of Chester Hospital NHS Foundation Trust
County Durham Primary Care Trust
Coventry and Warwickshire Cardiac Network
Covidien Ltd.
Cygnet Hospital Harrow
Daiichi Sankyo UK
David Lewis Centre, The
Department for Communities and Local Government
Department of Epidemiology and Public Health
Department of Health, Social Services and Public Safety - Northern Ireland
Derbyshire County Primary Care Trust
Derbyshire Mental Health Services NHS Trust
Det Norske Veritas - NHSLA Schemes
Diabetes Management and Education Group
Diet Plate Ltd, The
Diving Diseases Research Centre, The
DJO UK Ltd
Doctors Support Network
Dudley Primary Care Trust
Durham and Chester Primary Care Trust Podiatry Department
East and North Hertfordshire NHS Trust

Education for Health

Equalities National Council

Essex Cardiac & Stroke Network

ESyDoc

Expert Patients Programme CIC

Experts in Severe and Complex Obesity

Faculty of Public Health

Faculty of Sport and Exercise Medicine

Federation of Ophthalmic and Dispensing Opticians

Ferring Pharmaceuticals

Food Advertising Unit

Food for the Brain Foundation

George Eliot Hospital NHS Trust

Gloucestershire LINk

Great Western Hospitals NHS Foundation Trust

Greater Manchester West Mental Health NHS Foundation Trust

Grunenthal Ltd

Guy's and St Thomas' NHS Foundation Trust

Halton & St. Helens Primary Care Trust

Hammersmith and Fulham Primary Care Trust

Hampshire Partnership NHS Trust

Harrogate and District NHS Foundation Trust

Havering Primary Care Trust

Healing Honey International Ltd

Health and Safety Executive

Health Protection Agency

Health Quality Improvement Partnership

Healthcare Improvement Scotland
Heart of England NHS Foundation Trust
Heart of Mersey
HEART UK
Hertfordshire Partnership NHS Trust
Humber NHS Foundation Trust
Independent Healthcare Advisory Services
InferMed
Innovation Rehab
Institute of Biomedical Science
Institute of Physics and Engineering in Medicine
Insulin Dependent Diabetes Trust
Integrity Care Services Ltd.
International Glaucoma Association
Johnson & Johnson
Johnson & Johnson Medical Ltd
karimahs cuisina
KasTech Ltd
KCI Europe Holding B.V.
KCI Medical Ltd
King's College Hospital NHS Foundation Trust
Kingston Hospital
Knowsley Primary Care Trust
L.IN.C.Medical
Lancashire Care NHS Foundation Trust
Launch Diagnostics
Leeds Community Healthcare NHS Trust

Leeds Primary Care Trust (aka NHS Leeds)

Leeds Teaching Hospitals NHS Trust

Leicestershire, Northamptonshire and Rutland Cancer Network

Lesbian, gay, bisexual and trans domestic abuse forum

Lilly UK

Liverpool Primary Care Trust

Liverpool Women's NHS Foundation Trust

Lloyds Pharmacy

Luton and Dunstable Hospital NHS Trust

Maidstone and Tunbridge Wells NHS Trust

Maidstone Hospital

Manchester Metropolitan University

Maternity and Health Links

McCallan Group, The

Medicines and Healthcare products Regulatory Agency

Medway Community Centre

Mental Health Act Commission

Ministry of Defence

Molnlycke Health Care Ltd

MSD Ltd

National Clinical Guideline Centre

National Collaborating Centre for Cancer

National Collaborating Centre for Mental Health

National Collaborating Centre for Women's and Children's Health

National Council for Palliative Care

National Diabetes Nurse Consultant Group

National Heart Forum

National Obesity Forum
National Patient Safety Agency
National Pharmacy Association
National Prescribing Centre
National Public Health Service for Wales
National Treatment Agency for Substance Misuse
NDR UK
NHS Blood and Transplant
NHS Bournemouth and Poole
NHS Clinical Knowledge Summaries
NHS Connecting for Health
NHS Cornwall and Isles Of Scilly
NHS Devon
NHS Kirklees
NHS London
NHS Milton Keynes
NHS Nottingham City
NHS Nottinghamshire County
NHS Plus
NHS Plymouth
NHS Sefton
NHS Sheffield
NHS Trafford
NHS Warwickshire Primary Care Trust
NHS Yorkshire and the Humber Strategic Health Authority
North Cheshire Hospitals NHS Trust
North East London Community Services

North East Yorkshire and Northern Lincolnshire Cardiac & Stroke Network

North Essex Mental Health Partnership Trust

North Staffordshire Primary Care Trust

North Tees and Hartlepool NHS Foundation Trust

North West London Hospitals NHS Trust

North Yorkshire & York Primary Care Trust

Northern Ireland Chest, Heart & Stroke

Northumbria Diabetes Service

Northumbria Healthcare NHS Foundation Trust

Nottinghamshire Healthcare NHS Trust

Nova Biomedical UK

Nutrition and Diet Resources UK

Obesity Management Association

OPED UK Ltd

Optical Confederation, The

OSI Pharmaceuticals

Overeaters Anonymous

Owen Mumford Ltd

Oxford Centre for Diabetes, Endocrinology and Metabolism

Oxford Nutrition Ltd

Oxleas NHS Foundation Trust

Pancreatic Cancer UK

Patient Assembly

PERIGON Healthcare Ltd

Peterborough City Hospital

Pharmametrics GmbH

Powys Local Health Board

Primary Care Cardiovascular Society

Primary Care Diabetes Society

Primary Care Pharmacists Association

ProStrakan Group

Public Health Agency

Public Health Wales NHS Trust

Queen Elizabeth Hospital

Queen Mary's Hospital NHS Trust

RioMed Ltd.

Robert Jones & Agnes Hunt Orthopaedic & District Hospital NHS Trust

Royal Berkshire NHS Foundation Trust

Royal Brompton Hospital & Harefield NHS Trust

Royal College of Anaesthetists

Royal College of General Practitioners

Royal College of General Practitioners in Wales

Royal College of Midwives

Royal College of Nursing

Royal College of Obstetricians and Gynaecologists

Royal College of Paediatrics and Child Health

Royal College of Paediatrics and Child Health , Gastroenetrology, Hepatology and Nutrition

Royal College of Physicians

Royal College of Physicians of Edinburgh

Royal College of Psychiatrists

Royal College of Psychiatrists in Wales

Royal College of Radiologists

Royal College of Surgeons of England

Royal Cornwall Hospitals NHS Trust

Royal National Institute of Blind People
Royal Pharmaceutical Society
Royal Society of Medicine
Royal Surrey County Hospital NHS Trust
Royal United Hospital Bath NHS Trust
Rupanyup Hospital/Nursing Home
Sanctuary Care
Sandwell and West Birmingham Hospitals NHS Trust
Sandwell Primary Care Trust
Sankyo Pharma U K Ltd.
Scarborough and North Yorkshire Healthcare NHS Trust
SCHOOL AND PUBLIC HEALTH NURSES ASSOCIATION
Scottish Intercollegiate Guidelines Network
Scottish Oral Health Group
Sebia
Servier Laboratories Ltd
Sexual Advice Association
Sheffield Childrens Hospital
Sheffield Primary Care Trust
Sheffield Teaching Hospitals NHS Foundation Trust
Shrewsbury and Telford Hospital NHS Trust
Slimming World
SNDRi
Social Care Institute for Excellence
Society and College of Radiographers
Society of District General Hospital Nephrologists
Society Of Vascular Nurses

Solihull NHS Primary Care Trust
Solvay
South Asian Health Foundation
South East Coast Ambulance Service
South East London Cardiac Network
South London & Maudsley NHS Trust
South Staffordshire Primary Care Trust
South Warwickshire NHS Foundation Trust
South West Yorkshire Partnership NHS Foundation Trust
South Western Ambulance Service NHS Foundation Trust
Southend Hospitals NHS Foundation Trust
Southern Alliance of Tissue Viability Nurses
Southern Health & Social Care Trust
Sport England
St Mary's Hospital
Stockton-on-Tees Teaching Primary Care Trust
Takeda UK Ltd
Tameside Hospital NHS Foundation Trust
Telemedcare Ltd
Teva UK
Thames Ambulance Service Ltd
The Association for Clinical Biochemistry
The Association of the British Pharmaceutical Industry
The British In Vitro Diagnostics Association
The National LGB&T Partnership
The Phoenix Partnership
The Prince’s Foundation for Integrated Health

The Rotherham NHS Foundation Trust

The Whittington Hospital NHS Trust

Tiny Tickers

Tunstall Healthcare UK Ltd

UK Anaemia

UK Clinical Pharmacy Association

UK National Screening Committee

UK Thalassaemia Society

University College London

University College London Hospital NHS Foundation Trust

University Hospital Aintree

University Hospital Birmingham NHS Foundation Trust

University of Huddersfield

University of Leeds

University of Nottingham

Vitaline Pharmaceuticals

Walsall Local Involvement Network

Walsall Teaching Primary Care Trust

Weight Concern

Welsh Endocrine and Diabetes Society

Welsh Government

Welsh Scientific Advisory Committee

West Hertfordshire Primary Care Trust

West Herts Hospitals NHS Trust

West London Mental Health NHS Trust

West Middlesex University Hospital NHS Trust

Western Cheshire Primary Care Trust

Western Health and Social Care Trust

Westminster Local Involvement Network

Wiltshire Primary Care Trust

Wirral University Teaching Hospital NHS Foundation Trust

Worcestershire Acute Hospitals Trust

Wound Care Alliance UK

Wrightington, Wigan and Leigh NHS Foundation Trust

Wye Valley NHS Trust

York Hospitals NHS Foundation Trust

Young Diabetlolgists Forum

Young People's Unit