Appendix A: Search strategies and review protocols

This guideline was developed in accordance with the process for short clinical guidelines set out in 'The guidelines manual' (2012). There is more information about how NICE clinical guidelines are developed on the NICE website.

A.1 Search strategies

The evidence reviews used to develop the guideline recommendations were underpinned by systematic literature searches, following the methods described in 'The guidelines manual' (2012). The aim of the systematic searches was to comprehensively identify the published evidence to answer the review questions developed by the Guideline Development Group and Internal Clinical Guidelines Technical Team.

The search strategies for the review questions were developed by the Information Services Team with advice from the Internal Clinical Guidelines Technical Team. Structured questions were developed using the PICO (population, intervention, comparison, outcome) model and translated into search strategies using subject heading and free text terms. The strategies were run across a number of databases, date restrictions were included when requested by the Technical Team.

The NHS Economic Evaluation Database (NHS EED) and the Health Economic Evaluations Database (HEED) were searched for economic evaluations. Search filters for economic evaluations and quality of life studies were used on bibliographic databases. Date restrictions were included when requested by the Technical Team.

Guideline Development Group members were also asked to alert the Internal Clinical Guidelines Technical Team to any additional evidence, published, unpublished or in press, that met the inclusion criteria.

The searches were undertaken between July 2012 and June 2013. The re-run searches took place in June 2014.

A.2 Scoping searches

Scoping searches were undertaken in March 2012 using the following websites and databases (listed in alphabetical order); browsing or simple search strategies were employed. The search results were used to provide information for scope development and project planning.

Guidance/guidelines

- Department of Health
- Canadian Medical Association Infobase
- Guidelines International Network (GiN)
- National Health and Research Council
- New Zealand Guidelines Group
- NHS Scotland
Main searches

The following sources were searched for the topics presented in the sections below.

22 Cochrane Database of Systematic Reviews – CDSR (Wiley)
23 Cochrane Central Register of Controlled Trials – CENTRAL (Wiley)
24 Database of Abstracts of Reviews of Effects – DARE (Wiley)
25 Health Technology Assessment Database – HTA (Wiley)
26 EMBASE (Ovid)
27 MEDLINE (Ovid)
28 MEDLINE In-Process (Ovid)

Systematic reviews and mapping searches

The MEDLINE search strategies are presented below. They were translated for use in each of the other databases.
Review Question 1: Which pharmacological blood glucose lowering therapies should be used to control blood glucose levels in people with type 2 diabetes?

July 2012

Ovid MEDLINE <1946 to July week 1 2012>

exp Diabetes Mellitus, Type 2/ (87707)
(Type* adj3 ("2" or "II" or two*) adj3 (diabete* or diabetic*)).tw. (75708)
((Maturit* or adult* or slow*) adj3 onset* adj3 (diabete* or diabetic*)).tw. (2310)
((Ketosis-resistant* or stable*) adj3 (diabete* or diabetic*)).tw. (537)
((Non-insulin* or Non insulin* or Noninsulin*) adj3 depend* adj3 (diabete* or diabetic*)).tw. (11408)
NIDDM.tw. (6762)
or/1-6 (113512)
Dipeptidyl-Peptidase IV Inhibitors/ (1767)
(Dipeptidyl* adj2 Peptidase* adj2 ("4" or "iv") adj Inhibitor*).tw. (859)
(DPP* adj2 ("4" or "iv")).tw. (2738)
(Sitagliptin* or Januvia*).tw. (745)
(Vildagliptin* or Galvus*).tw. (443)
(Linagliptin* or Trajenta*).tw. (210)
(Saxagliptin* or Onglyza*).tw. (205)
Alogliptin*.tw. (116)
or/8-15 (3932)
Glucagon-Like Peptide 1/ (5464)
(Glucagon* adj Like adj Peptide adj "1").tw. (5553)
(GLP* adj "1").tw. (5577)
(Exenatide* or Byetta* or Bydureon*).tw. (1030)
(Liraglutide* or Victoza*).tw. (743)
(Lixisenatide* or Lyxumia*).tw. (24)
or/17-22 (8332)
Thiazolidinediones/ (9833)
(Thiazolidinedione* or Glitazone*).tw. (4900)
(Pioglitazone* or Actos*).tw. (3375)
or/24-26 (11936)
exp Sulfonylurea Compounds/tu [Therapeutic Use] (4680)
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<td>(7488)</td>
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<td>(Metformin* or Glucophage*).tw.</td>
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<td>Insulin Infusion Systems/ (3982)</td>
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<td>(Insulin* adj3 (treat* or therap* or administrat* or dos* or human* or analogue* or biphasic* or basal* or protamine* or isophane* or inject* or pen* or deliver* or device* or system* or pump* or syringe* or needle*)).tw.</td>
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<td>(Insulin* adj3 (Intermediate* or shortact* or short-act* or short act* or longact* or long-act* or long act* or ultralong* or ultra-long* or ultra long*)).tw.</td>
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<td>22</td>
<td>(Actrapid* or Humulin* or Insuman* or Hypurin*).tw.</td>
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<td>23</td>
<td>(Aspart* or Novorapid*).tw.</td>
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1 60 Sodium-Glucose Transporter 2/ (326)
2 61 (Sodium* adj3 Glucose* adj3 Transporter* adj3 "2").tw. (104)
3 62 (Sodium* adj3 Glucose* adj3 (co-transporter* or cotransporter* or co transporter*) adj3 "2").tw. (183)
4 53 SGLT*.tw. (1264)
5 64 (Canagliflozin* or Dapagliflozin* or Empagliflozin*).tw. (125)
6 65 (Meglitinide* or Nateglinide* or Repaglinide*).tw. (894)
7 66 or/60-65 (2267)
8 67 16 or 23 or 27 or 35 or 41 or 44 or 59 or 66 (186449)
9 68 7 and 67 (25970)
10 69 Meta-Analysis.pt. (52213)
11 70 Meta-Analysis as Topic/ (14196)
12 71 Review.pt. (1924416)
13 72 exp Review Literature as Topic/ (7732)
14 73 (metaanaly$ or metanaly$ or (meta adj3 analy$)).tw. (60052)
15 74 (review$ or overview$).ti. (265955)
16 75 (systematic$ adj5 (review$ or overview$)).tw. (54185)
17 76 ((quantitative$ or qualitative$) adj5 (review$ or overview$)).tw. (4377)
18 77 ((studies or trial$) adj2 (review$ or overview$)).tw. (26148)
19 78 (integrat$ adj3 (research or review$ or literature)).tw. (5397)
20 79 (pool$ adj2 (analy$ or data)).tw. (14672)
21 80 (handsearch$ or (hand adj3 search$)).tw. (6759)
22 81 (manual$ adj3 search$).tw. (3235)
23 82 or/69-81 (2082990)
24 83 animals/ not humans/ (3974347)
25 84 82 not 83 (1946464)
26 85 Randomized Controlled Trial.pt. (390995)
27 86 Controlled Clinical Trial.pt. (90070)
28 87 Clinical Trial.pt. (505440)
29 88 exp Clinical Trials as Topic/ (297285)
30 89 Placebos/ (33814)
31 90 Random Allocation/ (81895)
32 91 Double-Blind Method/ (132149)
Search strategies and review protocols

A.4.2 Review Question 2: What are the serious adverse effects of long-term use of pharmacological interventions to control blood glucose in people with type 2 diabetes? January 2013

Ovid MEDLINE <1946 to January week 1 2013>

1  exp Diabetes Mellitus, Type 2/ (74370)
2  (Type* adj3 ("2" or "II" or two*) adj3 (diabete* or diabetic*)).tw. (61248)
3  ((Maturit* or adult* or slow*) adj3 onset* adj3 (diabete* or diabetic*)).tw. (2119)
4  ((Ketosis-resistant* or stable*) adj3 (diabete* or diabetic*)).tw. (473)
5  ((Non-insulin* or Non insulin* or Noninsulin*) adj3 depend* adj3 (diabete* or diabetic*)).tw. (11155)
6  NIDDM.tw. (6633)
7  or/1-6 (95582)
8  Dipeptidyl-Peptidase IV Inhibitors/ (1158)
9  (Dipeptidyl* adj2 Peptidase* adj2 ("4" or "iv") adj Inhibitor*).tw. (598)
10  (DPP* adj2 ("4" or "iv")).tw. (2100)
11  (Sitagliptin* or Januvia*).tw. (498)
12  (Vildagliptin* or Galvus*).tw. (314)
13  (Linagliptin* or Trajenta*).tw. (85)
14  (Saxagliptin* or Onglyza*).tw. (140)
15  Alogliptin*.tw. (79)
Search strategies and review protocols

1 16  or/8-15 (2907)
2 17  Glucagon-Like Peptide 1/ (3812)
3 18  (Glucagon* adj Like adj Peptide adj "1").tw. (3838)
4 19  (GLP* adj "1").tw. (3809)
5 20  (Exenatide* or Byetta* or Bydureon*).tw. (670)
6 21  (Liraglutide* or Victoza*).tw. (350)
7 22  (Lixisenatide* or Lyxumia*).tw. (9)
8 23  or/17-22 (5794)
9 24  Thiazolidinediones/ (8371)
10 25  (Thiazolidinedione* or Glitazone*).tw. (4239)
11 26  (Pioglitazone* or Actos*).tw. (2761)
12 27  or/24-26 (10136)
13 28  exp Sulfonylurea Compounds/tu [Therapeutic Use] (4371)
14 29  (Sulfonylurea* or Sulphonylurea*).tw. (6700)
15 30  Tolbutamide*.tw. (3857)
16 31  Glibenclamide*.tw. (6282)
17 32  (Glipizide* or Minodiab*).tw. (777)
18 33  (Glimepiride* or Amaryl*).tw. (975)
19 34  (Gliclazide* or Diamicron*).tw. (862)
20 35  or/28-34 (17966)
21 36  Metformin/ (5951)
22 37  (Metformin* or Glucophage*).tw. (6856)
23 38  (Competact* or Janumet* or Eucreas*).tw. (11)
24 39  Biguanides/ (2625)
25 40  Biguanide*.tw. (1858)
26 41  or/36-40 (11027)
27 42  Acarbose/ (1033)
28 43  (Acarbose* or Glucobay*).tw. (1281)
29 44  or/42-43 (1465)
30 45  exp Insulins/tu [Therapeutic Use] (18814)
31 46  exp Insulin/ad [Administration & Dosage] (14523)
32 47  Insulin Infusion Systems/ (3585)
33 48  (Insulin* adj3 (treat* or therap* administrat* or dos* or human* or analogue* or biphasic* or basal* or protamine* or isophane* or inject* or pen* or deliver* or device* or system* or pump* or syringe* or needle*)).tw. (40387)
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National Institute for Health and Care Excellence, 2015
A.4.3 Review Question 3: What are the optimal target values for HbA1c, fasting blood glucose and post prandial blood glucose in people with type 2 diabetes? (December 2012)

Ovid MEDLINE <1946 to November week 3 2012>

1 exp Diabetes Mellitus, Type 2/ (76208)
2 (Type* adj3 ("2" or "II" or two*) adj3 (diabete* or diabetic*)).tw. (63336)
3 ((Maturit* or adult* or slow*) adj3 onset* adj3 (diabete* or diabetic*)).tw. (2166)
4 ((Ketosis-resistant* or stable*) adj3 (diabete* or diabetic*)).tw. (475)
5 ((Non-insulin* or Non insulin* or Noninsulin*) adj3 depend* adj3 (diabete* or diabetic*)).tw. (11214)
6 NIDDM.tw. (6654)
7 or/1-6 (98196)
8 *Hemoglobin A, Glycosylated/ (5205)
9 (hemoglobin* adj3 glyc*).tw. (7213)
10 (haemoglobin* adj3 glyc*).tw. (3389)
11 glycohemoglobin*.tw. (633)
12 glycohaemoglobin*.tw. (97)
13 (hba1c or hb a1c).tw. (10948)
14 or/8-13 (21025)
15 *Fasting/ (7688)
16 fast*.tw. (291196)
17 (diet adj3 restrict*).tw. (3734)
18 *Postprandial Period/ (1828)
19 (postprandial* or post-prandial*).tw. (17493)
20 or/15-19 (305960)
21 7 and 20 (12019)
22 Animals/ not Humans/ (3720385)
23 26 not 27 (11612)
24 limit 28 to english language (10446)
25 30 Epidemiologic Studies/ (5579)
Search strategies and review protocols

1 31 exp Case-Control Studies/ (586243)
2 32 exp Cohort Studies/ (1234174)
3 33 Cross-Sectional Studies/ (150828)
4 34 Comparative Study.pt. (1621448)
5 35 case control$.tw. (65792)
6 36 case series.tw. (27324)
7 37 (cohort adj (study or studies)).tw. (65854)
8 38 cohort analy$.tw. (2895)
9 39 (follow up adj (study or studies)).tw. (33920)
10 40 (observational adj (study or studies)).tw. (33241)
11 41 longitudinal.tw. (115334)
12 42 prospective.tw. (299660)
13 43 retrospective.tw. (223737)
14 44 cross sectional.tw. (130903)
15 45 or/30-44 (3057909)
16 46 Meta-Analysis.pt. (37918)
17 47 (metaanaly$ or metanaly$ or (meta adj2 analy$)).tw. (45163)
18 48 (systematic$ adj4 (review$ or overview$)).tw. (40486)
19 49 ((quantitative$ or qualitative$) adj4 (review$ or overview$)).tw. (3114)
20 50 ((studies or trial$) adj1 (review$ or overview$)).tw. (6564)
21 51 (integrat$ adj2 (research or review$ or literature)).tw. (3115)
22 52 (pool$ adj1 (analy$ or data)).tw. (7700)
23 53 (handsearch$ or (hand adj2 search$)).tw. (4489)
24 54 (manual$ adj2 search$).tw. (2443)
25 55 or/46-54 (100721)
26 56 animals/ not humans/ (3720385)
27 57 55 not 56 (98559)
28 58 Randomized Controlled Trial.pt. (342334)
29 59 Controlled Clinical Trial.pt. (85694)
30 60 Placebo$. (31583)
31 61 Random Allocation/ (76596)
32 62 Double-Blind Method/ (118498)
33 63 Single-Blind Method/ (17086)
34 64 Cross-Over Studies/ (30990)
35 65 ((random$ or control$ or clinical$) adj2 (trial$ or stud$)).tw. (570078)
Search strategies and review protocols

A.4.4 Review Question 4: Should intensive or conventional target values be used to control blood glucose levels in people with type 2 diabetes? (January 2013)

Ovid MEDLINE <1946 to November week 4 2012>
A.4.5  **Review Question 5: Should self-monitoring be used to manage blood glucose levels in people with type 2 diabetes? (November 2012)**

Ovid MEDLINE <1946 to November week 2 2012>

1  exp Diabetes Mellitus, Type 2/ (75950)
### Search strategies and review protocols

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<td>or/1-6 (97880)</td>
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<td>7</td>
<td>Blood Glucose Self-Monitoring/ (3875)</td>
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<td>((Self-monitor* or self monitor* or home-monitor* or home monitor*) adj3 (glucose* or sugar* or blood* or urine* or glycaemi* or advice*).tw. (1742)</td>
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<td>(Blood adj3 glucose* adj3 meter*).tw. (371)</td>
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Search strategies and review protocols

A.4.6 Review Question 6: Should aspirin and/or clopidogrel be used for primary prevention of cardiovascular disease in people with type 2 diabetes? (November 2012)

Ovid MEDLINE <1946 to October week 4 2012>

exp Diabetes Mellitus, Type 2/ (75451)

(Type* adj3 ("2" or "II" or two*) adj3 (diabete* or diabetic*)).tw. (62632)

((Maturit* or adult* or slow*) adj3 onset* adj3 (diabete* or diabetic*)).tw. (2152)

((Ketosis-resistant* or stable*) adj3 (diabete* or diabetic*)).tw. (474)

((Non-insulin* or Non insulin* or Noninsulin*) adj3 depend* adj3 (diabete* or diabetic*)).tw. (11204)
Search strategies and review protocols

1  6  NIDDM.tw. (6648)
2  7  or/1-6 (97234)
3  8  Aspirin/ (36490)
4  9  (Aspirin* or acetylsalicylic acid* or micropirin* or caprin*).tw. (41115)
5 10  (Clopidogrel* or Plavix* or Grepid*).tw. (5905)
6 11  or/8-10 (56239)
7 12  7 and 11 (658)
8 13  Animals/ not Humans/ (3707435)
9 14  12 not 13 (639)
10 15  limit 14 to (ed=20070101-20121107 and english language) (301)
11 16  Meta-Analysis.pt. (37222)
12 17  Meta-Analysis as Topic/ (12516)
13 18  Review.pt. (1749326)
14 19  exp Review Literature as Topic/ (6580)
15 20  (metaanaly$ or metanaly$ or (meta adj2 analy$)).tw. (44398)
16 21  (review$ or overview$).ti. (239135)
17 22  (systematic$ adj4 (review$ or overview$)).tw. (39724)
18 23  ((quantitative$ or qualitative$) adj4 (review$ or overview$)).tw. (3074)
19 24  ((studies or trial$) adj1 (review$ or overview$)).tw. (6497)
20 25  (integrat$ adj2 (research or review$ or literature)).tw. (3081)
21 26  (pool$ adj1 (analy$ or data)).tw. (7594)
22 27  (handsearch$ or (hand adj2 search$)).tw. (4445)
23 28  (manual$ adj2 search$).tw. (2423)
24 29  or/16-28 (1886158)
25 30  animals/ not humans/ (3707435)
26 31  29 not 30 (1757509)
27 32  Randomized Controlled Trial.pt. (340101)
28 33  Controlled Clinical Trial.pt. (85462)
29 34  Clinical Trial.pt. (475088)
30 35  exp Clinical Trials as Topic/ (262887)
31 36  Placebos/ (31496)
32 37  Random Allocation/ (76290)
33 38  Double-Blind Method/ (117930)
Search strategies and review protocols

A4.7 Review Question 7: What pharmacological treatment should be used to manage erectile dysfunction in men with type 2 diabetes? (October 2012 [multifile search strategy])

17 Ovid MEDLINE <1946 to October week 1 2012>
18 Ovid MEDLINE-in-Process <October 10, 2012>
19 EMBASE (Ovid) <1980 to 2012 week 40>

1 exp Diabetes Mellitus, Type 2/ use mesz (75110)
2 exp non insulin dependent diabetes mellitus/ use emez (116377)
3 (Type* adj3 ("2" or "II" or two*) adj3 (diabete* or diabetic*)).tw. (161562)
4 ((Maturit* or adult* or slow*) adj3 onset* adj3 (diabete* or diabetic*)).tw. (4594)
5 ((Ketosis-resistant* or stable*) adj3 (diabete* or diabetic*)).tw. (1121)
6 ((Non-insulin* or Non insulin* or Noninsulin*) adj3 depend* adj3 (diabete* or diabetic*)).tw. (24574)
7 NIDDM.tw. (14551)
8 Diabetes Mellitus, Type 1/ use mesz (57276)
9 exp insulin dependent diabetes mellitus/ use emez (70113)
10 (Type* adj3 ("1" or "I" or one*) adj3 (diabete* or diabetic*)).tw. (77647)
11 ((Autoimmune* or auto-immune* or auto immune* or sudden-onset* or sudden onset* or brittle* or juvenile-onset* or juvenile onset*) adj3 (diabete* or diabetic*)).tw. (9587)
12 ((Ketosis-prone* or ketosis prone*) adj3 (diabete* or diabetic*)).tw. (221)
Search strategies and review protocols

1 13 (Insulin* adj3 depend* adj3 (diabete* or diabetic*)).tw. (54382)
2 14 IDDM.tw. (14280)
3 15 or/1-14 (368668)
4 16 exp Erectile Dysfunction/ use mesz (14699)
5 17 exp erectile dysfunction/ use emez (15908)
6 18 impotence/ use emez (13770)
7 19 ((Erectile* or sex*) adj3 dysfunct*).tw. (37450)
8 20 ED.tw. (71486)
9 21 Impotence*.tw. (11497)
10 22 or/16-21 (126086)
11 23 Testosterone/ use mesz (57123)
12 24 testosterone/ use emez (75502)
13 25 testosterone undecanoate/ use emez (1362)
14 26 Testosterone*.tw. (124639)
15 27 (Restandol Testocaps or Strial SR or Nebido or Sustanon or Viormone or Intrinsa or Testim or Testogel or Tostran).tw. (843)
16 28 TRT.tw. (1696)
17 29 or/23-28 (170672)
18 30 Prostaglandins E/ use mesz (14417)
19 31 Alprostadil/ use mesz (6451)
20 32 prostaglandin E1/ use emez (14587)
21 33 Prostaglandin* E.tw. (13009)
22 34 (pge1 or pge-1 or "pge 1" or "pg e1" or "pg e-1" or "pg e 1").tw. (12625)
23 35 (Alprostadil* or Caverject* or Viridal* or Viridil* or Muse).tw. (1923)
24 36 or/30-35 (49004)
25 37 Phosphodiesterase 5 Inhibitors/ use mesz (997)
26 38 phosphodiesterase V inhibitor/ use emez (4034)
27 39 "Phosphodiesterase* 5 Inhibitor*".tw. (1761)
28 40 "Phosphodiesterase* V Inhibitor*".tw. (95)
29 41 ((pde5 or pde-5 or "pde 5") adj3 Inhibitor*).tw. (3661)
30 42 ((pdeV or pde-V or "pde V") adj3 Inhibitor*).tw. (130)
31 43 sildenafil/ use emez (13334)
32 44 tadalafil/ use emez (3345)
Search strategies and review protocols

The following sources were searched to identify economic evaluations and quality of life data featuring the patient population of type 2 diabetes:

- Ovid MEDLINE
- Ovid MEDLINE-in-Process
- EMBASE (Ovid)
- NHS EED (Wiley)
- HEED

The following search filters were added to all clinical search strategies:

1. Economics/ (26636)
2. exp "Costs and Cost Analysis"/ (172722)
3. Economics, Dental/ (1861)
4. exp Economics, Hospital/ (18697)
5. exp Economics, Medical/ (13342)
6. Economics, Nursing/ (3871)
7. Economics, Pharmaceutical/ (2445)
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<th></th>
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<th>Search strategies and review protocols</th>
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<tr>
<td>1</td>
<td>8</td>
<td>Budgets/ (9411)</td>
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<td>exp Models, Economic/ (9415)</td>
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<td>Markov Chains/ (9010)</td>
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<td>Monte Carlo Method/ (18608)</td>
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<td>12</td>
<td>Decision Trees/ (8471)</td>
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<td>13</td>
<td>econom$.tw. (143763)</td>
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<td>7</td>
<td>14</td>
<td>cba.tw. (8570)</td>
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<td>8</td>
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<td>cee.tw. (15284)</td>
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<td>9</td>
<td>16</td>
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<td>(monte adj carlo).tw. (19126)</td>
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<td>19</td>
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<td>21</td>
<td>(price$ or pricing$).tw. (21406)</td>
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<td>23</td>
<td>expenditure$.tw. (32597)</td>
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<td>17</td>
<td>24</td>
<td>(value adj2 (money or monetary)).tw. (1121)</td>
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<td>18</td>
<td>25</td>
<td>(pharmacoeconomic$ or (pharmaco adj economic$)).tw. (3114)</td>
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<td>19</td>
<td>26</td>
<td>or/1-25 (607987)</td>
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<td>20</td>
<td>27</td>
<td>&quot;Quality of Life&quot;/ (108608)</td>
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<td>21</td>
<td>28</td>
<td>quality of life.tw. (123243)</td>
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<td>22</td>
<td>29</td>
<td>&quot;Value of Life&quot;/ (5320)</td>
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<td>23</td>
<td>30</td>
<td>Quality-Adjusted Life Years/ (6276)</td>
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<td>24</td>
<td>31</td>
<td>quality adjusted life.tw. (5117)</td>
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<td>25</td>
<td>32</td>
<td>(qaly$ or qald$ or qale$ or qtime$).tw. (4282)</td>
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<td>26</td>
<td>33</td>
<td>disability adjusted life.tw. (995)</td>
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<td>daly$.tw. (992)</td>
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<td>35</td>
<td>Health Status Indicators/ (19253)</td>
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<td>29</td>
<td>36</td>
<td>(sf36 or sf 36 or short form 36 or shortform 36 or sf thirtysix or sf thirty six or shortform thirtysix or shortform thirty six).tw. (13766)</td>
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<td>30</td>
<td>37</td>
<td>(sf6 or sf 6 or short form 6 or shortform 6 or sf six or sfsix or shortform six or short form six).tw. (936)</td>
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<tr>
<td>31</td>
<td>38</td>
<td>(sf12 or sf 12 or short form 12 or shortform 12 or sf twelve or sftwelve or shortform twelve or short form twelve).tw. (2220)</td>
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<tr>
<td>32</td>
<td>39</td>
<td>(sf16 or sf 16 or short form 16 or shortform 16 or sf sixteen or sfsixteen or shortform sixteen or short form sixteen).tw. (18)</td>
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</table>
Search strategies and review protocols

1. (sf20 or sf 20 or short form 20 or shortform 20 or sf twenty or sftwenty or shortform twenty or short form twenty).tw. (319)
2. (euroqol or euro qol or eq5d or eq 5d).tw. (3108)
3. (qol or hql or hqol or hrqol).tw. (21283)
4. (hye or hyes).tw. (51)
5. health$. year$. equivalent$.tw. (36)
6. utilit$.tw. (101718)
7. (hui or hui1 or hui2 or hui3).tw. (775)
8. disutil$.tw. (179)
9. rosser.tw. (69)
10. quality of wellbeing.tw. (5)
11. quality of well-being.tw. (314)
12. qwb.tw. (153)
13. willingness to pay.tw. (1858)
14. standard gamble$.tw. (615)
15. time trade off$.tw. (670)
16. time tradeoff.tw. (194)
17. tto.tw. (523)
18. or/27-56 (289501)
19. 26 or 57 (858294)
### A.5.1.1 Review question 1: Which pharmacological blood glucose lowering therapies should be used to control blood glucose levels in people with type 2 diabetes?

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<tbody>
<tr>
<td><strong>Review question 1</strong></td>
<td>See objectives for further details of specific drug comparisons within initial therapy and further intensification</td>
<td>Following GDG meeting 6, the structure and wording of this review question changed to refer to initial therapy, followed by first, second and third intensification of pharmacological therapy (replacing monotherapy, dual therapy and triple therapy)</td>
</tr>
<tr>
<td>Which pharmacological blood glucose-lowering therapies should be used initially to control blood glucose levels in people with type 2 diabetes?</td>
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<tr>
<td>When first intensification of treatment is indicated, which blood glucose lowering therapies should be used to control blood glucose levels?</td>
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<tr>
<td>When second intensification of treatment is indicated, which blood glucose lowering therapies should be used to control blood glucose levels?</td>
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<tr>
<td>When third intensification of treatment is indicated, which blood glucose lowering therapies should be used to control blood glucose levels?</td>
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#### Objectives

**All anti diabetic treatments:**

- **Which drugs should be used as part of initial therapy and further intensification as blood glucose control declines?**
- **Should blood glucose-lowering therapies be used by all people with type 2 diabetes or should this be restricted to specific subgroups of the population? When should alternative drugs be considered?**
- **What adverse events and/or safety concerns are associated with pharmacological interventions?**
- **When different formulations of the same therapy are available (i.e. extended release vs. conventional), which one should be used?**

During the development of the guideline, the insulin specific objectives were replaced with specific drug comparisons that were prioritised by the GDG at meeting 6 (NB: OAD relates to non-insulin anti diabetics and includes GLP-1s which are injected):

**Initial therapy**

- 1 OAD vs. 1 OAD
- 1 OAD vs. placebo

**First intensification**

- 2 NIT vs. 2 NIT

**Second intensification**

- 3 NIT vs. 3 NIT
- Insulin + 2 NIT vs. 3 NIT
- Insulin + 1 NIT vs. 3 NIT
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<tbody>
<tr>
<td>Insulin + 1 NIT vs. insulin + 1 NIT</td>
<td>Insulin + 2 NIT vs. insulin + 2 NIT</td>
<td>Insulin vs. 3 NIT</td>
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<tr>
<td>Insulin vs. insulin + 2 NIT</td>
<td>Insulin vs. insulin + 1 NIT</td>
<td>Insulin + 1 NIT vs. insulin + 2 NIT</td>
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<tr>
<td>Third intensification</td>
<td>3 NIT vs. 4 NITs</td>
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OAD oral antidiabetic drug
NIT non-insulin based therapies

Language: English

Study design: RCTs and systematic reviews

For cross over trials, a 4-6 week washout period was considered appropriate. The following decisions about data extraction for cross over trials were taken:

- If the trial reports analysis that is appropriate for cross-over trials and a washout period of 4-6 weeks then the end of treatment data will be extracted
- If the trial reports analysis that is appropriate for cross-over trials but a washout period <4 weeks then data from the first treatment period will be extracted
- If the trial does not report analysis that is appropriate for cross-over trials then data from the first treatment period will be extracted.
### Population

Adults (aged 18 years and over) diagnosed with type 2 diabetes. Specific patient sub-groups for whom the management of type 2 diabetes may vary, this may include but is not restricted to:

- Older adults
- People with renal impairment
- People in specific ethnic groups
- People in specific cardiovascular risk groups

### Interventions

Pharmacological management of blood glucose levels. The following blood glucose-lowering therapies will be examined as part of treatment strategies involving initial therapy followed by first, second and third intensification:

- **DPP-4 inhibitors:**
  - sitagliptin, vildagliptin, linagliptin and saxagliptin
- **glucagon-like peptide-1 (GLP-1) receptor agonists:**
  - exenatide (conventional formula and prolonged release), liraglutide and lixisenatide
- **thiazolidinediones (peroxisome proliferator-activated receptor gamma [PPAR-γ] agonists):**
  - pioglitazone
- sulfonylureas
- metformin
- insulin
- acarbose

### Additional search terms for update

- Sulphonylureas (Glibenclamide, Gliclazide, Glimepiride, Glipizide, Tolbutamide), Insulin, Acarbose (alpha glucosidase inhibitor)

### Previous search terms used in CG87

- Glucagon-Like Peptide 1 or GLP-1, dipeptidyl peptidase-4 inhibitor, dipeptidyl peptidase-IV inhibitor, dpp-iv inhibitor, dpp-4 inhibitor, glargine or detemir (for insulin searches)
### Search strategies and review protocols

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<tr>
<td>meglitinides</td>
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<tr>
<td>Comparator</td>
<td>As specified in individually listed comparisons</td>
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<td>Outcomes</td>
<td>Changes in blood glucose levels (HbA1c) Changes in weight or Body Mass Index (BMI) Frequency, severity and timing of hypoglycaemic episodes Adverse events The development of microvascular and macrovascular complications: • retinopathy (specific lesions or macular changes, referable retinopathy, blindness/loss of vision, visual acuity) • kidney damage (eGFR, serum creatinine, proteinuria, microalbuminuria, dialysis) • cardiovascular disease (myocardial infarction, heart failure, stroke, ACS, TIA, revascularisation and stenting) • foot complications (amputations, diabetic foot ulcers, charcot osteoarthropathy, diabetic foot infection) Changes in lipid levels (LDL-C, HDL-C, TG and TC) and blood pressure Mortality Health-related quality of life Resource use and cost Progression to insulin treatment Total daily dose of insulin (where insulin treatment has been used)</td>
<td>CG66 and CG87: Progression to insulin treatment also considered as outcome for GLP-1’s and total daily dose of insulin when assessing insulin as treatment (alone or in combination). Cardiovascular risk factors were also reported (i.e. lipid, blood pressure data etc.)</td>
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</table>

At GDG 6, the group agreed that the important blood glucose measures for this review question was HbA1c as these are commonly used in clinical practice. Fasting and postprandial blood glucose are not normally used and for postprandial levels, there is no standardised method for assessment and self-monitored levels were also not important as more accurate measures of blood glucose levels were available. The GDG also agreed that beta-cell function and insulin resistance are not used in clinical practice and should not be reported. In addition, markers for CVD risk such as oxidative stress and c-peptides are also excluded.

The GDG discussed potential effect modifiers and suggested that the main variables were age, weight, renal function, duration of diabetes, activity levels, baseline HbA1c, diet and ethnicity.

The minimal important difference (MID) for HbA1c was agreed to be 0.5%. For blood pressure this was 5 mmHg, BMI was 10%, LDL cholesterol was 1mmol and 50 units for total daily insulin use. All other binary outcomes were 25% and for...
### Other criteria for inclusion/exclusion of studies

<table>
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<tr>
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<tbody>
<tr>
<td><strong>Inclusion criteria used in CG87:</strong></td>
<td>For the update, the use of standard UK comparators was not used as an inclusion criterion and all licensed drug comparisons were explored. Systematic reviews were only used as a source of reference.</td>
<td>continuous outcomes any statistically significant findings were considered clinically important. <strong>Critical outcomes:</strong> • change in BG levels (HbA1c) • hypoglycaemia and • adverse events <strong>Important outcomes:</strong> • change in weight •</td>
</tr>
<tr>
<td>• For RCTs, treatment for a minimum of 12 weeks (because of the time it takes for glycaemic control to be reflected in HbA1c, but this should be regarded as the minimum acceptable rather than satisfactory. Longer duration studies would be better) • For systematic reviews, they should include at least one RCT of at least 12 weeks duration (trials of at least 24 weeks’ duration are preferred) • Standard UK practice as comparator (CG66 used for each drug). This criterion was not applied in the update <strong>Additional inclusion for update:</strong> • Open label trials • Trials examining head-to-head drug comparisons • For first and second intensification, trials which do not report dosing information were included (this is because patients are most likely to be on pre-existing therapy, which has been titrated to the tolerated dose before starting the study</td>
<td>Data from the following time points were extracted: • 3 months (12-16 weeks) • 6 months (22-30 weeks) • 12 months (44-60 weeks) • 24 months (96-112 weeks)</td>
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<tr>
<td>drug(s). Therefore specific dosing is less important</td>
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<tr>
<td><strong>Exclusion criteria used in CG87:</strong></td>
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<tr>
<td>• Comparison with unlicensed indications (e.g. this includes NPL insulin; ILPS insulin; monotherapy with either GLP-1s or nateglinide)</td>
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<tr>
<td><strong>Additional exclusion criteria for update:</strong></td>
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<tr>
<td>• Studies examining a mixed population of people with type 1 and 2 diabetes (unless subgroup analyses are reported or 85% or more of the study population have type 2 diabetes)</td>
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<td>• Non-randomised evidence (including cohort studies, case–control studies and case series, uncontrolled or single arm trials), narrative reviews, conference abstracts, letters and editorials, observational study, trial protocols etc.</td>
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<tr>
<td>• Comparisons with drugs not listed in scope (e.g. this includes rosiglitazone, see scope for more details)</td>
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<tr>
<td>• Not focusing on pharmacological management of blood glucose levels in people with type 2 diabetes</td>
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<tr>
<td>• Trials focusing on markers of CVD or other diabetic complications without any blood glucose measures</td>
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<tr>
<td>• Trials of monotherapy using only doses of blood glucose-lowering therapies above the recommended daily dose</td>
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<td>• Mode of delivery that is not licensed (e.g. inhaled insulin)</td>
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<td>• Drug comparison not of interest (e.g. this includes comparisons across treatment strategy, see objectives for more details)</td>
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<td>Details</td>
<td>Additional Comments</td>
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<tr>
<td>• Unclear washout of previous pharmacological treatment or proportion or all patients continued pre-existing or other OADs (papers were excluded unless this represented a small proportion of patients &lt;5%)</td>
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<tr>
<td>• Unclear if analyses were adjusted in trials where rescue medication was available</td>
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<tr>
<td>• For initial therapy, trials were excluded if there was no information relating to doses (this is because patients are generally drug naïve and so it is important to establish that starting doses in trials are within the licensed recommendations)</td>
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<tr>
<td>• Trials termed monotherapy with individuals who were not drug naïve or had washout periods ≤4 weeks</td>
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<tr>
<td>• Other methodological reasons (e.g. no explicit inclusion/exclusion criteria)</td>
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</table>

**Previous search strategies**

**Previous date restrictions for CG87:**
- GLP-1’s limited from 1990-April 2008
- DPP-4 inhibitors limited from 1996-April 2008
- Insulin (glargine and detemir) limited from 1996-April 2008
- Thiazolidinediones limited from 1996-January 2008 (week 18 for safety and EMBASE)

**Previous date restrictions for CG66:**
- Metformin limited from 2001-2007
- Sulphonylurea limited from 2001-2007
- Acarbose limited from 2001-2007
- Biphasic insulin preparations (vs. NPH or biphasic analogue preparations) limited from 2001-2007
- Multiple analogue insulin injections limited

Full search for GLP-1 agonists and DPP-4 inhibitors did not have a date restriction applied as some of the individual drugs within these classes have not been previously searched for
<table>
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<tr>
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<tbody>
<tr>
<td>Drugs not covered by previous searches:</td>
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<tr>
<td>DPP-4 inhibitors linagliptin and alogliptin</td>
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<tr>
<td>GLP-1 mimetic lixisenatide</td>
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<tr>
<td>Search strategies for update RCTs and systematic reviews. Each drug</td>
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<tr>
<td>class can have a date restriction for searches (see above for details</td>
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<td>of previous searches).</td>
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<td><strong>Drugs reviewed in CG87:</strong> GLP-1 or exenatide or liraglutide (April</td>
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<tr>
<td>2008-present) DPP-4 or vildagliptin or sitagliptin or</td>
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<td>saxagliptin (April 2008-present)</td>
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<td>Insulin glargine or insulin detemir (April 2008-present)</td>
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<tr>
<td>Thiazolidinediones pioglitazone (January 2008-present)</td>
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<td><strong>Drugs reviewed in CG66 only:</strong> Metformin (2007-present)</td>
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<td>Sulphonylureas (2007-present)</td>
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<tr>
<td>Acarbose (2007-present)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insulin (2007-present)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Drugs not reviewed in either CG66 or CG87:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DPP-4 inhibitors linagliptin and alogliptin (no date restriction)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GLP-1 mimetic lixisenatide (no date restriction)</td>
<td></td>
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<tr>
<td>NB: In CG87 Ovid Auto-alerts were set-up for the clinical effectiveness</td>
<td></td>
<td></td>
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<tr>
<td>for the rest of 2008 in order to retrieve new studies published after</td>
<td></td>
<td></td>
</tr>
<tr>
<td>the initial searches were run.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review strategies The NICE methodology checklist for RCTs and systematic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>reviews will be used as a guide to appraise the quality of individual</td>
<td></td>
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</tr>
<tr>
<td>studies Data on all included studies will be extracted into evidence</td>
<td></td>
<td></td>
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<tr>
<td>tables.</td>
<td></td>
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</table>
Search strategies and review protocols

<table>
<thead>
<tr>
<th>Details</th>
<th>Additional Comments</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where statistically possible, a meta-analytical approach or mixed treatment comparison (MTC) will be used. All key outcomes from the evidence will be presented in GRADE profiles or modified profiles and further summarized in evidence statements. Outcomes from previously included studies will be incorporated into the analysis and GRADE profiles where appropriate.</td>
<td></td>
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</tbody>
</table>

Identified key studies

N/A

A.5.1.2 Review question 2: What are the serious adverse effects of long-term use of pharmacological interventions to control blood glucose in people with type 2 diabetes?

<table>
<thead>
<tr>
<th>Details</th>
<th>Additional comments</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review question 2: What are the serious adverse effects of long-term use of pharmacological interventions to control blood glucose in people with type 2 diabetes?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Objectives</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| What long term serious adverse effects are associated with the use of the following pharmacological blood glucose-lowering therapies (either alone or in combination):  
  - DPP-4 inhibitors:  
    o sitagliptin, vildagliptin, linagliptin and saxagliptin  
  - glucagon-like peptide-1 (GLP-1) receptor agonists:  
    o exenatide (conventional formula and prolonged release), liraglutide and lixisenatide  
  - thiazolidinediones (peroxisome proliferator-activated receptor gamma [PPAR-γ] agonists):  
    o pioglitazone  
  - sulfonylureas  
  - metformin  
  - insulin | | |
### Search strategies and review protocols

<table>
<thead>
<tr>
<th>Details</th>
<th>Additional comments</th>
<th>Status</th>
</tr>
</thead>
</table>
| • acarbose  
• meglitinides  
Are adverse events and microvascular and macrovascular complications more likely to occur in specific subgroups of the population? | | |

**Language**  
English

**Study design**  
Prospective cohort studies (including open label continuation studies)

**Status**  
Published papers (full papers only)

At GDG 1 the group discussed that this question may overlap with the aims of MHRA who may also use unpublished data. However, it was agreed that this review question will also cover safety issues when blood glucose-lowering therapies are compared with each other. This has been restricted to published papers only.

**Population**  
Adults (aged 18 years and over) diagnosed with type 2 diabetes. Specific patient sub-groups for whom the management of type 2 diabetes may vary, this may include but is not restricted to:  
• Older adults  
• People with renal impairment  
• People in specific ethnic groups  
• People in specific cardiovascular risk groups

**Intervention**  
The following blood glucose-lowering therapies will be examined as part of treatment strategies involving monotherapy, dual therapy and triple therapy:  
• DPP-4 inhibitors:  
  o sitagliptin, vildagliptin, linagliptin and saxagliptin  
• glucagon-like peptide-1 (GLP-1) receptor agonists:  
  o exenatide (conventional formula and prolonged release), liraglutide and lixisenatide

Previous search terms (CG87): risk or safety or adverse or harm or pharmacovigilance, side-effect or precaution or warning or
Details

- thiazolidinediones (peroxisome proliferator-activated receptor gamma [PPAR-γ] agonists):
  - pioglitazone
- sulfonylureas
- metformin
- insulin
- acarbose
- meglitinides

Additional comments

- contraindication or contra-indication

Comparator

placebo/no treatment or other treatment (including combinations)

Outcomes

- cancer
- cardiovascular disease (myocardial infarction, heart failure, stroke, ACS, TIA, revascularisation and stenting)
- cognitive impairment
- fracture
- pancreatic disease
- morbidity
- mortality

Other criteria for inclusion/exclusion of studies

Include:

- Studies with a minimum sample size of 200
- Studies with follow-up of at least 2 years
- Studies focusing on the development of long-term safety issues such as renal failure, severe pancreatitis, cancer (thyroid, bladder etc), cardiac failure and other microvascular or macrovascular complications.

Exclude:

- Conference abstracts, letters, editorials and other non-prospective observational studies (evidence from registries and healthcare databases are considered to be retrospective)
- Studies that do not report the incidence of the safety issue or exposure to pharmacological treatment
- Studies examining a mixed population of people with type 1 and 2 diabetes (unless subgroup analyses are reported or ≥85% of the study

At GDG 1 the group agreed that studies with a minimum of 200 people with diabetes should be included. The GDG agreed that a minimum 2 year follow-up would be sufficient to allow for adverse events and complications to occur (shorter durations will be covered by review question 1)
### Search strategies and review protocols

<table>
<thead>
<tr>
<th>Details</th>
<th>Additional comments</th>
<th>Status</th>
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</thead>
<tbody>
<tr>
<td>Population have type 2 diabetes</td>
<td></td>
<td></td>
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</tbody>
</table>

#### Search strategies
- Prospective cohort studies. No date restriction.

#### Review strategies
- The NICE methodology checklist for observational studies will be used as a guide to appraise the quality of individual studies.
- Data on all included studies will be extracted into evidence tables.
- Where statistically possible, a meta-analytical approach will be used to give an overall summary effect.
- All key outcomes from evidence will be presented in GRADE profiles or modified profiles and further summarized in evidence statements.
- Outcomes from previously included studies will be incorporated into the analysis and GRADE profiles where appropriate.
- Sub-group analysis will be undertaken where appropriate.

<table>
<thead>
<tr>
<th>Identified key studies</th>
<th>N/A</th>
</tr>
</thead>
</table>

### A.5.1.3 Review question 3: What are the optimal target values for HbA1c, fasting blood glucose and post prandial blood glucose in people with type 2 diabetes?

<table>
<thead>
<tr>
<th>Details</th>
<th>Additional comments</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review question 3</td>
<td>What are the optimal target values for HbA1c, fasting blood glucose and post-prandial blood glucose in people with type 2 diabetes?</td>
<td></td>
</tr>
</tbody>
</table>

#### Objectives
- What blood glucose values should be targeted to minimise the risk of future vascular damage?
- Do optimal target values for blood glucose measures differ according to pharmacological treatment and specific subgroups of the population?

#### Language
- English

#### Study design
- Prospective cohort studies

#### Status
- Published papers (full papers only)

#### Population
- Adults (aged 18 years and over) diagnosed with type 2 diabetes.
- Specific patient sub-groups for whom the management of type 2 diabetes may vary, this may include but is not restricted to:
  - Older adults

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National Institute for Health and Care Excellence, 2015
<table>
<thead>
<tr>
<th>Details</th>
<th>Additional comments</th>
<th>Status</th>
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</thead>
</table>
| - People with renal impairment  
- People in specific ethnic groups  
- People in specific cardiovascular risk groups | | |

**Intervention**
- N/A

**Comparator**
- N/A

**Outcomes**
- The development of microvascular and macrovascular complications
  - retinopathy (specific lesions or macular changes, referable retinopathy, blindness/loss of vision, visual acuity)
  - kidney damage (eGFR, serum creatinine, proteinuria, microalbuminuria, dialysis)
  - cardiovascular disease (myocardial infarction, heart failure, stroke, ACS, TIA, revascularisation and stenting)
  - foot complications (amputations, diabetic foot ulcers, charcot osteoarthropathy, diabetic foot infection)

**Mortality**

**Other criteria for inclusion/exclusion of studies**

**Include:**
- Prospective observational cohort studies focusing on the development of microvascular or macrovascular complications and its association with blood glucose measures

**Exclude:**
- Studies focusing on an association between HbA1c and microvascular or macrovascular complications without giving further information about the association
- Studies focusing only on an association between the variability of blood glucose measures (e.g. HbA1c-CV, HbA1c-SD) and long-term complications
- Case series, conference abstracts, letters and editorials and other non-prospective observational studies
- Studies examining a mixed population of people with type 1 and 2 diabetes (unless subgroup analyses are reported)
- Exploratory prognostic studies which examine HbA1c as one of many risk factors for diabetic complications
- Studies including rosiglitazone

**Additional comments**
- NB: due to the large UKPDS study in CG66 studies published from 2001 onwards were only considered if there was a sample size N of at least 2000 people with type 2 or mixed population of type 1 and 2 diabetes. Studies were not reviewed if they simply found associations between HbA1c and complications without giving further information

**Status**
- At GDG 1, the group discussed the sample size threshold that was used in the previous guideline and agreed this was arbitrary and may need to be lower for specific sub-groups of the population (this exclusion criteria was removed for the update). It was also agreed that for this review question, including papers with the majority of people with type 2 diabetes may not be appropriate as small numbers of people with type 1 diabetes may bias the findings.

Studies on rosiglitazone
### Search strategies and review protocols

<table>
<thead>
<tr>
<th>Details</th>
<th>Additional comments</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observational study design. No date restriction on all blood glucose</td>
<td>are to be excluded as its association with cardiovascular mortality is likely to confound the review findings.</td>
<td></td>
</tr>
<tr>
<td>should be applied as the sample size threshold in CG66 for HbA1c</td>
<td></td>
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<tr>
<td>studies was removed</td>
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</table>

<table>
<thead>
<tr>
<th>Search strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observational study design. No date restriction on all blood glucose should be</td>
</tr>
<tr>
<td>applied as the sample size threshold in CG66 for HbA1c studies was removed.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Review strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appropriate NICE methodology checklists (depending on the study design) will be</td>
</tr>
<tr>
<td>used as a guide to appraise the quality of individual studies. Data on all included</td>
</tr>
<tr>
<td>studies will be extracted into evidence tables. Where statistically possible, a</td>
</tr>
<tr>
<td>meta-analytical approach will be used to give an overall summary effect. All key</td>
</tr>
<tr>
<td>outcomes from evidence will be presented in GRADE profiles or modified profiles</td>
</tr>
<tr>
<td>and further summarized in evidence statements. Outcomes from previously included</td>
</tr>
<tr>
<td>studies will be incorporated into the analysis and GRADE profiles where appropriate.</td>
</tr>
<tr>
<td>Sub-group analysis will be undertaken when appropriate.</td>
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</tbody>
</table>

| Identified key studies | N/A |

**A.5.1.4 Review question 4: Should intensive or conventional target values be used to control blood glucose levels in people with type 2 diabetes?**

<table>
<thead>
<tr>
<th>Details</th>
<th>Additional comments</th>
<th>Status</th>
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</thead>
<tbody>
<tr>
<td>Should intensive or conventional target values be used to control blood</td>
<td></td>
<td></td>
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<tr>
<td>glucose levels in people with type 2 diabetes?</td>
<td></td>
<td></td>
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</tbody>
</table>

**Objectives**

- Should intensive strategies that target HbA1c levels, fasting blood glucose and post-prandial blood glucose below conventional values be used to manage blood glucose levels in people with type 2 diabetes?
- Should intensive strategies be used by all people with type 2 diabetes or should this be restricted to specific sub-groups of the population?
- When should intensive strategies be used to manage blood glucose levels in people with type 2 diabetes?

**Language**

English
### Study design
RCT's and systematic reviews

### Status
Published papers (full papers only)

### Population
Adults (aged 18 years and over) diagnosed with type 2 diabetes. Specific patient sub-groups for whom the management of type 2 diabetes may vary, this may include but is not restricted to:
- Older adults
- People with renal impairment
- People in specific ethnic groups
- People in specific cardiovascular risk groups

### Intervention
Intensive blood glucose control (using pharmacological blood glucose-lowering therapies listed below) with target blood glucose levels lower than conventional values:
- DPP-4 inhibitors:
  - sitagliptin, vildagliptin, linagliptin and saxagliptin
- glucagon-like peptide-1 (GLP-1) receptor agonists:
  - exenatide (conventional formula and prolonged release), liraglutide and lixisenatide
- thiazolidinediones (peroxisome proliferator-activated receptor gamma [PPAR-γ] agonists):
  - pioglitazone
- sulfonylureas
- metformin
- insulin
- acarbose
- meglitinides

### Comparator
Conventional/standard blood glucose targets

### Outcomes
Changes in weight or Body Mass Index (BMI)
Frequency, severity and timing of hypoglycaemic episodes
The development of microvascular and macrovascular complications
- retinopathy (specific lesions or macular changes, referable retinopathy, blindness/loss of vision, visual acuity)
- kidney damage (eGFR, serum creatinine, proteinuria, microalbuminuria,
**Search strategies and review protocols**

<table>
<thead>
<tr>
<th>Details</th>
<th>Additional comments</th>
<th>Status</th>
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</thead>
</table>

- dialysis
- cardiovascular disease (myocardial infarction, heart failure, stroke, ACS, TIA, revascularisation and stenting)
- foot complications (amputations, diabetic foot ulcers, charcot osteoarthropathy, diabetic foot infection)

**Mortality**

**Other criteria for inclusion/exclusion of studies**

**Include:**
- RCTs focusing on the use of intensive vs. conventional blood glucose control (this includes multifactorial interventions that include intensive HbA1c or other blood glucose targets and intensive insulin therapy)

**Exclude:**
- Non-randomised evidence (including cohort studies, case–control studies and case series), narrative reviews, conference abstracts, letters and editorials
- Studies examining a mixed population of people with type 1 and 2 diabetes (unless subgroup analyses are reported)

It was agreed at GDG 1 that for this review question, including papers with the majority of people with type 2 diabetes may not be appropriate as small numbers of people with type 1 diabetes may bias the findings.

**Search strategies**

RCT and systematic review filter. No date restriction.

**Review strategies**

- Appropriate NICE methodology checklists (depending on the study design) will be used as a guide to appraise the quality of individual studies
- Data on all included studies will be extracted into evidence tables
- Where statistically possible, a meta-analytical approach will be used to give an overall summary effect
- All key outcomes from evidence will be presented in GRADE profiles or modified profiles and further summarized in evidence statements
- Outcomes from previously included studies will be incorporated into the analysis and GRADE profiles where appropriate
- Sub-group analysis will be undertaken when appropriate

**Identified key studies**

N/A

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**A.5.1.5 Review question 5: Should self-monitoring be used to manage blood glucose levels in people with type 2 diabetes?**

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<th>Details</th>
<th>Additional comments</th>
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</table>

**Review question 5**

Should self-monitoring be used to manage blood glucose levels in people with type 2 diabetes?

This review question was amended at GDG 1 to
### Search strategies and review protocols

<table>
<thead>
<tr>
<th>Details</th>
<th>Additional comments</th>
<th>Status</th>
</tr>
</thead>
</table>
| **Objectives** | Should self-monitoring be used to manage blood glucose levels in people with type 2 diabetes? This will include:  
- people taking any glucose-lowering therapies (alone or in combination)  
- people receiving lifestyle intervention alone (without glucose-lowering therapies)  
Should all people with type 2 diabetes use self-monitoring or should this be restricted to specific sub-groups of the population?  
What target values should people who self-monitor blood glucose levels aim for?  
How often and when should people self-monitor blood glucose levels?  
Where (on the body) should people carry out self-monitoring tests? | cover the use of self-monitoring in people treated with lifestyle intervention alone |

<table>
<thead>
<tr>
<th>Language</th>
<th>Study design</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>Systematic reviews and RCTs</td>
<td>Published papers (full papers only)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Population</th>
<th>Intervention</th>
<th>Comparator</th>
<th>Outcomes</th>
</tr>
</thead>
</table>
| Adults (aged 18 years and over) diagnosed with type 2 diabetes. Specific patient sub-groups for whom the management of type 2 diabetes may vary, this may include but is not restricted to:  
- Older adults  
- People with renal impairment  
- People in specific ethnic groups  
- People in specific cardiovascular risk groups | self-monitoring of blood glucose levels using lancets | No self-monitoring of blood glucose, standard or usual care, self-monitoring of urine glucose, other types of self-monitoring of blood glucose (such as augmentation via education, telecare, continuous glucose monitoring; or different aspects of treatment for example frequency and location of testing) | Changes in blood glucose levels (HbA1c, fasting and postprandial blood glucose) |
### Search strategies and review protocols

<table>
<thead>
<tr>
<th>Details</th>
<th>Additional comments</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency, severity and timing of hypoglycaemic episodes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adverse events</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The development of microvascular and macrovascular complications:</td>
<td></td>
<td></td>
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<tr>
<td>- retinopathy (specific lesions or macular changes, referable retinopathy, blindness/loss of vision, visual acuity)</td>
<td></td>
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<tr>
<td>- kidney damage (eGFR, serum creatinine, proteinuria, microalbuminuria, dialysis)</td>
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<tr>
<td>- cardiovascular disease (myocardial infarction, heart failure, stroke, ACS, TIA, revascularisation and stenting)</td>
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<td></td>
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<tr>
<td>- foot complications (amputations, diabetic foot ulcers, charcot osteoarthropathy, diabetic foot infection)</td>
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<tr>
<td>Health-related quality of life</td>
<td></td>
<td></td>
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<tr>
<td>Resource use and cost</td>
<td></td>
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</tbody>
</table>

**Other criteria for inclusion/exclusion of studies**

**Include:**
- Studies focusing on the use of self-monitoring (as part of an overall education package) in people with type 2 diabetes (this will include people who are receiving lifestyle/dietary interventions alone or in combination with blood-glucose lowering therapies)
- Studies with a minimum follow-up of 4 weeks

**Exclude:**
- Non-randomised evidence (including cohort studies, case–control studies and case series), narrative reviews, conference abstracts, letters and editorials
- Studies examining a mixed population of people with type 1 and 2 diabetes (unless subgroup analyses are reported or 85% or more of the study population have type 2 diabetes)

At GDG 1, the group agreed that specifying a minimum follow-up over one month may lead to the loss of important information about short-term outcomes such as hypoglycaemia.

**Search strategies**

Systematic reviews and RCTs. Searches can be restricted from 2007-present as CG66 reviewed evidence from 2001-2007.

CG66 included search for qualitative studies (requested by GDG)

**Review strategies**

The NICE methodology checklist for RCTs and systematic reviews will be used as a guide to appraise the quality of individual studies.

Data on all included studies will be extracted into evidence tables.

Where statistically possible, a meta-analytical approach will be used to...
### Review question 6: Should aspirin and/or clopidogrel be used for primary prevention of cardiovascular disease in people with type 2 diabetes?

#### Details
- **Review question 6**: Should aspirin and/or clopidogrel be used for primary prevention of cardiovascular disease in people with type 2 diabetes?

#### Additional comments
- This relates to off-label use but was agreed as a review question due to the use of these drugs in current practice.

#### Objectives
- Should aspirin and/or clopidogrel be used to prevent cardiovascular disease in people with type 2 diabetes?
- Should all people with type 2 diabetes use aspirin and/or clopidogrel or should this be restricted to specific sub-groups of the population (e.g. does this include people with a lower CV risk?)
- When should aspirin and/or clopidogrel be used?
- What adverse events and/or safety concerns are associated with the use of aspirin and/or clopidogrel?

#### Language
- English

#### Study design
- Systematic reviews and RCTs

#### Status
- Published papers (full papers only)

#### Population
- Adults (aged 18 years and over) diagnosed with type 2 diabetes.
- Specific patient sub-groups for whom the management of type 2 diabetes
<table>
<thead>
<tr>
<th>Details</th>
<th>Additional comments</th>
<th>Status</th>
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</thead>
</table>
| may vary, this may include but is not restricted to:  
- Older adults  
- People with renal impairment  
- People in specific ethnic groups  
- People in specific cardiovascular risk groups | | |
| Intervention | Aspirin and/or clopidogrel (alone or in combination) | Comparisons of interest:  
Aspirin vs. placebo  
Clopidogrel vs. placebo  
Clopidogrel vs. aspirin  
Clopidogrel + aspirin vs. placebo  
Clopidogrel + aspirin vs. aspirin monotherapy  
Clopidogrel + aspirin vs. clopidogrel monotherapy | |
| Comparator | placebo or each other (including combinations) | |
| Outcomes | Adverse events  
The development of microvascular and macrovascular complications  
- retinopathy (specific lesions or macular changes, referable retinopathy, blindness/loss of vision, visual acuity)  
- kidney damage (eGFR, serum creatinine, proteinuria, microalbuminuria, diaysis)  
- cardiovascular disease (myocardial infarction, heart failure, stroke, ACS, TIA, revascularisation and stenting)  
- foot complications (amputations, diabetic foot ulcers, charcot osteoarthropathy, diabetic foot infection) | Mortality |
## Search strategies and review protocols

<table>
<thead>
<tr>
<th>Details</th>
<th>Additional comments</th>
<th>Status</th>
</tr>
</thead>
</table>
| Health-related quality of life  
Resource use and cost | | |

### Other criteria for inclusion/exclusion of studies

**Include:**
- Trials focusing on the use of aspirin and/or clopidogrel in people with type 2 diabetes

**Exclude:**
- Trials examining the use of aspirin and/or clopidogrel after acute cardiological events, cardiac interventions or cerebrovascular events
- Non-randomised evidence (including cohort studies, case–control studies and case series), narrative reviews, conference abstracts, letters and editorials
- Trials examining anti-platelet drugs other than aspirin or clopidogrel (e.g. dipyridamole, prasugrel, ticagrelor etc. as used in secondary prevention)
- Studies examining a mixed population of people with type 1 and 2 diabetes (unless subgroup analyses are reported or 85% or more of the study population have type 2 diabetes)

At GDG 1 the group agreed that there were clinical reasons why the use of these drugs would differ depending on the type of diabetes. Specifically, people with type 2 diabetes may differ to people with type 1 diabetes in terms of age and risk factors for CVD.

### Search strategies

Systematic reviews and RCTs. A date restriction of 2007-present can be applied as CG66 reviewed evidence from 2001-2007

### Review strategies

The NICE methodology checklist for RCTs and systematic reviews will be used as a guide to appraise the quality of individual studies

Data on all included studies will be extracted into evidence tables

Where statistically possible, a meta-analytical approach will be used to give an overall summary effect

All key outcomes from evidence will be presented in GRADE profiles or modified profiles and further summarized in evidence statements.

Outcomes from previously included studies will be incorporated into the analysis and GRADE profiles where appropriate.

Sub-group analysis will be undertaken when appropriate

### Identified key studies

N/A
### A.5.1.7 Review question 7: What pharmacological treatment should be used to manage erectile dysfunction in men with type 2 diabetes?

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<thead>
<tr>
<th>Details</th>
<th>Additional comments</th>
<th>Status</th>
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<tbody>
<tr>
<td>Review question 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What pharmacological treatment should be used to manage erectile dysfunction in men with type 2 diabetes?</td>
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</tbody>
</table>

#### Objectives
- Should the following pharmacological treatments be used to manage erectile dysfunction in men with diabetes either alone or in combination:
  - Phosphodiesterase 5 (PDE-5) inhibitors
  - Testosterone therapy
  - Alprostredil

- Should the use of pharmacological treatment for erectile dysfunction be restricted to specific sub-groups of the population?
- What adverse events and/or safety concerns are associated with the use of testosterone therapy, PDE-5 inhibitors and alprostredil?

#### Language
- English

#### Study design
- RCT and systematic reviews

#### Status
- Published papers (full papers only)

#### Population
- Men (aged 18 years and over) diagnosed with diabetes (type 1 and 2)
- Specific patient sub-groups for whom the management of type 2 diabetes may vary, this may include but is not restricted to:
  - Older adults
  - People with renal impairment
  - People in specific ethnic groups
  - People in specific cardiovascular risk groups

#### Intervention
- Testosterone therapy, PDE-5 inhibitors and alprostredil (alone or in combination)

Comparisons of interest:
- Testosterone therapy vs. placebo
- Testosterone therapy vs. PDE-5 inhibitors
- Testosterone therapy + PDE-5 vs. either alone
- PDE-5 vs. PDE-5
### Details

<table>
<thead>
<tr>
<th>Comparator</th>
<th>Placebo, standard care (or other treatment)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcomes</td>
<td>Erectile function (assessed using validated scale/measure such as International Index of Erectile Function; IIEF)</td>
</tr>
<tr>
<td></td>
<td>Adverse events</td>
</tr>
<tr>
<td></td>
<td>The development of microvascular and macrovascular complications</td>
</tr>
<tr>
<td></td>
<td>Health-related quality of life</td>
</tr>
<tr>
<td></td>
<td>Resource use and cost</td>
</tr>
</tbody>
</table>

### Additional comments

<table>
<thead>
<tr>
<th>Status</th>
<th>PDE-5 vs. placebo Alprostredil (alone or in combination) vs. placebo</th>
</tr>
</thead>
<tbody>
<tr>
<td>At GDG 1 the group discussed that rates of withdrawal (due to adverse events) would be useful outcomes to be reported. It was agreed that this would fall under adverse events and where reported in trials, this data would be extracted.</td>
<td></td>
</tr>
</tbody>
</table>

### Other criteria for inclusion/exclusion of studies

**Include:**
- Trials examining the use of testosterone therapy, PDE-5 inhibitors and alprostredil (alone or in combination) for the management of erectile dysfunction in men with diabetes

**Exclude:**
- Non-randomised evidence (including cohort studies, case–control studies and case series), narrative reviews, conference abstracts, letters and editorials
- Diagnosis of erectile dysfunction
- Use of testosterone therapy in men who do not have erectile dysfunction

### Search strategies

<table>
<thead>
<tr>
<th>RCT and systematic reviews only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date restriction for PDE-5 inhibitors (2007 onwards)</td>
</tr>
</tbody>
</table>

### Review strategies

| The NICE methodology checklist for RCTs and systematic reviews will be used as a guide to appraise the quality of individual studies |

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National Institute for Health and Care Excellence, 2015
Data on all included studies will be extracted into evidence tables. Where statistically possible, a meta-analytical approach will be used to give an overall summary effect. All key outcomes from evidence will be presented in GRADE profiles or modified profiles and further summarized in evidence statements. Outcomes from previously included studies will be incorporated into the analysis and GRADE profiles where appropriate. Sub-group analysis will be undertaken when appropriate.

<table>
<thead>
<tr>
<th>Identified key studies</th>
<th>N/A</th>
</tr>
</thead>
</table>
Search strategies and review protocols