

Type 2 Diabetes workshop notes

Group 1 notes – Abi / Nicole

4.1 Population

The group discussed the following sub groups that may need addressing:

- Men-as they tend to die earlier compared with women, their perceptions of health and health related issues may differ and they may find it more difficult to access healthcare services
- People with cardiovascular risk-this should be based on lifetime risk as this differs from 10 year risk
- Ethnicity-this was also considered in CG66 as treatment options may differ across different groups
- Age-older adults may need to be considered as a specific group as this is often linked with poorer health and renal function, which may change treatment decisions
- Other groups included people with a family history of cancer and people with different socio economic statuses

4.2 Healthcare setting

The group discussed that intermediate care such as satellite centres should also be addressed. However, it was agreed that this would be included as these services are commissioned by primary care. It was also discussed that the wording of this section could be revised to make clear that the update would cover all healthcare settings.

4.3 Clinical management

The group discussed each key clinical issue that will be covered in the draft scope:

- The group agreed with the drug classes set out in the pharmacological management section but also suggested that sulphonylurea, Alogliptin and different insulin regimes would also need to be included as an intervention (rather than being included as comparators alone). The group also highlighted drugs that may induce diabetes (such as steroids) as an important issue
- The group discussed target values for glucose control and agreed that although Hba1c should be covered, other measures may also need to be included. For example in older adults other measures may be needed in order to avoid episodes of hypoglycaemia which is an important issue in this subgroup
- The group also discussed cardiovascular risk estimation and agreed that this was important as there is no clear consensus within the diabetes community. This issue is also set out in the scope for the update of the clinical guideline on lipid modification (CG67), however the group felt that this may be better placed within the diabetes guideline because in clinical practice this assessment is often carried out in primary care and within diabetes clinics. The group also highlighted that the use of statins in people with type 2 diabetes should be reviewed, however this is also covered in the lipid scope. It was agreed that these issues would need clinical input from a diabetologist.
- The group agreed that antithrombotic therapy should be included as part of the update
- The group discussed bariatric surgery and suggested that this should be expanded to include which population this intervention should be used with and when it should be considered. There is some evidence to suggest that duration of diabetes may be an important factor to consider.

The group also considered clinical issues that will not be covered by the update:

- There was agreement that patient education should also be included for update as there may be new evidence relating to issues of compliance and new methods of providing information
- The group suggested that lifestyle and non-pharmacological management should also be included for update. Specifically the use of restricted diet and screening for psychological problems such as anxiety and depression were highlighted as important issues which may differ for people with diabetes. It was also agreed that this wider issue may need separating into specific areas in the guideline.
- There was also agreement that self-monitoring of plasma glucose was a major issue and should be updated as there is new evidence relating to when it is effective. There was discussion that the use of newer drugs may have changed how this is carried out and a review may need to be complete. It was also noted that this differs in type 1 compared with type 2 diabetes.
- The group discussed lipid levels, kidney disease, neuropathic pain and diabetic foot problems. It was generally agreed that these areas either should not be prioritised for update or would be covered by other NICE guidance and could be incorporated into the final update of diabetes without further review questions.
- The group discussed the use of HbA1c levels to diagnose diabetes (both type 1 and type 2) and suggested that there is still controversy in this area.
- There were also discussions relating to the use of ketone testing and testosterone therapy. Specifically, it was suggested that ketone testing is being increasingly used in clinical practice when dealing with diabetic ketoacidosis (DKA). In addition, it was agreed that testosterone therapy should be included as part of the update as there is new evidence in this area.

4.4 Main outcomes

The group discussed the main outcomes that were included in the draft scope and raised the following issues:

- Blood glucose levels should include other measures apart from HbA1c
- Resolution of type 2 diabetes should be added to address bariatric surgery
- Changes in weight should include other measures such as waist-hip ratio and abdominal circumference
- Changes in lipid levels and blood pressure should also be included
- Reduction in the use of pharmacological agents could also be included as an outcome
- Adverse events should include short, intermediate and long-term events

GDG constituency

The group also discussed the GDG constituency and felt that the following members may need to be recruited for the update:

- Psychologist or mental health specialist
- Dietitian
- Specialist in sexual dysfunction
- Primary care pharmacist

Other issues

The group discussed the end product of the diabetes guidance and agreed that separate documents for type 1 and type 2 diabetes would be preferable. It was also suggested that the scope needs to be clearer in terms of:

- what is being suggested to be reviewed for new evidence
- what will be incorporated but new evidence not reviewed and

- what will be covered by other guidance.

Group 2 notes – Vicky/ Dylan

4.1 Population

The group discussed the need for different sub groups to be addressed:

- Patients with renal disease: Dosages for certain drug therapies (for example ACE-inhibitors) may need to be maximised for patients with renal disease. There is also the need to think about dose lowering for DPP4-inhibitors.
- Frail/ elderly patients may also need to be specified as a sub-group. This is associated with the increased risk of renal disease. The group were however unable to specify an age-bracket that defined this population. This is because care is dependent upon specific patient needs and not necessarily distinctly age specific.
- It was suggested that patients with long term mental illness may also be considered as a potential sub-group. This is because people with schizophrenia or other conditions may have engagement issues that would need to be addressed separately.
- The group felt that weight and BMI should be specifically addressed from the outset. -. There is a need to specifically categorise BMI to ensure interventions could be tailored to patients needs.
- Ethnicity was also considered to be an appropriate sub-group. In some ethnic populations cardiovascular risk factors can be identified earlier. There was also the need to consider the influence of culturally held beliefs upon the affect of interventions.

4.2 Healthcare setting:

- The group felt that healthcare setting should not be divided into primary, secondary, tertiary or specialist care etc- but instead could be classed as 'all healthcare settings'. This would reflect the current trend not to specifically categorise all care settings.

4.3 Clinical management:

The group discussed the proposed key clinical issues that would be covered in the scope:

- The group agreed that on the whole the list of pharmacological interventions was complete. However, there was a specific request to remove acarbose from the list. It was thought that the evidence upon acarbose would not have changed since publication of CG66 and therefore should not be considered in this update.
- It was thought that where possible the guideline should consider all classes of drugs. This would ensure that evidence relating to Sulphonylureas and metformin should also be considered to ensure consistency.
- The group also suggested that evidence upon pharmacological interventions should be considered for both single and combination therapies.
- One point was raised to look at/ cross refer to the use of Orlistat for obesity. It was noted however that this was currently off label for blood glucose lowering.
- The group agreed that target values should be an area for update. Although there was no conclusive agreement over whether to include other target values (other than HBA1c), a point was raised that consideration should be

made to acknowledge hypoglycaemia and therefore it may be appropriate to look at a range of blood glucose levels (not exclusively HBA1c).

- The group agreed that cardiovascular risk is currently estimated using the recent British joint societies (BJS) guidelines for CV risk estimation. It was therefore thought that CV risk estimation should not necessarily be reviewed on its own, but because CV risk is directly linked to anti thrombotic therapy it could potentially be an area for update. This is because there are some patient sub-groups (for example much younger people being diagnosed with Type 2 diabetes and this raises some issues regarding the use of aspirin).
- A point was raised over the terminology used to report blood glucose. The group raised the point that since October 2011 HBA1c targets should now be provided in mmol/mol rather than percentage values and therefore this new measure should be correctly reported within the scope.
- The group also discussed whether bariatric surgery was appropriate. It was thought that the obesity guidance was very good, but PCTs are not prioritising the correct target population and this means it is being offered to the wrong people. Therefore there is a need to consider specific populations. The management of obesity should be considered throughout the Type 2 diabetes guideline update to provide closer links.

The group also looked at the proposed areas that would not be updated:

- It was thought there were no new areas upon patient education and it was correct that this area should not be updated.
- The group felt that although lifestyle interventions should not be updated, depression and other broader mental health issues may be an area that could be revisited.
 - There may also be a need to address how cognitive disorders can influence why patients do not take medication. Related to this was the need to consider practitioner training for patients with mental health issues.
 - The point was raised that, like obesity, mental health issues should be considered at all levels, NICE has published various guidelines relating to chronic conditions and there is the potential to cross-refer to other guidance if issues relating to cognitive disorders were to be considered.
- The group agreed that Rosiglitazone should not be updated
- The group also agreed that self monitoring of blood glucose should not be updated.
- The group did not think that evidence pertaining to blood pressure control had changed enough to warrant this area to be updated, although there is a need to ensure consistency with the recommendations set out in the 2011 update of CG127- hypertension.
- The group acknowledged that management of blood lipids will be best placed in the lipid modification guideline update (currently in progress).
- The group acknowledged that the management of kidney disease may be covered by the CKD guideline update (currently referred for update). They group were mindful of the need to consider other areas of renal complications not necessarily being considered in the CKD update (for example renal anaemia)
- It was noted that the neuropathic pain update (currently in progress) may cover some aspects of diabetic neuropathy; the group did consider autonomic neuropathy could be an area to specifically be addressed.
- The group agreed that there was no need to update the existing recommendations for diabetic foot problems.

The group also looked at areas which would not be covered:

- The group felt that diagnosis of Type 1 and Type 2 diabetes is becoming increasingly difficult to diagnose correctly. The group thought there may be potential to consider screening for diabetes however it was pointed out that this is currently outside the remit.
- A point was also raised that cognitive functioning could also be considered. This could incorporate diagnosis, screening and then incorporate to all tiers of management.

4.4 Outcomes:

- A point was raised that outcomes could also include cognitive changes. It is important to note that although microvascular/ macrovascular changes are intrinsic to diabetes, changes to other organs (such as the brain) deserve similar regard.

4.5 Review questions:

- The group felt that the review question covering safety issues associated with the use of pharmacological interventions to control blood glucose in people with type 2 diabetes could be expanded to consider all outcomes (for example complications) that may arise.
- Review questions should also look at health economic analogues.

Other issues

GDG composition:

- The group felt that the role of the diabetologist needed to be explicitly defined. This is because roles are varied.
- The group also felt that there should only be one GP.
- It was also suggested that there may also be a gap for social care/ community representation within the GDG.
- The group also acknowledged that a gastric surgeon should be replaced with bariatric surgeon.

Type of end product:

- The group felt there should be one document incorporating CG66 and CG87. There is a need to keep diabetic foot care guidance separate from the other CG type 2 diabetes.
- Overall the group agreed that there is a need for the finished document to be as complete as possible.