Managing Glucose Control in People with Known Diabetes On Once Daily Steroids (glucocorticoids)

KNOWN DIABETES, reassess glucose control and current therapy

- Set target blood glucose e.g. 6-10mmol/L (see glycaemic targets box below)
- Check capillary blood glucose (CBG) 4 times a day and use this flowchart to adjust diabetes medication accordingly
- In Type 1 diabetes also check daily for ketones if CBG> 12mmol/L

Type 2 diet control OHA +/- GLP1

If no 'hypo' symptoms and NOT on an SU:

- Commence gliclazide 40mg a.m., titrate daily until a maximum dose of 240mg a.m. or glycaemic targets are reached
- Seek specialist advice if you are concerned about dose titration in those taking 160mg with no improvement in glycaemic control
- If on twice daily gliclazide and targets not reached consider referral to specialist care for titration to 240mg morning dose plus 80mg p.m.

If no 'hypo' symptoms and taking maximum dose (320mg/day)

- Add Insuman Basal, Humulin I or Human Insulatard
- Aim for CBG appropriate to patients' needs

If CBG remains above desired target before the evening meal

- Increase insulin by 4 units or 10 - 20%
- Review daily
- If remains above target titrate daily by 10 - 20% until glycaemic target reached

Insulin controlled (Type 1 and Type 2). In Type 1 diabetes always test for ketones, if blood ketones more than 3mmol/L or urinary ketones >++ assess for DKA In Type 2 diabetes check for ketones if CBG levels >12mmol/L and the patient has osmotic symptoms

Once daily night time insulin, transfer this injection to the morning:

- Titrate by 10 - 20% daily according to pre-evening meal CBG readings
- If targets not achieved consider BD, or basal bolus regimen

Twice daily insulin:

- Morning dose will need to increase 10 - 20% daily according to pre-evening meal CBG readings
- Aim for CBGs to individual needs as stated above, unless patient experiences 'hypo' despite snacks

Basal bolus insulin:

- Consider transferring evening basal dose insulin to the morning and increase short/fast acting insulin by 10 - 20% daily until glycaemic target reached
- Aim for agreed CBGs target to patients needs pre-meal, unless patient has hypo despite snacks or has long gaps between meals

If steroids are reduced or discontinued:

- Blood glucose monitoring may need to be continued in inpatients and, in discharged patients assessed by their GP
- Any changes made should be reviewed and consideration given to reverting to previous therapy or doses

If unsure at any stage about next steps or want specific advice on how to meet with patients needs or expectations please discuss with the team who usually looks after their diabetes (GP/Specialist Team).

Glycaemic targets:

- **Aim for 6 - 10mmol/L (acceptable range 4 - 12mmol/L)**
- End of life care: **Aim for 6 - 15mmol/L and symptom relief**

[Version 2.0] 25/09/2014

To be used in conjunction with the Management of Hyperglycaemia and Steroid (Glucocorticoid) Therapy - http://www.diabetologists-abcd.org.uk/JBDS/JBDS_IP_Steroids.pdf