

National Institute for Health and Care Excellence

Type 2 diabetes

Stakeholder Comments – Draft Guideline

NOTE:

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Please fill in both the ‘stakeholder organisation’ and ‘name of commentator’ fields below in order for your comments to be considered.

Stakeholder Organisation:		<u>Diabetes UK</u>		
Name of commentator:				
Order number <i>(For internal use only)</i>	Document	Page Number	Line Number	Comments
	Indicate if you are referring to the Full version NICE version or the Appendices	Indicate number or ‘general’ if your comment relates to the whole document	Indicate number or ‘general’ if your comment relates to the whole document	<p>Please insert each new comment in a new row.</p> <p>Please do not paste other tables into this table, as your comments could get lost – type directly into this table.</p>
Example	Full	16	45	Our comments are as follows
Proformas that are not correctly submitted as detailed in the example above may be returned to you.				
1	NICE version	13	1.1.1	<p>Individualised care</p> <p>The recommendation to individualise care is very welcome. We should also emphasise the fact that some patients may have had Type 2 diabetes for a while before diagnosis and with possible complications (e.g. retinopathy). Therefore initiating therapy has to be tailored in order not to worsen such complications.</p> <p>Additionally, it is important to ensure that systematic processes are used to tailor treatments. Therefore, care and support planning, as recommended in the NICE quality standards 6, should be included within the guidelines and emphasised as recommended good practice.</p>
2		13	1.2.1	<p>Patient education</p> <p>We understand and support the need for structured education programmes to be the gold standard.</p>

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				<p>However, given that only about ten per cent of newly diagnosed people with diabetes access such programmes, we should consider different means of education e.g. peer support, locally developed education programmes, online programmes etc.</p> <p>Even though this recommendation was not reviewed for this consultation, we see patient education as an integral part of diabetes management. Given the low levels of availability, and uptake, of current structured education programmes in certain areas of the country, we think it is extremely important to consider other options in addition to, not replacements of, structured education, and to encourage uptake.</p>
3		16	1.4.3	<p>Blood pressure targets Agree with upper limits. However there should be guidance on lower levels, given the evidence that there is no benefit (indeed possible harm) of pursuing targets that are too low.</p> <p>Even though this recommendation was not reviewed for this consultation, we feel that the dangers of very low blood pressure should be highlighted</p>
4		18	1.5.1	<p>Antiplatelet therapy in primary CVD prevention This ignores the extremely high risk of Cardiovascular disease in people with microalbuminuria (eGFR <60 ml/min). It also does not consider the data from the STENO 2 study that showed in people with Type 2 diabetes and microalbuminuria, aspirin 75 mg daily as part of a package of intensive care substantially reduces the incidence of CVD, progression of renal disease and need for laser therapy. We would suggest modifying this recommendation to: Do not use antiplatelet therapy generally in individuals without CVD. However, consider its use in those with any evidence of chronic kidney disease (albuminuria or eGFR <60 ml/min).</p>
5		18	1.6	<p>Blood glucose target The guidelines do not provide guidance on target blood glucose levels for people who self-monitor. As people are encouraged to self-monitor, there should be set target levels to aim for. Without any guidance on what levels of blood glucose to aim for pre and post prandial, it would be difficult for clinicians to have a meaningful conversation with their patients who self-monitor. Perhaps, consider targets similar to the ones in the Type 1 diabetes guidelines.</p>
6		19	1.6.8	HbA1c target

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				<p>This recommendation suggest waiting until levels go beyond 58mmol/mol (7.5%) before intensifying treatment. Is 58mmol/mol (7.5) not too high? Should we be looking at above 53mmol/mol (7%)? We are concerned that intensification is being left too long. We propose that following any change of medication, HbA1c should be further assessed within three month, and if target HbA1c are not met further intensification of treatment should be considered.</p>
7		21	1.6.13	<p>Blood glucose self-monitoring</p> <p>The list of scenarios to consider blood glucose self-monitoring is too restrictive particularly with regards to ‘symptomatic’ hypoglycaemia. This downplays the importance of testing in people on medications such as sulphonylurea who may experience asymptomatic hypoglycaemia or would benefit from testing to understand the effect of food and exercise on their blood glucose levels. We believe ‘symptomatic’ should be removed so that testing can be considered for anyone who experiences a hypo. Testing should also be considered for anyone who is on any medication that is accompanied with risks of hypoglycaemia irrespective of whether they drive or operate a machinery.</p> <p>Self-monitoring should also be considered for people who may require the added motivation of monitoring the effect of lifestyle changes on blood glucose levels.</p> <p>Diabetes UK survey shows what people use blood glucose monitoring for. http://www.diabetes.org.uk/Documents/Reports/access-test-strips-report-0813.pdf</p>
8		21	1.6.13	<p>Blood glucose self-monitoring</p> <p>There is a recommendation for short-term monitoring for people who start steroid treatments. Short-term monitoring should also be considered for those with intercurrent illness or any condition (or circumstances) likely to destabilise blood glucose control.</p> <p>Short-term self-monitoring should also be considered for people who may require the added motivation of knowing the effect of lifestyle changes on blood glucose levels.</p>
9		22	1.6.18	<p>Metformin</p> <p>In addition to the usual cautions about kidney disease, it would be very useful to add the recommendation that any individual prescribed metformin is cautioned to stop it temporarily if they become acutely unwell, particularly with vomiting or diarrhoea.</p>

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10		22	1.6.19	<p>Initial drug treatment</p> <ul style="list-style-type: none"> • The fact that repaglinide is mostly taken three times a day, raises serious concerns about adherence issues. Other therapies with less dosing would be preferable. • There is the added complication that repaglinide is not licensed with other oral glucose lowering agents apart from metformin, so that when a second agent is needed, a further change which requires an additional time and effort to explain the situation to the person with diabetes. In practice, this will be making life much more difficult for the person with Type 2 diabetes. • Safety concerns exist regarding Pioglitazone; potential risks including bone fractures, weight gain, bladder cancer etc. These should be highlighted and other alternatives should be considered first. • There is a useful guidance on when Metformin could be contraindicated (in recommendation 1.6.18). There should be a similar statement of when Pioglitazone could be contraindicated. For example those who have a heart failure, or at higher risk of fractures <p>In view of the above concerns, and the cursory mention of SGLT-2 inhibitors in the guidelines, we suggest that the whole drug treatment section of the guidelines should be looked at again. This should be done taking into consideration patients' safety and practical aspects of care such as multiple dosing and the need for self-monitoring. The section should fully incorporate all the current treatment options that have evidence of effectiveness including the SGLT-2 inhibitors in order to offer more options to clinicians and their patients. The guidelines should also reflect current best practice and other international guidelines such as the ADA/EASD guidelines. This will ensure that the application of research and shared practice is sustained and that the UK is not isolated in that regard.</p>
11		24	1.6.26	<p>First intensification of drug treatment</p> <p>The inclusion of SGLT-2 inhibitors seems to be an afterthought. These agents are commonly used and have been NICE approved (NICE Technology Appraisals Guidance TA288 and TA315). Therefore, the section has to be looked at again and SGLT-2 inhibitors fully incorporated rather than just a reference to other guidance.</p>

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12		26	1.6.31	<p>Second intensification of drug treatment</p> <p>The inclusion of SGLT-2 inhibitors seems to be an after-thought. These agents are commonly used and have also been recommended in NICE Technology Appraisals Guidance TA288 and TA315. Therefore, the section has to be looked at again and SGLT-2 inhibitors fully incorporated rather than just a reference to other guidance.</p>
13		31	1.7.16	<p>Eye screening wording</p> <p>We suggest changes in the wording.</p> <p>Currently: ‘Arrange or perform eye screening at or around the time of diagnosis. Arrange repeat of structured eye screening annually’.</p> <p>Suggested change: ‘Arrange or perform eye screening at or around the time of diagnosis. For people suspected of having undiagnosed Type 2 diabetes for a longer time – those symptomatic and/or with very high HbA1c – perform eye screening as soon as possible before initiating medication for blood glucose treatment. Arrange repeat of structured eye screening annually’</p> <p>Even though this recommendation was not reviewed for this consultation, we consider the safety issues associated with worsening retinopathy that could result in sight loss as a consequence of intensive blood glucose treatment to be very serious. Therefore, we will entreat the group to seriously consider rewording the eye screening recommendation for clarity.</p>
14		General		<ul style="list-style-type: none"> • There is no mention of modified-release metformin, and when it should be considered. • There is no mention of bariatric surgery. There must be a reference to the NICE CG 189 to highlight bariatric surgery as a viable treatment option for some people with Type 2 diabetes • There is no mention of oral care. Given the fact that poor oral health can affect blood glucose control, and that poor blood glucose control can affect oral health, there should be guidance on oral health. We also suggest ‘The role of oral care in Type 2 diabetes management’ be added to the recommendations for research. This will help us better understand how to incorporate oral care into diabetes management.
15				

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Closing date: 4 March 2015

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