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Insulin Therapy: Initiation, Titration and Monitoring

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Dr. Davies:
I'm Professor Melanie Davies from Leicester in the UK. This is CME on PACE CME and ReachMD. And I'm going to be talking about insulin therapy initiation, titration strategy, and monitoring, really from the point of view of the guidelines.

So, I just want to really set the scene, just in terms of our overall choice of glucose-lowering medication, that we need to ensure that in the system that we work with, that our clinicians are really updated about the efficacy and side effects of the diabetes treatments they're going to be using, particularly insulin therapy. But clearly, we need to think about the profile of the individual living with diabetes and why insulin may be required at that time and we need to talk through with them the adverse events, for example, the risk of hypoglycemia, and ensure that they have all the knowledge and skills to be able to use the medication that we're prescribing for them.

Now, in the ADA/EASD consensus report, we talk about the holistic approach, not only just around glycemic management, but also around weight management, cardiovascular risk factor protection, and also the use of glucose-lowering therapies that are able to offer organ protection. And for that reason, we often advocate the GLP-1 and the SGLT2 therapies, importantly in type 2 diabetes, early.

But clearly, insulin remains a cornerstone for diabetes treatment. Approximately500 million people with diabetes worldwide was the case in 2021. That number continues to increase. And around 40%, so 4 in 10 of those individuals, will require insulin. It's really important that we are proactive and recognize when insulin is required in people living with type 2 diabetes. When we initiate insulin, we recommend starting with a basal insulin and titrating that dose in a timely fashion to achieve the individualized target for that person, but we need to continue the use of organ-protective glucose lowering medications when we start insulin. And really important that we support with structured self-management support when we initiate insulin and particularly, if we require intensification of the insulin regime.

When we talk about insulin therapy in type 2, we usually start basal insulin at 10 units, or between 0.1 and 0.2 units per kilogram, usually at bedtime but there can be flexibility for some of the longer acting insulin analogues.

We titrate to the fasting glucose target, but we want to be sure that we don't over insulinize patients and be clear that we get to an appropriate basal insulin dose. If the fasting glucose is at target but the A1C is not, then we need to think about whether we need to add prandial insulin therapy, and important to look at the glucose profile to decide about that.

So, I think the key messages are; make sure that we're proactive when we start. There are good guidelines around the use of insulin in type 2 diabetes, including starting with a basal insulin, making sure that you adequately titrate and thinking about when to intensify insulin therapy if you're not getting to A1C target despite adequate titration of basal insulin therapy.

Thank you very much for your attention.

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