Clinical Guideline – Type 2 Diabetes in Adults (excluding pregnancy)

Check HbA1c, fasting lipids, urine ACR, BP, BMI, urinalysis as well as routine bloods.
Refer to dietician or/and community diabetes education service, as appropriate. Refer for foot screening and notify diabetes register in order to commence eye screening service.
Assess cardiovascular risk in all patients and treat as appropriate. Do not offer antiplatelet therapy in patients without cardiovascular disease. Assess blood pressure and treat if lifestyle advice does not reduce blood pressure to below 140/80mmHg (below 130/80mmHg if there is kidney, eye or cerebrovascular damage).
Further advice at NICE Guidelines NG28 and Wirral Home Blood Glucose Guidelines
For highly symptomatic patients with significant weight loss, test urine for ketones and if positive, treat as Type 1 diabetes. Consider immediate referral to secondary care. Otherwise, start treatment with a sulfonylurea or insulin first.

A trial of diet and exercise may be appropriate (minimum 3 months).
Otherwise, if HbA1c is **>48 mmol/mol (6.5%) then offer:**
Metformin 500mg od (with food) and increase to bd or tds over 2-3 weeks. If tolerated, consider increasing to 2-3g daily.
If problems with tolerability persist, consider metformin SR (Sukkarto SR). If unable to tolerate or metformin is contraindicated, then consider other agents (see below).
Aim for HbA1c < 58 mmol/mol (7.5%), or lower if appropriate. HbA1c targets should be individualised. Review 3 - 6 monthly.

If HbA1c >58 mmol/mol (7.5%) then:

- Reinforce advice about diet, lifestyle and adherence to drug treatment and
- Support the person to aim for a HbA1c level of 53mmol/mol (7.0%) and
- Intensify drug treatment.

Consider dual therapy metformin with:
NB: if no preference between agents then use drug with lowest acquisition costs.

- DDP-4 inhibitors (alogliptin, saxagliptin or sitagliptin). NB: Aloglitpin in first line choice in new patients.
- SGLT-2 inhibitors may also be considered. TA288, TA315, TA336, TA390
- Consider pioglitazone (if there is intolerance to other agents (discuss potential risks and benefits with the patient).
- Sulfonylurea (if BMI<25), such as gliclazide 40-80mg od. Titrate up to 160mg bd if required. If hypoglycaemia or weight gain with sulfonylurea therapy then consider other treatment options above.

If metformin is contraindicated or not tolerated then consider dual therapy with:

- A DPP-4 inhibitor and a sulfonylurea.
- A DPP-4 inhibitor and pioglitazone.
- Pioglitazone and a sulfonylurea.
- SGLT-2 inhibitors may also be considered (as above).

If an agent causes hypoglycaemia then consult Wirral Home Blood Glucose Guidelines

If HbA1c is <58 mmol/mol (7.5%), continue current therapy, review 4-6 monthly
If HbA1c >58 mmol/mol (7.5%) then consider triple therapy with metformin, a DPP-4 inhibitor and a sulfonylurea **OR** metformin, pioglitazone and a sulfonylurea. SGLT-2 inhibitors may also be considered. Review 3-4 monthly.
Early referral to secondary care is advisable for patients who remain symptomatic or those with persistently high HbA1c (such as HbA1c >69 mmol/mol (8.5%) despite oral medications.

If HbA1c is <58 mmol/mol (7.5%), continue current therapy, review 4-6 monthly.
If HbA1c >58 mmol/mol (7.5 %) despite oral medication then consider:
1. Insulin refer to NG28 for more information.
2. GLP-1 mimetic/analogue (1st line: exenatide MR/exenatide 2nd line: liraglutide). NICE recommends these agents are to be continued only if there is a reduction in HbA1c of at least 11mmol/mol (1%) and a weight loss of at least 3% of initial body weight, at **six months.**
3. Acarbose