Welcome to Diabetes in the 21st Century

Beverly Dyck Thomassian, RN, MPH, BC-ADM, CDE
President, Diabetes Education Services
www.DiabetesEd.net

Diabetes in the 21st Century:
A Clinical and Educational Update

1. Describe impact of diabetes
2. Discuss prevention, management strategies
3. Discuss different types of diabetes
4. Describe insulin therapy
5. Review glucose patterns and determine how to adjust therapy to improve glucose.
6. Discuss medical nutrition therapy
7. Gain understanding of Type 2 Meds.
8. Demonstrate successful teaching strategies

CDC Announces

35% of Americans will have Diabetes by 2050

Boyle, Thompson, Barker, Williamson
2010, Oct 22:8(1)29
www.pophealthmetrics.com
Diabetes in America 2014
- 29 million or > 9.3%
- 27% don’t know they have it
- 37% of US adults have pre diabetes (79 mil)

Type 2 in Kids
- 7 fold increase 1990
- 1 in 6 overt wt kids (age 12-19) have prediabetes.
- ~2,500 to 3,700 new cases in U.S. annually.
- Highest risk: very obese, minority, female, low socioeconomic status, limited education
- In age range 12-19, less than 1% have Type 2 – NHANES
- Environmental changes to urgently needed

Global Epidemic
- Every 10 seconds
  - 1 person dies with diabetes
  - 2 people develop diabetes
- Every year
  - 3 million deaths
  - 6 million new cases
- World Diabetes Day is November 14
- March is ADA Sound the Alert Day “find people w/ undetected diabetes”
World Diabetes Day
November 14

The right education for all

Diabetes: protect our future

The right environment for all

Diabetes: protect our future

Age-adjusted Diabetes Prevalence
20 yrs or older, by race/ethnicity—U.S. 2001

Age-adjusted* percentage of people aged 20 years or older with
diagnosed diabetes, by race/ethnicity, United States, 2010–2012

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Prevalence</th>
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</thead>
<tbody>
<tr>
<td>Non-Hispanic whites</td>
<td>7.5</td>
</tr>
<tr>
<td>Asian Americans</td>
<td>9.0</td>
</tr>
<tr>
<td>Hispanics</td>
<td>12.8</td>
</tr>
<tr>
<td>American Indians/Alaska Natives</td>
<td>15.9</td>
</tr>
</tbody>
</table>

*Based on the 2003 U.S. standard population.


- Among Hispanic adults, the age-adjusted rate of diabetes was 8.5% for Central and South Americans, 9.9% for Cubans, 13.6% for Mexican Americans, and 14.8% for Puerto Ricans.
- Among Asian American adults, the age-adjusted rate of diabetes was 9.4% for Chinese, 11.3% for Filipinos, 13.6% for Asian Indians, and 4.6% for other Asians.
- Among American Indian and Alaska Native adults, the age-adjusted rate of diabetes tended to vary from 2.4% among Alaska Natives to 11.9% among American Indians in northern Arizona.

Why Should Zip Code Determine Life Expectancy?

California Endowment – look up your zip code at www.measureofamerica.org
Engaging and supporting Kids to help slow the epidemic

Phases of Life
- During Childhood

Environment
- Access to safe places to exercise
- Access to healthy foods
- Access to learning rich environments
- Access to health care

LifeStyle
- Limit screen time to 2 hours a day
- 1 hour a day of activity
- Healthy Snacks
- Limit junk food, sugary beverages
- Fruits and Veggies

Thoughts on Diabetes, Weight, Social Change

“The only way on a societal basis to reduce the prevalence of obesity is through community action” – Dr. Frieden, CDC

Obesity (BMI 30+) prevalence 22% to 40%
Poverty, Obesity, Diabetes inter-related

Weight and Gut Bacteria
New and Early Research

Lower levels among obese and DM patients compared with healthy controls of:
- Firmicutes: 4% lower in obese patients, 13% lower in DM
- Bifidobacteria: 14% lower in obese patients, 28% lower DM
- Clostridium Leptum: 14% lower in obese patients, 11% lower DM

Based on prospective study involving:
- 27 morbidly obese pts with mean BMI of 40
- 26 pts with new type 2 – BMI 29
- 28 healthy controls (mean BMI 23 kg/m2).

“The human gut microbiome consists of some 100 trillion bacteria, or some 100 trillion friends you didn’t know you had.”
- Yalcin Basaran, MD, presented at International Endocrine Meeting
Free Live Webinars and Live Seminars at DiabetesEd.net

- Free Webinars
  - Preparing to take CDE
  - New Frontiers
  - New Medications
  - BC-ADM

Beta Cells - Insulin
Anabolic hormone - helps store glucose as glycogen in muscle, liver
- secreted in response to elevated glucose
- halts breakdown of glycogen in liver
- increases protein synthesis, fat storage
- powerful hypoglycemic

Beta Cells - Amylin
- secreted in 1:1 ratio with insulin
- Causes satiety
- Lowers post-prandial glucagon response
- Slows gastric emptying
- Type 1 make none
- Type 2 make less than normal amounts

Role of the Pancreas
Endocrine Functions

- Beta – insulin - 60%
- Alpha – glucagon 30%
- Delta – somatostatin 10%
Role of the Pancreas Endocrine Functions

**Alpha cells - Glucagon**
- Opposes action of insulin at the liver
- Stimulated in response to low glucose levels
- Stimulates liver to convert glycogen to glucose
- Inhibits liver from glucose uptake
- Causes hyperglycemia

Hormones Effect on Glucose

<table>
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<tr>
<th>Hormone</th>
<th>Effect</th>
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<tbody>
<tr>
<td>Glucagon (pancreas)</td>
<td></td>
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<tr>
<td>Stress hormones (kidney)</td>
<td></td>
</tr>
<tr>
<td>Epinephrine (kidney)</td>
<td></td>
</tr>
<tr>
<td>Insulin (pancreas)</td>
<td></td>
</tr>
<tr>
<td>Amylin (pancreas)</td>
<td></td>
</tr>
<tr>
<td>Gut hormones - incretins (GLP-1)</td>
<td>released by L cells of intestinal mucosa, beta cell has receptors</td>
</tr>
</tbody>
</table>

GLP-1 Effects in Humans
Understanding the Natural Role of Incretins

- GLP-1 secreted upon the ingestion of food
- Promotes safety and reduces appetite
- Beta-cell response
- Enhances glucose-dependent insulin secretion
- Liver: GLP-1 reduces hepatic glucose output
- Stomach: Helps regulate gastric emptying
- GLP-1 degraded by DPP-4 within minutes

Adapted from Nauck MA, et al. Diabetologia. 1996;39:1546-1553
Adapted from Drucker DJ. Diabetes. 1998;47:159-169
Bariatric Surgery

- Consider on diabetes pts w/ BMI >35, esp with comorbidities
- Remission (BG normalized)
  - rates range from 40 – 95%
  - Better results with newer diabetes (more beta cell mass)
- Due to increase incretins (gut hormones)
- Still researching long term benefits, cost effectiveness and risk

Natural History of Diabetes

- Normal: FBG <100 Random <140 A1c <5.7%
- Prediabetes: FBG 100-125 Random 140 - 199 A1c ~ 5.7 - 6.4%
  - 50% working pancreas
- Diabetes: FBG 126 + Random 200 + A1c 6.5% or +
  - 20% working pancreas

Development of type 2 diabetes happens over years or decades

Signs of Diabetes

- Polyuria
- Polydipsia
- Polyphasia
- Weight loss
- Fatigue
- Skin and other infections
- Blurry vision
- Glycosuria, H₂O losses
- Dehydration
- Fuel Depletion
- Loss of body tissue, H₂O
- Poor energy utilization
- Hyperglycemia increases incidence of infection
- Osmotic changes
Diabetes Classifications
- Type 1
- Type 2
- Gestational
- Secondary

Case Study
1. Pt profile: 5’8”, 192 lb male
   Diabetes 12 years, on insulin 3 yrs
   What type of DM and how do you know?

2. Pt profile: 5’6”, 108 lb female
   On insulin 3u Novolog before meals,
   10u Lantus at bedtime
   What type of DM and how do you know?

Type 1 Rates Increasing Globally
- 23% rise in type 1 diabetes incidence from 2001-2009
- Why?
  - Autoimmune disease rates increasing over all
  - Changes in environmental exposure and gut bacteria?
  - Hygiene hypothesis
  - Obesity?
Type 1 Diabetes Facts

- As many as 3 million Americans may have type 1 diabetes.
- Each year, approximately 80 people per day are diagnosed with type 1 diabetes in the U.S.
- Approximately 85 percent of people living with type 1 diabetes are adults, and 15 percent are children.
- The rate of type 1 diabetes incidence among children under age 14 is estimated to increase by 3 percent annually worldwide.
- Type 1 diabetes accounts for $14.9 billion in healthcare costs in the U.S. each year.

Source: JDF

Type 1 – 10% of all Diabetes
Genetics and Risk Factors

- Autoimmune pancreatic beta cells destruction
- Most commonly expressed at age 10-14
- Insulin sensitive (require 0.5 - 1.0 units/kg/day)

- Combo of genes and environment:
  - Autoimmunity tends to run in families
  - Higher rates in non breastfed infants
  - Viral triggers: congenital rubella, coxsackie virus B, cytomegalovirus, adenovirus and mumps.

Incidence of Type 1 in Youth

- General Pop 0.3%
- Sibling 4%
- Mother 2-3%
- Father 6-8%
- Rate doubling every 20 yrs
- Many trials underway to detect and prevent (Trial Net)
Autoantibodies Assoc w/ Type 1
Panel of autoantibodies –
- GAD65 - Glutamic acid decarboxylase –
- ICA - Islet Cell Cytoplasmic Autoantibodies
- IAA - Insulin Autoantibodies

Type 1 Diabetes Associated with other immune conditions
- Celiac disease (gluten intolerance)
- Thyroid disease
- Addison's Disease
- Rheumatoid arthritis
- Other

Medalist Study – Harvard Joslin Diabetes Center
- After 50 years with diabetes
  - Many still produced some insulin
  - Many had no eye disease
Type 1 Summary

- Autoimmune
- Complete pancreatic destruction
- Need insulin shots
- Often first present in DKA

Type 1 in Hospital

- 43 yr old admitted to evaluate angina.
- Morning blood sugar is 92.
- Based on Regular insulin sliding scale, no insulin required.
- Breakfast tray shows up and patient says, I need my insulin shot before I eat.

What do you say?
Natural Progression of Type 2 Diabetes

Cardio Metabolic Risk -
5 Hypers -

- Hyperinsulinemia (resistance)
- Hyperglycemia
- Hyperlipidemia
- Hypertension
- Hyper"waistline"emia (35” women, 40” men)

Manifestations of Insulin Resistance

Diabetes 2 - Who is at Risk?

1. Testing should be considered in all adults who are overweight (BMI ≥ 25) and have additional risk factors:
   - First-degree relative w/ diabetes
   - Member of a high-risk ethnic population
   - Habitual physical inactivity
   - PreDiabetes
   - History of heart disease
Diabetes 2 - Who is at Risk?
(ADA Clinical Practice Guidelines)

Risk factors cont’d

- HTN - BP > 140/90
- HDL < 35 or triglycerides > 250
- baby >9 lb or history of Gestational Diabetes Mellitus (GDM)
- Polycystic ovary syndrome (PCOS)
- Other conditions assoc w/ insulin resistance:
  - Severe obesity, acanthosis nigricans (AN)

Acanthosis Nigricans (AN)

- Signals high insulin levels in bloodstream
- Patches of darkened skin over parts of body that bend or rub against each other
  - Neck, underarm, waistline, groin, knuckles, elbows, toes
  - Skin tags on neck and darkened areas around eyes, nose and cheeks.
- No cure, lesions regress with treatment of insulin resistance

Diabetes Detectives Needed

- On average – takes 6.5 years to diagnose diabetes
- 1/4 of all people with diabetes don’t know they have it
Ominous Octet

- Increased glucagon secretion
- Decreased amylin, β-cell secretion (80% loss at dx)
- Decreased gut hormones
- Increased lipolysis
- Increased glucose production
- Decreased glucose uptake
- Decreased satiation neurotransmission
- Increased renal glucose reabsorption

Comparison of Type 1 and Type 2

<table>
<thead>
<tr>
<th></th>
<th>Type 1</th>
<th>Type 2</th>
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<tbody>
<tr>
<td>Obesity</td>
<td>x</td>
<td>xxx</td>
</tr>
<tr>
<td>Insulin dependence</td>
<td>xxx</td>
<td>30%</td>
</tr>
<tr>
<td>Respond to oral agents</td>
<td>0</td>
<td>30%</td>
</tr>
<tr>
<td>Ketosis</td>
<td>xxx</td>
<td>x</td>
</tr>
<tr>
<td>Antibodies present</td>
<td>xxx</td>
<td>0</td>
</tr>
<tr>
<td>Typical Age of onset</td>
<td>teens</td>
<td>adult</td>
</tr>
<tr>
<td>Insulin Resistance</td>
<td>0</td>
<td>xxx</td>
</tr>
</tbody>
</table>

Diabetes is also associated with:
- Fatty liver disease
- Obstructive sleep apnea
- Cancer; pancreas, liver, breast
- Alzheimer’s
- Depression
Gestational DM ~ 7% of all Pregnancies

- GDM prevalence increased by ~10–100% during the past 20 yrs
- Native Americans, Asians, Hispanics, African-American women at highest risk
- Immediately after pregnancy, 5% to 10% of GDM diagnosed with type 2 diabetes
- Within 5 years, 50% chance of developing DM in next 5 years.

Diabetes in pregnant mothers associated with ...

- Offspring
  - Fetal Complications
  - Obesity and diabetes later in life
- Mother
  - More complicated pregnancy and delivery
  - Diabetes later in life
- Intraterine environment is important

Screen Pregnant Women Before 13 weeks

- Screen for undiagnosed Type 2 at the first prenatal visit using standard risk factors.
- Women found to have diabetes at their initial prenatal visit treated as “Diabetes in Pregnancy”
- If normal, recheck at 24-28 weeks
Increasing Prevalence –
A public health perspective

- Body weight before and during pregnancy influences risk of GDM and future diabetes
- Children born to women with GDM at greater risk of diabetes
- Focus on prevention

Postnatal Health:
Maternal Behavior

- Encourage breastfeeding for one year
  - (25% of women achieving this goal)
- Screening 6-12 weeks post partum using non-pregnant OGTT criteria (50%)
- Repeat at 3 yr intervals or signs of DM
- Encourage weight control and exercise
- Make sure connected with health care
- Preconception counseling

Start Metformin therapy

- For women with PreDiabetes and History of GDM
Other Causes of Hyperglycemia

- Steroids
- Agent Orange
- Tube feedings / TPN
- Transplant medications
- Cystic Fibrosis

Regardless of cause, requires treatment

- Insulin always works
- Sign of pancreatic malfunction

DiaBingo

- Frequent skin and yeast infections
- A BMI of ____ or greater is considered overweight
- To reduce complications, control A1c, blood pressure, cholesterol
- PreDiabetes – fasting glucose level of ____ to ____
- Erectile dysfunction indicates greater risk for ____
- Diabetes – fasting glucose level ____ or greater
- Type 1 diabetes is best described as an ____ disease
- People with diabetes are ____ times more likely to die of heart dx
- Elevated triglycerides, < HDL, smaller dense LDL
- Each percentage point of A1c = ____ mg/dl glucose
- At dx of type 2, about ____% of the beta cell function is lost
- Diabetes – random glucose ____ or greater

Life Study – Mrs. Jones

Mrs. Jones is 62 years old, overweight and complaining of feeling tired and urinating several times a night. She is admitted with a urinary tract infection. Her WBC is 12.3, glucose 237. She is hypertensive with a history of gestational diabetes. No ketones in urine.

- What are her risk factors, signs of diabetes
- What type of diabetes does she have?
- Does she have insulin resistance?
What Do You Say?
Mrs. Jones asks you

- What is type 2 diabetes?
- Will this go away?
- Will I get complications?
- Will I need to take diabetes medication for the rest of my life?
- How come I got diabetes?
- Do I have to check my blood sugars?

Running into Roadblocks?

- HUG Patients
  - Help with
  - Unconditional
  - Guidance and Support
    Anne Peters, MD, CDE
    ADA Post Grad

- Unconditional Positive Regard
  involves showing complete support and acceptance of a person no matter what that person says or does.

No one is Unmotivated

- to lead and long and healthy life

- These are the 3 usual Critical Barriers
  - Perceived worthlessness
  - Too many personal obstacles
  - Absence of support and resources

Bill Polonsky, PhD, CDE
Overcoming barriers

- Confront the key misbelief. Ask the question, does dm cause complications?
- Offer pts evidence based hope message –
- Frequent contact
- Paired glucose testing

Bill Polonsky, PhD, CDE

How Often Should I Check?

- Be realistic!!
- Type 1 – as often as needed
- Type 2 – as needed
- Consider:
  - Types and timing of meds
  - Goals
  - Ability (physical and emotional)
  - Finances

How will it help me?

- See if your treatment plan is working
- Make decisions regarding food and/or med adjustment when exercising
- Find out how that pizza affected your BG
- Avoid unwanted weight gain
- Enhanced athletic performance
- Find patterns
- Manage illness
New Meters – a little goes a long way

- 0.3 microliters of blood
- minimal pain

Customer Service (toll-free): Look for 800 number

Complications - Why?

- Degree of hyperglycemia
  “glucose toxicity”
- Duration of hyperglycemia
- Genes
- Multiple risk factors:
  smoking, vascular disease, dyslipidemia, hypertension, other

Diabetes Complications

- Heart disease leading cause of death.
- CAD death rates are about 2 -4x’s as high as adults without diabetes (it’s not getting better)
- Risk of stroke is 2 - 4 times higher
- 60% - 65% of people with DM have HTN.
- DM accounts for 40% of new cases of ESRD
- 60 - 70% have mild - severe forms of neuropathy
- Diabetes is the leading cause of blindness
- Accounts for 50% of lower limb amputations
Control Matters

- Trials
- Practice Recommendations

Financial Advisor

- Mid 30s, friendly, he smiles to greet you and you notice his gums are inflamed. You’d guess a BMI of 26 or so, with most of the extra weight in the waist area.
- If you could give him some health related suggestions, what would they be?

Preventing Pre Diabetes
Can Type 2 be Prevented in Older Adults?

Overall, 9 of 10 new cases of diabetes attributable to these 5 lifestyle factors.

- Physical activity (30 mins a day)
- Dietary score (higher fiber intake, low saturated fat and trans-fat, lower mean glycemic index)
- Not Smoking
- Alcohol use (up to 2 drinks a day);
- BMI <25 and waist circumference


Can we stop pre diabetes from progressing?

3, 234 people w/ Pre-Diabetes randomized:
- Placebo
- Diet/Exercise or
- Metformin

over a three year period

Diabetes Prevention Program (DPP) 2001

Diabetes Prevention Program

- Standard Group - 29% developed DM
- Lifestyle Results - 14% developed DM
  - 58% (71% for 60yrs +) Risk reduction
    - 30 mins daily activity
    - 5-7% of body wt loss
- Metformin 850 BID - 22% developed DM
  - 31% risk reduction (less effective with elderly and thinner pt’s)
Weight loss and Prevention

- For every 2.2 pounds of weight loss, risk of type 2 diabetes was reduced by 13%.

Goals of Care
ABCs of Diabetes

A1C
Blood Pressure
Cholesterol

Standards of Medical Care – American Diabetes Association

Glucose and BP Control Matter

- 1% decrease in A1c reduces microvascular complications by 35%
- 1% decrease in A1c reduces diabetes related deaths by 25%
- B/P control (144/82) reduced risk of:
  - Heart failure (56%)
  - Stroke (44%)
  - Death from diabetes (32%)


A1c and Estimated Avg Glucose (eAG) 2008

<table>
<thead>
<tr>
<th>A1c (%)</th>
<th>eAG</th>
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<tr>
<td>5</td>
<td>97</td>
</tr>
<tr>
<td>6</td>
<td>126</td>
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<tr>
<td>7</td>
<td>154</td>
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<td>8</td>
<td>183</td>
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<td>9</td>
<td>212</td>
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<td>10</td>
<td>240</td>
</tr>
<tr>
<td>11</td>
<td>269</td>
</tr>
<tr>
<td>12</td>
<td>298</td>
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</table>

eAG = 28.7 x A1c-46.7 ~ 29 pts per 1%

Translating the A1c Assay into Estimated Average Glucose Values – ADA Study
Diabetes Care 31, 80, August 2008

Order teaching tool kit free at diabetes.org
ABCs of Diabetes –

- A1c less than 7% (avg 3 month BG)
  - Pre-meal BG 70-130
  - Post meal BG <180
- Blood Pressure < 140/80
- Cholesterol
  - HDL >40
  - LDL <100 (if CHD, <70)
  - Triglyceride < 150

“Legacy Effect”

- For participants of DCCT and UKPDS
  - Long lasting benefit of early intensive BG control prevents
  - Microvascular complications
  - Macrovascular complications (15-55% decrease)
  - Even though their BG levels increased over time
  - Message – Catch early and Treat aggressively

Vaccinations- Immunizations

- Flu vaccine
  - Every year starting 6 months
- Pneumococcal starting at 2 years.
  - One time Revaccination for those over 64 and had first vaccine >5 years prior
- Hepatitis B Vaccine (ADA Stds 2013, pg s28)
  - For diabetes pts age 19 – 59 (not previously vaccinated)
  - Double risk of Hep B due to lancing devices/glucose meter exposure
DiaBingo - G

G ADA goal for A1c is less than ____%.
G People with DM need to see their provider at least every month.
G Blood pressure goal is less than.
G People with DM should see eye doctor (ophthalmologist) at least.
G The goal for triglyceride level is less than.
G Goal for my HDL cholesterol is more than.
G The goal for blood sugars 1-2 hours after a meal is less than:.
G People with DM should get this shot every year.
G People with DM need to get urine tested yearly for __________.
G Periodontal disease indicates increased risk for heart disease.
G The goal for blood sugar levels before meals is:
G The activity goal is to do ____ minutes on most days.

Mr. Jones - What are Your Recommendations?

Patient Profile
64 yr old with type 2 for 11 yrs. Hx of CVD.

Labs:
- A1c 9.3%
- HDL 37 mg/dl
- LDL 114 mg/dl
- Triglyceride 260 mg/dl
- Proteinuria - neg
- B/P 142/92

Self-Care Skills
- Walks dog around block 3 x’s a week
- Bowls every Friday
- 3 beers daily
- Widowed, so usually eats out
- 15 lbs overweight
- My foot hurts

Diabetes Care Guidelines - ADA

<table>
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<th>Test/Exam</th>
<th>Frequency</th>
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<tbody>
<tr>
<td>A1c</td>
<td>At least twice a year</td>
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<tr>
<td>B/P</td>
<td>Each diabetes visit</td>
</tr>
<tr>
<td>Cholesterol (LDL, HDL, Tri)</td>
<td>Yearly (less if normal)</td>
</tr>
<tr>
<td>Weight</td>
<td>Each diabetes visit</td>
</tr>
<tr>
<td>Microalbumin/GFR/Creat</td>
<td>Yearly</td>
</tr>
<tr>
<td>Eye exam</td>
<td>Yearly</td>
</tr>
<tr>
<td>Dental Care</td>
<td>At least twice a year</td>
</tr>
<tr>
<td>Comprehensive Foot Exam</td>
<td>Yearly (more if high risk)</td>
</tr>
<tr>
<td>Physical Activity Plan</td>
<td>As needed to meet goals</td>
</tr>
<tr>
<td>Preconception counseling</td>
<td>As needed</td>
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</tbody>
</table>
Foot Care

Lift the sheets and look at the Feets!

Foot Wounds

Blisters
Calluses
Ultrcers
Bone infection

No Bathroom Surgery
5.07 monofilament = 10gms linear pressure
If pt can’t feel pressure = neuropathy

3 Most Important Foot Care Tips

- Inspect and apply lotion to your feet every night before you go to bed.
- Do NOT go barefoot, even in your house. Always wear shoes!
- Every time you see your doctor, take off your shoes and show your feet.

Glucose Management and Hospitalized Patients

- In hospitalized patients with critical illness, hyperglycemia is a signal that warrants our attention.
Hospitals and Hyperglycemia – What’s the Big Deal?

- Hyperglycemia is associated with increased morbidity and mortality in hospital settings.
  - Acute Myocardial Infarction
  - Stroke
  - Cardiac Surgery
  - Infection
  - Longer lengths of stay

Hyperglycemia*: A Common Comorbidity in Medical-Surgical Patients in a Community Hospital

- Hyperglycemia: Fasting BG ≥ 126 mg/dl or Random BG ≥ 200 mg/dl X 2

Effect of Hyperglycemia on Hospital Mortality

- Prior history of
  - Normoglycemia
  - Known diabetes
  - New hyperglycemia


Mortality (%)

- Total
- Non-ICU
- ICU

*P<.01 compared with normoglycemia and known diabetes.

BG Above Normal = Trouble

- Pre Diabetes
  - Fasting Glucose = 100-125mg/dl
  - A1c 5.7 – 6.4%
- Diabetes
  - Fasting Glucose = 126 mg/dl +
  - Random Glucose = 200 mg/dl +
  - A1c 6.5% +
- Any blood glucose above 140 requires treatment

Umpierrez et al

WHAT SHOULD WE AIM FOR?

Critically Ill pts
- BG > 180- Start insulin
- BG goal 140-180

Non Critically Ill patients BG Goals
- Premeal <140
- Post meal <180

-Insulin therapy preferred treatment
Consensus: Inpt Hyperglycemia, Endocr Pract. 2009;15 (No.4)

Management of Hyperglycemia and Diabetes

- Stop oral agents (ie) metformin & sulfonylurea on admission
- “The sole use of Sliding Scale insulin is discouraged” – ADA 2014
- For discharge, oral meds can be resumed

Start Basal/bolus therapy
- NPH and Regular insulin
- Long-acting and rapid-acting insulin
- Premixed insulin
In Patient Strategies – Start Early, Focus on Survival Skills

Discharge insulin Algorithm

Discharge Treatment

A1C < 7%
- Re-start outpatient treatment regimen (Orals and/or insulin)

A1C 7%-9%
- Re-start outpatient oral agents and D/C on glargine once daily at 50-80% of hospital dose

A1C >9%
- D/C on basal bolus at same hospital dose.
- Alternative: re-start oral agents and D/C on glargine once daily at 50-80% of hospital dose

Now What?

- Nurse had an emergency and pt already ate lunch?
- Nurse administered insulin and pt only ate a few bites of turkey and drank non sugar tea?
- You just gave 3 units of Aspart and patient needs to go to OR NOW!
5 Survival Skills

1. Basics of Diabetes
2. Can patient perform self blood glucose monitoring? Do they need meter?
3. Can pt safely take meds / insulin? Teach side effects.
4. Meal Planning?
5. Self Care including hypo prevent/treat
   - Follow-Up plan - Does pt know who to contact when need help?
   - Diabetes Ed, PCP, Home Health

Bottom Line

- 30-40% of hospitalized patients have diabetes
- 10% aren’t officially diagnosed
- Cardiovascular disease is the leading cause of hospitalization for people with diabetes
- Look for patients with hyperglycemia and cardiometabolic risk factors: smokers, HTN, central obesity, abnormal lipids, Acanthosis.
- Provide education and promote self-advocacy

Diabetes Self-Management

- Self Monitor Blood Glucose
- Meal Plan
- Exercise / Activity
- Medications
Insulin - the Ultimate Hormone Replacement Therapy

Objectives:
• Discuss the actions of different insulins
• Describe using pattern management as an insulin adjustment tool.

Psychological Insulin Resistance (PIR)

- 50% of providers in study threatened pts “with the needle”.
- Less than 50% of providers realized insulins’ positive effect on type 2 dm
- Most pts don’t believe that insulin would “better help them manage their diabetes”.
- Solutions: Find the root of PIR and address it, use more insulin pens

Diabetes Attitudes, Wishes, Needs Study - Rubin

Needle Size often a Barrier
Size Does Matter

- Use more short needles – 4 mm
- Effective for pts with BMI of 24-49
- Keeps it subq
- If pt thin, inject at angle
- To avoid leakage, count to 10 before withdrawing needle
- ½ the patients who could benefit from insulin are not using it due to needle phobias
- Consider inhaled insulin
Physiologic Insulin Secretion: 24-Hour Profile

Insulin Action Teams
- **Bolus**: lowers after meal glucose levels
  - Rapid Acting
    - Aspart, Lispro, Glulisine
  - Short Acting
    - Regular
  - Afrezza - Inhaled
- **Basal**: controls glucose between meals, hs
  - Intermediate
    - NPH
  - Long Acting
    - Detemir (Levemir)
    - Glargine (Lantus)

Case Study
- 70 yr old, weighs 100kg
- History of CABG, tobacco
- A1c – 11.3%, BG 400-500 for past weeks
- Insulin – 100+ units Lantus at hs (solostar)
- Oral Meds: Metformin, Invokana
- What is a better insulin dosing strategy?
- Pt can’t afford insulin pen – what other option
- Diabetes Meds on a Budget - 2014 - provides practical and affordable strategies to manage hyperglycemia
Cost Per Vial in Northern CA

<table>
<thead>
<tr>
<th>Product</th>
<th>Walmart</th>
<th>Walgreens</th>
<th>Costco</th>
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<tr>
<td>Regular Insulin</td>
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<td>$99</td>
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<tr>
<td>NPH</td>
<td>$25*</td>
<td>$92</td>
<td>$99</td>
</tr>
<tr>
<td>70/30</td>
<td>$25*</td>
<td>$92</td>
<td>$101</td>
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<tr>
<td>Humalog</td>
<td>$200</td>
<td>$220</td>
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<tr>
<td>Novolog</td>
<td>$197</td>
<td>$217</td>
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<tr>
<td>Apidra</td>
<td>$180</td>
<td>$246</td>
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<tr>
<td>Levemir</td>
<td>$300</td>
<td>$300</td>
<td>$300</td>
</tr>
<tr>
<td>Lantus</td>
<td>$226</td>
<td>$221</td>
<td>$206</td>
</tr>
</tbody>
</table>

Afrezza – Inhaled Insulin – Approved 2014

For adults over 18
Not indicated for pregnancy, while breastfeeding

Bolus Insulins
(½ of total daily dose ÷ meals)

<table>
<thead>
<tr>
<th>Name</th>
<th>Onset</th>
<th>Peak Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lispro (Humalog)</td>
<td>15-30 min</td>
<td>1-1.5 hrs</td>
</tr>
<tr>
<td>Aspart (NovoLog)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glulisine (Apidra)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Afrezza (Inhaled)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regular</td>
<td>30 mins</td>
<td>2-4 hrs</td>
</tr>
</tbody>
</table>
Afrezza Dosing and Considerations

- Bolus regular insulin – inhaled before meals
- Dosing: 4 and 8 unit cartridges
  - Convert with 1:1 ratio to existing insulin dose
- Lung function test before start (incentive spiro)
  - Not for pts w/ chronic lung issues
    - Asthma, COPD, history of lung cancer, smokers
    - Can cause acute bronchospasm
- Side effects:
  - Hypoglycemia, sore throat, cough

Afrezza Inhaler

Know your AFREZZA® inhaler:

Replace inhaler every 15 days

Afrezza – Foil Packages Contain 30 cartridges – Use w/in 10 days

There are two strengths of AFREZZA® cartridges:

- One blue cartridge approximates 4 units of injected insulin.
- One green cartridge approximates 8 units of injected insulin.

Let cartridges and inhaler sit at room temp for 10 minutes before using.
Afrezza – Storage

- Refrigerated - Not in use and sealed – till expires
- Foil package at room temp – use within 10 days
- Once strips opened, good for 3 days

Afrezza – Combos

To switch from injected mealtime insulin to AFREZZA®,

Find your injected insulin dose in the chart.

Example:

If you need to dose 12 units of AFREZZA®, you can use:

- 1 blue 4 unit cartridge + 3 green 4 unit cartridges

Afrezza – Loading Cartridge into device

- Hold inhaler level
- Open inhaler by lifting white mouthpiece
- Hold insulin cartridge with cup facing down.
- Place cartridge inside and close lid. Keep level.
- Make sure cartridge has been at room temp for 10 minutes
Afrezza – Proper Inhale Technique

- Exhale
- Position inhaler in mouth (take off cover)
- Tilt inhaler down toward chin, keep head level
- Inhale deeply and hold breath for as long as comfortable
- Remove cartridge
- Replace cover

Bolus Insulin Summary

- Regular, Novolog, Humalog, Apidra, Afrezza
- Starts working fast (15-30 mins)
- Gets out fast (3-6 hours)
- Post meal BG reflects effectiveness
- Should comprise about ½ total daily dose
- Covers food or hyperglycemia.
- 1 unit
  - Covers = 10-15 gms of carb
  - Lowers BG = 30 – 50 points

Bolus Insulin Timing

- How is the effectiveness of bolus insulin determined?
  - 2 hour post meal (if you can get it)
  - Before next meal blood glucose
- Glucose goals (ADA) – may be modified by provider/pt
  - 1-2 hours post meal <180
  - Before next meal – 70 - 130
Bolus – Insulin Sliding Scale
Starts at 150, 2 units for every 50 mg/dl >150

<table>
<thead>
<tr>
<th></th>
<th>Break</th>
<th>Lunch</th>
<th>Dinner</th>
<th>HS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1</td>
<td>94</td>
<td>212</td>
<td>148</td>
<td>254</td>
</tr>
<tr>
<td></td>
<td>no insulin</td>
<td>4 uR</td>
<td>no insulin</td>
<td>8 uR</td>
</tr>
<tr>
<td>Day 2</td>
<td>243</td>
<td>254</td>
<td>201</td>
<td>199</td>
</tr>
<tr>
<td></td>
<td>4uR</td>
<td>6 uR</td>
<td>4uR</td>
<td>no insulin</td>
</tr>
<tr>
<td>Day 3</td>
<td>189</td>
<td>243</td>
<td>162</td>
<td>244</td>
</tr>
<tr>
<td></td>
<td>2uR</td>
<td>4uR</td>
<td>2uR</td>
<td>4uR</td>
</tr>
<tr>
<td>Day 4</td>
<td>66</td>
<td>287</td>
<td>144</td>
<td>272</td>
</tr>
<tr>
<td></td>
<td>No insulin</td>
<td>6uR</td>
<td>none</td>
<td>6uR</td>
</tr>
</tbody>
</table>

Basal Insulins
(½ of total daily dose)

Intermediate Acting  Peak Action  Duration
- NPH     4-12 hrs  12-24

Long Acting  Peak Action  Duration
- Detemir (Levemir)  peakless  20 hrs
- Glargine (Lantus)  No peak  24 hrs

Fasting BG reflects efficacy of basal

Basal Insulin Summary
- NPH, Levemir, Lantus
- Covers in between meals, through night
- Starts working slow (4 hours)
- Stays in long (12-24 hours)
  - NPH/ Lente 12 hrs
  - Levemir, Lantus 20-24 hrs
- Fasting blood glucose reflects effectiveness
Basal Only
Type 2, 60kg – A1c 8.7%

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<td></td>
<td>298</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>10uLan</td>
<td></td>
</tr>
<tr>
<td>Mo 2</td>
<td>180s</td>
<td></td>
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<td>233</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>20uLan</td>
<td></td>
</tr>
<tr>
<td>Mo 3</td>
<td>140s</td>
<td>283</td>
<td>265</td>
<td>206</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>30uLan</td>
<td></td>
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</tbody>
</table>

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Combo Sub-Q Insulin

<table>
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<tr>
<th>Insulin Type</th>
<th>Onset</th>
<th>Peak</th>
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<tbody>
<tr>
<td>Humalog Mix</td>
<td>0.25 - 0.5 hr</td>
<td>0.5-6.5 hrs</td>
</tr>
<tr>
<td>75/25: 75% NPL, 25% lispro</td>
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</tr>
<tr>
<td>50/50: 50% NPL, 50% lispro</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NovoLog Mix</td>
<td>0.25 - 0.5 hr</td>
<td>1 – 4 hrs</td>
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<tr>
<td>70/30: 70% NPA, 30% aspart</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NPH + Reg Combo</td>
<td>0.5 – 1.0 hr</td>
<td>2 - 16 hrs</td>
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<tr>
<td>70/30: 70%N/30%R</td>
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<tr>
<td>50/50: 50%N/50%R</td>
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</tbody>
</table>

**Considerations:**
- Pre-mixed, difficult to fine tune therapy
### 10u 70/30 BID Patterns? Changes needed?

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<td>102</td>
<td>63</td>
<td>92</td>
<td>181</td>
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<tr>
<td>Day 2</td>
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<tr>
<td>Day 3</td>
<td>98</td>
<td>56</td>
<td>112</td>
<td>201</td>
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<tr>
<td>Day 4</td>
<td>99</td>
<td>71</td>
<td>132</td>
<td>211</td>
</tr>
</tbody>
</table>

### Pattern Management

- **Safety 1st!!** - Evaluate 3 day patterns
- **Hypo**: eval 1st and fix:
  - If possible, decrease medication dose
  - Timing of meals, exercise, medications
- **Hyperglycemia**: evaluate 2nd
  - Identify patterns
  - Before increase insulin, make sure not missing something (carbs, exercise, omission)
### Type 2 – New diagnosis – No meds Patterns?

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<td>164</td>
<td></td>
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<td>181</td>
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<tr>
<td>Day 2</td>
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<td>124</td>
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<tr>
<td>Day 3</td>
<td>149</td>
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<td>242</td>
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<tr>
<td>Day 4</td>
<td>151</td>
<td>81</td>
<td></td>
<td>211</td>
</tr>
</tbody>
</table>

### Type 2 – Amaryl 4mg AM, 10u Lantus pm

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<tr>
<td>Day 2</td>
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<tr>
<td>Day 3</td>
<td></td>
<td>84</td>
<td>81</td>
<td>242</td>
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<tr>
<td>Day 4</td>
<td>159</td>
<td>43</td>
<td></td>
<td>211</td>
</tr>
</tbody>
</table>

### Basal Bolus – What Adjustments?

#### Pt weighs 80kg

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<td>Day 1</td>
<td>69</td>
<td>79</td>
<td>245</td>
<td>190</td>
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<tr>
<td></td>
<td>7H</td>
<td>5H</td>
<td>8H</td>
<td>22u Det</td>
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<tr>
<td>Day 2</td>
<td>81</td>
<td>87</td>
<td>170</td>
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<td></td>
<td>7H</td>
<td>5H</td>
<td>8H</td>
<td>22u Det</td>
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<td>127</td>
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<tr>
<td></td>
<td>7H</td>
<td>5H</td>
<td>8H</td>
<td>22u Det</td>
</tr>
</tbody>
</table>
Intensive Diabetes Therapy
Insulin Dosing Strategy

**50/50 Rule**
- 0.5-1.0 units/kg day
- Basal = 50% of total
  - Glargine QD
  - NPH or Detemir BID
- Bolus = 50% of total
  - usually divided into 3 meals

**Example**
- Wt 50kg x 0.5 = 25 units of insulin/day
- Basal dose: 13 units
  - Glargine 13 units QD
  - NPH/Detemir 6u BID
- Bolus dose: 12 units
  - 4 units NovoLog, Apidra Humalog, Regular each meal

---

**Example – You Try**
- Wt 60 kg x 0.5 = ___ units of insulin/day
- Basal dose: ____ units
  - Glargine ____ QD
  - NPH/Detemir ____ BID
- Bolus dose: ____ units
  - ___units NovoLog, Apidra Humalog, Reg each meal

---

**Example – You Try**
- Wt 60kg x 0.5 = 30 units of insulin/day
- Basal dose: 15 units
  - Glargine 15 QD or
  - NPH/Detemir 7u BID
- Bolus dose: 15 units
  - 5 NovoLog, Apidra, Humalog, Reg each meal
Basal Bolus – Using 50/50 Rule - Pt weighs 80kg

<table>
<thead>
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<th>HS</th>
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</thead>
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<tr>
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<td>84</td>
<td>89</td>
<td>145</td>
<td>190</td>
</tr>
<tr>
<td></td>
<td>6H</td>
<td>7H</td>
<td>7H</td>
<td>20 u Det</td>
</tr>
<tr>
<td>Day 2</td>
<td>81</td>
<td>97</td>
<td>107</td>
<td>133</td>
</tr>
<tr>
<td></td>
<td>6H</td>
<td>7H</td>
<td>7H</td>
<td>20u Det</td>
</tr>
<tr>
<td>Day 3</td>
<td>79</td>
<td>104</td>
<td>124</td>
<td>110</td>
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<td></td>
<td>6H</td>
<td>7H</td>
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<td>20u Det</td>
</tr>
<tr>
<td>Day 4</td>
<td>89</td>
<td>103</td>
<td>208</td>
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<td></td>
<td>6H</td>
<td>7H</td>
<td>7H</td>
<td>20u Det</td>
</tr>
</tbody>
</table>

Insulin Teaching Keys
- Bolus insulin with meals
- Basal 1-2xs daily
- Abdomen preferred injection site
- Stay 1” away from previous site
- Don’t re-use ultra fine syringes
- Keep unopened insulin in refrigerator
- Toss opened insulin vial after 28 days
- Proper disposal
- Review patients ability to withdraw and inject.
- Side effects include hypoglycemia/wt gain
- Insulin pens –
  - Prime needle to assure accurate insulin dose given
  - Hold needle in for 5 seconds after injection
  - Roll 70/30 pens

Sharps Disposal: Product and Info
- Look in the Government section white pages for a household hazardous waste listing for your city or county.
- Call 1-800-CLEANUP (1-800-253-2687)
DiaBingo - I
I Injected hormone that is an analog of amylin
I Glargine, Detemir, NPH are types of
I Breakdown of glycogen into glucose
I Anabolic hormone
I Insulin is released when glucose levels are low
I Once opened, insulin vials are good for one
I Elevated post-prandial glucose indicate need for pre-meal
I Epinephrine increases insulin resistance
I Creation of glucose from amino acids and lactate
I Decreasing renal function for people on insulin can cause
I Bolus insulins
I A hormone that increases blood glucose levels

Medical Nutrition Therapy

Patsy Obayashi, MS, RD, CDE
Transplant Dietitian
Stanford Hospital and Clinics

Obesity in America

- 68% overweight or obese
- 34% BMI 30+, 34% BMI 25-29
- 2/3 of all overweight people don’t get diabetes
- We burn 300 calories a day at work
- Overall, food costs ~10-15% of income
- Calorie intake is on the rise
Average American Consumes
25 teaspoons of sugar a day (400 cals)

- Warning label on sodas proposed
- One soda has 12 teaspoons soda
- On avg, 1 person consumes 40 gallons of soda each year
- ADA guidelines “limit sodas and beverages with sugar, High Fructose Corn Syrup, (HFCS)

BMI – Visual Image

Medical Nutrition Therapy – ADA 2014 Updates

- No ideal percentage of calories from protein, carbohydrate and fat for people with diabetes.
- Macronutrient distribution should be based on an individualized assessment of eating patterns, preferences and metabolic goals.
Medical Nutrition Therapy – ADA 2014
  
- Focus on the individual
- Maintain pleasure of eating
- Provide positive messages about food
- Limit food choices only when backed by science
- Provide practical tools
- Refer to a RD and Diabetes Education – Lowers A1c by 1-2%

Sodium, Fat and Fiber
  
- Sodium – Try and keep less than 2,300 mg a day
- Vitamin and mineral supplements not recommended -lack of evidence.
- Fat - same as recommended for general population
  - Less than 10% saturated fat,
  - Limit trans fats
  - Less than 300 mg cholesterol daily
  - Mediterranean Diet looks like good option
- Fiber 25 -38 gms a day

Approach Depends on Patient
  
- New Type 2
  - Portion Control
  - Plate Method
  - Record Keeping
  - Education
- On Insulin?
  - Carb counting
  - Post prandial checks
Losing 2-8kg Early in diagnosis Type 2 Helpful
ADA 2014

- Weight Loss –
  - The optimal macronutrient intake to lose weight not known
  - The literature does not support one particular nutrition therapy to reduce weight, but rather a spectrum of eating patterns that result in reduced energy intake.

- To lose one pound – avoid 3,500 cals
  - Decrease intake 250-500 cals daily + exercise

Successful weight loss strategies include

- Weekly self-weighing
- Eat breakfast
- Reduce fast food intake.
- Decrease portion size
- Increase physical activity
- Use meal replacements
- Eat healthy foods

Diabetes Prevention Program
Focus on fat = wt loss success

To help you lose weight and improve your health, stay as close as possible to your fat and calorie goals.
Find your starting weight below. Your fat and calorie goals are in the same row. Circle your fat and calorie goals.

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<thead>
<tr>
<th>Weight (lb)</th>
<th>Fat Goal (grams)</th>
<th>Calorie Goal</th>
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<tbody>
<tr>
<td>120-174</td>
<td>33</td>
<td>1,200</td>
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<tr>
<td>175-219</td>
<td>42</td>
<td>1,500</td>
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<td>220-249</td>
<td>50</td>
<td>1,800</td>
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<tr>
<td>&gt;250</td>
<td>55</td>
<td>2,000</td>
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</table>

Public Health Issue?

- 66% of our people are obese/overweight
- Rates of gestational diabetes on rise
- 30% of kids are obese/overweight

How nutrients affect blood sugar

Teaching About Eating Healthy

Major food groups
- “Handy Diet”
- Plate Method
- Exchange Lists
- Food Diaries / Glucose Records
- Carbohydrate Counting
  
Assess what is best for the situation.
Move toward the Tomato

ADA recommendation
Eat Less Junk Food & Sugary Drinks –
- Less Processed Foods
- Less Sugary Beverages
  - increase visceral adiposity
  - With sugar or
  - High fructose corn syrup
- Soda Tax?
- Junk Food Tax?

10 Superfoods
- Beans
- Dark Green Leafy Veggies
- Citrus Fruit
- Sweet Potatoes
- Berries
- Tomatoes
- Fish High in Omega-3 Fatty Acids
- Whole Grains
- Nuts
- Fat-Free Milk and Yogurt
USDA Plate Method
www.myplate.gov

Balancing Calories
› Enjoy your food, but eat less.
› Avoid oversized portions.

Foods to Increase
› Make half your plate fruits and vegetables.
› Make at least half your grains whole grains.
› Switch to fat-free or low-fat (1%) milk.

Foods to Reduce
› Compare sodium in foods like soup, bread, and frozen meals — and choose the foods with lower numbers.
› Drink water instead of sugary drinks.

Another plate example

Mindful Eating
Nutrition Facts

Serving Size 1/2 cup (114 g)
Servings Per Container 4

Amount Per Serving

Calories 90
Calories from Fat 30

% Daily Value*

Total Fat 3g
Saturated Fat 0g
Cholesterol 0g
Sodium 300mg
Total Carbohydrate 13g
Sugars 3g
Protein 3g

Vitamin A 80%
Vitamin C 60%
Calcium 4%
Iron 4%

* Percent Daily Values are based on a 2,000 calorie diet. Your daily values may be higher or lower depending on your calorie needs:

- Calories: 2000, 2500
- Total Fat: Less than 65g, 80g
- Sat Fat: Less than 20g, 25g
- Cholesterol: Less than 300mg, 300mg
- Sodium: Less than 2400mg, 2400mg
- Total Carbohydrate: 300g, 375g
- Fiber: 25g, 30g

Calories per gram: Fat 9, Carbohydrates 4, Protein 4

Fooducate App – gives grade and nutrition info.

1 tsp sugar = 4 gms

Carbs affect Post meal Blood Glucose

- Starch
- Fruit
- Milk
- Desserts

Carbohydrate Needs for Most Adults

<table>
<thead>
<tr>
<th>Each Meal</th>
<th>Servings</th>
</tr>
</thead>
<tbody>
<tr>
<td>45-60 gm</td>
<td>3 - 4</td>
</tr>
<tr>
<td>15-30 gm</td>
<td>1 - 2</td>
</tr>
</tbody>
</table>

Carbs affect Post Meal Blood Glucose
Choose Healthy Carbs

- Carbs have fiber, vitamins, minerals and phytonutrients
- 25 gms of fiber a day
- Power Carbs include:
  - Beans
  - Veggies
  - Fruits
  - Whole grain foods

Handy Meal Plan

- Per Meal Serving
  - Each finger = 15 gms carb (can have 3-4 servings/meal)
  - Palm of hand = 3 oz’s protein
  - Thumbnail = 1 tsp fat serving

Carb Counting - Starch

Each Food has:
- 80 Calories
- 15 grams carb
Carb counting - fruit

Each Food has:
60 Calories
15 grams carb

1 small fresh fruit
1 1/4 cup strawberries
1 slice bread
17 small grapes
1/2 cup dried fruit
2 tbsp raisins
1 1/4 cup strawberries
1 cup melon
1/2 cup fruit juice
1/2 cup unsweetened apple sauce
1 1/4 cup strawberries

Carb Counting - Milk

Each Food has:
90-150 calories
12-15 grams carb

8 oz buttermilk
1 packet diet hot cocoa
1 slice bread
8 oz soy milk
6 oz plain yogurt
8 oz milk
6 oz light fruit yogurt

Carb Counting - Sweets

Each Food has:
Calories vary
15 grams carb

2 inch square cake or brownie, unfrosted
1/2 cup cake batter
2 tbsp light syrup
2 small cookies
1/2 cup 1% cream or frozen yogurt
1/2 cup sherbet
1 tbsp syrup, jam, jelly, table sugar, honey
1/2 cup 1% cream or frozen yogurt
Go Lean with Protein

- Choose lean protein
  - Poultry, fish, egg, lean beef
  - Plant sources - beans, lentils, nuts
  - Low fat cheese - cottage cheese, mozzarella cheese

- Limit high fat protein
  - Bacon & sausage
  - High fat cuts of beef
  - Whole milk cheese

- Serving size
  - 1 oz = ¼ cup
  - 3 oz = deck of cards

Fats - Aim for heart health

- **Saturated fats (LIMIT)**
  - Solid
  - Animal
  - Tropical (palm, coconut)
  - Trans fats (deep fried)

- **Monounsaturated**
  - Olive & canola oils
  - Nuts
  - Avocado

- **Polyunsaturated**
  - Veg oils: canola, corn, walnut, safflower, soybean

Using Alcohol Safely

- Women - 1 or fewer alcoholic drinks a day
- Men - 2 or fewer alcoholic drinks a day
  - 1 alcoholic drink equals
    - 12 oz beer, 5 oz glass of wine, or 1.5 oz distilled spirits (gin etc)
- If drink, limit amount and drink w/ food
- Ask HCP if safe for you to drink. Tell them your usual quantity and frequency.
- Can cause hypo and worsen neuropathy
Ms. Gonzales’ Daily Meal plan

<table>
<thead>
<tr>
<th>Break</th>
<th>Lunch</th>
<th>Dinner</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 corn tortillas, 1/2 c. beans, salsa, peppers, egg beaters</td>
<td>Sandwich, low fat potato chips, 1c. juice, 2-4 low fat cookies</td>
<td>Lg bowl low salt soup, 1c. rice, BBQ meat, salad cooked veggies</td>
<td>1 bowl of cereal</td>
</tr>
<tr>
<td>Avg BG 120’s</td>
<td>Avg BG 200’s</td>
<td>Avg BG 200’s</td>
<td>Avg BG 180’s</td>
</tr>
</tbody>
</table>

Resources

- [www.eatright.org](http://www.eatright.org) American Dietetic Association website for nutrition information, resources, and access to Registered Dietitians
- [www.diabetes.org](http://www.diabetes.org) American Diabetes Association website, advocates to prevent, cure and improve the lives of all people affected diabetes
- [www.americanheart.org](http://www.americanheart.org) American Heart Association website; resources, recipes and tips; learn about efforts to reduce death caused by cardiovascular disease

Resources

DiaBingo - N

- Injected hormone called an incretin mimetic
- DPP demonstrated that exercise and diet reduced risk of DM by ___%
- An ______ a day can help prevent heart attack and stroke
- Rebound hyperglycemia
- Scare tactics are effective at motivating patients to change behavior
- Losing ___ % of body weight, can improve blood glucose, BP, lipids
- Drugs that can cause hyperglycemia
- N 3/3 cups of rice equals ______ serving carbohydrate
- N A1c of 7% equals glucose of
- N One % drop in A1c reduces risk of complications by ___%
- N 1 gm of fat equal _____kilo/calories
- N Metabolic syndrome = hyperglycemia, hyperlipidemia, hypertension
- N 1% A1c = ______ of Blood Glucose

Diabetes Meds for Type 2: Objectives

1. Describe the main action of the 5 different categories of type 2 diabetes medications.
2. Discuss strategies to determine the right medication for the right patient.
3. List the side effects and clinical considerations of each category of medication.

Resources for Medications

- Partnership for Prescription Assistance
  - www.pparx.org
- NeedyMeds.org
- www.rxassist.org
Diabetes Agents Considerations

- Diabetes medications can be used as monotherapy, in combo or with insulin
- Combining agents from different classes has additive effect
- Most reduce A1c 0.5 – 2.0%
- Not to be used during preconception, pregnancy or when breastfeeding

ADA-EASD Position Statement: Management of Hyperglycemia in T2DM

Patient-Centered Approach

- "providing care that is respectful of and responsive to individual patient preferences, needs, and values - ensuring that patient values guide all clinical decisions."
- Gauge patient's preferred level of involvement.
- Explore, where possible, therapeutic choices.
- Utilize decision aids.
- Shared decision making – final decisions re: lifestyle choices ultimately lie with the patient.

Ideal Diabetes Med -

- No hypoglycemia
- No weight gain
- Affordable
- Lowers CV risk
- Most people can tolerate /use?
Action/Classes of Type 2 Meds

1. Suppressor
   - Biguanide – Metformin

2. Squirters
   - Sulfonylureas
   - Meglitinides

3. Satiators
   - AmylinoMimetics
   - Incretin Mimetics
   - DPP-4 Inhibitors

4. Sensitizer
   - Thiazolidinediones (TZD)

5. Glucoretics
   - SGLT2 Inhibitors

6. Circadian Switchers
   - Dopamine Receptor Agonists

7. Slower
   - Alpha-glucosidase inhibitors

Biguanides - Metformin

- **Action:** decrease hepatic glucose (glycogen)
- **Names:**
  - Metformin (Glucophage)
    - Starting dose: 500 BID, max 2500mg daily
    - Metformin XR - extended release – less GI upset
    - Starting dose 500mg at dinner, max dose 2000 to 2500 mg daily
- **Efficacy:**
  - Decrease fasting plasma glucose 60-70 mg/dl
  - Reduce A1C 1.0-2.0%

Glycemic Control Algorithm

**Lifestyle Modification**
- Entry A1c > 9.0%
- Entry A1c ≥ 7.5%
- No therapy
- Dual Therapy
- Triple Therapy
- Add or interrupt insulin

**Progression of Disease**

- Oral agents in patients who need more intensive management or who have class specific contraindications or side effects
What is next step?

69 year old male, BMI 25, on Metformin 1000mg BID. AM glucose 120s, A1c 8.1%. Creat 1.3

Sulfonylureas - Squirts

- Action: Increase endogenous insulin secretion
- Efficacy:
  - Decrease FPG 60-70 mg/dl
  - Reduce A1C by 1.0-2.0%
- Secondary failures: 5-10% shortly after initial response, many more later
  - Usually after 5 or more years of therapy due to natural history of DM 2

What Medications Cause Hypoglycemia?

- Insulin
- Sulfonylureas
- Meglitinides
- Or any combo medication that includes these
Hypoglycemia = “Limiting Factor”

- Defined as glucose of 70mg/dl or below
- 50% of episodes occur during the night
- Higher mortality rate with severe hypoglycemia secondary to sulfonylureas
  - Especially (glyburide) Micronase®, Diabeta®
- Blood glucose levels don’t describe severity, response is individual

Hypoglycemic Symptoms

- Autonomic
  - Anxiety
  - Palpitations
  - Sweating
  - Tingling
  - Trembling
  - Hypoglycemic Unawareness
- Neuroglycopenia
  - Irritability
  - Drowsiness
  - Dizziness
  - Blurred Vision
  - Difficulty with speech
  - Confusion
  - Feeling faint

Treatment of Hypoglycemia

- If blood glucose 70mg/dl or below:
  - 10-15 gms of carb to raise BG 30 - 45mg/dl
  - Retest in 15 minutes, if still low, treat again, even without symptoms
  - Follow with usual meal or snack
  - If BG less than 40, allow recovery time
15 - 20 Gms Carb Sources
- 3 - 4 Glucose Tablets
- 8 - 10 Lifesavers candy
- 8 - 10 Hard candies
- 2 Tablespoons Raisins
- 4 - 6 oz’s Nondiet soda
- 4 - 6 oz’s Fruit Juice
- 8 oz Milk (non fat)

What questions?

DPP-4 Inhibitors – “Incretin Enhancers”
Januvia (sitagliptin) – Tradjenta (linagliptin)
Onglyza (saxagliptin) – Nesina (alogliptin)

- **Action:**
  - Increase insulin release w/ meals
  - Suppress glucagon
- **Dosing:**
  - Januvia – 100mg a day
  - Onglyza – up to 5mg a day
  - Tradjenta – 5mg a day
  - Nesina – up to 25 mg a day
- **Efficacy:** Decreases A1c by 0.6 -0.8%
- **Indication:** For type 2s
If on Metformin and Sulfonylurea – BG still high, other options? Pt overweight.

Incretin Mimetics – “Gut Hormone Imitators”
GLP-1 Agonists

How do they work?

GLP-1 Effects in Humans
Understanding the Natural Role of Incretins

GLP-1 secreted upon the ingestion of food
Promotes satiety and reduces appetite

↑ Beta-cell response
Enhances glucose-dependent insulin secretion

Liver:
↓ Glucagon reduces hepatic glucose output

Stomach:
Helps regulate gastric emptying

GLP-1 degraded by DPP-4 w/in minutes

Adapted from Nauck MA, et al. Diabetologia. 1996;39:1546-1553
Adapted from Drucker DJ. Diabetes. 1998;47:159-169
### Incretin Mimetics

**Exenatide (Byetta), Exenatide XR (Bydureon)**

- **Action:**
  - Insulin release in response to meal
  - Slows gastric emptying
  - Causes Satiety
  - Preserves Beta Cells
- **Exenatide Dosing:**
  - 5-10 mcg before break, dinner
  - Long acting version - 1x week (available in pens in 2015)
- **Efficacy:**
  - Decreases A1c by 0.7%, wt by 3lbs
- **Indication:**
  - For type 2s only - mono or in combo

### Incretin Mimetics – Albiglutide - Tanzeum

- **Once a Week Dosing:** 30 – 50mg
- **Efficacy:**
  - Decreases A1c by ~ 1%, wt by ~2lbs
- **Indication:**
  - For type 2s only
- **Other:**
  - Pen injector
- **Caution:**
  - not indicated for those with history of medullary thyroid tumor - pancreatitis warning

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*Patient Friendly Injector - Eli Lilly received FDA Approval for their Ready-to-Use once weekly GLP-1 agonist, Trulicity. The unique quality about this injector is that unlike the other once weekly GLP-Agonists, which require mixing of powder and fluid, it comes in a single-dose pen and does not require mixing, measuring or needle attachment. And the needle is hidden from the user and retracts after use. This definitely makes it a stand out amongst it’s competitors and is a leap forward in terms of convenience.

It comes in both .75 and 1.5 mg doses. Given its ease of use, efficacy and weight loss benefits, maybe we will start seeing Trulicity used earlier in the course of diabetes care.*
For all the Previous DPP-IV and GLP-1 Agonists

- Pancreatitis Warning
  - Please tell all patients to report signs right away and discontinue meds
  - Signs include:
    - Sudden abdominal pain, nausea and vomiting

Next Step?

- 69 year old male, BMI 25, on Metformin 1000mg BID and Exenatide 10mcg before breakfast and dinner.
- Pt overweight - A1c 8.1%. Creat 1.2

SGLT2 Inhibitors - “Glucoretics”

- **Action**: “Glucoretic” decreases renal reabsorption in the proximal tubule of the kidneys (reset renal threshold and increase glucosuria)

- **SGLT2 Inhibitors**
  - Decrease glucose reabsorption in kidneys
  - “glucoretic”
  - Canagliflozin (Invokana)
  - Dapagliflozin (Farxiga)
  - Empagliflozin (Jardiance)

- **Dosages**
  - 100-300 mg once daily
  - 5-10 mg once daily
  - 10-25 mg once daily

For all, monitor BP, K+, and renal function. If GFR<60, stop Farxiga. If GFR<45, stop Invokana.
Do not start pts w/ GFR<60 on Jardiance.
Side effects: hypotension, UTIs, increased urination, genital infections. Avoid Farxiga in pts w/ bladder cancer. Lowers A1c 0.7% - 1.5%, lowers wt 1-3 lbs.
Considerations

- Monitor B/P, K+ & renal function.
- Side effects: hypotension, UTI, increased urination, genital yeast infections.
- Improves beta cell function?
  - Reverses glucose toxicity by increasing GLUT4 transport in muscle
  - Increase liver sensitivity to insulin and decreases gluconeogenesis.

Indications for Insulin Sensitizers
Rosiglitazone (Avandia), Pioglitazone (Actos)

- **Action**: decrease insulin resistance by making muscle and adipose cells more sensitive to insulin. Decrease free fatty acids
- **Names**:
  - pioglitazone (Actos) – bladder cancer warning
  - rosiglitazone (Avandia) – restriction relaxed
- **Dosing**:
  - pioglitazone: 15-45 mg daily
  - rosiglitazone: 4-8 mg daily
- **Efficacy/Considerations**
  - Reduce A1C ~0.5-1.0%
  - 6 weeks for maximum effect
  - $100 a month
  - Can cause fluid retention, not indicated w/ CHF

Keeping Healthy in Long Run

- **HUG Patients**
  - Help with
    - Unconditional
  - Guidance and Support
    - Anne Peters, MD, CDE
    - ADA Post Grad

*Unconditional Positive Regard* – involves showing complete support and acceptance of a person no matter what that person says or does.

Carl Rogers
Thank You

- Questions?
- Email
  bev@diabetesed.net
- Web
  www.DiabetesEd.net