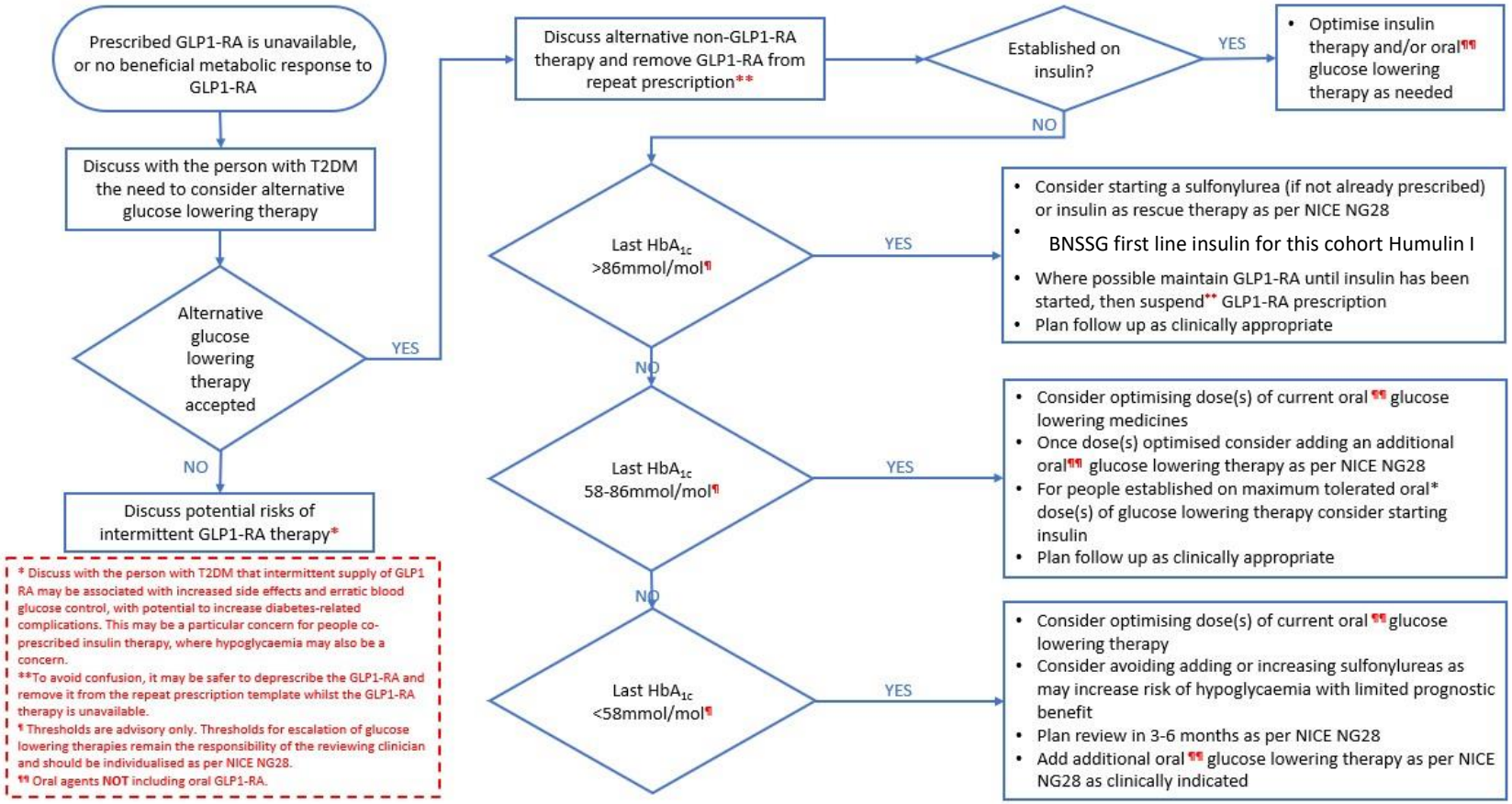
BNSSG Quick reference guide for selecting alternative glucose-lowering therapy when GLP-1 RAs are unavailable or where there is no beneficial metabolic response to GLP-1 RA therapy



Note: Symptomatic hyperglycaemia may indicate clinical need for insulin therapy. If in doubt, discuss with specialist. Symptoms of hyperglycaemia include polyuria, polydipsia, weight loss and fatigue. Think 4Ts – Thirst, Toilet, Thinner, Tired.

(Adapted from Joint PCDS and ABCD guidance: GLP-1 receptor agonist national shortage)

Children and young people with T2DM prescribed GLP-1 RAs under the care of specialist paediatric services should be directed back to specialist services

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Improving health and care in Bristol, North Somerset and South Gloucestershire

Approved BNSSG Area Prescribing and Medicines Committee 3/8/23 Review August 2024

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First-line treatment - to achieve individualised HbA1c target – alongside comprehensive lifestyle change to support change in dietary and physical activity behaviours

Treat cholesterol and blood pressure to individualised targets as appropriate

Rescue therapy (NPH Insulin or gliclazide) for symptomatic hyperglycaemia at any stage. To be reviewed when blood glucose control achieved

ASSESS CARDIOVASCULAR STATUS AND RISK

NO CVD or Chronic Heart Failure (HF)	**Established CVD**	**Chronic Heart Failure (HF)**
Metformin	Metformin + SGLT2 inhibitor	Metformin + SGLT2 inhibitor
Add from options below:	Add from options below:	Add from options below:
Gliclazide (Sulfonylurea)	Gliclazide (Sulfonylurea)	Gliclazide (Sulfonylurea)
Pioglitazone	Pioglitazone	Sitagliptin (DPP-4 inhibitor) *
SGLT2 inhibitor	Sitagliptin (DPP-4 inhibitor) *	
Sitagliptin (DPP-4 inhibitor) *		
Humulin I	Humulin I	Humulin I

***The addition of a DPP-4 inhibitor to treatment with an existing SGLT2 inhibitor will have limited incremental benefit to HbA1c and would not be considered a first line option.**

Sitagliptin is now the DPP-4 inhibitor of choice on the BNSSG formulary

HbA1c should be repeated 3-6 months after any change to medications and any medicines that have had no impact on glycaemic control stopped (unless additional cardio-renal protection from continued treatment)

CONSIDER eGFR - SGLT2 inhibitors have limited or no glucose lowering effect at eGFR <45ml/min/1.73m^2. Therefore, their use in eGFR <45ml/min/1.73m^2 is for cardio-renal benefit only. If eGFR ≥45ml/min/1.73m^2 SGLT2 inhibitors will support improvement in glucose control and adjustment of current medications should be considered, specifically Gliclazide (or other Sulfonylureas) if HbA1c is at target or within 10mmol of target reduce dose and adjust further as blood glucose levels dictate.

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