Proposed changes to the NICE type 2 diabetes guideline

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It has been a while since I wrote an editorial – many thanks to Hannah Beba for her guest editorial last issue, highlighting the major restructures underway for ICBs in England and how this might affect future diabetes care. For me, the summer months were somewhat quieter but, having just returned from a week away, I find all things diabetes-related are once again gathering pace.

Medicine supply issues

Lately we seem to have been inundated with Medicine Supply Notifications (MSNs), many of which will impact people living with diabetes. The Department of Health & Social Care has recently published a Tier 2 MSN for repaglinide 500 µg, 1 mg and 2 mg tablets. The 500 µg and 1 mg tablets will be out of stock from late August until early December 2025, while the 2 mg dose will be in limited supply until early December 2025 and cannot support any increase in demand.

Although repaglinide is not a commonly prescribed blood glucose-lowering drug, it does have certain unique characteristics that make it difficult to replace. Arguably, a sulfonylurea such as gliclazide is the closest in terms of mode of action, although there are some significant differences in terms of onset and duration of action. However, in practice, I've found it quite challenging, as all of the individuals I have reviewed were on repaglinide for a specific reason. For example, one had encountered problematic hypoglycaemia on gliclazide and another preferred the flexibility of being able to omit a dose when a meal is missed. So this is a difficult situation, adds to our workload and, frankly, is something busy clinicians could do without.

Up-to-date information about this and other medicine supply issues can be found in the DHSC and NHSE/I online Medicines Supply Tool. It may also be useful to refer to our *Prescribing pearls* article on sulfonylureas.

Levemir discontinuation

Another MSN has been issued for Levemir® (insulin detemir), which is due to be discontinued and has an anticipated supply end date of December 2026. At least we have received plenty of warning, but again switching will not be straightforward. Thankfully, the Primary Care Diabetes & Obesity Society has collaborated with the Association of British Clinical Diabetologists and published joint guidance to support clinicians in appropriately selecting and safely prescribing alternative insulin therapy (Newland-Jones et al, 2025).

You can read the guidance here, and an interview with the lead author can be viewed here. We will also be covering the recommendations in detail at the PCDO Society National Conference in November – I hope you can make it!

Tirzepatide price increases

The injectable incretin-based therapies seem to be forever in the mainstream news. We recently heard that the private cost of tirzepatide (Mounjaro®) is set to rise by up to 170%. This has caused much discontent in the private sector, where its use for weight loss has rocketed. In my practice, I am already being approached by people who have been prescribed the drug for their type 2 diabetes and are concerned that it may be stopped due to the price increase. Thankfully, however, there have been assurances that the price rise will not apply to NHS prescriptions.

If proposed changes to the NICE NG28 guideline go ahead, many more people with type 2 diabetes could be eligible for injectable semaglutide and possibly tirzepatide.

NICE proposes changes to its type 2 diabetes guideline

So, what do we know about the proposed changes to NG28? The long-awaited new draft guidance has now been published and is open for consultation until Thursday 2 October 2025.

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You can view the draft here, and the PCDO Society will be formally responding to the consultation as a stakeholder.

Unsurprisingly, given their well-established cardiorenal benefits, the draft proposes that SGLT2 inhibitors be offered as first-line treatment, alongside metformin, for all adults at diagnosis, even where there are no significant comorbidities. They can also be offered as monotherapy where metformin is not tolerated or contraindicated.

Another change, already alluded to, is the earlier use of GLP-1 receptor agonist therapy, with proposals to initiate these as part of initial triple therapy (alongside metformin and an SGLT2 inhibitor) in people with type 2 diabetes and atherosclerotic cardiovascular disease, or for those with early-onset type 2 diabetes. In addition, GLP-1 RA therapy can be considered earlier – after just 3 months on initial therapy with metformin and/or an SGLT2 inhibitor – in those with type 2 diabetes and obesity in whom further blood glucose lowering is needed.

The evidence base for the incretin-based therapies is growing, with many trials underway to explore the benefits beyond glucose lowering and weight loss. Among people with obesity-related heart failure with preserved ejection fraction (HFpEF) and type 2 diabetes, the STEP-HFpEF-DM trial demonstrated that semaglutide led to larger reductions in heart failure-related symptoms and physical limitations, and greater weight loss, than placebo at 1 year (Kosiborod et al, 2024). This is reflected in the draft guidance, which recommends consideration of subcutaneous semaglutide in people with type 2 diabetes and HFpEF if they need further medicines to reach their weight management targets, provided they are living with obesity and there are no concerns over frailty.

In this issue

Once again, obesity and obesity drugs featured prominently at this year's American Diabetes Association's Scientific Sessions, held in Chicago on 20–23 June. Pam Brown summarises some of the highlights of the conference.

The promise of weight loss is highly compelling and explains why so many people seek the so-called "weight loss jabs" at significant cost, be it personal or financial. Unfortunately, for many they are seen as a fast-track miracle cure for overweight and obesity. All too often, the focus is on how much weight a person can lose and how quickly. But the message that really needs to be conveyed is that the type of weight loss matters. In any weight loss intervention, an important goal must be to preserve skeletal muscle function and muscle mass. Earlier this year, we highlighted the dangers of loss of lean mass, especially muscle, and the importance of a healthy diet and strengthening exercises. This issue, we pick up on this topic again, exploring the concept of "weight loss quality" and proposing a number of targets for this in weight loss interventions.

Since its launch, we have been aware that tirzepatide may affect the absorption of oral contraceptives, and it is advised to switch to a non-hormonal contraceptive method, or to add a barrier method of contraception, for 4 weeks, both when initiating tirzepatide therapy and after each dose escalation (Faculty of Sexual & Reproductive Healthcare, 2025).

More recently, concerns have been raised over potentially reduced absorption and bioavailability of oral hormone replacement therapy for menopause and, in particular, inadequate endometrial protection due to potentially reduced absorption of oral progestogens. The British Menopause Society (2025) has published guidance on this, and we summarise their recommendations in our latest *Need to know*.

Concerns over retinopathy complications were raised after the SUSTAIN-6 trial found a significantly higher rate of retinopathy complications in some participants treated with semaglutide compared to those on placebo (Marso et al, 2016). These findings suggest a need for careful monitoring and consideration of risk prior to initiating semaglutide, but the same caution should be exercised with tirzepatide, given that individuals with more advanced diabetic retinopathy were not included in the latter's clinical trials. This is highlighted in the current SmPC for the drug, which states that, *"Tirzepatide has not been studied in patients with non-proliferative diabetic retinopathy requiring acute therapy, proliferative diabetic retinopathy*

or diabetic macular oedema, and should be used with caution in these patients with appropriate monitoring." In practice, I do not initiate either therapy without an up-to-date retinal screen, and where I have concerns relating to the retinal status I seek specialist advice and guidance before proceeding. For practical advice on this, see our *At a glance factsheets*:

- Diabetic retinopathy.
- GLP-1 RAs and diabetic retinopathy.
- Tirzepatide for type 2 diabetes.

Further clinical trials exploring a potential link are underway; however, in the meantime we report on a real-world retrospective cohort study showing that, while new-onset proliferative diabetic retinopathy (with or without maculopathy) was more common with tirzepatide and mostly occurring in those with moderate to severe or mild non-proliferative retinopathy without maculopathy at baseline, in people without retinopathy at baseline, tirzepatide was in fact associated with a significantly **reduced** risk of developing new retinopathy, and no significant association with retinopathy progression, in those treated with the drug who had mild, non-proliferative diabetic retinopathy (R1M0 or R1M1).

Around half of people with diabetes develop neuropathy at some point, and for 20–30% this can cause pain. Managing painful neuropathy is challenging, and many of the pharmacological treatments available are associated with tolerability issues. Guidelines recommend offering a choice of amitriptyline, duloxetine, gabapentin or pregabalin, with a stepwise approach to prescribing (refer to O'Neil, 2023, for guidance). However, recently, concerns have been raised over a link between pregabalin initiation and an increased risk of new-onset heart failure, in a population that included people being treated for diabetic neuropathy. Pam Brown reviews the findings here. From a practice perspective, we should consider carefully before prescribing pregabalin for painful diabetic neuropathy in people aged over 65 years, and consider assessing cardiovascular disease and heart failure risk in people already taking pregabalin to decide whether it is safe to continue.

Diabetes is associated with an increased risk of cognitive impairment and dementia. This issue, we have two resources from David Morris to support our practice; his *At a glance factsheet* outlines the relationship between these co-existing conditions, and the principles of management are covered in *How to approach and manage diabetes in people with dementia*.

I spend a lot of time addressing questions around diet and am often asked what a person can and cannot eat. I was therefore drawn to our final *Diabetes Distilled* summary on potatoes and the risk of developing type 2 diabetes. The highlighted study suggests that French fries, but not other types of potato, including boiled, mashed and baked, are associated with increased risk of developing type 2 diabetes. Interesting, although I did wonder how one controls for so many variables in a study like this. The finding that high-fat and, usually, ultra-processed French fries may increase type 2 diabetes risk may not come as a surprise, but it is reassuring that other more "real" preparations of potatoes have a limited effect on risk. However, given the high glycaemic index of potatoes in general, I suspect their impact on glycaemic control in those with established type 2 diabetes remains an issue.

Finally, ahead of our PCDO Society National Conference in Birmingham on 19–20 November, I would like to encourage you to consider standing for election to the PCDO Society Committee. We are losing a couple of nurses from the group, and it would be fantastic to see a few more nurse applicants this year. ■

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