Conference over coffee: Oncology, end-of-life care, psychology and insulin dilemmas

The 14th Northern Irish conference of the Primary Care Diabetes Society was held in Belfast on 19 September. In addition to masterclasses on diet, CGM, podiatry and new local pathways, the plenary sessions covered cancer and diabetes, palliative care, insulin therapy and psychological support. In this report, Pam Brown distils the key messages and practice points from the main sessions. Slides will be made available soon: click here to access.

Oncology and palliative care

Su Down, Diabetes Nurse Consultant, Somerset

- 20% of people with cancer have diabetes.
- Diabetes provides the perfect environment for cancer cell growth:
  - Insulin is a growth factor.
  - Inflammation.
  - Hyperglycaemia.

Type 3c or pancreatogenic diabetes

- Results from structural damage to the pancreas (due to e.g. pancreatitis, cystic fibrosis, haemochromatosis). 80% of cases will be related to pancreatitis.
- Type 3c makes up 8–10% of all diabetes, yet we rarely consider it.
- We should ask ourselves, "How do I know this is type 2 diabetes – could it be another type?"
- Check faecal elastase test; CT to assess pancreatic damage; exclude autoantibodies which would suggest type 1 diabetes.
- Can identify these people by looking at those who needed insulin within 5 years of diagnosis.

Pancreatic carcinoma

- Difficult diagnosis and often made late.
- Have high index of suspicion – NICE NG12 recommends urgent 2-week-wait CT scan in all over age 60 years who have weight loss and new type 2 diabetes; also in those whose glycaemic control suddenly deteriorates.

Management of diabetes during chemotherapy

- Hyperglycaemia can make chemotherapy less effective; increased risk of infections and of hospitalisation.
- Steroids are often used in large intermittent doses – goals are to limit glucose rises later in the day whilst avoiding overnight hypoglycaemia.
  - Prednisolone usually taken as morning dose; hyperglycaemia may develop a few hours after taking and may then wear off.
  - Dexamethasone may result in more prolonged hyperglycaemia through whole 24 hours (see *Table 1*).
- Some drugs (e.g. checkpoint inhibitors), can cause rapid-onset new type 1 diabetes.

Table 1. Corticosteroid dose equivalents and durations of action.

Steroid	Potency (equivalent dose)	Duration of action (half-life)
Hydrocortisone	20 mg	8 hours
Prednisolone	5 mg	16–36 hours
Methylprednisolone	4 mg	18–40 hours
Dexamethasone	0.75 mg	36–54 hours
Betamethasone	0.75 mg	26–54 hours

Deprescribing and end-of-life care

- Language matters, good communication is important and regular discussion is needed.
- Manage nausea and vomiting.
- Cancer cachexia and sarcopenia are common; gradually deprescribe therapies and provide nutritional support. Any type of energy intake, including nutritional supplement drinks, is important – it is the clinician's role to manage the impact on glycaemia. Prescribe to avoid symptomatic hyperglycaemia and hypoglycaemia.
- Ideally provide CGM to avoid distressing capillary glucose testing.
- If prognosis >3 months: deprescribe SGLT2 inhibitors, ACE inhibitors, ARBs, statins.
- If prognosis <2 months: remove mealtime insulin, retain basal background therapy, decrease sulfonylurea.
- Prioritise removing drugs if they interfere with appetite (e.g. metformin, DPP-4 inhibitors, GLP-1 receptor agonists) or carry hypoglycaemia risk.

Psychological care in diabetes

Becky Houghton and Shannon McAleese, Psychologists, Northern Health & Social Care Trust

Qualitative research demonstrates that both HCPs and people with type 1 diabetes have similar views about what is important to them. Three interconnected themes were raised by the research shared:

- The importance of being seen and heard.

- Management should feel like a collaborative alliance of two experts.
- Impact of the healthcare system – time, lack of resources impactful. Telehealth may provide a partial solution.

Questions to use for a wellbeing check-in:

- How can I be of most help to you today?
- What do we need to make sure we talk about?
- How are things going with your diabetes at the moment?
  - ➤ What do you feel isn't going as well as you would like?
  - ➤ What do you feel is going well (can use the PAID [Problem Areas in Diabetes] questionnaire to help identify what is going well or not).
- Who do you talk to when your diabetes gets rough going? And how do they help?
- Is there anything getting in the way of you looking after your diabetes at the moment?

Resource
Problem Areas in Diabetes scale

Insulin dilemmas

Neil Black, Consultant Physician and Clinical Lead, Endocrinology & Diabetes, Western Health & Social Care Trust

Steroid-induced hyperglycaemia

- In those without diabetes, 30% develop hyperglycaemia and 18% develop diabetes; may resolve with cessation of steroids. In those with pre-existing diabetes, 100% develop hyperglycaemia.
- Management: gliclazide 40–80 mg morning; uptitrate to 160–240 mg; add afternoon dose – total 320 mg per 24 hours. Insulin may be required.
- Glucose lowers within 2–3 days of steroids being reduced – so adjust gliclazide dose.
- Seek specialist support if insulin required.
- In end-of-life care, avoid hypoglycaemia and symptomatic hyperglycaemia.

Rescue therapy

- Consider if HbA_{1c} is ≥90 mmol/mol, or lower if osmotic symptoms.
- Add in sulfonylurea to maximum dose, then add insulin if needed.
- Remember to exclude other types of diabetes – type 1 and LADA.

Downtitration of hypoglycaemic agents

- Important to understand the modes of action of different therapies and their benefits and potential adverse effects.
- When adding a new agent: halve the sulfonylurea dose (can consider reducing it to once daily); reduce insulin dose by 20–30%.

Resource
JBDS-IP Management of hyperglycaemia and steroid (glucocorticoid) therapy

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