Table 1. Summary of relevant guidelines for management of hyperglycaemia in people with cancer.

	Screening/monitoring	Management	Ref
Prior to starting systemic anti-cancer therapies	• HbA_{1c} and random plasma glucose (RPG)	• If HbA_{1c} >47 mmol/mol, refer to GP • If RPG ≥20.1 mmol/L, check for hyperglycaemic emergency; once excluded, refer urgently to the diabetes team for treatment • If RPG 12–20 mmol/L, check for ketones and commence gliclazide therapy • If RPG <12 mmol/L, continue screening at each visit	14
Glucocorticoid-induced hyperglycaemia in a person with known T2DM on oral agents	• HbA_{1c} prior to commencement • Test capillary blood glucose (CBG) four times daily	• Acceptable CBG range 4–12 mmol/L • Add or titrate gliclazide 40 mg daily, titrate to maximum 240 mg in morning and 80 mg in evening • Add NPH insulin 10 units daily and titrate by 10–20% daily to achieve target • Upon cessation of steroids, reduce glucose-lowering treatment to pre-steroid levels • Proactive monitoring and treatment at next cycle of treatment	15
Glucocorticoid-induced hyperglycaemia in a person with known T1DM or T2DM on insulin	• HbA_{1c} prior to commencement • Test CBG four times daily	• Acceptable CBG range 4–12 mmol/L, but might be individualised to patients' needs • Involve the specialist diabetes team if needed • If on once-daily night-time insulin: Transfer night-time insulin injection to the morning; titrate by 10–20% daily; if targets not achieved, consider twice-daily insulin • If on twice-daily insulin: Increase morning dose by 10–20% according to pre-evening-meal glucose readings • If on basal–bolus insulin: Consider transferring basal insulin dose to morning instead of evening; increase short/fast-acting insulin dose by 10–20% daily until target reached • Upon cessation of steroids, reduce treatment to pre-steroid levels • Proactive monitoring and treatment at next cycle of treatment	15
Glucocorticoid-induced hyperglycaemia in a person not known to have diabetes	• HbA_{1c} prior to commencement • At least once-daily monitoring of CBG, prior to lunch or evening meal • If CBG >12 mmol/L consistently, enter treatment algorithm	• Acceptable CBG range 4–12 mmol/L • Gliclazide 40 mg with breakfast; titrate to maximum 240 mg in morning and 80 mg in evening • Add NPH insulin 10 units daily and titrate by 10–20% daily to achieve target • Upon cessation of steroids, reduce treatment to pre-steroid levels • Proactive monitoring and treatment at next cycle of treatment	15
Enteral feeding in a person with T1DM	• HbA_{1c} prior to commencement • CBG four times daily	• Involve the diabetes specialist team • Avoid VRIII if possible; if on insulin pump, stop and convert to multiple-dose insulin regimen • Continue basal insulin and consider bolus doses of short/rapid-acting insulin at start of feed, and at 6 and 12 hours into feed	16
Enteral feeding in a person with well-controlled T2DM	• HbA_{1c} prior to commencement • CBG four times daily	• Acceptable CBG range 4–12 mmol/L • Consider metformin powder via nasogastric tube if CBG is >12 mmol/L consistently	16
Enteral feeding in a person with poorly controlled T2DM	• HbA_{1c} prior to commencement • CBG four times daily	• Acceptable CBG range 4–12 mmol/L • Continue metformin as powder via nasogastric tube • If CBG is >12 mmol/L consistently, consider: Pre-mixed (30/70) insulin at start and middle of feed NPH insulin at start and middle of feed Continue basal insulin and consider bolus doses of short/rapid-acting insulin at start of feed, and at 6 and 12 hours into feed	16
End-of-life care	• Consider reduction in monitoring	• Careful discussion of diabetes management with patient and carers • Offer reduction in monitoring and prescribing in patients with short life expectancy • T2DM on diet or metformin alone: Stop monitoring CBG • T2DM on tablets, GLP-1 RA or insulin: Consider: Stopping tablets and GLP-1 RA injections Stopping insulin depending on dose If insulin to continue, consider once-daily regimen • T1DM on insulin: Continue once-daily basal insulin in the morning	17

CBG=capillary blood glucose; NPH=neutral protamine Hagedorn insulin (e.g. Insuman Basal, Humulin I, Insulatard); RPG=random plasma glucose; T1DM=type 1 diabetes; T2DM=type 2 diabetes; VRIII=variable-rate intravenous infusion of insulin.