NICE additions to the type 2 guideline

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We live in interesting times. The bad news is that the number of people diagnosed with type 2 diabetes is rising rapidly, exceeding expectations. The good news is that these people are living longer and healthier lives. But we know this type of diabetes is progressive and we are in a position where many people are outliving the effectiveness of traditional therapies. Since nothing on the horizon suggests that obesity – and therefore type 2 diabetes – is likely to dwindle, we need more options in our armoury to treat diabetes.

In May 2008 NICE published an update on its guidance for type 2 diabetes (National Collaborating Centre for Chronic Conditions [NCCCC], 2008). It focused on traditional oral agents, updated its advice on thiazolidinediones and included one of the two available long-acting insulin analogues. Many newer agents were, however, already available, or in the pipeline, and healthcare professionals needed direction on how best to use them. It is appropriate, therefore, that NICE has published its long-awaited guidance on these newer therapies (NICE, 2009). The guidance includes dipeptidyl peptidase-4 (DPP-4) inhibitors, thiazolidinediones, the glucagon-like peptide-1 (GLP-1) receptor agonist exenatide, and long-acting insulin analogues. The guideline indicates where in the care pathway these newer agents could be used.

I am particularly pleased to see the emphasis on the full participation of the person with diabetes in making decisions about their treatment – and not just on diet and lifestyle. They have a right to know the potential side-effects and benefits of proposed changes and to make an informed choice. This fits neatly into plans to introduce information prescriptions for all people with a long-term condition (more information can be found at www.informationprescription.info). Information prescriptions are intended to guide people to relevant and reliable sources of information to allow them to feel more in control and better able to manage their condition and maintain their independence (Department of Health, 2006).

Equally pleasing is the emphasis on tailoring the treatment to match the individual's needs. No one algorithm is going to suit all people, and healthcare professionals are going to have to navigate their way through several options and take the time to agree a plan of action. Tighter indicators for HbA_{1c} levels included in the quality and outcomes framework may mean that people are encouraged to achieve results that allow their day-to-day glycaemic control to drop too low at times, causing hypoglycaemia. "Hypos" are dreaded by people with diabetes. NICE recognises that fact and suggests options to limit or avoid their occurrence. Weight management is also considered and we will need to keep abreast of developments as additions to the GLP-1 receptor agonist and DPP-4 inhibitor classes of drugs become available.

Initiation of insulin is treated seriously, as pressure is put on primary care to become more involved. Any nurse asked to take on this role, but who feels that it is beyond their knowledge and skills, can quote procedures that should be in place. NICE requires that "structured education, continuing telephone support, frequent self-monitoring, dose titration to target, dietary understanding, management of hypoglycaemia, management of acute changes in plasma glucose control and support from an appropriately trained and experienced healthcare professional" be included in a care programme (NICE, 2009).

Nursing management of diabetes was never simple. Newer therapies will augment our therapeutic options. More than ever we must work with people with diabetes to achieve their goals. ■

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