Plotting a course through the diabetes guidance in a changed world

As we reach the end of what has been the most challenging year of most of our careers, it feels like a good time to reflect on how we have all learnt to deliver diabetes care in completely new ways and how, having reached this point, it is unlikely we will ever go back to our old ways. Indeed, as Ralph Waldo Emerson reminds us, "The mind, once stretched by a new idea, never returns to its original dimensions". So, let's explore how delivering diabetes care during the pandemic has stretched our minds in 2020 and how that will change what we choose to do going forward into 2021.

Shortly after the pandemic struck, diabetes and other chronic disease management was largely suspended, routine face-to-face consultations were replaced by telephone and video remote consultations, and primary and community care diabetes that we had all devoted so much time and energy to optimise, changed, perhaps forever.

As Jane Diggle and I honed our skills in remote consulting, we decided to distil our personal learning from delivering diabetes care in new ways to help our colleagues learn from our experience. We are grateful to everyone, including Partha Kar, Clare Hambling and the PCDS Committee, who helped us fine-tune our core document, "How to undertake a remote diabetes review", ensuring its usefulness. The number of downloads of the document and large audiences for the two national and many local virtual webinars highlighted the need for such a resource at that time (the "How to" has been one of our most-read articles ever, while the webinar was followed live by a very large audience and subsequently watched on demand many more times). PCDS is grateful to Novo Nordisk for a hands-off educational grant to help fund the two national webinars and the Question Time webinars discussed below.

After the first wave of the COVID-19 pandemic began to recede and we all realised we had a backlog of 6 months' worth of diabetes reviews, guidance began to emerge on different ways that practices and community teams might begin to tackle their backlog efficiently and effectively, ensuring that those most in need of diabetes care received it. However, much of the guidance was complex and not clearly aligned with practical implementation, so Jane's and my attention turned to ways to distil this into "How to prioritise primary care diabetes services during and post COVID-19 pandemic". Linked to this document, the PCDS hosted two Question Time speaker panels. The first, chaired by Clare Hambling, explored prioritisation in more depth and the second, chaired by and David Millar-Jones, discussed prescribing challenges faced during and after the pandemic. Our thanks go to expert panel members for their passionate and practical debate and their guidance crystallised in "PCDS Question Time: Prescribing guidance in primary care", published in this issue. Again, the number of participants, using the resources exceeded all our expectations. Both webinars are available on demand and continue to be accessed regularly.

All our planned PCDS conferences – Welsh, Scottish, Northern Ireland, All Ireland and the National – took place remotely this year and, again, numbers demonstrated the demand for high quality, relevant and implementable education. I am sure I speak for all attendees that we missed the interaction with friends and colleagues, since networking is such an important part of any conference. If you missed any of the conferences, or were not able to attend all the masterclasses in real time, you can view them on demand. In this issue of the journal, we share parts 1 and 2 of the Welsh PCDS Conference report, with reports from other conferences due early in 2021. Next year's virtual Welsh conference will return to its usual slot earlier in the year on Thursday 13 May. Programme planning is under way, taking into account feedback from this year's attendees.

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"All of the current guidelines agree on the importance of lifestyle, of patient-centred and individualised targets and care, and of using newer drugs for their beneficial effects beyond glucose-lowering."

New opportunities

In many parts of the UK, clinicians continue to be encouraged to base prescribing decisions on the NICE adult type 2 diabetes guideline (NICE, 2015). This is now significantly out of date and based purely on the glucose-lowering effects of drugs, without considering the significant, proven benefits of SGLT2 inhibitors and GLP-1 receptor agonists (RAs) on cardiovascular disease (CVD), heart failure (HF) outcomes and renal disease progression, and beneficial weight loss and low risk of hypoglycaemia for most people. The updated NICE guideline on type 1 diabetes and type 2 diabetes in children and adolescents was published this week, but the date for the consultation draft of the new adult type 2 diabetes guideline is still to be confirmed.

Initiation of newer drugs, such as SGLT2 inhibitors and GLP-1 RAs, in primary care remains low. Discussion with colleagues and when teaching suggests low use can reflect uncertainty about how and when to use which drug, partly fuelled by confusion generated by differing recommendations in different guidelines, combined with lack of confidence in how to use these newer drugs safely. The result is often either clinical inertia, where no therapy is added, or the initiation of older drugs with which the clinician is comfortable, such as sulfonylureas and DPP-4 inhibitors, despite these not offering added cardiovascular, HF or renal benefits.

It is hardly surprising that, faced with managing all chronic diseases in primary care, clinicians struggle with diabetes when there are at least 14 oral drugs, five GLP-1 RAs and over 30 different insulins available in the UK, and recommendations on glucose-lowering drug choice come from five different sets of guidance – the 2018 ADA/EASD consensus on glycaemic management (Davies et al, 2018) and its 2019 update (Buse et al, 2020), the Primary Care Diabetes Europe guideline (Seidu et al, 2020), the European Society for Cardiology (ESC) guideline (Cosentino et al, 2020) focusing on those with or at risk of CVD, and the KDIGO guideline targeting those with diabetes and CKD (KDIGO Diabetes Working Group, 2020). This week saw the launch of further guidance from the *ADA Standards of Medical Care in Diabetes – 2021* (ADA, 2021) and, although many sections have been updated and provide useful summaries of the advancing evidence base and guidance on how this might translate into diabetes care delivery, the section on glycaemic management of type 2 diabetes has most practical guidance for us in primary care. The algorithm in this section, which is an update of that in the 2018 ADA/EASD consensus on glycaemic management and its 2019 update, looks quite different at first glance. However, the changes are mainly in the layout, and reflect findings from recently published studies and formalise the way that many of us are already choosing to individualise our use of the newer drugs.

The plethora of perceived conflicting guidance at this challenging time, however, does risk further confusion amongst primary care teams, a theme eloquently discussed by members of the ADA/EASD consensus and the ESC groups in their recent paper (Marx et al, 2020).

We would do well to focus on the many similarities between the guidelines and remember that all are based on the evolving evidence base available at the time when they were published. All agree on the importance of lifestyle, of patient-centred and individualised targets and care, and of using newer drugs for their beneficial effects beyond glucose-lowering. All recommend metformin as first-line therapy either as monotherapy or in combination, although the ESC only recommends metformin first line in those at "moderate" CVD risk, prioritising an SGLT2 inhibitor or GLP-1 RA first line instead for those at high and very high CVD risk (Cosentino et al, 2020).

All recommend combination first-line therapy for some groups and, if this option is not chosen, I believe we have a responsibility to undertake an early review to check whether a second therapy is required due to failure to achieve the individualised glycaemic target, or presence or development of a comorbidity, such as atherosclerotic CVD, HF or chronic kidney disease (CKD), that would benefit from additional therapy. Despite recommendations, when initiating therapies that can have significant side effects, many of us remain cautious and prefer to initiate one therapy at a time, thus avoiding the need to discontinue and "waste" more than one therapy if intolerance develops.

Likewise, jumping straight into a once-weekly injectable GLP-1 RA may risk losing the confidence of a person with newly diagnosed diabetes, who may feel more comfortable with oral therapy first line.

We know that people with diabetes are at much higher risk of ASCVD, HF and the mortality associated with these than those without diabetes. Risk of CKD, with its associated further increased CVD risk as well as progression to end-stage renal disease, is also significantly higher in those with diabetes. Use of the newer drugs, such as SGLT2 inhibitors and GLP-1 RAs, can reduce and help to manage those conditions, so it is important for us all to understand where the guidelines recommend the newer drugs and how to use them safely. Once we have that framework, we can build on it.

Our "How to use GLP-1 receptor agonist therapy safely and effectively" by Nicola Milne, updated in this issue, and "How to use SGLT2 inhibitors safely", which will be published in the next issue, provide more detail about using these drugs. Each contains an algorithm based on the most up-to-date guidance available at the time of publication. We'll talk about guidelines in early 2021.

In this issue

After several months of development, we are excited to share with you the first in a series of interactive case studies by David Morris, which looks at the thin person diagnosed with type 2 diabetes. We hope you will enjoy working through this, and please do provide feedback on how we could make future case studies even more useful.

Michael Edmonds' team provide a call to action with their ACTNOW project to prevent foot ulcers and amputations, so very important at this time when we are working remotely much of the time. Laura Willcocks and colleagues reflect on their experience of diabetes upskilling for pharmacy support and we conclude our EASD conference coverage with insights from Fidelma Dunne's "Preventing Gestational Diabetes: Pitfalls and hope" lecture.

In *Diabetes Distilled*, Kevin Fernando provides concise summaries of key papers, including the SCORED and SOLOIST-WHF studies with sotagliflozin, and FIDELIO-DKD exploring effects of finerenone on renal and cardiovascular outcomes in people with type 2 diabetes. He looks at a study about diabetic ketoacidosis with SGLT2 inhibitors and we offer reassurance that cotreatment with metformin does not interfere with SGLT2 inhibitor benefits.

I am so proud of the professionalism shown by all of our in-house team at OmniaMed, our authors, our editorial board and the PCDS Committee who have made time to support Jane and I to continue to publish *Diabetes & Primary Care* during 2020. My very special thanks to Jane Diggle who has tirelessly shared her knowledge, experience and enthusiasm throughout the year, and inspired me to keep pushing forward when some of our projects seemed impossible.

It has been a challenging year for all of us, but one where we have all learnt flexibility, new ways of working and to continue to inspire and support the people with diabetes we care for. I hope we all manage to have some time to spend with family and friends over the festive season, even though that may have to be achieved virtually, and that we return refreshed and re-energised, not only to deliver great diabetes care, but also to begin our COVID-19 vaccination campaigns. Let's wish for ourselves and those we love and care about, a healthy and happy 2021. ■

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