To treat or not to treat – that is the question?

Phil Holdich – Chair
Dr Paul Jennings – Consultant Diabetologist
Dr Andrew Inglis – GP
Julie Dale – Macmillan Clinical Nurse Specialist

Mr Tom Stocks

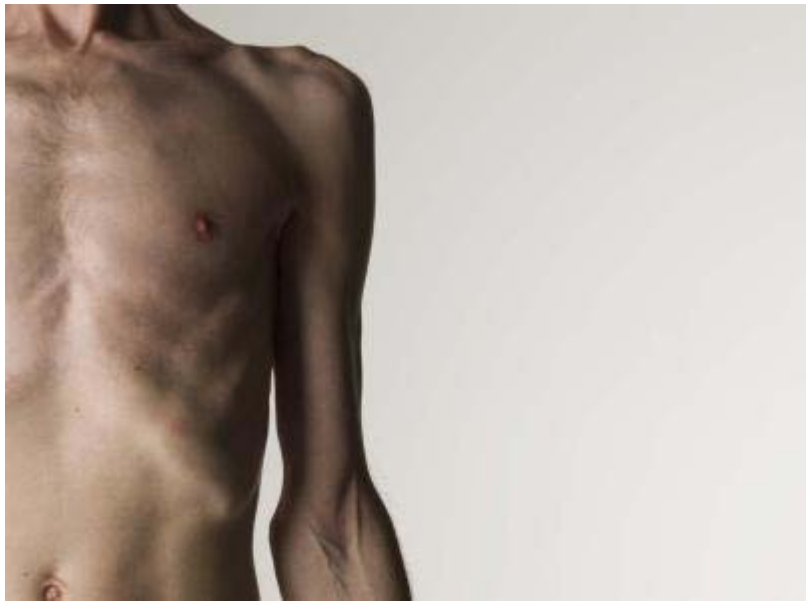
- Tom Stocks is a 62 year old gentleman with an 11 year history of type 2 diabetes
- He has been managed by his general practice since diagnosis
- Significant weight loss over the last 12 months
- Tx: metformin 850mg tds; gliclazide 160 mg bd; sitagliptin 100mg
- c/o ‘funny do’s’ sometimes before lunch or late afternoon

Consultant view

Dr Paul Jennings

Red flags from referral

- Wt loss



- Possible hypoglycaemia

Causes of hypoglycemia in adults

Ill or medicated individual
1. Drugs
Insulin or insulin secretagogue
Alcohol
Others (Table 2)
2. Critical illnesses
Hepatic, renal, or cardiac failure
Sepsis (including malaria)
Inanition
3. Hormone deficiency
Cortisol
Glucagon and epinephrine (in insulin-deficient diabetes mellitus)
4. Nonislet cell tumor
Seemingly well individual
5. Endogenous hyperinsulinism
Insulinoma
Functional $_{\beta}$-cell disorders (nesidioblastosis)
Noninsulinoma pancreatogenous hypoglycemia
Post gastric bypass hypoglycemia
Insulin autoimmune hypoglycemia
Antibody to insulin
Antibody to insulin receptor
Insulin secretagogue
Other
6. Accidental, surreptitious, or malicious hypoglycemia

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Possibilities

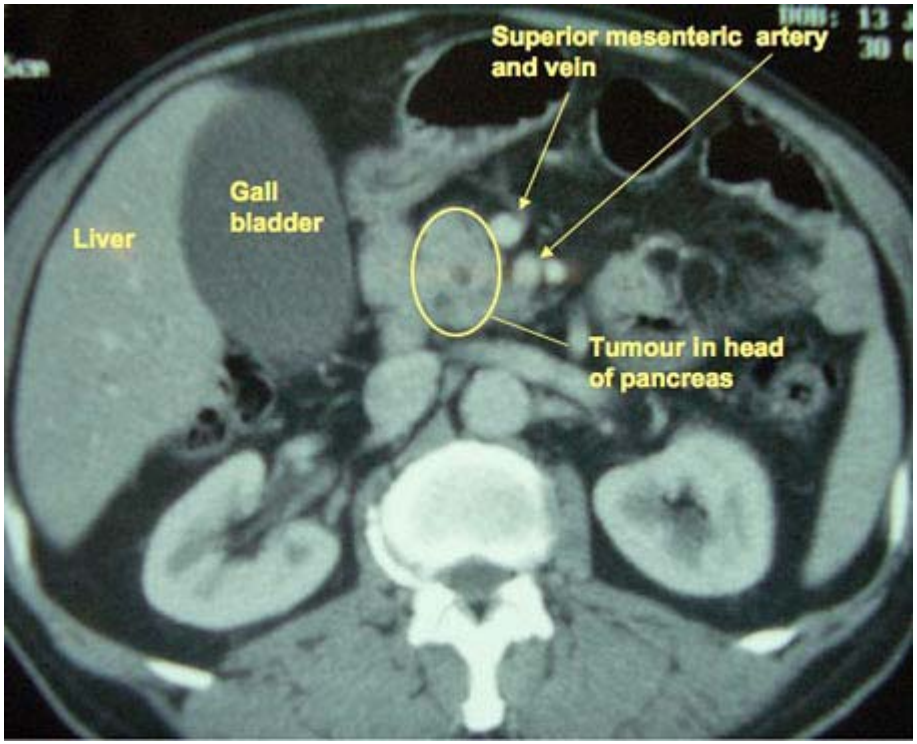
- Diabetic Cachexia
- Drug interactions
- Systemic illness
- Tumours
  - T2DM have increased risk of Breast, Colon, Endometrial and Pancreatic Cancer.

Further Investigation

- Liver, renal and thyroid Screen
- FBC and Inflammatory markers
- CXR
- Detailed imaging to demonstrate and stage any potential tumours

Results of Investigations

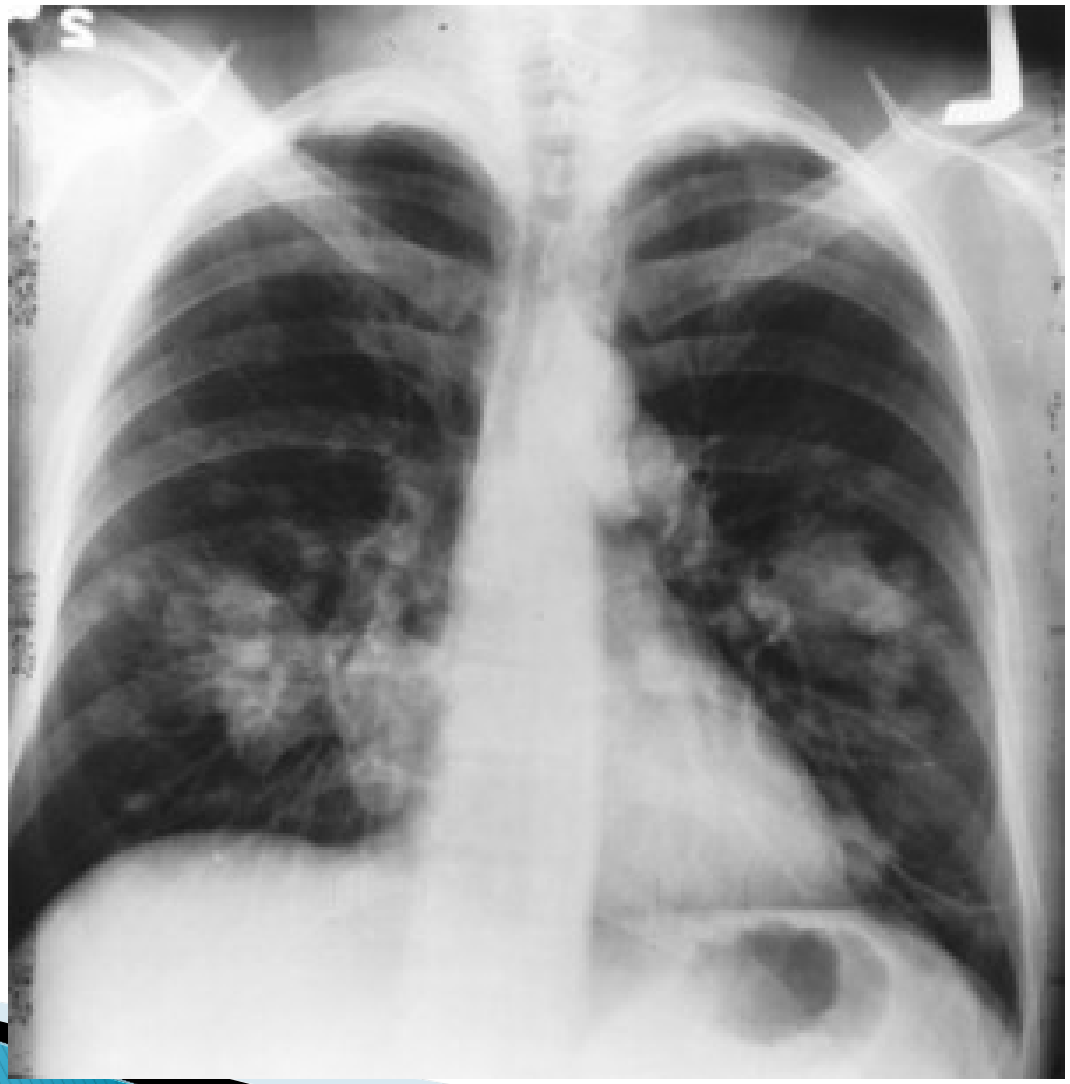
- Localised Pancreatic Tumour



Importance of Hospital In-Patient Diabetes team Peri-operatively

- Prepare patient for need for insulin infusions during and immediately after surgery.
- Probable need for insulin after surgery due to
  - Initial Parenteral feeding regimes
  - Optimise glucose levels to < 8mmol/l for speedy recovery
  - Instigate home blood glucose monitoring and an understanding of insulin adjustments
  - Educate for instant adjustments to cope with chemotherapy, nausea, steroid use, intercurrent infections etc
  - Potentially use a bd or basal bolus insulin regime

Follow up after chemotherapy completed



Transition to Palliative Care with disease progression.

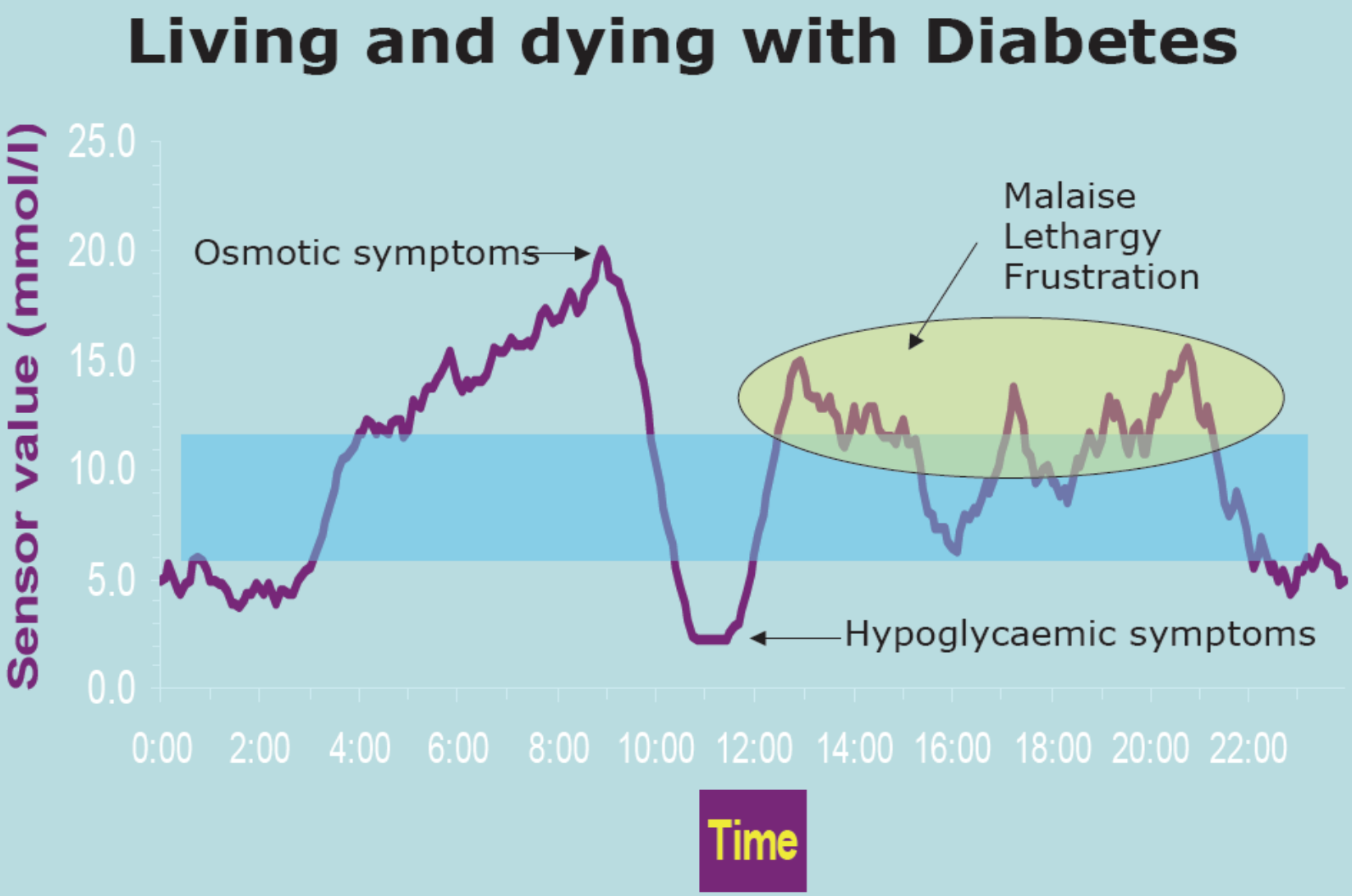
- Ensure that diabetes does not cause dying to be uncomfortable

  - Minimise diabetic symptoms
  - Avoid risk of hypoglycaemia
  - Finger pricking to a minimum

Problems caused by diabetes at the end of life.

- Poor nutrition risking hypoglycaemia
- Reduced exogenous glucose due to glycogen depletion
- Defective hypoglycaemic awareness due to pain control and other drugs
- Defective counter regulation either due to the terminal disease or drug side-effects
- Reduced renal clearance of insulin and other drugs

Aim for blood glucose between 5–15 mmol/l



Terminal Care in a patient with Diabetes – a GP's perspective

Dr Andrew Inglis

Priorities in providing best care

- Changing the emphasis (prognosis?)
- Patient choice must be *the* priority
- Psychological effects
- Symptom overlap
- Monitoring
- Adjusting/withdrawing therapies
- CARE PLANNING/MULTIDISCIPLINARY TEAM

Changing the emphasis of care

- Depends primarily on patient desire and prognosis
- Maintain comfort and quality of life
- Are (tight) control of BP and lipids relevant or desirable?
- Relax glycaemic control, dietary restrictions and monitoring?
- Review management regularly in light of changes in renal/liver function and weight.

Psychological changes

- Good communication between patient, family and care team
- Patient may want to relax treatment regime to reduce pill burden and/or reduce anxiety about LTC management
- *Or* patient may feel that reducing/withdrawing treatment results in a loss of control of condition or an admission of defeat
- Consider underlying diagnosis of depression

Overlapping symptoms

- Are the patient's symptoms caused by their diabetes, their cancer, or something else?
- Multiple possible causes of symptoms such as thirst, fatigue, nausea, sweating.
- Relaxing glycaemic control may increase risks of thrush, infection, delayed wound healing.
- Undiagnosed hypoglycaemia?

Monitoring

- Discuss and agree role of home monitoring – blood/urine/none
- Agree target HbA1c or glucose levels?
- Patient and family may need additional explanation and reassurance about changing targets.

Adjusting/withdrawing therapies

- Informed choice guided by patient
- Glycaemic control: Metformin, Sulphonylureas, Gliptins, GLP-1 analogues, Insulin type/doses/delivery method
- Cardio-protective therapies: ACEI/A2RA, Statin, Aspirin
- Effects of Steroids – predictable?
- Sick day rules

GP perspective summary

- Management of Diabetes in terminal illness is complicated and differs between patients.
- The patient must be allowed to make informed choices about their care including at the end of life when they may not be able to express their wishes.
- A multidisciplinary team approach with care planning and regular review is vital.

Julie Dale

Clinical Nurse Specialist in
Palliative Care

NHS
End of Life Care

The Aim of The National End of Life Care Strategy

To ensure high quality care for all reaching the end of life.

Key Principles

To be treated as an individual

To receive equity of service provision

Receive high standards of care

To involve patients and public in services

Consideration to dignity

What the End of Life Care Strategy means for patients and carers (July, 2008)

You will have access to:

The opportunity to discuss your personal needs and preferences with professionals who can support you. You will have the opportunity for these to be recorded in a care plan so that every service which will be involved in supporting you will be aware of your priorities. Your preferences and choices will be taken into account and accomodated wherever possible.

Suggested tools to deliver high quality end of life care

Gold Standards Framework – because 90% of the patients last year of life will be spent at home

Preferred Priorities for Care Document – page 6 invites patients to write down their questions i.e. “How will you manage my diabetes at the end of my life?”

Liverpool Care Pathway – some locally adapted versions contain useful algorithms regarding diabetes management at EOL

Useful resources for end of life discussions

Coping with advanced cancer

End of Life – The Facts

Planning for your future care

With the individuals agreement, discussions should be:

Documented and regularly reviewed

Communicated to key persons involved in their care

If the individual wishes, their family and friends may be included.

Main aim of End of Life Care Strategy – “a good death”

Treated with dignity and respect

Without pain or other symptoms – 5 most common end of life symptoms are pain, nausea and vomiting, agitation, breathlessness and troublesome secretions

In familiar surroundings with family and / or friends

Because

How people die remains in the memory of those who live on – Dame Cicely Saunders
Founder of the modern hospice movement