Anti-Diabetic Therapy Guidelines for Type 2 Diabetes Mellitus

NHS Lothian

BMI > 25mg/m² (or >23.5 for some populations – see below*)

NO

Reconsider if diagnosis of type 2 diabetes is correct

Treatment options include :

- **Oral Gliclazide**
- **SC insulin**

Review comorbidities

Established ASCVD
or
Chronic symptomatic HF
or
eGFR 25-75 + urine ACR >23 mg/mmol

YES

First Line

Metformin up to 2 g daily
As soon as tolerability determined add (or replace with if intolerant/contraindicated)
Dapagliflozin 10mg od

NO

First Line

Metformin up to 2g daily

(eGFR 30-44 = max 1g daily)

If not reaching target within 3-6 months review adherence then

Second Line

Dapagliflozin 10mg daily

If not reaching target within 3-6 months review adherence then

Third line Line

Oral Semaglutide up to 14mg daily OR SC Semaglutide (up to 1mg) /Dulaglutide (up to 4.5mg) weekly#.

If not reaching target within 3-6 months or intolerant, review adherence then

Fourth Line (secondary care initiation only)

Stop Dulaglutide/Semaglutide and start Tirzepatide SC 2.5mg weekly titrating to 5mg weekly after 4 weeks if tolerated $

Refer/seek advice from secondary care if:

- **Uncertainly about cause of diabetes**
- **Patient has suboptimal glycaemic control despite maximum tolerated oral therapy**
- **Female considering pregnancy**

ASCVD = atherosclerotic cardiovascular disease

All medications (except metformin and insulin) are contraindicated in women of reproductive age who are not using adequate contraception

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*** BMI**	People with a South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean family background are prone to central adiposity and their cardiometabolic risk occurs at lower BMI. • overweight: BMI 23 kg/m^2 to 27.4 kg/m^2 • obesity: BMI 27.5 kg/m^2 or above.
# GLP1a availability	Availability of these drugs is unreliable at the time of writing. Up to date advice on prescribing recommendations can be found on MCN website. https://services.nhslothian.scot/diabetesservice/information-for-health-professionals/prescribing-information/
$Tirzepatide	Tirzepatide uses pen device which contains 4x weekly doses. Needles are not supplied and so 4mm needles should be prescribed in addition. Dose titration: Initially 2.5 mg once weekly for 4 weeks, then increased to 5 mg once weekly for at least 4 weeks. Review 6 monthly. **When escalating dose this should be in steps of 2.5 mg at intervals of at least 4 weeks.** **Patients on sulphonyluea therapy and those on insulin will be at higher risk of hypoglycaemia and should monitor appropriately, including before driving. Dose reduction will likely be required.** **There is limited information about the effect of tirzepatide on the pharmacokinetics and efficacy of oral contraceptives in women with obesity or overweight. Since reduced efficacy of oral contraceptives cannot be excluded, it is advised switching to a non-oral contraceptive method, or add a barrier method of contraception upon initiating tirzepatide therapy (for 4 weeks), or after each dose escalation (for 4 weeks).**
Metformin	Consider slow-release preparation if gastrointestinal side effects Should only be continued if eGFR <30 mL/min/1.73m² under specialist supervision
SGLT-2 inhibitors (e.g. Dapagliflozin/ Empagliflozin)	Increased risk of genital infection Risk of euglycaemic ketoacidosis; require clear guidance to stop treatment if intercurrent, dehydrating illness. Dapagliflozin should be initiated with specialist supervision if eGFR <25 ml/min, but once initiated can remain on treatment until dialysis. Dapagliflozin should be reduced to 5mg in severe hepatic impairment. There is no requirement to switch patients to dapagliflozin if established on another SGLT-2 inhibitor 'flozin' drug.
Semaglutide/ Dulaglutide	Gastrointestinal side-effects; caution if previous pancreatitis Can worsen diabetic retinopathy, discuss with local diabetes team if pre-existing retinopathy. For oral therapy take on an empty stomach with small glass water and avoid food, drink or other oral medication for 30mins. Once weekly injectable GLP-1 agonists are an alternative if adherence to oral administration guidance is difficult. May need reduction of insulin or sulphonylureas.
DPP4 inhibitors (e.g. Sitagliptin)	Less effective than alternate therapies and lack evidence for reducing/preventing complications. Use only use if other therapies are contraindicated
Sulphonylureas (e.g. Gliclazide)	Moderate to high risk of hypoglycaemia, particularly in the elderly. Patients should have education around hypoglycaemia symptoms and treatment and blood glucose monitoring to be performed if symptoms occur. DVLA consider it good practice to monitor blood glucose at times relevant to driving