Oral Anti-Diabetic Therapy Guidelines for Type 2 Diabetes Mellitus

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
HFrEF
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

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

Weekly SC Semaglutide (up to 1mg) or Dulaglutide (up to 4.5mg). Can use oral semaglutide up to 9mg if required #.

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

Fourth Line

Tirzepatide up to 15mg SC weekly

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

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

*** 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. If unable to commence GLP1a SC due to practice facilities, oral semaglutide can be used. please consult MCN guidance on alternatives during shortage. https://services.nhslothian.scot/diabetesservice/information-for-health-professionals/prescribing-information/
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	Increased risk of genital infection Risk of euglycaemic ketoacidosis; require clear guidance to stop treatment if intercurrent, dehydrating illness. Dapaglaflozin should be initiated with specialist supervision if eGFR <25 ml/min but once initiated can remain on treatment until dialysis. Dapaglaflozin should be reduced to 5mg in severe hepatic impairment. For patients establisted (link for SGLT2i patient leaflets)
Semaglutide	Gastrointestinal side-effects; caution if previous pancreatitis Can worsen diabetic retinopathy, discuss with local diabetes team if pre-existing retinopathy. 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, only use if other therapies are contraindicated
Sulphonyl Ureas	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.