



**PROPOSED REVIEW OF SIGN GUIDELINE 2005  
CONSULTATION FORM**

Title of guideline	SIGN 55: Management of diabetes
Date of publication	2001
SIGN scoping search – sources	<p>MeSH headings for the condition specified, plus any common variations as free text</p> <p>Sources: <b>Guidelines:</b> NICE; National Library for Health guidelines finder; National Guidelines Clearinghouse; GIN Web site. <b>Technology appraisals:</b> NICE; UK HTA database (Southampton); INAHTA database. <b>Cochrane reviews:</b> Cochrane library.</p> <p><b>Other good quality systematic reviews:</b> UK HTA database (Southampton); DARE.</p> <p><b>Individual studies:</b> Embase and Medline. Date of publication - 2005.</p>
SIGN scoping search - summary	<p><b>Guidelines</b> – numerous</p> <p><b>HTAs</b> – 4</p> <p><b>Cochrane reviews</b> – 17</p> <p><b>Other good quality systematic reviews</b> – 23</p> <p><b>Individual RCTs</b> – 5 major studies in last 2 years</p>
Other guidelines/HTAs	<p><i>There are a large number of guidelines available on diabetes: This is a selective list focusing on recently published guidelines from developers known to use acceptable methodologies.</i></p> <ul style="list-style-type: none"> <li>▪ <b>Australia. National Health and Medical Research Council.</b> Clinical practice guidelines: type 1 diabetes in children and adolescents. 2005.</li> <li>▪ <b>National Institute for Clinical Excellence.</b> Type 1 diabetes: diagnosis and management of type 1 diabetes in adults. London;NICE:2004. (Clinical Guideline 15).</li> <li>▪ <b>National Institute for Clinical Excellence.</b> Management of type 2 diabetes - Managing blood glucose levels (Guideline G). London;NICE:2002.</li> <li>▪ <b>National Institute for Clinical Excellence.</b> Type 2 diabetes footcare. London;NICE:2004. (Clinical Guideline 10).</li> <li>▪ <b>National Institute for Clinical Excellence.</b> Management of Type 2 Diabetes - management of blood pressure and blood lipids (Guideline H). London;NICE:2002.</li> <li>▪ <b>National Institute for Clinical Excellence.</b> Management of Type 2 Diabetes - Renal Disease, prevention and early management (Guideline F). London;NICE:2002.</li> <li>▪ <b>National Institute for Clinical Excellence.</b> Management of Type 2 Diabetes - retinopathy (Guideline E). London;NICE:2002.</li> <li>▪ <b>New Zealand Guidelines Group (NZGG).</b> Management of type 2 diabetes. Wellington (NZ): New Zealand Guidelines Group (NZGG); 2003.</li> <li>▪ United States of America. <b>American Diabetes Association.</b> Diagnosis and classification of diabetes mellitus. Diabetes Care 2005;28(suppl 1):S37-42.</li> <li>▪ United States of America. <b>American Diabetes Association.</b> Standards of medical care in diabetes. Diabetes Care 2004;27(Suppl 1):S15-35.</li> <li>▪ United States of America. Care Management Institute, Kaiser Permanente. Adult diabetes clinical practice guidelines. Oakland (CA): Kaiser Permanente, Care Management Institute; 2004.</li> <li>▪ United States of America. Institute for Clinical Systems Improvement (ICSI). Management of type 2 diabetes mellitus. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2004.</li> <li>▪ <b>National Institute for Clinical Excellence.</b> Diabetes (type 1) - insulin pump therapy. London;NICE:2003. (Technology Appraisal 57)</li> <li>▪ <b>National Institute for Clinical Excellence.</b> Diabetes (type 2) - glitazones (review) London;NICE:2003. (Technology Appraisal 63).</li> </ul>

	<ul style="list-style-type: none"> <li>▪ <b>National Institute for Clinical Excellence.</b> Diabetes (types 1 and 2) - long acting insulin analogues. London;NICE:2002. (Technology Appraisal 53).</li> <li>▪ <b>National Institute for Clinical Excellence.</b> Diabetes (types 1 and 2) - patient education models. London;NICE:2003. (Technology Appraisal 60).</li> </ul>
<p>Main conclusions from new evidence</p> <p><i>current guideline content given in italics</i></p>	<ul style="list-style-type: none"> <li>▪ Home-based management of children at onset of diabetes may be as safe as hospital-based management. <i>Guideline recommends home based management as an appropriate alternative (C).</i></li> <li>▪ Educational and psychosocial programmes for adolescents result in modest improvements across a range of outcomes but improvements are often not sustained. <i>Cognitive coping strategies (A) and parental and family communication (B) recommended.</i></li> <li>▪ No evidence that treatment or level of control of Type II diabetes influences cognitive function. <i>Not discussed in guideline.</i></li> <li>▪ Group-based training for self-management strategies in people with type 2 diabetes results in better diabetes management. Self-monitoring of blood glucose may be effective in improving glycaemic control in patients with type 2 diabetes who are not using insulin. Self-management education improves GHb levels at immediate follow-up, and increased contact time increases the effect. <i>Compliance is discussed for specific issues, eg dietary management or exercise.</i></li> <li>▪ Simple application of a single daily insulin injection in addition to oral hypoglycaemic agents may facilitate the initiation of insulin therapy in type 2 diabetes mellitus. <i>Issue not discussed.</i></li> <li>▪ Herbal medicines should not be recommended for routine use in diabetic patients of type 2 diabetes. <i>Not discussed.</i></li> <li>▪ Care by diabetes nurses has not been shown to improve health or quality of life outcomes for people with diabetes in the long-term. <i>Not discussed.</i></li> <li>▪ No high quality data on the efficacy of diet alone exists for treatment of type 2 diabetes mellitus. <i>Diet is discussed in terms of risk reduction rather than treatment.</i></li> <li>▪ Fluoxetine, orlistat and sibutramine can achieve modest short-term weight loss when used as a primary weight reduction strategy among adults with type 2 diabetes. <i>Weight loss not discussed explicitly.</i></li> <li>▪ There are no substantial differences in the safety and efficacy between insulin species. Short acting insulin analogues are almost identically effective to regular human insulin in long term glycaemic control and are associated with similar episodes of low blood sugar. <i>Not discussed.</i></li> <li>▪ Inhaled instead of injected short-acting insulin appears no more effective for glycaemic control but may be preferred by people with diabetes. Glycaemic control is better during continuous subcutaneous insulin infusion compared with optimised injection therapy, and less insulin is needed to achieve this level of strict control. <i>Not discussed.</i></li> <li>▪ The best way of identifying and treating women with abnormal blood glucose tests in pregnancy is not known. <i>No recommendations made in this area.</i></li> <li>▪ Simvastatin significantly reduces the risk of major vascular events for diabetic patients without coronary heart disease at any initial low density lipoprotein concentration. <i>Guideline recommends lipid lowering should be considered in patients with type 2 diabetes without evidence of neuropathy when 10 year risk of major coronary event is <math>\geq 30\%</math> (D) and at a lower risk threshold for those with neuropathy (D).</i></li> <li>▪ In type 2 diabetes, there are improvements in long-term glycaemic control and psychological distress but not in weight control or blood glucose concentration in people who receive psychological therapies. <i>Guideline recommends that clinical interventions aimed at dietary change are more likely to be successful if a psychological approach based on a theoretical model is included (B). Not discussed in relation to QoL.</i></li> <li>▪ Metformin has multiple benefits in patients with type 2 diabetes. It can effectively lower HbA1c values, positively affect lipid profiles, and improve vascular and</li> </ul>

	<p>haemodynamic indices. <i>Guideline recommends Metformin as the first line oral hypoglycaemic agent in overweight patients with diabetes (A).</i></p> <ul style="list-style-type: none"> <li>▪ ARBs have not proved to be superior to standard anti-hypertensive treatment in diabetic patients. <i>Guideline recommends that patients with microalbuminuria or proteinuria should be considered for AIIA therapy (A).</i></li> </ul>
New areas that could be added to the guideline	<ul style="list-style-type: none"> <li>▪ Type of insulin and method of delivery</li> <li>▪ Self-management, improving compliance</li> </ul>
Summary of the recommendations that could be updated	<ul style="list-style-type: none"> <li>▪ Recommendation on Metformin</li> </ul>

### Results of consultation

Contributions from:	<ul style="list-style-type: none"> <li>▪ General practitioner x 4</li> <li>▪ Consultant physician x 8</li> <li>▪ Consultant diabetologist x 4</li> <li>▪ Staff grade doctor</li> <li>▪ Diabetes nurse specialist x 2</li> <li>▪ Consultant paediatrician</li> <li>▪ Consultant in diabetes and endocrinology</li> <li>▪ Lay representative</li> <li>▪ Consultant ophthalmologist</li> <li>▪ Consultant paediatric neurologist</li> </ul>
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1(a) Is there still a requirement for an evidence-based guideline on this topic?

Yes - 23

1(b) If no, should the guideline be withdrawn?

2(a) Based on the information given above, and your own clinical judgement, does the guideline require revision in the light of new evidence? *Please give details.*

- Yes – 9
- Continues to be one of the most significant chronic conditions affecting patients. Good management of the condition and its complications are vital in ensuring high quality patient care. Continuing research highlights changes in the way that the condition can be best managed – and we need to ensure that all health care professionals are kept aware of this.
- Multiple randomised trials of reducing CVD risk and control of glycaemia, comparisons of different strategies
- Role of new therapies ie glitazones. Primary prevention revised and not covered in previous guideline
- The children and young person section already had very little research available – hence the low quality of recommendations made in the guideline. Other sections may have more new research available, much of which may be relevant to the young person section (eg insulin dev.) but perhaps not specifically
- 1. Diagnosis 2 Insulintherapy 3. Psychological support.
- Lipids, EIE screening, insulin pumps, new oral agents etc
- Glucose intervenes strategy in type 2
- Use of agents to promote WT reduction.
- Some sections require revision more urgently e.g. cardiovascular in particular. The lifestyle section could be expanded to include other areas although there is not a great deal of new evidence for the existing areas covered.
- All areas need to be reviewed.
- New evidence and new guidelines including from Australian and N. America should be considered.
- I feel simvastation and metformin information needs to be added.
- I think revision in the areas suggested would be needed
- In my view the conclusions that can be drawn from the new evidence would be beneficial to people with diabetes
- My recommendation is that selected elements of the guideline are reviewed, particularly the evidence about simvastatin as although the evidence appears to be compelling it has not made it through to routine clinical practice.
- Some not many parts.
- Updating the evidence would be worthwhile

- There are some new advances but nothing major
- Selective revision – especially statins for all type 2, hypertension including ARB's, the 2 new areas suggested, links to SIGN CHD and to Scottish Diabetes Network

2(b) Do you agree with the assessment of the impact of the new evidence and its likely effect on recommendations?

- Yes – 11
- Overall yes
- Some of the conclusions mentioned are debatable.
- There is likely to be new evidence on OHAs (pisqhtoyone) soon that may be important.
- Haven't got a copy of the guideline to hand but it seems likely
- It is very important to assess new evidence with accepted methodology. Areas requiring more attention and/or upgrading include 1. Insulin pump therapy 2. lipid lowering 3. evidence for optimum therapy in young type 1 patients with evidence from Scandinavia is to be included.
- The new evidence cited in the reviews is already out of date. By time NICE comes up with a guideline much more evidence has come to light.
- Multiple recommendations so cannot comment
- No – 1 – cardiovascular trawl does not deal sufficiently with hypertension in diabetes.
- There is nothing listed about feet

3 Please list any additions to the remit of the guideline that you think would be beneficial

- Almost every component part requires revision. I think an addition on diabetes care in patients from ethnic minority groups is required
- DIGAMI 2 and management of glucose levels across ACS
- The guideline has enough sections
- Glitazones – lipid management other than cholesterol
- Original guideline had no recommendations on glucose control and this would be a useful addition
- While I appreciate the guidelines are evidence-based, there seems almost no allowance for areas of important care advice (egg to non specialists/gps) who still need clear guidance as to best practice. This situation is difficult to address
- Methods of patient education – T.I. and metformin
- Use of statins
- See above 2a
- Structured education, weight reduction, insulin pumps, statins, blood glucose monitoring.
- More on structured education and group education. Advice on oral agents (not covered at present). Advice on insulin regimes for type one and two.
- Data on TDL's and inhaled insulin and ELP-1 will be available soon.
- I feel simvastation research findings need to be added
- Some significant new evidence in retinopathy
- The 2 new areas suggested

4 Please tick your preferred option for reviewing this guideline

a. there is no new evidence that will affect existing recommendations and the guideline should not be reviewed at this time

b. some recommendations will change in the light of the new evidence and selected elements of the guideline should be reviewed

c. the entire guideline should be reviewed

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