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Key Considerations of Once-weekly Basal Insulin in Clinical Practice

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Dr. Tsimikas:
This is CME on PACE CME and ReachMD, and I'm Dr. Athena Philis-Tsimikas, and here with me today is Dr. Melanie Davies. And we are going to be speaking about a case that involves once-weekly insulin in a situation that you might encounter in your environment as well.

Melanie, could you tell us a little bit about a case that might require insulin, and we can have a discussion about this over the next 5 to 7 minutes?

Dr. Davies:
So, Athena, thank you. And I think this is a scenario that we often see in the clinic.

So, I'll talk about a hypothetical case, but it really represents a person living with diabetes that we see all the time. So, Mary is in her mid-50s. She was diagnosed with type 2 diabetes around 5 years ago, and if we look at what's happened just in terms of her HbA1C over time, we see a sort of typical scenario. So, she was diagnosed with type 2. Her family practitioner started her on metformin. When she was diagnosed, her A1C was in the high 8%, so about 8.8, and we see a reduction starting with metformin. And she was given, I think, good advice about lifestyle, healthy eating, all of the things that we would expect to happen. We see the A1C fall, but then it starts to rise again. So, the family doctor intensifies treatment, thinks about sulfonylurea, which is something easily accessible. The sulfonylurea was started, and the dose was titrated up, and we see some benefit in HbA1C. But by three years into her type 2 diabetes, the A1C has started to rise again.

At this point, the SGLT-2s are available and commonly used, and so she was started on an SGLT-2 inhibitor. And that resulted in some improvement in the HbA1C, and it comes down to around 7.5%, but then starts to increase again and is again, around 8-and-a-half-percent. And at that time, a GLP-1 therapy is introduced, but unfortunately, Mary is not able to tolerate a GLP-1 and that's stopped. And then, by five years in diagnosis, we see the A1C start to rise and it's around about 9%, and she's already on triple oral therapy. And that's when, I think, we're faced with the conversation with her about commencing insulin.

Dr. Tsimikas:
You present a common scenario and so many things around this that I think all of us have to think about. You're adding medications, the A1C initially does better, but then rises again. And of course, we're thinking about the complications that could occur for the more prolonged time period that her A1C is elevated. I'm not so sure that Mary is necessarily thinking about that. It sounds like she has been educated, which is great. But sometimes, some of those moments of education don't necessarily sink in.

Or there might be fear associated with what the next steps are, and that's what's preventing her from continuing to what might be

needed as a next step. In addition, I think you and I may feel comfortable with adding insulin, which is really the next step that's needed here. But sometimes primary care physicians are not so comfortable with that. So, overcoming that hesitancy from the physician side as well needs to be overcome.

Additional referral to the educator and have the discussion together with Mary could help. In our situation, if it's any other fear or other emotional barrier, we happen to have a psychologist that's part of our team and we always offer that referral if needed. And then, of course, a referral to an endocrinologist if needed.

But if not, if Mary is open to starting insulin at this time, I do think that is probably the next best step. And now, with these new insulins available, new once-weekly insulins, coming down the pike, this is an option that maybe can address a few of those concerns that she might have, that the provider might have, and allow it to be a little bit easier to start insulin.

Dr. Davies:
So, Athena, I completely agree, and I think one of the discussion points is about that greater convenience, the improved quality of life in terms of it feeling less overwhelming moving to a weekly injection rather than a daily injection. And clearly, that was one of the issues that she was keen to discuss. And I think it can make it much easier for individuals, the thought of a weekly injection rather than a daily injection.

Dr. Tsimikas:
Yeah, that sounds good. Well, hopefully we'll get Mary on her insulin and get her on her way.

Melanie, thanks so much for joining us today. That was a great case and a great discussion. It’s been a pleasure, and hopefully this will help our audience as well when they think about starting insulin in their patients with type 2 diabetes.

Announcer:
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