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Getting Ahead of Hypoglycemic Emergencies: Counseling Strategies for High-Risk T2D Patients

Announcer:
You're listening to ReachMD, and this episode of Diabetes Discourse is sponsored by Lilly.
Here's your host, Dr. Charles Turck.

Welcome to Diabetes Discourse on ReachMD. I'm Dr. Charles Turck and joining me to discuss how to get ahead of hypoglycemic emergencies and share counseling strategies for patients with high-risk type 2 diabetes is Dr. Alexis McKee. She's a practicing endocrinologist and an Assistant Professor of Medicine at Washington School of Medicine in St. Louis, Missouri. Dr. McKee, welcome to the program.

Dr. McKee:
Oh, thank you so much. I'm happy to be here.

Dr. Turck:
Dr. McKee, to start us off, would you give us an overview of glycemic control in patients with type 2 diabetes?

Dr. McKee:
Sure. So, I think we've kind of shifted a little bit to really focusing on the patient sitting across from us and individualizing diabetes care to that patient. And whenever I see somebody in my clinic or in the hospital, I'm looking at a lot of different things like age, maybe life expectancy, comorbidities, polypharmacy and other things and that kind of informs where I'm gonna target their hemoglobin A1C level and try to minimize hypoglycemia while still maintaining good glycemic control but trying to avoid the low blood sugars at all costs.

Dr. Turck:
Now, let's focus on hypoglycemia. What do we need to know about this medical emergency in patients with type 2 diabetes?

Dr. McKee:
So what I see at least, and I've been on service a lot this month, so I've been talking to patients quite a bit about it. Our patients with type 2 diabetes on multiple daily injections of insulin are really at high risk of hypoglycemia. And at least my experience is when we use fixed doses of prandial insulin, it can be really, really difficult for patients who are eating various amounts of carbs at different meals and if they eat less carbs on their fixed dose then they drop low, that's a real concern for me. What I've been doing in my practice at least is trying to see where I can swap out prandial insulin, usually not started by me but by somebody else for other therapies like let's invite the metformin back in that was stopped for reasons I don't know, but I make sure they have no contraindications to it, or let's use a GLP1 receptor agonist, which are very potent and I balance that against the side effects of nausea, or SGLT2 inhibitors, which are great medications. And both the GLP1s and the SGLT2s have cardiovascular and renal outcome data, so we really should be prioritizing those over prandial insulin. So I do my best to kind of switch things around and simplify the regimen for the patient and also look at the potency of the A1C lowering and minimize risk of hypoglycemia. I really rarely prescribed sulfonylureas anymore. You know, this day and age, I teach my fellows there really only two pros for that class and it would be that they're oral and they're inexpensive, but beyond that, I can't find much else good to say about them.

Dr. Turck:
How does the risk of hypoglycemic emergencies differ in patients with high-risk type 2 diabetes?

Dr. McKee:
I just think it's kind of a topic that's maybe isn't discussed as much. I mean, I think people remember maybe more so to talk about the

risk of hypoglycemia with type 1. But in type 2 I think it might often be missed. One of the things that we've done at Barnes-Jewish Hospital here where I work, where the Washington University physicians work, is create a discharge order set and patients leaving the hospital on insulin do get backup glucagon and whether that's the nasal BAQSIMI or Gvoke or the standard, glucagon kit, we try to incorporate that into their discharge plan. And the diabetes educators teach their family members how to use whichever is covered. And then we also incorporate instructions for how to treat low blood sugars the fifteen by fifteen rule. So I counsel my patients if you're below 70, you take 15 g of carbs and repeat your blood sugar 15 minutes later and keep repeating that plan until you're above 70. So I make sure they know to have glucose tablets at home four tablets is 15 g. But I also go over things like, you know, even six large jellybeans or a tablespoon of sugar or a half a cup of juice, so whatever they can have around the house just so we have some sort of plan with how to deal with low blood sugars. But I do think it's something that we often overlook with type 2 and think more so about discussing with our patients with type 1.

Dr. Turck:
For those just tuning in, you're listening to Diabetes Discourse on ReachMD. I'm Dr. Charles Turck and today I'm speaking with Dr. Alexis McKee about how to get ahead of hypoglycemic emergencies and counseling strategies for high-risk type 2 diabetes patients.

Dr. McKee, let's talk about prevention strategies. What can we do to help our high-risk type 2 diabetes patients avoid hypoglycemia emergencies?

Dr. McKee:
I'm a big proponent of diabetes technology. I could read about diabetes technology all day. So, whoever I can get on a continuous glucose monitor, whether it's a flash CGM or continuous CGM, they are on it. And those are life-saving devices, and we are seeing more and more benefit in patients who have type 2, maybe not even on insulin, sort of like this Santa Claus effect where the patient feels like someone is watching them. They're really trying to do better. So people are on CGM and certainly if they're very high-risk and they have hypoglycemia unawareness, this is very, very important. The ability to share the CGM with their loved ones, family and friends. You know, I've had patients whose family members travel, you know, the wife's in town and the husband's traveling, but he wants to be able to check on his wife from afar and make sure that nothing happens. And I mean, that peace of mind is invaluable.

Some of the other things I make sure to go over with patients and I was doing this in the hospital yesterday with someone young in their twenties, we can't forget to talk about things like alcohol. If we're having alcohol and we're out at a party or dinner, that can cause low blood sugars. And remember that the type 2 population is really exploding in young people so something we have to think about. We're gonna see more patients on insulin at a younger age. And young people, you know, do lots of crazy things, but we have to counsel people to watch their blood sugars and make sure they're, you know, they might need to eat food while they're drinking and so on and so forth.

And then the other thing that I do is really encourage physical activity with our patients, and my patients, especially. I want them to be able to do all of the things that, you know, they envision and being active and exercising safely. So one of the things I have learned about when I was a fellow at Endo Society was this website called excarbs.sansum.org by Mike Riddle and his group and you can put in like what insulin you're taking, what exercise you're gonna do, and it'll give recommendations for how to achieve that exercise safely. So I think those are important things to cover with patients. I make sure to tell them if you're a weight-lifter and a runner, try to do weight-lifting first, then the cardio so that your blood sugar doesn't drop so quickly. But we really want to, as much as we can, decrease the burden of diabetes for our patients; let them be able to do all the things that they wanna do and still have safe blood sugars.

Dr. Turck:
Are there any counseling strategies you would recommend to help patients manage and treat this medical emergency?

Dr. McKee:
So, I have really been a big fan of the nasal glucagon, the BAQSIMI. So I've made sure that patients, you know, have all the tools that they need to be able to treat the lows themselves without causing a reactive hyperglycemia. But I also make sure that their family members are comfortable giving glucagon. And we have to remember that, you know, if you're never used a needle or have needle phobia, the nice thing about the BAQSIMI is that it's just a nasal spray. And that's really easy, people can comfortably give that to somebody, god forbid that they are unable to treat themselves and have a severe low. I really make sure that's prioritized. Or the Gvoke, which is really easy to administer as well. So everybody on my patient list and in the hospital who are on insulin leave with some form of glucagon.

Dr. Turck:
And finally, Dr. McKee, are there any take-aways you'd like to leave our listeners with?

Dr. McKee:

I think we can't forget in our patients who have type 2 on insulin to cover hypoglycemia management. A quick dot phrase that you can drop in the after-visit summary or a sheet that you can pass out and ADA has great things and ADCS has great resources. The fifteen by fifteen minute rule and making sure that they have backup glucagon and a plan for how to deal with this, it really will keep them safe and hopefully out of the hospital and prevent any adverse events.

Well, I want to thank you, Dr. Alexis McKee for coming on to discuss hypoglycemia and strategies for helping our patients at high-risk for type 2 diabetes. Dr. McKee, it was great having you on the program.

Dr. McKee:
Thank you so much for having me. It was wonderful.

Announcer:
This program was sponsored by Lilly. To revisit any part of this discussion and to access other episodes in this series, visit ReachMD.com/diabetesdiscourse where you can Be Part of the Knowledge. Thanks for listening.