

# Type 2 DM – Glucose Control

## DM DX – at least two (same or combination)

1. FPG  $\geq$  126
2. 2° (OGTT)  $\geq$  200
3. Non-fasting lab glucose  $\geq$  200 with symptoms

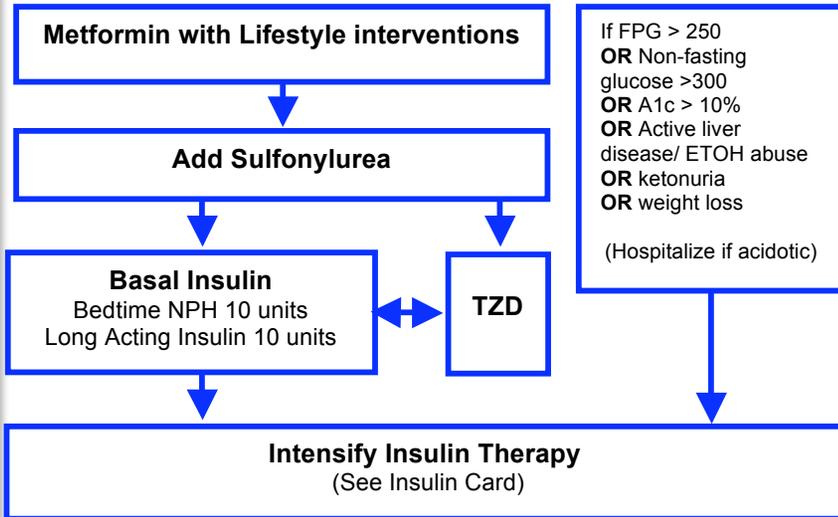
## Impaired Fasting Glucose = FPG 100-125

Impaired Glucose Tolerance = 2° OGTT 140-199

## DM BG Targets

Premeal: < 70-130  
 2°PP: <160-180  
 A<sub>1</sub>C: 6.5-7%

Individualize if elderly  
 or co-morbidity



## Immunizations

Pneumovax—At Dx & again at age 65  
 (if  $\geq$ 5 yrs. since 1<sup>st</sup> shot)  
Flu shots yearly  
Td /Tdap (routine)  
PPD once after Dx of DM (Pos is  $\geq$ 10mm)

## Don't Forget

Glucose toxicity— Insulin production ↓'s if prolonged hyperglycemia; insulin shots short-term reverse this.  
Pancreatic Exhaustion— Almost all Type 2 diabetics will eventually require insulin.

## Monitoring of DM

A1c every 3 months  
 Creatinine and GFR yearly  
 UA yearly  
 Microalbumin yearly  
 Lipid Panel yearly  
 EKG every 2-5 years  
 Complete Foot Exam yearly  
 - Foot inspection each visit  
 Retinopathy exam yearly  
 Paps, Mammograms,  
 Contraception  
 Evaluate sexual function  
 Depression, Tobacco, ETOH,  
 DV screening yearly

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## Biguanides: Metformin & Metformin XR (Glucophage®)

Start 500 mg daily with meals and increase no faster than 500 mg each week. If GI sx occur may increase more slowly.  
 Max. dose: 2000mg daily or divided with XR tablets. Do not split XR tablets.  
 2500 mg divided BID-TID with regular release tablets.  
 Can decrease weight. Pt. must have normal creatinine (males <1.5, females <1.4), no heart failure or liver disease (check ALT) and no significant ETOH use. Discontinue before surgery or IV contrast dye administration.

## Sulfonylureas: Glyburide (Micronase®) and Glipizide (Glucotrol®)

Start 2.5-5mg daily – Max 10 mg BID  
 Can increase weight and cause hypoglycemia

## Thiazolidinediones: Pioglitazone (Actos®)

Start 15mg daily; may increase to 30mg daily (little benefit dosing over 30mg)  
 Max A1c changes may take up to 12 weeks to occur  
 Check ALT at baseline & periodically. No underlying liver dz or significant ETOH use.  
 Warning: may cause Heart Failure. May use in renal insufficiency. Can cause weight gain.

## Sitagliptin (Januvia®) - DPP-4 Inhibitor

May reduce weight, mild to mod A1c lowering      Dose: 100mg PO daily  
 Reduce dose if  $\geq$  Stage 3 CKD

## Vildagliptin (Galvis®) - DPP-4 Inhibitor

May reduce weight      Dose: 50-100mg PO daily

## Exenatide (Byetta®) - GLP1 mimetic

May reduce weight, mild to mod A1c lowering  
 Start 5 mcg/dose BID      Administer 60 minutes before meals  
Weekly dose (Byetta LA®) is under investigation  
 May increase to 10 mcg/dose BID after 1 month of treatment  
 Do not use if  $\geq$  Stage 4 CKD    Do not mix in same syringe as insulin  
 May be associated with pancreatitis – seek medical care if persistent severe abdominal pain with or without vomiting

## Pramlintide (Symlin®) - Amylin mimetic

Use in Type 2 Diabetes unclear; May consider in Type 1 Diabetes  
 Start 60micrograms daily subcutaneously immediately before a major meal  
 (Reduce preprandial (short acting) insulin by 50% as appropriate)  
 May increase to 120micrograms after significant nausea is gone x 3-7 days  
 Do not mix in same syringe as insulin

Drugs names in *italics* are not on the IHS National Core Formulary

Ref: ADA Clinical Practice Recommendations 2007, 2008  
[http://care.diabetesjournals.org/content/vol30/suppl\\_1/](http://care.diabetesjournals.org/content/vol30/suppl_1/)