

# **Empowering T2D management: The evolution of basal insulin therapy**

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# Expert faculty



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# Discussion 1

## *Understanding clinical inertia in T2D: A multidisciplinary approach*

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*Patient Advocate*



# When to add insulin in type 2 diabetes

## Initiate insulin when:<sup>1,2</sup>

- The patient is experiencing severe hyperglycaemia
- The patient is not at HbA1c target despite maximal non-insulin therapy
- The patient is experiencing acute glycaemic dysregulation
- T1D is suspected

Start using basal insulin (10 units or 0.1–0.2 units/kg/day) at bedtime or more flexibility with timing for longer-acting analogues

Titrate to FPG target but avoid overbasalization of insulin (consider introduction of CGM)

When FPG is at target but HbA1c or TIR is not

If not already on GLP-1RA, consider use of GLP-1RA

### ADD MEALTIME INSULIN AS:

Basal plus (progressive addition of boluses)

Premixed insulins

Multiple daily injections

# Overcoming patient-related barriers to insulin initiation



What questions do you have about insulin?
What frightens you most about diabetes?
How does diabetes affect your day-to-day activities and family?
How do you feel about going on insulin?
What have you heard from other people who use insulin?
Are there any religious beliefs or spiritual values, traditions, or customs that are important to you and may help us work together?
What do you think are the benefits/disadvantages of using insulin?
How do you think insulin might affect your health and lifestyle?
What is your main concern about insulin?

# Discussion 2

## *Evolving options for insulin therapy*

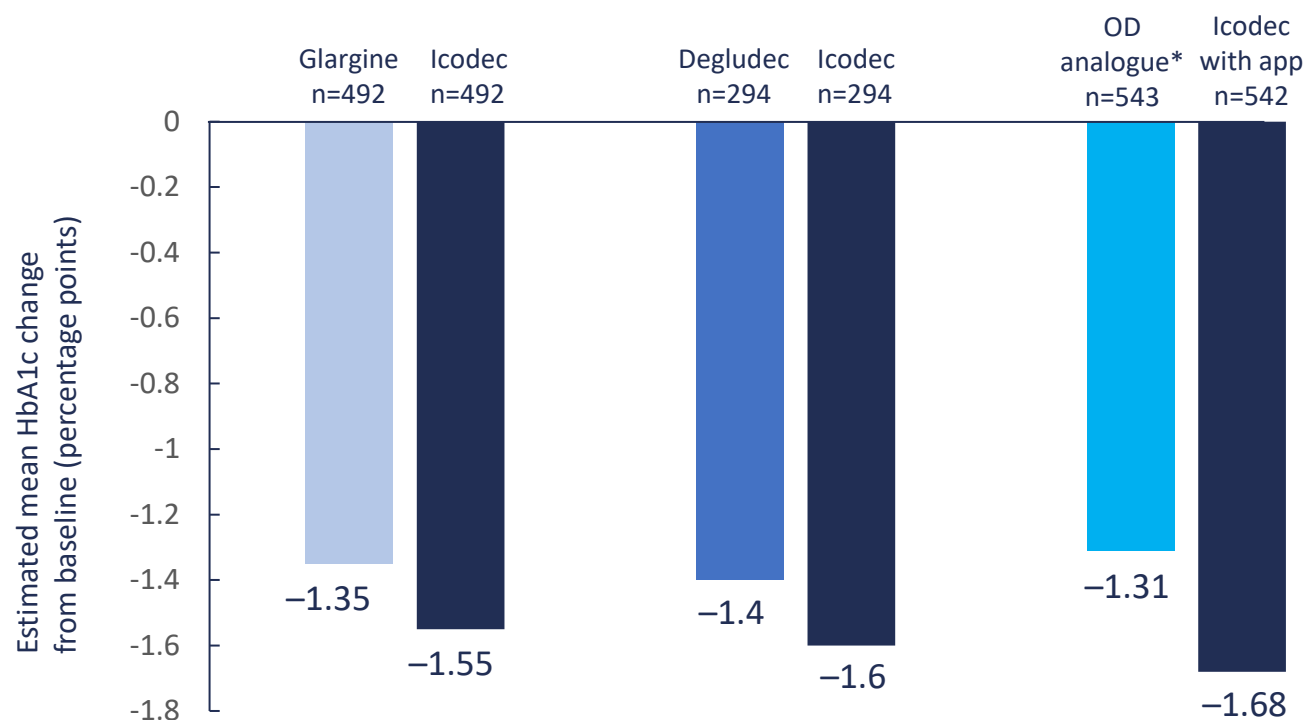
Dr Gihane Zarifa  
*Primary Care Physician*



Prof Tina Vilsbøll  
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# Weekly insulin icodec: Efficacy and safety



Estimated between-group difference confirmed the noninferiority ( $p < 0.001$ ) and superiority ( $p = 0.02$ ) of icodec

Estimated between-group difference confirmed the noninferiority ( $p < 0.001$ ) and superiority ( $p = 0.002$ ) of icodec

Estimated between-group difference confirmed the noninferiority ( $p < 0.001$ ) and superiority ( $p = 0.009$ ) of icodec

## Hypoglycemia episodes: Events per patient-year

### ONWARDS 1<sup>1</sup>

Glargine	Icodec
0.16	0.30

### ONWARDS 3<sup>2</sup>

Degludec	Icodec
0.15	0.31

### ONWARDS 5<sup>3</sup>

OD analogue*	Icodec with app
0.14	0.19

\*once-daily basal insulin analogue (insulin degludec, insulin glargine U100, or insulin glargine U300).  
OD, once-daily.

1. Rosenstock J et al. *N Engl J Med*. 2023;389:297–308; 2. Lingvay I et al. *JAMA*. 2023;330:228–37; 3. Bajaj HS, et al. *Ann Intern Med*. 2023;176:1476–85.

# Best practices for initiating weekly insulin

When to initiate	<ul style="list-style-type: none"><li>• HbA1c remains above target despite dual/triple therapy</li><li>• Already on GLP-1RA, GLP-1RA is not appropriate, or insulin is preferred</li><li>• HbA1c <math>\geq 11\%</math> (97 mmol/mol), symptoms of catabolism, T1D is a possibility</li></ul>
Setting treatment goals	<ul style="list-style-type: none"><li>• "Fix the fasting first" approach</li><li>• FPG targets should be individualized</li><li>• To reach HbA1c of <math>\leq 7\%</math> (53 mmol/mol), FPG should be maintained at <math>&lt;130</math> mg/dL (7.2 mmol/L)</li></ul>
Initial dose and titration	<ul style="list-style-type: none"><li>• Choose a simple patient-directed titration algorithm</li><li>• Start with an initial dose of 10 IU/day (or 0.2 U/kg/day)</li><li>• Increase dose by 1U/day until target FPG is reached</li></ul>
Monitoring	<ul style="list-style-type: none"><li>• Monitor FPG</li><li>• If HbA1c levels are not properly controlled and FPG values are within range, PPG monitoring may be needed</li></ul>
Combination therapy	<ul style="list-style-type: none"><li>• Basal insulin is added to pre-existing therapies</li><li>• May offer advantages, e.g. limiting weight gain, lowering insulin dose, CVD benefits</li><li>• Choice of combination therapy should be individualized based on patient characteristics</li></ul>
Hypoglycaemia	<ul style="list-style-type: none"><li>• Patients at risk of hypoglycaemia should be identified and modifiable risk factors adjusted</li><li>• Less stringent glycaemic goals, additional monitoring or education may be needed</li><li>• After a hypoglycaemic event, identify the cause to prevent future events</li></ul>
When basal insulin is not enough	<ul style="list-style-type: none"><li>• If 2-hour PPG is <math>&gt;180</math> mg/dl (10.0 mmol/L), treatment intensification may be required</li><li>• Options include addition of a prandial insulin injection ("basal plus"), addition of SGLT2 inhibitor, addition of GLP-1RA, switching to a premixed insulin</li></ul>

## Discussion 3

### *Implementing continuous glucose monitoring in T2D: Why and how?*

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# Overview of CGM

## Limitations

- Learning curve for use
- Cost of device; coverage
- Ongoing sensor wear
- Data overload
- Alarm fatigue

## Benefits

- Potential for improved glycaemic control
- Insight into glucose patterns
- TIR, TBR, TAR - easy to visualize
- No finger sticks
- Safety with alarms
- Reduction in hypoglycaemia

# CGM-based target for T2D

