Management of diabetes in the advanced terminal care setting.

1) Diet Controlled type 2 – no routine monitoring required

2) Drug controlled type 2 -
   Reduce, aiming to stop drugs and periodically check blood glucose

3) Insulin Treated Type 2 –
   Reduce, aiming to stop insulin if possible. Check once daily blood glucose, treat if significantly elevated (e.g. >20mmols) or symptomatic.

4) Insulin Dependent (Type 1) -
   Continue as simple an insulin regime as possible, possibly once daily with blood sugar check prior to giving insulin. Aiming to run blood glucose between 10-15mmols. Priority is to prevent hypoglycaemia.

It is vital to understand the difference between an insulin **dependent** diabetes patient (type 1) and an insulin **treated** non-insulin dependent patient (type 2) and what would happen on stopping insulin.[1] The former case will (fairly) rapidly develop diabetic ketoacidosis and if untreated would die. The latter would (more slowly) develop a rise in blood sugar and if untreated would develop a hyperosmolar non-ketotic state. For our terminal palliative care patients, the situation would be modified by a likely minimal food and sugar intake.

Therefore deciding whether a patient is insulin treated or truly insulin dependent is important. Type 1 patients usually started insulin, were underweight and aged < 40 at diagnosis. Type 2 patients were usually overweight/aged > 40 at diagnosis, develop ketones only with starvation and managed with diet/drugs before starting insulin. To complicate matters about 10% of patients will fall between the two types, but the majority of palliative care patients on insulin and those with secondary diabetes will be type 2.

References

1) Boyd K. Diabetes mellitus in hospice patients: some guidelines
Palliat Med 1993;7:163-4

Dr Dean Blackburn
Palliative Care Physician, St Barnabas Hospice, Lincoln.
Former Hospital Practitioner in Diabetes

Dr Steve Olczak
Consultant Endocrinologist
Pilgrim Hospital, Boston, Lincs