Check HbA1c at baseline for all cancer patients

Check random plasma glucose prior to commencing anti-cancer therapy / steroids

Commence anti-cancer/GC therapy

Check plasma glucose at each treatment visit

- <12 mmol/L
  - Recheck plasma glucose at each treatment visit
  - If consistently <12 mmol/L consider cessation of testing
  - Provide relevant information leaflet (steroids)
  - Provide glucose meter if ‘high risk’ or commencing steroids, to monitor daily pre-meal

- ≥12 mmol/L <20 mmol/L
  - Ensure patient has a glucose meter & testing strips
  - Check: - Hyperglycaemia symptoms for - Ketonuria/ ketonaemia
  - Commence gliclazide 40 mg with breakfast if ≥12 mmol/L and/or prompt referral to primary care to initiate treatment
  - Ensure blood glucose meter provided
  - Advise to test CBG 4x daily
  - Recheck plasma glucose at each treatment visit
  - IR max dose 320 mg/day
  - MR max dose 120 mg/day
  - Max morning dose 240 mg
  - & evening dose 80 mg

- ≥20.1 mmol/L
  - If: Hyperglycaemia symptoms
    - Ketonuria (>2+) or Ketonaemia >3 mmol/L
    - Venous Bicarb <15 mmol/L +/- pH <7.3*
  - DKA/HHS diagnosed
  - DKA/HHS excluded

- If >47 mmol/mol at baseline visit, refer to GP
  - Do not delay initiating anti-cancer therapy

If treatment reduced/discontinued:
- Continue plasma glucose/CBG testing if ≥12 mmol/L
- Any changes made should be reviewed and consideration given to reverting to previous therapy or doses
- Discuss with diabetes team if unsure at any stage

* Patients not meeting this criteria may still require referral to MAU/AE – exercise clinical judgement
¥ See JBDS steroid guidelines appendix 2 for further details [71,74]
φ See JBDS DKA/HHS guidelines [77, 80]
Check **HbA1c** at baseline for all cancer patients

Check **random plasma glucose** prior to commencing ICP

Commence ICP

- **<12 mmol/L**
  - Recheck with each ICP treatment visit

- **≥12 mmol/L <20 mmol/L**
  - Check: - Hyperglycaemia symptoms for - Ketonuria/ Ketonaemia
    - if DKA/HHS excluded
      - Refer to diabetes team early
      - Recheck at each treatment visit
      - Advise patient re: symptoms of hyperglycaemia
    - Ensure patient has CBG meter/ test strips
      - Advise to test CBG 4x daily
      - To seek medical advice if ≥ 20 mmol/L at home

- **≥20.1 mmol/L**
  - Check: Hyperglycaemia symptoms
    - Ketonuria (>2+) or Ketonaemia >3 mmol/L
    - Venous Bicarb <15 mmol/L +/- pH <7.3*
  - DKA/HHS diagnosed ¥
    - DKA/HHS excluded
      - Refer to local AE/ MAU department urgently
      - Urgent referral to diabetes team/ consider admission
      - Check anti-GAD +/- anti islet cell antibodies
      - Patient requires treatment with insulin therapy φ

¥ See JBDS DKA/HHS guidelines [77, 80]

* Patients not meeting this criteria may still require referral to MAU/AE – exercise clinical judgement

φ ICP should be withheld with grade 3 hyperglycaemia. Consider restarting once regulated with insulin

Do not delay initiating anti-cancer therapy

Counsel patients to seek immediate medical attention if there are symptoms of hyperglycaemia as DKA can occur rapidly in these patients

If >47 mmol/mol at baseline visit, refer to GP

Check plasma glucose at each treatment visit

Recheck at each treatment visit

Advise patient re: symptoms of hyperglycaemia if DKA/HHS excluded

Ensure patient has CBG meter/ test strips

Advise to test CBG 4x daily

To seek medical advice if ≥ 20 mmol/L at home
Check HbA1c at baseline for all cancer patients

Check random plasma glucose prior to commencing anti-cancer therapy / steroids

Ensure patient has a blood glucose meter & testing strips

<12 mmol/L

Continue usual diabetes regimen

≥12 mmol/L

On 2 separate readings

PWD – diet controlled or on other NON SULFONYLUREA treatments eg:
- Metformin
- Gliptins eg Sitagliptin, Linagliptin
- Flozins eg. Dapagliflozin, Canagliflozin
- Pioglitazone
- Non-insulin injectables (eg. Victoza, Byetta)

If no hypo symptoms, commence gliclazide 40 mg morning

Refer to usual diabetes care provider

≥20.1 mmol/L

Rule out DKA/HHS*

Patients has no symptoms of hypoglycaemia, day or night. Is patient on max dose?

No

Aim CBG 6-15 mmol/L pre-evening meal

Titrate morning dose up to max dose

If CBG remains ≥12 contact usual DCP ¥

Yes

Contact usual diabetes care provider

If >60 mmol/mol at baseline visit refer to usual diabetes care provider (DCP)

PWD already on SULFONYLUREA eg
- Gliclazide

(IR max dose 320 mg/day)
(MR max dose 120 mg/day)
Max morning dose 240 mg & evening dose 80 mg

Urgently refer and contact diabetes team

PWD = Person with diabetes
IR = Immediate Release
MR = Modified Release
¥ See JBDS steroid guidelines appendix 2 [71,74]
*See JBDS DKA/HHS guidelines [77, 80]
Check HbA1c at baseline for all cancer patients

Advise patients to monitor/record CBGs QDS

Check random plasma glucose prior to commencing anti-cancer therapy / steroids

≥12 mmol/L

On 2 separate readings

≥60 mmol/mol at baseline visit, refer to usual diabetes care provider (DCP)

Check for urinary ketones

If treatment reduced/discontinued any changes made should be reviewed and consideration given to reverting to previous therapy or doses (discuss with diabetes team if unsure at any stage)

If >60 mmol/mol at baseline visit:

If 12 mmol/L on 2 separate readings:

If on once daily insulin* e.g. Insulatard, Humulin I, Lantus or Degludec:

Contact diabetes team

If unable to contact DM team:

Titrated by 10-20% according to pre evening meal CBG

If on twice daily insulin:

Contact diabetes team

If unable to contact DM team:

If unable to contact DM team:

If on basal bolus insulin:

Contact diabetes team

If unable to contact DM team:

Increase short/fast acting insulin by 10-20% until glycaemic target reached

Review patient recorded blood glucose at each visit

If on once daily insulin* e.g. Insulatard, Humulin I, Lantus or Degludec:

Contact diabetes team

If unable to contact DM team:

Titrated by 10-20% according to pre evening meal CBG

If on twice daily insulin:

Contact diabetes team

If unable to contact DM team:

If unable to contact DM team:

If on basal bolus insulin:

Contact diabetes team

If unable to contact DM team:

Increase short/fast acting insulin by 10-20% until glycaemic target reached

*If long acting insulin is taken once nightly, move this pre-bed injection to the morning and increase dose according to pm CBG

¥ See JBDS steroid guidelines appendix 2 for further management on titration [71, 74]