INTRODUCTION

• The incidence of diabetes in patients with cancer is thought to be six times greater than that found in the general population1.
• The causes of this are thought to include an increased incidence of diabetes and advanced disease in older people, diabetogenic medications such as corticosteroids and metabolic changes due to cancer2,3.
• Patients with diabetes approaching the end of life have a unique set of care needs4, however, there is a lack of evidence-based guidance on best clinical practice when managing diabetes as part of end of life care5.
• Diabetes UK published national guidelines in 2013 for the monitoring and management of diabetes at the end of life6. Comprising mostly diabetologists’ professional opinions, the uptake of the recommendations within palliative medicine is anecdotally variable.

This project describes an audit of our regional adherence to these guidelines and exploration of palliative care experts’ professional opinions to supplement the existing guidance.

AIMS

Aim 1: To investigate to what extent this guideline is used and adhered to regionally within palliative medicine.
Aim 2: To provide palliative medicine expert opinion which complements this guideline in order to aid its adoption within the specialty.

METHOD

Aim 1: Two regional audits were carried out in August-September 2016 on the monitoring and management of patients with diabetes in the last days to hours of life. One collated professional opinion amongst palliative care professionals, the other was a six-month retrospective case note audit of practice. Results were compared against the Diabetes UK guideline for the monitoring and management of diabetes at the end of life.
Aim 2: The above audit results were presented at the North West Coast Strategic Clinical Network regional meeting in November 2016. Areas of deviance from guidance were discussed and their appropriateness to palliative medicine practice was debated. Professional consensus was sought on a number of areas where non-adherence to guidance was noted or where guidance was lacking.

RESULTS

83 results were obtained from the case note audit. 17% had multiple episodes of hyperglycaemia, mostly treated with insulin. 44% of asymptomatic hypoglycaemia was untreated. 58% of cases did not have documentation about how their glucose should be monitored, and most patients remaining on insulin did not have their blood glucose checked regularly.

Also of note, despite strong recommendation that diabetic control at the end of life should be discussed as part of a patient’s advance care plan, this was only done in 10 (12%) of cases.

RESULTS Continued...

How Often Were Glucose Levels Routinely Monitored on a Patient Who Was on Insulin in the Last Hours to Days of Life

- 28.6% were monitored 4 hourly
- 11.4% were monitored 8 hourly
- 11.4% were monitored 12 hourly
- 17.1% were monitored 24 hourly
- 5.7% were monitored less frequently
- 17.1% were not monitored
- 12.9% were monitored only when symptomatic

Also of note, despite strong recommendation that diabetic control at the end of life should be discussed as part of a patient’s advance care plan, this was only done in 10 (12%) of cases.

PROFESSIONAL OPINION

These results were discussed at a regional meeting attended by a mixture of palliative care and diabetes clinicians as well as public and patient representatives. Key areas of consensus of professional opinion were:

• Differentiating hypoglycaemia from a patient approaching the end of life is complex, however as hypoglycaemia is a reversible cause of deterioration, treatment for this should be offered to patients in the last hours to days of life, unless clearly inappropriate.
• Management of diabetes at the end of life is an important topic to include in advance care planning, and palliative care physicians need to think more on this subject when undertaking these conversations earlier in a patient’s illness.
• It is acceptable not to treat hypo or hyperglycaemia in patients approaching the end of life if it is agreed and documented that they would not be suitable for treatment.
• Due to inaccuracies of urinalysis for determining hyperglycaemia, capillary blood glucose monitoring is recommended for monitoring of blood glucose in patients at the end of life.
• It is reasonable to reduce and withdraw diabetic therapies as patients’ appetites decrease and they deteriorate. However, daily blood glucose monitoring should continue whilst on insulin therapy.

CONCLUSION

• There is variability in practice regarding diabetes monitoring and management at the end of life, as well as variable compliance with national guidelines. Comparing our audit results against national guidance and obtaining inter-professional consensus around discrepancies, we have developed a new regional guideline for the monitoring and management of diabetes at the end of life.
• Further efforts should be made to educate and standardise practice in this clinical context on a national basis in line with shared expert opinions between the 2 specialties.

REFERENCES


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