Pre-terminal disease will influence glycaemic control (see BOX 1)

- Goal of treatment is to avoid hypoglycaemia and manage symptoms of hyperglycaemia (balance against burdens of additional treatment and monitoring)
- Type 1 diabetes has an absolute insulin requirement (wish to avoid diabetic ketoacidosis)

**TYPE 1 DIABETES**

- Monitor BM less frequently – individualise monitoring based on patient factors and goals of care
- Relax blood glucose targets (aim > 7 to <15 mmol/L as long as asymptomatic)
- **Always continue basal insulin** – patients may have reduced insulin requirement (reduce by 30 to 50%)
- Consider omitting doses of rapid acting insulin if not eating

**TYPE 2 DIABETES**

Individualised treatment

Consider:

- Stopping or reducing oral hypoglycaemic agents (Sulfonylureas, Metformin, Pioglitazone, Gliptins)
- Stopping GLP-1 analogues
- Reducing pre-mix bd insulin
- Consider once daily long-acting basal insulin instead (Lantus, Detemir, Insulatard)

**TERMINAL PHASE - Time is short (may be weeks)**

**TYPE 1 DIABETES**

Once daily basal insulin (Lantus, Detemir, Insulatard). If unsure reduce normal basal dose by 30 – 50%. Avoid dextrose containing fluids. Do not be afraid of stopping therapies at this stage.

See box 3 for communication issues.

Stop monitoring

**TYPE 2 DIABETES**

Stop all diabetes therapy

**TERMINAL PHASE**

For persistent difficult symptoms contact local diabetes team.
Box 1 Palliative Care Considerations for Glycaemic Control

- Anorexia & Cachexia
  - Inability to take food or medicines
  - Increased hypoglycaemia risk
- Infection
- Metastatic disease
  - Increased risk of hypoglycaemia (liver, adrenals)
  - Increased risk of lactic acidosis
- Cirrhosis
  - Hypoglycaemia risk
- Tumour products
  - Most promote insulin resistance
  - Some may induce hypoglycaemia

Box 2 Drugs which may adversely affect blood glucose

- Octreotide
  - Inhibits insulin secretion, causing hyperglycaemia
- Steroids (given in the morning can cause late afternoon and evening hyperglycaemia)
  - Orexigenic (stimulates appetite), may contribute to hyperglycaemia
  (If steroids are withdrawn, reduce insulin to avoid hypoglycaemia. However, if insulin is reduced too much or stopped altogether, hyperglycaemia may result, particularly when steroids remain in the system)
- Some diuretics
- Some atypical antipsychotics may increase insulin resistance and cause hyperglycaemia

Box 3 Communications with patients and families

Patients/families who have lived with diabetes over a long period of time may find a more relaxed attitude to diet and monitoring difficult to come to terms with. It is important that the addition of insulin therapy is not seen as adding to anxiety or withdrawal perceived as abandonment of care.