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Testing times! Choosing Wisely when it comes to monitoring type 2 diabetes

Harnessing the value of self-monitoring of blood glucose among people with non-insulin-treated type 2 diabetes

Australian College of General Practitioners, made only one about diabetes. This was: "Don’t advocate routine self-monitoring of blood glucose for people with type 2 diabetes who are on oral medication only."4

Originating in the United States, Choosing Wisely is a laudable global movement encouraging clinicians and consumers to question the use of unnecessary medical tests, treatments and procedures.

In the US and Canada, Choosing Wisely recommendations for diabetes have focused similarly on restricting SMBG strips for people with non-insulin-treated T2D; in the United Kingdom, recommendations are expected in late 2015.

Despite nuances of language in these international recommendations, SMBG among people with non-insulin-treated T2D is clearly a “hot topic”.

The evidence base indicates ...

In 2012, two highly influential systematic reviews — a Cochrane review and a meta-analysis — were published.5,6 Based largely on the same set of randomised controlled trials (RCTs), their conclusions were comparable: "clinical benefit is limited" for SMBG in people with non-insulin-treated T2D.

The Cochrane review5 included 12 RCTs (3249 participants). Among these, nine trials of 6 months’ duration found that glycated haemoglobin (HbA1c) levels were reduced on average by 0.3% (a statistically, but not clinically, significant improvement).7 There was no significant reduction in HbA1c levels in trials with 12 months of follow-up. Overall, no benefit was shown for patient satisfaction, emotional wellbeing or health-related quality of life, and SMBG was considered unlikely to be cost-effective.8

Challenging the evidence and assumptions

Our own critical appraisal revealed too much variation in trial methods and populations to draw firm conclusions about the value of SMBG overall.7 In particular, in some trials, participants were not given instructions about when or how often to check their blood glucose level (or this was not reported). Among trials where frequency was reported, it varied enormously — from four times per month to six times per day, 7 days per week. In most cases, the SMBG conducted was insufficient to provide interpretable blood glucose patterns that could inform
diabetes self-management and lifestyle choices (eg, food intake or physical activity). Some studies incorporated feedback and education about self-management, but others did not.

We refer to this random, low frequency, routine SMBG as “unstructured”, and suggest it is ineffective because it does not enable people with T2D or health professionals to detect blood glucose level patterns or act upon them. Indeed, people with non-insulin-treated T2D reported that their GPs rarely refer to their glucose diary data, and perceive this to mean that SMBG is worthless.7 They experience SMBG as “frustrating”, “painful”, “inconvenient” and “expensive”, they lack motivation for it, and report “feelings of failure or anxiety in response to high blood glucose readings”.7

However, in studies where the protocol for a “structured” approach to SMBG was clearer, the findings were more positive — reduced HbA1c levels, less glycaemic variability overall, less time spent in hyperglycaemia.5,7

Structured monitoring is effective, economical and engaging

After the systematic reviews were concluded, an RCT of structured SMBG was published.1 In the STeP study, structured SMBG was defined as seven checks per day over 3 consecutive days in the week before their consultation with a doctor about their diabetes.8 STeP showed that structured SMBG was associated with a statistically significant reduction in HbA1c level (0.3%; P < 0.001; intention-to-treat analysis), and a per protocol analysis (focused on those who conducted structured SMBG as intended) showed a clinically significant reduction in HbA1c level (0.5%).8

Notably, trials of structured SMBG have also shown important psychological benefits — increased satisfaction with treatment, reduced diabetes-related distress, improved general emotional wellbeing and greater confidence in, and motivation for, diabetes self-care.7,9

The findings of the STeP study suggest that SMBG does not have, as such, a dose-related response, and needs to be viewed, rather, in terms of quality rather than quantity of monitoring.7 The protocol suggests that a person with non-insulin-treated T2D using structured SMBG could use as few as 84 test strips per year (ie, 21 in the week before each quarterly general practitioner visit). This, in fact, compares very favourably with the current Australian average of 300 strips per annum per person with non-insulin-treated T2D, and suggests great potential for the federal government’s restricted access policy (100 strips over 6 months) to be applied sensibly.

Our recent observational study, STeP-IT-UP, (involving 98 people with non-insulin-treated T2D attending 22 general practices across our eastern seaboard), showed that structured SMBG is feasible in Australia.10 Furthermore, our findings support US and European evidence showing significant reductions in HbA1c levels (without increasing hypoglycaemia) and diabetes-related distress.

What is structured SMBG?

Structured SMBG is more than just 21 finger pricks. It involves meaningful (rather than random) glucose checks at set times (eg, pre-meal and 2 hours post-meal, and before bedtime) to generate a pattern over at least 3 consecutive days. The person with T2D also notes their meal sizes and energy levels to provide context for the readings. While most trials have evaluated SMBG as though it were an active agent, it is actually just one aspect of a complex intervention, requiring:

- agreement between the person with T2D and their health professional on glucose targets and the timing and frequency of SMBG;
- a supportive and enthusiastic health professional trained in the interpretation of SMBG data;
- appropriate feedback to, and education for, the person with T2D;
- collaborative review of the SMBG pattern to determine areas for improvement and to discuss what contributed to low, high or within-target glucose levels;
- a plan for how to change diet, activity levels or medication to improve glucose levels;
- action (ie, actual change in diet, activity levels or medication); and
- motivation on the part of the person with T2D, which is likely to be contingent on much of the above being in place.

A closer look at the Choosing Wisely Australia recommendation

We take issue with Choosing Wisely’s initial statement, that there “is no evidence that self-monitoring of blood glucose (SMBG) affects patient satisfaction, general well-being or general health-related quality of life.”4 There is compelling evidence on both sides of this debate, depending on whether SMBG is structured or unstructured.7

Choosing Wisely claimed that Australian Government spending on glucose monitoring strips was $143 million in 2012.2 This is true, but misleading. Only 35% of this spending was for people with non-insulin-treated T2D.3 Most of this funding was for SMBG essential for informing insulin dosing and detecting hypoglycaemia in people with type 1 diabetes and those with T2D using insulin or sulphonylureas. Substantial cost savings therefore seem unlikely.

The most positive aspects of the Choosing Wisely recommendation are the exceptions, in particular the usefulness of SMBG for “short-term education about...
diet influencing blood sugar”, although we would expand this to include physical activity.

**Choosing more Wisely Australia**

We appreciate absolutely the need for evidence-based medicine — and have described the complexity of this evidence base. Nevertheless, we remain concerned that restricting access to glucose monitoring strips conveys the wrong message philosophically. At face value, it implies that some forms of diabetes require less monitoring and are, therefore, less serious than others. Yet all diabetes is serious and all diabetes leads to complications if not monitored and managed appropriately: conveying any other message is confusing, inaccurate and potentially dangerous.

As with most behaviour, if individuals do not value it, or perceive more costs than benefits, they are unlikely to instigate or maintain the behaviour. This applies not only to people with non-insulin-treated T2D, but also to health professionals. While the government is undoubtedly interested in potential costs savings, the PBS final report also recognises the need to emphasise to clinicians and people with T2D that “changes are being implemented to encourage better practice and direct more attention to appropriate use of test strips”.3

Far from recommending against routine SMBG, which may unintentionally deter any SMBG in people with non-insulin-treated T2D, we believe Choosing Wisely Australia should positively advocate structured SMBG for all people with T2D not using insulin or other hypoglycaemia-inducing medications. This would be more consistent with its mission not only to reduce unnecessary medical tests, but also to promote evidence-based clinical practice. Structured SMBG offers an evidence-based model for effective blood glucose monitoring and engagement in diabetes self-management.

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