香港糖尿科護士協會
Association of Hong Kong Diabetes Nurses

AHKDN Newsletter

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Editorial

Evidence-based practice (EBP) enhances nurses to provide high quality and effective nursing care. Insulin injection teaching is one of the core components in diabetes patient education. The first evidence-based clinical guideline on subcutaneous insulin injection for people with diabetes mellitus was published in 2014 and renewed recently in 2021. We hope this guideline can enhance all health professionals in administrating insulin safely. Injectable anti-diabetic agent is not solely insulin therapy, glucagon-like peptide-1 receptor agonist (GLP-1 RA) is another kind of treatment that requires subcutaneous injection and has been developed in recent decades. A summary of GLP-1 RA can give our nurses a better understanding on it. Also, this issue of our Newsletter will provide us a background on District Health Centre that enhances diabetes care in the community.

Updated evidence-based clinical guidelines Subcutaneous insulin injection for people with diabetes mellitus

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Correct insulin injection technique is as important in achieving glycemic goal as the type and dose of insulin delivered. To create recommendation regarding this, Evidence-based clinical guidelines – Subcutaneous insulin injection for people with diabetes mellitus was first developed by Association of Hong Kong Diabetes Nurses (AHKDN) in 2014. In 2021, the guidelines have been updated incorporating additional information and evidence.



Updated Guidelines development

A workgroup was reformed within the AHKDN in 2019. It consisted of six members: Annie Leung, Shimen Au, Sarita Chan, Eva Kan, Kit Man Loo, Maisy Mok, and an advisor Dr. Ann Shiu. The workgroup also reformed the evidence-based questions to guide the work:

1. How should insulin injections be prepared?
2. Which sites should be used for insulin injection?
3. What should be the appropriate needle length?
4. How should insulin injection be performed?
5. How should insulin and insulin pens be stored?
6. How should lipohypertrophy and lipoatrophy be managed?

Summary of Major Changes

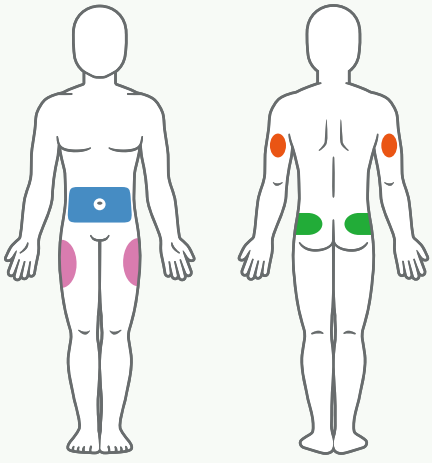
As a basis for the developed recommendations set forth in the guidelines, the workgroup reviewed the literature and mainly focused on the period 2014-2019. Each guideline development committee member was held responsible for examining one to two evidence-based question(s) and studied

relevant literature to develop recommendations. Subsequently, the workgroup held seven meetings to scrutinize the literature and recommendations, resulting in the guidelines with 45 recommendations. Each recommendation consisted of a statement, its level of scientific evidence and strength of recommendation.

Needle length

Based on improved understanding of skin and subcutaneous tissue at common injection sites, intramuscular (IM) injection is a real risk with longer needles, including the previously recommended 8mm length. Recent recommendations on injection technique strongly advise using shorter-length needles[3,5]. The shortest pen needle is 4 mm in length, and the shortest syringe needle is 6 mm. For patients using insulin syringes, 6 mm insulin syringes are the shortest needle length available and should be used to minimize accidental IM risk. The 4mm pen needle has been tested in a number of clinical trials and has proven its safety and efficacy in both adults and children, as well as in persons spanning a range of body mass index, including the obese ones.

Insulin should be delivered consistently into subcutaneous tissue. Use of a 4 or 5 mm pen needle and 6 mm needle syringe, along with good injection technique, can substantially reduce the risks of IM injection.



Way of insertion

Studies demonstrate that needle length and injection technique are both important contributors in determining the risk of intramuscular injections[6,7,10]. The recommended injection technique for diabetes patients include a lifted or pinched skinfold or angled injection. Studies showed that pinching increased the subcutaneous fat thickness more in the abdomen than the thigh. Pinching of the thigh with a subcutaneous fat thickness <10 mm resulted in no increase in fat depth and indeed reduced fat depth in some subjects[7]. Changing the insertion angle of 6-8 mm needles from 90 to 45-degree (effective depth of around 4.2 mm[7] and 5.6 mm[7,10] respectively) increased the rate of subcutaneous injection and decreased IM rates.

The recommended injection technique with 4 and 5 mm length needles is 90° insertion without a skinfold in nearly all patients. For very thin ones or young children using 4mm needles, in whom a skinfold may be applied[6]. An angled 6-mm needle technique reliably injects into the subcutaneous fat[7]. For needle length > 6mm, patient is recommended to inject at angle with pinched skinfold.

The practice of pre-loading insulin in the syringe

The pre-loading of insulin syringe for people with diabetes to self-administer in their own homes has been an established practice for many years. Over the past few years, more people with diabetes have been able to find a pen device that suits their needs, and the number of people requiring pre-loaded insulin syringes has reduced. Nevertheless, there still remains a small number of people with diabetes who require this practice as there is no insulin pen devices suitable for their individual circumstances. However, there are currently no guidelines to support this practice. The storage, stability and sterility of pre-loaded insulin syringes in the home are another important consideration.

The practice of pre-loading insulin in the syringe is not recommended as it is considered a form of secondary dispensing and is not considered to be a best practice[8].

Training of health care professionals and patients to identify lipohypertrophy

The most common local complication seen in diabetic individuals treated with insulin is lipohypertrophy (LH). When injected into lipodystrophic areas, insulin gets altered in terms of pharmacokinetics and pharmacodynamics, which causes variable and unpredictable absorption and affects glycaemic control[1]. However, there is no systematic educational program to teach health care professions (HCP) or people with diabetes how

to recognize and diagnose LH lesions regardless of size, location and texture[4]. Thus, a sub-workgroup is formed to design a specific training program for HCPs to easily acquire diagnostic accuracy in identifying LH lesions independent of site, size and shape.

Training of HCP is required to identify lipohypertrophic lesion. People with diabetes should be provided with appropriate education and training sessions on proper injection technique, systematic rotation and frequent inspection of injection sites. Inspection and palpation of injection sites by HCP should be carried out systematically and regularly in all patients on subcutaneous therapy.

Conclusion

The updated guideline reviews the most recent studies and guidelines in the field and offers new injection recommendations. Recommendations were revised to incorporate new evidence, clarify the prior recommendation, or align the strength of the wording to that of the evidence in order to promote best practice in insulin injection technique and assist nurses who are not specialists in diabetes care to administer insulin accurately and safely.

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Glucagon-Like Peptide 1 Receptor Agonists (GLP-1 RA) in Hong Kong

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In recent decades, several new class of diabetes drugs have been developed. Glucagon-like peptide analogues are a new class of drugs used in the treatment of type 2 diabetes that mimic the endogenous hormone glucagon-like peptide 1. GLP-1 is an incretin, a gastrointestinal hormone that is released into the circulation in response to ingested nutrients. GLP-1 regulates glucose levels by stimulating glucose-dependent insulin secretion and biosynthesis, suppressing glucagon secretion, and delaying gastric emptying and promoting satiety[1].

GLP-1 RA is widely recommended by "Glucose-lowering medication in type 2 diabetes: 2021 American Diabetes Association Professional Practice Committee" (PPC)[2] in the following scenarios:

1. Indicators of high ASCVD risk or Established ASCVD (GLP-1 RA with proven CVD benefit)
2. CKD (Diabetic Kidney Disease and Albuminuria)(GLP-1 RA with proven CVD benefit if SGLT-2 inhibitor not tolerated or contraindicated)
3. If HbA1c above individualized target,
   A. compelling need to minimize hypoglycemia
   B. compelling need to minimize weight gain or promote weight loss (GLP-1 RA with good efficacy for weight loss)

In the progression of DKD (Diabetic Kidney Disease)–

- Benefit on renal end points in Cardiovascular Outcomes Trials (CVOTs), driven by albuminuria outcomes: Liraglutide, Semaglutide, Dulaglutide

In dosing/ use considerations –

- Exenatide, Lixisenatide:
  avoid for eGFR < 30ml/min/1.73m^2
- No dose adjustment for Dulaglutide, Liraglutide, Semaglutide
- Caution when initiating or increasing dose due to potential risk of nausea, vomiting, diarrhea, or dehydration. Monitor renal function in patients reporting severe adverse GI reactions when initiating or increasing dose of therapy

Research has shown that treatment with Dulaglutide, Liraglutide or Semaglutide is link to significant reduction in major heart attacks, in people with diabetes and existing heart disease[3,4,5,6]. Also, they have shown robust benefits on reducing the incidence of macroalbuminuria[3].

Additional considerations in usage of GLP-1 RA:

1. The Food & Drug Administration (FDA) Black Box: Risk of thyroid C-cell tumors in rodents; human relevance not determined (Liraglutide, Albiglutide, Dulaglutide, Exenatide Extended Release, Semaglutide)
2. GI side effects common (nausea, vomiting, diarrhea)
3. Injection site reaction
4. Pancreatitis has been reported in clinical trials but causality has not been established. Discontinue if pancreatitis is suspected

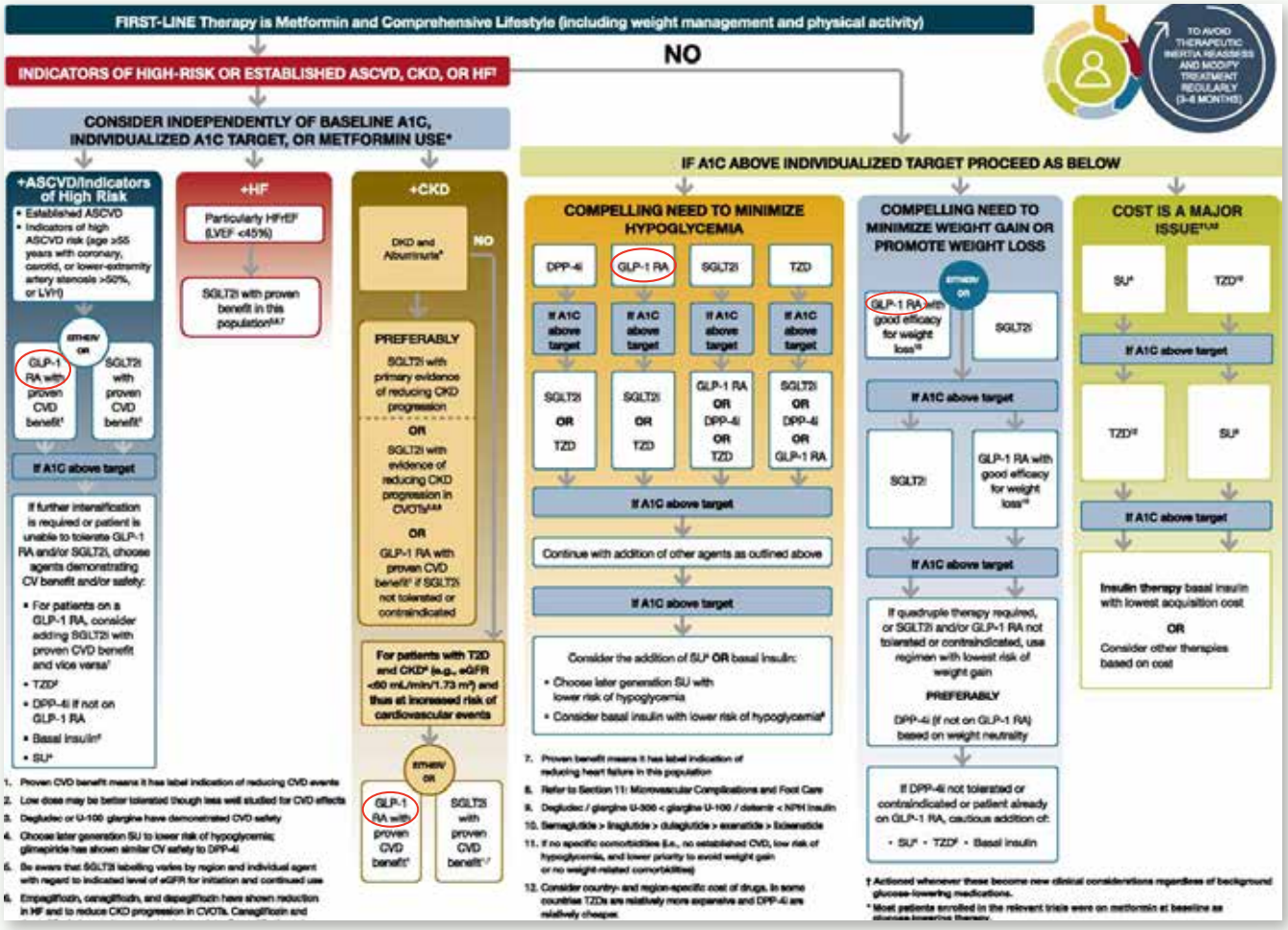


Figure 1: Glucose-lowering medication in type 2 diabetes: 2021 American Diabetes Association Professional Practice Committee

GLP-1 RA	Administration	Elimination	Half-life	Starting dose	Maximum dose	Renal function*
Short-acting GLP-1 receptor agonists						
Exenatide (Byetta)	Twice daily	Mainly renal	2.4 hours	5 mcg	10 mcg	Not recommended eGFR < 30
Lixisenatide (Lyxumia)	Daily	Mainly renal	3 hours	10 mcg	20 mcg	Not recommended eGFR < 30
Long-acting GLP-1 receptor agonist						
Liraglutide (Victoza)	Daily	Peptidases, renal and faeces	13 hours	0.6 mcg	1.8 mcg	No dosage adjustment
Semaglutide (Ozempic)	Weekly	Peptidases and renal	1 week	0.25 mg	1.0 mg	No dosage adjustment
Exenatide QW (Bydureon)	Weekly	Mainly renal	2 weeks	2.0 mg	2.0 mg	Not recommended eGFR < 30
Dulaglutide (Trulicity)	Weekly	Peptidases and renal	5 days	0.75 mg	1.5 mg	No dosage adjustment

*Drug manufacturer dosage adjustments for renal impairment

Table 1: GLP-1 receptor agonists characteristics and recommendations with patients with renal impairment[6,7]

Drug	Within class comparability of A1C (hemoglobin A1C) lowering efficacy	Within class comparability of effect on weight	Within class comparability of GI (gastrointestinal) adverse effects
Exenatide (twice daily)	Low	Low	Highest
Lixisenatide	Low	Low	Intermediate
Liraglutide	High	High	Intermediate
Exenatide XR	Intermediate	Low	Low
Dulaglutide	High	Intermediate	Intermediate/high
Semaglutide	Highest	Highest	High

Table 2: Summary of head-to-head trial data for GLP-1 receptor agonists[4]

Under Hospital Authority Drug Formulary (HADF) supplementary operation guideline version 17.2 published on 9 October 2021, Exenatide or Lixisenatide can be prescribed as special drugs for patients with Type 2 DM with body mass index (BMI) ≥ 30 as add on to 3 oral antidiabetic drugs; discontinue if decrease in HbA1c < 1% or weight loss < 3% of initial body weight within 6-8 months. Whereas Dulaglutide, Liraglutide or Semaglutide can be prescribed as special drugs for patients with Type 2 DM with BMI ≥ 30 & established CVD, as add on to 3 oral antidiabetic drugs; discontinue if decrease in HbA1c < 1% or weight loss < 3% of initial body weight within 6-8 months.

The US FDA approved Rybelsus (Semaglutide) an oral tablet to improve control of blood sugar in adults with type 2 diabetes, along with diet and exercise[8]. In Hong Kong, we are still using injectable GLP-1 RA for glycaemic control and no oral preparation of GLP-1 RA is yet available in the market.

Apart from using GLP-1 RA for treating Type 2 people with diabetes, combining basal insulin with GLP-1 RA has been demonstrated to be effective and well tolerated. Two fixed ratio combination therapies (FRC), iGlarLixi (Glargine + Lixisenatide / Soliqua) & IDegLira (Degludec + Liraglutide / Xultophy), that combine basal insulin and a GLP-1 RA in a once-daily subcutaneous injection were approved by FDA in 2016. FRCs can help to simplify treatment regimens into one daily injection, potentially enhancing patients' adherence. FRCs have demonstrated enhanced glycaemic control, comparable risk of hypoglycaemia and better tolerability in comparing with GLP-1 RA alone[9].

Drug	Dosing	Storage (opened)	Storage (unopened)
iGlarLixi Soliqua (Glargine + Lixisenatide)[10]	Two preparations: **1) 100 unit/ml Glargine + 50 mcg/ml Lixisenatide** Recommended starting dose: 10 dose steps from adding on to OADs (oral anti-diabetic drug) Recommended starting dose: 20 dose steps from glargine 20-30 unit/day **2) 100 unit/ml Glargine + 33 mcg/ml Lixisenatide** Recommended starting dose: 30 dose steps from glargine 30-60 unit/day	Stored below 25^{0}C and use within 28 days	Stored in refrigerator 2^0 to 8^{0}C until expiration date on stamp
IDegLira Xultophy (Degludec + Liraglutide)[11]	**100 unit/ml Degludec + 3.6 mg/ml Liraglutide** 1 dose step = 1 unit of Degludec + 0.036 mg Liraglutide Maximum dose: 50 dose step = 50 unit of Degludec + 1.8 mg Liraglutide Recommended starting dose: 16 dose steps from basal insulin or GLP-1 RA Recommended starting dose: 10 dose steps from adding on to OADs	Stored below 30^{0}C and or in refrigerator 2^0 to 8^{0}C use within 21 days	Stored in refrigerator 2^0 to 8^{0}C until expiration date on stamp

Table 3: Fixed ratio combination therapies characteristics and storage[10,11]

Special precaution before initiating GLP-1 RA

GLP-1 RA has additional benefit in cardio and renal protection, but still special precaution should be considerd before initiating this group of anti-diabetic agents.

- Enquire any family history of Medullary Thyroid Carcinoma
- Enquire any history of pancreatitis
- Educate the potential side effects and drug interactions of GLP-1 RA, monitor blood glucose levels, weight, kidney functions as well as for signs and symptoms consistent with pancreatitis
- Educate the ways in reducing GI upset, e.g. avoid large portions of meals, avoid spicy foods, encourage to eat slower and eat smaller portion. Also, avoid high fat meals that tend to slow gastric emptying and can make the symptoms worse[12].

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深水埗地區康健中心 (Sham Shui Po District Health Centre)

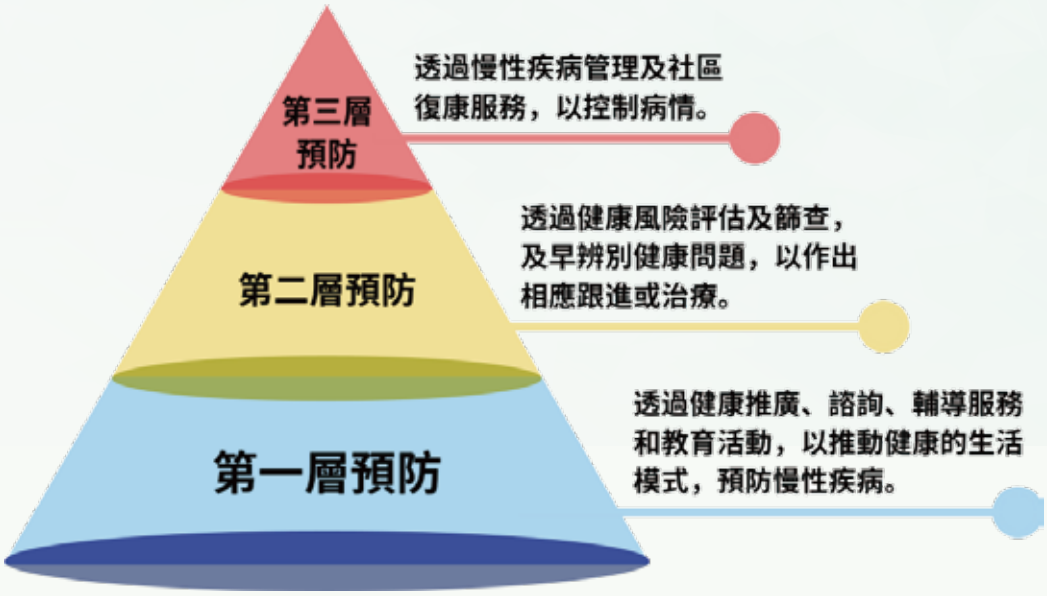
鍾巧儀 深水埗地區康健中心 (總護理統籌主任)

2017年的施政報告提到香港需要加強基層醫療服務 (Primary Care) ，所以政府斥資在全港十八區成立「地區康健中心」及「地區康健站」。 而「深水埗地區康健中心」是本港第二間的地區康健中心，由聖雅各福群會營運並已經於2021年六月底投入服務，提供服務予深水埗區的市民及工作的人士。希望藉此文介紹有關深水埗地區康健中心的服務，讓讀者多一點認識我們在地區的工作。

基層醫療服務

深水埗地區康健中心的服務都是建基於基層醫療的概念。基層醫療是個人和家庭在整個持續醫療過程中最先接觸的第一站，亦是所有人需要的基本醫療服務。地區康健中心的出現使香港的基層醫療服務邁出重要的一步，希望能夠從醫療體系中的「重治療、輕預防」的狀況，改變為「重預防」的三層預防性護理為服務重點 (圖一)；亦同時推廣家庭醫生的概念及家庭醫學。改善基層醫療服務能夠發揮把關的重任，減少市民使用專科及急症服務的使用率、降低住院需要、減輕昂貴的醫療開支和護理服務的需求。

三層預防性護理中的第一層是透過健康推廣、諮詢和疾病預防，提高市民的健康意識、健康識能及提升市民健康質素。第二層預防指透過健康風險評估和疾病篩查，識別出高風險群組，以安排及早診斷和治療，減慢疾病演變進程。而第三層預防是透過慢性疾病管理，控制病情，以促進康復的進度和預防併發症的出現。



(圖一)：基層醫療服務的三層預防性護理

圖片來源：https://www.dhc.gov.hk/tc/what_is_primary_healthcare.html

健康先至係中心 (Health is CORE)

深水埗地區康健中心 (主中心) 坐落於石硤尾邨美禧樓，佔地超過一萬呎。服務地區包括美孚、荔枝角、長沙灣、深水埗、西九龍填海區、石硤尾和又一村。另外設有三間附屬中心位於深水埗的中南區、東區及西區，並設有「流動健康車」遊走於區內較偏遠的地方，主動接觸市民及方便他們預約使用中心的服務。除了主中心、附屬中心及「流動健康車」提供服務之外，我們還會與社區的不同的持分者成為合作夥伴，擴展網絡，以外展方法接觸市民提供服務。

六歲或以上於區內居住或工作的香港市民，並註冊成為「醫健通」用戶以建立公私營醫療紀錄互通之後，便可以免費登記成為我們中心的會員。我們的服務理念是「健康先至係中心(Health is CORE)」，目的是希望幫助市民儘管每日生活在急速節奏當中，但只要透過建立健康飲食及運動習慣，加上中心的健康風險評估、疾病預防等服務，讓市民的健康生活重回正軌，真正體會健康先至係中心。

中心提供十分完善的免費健康服務，例如健康推廣、護理諮詢、協調及教育、藥劑師諮詢和用藥指導、社工諮詢和輔導服務、糖尿病和高血壓篩查、慢性疾病自我管理計劃等。此外我們亦都扮演著地區服務資源配對的角色，讓市民可以認識和善用地區資源。藉以幫助市民提升自我管理健康的能力，並且可以支援長期病患者的醫療服務，及減輕公營醫療系統的壓力。

為了更有效運用地區的醫療資源，我們的跨專業團隊經常與醫管局、衛生署、長者服務中心及地區網絡私營醫療提供者緊密合作，提供以地區為本的基層醫療服務。亦透過「醫社合作」及「公私營合作」的模式，政府資助市民能夠以可負擔的費用，使用地區網絡的私營醫療服務，主要提供慢性疾病診治及社區復康服務 (表一)。

資助服務	疾病類別	資助的私營醫療服務
(一) 慢性疾病	「地區康健中心」新診斷的糖尿病 / 高血壓	醫務診斷及諮詢服務、病理化驗、物理治療、職業治療、營養飲食治療、足病治療、視光學評估及中醫服務
(二) 肌肉骨骼問題	退化性膝關節痛症 / 腰背痛	物理治療、職業治療、營養飲食治療及中醫服務
(三) 社區復康	急性心肌梗塞 / 中風 / 髖關節骨折	言語治療*、物理治療、職業治療、營養飲食治療及中醫服務 (*只限中風患者)

(表一)：「地區康健中心」資助的私營醫療服務

健康生活8+1

我們的跨專業團隊包括護士、社工、物理治療師、職業治療師、營養師、藥劑師及健身教練等。 除了提供基本的醫療健康服務外，中心亦因應深水埗區的特色，設計了健康服務主題「健康生活8+1」(表二)，同時融合了三層預防性護理在內，針對不同健康需要的會員。對象可以涵蓋男士、婦女、青少年、基層家庭及非華裔家庭。

8+1	健康主題	健康生活 8+1 (例子)
1	健康生活	健康飲食、運動習慣、戒煙計劃、戒酒計劃
2	疾病預防	健康評估/篩查和及早診斷、糖尿病預防計劃、三高預防及管理、口腔健康、正確使用藥物、婦女健康、男士健康、家庭健康
3	體適能鍛練	體重管理、強化肌肉運動訓練、心肺耐力、肌耐力
4	精神心理衛生	睡眠衛生、壓力管理、正向情緒、精神健康急救、維持認知能力
5	骨骼健康	預防跌倒、預防骨質疏鬆、預防肌肉流失
6	慢性病管理	糖尿病管理、高血壓管理、心血管疾病管理
7	復康訓練	中風、心肌梗塞、髖關節骨折
8	朋輩支援	健康大使訓練、互助小組、地區資源配對
+1	季節性主題	世界健康日、世界心臟日、疫苗注射、器官捐贈、餵哺母乳

(表二)：深水埗地區康健中心「健康生活8+1」



健康講座 (秋冬疾病預防)



外展 - 非華裔婦女健康推廣



兒童脊科義診計劃



健康飲食親子班



男士健康推廣



外展 -健康運動推廣



流動健康車服務

地區康健中心(DHC) 及 地區康健站(DHC Express)

隨著去年十月已經有十一間規模較小，屬過渡性質的「地區康健站」全面投入服務後；另外五間的「地區康健中心」亦將於今年內陸續落成 (圖二)。

地區康健中心

葵青區、深水埗區、黃大仙區、
屯門區、元朗區、荃灣區、南區

地區康健站

西貢區、九龍城區、油尖旺區、
灣仔區、北區、離島地區、觀塘區、
大埔區、中西區、東區、沙田區



(圖二)：地區康健中心、地區康健站的分佈

圖片來源：https://www.dhc.gov.hk/tc/dhc_express_brief_introduction.html

期待全港十八區的「地區康健中心」及「地區康健站」的落成，可以大大提升市民掌控自己健康狀態的能力，成為健康達人；同時減少慢性疾病的病發率及可能引致的併發症。透過各中心的工作，可以成功構建一個社區私營醫療服務網絡，再配合政府的資助，市民可以有更多的醫療選擇。

深水埗地區康健中心網頁 www.sspdhc.org.hk

Upcoming Professional Meetings

Course / Conference	Date / Duration	Venue
12th Emirates Diabetes and Endocrine Congress https://edec-uae.com/	24th - 26th February, 2022	Virtual
82th Scientific Session of American Diabetes Association(ADA) https://professional.diabetes.org/scientific-sessions	3rd - 7th June, 2022	New Orleans, LA, USA
Association of Diabetes Care & Education Specialists Annual Conference 2022 https://www.adcesmeeting.org	12th - 15th August, 2022	Baltimore, MD, USA
58th Annual Meeting of European Association for The Study of Diabetes (EASD) https://www.easd.org/annual-meeting/easd-2022.html	19th - 23rd September, 2021	Stockholm, Sweden
International Diabetes Federation Congress 2022 https://www.idf.org	5th - 8th December, 2022	Lisbon, Portugal

Annoucement

The 14th AHKDN Annual General Meeting & Symposium

Theme: DM and Cardiovascular and Liver Disease

Date: 25th June 2022

Venue: TBC