Insulin Therapy in Type 2 Diabetes Mellitus: A Practical Approach for Primary Care Physicians and Other Health Care Professionals

James R. LaSalle, DO
Rachele Berria, MD, PhD

The responsibility of diabetes management and insulin therapy has definitively moved to primary care physicians. Within the primary care setting, there is a growing need for clear, evidence-based guidelines related to the management of insulin therapy. Straightforward algorithms regarding insulin initiation, titration, and follow-up management can help physicians effectively treat patients with type 2 diabetes mellitus. Once 2 oral diabetic drugs have failed in a patient whose disease duration is 7 to 10 years, use of insulin therapy with a basal insulin analog should be considered. For patients who receive maximal basal insulin doses without reaching fasting blood glucose and target glycated hemoglobin levels with basal insulin analogs, a mealtime-insulin intensification approach should be considered. The authors discuss how simplified insulin initiation and titration regimens allow primary care physicians and other health care professionals to care for patients with type 2 diabetes mellitus.

D iabetes affects 25.8 million people in the United States; most (90-95%) adults with a diagnosis of diabetes have type 2 diabetes mellitus (T2DM).1 Primary care physicians (PCPs) deliver approximately 90% of diabetes care in the United States.2 Type 2 diabetes mellitus is characterized by progressive β-cell failure and increasing difficulty in maintaining glycemic control.3,4 Even with multiple oral antidiabetic drugs, many patients need insulin therapy to achieve and maintain glycated hemoglobin (HbA1c) target levels.4

The intensification of diabetes treatment—that is, the transition from oral antidiabetic drugs to injectable treatments such as insulin—is often delayed in many patients, which substantially increases the risk of diabetes-related complications.3,10 In a population-based analysis,5 25% of patients with T2DM initiated insulin therapy within 1.8 years and 50% of patients initiated insulin therapy within 5 years of failure to achieve or maintain glycemic control despite multiple oral antidiabetic drugs, even in the presence of diabetes-related complications.

There are several barriers to initiation of insulin therapy. For patients, barriers include fears about injections and the risk of hypoglycemia, difficulties in managing insulin therapy, perceptions that insulin may impose lifestyle restrictions, and beliefs that insulin use indicates greater severity of disease and failure of self-management.11-13 Physicians’ barriers to initiation of insulin therapy include concerns about potential adverse effects (eg, increased hypoglycemia and weight gain) and practical concerns (eg, patient anxiety about insulin, perceived adherence issues, difficulties in training patients to administer insulin).14,15 In an international survey16 and a clinical practice review,17 PCPs and diabetes specialists reported that insulin initiation was prevented by lack of:

- time required to train patients
- clear guidelines and definitions
- support, as represented by Certified Diabetes Educators

From the Medical Arts Research Collaborative in Excelsior Springs, Missouri (Dr LaSalle) and Sanofi US, Inc, Bridgewater, New Jersey (Dr Berria).

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Address correspondence to James R. LaSalle, DO, 950 N Jesse James, Suite A, Medical Arts Center Inc, Excelsior Springs, MO 64024-1238.

E-mail: jlasalle4@aol.com
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early in the disease lifecycle gradually becomes more difficult to manage. As HbA1c levels begin to rise, multiple drugs may be added to improve glycemic control, causing patients to lose confidence; the extra efforts—which include an increased emotional burden, monetary investment, and need for treatment compliance—do not seem to lead to directly proportional improvement of the disease. The sense of a slowed improvement could leave patients with the perception of personal failure. Patients have been reported to blame themselves when they need to intensify treatment. Likewise, family physicians may experience a sense of frustration. Therefore, for patients who have had T2DM for 7 to 10 years, for whom 2 oral antidiabetic drugs have failed, and for whom HbA1c levels are outside the acceptable range, insulin therapy deserves consideration as a third antihyperglycemic agent instead of a third oral antidiabetic drug or a glucagon-like peptide-1 (GLP-1) receptor agonist.

Transition to Basal Insulin: Basal Insulin Analogs vs Human Insulin
The 2012 American Diabetes Association and the European Association for the Study of Diabetes position statement endorses the addition of a basal insulin to existing oral antidiabetic drugs. There are 2 approved basal insulin analogs in use—insulin glargine and insulin detemir—with additional basal insulin analogs in development. Ideally, basal insulin should have no pronounced peak in activity, a low risk of hypoglycemia, low within-patient variability, and a duration of action of approximately 24 hours to enable once-daily injections. Several studies that evaluated the glycemic efficacy of insulin analogs compared with human neutral protamine Hagedorn (NPH) insulin have shown varying results. Regardless, basal insulin analogs have pharmacokinetic and pharmacodynamic advantages over NPH insulin—namely, a less pronounced peak effect, less variable absorption profiles, and a longer duration of action.
Insulin analogs are also associated with lower rates of hypoglycemia, particularly nocturnal hypoglycemia, compared with NPH, which may at least partly offset the overall higher treatment costs related to insulin analogs.28

**Starting Basal Insulin: Fix the Fasting First**

Once providers decide to intensify treatment with insulin, they need to determine the optimal regimen for patients. The Treating to Target in Type 2 Diabetes trial29 investigated the efficacy and safety of 3 different insulin regimens, evaluating which regimen led to optimal glycemic control in patients whose T2DM was poorly controlled with oral antidiabetic drugs. Twice-daily biphasic insulin aspart, 3-times daily prandial insulin aspart, or once-daily (twice if required) basal insulin detemir was added to the treatment regimens of insulin-naïve patients. After 3 years, HbA\textsubscript{1c} levels were similar in patients receiving biphasic (n=235), prandial (n=239), or basal (n=234) insulin analogs (7.1%, 6.8%, and 6.9%, respectively; \(P=.28\)), yet fewer patients (75 [31.9%]) receiving biphasic insulin achieved an HbA\textsubscript{1c} level of 6.5% or lower compared with patients receiving prandial (107 [44.8%], \(P=.006\)) or basal insulin analogs (101 [43.2%], \(P=.03\)). Prandial insulin led to more weight gain than the other 2 insulin treatment regimens. The rate of hypoglycemia was lowest with basal insulin (1.7 events per patient per year, \(P<.001\)) compared with biphasic insulin (3 events per patient per year) and prandial insulin (5.7 events per patient per year). Overall, data from the trial suggest that patients who do not reach optimal glycemic control with oral antidiabetic drugs may benefit most from the addition of basal insulin analog–based regimens.

In general, initiation of a basal insulin analog should occur with a low starting dose; a starting dose of 10 U/d is recommended by various national and international medical societies and is commonly used as a starting point for titration algorithms in clinical trials (Table 1 and Table 2).31,36,40-48 It is important to consider this dose as a safe starting point only; titration will be required to achieve therapeutic efficacy. Many titration schedules have been developed. The simplest schedule titrates the evening dose of basal insulin on the basis of FBG levels, as in the INSIGHT trial,46 in which evening insulin doses were adjusted by adding 1 U/d until fasting glucose levels were \(\leq 100\) mg/dL (5.5 mmol/L). If the glucose levels

### Table 1.

**Basal Insulin Titration Algorithms From World Medical Societies**

<table>
<thead>
<tr>
<th>Measure</th>
<th>ADA/EASD(^{40})</th>
<th>AACE/ACE(^{41})</th>
<th>IDF(^{43})</th>
<th>CDA(^{44})</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Algorithm</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial dosage</td>
<td>10 U/d</td>
<td>10 U/d</td>
<td>Not specified</td>
<td>10 U/d</td>
</tr>
<tr>
<td>Titration</td>
<td>2 U every 3 d</td>
<td>1-3 U every 2-3 d</td>
<td>2 U every 3 d</td>
<td>1 U every d</td>
</tr>
<tr>
<td>Target FBG, mg/dL</td>
<td>70-130</td>
<td>(&lt;110a)</td>
<td>(&lt;110)</td>
<td>72-126</td>
</tr>
<tr>
<td>Target HbA\textsubscript{1c}, %</td>
<td>(&lt;7.0)</td>
<td>(\leq6.5)</td>
<td>(\leq6.5)</td>
<td>(\leq7.0)</td>
</tr>
</tbody>
</table>

\(^{a}\) Fasting blood glucose (FBG) target recommendation from the American Association of Clinical Endocrinologists (AACE) 2011 guidelines.42

**Abbreviations:** ACE, American College of Endocrinology; ADA, American Diabetes Association; CDA, Canadian Diabetes Association; EASD, European Association for the Study of Diabetes; HbA\textsubscript{1c}, glycated hemoglobin; IDF, International Diabetes Federation.
This premise assumes that the β cell still functions well enough to cover meals with intrinsic insulin synthesis and secretion. However, when basal insulin levels are titrated appropriately on the basis of units per kilogram (while also considering any insulin resistance) and glycemic control remains elusive, adding basal insulin may become detrimental. Overbasalization occurs in clinical practice because upper dose limits for insulin have not been well established. Whereas basal insulin titration has become part of clinical practice, there is no standard ceiling for titration. As currently defined, overbasalization occurs when FBG is not controlled with uptitration of basal insulin and HbA1c targets remain elusive. Providers must understand the concept of overbasalization because it should trigger progression to mealtime insulin intensification in patients.

To understand overbasalization, providers should consider the following simple formula and 1 simple rule. In the clinical experience of our lead author (J.R.L.), the total daily insulin requirement for an insulin-resistant patient with T2DM is approximately 1.0 to 1.5 U/kg per day. If FBG is much lower than 100 mg/dL, the daily dose can be decreased by 1 U/d until glucose levels are stabilized. Sulphonylurea medication may need reduction as fasting glucose levels approach the target. Such titration algorithms are widely used in real-world clinical practice.

### “Overbasalization”: Too Much Basal Insulin, Too Little Effect

“Overbasalization” describes an issue that arises from increased use of basal insulin in primary care, as well as the complexities of β-cell dysfunction. Early in the management process, adding basal insulin seems to assist β cells and be an efficient step in controlling FBG levels. However, when basal insulin levels are titrated appropriately on the basis of units per kilogram (while also considering any insulin resistance) and glycemic control remains elusive, adding basal insulin may become detrimental. Overbasalization occurs in clinical practice because upper dose limits for insulin have not been well established. Whereas basal insulin titration has become part of clinical practice, there is no standard ceiling for titration. As currently defined, overbasalization occurs when FBG is not controlled with uptitration of basal insulin and HbA1c targets remain elusive. Providers must understand the concept of overbasalization because it should trigger progression to mealtime insulin intensification in patients.

<table>
<thead>
<tr>
<th>Algorithm</th>
<th>INITIATE</th>
<th>Treat to Target</th>
<th>INSIGHT</th>
<th>LANMET</th>
<th>TITRATE</th>
<th>Rosenstock et al.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial dose</td>
<td>10 U</td>
<td>10 U</td>
<td>10 U</td>
<td>10-20 U</td>
<td>10 U</td>
<td>12 U</td>
</tr>
<tr>
<td>Titration</td>
<td>2-4 U every 3 d</td>
<td>2-8 U/wk</td>
<td>1 U/d every 3 d</td>
<td>2-4 U every 3 d</td>
<td>No adjustment; −4 to +12 U/wk</td>
<td></td>
</tr>
<tr>
<td>Target FBG Level, mg/dL</td>
<td>72-100</td>
<td>&lt;100</td>
<td>&lt;100</td>
<td>72-100</td>
<td>70-90 or 80-110</td>
<td></td>
</tr>
</tbody>
</table>

For 3.9-5.0 mmol/L target: <3.9, −3 U; >5.0, +3 U. For 4.4-6.1 mmol/L target: <4.4, −3 U; >6.1, +3 U.

Abbreviations: FBG, fasting blood glucose; INITIATE, Initiate Insulin by Aggressive Titration and Education; INSIGHT, Implementing New Strategies with Insulin Glargine for Hyperglycaemia Treatment; LANMET, Lantus plus Metformin; TITRATE, Treat to target with once-daily Insulin Therapy: Reduce A1c by Titrating Effectively.
Adding to Basal Insulin: A Stepwise Approach

New therapeutic options, such as GLP-1 receptor agonists and dipeptidyl peptidase-4 inhibitors, are now considered as potential add-on treatments to basal insulin, along with thiazolidinediones and more complex insulin strategies. In the following section, we describe a simpler insulin intensification regimen that parallels the pathophysiologic characteristics of the disease, especially in primary care. Just as there are basal human insulin and long-acting basal insulin analogs, there are also regular human insulin and rapid-acting insulin analogs for mealtime administration. Rapid-acting insulin analogs closely mimic physiologic meal-stimulated insulin release, with faster absorption, higher maximum concentration, shorter duration, and a lower risk of hypoglycemia than regular insulin. In addition, rapid-acting premixed insulin analogs—such as biphasic insulin aspart 30 (30% soluble insulin aspart and 70% protamine-crystallized insulin aspart)—have been developed, which can prevent excessive postprandial glucose levels whether injected at the beginning of a meal or 15 to 20 minutes after starting a meal.

During mealtime insulin intensification, the patient continues to receive basal insulin therapy but also administers a rapid-acting insulin at the largest meal of the day to manage glucose excursions after meals. Rapid-acting insulin is administered around the time of either the largest perceived meal of the day or the meal with the greatest postprandial glucose increase. Several studies have shown that the addition of only 1 prandial insulin injection can effectively reduce HbA1c levels in patients with T2DM whose disease is poorly controlled with basal insulin and oral antidiabetic drugs. When rapid-acting insulin glulisine was added to insulin glargine and oral antidiabetic drugs at the main mealtime, HbA1c levels showed a statistically significant improvement from 7.3% at baseline to 6.9% at the end of the study (P < .001). Furthermore, recent studies show that adding 1 prandial insulin injection may be no less effective at improving glycemic control than the stepwise
approach to a full basal bolus regimen of 3 daily prandial injections. Given its inherent simplicity, the addition of only 1 injection appears to be a useful approach to insulin intensification. Also, certain GLP-1 receptor agonists have been shown to improve glycemic control without increased hypoglycemia or weight gain in patients with T2DM who did not achieve glycemic control despite treatment with a basal insulin.44

The "How to" of Mealtime Insulin Intensification
A rapid-acting insulin analog is generally administered around the time of the largest meal of the day because maximum glycemic control is likely to be obtained during the highest postprandial glucose excursion.40 Titration algorithms that are recommended by various national and international medical societies and commonly used in clinical trials are illustrated in Table 3 and Table 4.40-44,56,61,65-68 The aim of mealtime insulin intensification is to control postprandial glucose excursions during the immediate 2 hours after the meal. Therefore, it is important to check glucose levels just before the first bite of the meal and 2 hours after the meal to assess the effectiveness of the mealtime insulin and to provide guidance for further insulin titration. There is no absolute need for carbohydrate counting with this method.

Safety is paramount when selecting the starting dose of mealtime insulin. Three to 4 units of a rapid-acting insulin analog is a generally accepted safe starting dose (Figure). Titration follows based on the plasma glucose level 2 hours after that meal. For example, 1 U of rapid-acting insulin analog is added at the largest meal the following day if the blood glucose level 2 hours after the meal is greater than 180 mg/dL or if the difference between preprandial and postprandial glucose levels is greater than 50 mg/dL. This titration schedule should continue until the postprandial glucose level is less than 180 mg/dL. As the mealtime insulin target is achieved, the basal insulin dose must be reassessed. If the largest meal is the evening meal and postprandial glucose levels are less than 180 mg/dL, the bedtime dose of the basal

<table>
<thead>
<tr>
<th>Measure</th>
<th>ADA/EASD40</th>
<th>AACE/ACE41</th>
<th>IDF43</th>
<th>CDA44,a</th>
</tr>
</thead>
<tbody>
<tr>
<td>Algorithm</td>
<td>Initial dose</td>
<td>4 U</td>
<td>5 U</td>
<td>Not specified</td>
</tr>
<tr>
<td></td>
<td>Titrate</td>
<td>2 U every 3 d</td>
<td>2-3 U every 2-3 d</td>
<td>2 U every 3 d</td>
</tr>
<tr>
<td>Target HbA1c Level, %</td>
<td>&lt;7</td>
<td>≤6.5</td>
<td>≤6.5</td>
<td>≤7</td>
</tr>
<tr>
<td>Target FPG Level, mg/dL</td>
<td>&lt;180</td>
<td>&lt;140b</td>
<td>&lt;145</td>
<td>90-180c</td>
</tr>
</tbody>
</table>

* For initiation of intensive basal/bolus therapy.

* Postprandial glucose target recommendation from AACE 2011 guidelines.42

* Adjust to 90-144 mg/dL if HbA1c targets are not being met.

Abbreviations: AACE, American Association of Clinical Endocrinologists; ACE, American College of Endocrinology; ADA, American Diabetes Association; CDA, Canadian Diabetes Association; EASD, European Association for the Study of Diabetes; IDF, International Diabetes Federation; NA, not available; PPG, postprandial glucose.
Table 4.
Selected Titration Algorithms for Prandial Insulin From Selected Clinical Trials

<table>
<thead>
<tr>
<th>Measure</th>
<th>GINGER&lt;sup&gt;45&lt;/sup&gt;</th>
<th>OPAL&lt;sup&gt;41&lt;/sup&gt;</th>
<th>ELEONOR&lt;sup&gt;58&lt;/sup&gt;</th>
<th>Davidson et al&lt;sup&gt;66&lt;/sup&gt;</th>
<th>4-T&lt;sup&gt;39&lt;/sup&gt;</th>
<th>APOLLO&lt;sup&gt;67&lt;/sup&gt;</th>
<th>Liebl et al&lt;sup&gt;68&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Algorithm</td>
<td>Initial: 50% of total baseline insulin dose with minimum 6 U each mealtime. Titrated: every 2 d based on 2-d highest postprandial glucose level, mg/dL: &gt;135-160: +1 U 160-200: +2 U &gt;200: +3 U</td>
<td>Investigator's discretion to reach target while avoiding hypoglycemia; either breakfast or main mealtime</td>
<td>Initial: 0.05 U/kg Titration: every 2 d based on 2-d mean postprandial glucose level, mg/dL: &gt;140: +2 U &lt;100: −2 U 100-140: no change</td>
<td>Initial: 10% of basal insulin dose at randomization Titration: weekly according to investigator's discretion to reach target while avoiding hypoglycemia</td>
<td>Initial: set by investigator Titration: Individually titrated based on investigator's discretion to reach target based on 2-d mean randomization titrated based on either breakfast or main mealtime dose, with increases of 1-3 U if preprandial glucose level was above target and decreases of 1-3 U if preprandial glucose level was below target</td>
<td>Initial: 4 U Titration: weekly Preprandial glucose level, mg/dL: &gt;200: +3 U &gt;150-&lt;200: +2 U &gt;100-&lt;150: +1 U &lt;100: no change Postprandial glucose level, mg/dL: &gt;185: +2 U &gt;135-&lt;185: +1 U ≤135: no change</td>
<td></td>
</tr>
</tbody>
</table>

Target FBG level, mg/dL

<table>
<thead>
<tr>
<th></th>
<th>Preprandial</th>
<th>Postprandial</th>
<th>Bedtime</th>
</tr>
</thead>
<tbody>
<tr>
<td>NA</td>
<td>≤135</td>
<td>≤135</td>
<td>≤135</td>
</tr>
<tr>
<td>NA</td>
<td>&lt;140</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>NA</td>
<td>70-129</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

Abbreviations: 4-T, Treating to Target in Type 2 Diabetes; APOLLO, A Parallel design comparing an Oral antidiabetic drug combination therapy with either Lantus once daily or Lispro at mealtime in type 2 diabetic patients failing Oral treatment; ELEONOR, Evaluation of Lantus Effect ON Optimization of use of single dose Rapid insulin; FBG, fasting blood glucose; GINGER, Glulisine in Combination with Insulin Glargine in an Intensified Insulin Regimen; NA, not available; OPAL, Orals Plus Apidra and LANTUS.
Add 3 to 4 units of a rapid-acting insulin analog at the largest meal and continue with basal insulin regimen.

Add 1 extra unit of rapid-acting insulin analog the following day if plasma glucose levels are <180 mg/dL at 2 hours after the meal or if the difference between premeal and postmeal glucose levels is >50 mg/dL.

Continue titration until postmeal glucose is <180 mg/dL.

Reassess basal insulin if required.

**Conclusion**

For PCPs and other nonspecialists who care for patients with T2DM, simple algorithms are now available to effectively manage insulin initiation, titration, and follow-up. Physicians should continually monitor for overbasalization and consider using a mealtime insulin intensification approach for patients who receive basal insulin analogs but who have not reached target levels of FBG and HbA1c.

Further insulin intensification beyond 1 prandial injection is the same process: a rapid-acting insulin analog is administered at a meal in addition to the largest meal of the day. Stepwise titrating of rapid-acting insulin alongside a full basal bolus regimen is emerging as a favored approach to insulin intensification. Sequentially adding up to 3 insulin injections in a stepwise manner if HbA1c levels do not remain (or decrease) below 7% may mirror a full basal bolus approach. In a study by Raccah et al, stepwise addition of up to 3 daily injections of insulin glulisine to basal insulin glargine resulted in a statistically significant level of reduced weight gain than the basal bolus approach (*P* = .04). Statistical noninferiority for the adjusted difference in HbA1c levels at the study completion, however, was observed in a subgroup analysis of patients with a HbA1c level of 8% or less at randomization (0.087: 95% confidence interval, −0.175 to 0.349). Finally, reports of other studies have suggested that the stepwise approach to insulin intensification may lead to less hypoglycemia than premixed insulin, with similar proportions of patients achieving the glycemic control goal of HbA1c levels below 7%, as well as lower blood glucose levels.

**Figure.** Proposed insulin intensification scheme in patients who are receiving maximal basal insulin without achieving target fasting blood glucose and glycated hemoglobin levels.

Insulin may have to be titrated downward by 1 or more units, particularly if the FBG level is consistently less than 100 mg/dL. This measure may be necessary in order to avoid the potential for nocturnal hypoglycemia in a patient whose T2DM is more controlled than at initiation of insulin intensification.

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58. Rosenstock J, Vlahakis A, Jones BA, Riddle MC. Time course of fasting glucose, hypoglycemia and body weight during systematic insulin dose titration: BID aspart premixed vs glargine +1 prandial glulisine or stepwise addition of glulisine to glargine in type 2 diabetes uncontrolled with oral agents [abstract 73-OR]. *Diabetes.* 2011;60(suppl 1):A20.

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