Higher-Than-Conventional Subcutaneous Regular Insulin Doses in Diabetic Ketoacidosis in Children and Adolescents

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What is already known on this topic?

Although dosages of 0.5 U/kg/day to 2 U/kg/day have been used as initial doses in various diabetes centers, little is known about their effect on glycemic control in new-onset type 1 diabetes mellitus (T1DM).

What this study adds?

An initial dose of 1.4-1.5 U/kg/day regular insulin may safely be used after resolution of diabetic ketoacidosis in children with new-onset T1DM without an increased risk of hypoglycemia.

Abstract

Objective: To evaluate the effect of initial insulin dosage on glycemic control in the first 48 hours of subcutaneous regular insulin therapy after resolution of diabetic ketoacidosis (DKA).

Methods: Records of patients with DKA hospitalized in the past 3 years [n = 76, median age = 10.0 (6.0-12.0) years, Male/Female: 44/32] were reviewed. The patients were designated into two groups according to distribution of starting doses of subcutaneous insulin. Group 1 (n = 28) received a median dose of 1.45 U/kg/day (1.41-1.5) and group 2 (n = 48) a median dose of 0.96 U/kg/day (0.89-1). Clinical and laboratory data were analyzed.

Results: Median, minimum, and maximum blood glucose levels of Group 1 in the first 48 hours of treatment were significantly lower than that of Group 2 [213 (171-242) vs. 255 (222-316), p = <0.001; 102 (85-151) vs. 129 (105-199), p = 0.004; and 335 (290-365) vs. 375 (341-438), p = 0.001, respectively]. The number of patients who experienced hypoglycemia (<70 mg/dL) were similar [Group 1, 5 (17.9%) vs. Group 2, 4 (8.3%), p = 0.276] and none had severe hypoglycemia. In Group 1, the ratio of blood glucose levels within the target range (100-200 mg/dL) were higher (37.5% vs. 12.5%) and the number of results >200 mg/dL were lower (50% vs. 81.3%) compared to Group 2 (p = 0.001 and p = 0.001, respectively).

Conclusion: After resolution of DKA, a higher initial dose of 1.4-1.5 U/kg/day regular insulin is associated with better glycemic control in children and adolescents without an increase in risk of hypoglycemia.

Keywords: Type 1 diabetes mellitus, regular insulin, initial doses, children, adolescent

Introduction

Diabetic ketoacidosis (DKA) occurs in 20-40% of children and adolescents with new-onset type 1 diabetes mellitus (T1DM) and after DKA resolves, the therapy is switched to any insulin regimen that aims to control blood glucose (BG) levels. It is known that the required initial daily insulin dose may vary according to many factors including age, body weight, stage of puberty, duration and phase of diabetes (1). The optimal insulin dose for the patient can only be determined empirically (2). An excellent initial insulin dose estimate is one that provides tight BG control and minimizes the risk of hypoglycemia.
Regular insulin is a soluble crystalline zinc insulin, an essential component of most daily replacement regimens (3). Due to its chemical structure, it has a wide peak and a long tail for bolus insulin, and thus cannot mimic the activity of the β cell but is available to initiate treatment after resolution of DKA and serves to determine the daily insulin dose before basal-bolus insulin regimen. Although guidelines recommend 0.5-1.0 U/kg/day of subcutaneous insulin following resolution of DKA, up to 2 units/kg/d are used in various centers, depending on the preference and experience of the particular diabetes team.

It has previously been reported that intensive insulin therapy would improve endogenous insulin secretion, consequently leading to better metabolic control (4). Thus, one of the aims of therapy following DKA is to control BG levels as early as possible. Higher initial insulin doses could rapidly decrease BG level, but their effect on BG fluctuations have not been extensively investigated (5). This present study aimed to evaluate the effect of the initial insulin dose on glycemic control in the first 48 hours of DKA treatment in children and adolescents with new-onset T1DM and also to compare BG fluctuations with higher and conventional doses of subcutaneous regular insulin therapy.

Methods

The study was conducted in one of the major tertiary hospitals in the region. Hospital records of patients who presented in the last 3 years were reviewed for the study. Diagnosis of T1DM and DKA were made according to the 2014 International Society for Pediatric and Adolescent Diabetes (ISPAD) Clinical Practice Consensus Guidelines for Diabetes in Childhood and Adolescence (6). Newborns, patients who had been treated with any insulin or anti hyperglycemic drugs before admission, patients having additional endocrine (hypo-hyperthyroidism, hypo-hypercortisolism, etc.) or non-endocrine diseases (any infectious or inflammatory disease), and those with inadequate hospital records were excluded. Finally, 76 children and adolescents [median age = 10.0 (6.0-12.0) years, Male/Female: 44/32] who presented with DKA due to new-onset T1DM were enrolled as the study group. Age, gender, stage of puberty (patients were noted as pubertal if they had at least Tanner 2 breast development or ≥4 mL testicular volume), body weight and height, glycosylated hemoglobin (HbA1c) levels, BG levels on admission and at the start of regular subcutaneous insulin, insulin dose administered for DKA, and initial dose of regular subcutaneous insulin were recorded. As shown in Figure 1, the patients were designated into two groups according to distribution of starting doses of subcutaneous insulin. Group 1 consisted of patients who received ≥1.25 U/kg/day [n=28, median dose = 1.45 U/kg/day (1.41-1.5)] and Group 2 consisted of those who were treated with <1.25 U/kg/day [n=48, median dose = 0.96 U/kg/day (0.89-1)].

Clinical and laboratory data were collected and analyzed after Behçet Uz Children’s Hospital Ethics Committee's approval, in concordance with the principles of Declaration of Helsinki (7).

Treatment Protocol

After resolution of DKA, all patients with new-onset T1DM were started on regular insulin (Humulin R, Lilly, USA) every 6 hours to determine the daily insulin requirement before transition to basal-bolus regimen. As the tissue half-life of insulin is longer than that of intravenous insulin, the first dose of subcutaneous basal insulin was given 30 min before the cessation of intravenous insulin infusion. Premeal BG measurement was performed before each insulin injection 30 minutes before the meals and the insulin dose was determined according to the BG levels: 100-200 mg/dL, same as the previous dose; >200 mg/dL, 110% of the previous dose; <100 mg/dL, 90% of the previous dose (2). The insulin dose was also adjusted according to the consumed amount of the meals. The decision to switch to basal-bolus regimen was made when no significant change was needed in regular insulin doses, generally after 3-4 days. BG levels were measured more frequently in patients who suffered from any symptom of hypo- or hyperglycemia. During hospitalization, the meals of the patients were prepared by dietitians according to the ISPAD Clinical Practice Consensus Guidelines 2014 on nutritional management in children and adolescents with diabetes. The diets contained carbohydrates providing approximately 50-55%, fat up to 30-35%, and protein 10-15% of daily energy requirements (8). Four meals and three snacks were given a day and no additional food was consumed unless hypoglycemic events occurred.

Study Variables

Descriptive characteristics of the patients, treatment information, and every BG measurement during the first 48 hours of subcutaneous regular insulin treatment were recorded. Glycemic variability indices [standard deviation (SD), coefficient of variation (CV), maximum BG, minimum BG, difference between maximum and minimum BG, rate of BG change (the amount of change between consecutive measurements, mg/dL/min)] were calculated. All BG measurements were performed by the same capillary BG monitoring system (Astracheck Plus*, Medisign MM 600, Empecs, Beijing, China), an electrochemical glucometer using the modified glucose oxidase method, calibrated monthly by electronical calibrators.
Statistical Analysis

The data were statistically analyzed using computer software SPSS 15.0 (Chicago, IL, USA). Mann-Whitney U-test and chi-square test were used to compare numerical and categorical variables, respectively, between groups. Univariate correlation analysis was performed between insulin starting dose and median glucose levels during 48 hours. General linear model with repeated measures was applied to assess the differences between the groups regarding the trajectory of glucose levels. Wilcoxon two-related samples test was employed to compare insulin doses at the start and at the 48th hour of treatment among groups. A p-value of <0.05 was chosen to represent statistical significance. Data were presented as median (25p-75p) or n (%).

Results

The study consisted of 76 children and adolescents [median age=10.0 (6.0-12.0); age range, 1.5-16.0 years; M/F: 44/32] with new onset T1DM admitting with DKA. Thirty-six patients (47.4%) were pubertal. The median BG level on admission was 466 mg/dL (383-574) while the median BG level at the start of insulin was 158 mg/dL (123-198). Baseline characteristics of the study group are presented in Table 1.

Group 1 and Group 2 were comparable regarding age, gender, pubertal status, HbA1c, and BG levels both on admission and at the start of subcutaneous insulin treatment. Table 2 presents the descriptive data of the groups.

Both of the groups had similar numbers of BG measurements [Group 1, 8 (8-8) vs. Group 2, 8 (8-8), p = 0.250]. Median BG levels of Group 1 in the first 48 hours were significantly lower than those of Group 2 [213 (171-242) vs. 255 (222-316), p = <0.001]. Figure 2 shows the trajectory of median BG levels during 48 hours and the difference between the curves was found to be statistically significant (p = <0.001). All median BG levels at specific time points in Group 1 were lower than those of Group 2, but statistical significance was present at 6th [163 (103-247) vs. 232 (188-294), p = 0.009], 30th [176 (103-219) vs. 258 (178-326), p = 0.001], 36th [184 (159-233) vs. 279 (222-360), p = <0.001], and 48th [198 (105-223) vs. 277 (205-316), p = <0.001] hours. Starting insulin dose (U/kg/day) and median glucose levels after starting subcutaneous insulin was found to be mildly correlated (r = -0.489, p = 0.001) (Figure 1).

Rates of BG levels <50 mg/dL and <70 mg/dL were compared between the groups to evaluate the frequency of hypoglycemia, while the frequency of BG levels >200 mg/dL was evaluated in order to assess hyperglycemia (Table 3). Only two patients in Group 1 had experienced
BG levels <50 mg/dL and those episodes were treated with oral glucose solutions. Frequency of BG levels <50 mg/dL, <70 mg/dL, and <100 mg/dL were similar in the two groups, while the percentage of BG levels >200 mg/dL were significantly lower in Group 1 (p = <0.001). The number of BG measurements in the target range (100-200 mg/dL) were significantly higher in Group 1 than in Group 2 (p = 0.001).

The minimum and maximum BG levels during 48 hours were significantly lower in Group 1 than in Group 2 (p = 0.004 and p = 0.001) (Table 4). Table 4 presents additional glycemic variability indices of the two groups including BG rate of change, difference between minimum and maximum BG, SD and CV of BG.

During follow-up, subcutaneous insulin doses needed to be increased in order to avoid hyperglycemia. As a result, insulin doses (units/kg/d) administered on the second day in both Group 1 [1.63 (1.47-1.77) and Group 2 [1.07

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**Table 3.** The characteristics of blood glucose fluctuations in patients with high-dose and conventional-dose subcutaneous regular insulin after resolution of diabetic ketoacidosis

<table>
<thead>
<tr>
<th></th>
<th>Group 1 (n = 28)</th>
<th>Group 2 (n = 48)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of episodes &lt;50 mg/dL</td>
<td>0 (0-0)</td>
<td>0 (0-0)</td>
<td>0.062</td>
</tr>
<tr>
<td>Percentage of episodes &lt;50 mg/dL</td>
<td>0 (0-0)</td>
<td>0 (0-0)</td>
<td>0.062</td>
</tr>
<tr>
<td>Number of patients who experienced episodes &lt;50 mg/dL</td>
<td>2 (7.1%)</td>
<td>0 (0-0)</td>
<td>0.133</td>
</tr>
<tr>
<td>Number of episodes &lt;70 mg/dL</td>
<td>0 (0-0)</td>
<td>0 (0-0)</td>
<td>0.204</td>
</tr>
<tr>
<td>Percentage of episodes &lt;70 mg/dL</td>
<td>0 (0-0)</td>
<td>0 (0-0)</td>
<td>0.234</td>
</tr>
<tr>
<td>Number of patients who experienced episodes &lt;70 mg/dL</td>
<td>5 (17.9%)</td>
<td>4 (8.3%)</td>
<td>0.276</td>
</tr>
<tr>
<td>Percentage of episodes &lt;100 mg/dL</td>
<td>6.25 (0-25)</td>
<td>0 (0-12.5)</td>
<td>0.021</td>
</tr>
<tr>
<td>Percentage of episodes between 100-200 mg/dL</td>
<td>37.5 (25-50)</td>
<td>12.5 (3.13-25)</td>
<td>0.001</td>
</tr>
<tr>
<td>Percentage of episodes &gt;200 mg/dL</td>
<td>50 (25-75)</td>
<td>81.3 (62.5-87.5)</td>
<td>0.001</td>
</tr>
</tbody>
</table>

**Table 4.** Glycemic variability indices among groups

<table>
<thead>
<tr>
<th></th>
<th>Group 1 (n = 28)</th>
<th>Group 2 (n = 48)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>BG rate of change (mg/dL/min)</td>
<td>0.5 (-0.73-2.13)</td>
<td>2.13 (0.89-3.4)</td>
<td>0.001</td>
</tr>
<tr>
<td>Minimum BG (mg/dL)</td>
<td>99 (86.3-120)</td>
<td>137 (99-192)</td>
<td>0.004</td>
</tr>
<tr>
<td>Maximum BG (mg/dL)</td>
<td>335 (290-365)</td>
<td>375 (341-438)</td>
<td>0.001</td>
</tr>
<tr>
<td>Difference between minimum and maximum BG level (mg/dL)</td>
<td>222 (168-272)</td>
<td>219 (169-304)</td>
<td>0.445</td>
</tr>
<tr>
<td>Standard deviation</td>
<td>78.7 (55.9-91.5)</td>
<td>75.8 (60.8-96.1)</td>
<td>0.504</td>
</tr>
<tr>
<td>Coefficient of variation</td>
<td>0.36 (0.29-0.44)</td>
<td>0.3 (0.24-0.59)</td>
<td>0.094</td>
</tr>
</tbody>
</table>

BG: blood glucose
Clinical and laboratory data

Several studies have shown that the most prominent barrier rather than BG fluctuation was correlated with vascular damage is controversial in the literature. Peña et al. (14) reported that BG fluctuations were also associated with oxidative stress with coexistence of high BG levels and mitochondrial superoxide overproduction, which leads to the activation of major pathways involved in the pathogenesis of complications of diabetes (11). Thus, the primary goal of treatment in children and adolescents with T1DM is to maintain near-normoglycemia as early as possible (12,13). In our study, there was no statistically significant difference between the groups with regard to hypoglycemia. In Group 1, only 2 patients had suffered < 50 mg/dL hypoglycemia (each with 1 BG episode of < 50 mg/dL) which was treated with oral glucose solutions. The number and ratio of BG < 70 mg/dL and < 100 mg/dL episodes were also similar in the two groups. None of our patients experienced severe hypoglycemia.

In conclusion, we suggest that an initial dose of 1.4-1.5 U/kg/day regular insulin may safely be used after resolution of DKA in children with new-onset T1DM with no increase in risk of hypoglycemia.

Ethics

Ethics Committee Approval: Clinical and laboratory data were collected and analyzed after Behçet Uz Children’s Hospital Ethics Committee’s approval, in concordance with the principles of Declaration of Helsinki.

Informed Consent: Not applicable.

Peer-review: Externally and Internally peer-reviewed.

Authorship Contributions

Concept: Özlem Bağ, Korcan Demir, Design: Özlem Bağ, Korcan Demir, Data Collection and Processing: Özlem Bağ, Selma Tunç, Özlem Nalbantoğlu, Çiğdem Ecevit, Aysel
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References


