Multi-centre STAR Glycemic Control Pilot Trials in New Zealand And Hungarian ICUs

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INTRODUCTION

Background: ICU patients often receive glycemic control to mitigate the negative effects of prolonged hyperglycemia. However, results of glycemic control protocols have been mixed. Quality and consistency can be variable, leading to sub-optimal outcomes due to both patient-specific and external factors. In particular, intensive insulin therapy can lead to risk of iatrogenic hypoglycemia.

Objective: To report initial clinical pilot results of the computerised STAR glycemic control protocol in a Hungarian and New Zealand ICU.

RESULTS

STAR was able to target BG to an equivalent level in two distinct ICUs, with cohort BG at 6.0 [5.4 - 6.8] mmol/L (Gyula) and 6.1 [5.6 - 6.8] mmol/L (Christchurch). Effort was similar (12.3 and 12.8 measurements/day in Gyula and Christchurch, respectively).

Gyula performance/safety: 72.7% and 80.43% of BG in 4.4-7.0 and 4.4-8.0mmol/L bands and 2.2% BG<4.0mmol/L. Christchurch performance/safety: 77.8% and 89.43% of BG in the 4.4-7.0 and 4.4-8.0mmol/L bands and 0.87% BG<4.0mmol/L. There were no severe hypoglycemic events during STAR in either ICU.

Performance differences were due to 1 Gyula patient without whom all metrics were within 0.1-1.0% difference. Insulin and nutrition inputs were comparable, with Gyula patients receiving increased nutrition inputs due to clinical practice.

BG distributions in Christchurch were markedly similar to those predicted by virtual trials.

METHODS

15 pilot episodes (1168 hours) using STAR at Kálmán Pándy Hospital (Gyula, Hungary) are directly compared to 38 episodes (3763 hours) in Christchurch Hospital. Only patients with a target range of 4.4 - 8.0 mmol/L are included. Performance is assessed by percentage of (hourly re-sampled) BG measurements in glycemic bands. Safety is assessed by numbers of patients with severe hypoglycemia (BG < 2.2mmol/L) and degree of mild hypoglycemia (%BG<4.0mmol/L). Clinical effort is assessed as average BG measurements per day.

Gyula administers insulin as constant infusions, and STAR actively controls both enteral and parenteral nutrition inputs. Christchurch uses insulin boluses, and STAR actively controls enteral nutrition (parenteral nutrition is clinically determined). Measurements were 1-3-hourly, with available intervals determined by STAR, and chosen by nursing staff.

STAR determines optimal combinations of nutrition and insulin by identifying patient-specific insulin sensitivity (SI), and using stochastic forecasting to predict how patient condition is likely to change over the next 1-3 hours.

CONCLUSIONS

STAR was equally effective in two ICUs, across geographically distinct clinical units, patients, and clinical practice. No significant difference was seen using infusion or bolus insulin. The STAR framework was readily transposed and quality glycemic control was achieved.