Clinical Experience with the Hybrid Closed-Loop Insulin Delivery System (Minimed™ 670G) compared to Sensor Augmented Therapy (MiniMed™ 640G) and standard care

Larry A Distiller1*, Stanley Landau1, David Segal2, Sedeshan Govender3, Wayne May4, Greg Hough5 and Jacobus van Dyk6

1Centre for Diabetes and Endocrinology, 81 Central Street, Houghton 2198, Johannesburg, South Africa
218 Eton Rd, Park town, 2193, Johannesburg, South Africa
3Centre for Diabetes, Endocrinology and Heart Care Suite 3, Netcare Umhlanga Hospital, 323 Umhlanga Rocks Drive Umhlanga, Durban, 4231, South Africa
4Kingsbury Medical Suites, Claremont 7708, Cape Town, South Africa
5Suite 308, Greenacres Hospital, Cnr Cape & Rochelle Rd, Greenacres, Port Elizabeth, 6045
6Suite 211, Life Groenkloof Hospital, 50 George Storrar Drive, Groenkloof, Pretoria

Abstract

Background: This real-world clinical study compared the efficacy of a hybrid closed-loop system (HCL) to a sensor integrated pump (SIP) system and usual care.

Methods: Twenty-four subjects aged 8 to 65 years were randomly selected from 6 clinical centers to take part in this prospective study. Subjects were on a variety of standard care programs at base-line (Phase 1) and then used SIP for two months (Phase 2) followed by two months on HCL (Phase 3).

Results: Compared with baseline, the mean HbA1c for the cohort reduced by 0.37% after 2 months of SIP therapy and by 0.7% after 2 months of HCL therapy. At study end, the mean HbA1c for the cohort was 7.2%. Time in severe hypoglycemia reduced to 0.4% (0.7% at baseline) for both SIP and HCL therapies. Time below 70 mg/dl reduced progressively between Phase 1 (baseline therapy), Phase 2 (SIP) and Phase 3 (HCL) (6%, 2.5% and 1.5% respectively) of the study. In the study intervention arms, less time was spent above 180 mg/dl (32.1% with SIP and 25.5% with HCL) versus 37% at baseline. The mean time-in-range (TIR) achieved was 72.5% with HCL, versus 65.2% with SIP (58.3% at baseline). Similarly, 50% of the subjects achieved a TIR of over 70% on HCL versus 33% on SIP (8% at baseline).

Conclusions: This small, prospective, real-world study demonstrated that irrespective of the starting parameters, SIP therapy reduced mean HbA1c levels, TIR and hypoglycemic events. Implementation of an HCL system enhanced these outcomes further.

Key Words: Type 1 diabetes; Continuous glucose monitoring; Hybrid closed loop system; Sensor integrated pump; Glucose time-in-range; Automated insulin delivery.

Introduction

The advent of Continuous Glucose Monitoring (CGM) has opened a new paradigm for people with diabetes on insulin therapy. The use of CGM with Insulin pump therapy (CSII) is well established[1], but increasingly has been promoted for use with individuals on Multiple Insulin Injection Regimens (MIR)[2-4]. Of interest, the COMISAIR study[3] suggested that individuals using CGM with MIR could do as well as those on CSII with regard to HbA1c reductions. The GOLD study[5] demonstrated that individuals on CGM also had less severe hypoglycemia than those using conventional finger-prick blood glucose monitoring, despite lower HbA1c levels. The efficacy of CGM in reducing hypoglycemia in individuals with severe hypoglycemia unawareness has recently been confirmed[6].

While most studies comparing CGM (with or without CSII), to conventional finger-prick testing traditionally utilize the A1C as a primary end-point, these studies have also better delineated the limitations of the HbA1c. This test does not reflect intra- and inter-day glycemic excursions that may lead to acute events (such as hypoglycemia), postprandial hyperglycemia and glycemic variability[7]. New metrics to better assess glycemic control have been identified and include estimated mean glucose, time-in-range (TIR), and percentage of time in both hyperglycemic (glucose >180 mg/dl) and hypoglycemic ranges (glucose <70 mg/dl) [8]. International Societies have subsequently endorsed these new metrics and recommended the appropriate targets that should be achieved [9].
Sensor-integrated pump therapy (SIP) has demonstrated improved HbA1c levels[10-11], less glycemic variability[12-13] and reduced hypoglycemia[3,14]. Subsequently, the first hybrid closed-loop system (HCL) that automatically adjusts basal insulin delivery every 5 minutes based on sensor glucose data has become commercially available. This system has been shown to be safe and effective in improving glycemic control[15-16].

This study compares the sequential effects of standard therapy versus the use of SIP using the MiniMed™ 640G and then HCL with the MiniMed™ 670G system (both devices manufactured by Medtronic MiniMed, Inc., Northridge, CA) in a group of subjects with type 1 diabetes. The purpose was to determine and quantify any difference in glycemic parameters in the same subjects on the 3 different forms of therapy. More particularly, we sought to identify whether there was any advantage to HCL versus SIP in a same-subject cohort in a real-world situation.

Materials and Methods

Six Diabetes Centers with extensive experience in insulin pump therapy were identified. These included 4 Adult centers and 2 pediatric centers. Each center was asked to randomly select 4 type 1 subjects for the study. Thus 24 subjects were enrolled into the study. Subjects were on a variety of therapies for their diabetes. Subject demographics and therapies prior to inclusion in the study are listed in Table 1. Subjects were eligible for recruitment if they were 7 years of age or older, not pregnant, and using a minimum of 8 units of insulin per 24 hours. Subjects with any other systemic disease or any therapy other than insulin were excluded.

Table 1: Treatment options and demographics of the subjects

<table>
<thead>
<tr>
<th>Baseline Therapy</th>
<th>Number of Subjects</th>
<th>Gender (M/F)</th>
<th>Age Range (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIR &amp; SMBG</td>
<td>11</td>
<td>5-Jun</td>
<td>12 to 58</td>
</tr>
<tr>
<td>MIR &amp; FGM</td>
<td>1</td>
<td>0/1</td>
<td>15</td>
</tr>
<tr>
<td>MIR &amp; CGM</td>
<td>2</td>
<td>1-Jan</td>
<td>25-49</td>
</tr>
<tr>
<td>CSII &amp; SMBG</td>
<td>9</td>
<td>3-Jun</td>
<td>Jul-65</td>
</tr>
<tr>
<td>CSII &amp; FGM</td>
<td>1</td>
<td>Jan-00</td>
<td>16</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td></td>
<td>14/10</td>
</tr>
</tbody>
</table>

*MIR = Multiple Daily Injection Regimen

*SMGB=Self-Monitoring of Blood Glucose (Finger prick)

*FGM= Flash Glucose Monitoring (Abbott Libre Personal)

*CGM= Real-time Continuous Glucose Monitoring

*CSII=Continuous Subcutaneous Insulin Infusion (Insulin Pump Therapy)

4 children (aged 7 - 10 years), 6 adolescents (aged 10 - 18 years) and 14 adults (over 18 years of age) were included in the study.

Following the signing of informed consent, the subjects underwent 3 Phases of management, namely:

- In Phase 1, on their current therapy, the subjects underwent 2 weeks of CGM, utilizing Abbott Libre personal flash monitoring. The glycaemic data generated was downloaded and analyzed.
- In Phase 2, the subjects were provided with a MiniMedTM 640G pump and Medtronic GuardianTM Sensor 3 sensors and trained in their use. They were instructed to utilize the fully-integrated system (SIP) and were expected to achieve at least 80% sensor utilization. After 2 months, the last 2 weeks of CGM data was downloaded and analyzed.
- In Phase 3, subjects were converted to HCL using the MiniMedTM 670G pump and were instructed to aim for 100% sensor usage on Auto Mode. After 2 months, the last 2 weeks of CGM data was downloaded for analysis.

Blood was drawn for HbA1c analysis at the end of each Phase.

Statistical Analysis

The data in this study was analyzed in an exploratory manner, as the sample size was not determined using power analysis. Quantitative data was summarized using number of observations - mean, standard deviation, median, 25th and 75th percentiles, minimum and maximum. Categorical data was summarized using counts and frequencies. Given the small sample size and the presence of outlying observations, HbA1c changes from baseline to Phase 2 and to Phase 3, and from Phase 2 to Phase 3 were analyzed using Wilcoxon signed rank tests with Bonferroni correction. p values <0.05 were considered statistically significant. CareLink™ software was utilized to calculate mean glucose, estimated HbA1c (eAIC), time-in-range, and time in hypoglycemia (<70 mg/dl and <54 mg/dl) for each subject.

Results

CGM data was not available for 4 of the 24 subjects at baseline, leaving 20 subjects for baseline analysis. CGM data was available for the end of Phases 2 and 3 for all 24 subjects. Changes in HbA1c are depicted in Figure 1. After 2 months of SIP, the median HbA1c had reduced by 0.1% overall and mean HbA1c by 0.37%. Following a further 2 months on HCL, the median HbA1c reduced
Clinical Experience with the Hybrid Closed-Loop Insulin Delivery System (Minimed™ 670G) compared to Sensor Augmented Therapy (MiniMed™ 640G) and standard care

0.4% from baseline with a 0.7% reduction in mean HbA1c. Despite the small number of subjects, this reduction in median HbA1c was statistically significant (p=0.006). The mean HbA1c for the entire cohort at the end of the study was 7.2%.

12 of the subjects were excluded from analysis of other metrics because of missing data points, no baseline data (4 subjects) or because the TIR had been calculated on parameters other than 70 to 180 mg/dl.

Figure 1: Changes in HbA1c during the study Phases
Phase 1: Standard Therapy
Phase 2: Automated pump therapy (MiniMedTM 640G)
Phase 3: Hybrid Closed Loop system (MiniMedTM 670G)

Figure 2 depicts analyses of all parameters of glycemic control for the remaining 12 subjects where full data was available. For all parameters measured, a progressive improvement was seen with each phase of therapy. Of clinical importance, the reduction in percent time in severe hypoglycemia (<54 mg/dl) was the same for SIP and HCL therapies (0.4%), and reduced from 0.7% in Phase 1. However, the percent time below 70 mg/dl reduced progressively between Phase 1 (baseline therapy), Phase 2 (SIP) and Phase 3 (HCL) (6%, 2.5% and 1.5% respectively). Also, less time was spent above 180 mg/dl (37% at baseline, 32.1% with SIP and 25.5% with HCL). As a result, the mean percent TIR achieved was 72.5% with HCL, 65.2% with PIC and 58.3% at baseline. Similarly, 50% of the subjects achieved a percent TIR of over 70% on HCL versus 33% on SIP and only 8% at baseline.

Figure 2: Continuous Glucose Monitoring results comparing the last two weeks sensor data at each Phase of the study (12 subjects)

Discussion

Utilizing metrics recommended by the International Consensus on Use of Continuous Glucose Monitoring[8-9], the comparison between standard therapy, SIP therapy and HCL is clear. On all parameters, SIP is better than standard therapy and this is improved further with HCL. This small cohort of subjects had a wide age-range and the subjects had multiple variations of therapy at baseline. While the uncontrolled nature of the subject selection could be criticized, this is a real-world study and the results might suggest that irrespective of the subjects’ baseline therapy, they are likely to benefit from sensor augmented pump therapy, particularly HCL. This is in line with the findings of Cordero et al[18] who, with a much larger cohort of subjects, reported that individuals without prior CGM experience,
and those already using CGM, similarly benefitted from the MiniMedTM 670G HCL system.

The reductions in time spent in hypoglycemia (blood glucose <70 mg/dl) and particularly <54 mg/dl are striking. It is perhaps not surprising that no difference was seen in the percentage of documented severe hypoglycemia incidences <54 mg/dl between the SIP and HCL systems, since both have the ‘low glucose suspend’ functionality. However, the advanced system employed by the HCL appears to be more effective in reducing the number of episodes below 70 mg/dl. While this might not have a major effect on long-term outcomes, it can be expected to improve subject confidence and quality of life.

All long-term outcome studies have relied on the HbA1c as a surrogate marker of glycemic control and the HbA1c remains the gold standard. However, the HbA1c is not without problems as comprehensively reviewed in the publication by the “Beyond HbA1c writing group”[7]. With the ability to measure other glycemic parameters, the use of the HbA1c in assessing glycemic control can be enhanced by taking TIR into account. To date there have been no outcome studies supporting the perception that TIR or glycemic variability may be as good or a better marker of long-term outcomes than HbA1c, and it is unlikely that such data will be forthcoming in the near future. Nevertheless, studies have indicated that by addressing these parameters, HbA1c levels can be reduced, and that this can be achieved with reductions in hypoglycemia using sensor-augmented insulin pump therapy [9,10,16-18]. Expert opinion suggests that these parameters should be considered as important aspects in the assessment of glycemic control[7-9].

This was not constructed as a formal clinical study but is rather a report on real-world experience in the use of the Hybrid Closed-Loop Insulin Delivery System (MinimedTM 670G) compared to Sensor Augmented Therapy (MiniMedTM 640G) and standard care. There are therefore several weaknesses inherent in this report, which include the absence of data on some of the patients. Further, if constructed as a formal study, it may have been advantageous to institute a cross-over design, but this is not standard practice in a real-world setting. We also did not formally canvas the patients with regard to their experience on the two different systems. Nevertheless, this small cohort demonstrates that in a largely unscreened and disparate group of patients visiting a routine diabetes clinic, the use of the Sensor Augmented Therapy (MiniMedTM 640G) pump improves parameters of glycemic control, and this is further enhanced by the Hybrid Closed-Loop Insulin Delivery System (MinimedTM 670G).

Conclusions

This small prospective study was performed in a real-world clinical situation and involved a wide variety of subjects with respect to both age and levels of glycemic control. Irrespective of the starting parameters, SIP reduced mean HbA1c levels, TIR and hypoglycemic events, and implementation of the HCL system resulted in further improvements.

Acknowledgements

Michael Brown for editing this manuscript

Conflict-of-interest disclosure

The authors declare that there is no conflict of interest. None of the authors have received funding or compensation from Medtronic, either for partaking in this study or for consultation work done directly or indirectly. Medtronic provided research support by way of assisting in collation of data and statistical analysis of the results. Javier Castañeda, Statistics Manager, Diabetes, Medtronic Bakken Research Center, provided the statistical analysis

Author Disclosure Statement

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors. Medtronic supplied 20 each of MMT-1751WWKA (MiniMedTM 640G Insulin Pumps), MMT-1762WWKA (MiniMedTM 670G Insulin Pumps), MMT-7810W1 (Guardian 3 Link Transmitters) and MMT-1151ZA (Contour Link Next 2.4 Glucometers) for the study for subject care and educational purposes. No direct financial support was received from Medtronic for the conduct of this study.

Abbreviations

CGM: continuous glucose monitoring
HCL: Hybrid closed loop system insulin pump (MiniMedTM 640G),
SIP: Sensor integrated pump system (MiniMedTM 640G),
CSI: Continuous subcutaneous insulin infusion - Insulin pump therapy,
MIR: Multiple Insulin Injection Regimen,
eA1c: Estimated HbA1c,
TIR: Percent time-in-range.

References


Citation: Larry AD, Stanley L, David S, Govender S, et al. (2019) Clinical Experience with the Hybrid Closed-Loop Insulin Delivery System (Minimed™ 670G) compared to Sensor Augmented Therapy (MiniMed™ 640G) and standard care. J Endocrinol Diab. 6(2): 1-5. DOI: 10.15226/2374-6890/6/2/001132


