



# FORMACIÓN *FLASH*

## MONITORIZACIÓN FLASH DE GLUCOSA EN DIABETES TIPO 2

MATERIAL DIRIGIDO A PROFESIONAL SANITARIO

MÓDULO 0



### EVIDENCIA CIENTÍFICA

**TABLA 1. EVIDENCIA DE UTILIDAD DE LA MONITORIZACIÓN GLUCEMIA FLASH EN DM2**

	↓ HBA1C	↓ HIPOGLUCEMIAS	↑ TIEMPO EN RANGO	↑ SATISFACCIÓN Y CALIDAD DE VIDA	COMPLICACIONES	COSTES
ECA Y EC NO A (BOLO-BASAL/ MÚLTIPLES DOSIS INSULINA)	-0,3 – 0,5% <sup>1,2,3,4</sup> Mayor B <sup>a</sup> <65 años <sup>1</sup>	No significativas <sup>2,3,4</sup> ↓ 43%, 53% (graves) y 52% (nocturnas) <sup>1</sup>	No significativo <sup>1,2</sup> Más tiempo en rango (no insulinas) <sup>3</sup>	Mayor satisfacción <sup>1,3,4</sup>		
METAANÁLISIS Y REVISIONES SISTEMÁTICAS	De no significativa a -0,55% <sup>5,6,7,8</sup> La reducción depende de HbA1c de inicio <sup>8</sup> Mayores bajadas a los 2 meses y se mantienen hasta los 12m <sup>8</sup>	↓ tiempo y n <sup>o</sup> episodios: -0,47 h / -0,16 eventos <sup>7,8,9</sup>	Desde no diferencia <sup>7</sup> a ↑ 1 hora en rango y 0,37 horas (22 minutos) menos en nivel alto de glucosa <sup>9</sup>	De no diferencia <sup>9</sup> a mayor satisfacción y calidad de vida y reducción de angustia por la DM <sup>7</sup> Parecen mejorar satisfacción y calidad de vida, aunque no hay certeza por la gran variabilidad <sup>10</sup>		MGF era rentable si el autocontrol >10 veces/día. Era más costoso debajo de 5,6 veces/día <sup>9</sup>
VIDA REAL	Desde ns a -1,3% <sup>11,12,13,14,15,16,17</sup> ↓ más importantes con HbA1c más elevadas <sup>12,13,16</sup> No significativo para <7,5% <sup>16</sup>	↓ de 3,1 a 1,2 episodios/mes (todos los fármacos) <sup>11,14</sup> Detectó hipos con SU, sobre todo si HbA1c < 6,3% <sup>18</sup> ↓ desde el día 3 de la MGF ↓ sobre todo en los de HbA1c más baja <sup>19</sup>	↑ +1,7 ± 3,0 h/día <sup>14</sup> ↓ de la glucemia media <sup>19</sup>	↑ manejo de glucosa, dieta, actividad física, uso de atención médica y autocuidado <sup>11</sup> ↑ Satisfacción <sup>14,17,20,21</sup> ↑ Calidad de vida <sup>21</sup> ↑ Ejercicio físico <sup>20</sup>	↓ Hospitalizaciones por la diabetes <sup>21</sup> ↓ Absentismo laboral <sup>21</sup> ↓ Complicac agudas <sup>22,23,24</sup> ↓ Hospitalizaciones por todas las causas <sup>23,24</sup>	Monitorizar 11 veces para euglucemia <sup>19</sup>
ESTIMACIÓN POR MODELO						2.700€ y 2.120€/año/paciente utilizando el sistema SMBG o FreeStyle Libre 2, respectivamente. Tiene en cuenta costes de hipoglucemias y hospitalizaciones <sup>25</sup>



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**TABLA 2.** EVIDENCIA EN SUBGRUPOS ESPECIALES Y OTRAS APORTACIONES EN DM2

SUBGRUPOS ESPECIALES	
Ramadán <sup>26,27</sup>	↓ Hipoglucemias y ↑ Tiempo en rango en tto con insulinas y SU Mejor valoración que la HbA1c
Enfermedad Renal Crónica <sup>28</sup>	Menos sesgo que la albúmina glicosilada y la fructosamina
Hemodiálisis <sup>29,30,31</sup>	Buena correlación con HbA1c promedio y albúmina glicosilada
Neuropatía diabética <sup>32,33</sup>	< Tiempo en rango = > más síntomas de neuropatía diabética
Angina espástica coronaria <sup>34</sup>	La variabilidad glucémica intradía se asoció con espasmo de la arteria coronaria en pacientes con disglucemia

  

OTRAS APORTACIONES DE LA MGF	
Identificar hipoglucemias en pacientes con SU <sup>18</sup>	Aumento de hipoglucemias con SU si HbA1c < 6,3
Útil para valorar célula β y clasificar diabetes <sup>35</sup>	Tiene correlación con el péptido C en ayunas
MGF tiene buena correlación entre los niveles promedios de glucemia y la HbA1c, para cualquier nivel de HbA1c <sup>36</sup>	
MGF es similar a la MCG con buena correlación con glucemias capilar y venosa <sup>37</sup>	
Control DM2 durante la pandemia por COVID-19 <sup>38</sup>	



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