Continuous glucose monitoring and external insulin pump: towards a subcutaneous closed loop

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SUMMARY
The development of an artificial pancreas for the treatment of type 1 diabetes is a highly desired endeavour for type 1 diabetic patients, physicians, scientists and engineers. The development of the first miniaturized external pumps in the 70s and the pharmacokinetic properties of short acting insulin analogues, closer to physiology, have raised hopes for the elaboration of such a device. Recent technological progress in the development of continuous glucose sensors, have improved the reliability and accuracy of these devices. This has led to the development of prototypes of closed-loop system based on the combination of a continuous monitor, a control algorithm, and an insulin pump. This review focuses on the SC-SC approach, employing subcutaneous glucose monitoring and subcutaneous insulin delivery. The feasibility of this solution has been proven at a small scale, but remains to be confirmed in the home setting. Intermediate solutions, such as semi-automatic systems, might be immediately valuable.

Key-words: Type 1 diabetes • Continuous glucose monitoring • Continuous subcutaneous insulin infusion • Artificial pancreas • Automated insulin delivery • Review.
The goal of type 1 diabetes treatment is to achieve tight glucose control, in order to avoid chronic complications, while limiting the frequency of hypoglycaemic episodes in the day-to-day life. Although considerable efforts have been made to improve the pharmacokinetics of insulin and to develop user-friendly monitoring and treatment tools, this goal remains difficult to achieve, and the desire and demand for an automated artificial pancreas is still up to date. Such a system includes an insulin pump, capable of delivering insulin continuously, a monitoring device, capable of sensing continuously glucose, and algorithms for calculating the insulin delivery rate, in order to achieve the normalisation of glucose concentrations [1].

Several control algorithms have been proposed for the automated regulation of glucose by insulin. The pioneering device, the Biostator, was developed in the 1970’s [2]. However, the use of this bulky device remains limited to hospitals and research centres.

In the last decades, considerable technological progress has been made. Since the introduction of continuous subcutaneous insulin infusion, the insulin pumps have been miniaturised and their reliability improved. The accuracy and reliability of glucose sensing devices has also been improved. It is now tempting to develop a closed-loop system based on these two devices, despite the drawbacks of the subcutaneous tissue, i.e. the delays in glucose sensing and in insulin delivery.

The present review focuses on the development of subcutaneous—subcutaneous (SC-SC) closed-loop systems, which adopt the subcutaneous route for both glucose monitoring and insulin delivery. The intravenous–intraperitoneal approach is developed in this issue by E. Renard et al [3].

Continuous glucose monitoring

The information obtained with the glucose monitoring system should be accurate, real-time, and continuous (or frequent if intermittent). The glucose sensors that measure glucose concentrations in the interstitial fluid can be non-invasive or minimally invasive. Most non-invasive approaches are carried out using optical glucose sensors. The basic premise of optical glucose sensors is to direct a light beam through the skin and to measure the alterations of the properties of the reflected light. Although this approach seems attractive, the specificity of glucose measurement is poor, because of numerous interferences [4]. The reverse iontophoresis approach (Glucowatch®, Cygnus) allows the measurement of glucose concentration in the interstitial fluid after its transdermal extraction [5]. After a 3-h warm-up period, the device is capable of providing up to three glucose readings per hour for 12 h after a single point calibration with a self blood glucose measurement. However, the measurement result is not immediately available (the time required for sample extraction and analysis is 20 minutes), and the current applied to the skin causes some degree of irritation. The device cannot be used in case of increased sweating, and this is a concern for the detection of hypoglycaemia. For all these reasons, these two approaches are not suitable for the closed-loop.

Minimal-invasive methods are based on the microdialysis or on the use of amperometric enzyme electrodes.

The microdialysis system developed by Menarini (Glucoday®) can be used for three days [6]. The semi-permeable dialysis fibre is inserted into the subcutaneous tissue and perfused with glucose-free isotonic fluid. Due to the concentration gradient, glucose diffuses from the interstitial fluid through the dialysis membrane into the perfusate. The dialysate is pumped to a glucose sensor outside the body where the glucose concentration is measured continuously. A calibration is required once daily. As the glucose sensor is outside the body, no significant signal drift has to be feared. However, the time lag inherent to the technique is a disadvantage. It is related to the length of the tubing and the perfusion flow rate.

The other minimal invasive approach is based on the use of electrodes covered with glucose oxidase and submitted to the application of a potential. The electrode is inserted in the subcutaneous tissue and measures the change in current flow caused by the enzyme-catalyzed production of hydrogen peroxide, which is proportional to the amount of glucose at the site of insertion. The main drawback of this technique is the signal drift induced by the reaction of the subcutaneous tissue to the electrode and the changes in glucose and oxygen diffusion near the electrode. This can be compensated for by frequent recalibrations.

The continuous glucose monitoring system (CGMS®, Medtronic MiniMed) is the first currently available monitoring system based on this technique. It uses a subcutaneously inserted flexible needle sensor containing glucose oxidase, which converts interstitial glucose into a measured electrical current [7]. It requires four calibrations per day, does not display the current glucose concentration measured, but allows retrospective analysis of interstitial glucose readings every 5 minutes for 72 hours. The next generation of the system (Guardian RT®) functions in real time, with hypoglycaemic and hyperglycaemic alarms, and allows extended use by the patient himself [8].

Two other devices based on the glucose electrode technique and capable of displaying glucose measurements in real-time are currently submitted to the FDA approval: the Navigator® system (Abbott) [9] and the Dexcom® system [10].

All these devices have been studied for their reliability, and most of them for their ability to improve glycaemic control (HbA1c and/or frequency of hypoglycaemic episodes) when used in the real life. At present, the non invasive techniques based on spectroscopy and the reverse iontophoresis technique do not fulfil the desirable features of a glucose monitoring system included in a closed-loop. Minimal invasive techniques, microdialysis and glucose electrodes, allow frequent, durable and reliable glucose monitoring, and can...
therefore be used for an automated insulin delivery system. Their weaknesses are the delay of glucose measurement and the disparity of interstitial and venous glucose measurement [11], and the need for frequent recalibration.

**Continuous insulin delivery**

Continuous subcutaneous insulin infusion (CSII) with external insulin pumps was introduced in the 1970s as a way of achieving and maintaining strict control of blood glucose concentrations in type 1 diabetic patients [12], by means of more physiological insulinisation than that with multiple daily injections (MDI). The exclusive use of soluble, short acting insulin, infused subcutaneously at the same site for 2 or 3 days, reduces the variability of insulin absorption when compared to long acting insulins. CSII allows a wide flexibility of insulin infusion, thanks to the ability of programming several basal rates and adjusting meal boluses when required. Several studies have concluded to the superiority of CSII over MDI in terms of HbA1c [13-16]. In the DCCT (Diabetes Control and Complication Trial), HbA1c levels in the intensive group were significantly lower with CSII than with MDI (-0.2 to -0.4%) [17]. Recent meta-analyses report an overall benefit of CSII over MDI, with a reduction of HbA1c in the range of 0.4 – 0.5% [18, 19].

Several randomised controlled trials have shown that the use of short-acting insulin analogues is more efficient on HbA1c levels than human insulin [20-22], this has been confirmed by a meta-analysis [23]. The pharmacokinetic properties of the analogues are certainly responsible for the improvement in postprandial glucose levels and stability. However, the efficacy of CSII versus MDI therapy has been evaluated only in a limited number of randomised controlled trials in which rapid-acting analogues were used for both regimes, two out of three concluding to a superiority of CSII [24-26]. The pooled analysis of these three studies suggests that CSII is associated with better glycaemic control, particularly in those patients with suboptimal initial control [27].

The subcutaneous route of insulin delivery is easy to use, and recent improvements in terms of reliability of the devices and pharmacokinetics of the insulin analogues allow to consider its use for an automated insulin delivery, although the subcutaneous site introduces additional delays in insulin kinetics not seen with intravenous delivery.

**Subcutaneous – subcutaneous closed loop – system**

Two major practical solutions of a closed-loop system based on the body interface exist. The IV – IP approach relies on intravenous glucose monitoring and intraperitoneal insulin delivery and is described elsewhere. The developments of the SC– SC approach, which adopts the subcutaneous route for both glucose monitoring and insulin delivery, is discussed here.

**Clinical considerations for the use of a SC–SC closed-loop**

The SC– SC approach has the advantage of a minimally invasive solution, with the greatest potential to achieve widespread application. On the other hand, the use of the subcutaneous site is responsible for delays in glucose reading and in insulin action that may be difficult to overcome, especially when rapid changes in insulin delivery are needed to compensate for rapid and large glucose levels changes, especially during the meals.

There are several causes explaining these delays. When glucose levels change, there is a lag in the equilibration between the interstitial and plasma glucose that will vary depending on physiologic conditions. Following a glucose load, the interstitial glucose concentration lags behind the blood glucose. On the contrary, following insulin administration, the decline in glucose concentration in the interstitium precedes that in the blood [28]. With microdialysis based systems, there is an additional lag required to transfer the interstitial fluid sample to the glucose sensor [29]. The delayed absorption kinetics of subcutaneously delivered insulin is an additional factor to be taken into account. It may lessen the efficacy of insulin when glucose levels change rapidly after a meal, but also result in an extended postprandial glucose lowering effect, compromising the efficacy of the system. Therefore, the first control systems based on the SC– SC approach will probably be semiclosed-loop systems or hybrid systems, requiring at least a partial manual assistance to the delivery of insulin for meals [30].

**System variability**

Not only the difficulty to overcome wide glucose fluctuations after the meals can disturb the efficacy of a control system. Even in healthy individuals, insulin sensitivity varies both day-to-day and throughout the day. Diurnal variance can result either from a change in insulin sensitivity per se, or a change in endogenous glucose production. In a type 1 diabetic patient, these changes result in varying basal insulin requirements throughout the day [31]. Insulin requirements for meals of identical carbohydrate content can also vary, depending on the type of carbohydrate and the presence of dietary fat and alcohol. Insulin sensitivity is also modified by physical exercise, in an individual-specific manner. A large number of parameters can influence insulin requirements, and might interfere with the efficacy of a closed-loop insulin delivery algorithm.

**Model Predictive Control (MPC)**

In this control approach, a mathematical model of the subject’s glucose response is derived from one of the many models of the glucoregulatory system [32]. Measured glucose values enter a “parameter optimiser” which estimates individual parameters of the glucoregulatory model. These parameters are used to make individualised predictions of
glucose excursions, and take into account the estimation of insulin sensitivity. The model predicts how insulin would affect the future glucose profile, and calculates the first insulin delivery value. On the next sample interval, the difference between the measured glucose and the model-predicted values is reassessed, and the optimal insulin delivery profile is calculated. These steps are repeated, improving the predictive accuracy of the model.

The MPC-based system has been studied by the European consortium of partners on the Advanced Insulin Infusion using a Control Loop (ADICOL) since 2000 [33]. The first clinical studies have been performed with an intravenous (IV) sensor with a 15 minutes sample time and subcutaneous delivery of insulin lispro. The following studies were performed with the same IV sensor, but the measurements were delayed by 30 minutes in order to mimic the time lag associated with a subcutaneous sensor. In these two sets of experiments, the MPC system was able to achieve normoglycaemia during fasting conditions while avoiding hypoglycaemia. A progressive and pronounced reduction in the standard deviation of plasma glucose was observed, demonstrating the ability of the algorithm to bring all subjects close to the target. Another experiment was conducted in the fasting and postprandial condition, the prandial glucose values to a computer which calculates insulin delivery rates every minute and transmits the rate to an external pump. The first studies with a fully closed-loop were carried out in dogs. The algorithm allowed to reach the glucose target under fasting conditions, but failed to achieve normoglycaemia in the postprandial state [35]. A recent evaluation of the PID system was carried out in 10 type 1 diabetic subjects over 24 hours with meals. Satisfactory glucose control was obtained overnight, but postprandial glycaemic excursions remained excessive. Therefore, a hybrid, semi-automatic control with “priming” conventional pre-meal bolus is currently under investigation in the Yale group.

**Conclusion**

Glucose monitoring has been the main limiting factor to the development of a viable closed-loop solution, and the perspective of a closed-loop system has been one of the main driving forces for glucose sensor development. The currently available sensors display satisfactory properties in terms of reliability and accuracy. If the subcutaneous route of insulin infusion remains a barrier, the reliability of insulin pumps and the pharmacokinetics of insulin analogues have given adequate answers enough to encourage the hopes for an automated artificial pancreas. Several algorithms are under evaluation, and if the results obtained in the fasting state are more than encouraging, the postprandial state remains difficult to handle. Therefore, a hybrid, semi-automatic control with “priming” conventional pre-meal bolus is currently under investigation in the Yale group.

**Physiologic Insulin Delivery system (PID)**

The PID system, aims at mimicking the mechanisms by which the beta-cell maintains tight glucose control. The main points are that the beta-cell adapts its secretory response to the individual’s underlying insulin sensitivity, and that it adjusts the ratio of first- to second-phase insulin to compensate for a delay in insulin action. The Medtronic MiniMed external PID system [34] includes three terms: proportional, integral and derivative (figure 1). Basal insulin delivery is determined by the slow component (integral). Once the meal begins, the rate of change component (derivative) results in a rapid rise in insulin delivery, and is accompanied by a proportional component (proportional), as glucose rises above a set-point [35]. This third component is equal to zero when glucose is at target concentration. The derivative component counteracts rapid changes and can be considered to produce the first phase of insulin secretion. The integral component adapts to changes in insulin sensitivity and links insulin administration to the difference between the ambient and the target glucose.

The closed-loop insulin delivery system developed by Medtronic-MiniMed is composed of a Guardian-type subcutaneous sensor equipped with a transmitter, and transmitting
References