

Suggestions for When to Refer to an Endocrinologist

Diagnosis	When to Refer	Ideal Investigations
Type 1 diabetes	<ul style="list-style-type: none"> all patients should be assessed at least q3 years (continuing specialist F/U may be individualized) 	FPG, A1c Lipids, uACR, eGFR
Type 2 diabetes	<ul style="list-style-type: none"> newly diagnosed or drug-naïve patients pregnancy & ante-partum planning any patient needing diabetes education or refresher any patient wishing to lose weight or improve their lifestyle patients with A1c \geq 8% unable to achieve target A1c despite multiple Rx's patients considering injectable therapy active diabetes complications 	FPG, A1c lipids eGFR uACR
Hyperthyroidism	<ul style="list-style-type: none"> low or suppressed TSH 	TSH, free T4, free T3 Thyroid uptake and scan
Hypothyroidism	<ul style="list-style-type: none"> TSH challenging to control w replacement therapy 	TSH anti-thyroid antibodies
Enlarged thyroid thyroid nodules	<ul style="list-style-type: none"> enlarged thyroid gland or nodule(s) on examination 	TSH ultrasound
Thyroid cancer	<ul style="list-style-type: none"> all patients 	TSH, ultrasound (pathology and hospital reports)
Lipids	<ul style="list-style-type: none"> challenging to control lipid abnormalities statin intolerance heterozygous Familial Hypercholesterolemia (FH) 	Lipids
Obesity/prediabetes	<ul style="list-style-type: none"> obesity + glucose intolerance (pre-diabetes) (+ other risk factors) 	FPG, A1c, lipids TSH
Osteoporosis	<ul style="list-style-type: none"> BMD showing 'high' fracture risk, with deterioration despite treatment or intolerance to current therapy known fragility fracture 	Most recent BMD test
PCOS/menstrual disorders	<ul style="list-style-type: none"> amenorrhea, oligomenorrhea (< 9 periods/year) clinical hyperandrogenism (hirsutism, hair loss, acne) 	none
Male hypogonadism	<ul style="list-style-type: none"> low libido, erectile dysfunction, loss of muscle mass 	Total testosterone LH, FSH, prolactin

Considerations when choosing a second-line agent

Class	A1C Lowering	Hypo-glycemia	Weight	Other therapeutic considerations	Cost
a-glucosidase inhibitor (acarbose)	↓	Rare	neutral to ↓	Improved postprandial control, GI side-effects	\$\$
Incretin agents: DPP-4 Inhibitors GLP-1 RAs	↓↓ ↓↓ to ↓↓↓	Rare Rare	neutral to ↓ ↓↓	GI side-effects	\$\$\$ \$\$\$\$
Insulin	↓↓↓	Yes	↑↑	No dose ceiling, flexible regimens	-\$\$\$\$\$
Insulin secretagogues: Meglitinide Sulfonylurea	↓↓ ↓↓	Yes* Yes	↑ ↑	gliclazide and glimepiride associated with less hypoglycemia than glyburide	\$\$ \$
SGLT2 inhibitors	↓↓ to ↓↓	Rare	↓↓	UTIs, GTIs, hypotension, restriction/caution with loop diuretics, do not initiate with eGFR < 60	\$\$\$
TZDs	↓↓	Rare	→	CHF, edema, fractures, rare bladder cancer (pioglitazone), CV controversy (rosiglitazone), 6-12 weeks required for maximal effect	\$\$
Weight loss agent (orlistat)	↓	None	↓	GI side effects	\$\$\$