THE ABLE DIABETIC
Able Guide No. 16

INNER CIRCLE RESOURCE

Transitioning Your Basal Insulin: What I Know Now
What the process actually involves, what can go wrong, and how to give yourself the best chance

Why this guide exists

When you are told you need to switch your basal insulin, the clinical guidance you receive will cover the practicalities: what dose to start on, how to overlap the two insulins, what your follow-up appointment looks like. What it will not cover is what the experience actually feels like - the disruption to rhythms you are highly familiar with, the difficulty of not knowing whether anomalies are due to temporary adjustment or a sign that this insulin is not right for you, the emotional weight of feeling out of control of something you normally manage well.

This guide is written from my own experience of switching from Levemir to Tresiba in 2023 - a switch that did not go well, and that I ultimately reversed after eight weeks. It covers what I learned, what I would do differently, and what I think matters most when navigating a basal insulin transition. It is personal experience, not clinical guidance. Your team knows your situation. Use this alongside that, not instead of it.

1. The transition is disruptive - even when it goes well

A basal insulin transition is not a simple swap even though it seems like it will be at first. You are not changing the brand; you are changing the molecule, the duration, the behaviour profile. Your body has adapted to your current insulin over years. It will take time - weeks, not days - to adapt to a new one.

The physical dosing transition itself requires a staged overlap: both insulins run simultaneously for several days at reduced doses while the new one builds up. During that window your glucose profile will be unusual. You may run higher than expected, or lower. You may find that your familiar responses to food and exercise no longer produce the results you expect. This is normal, but it is also disorienting - particularly if you are experienced and accustomed to being in control.

Plan the transition window deliberately. You want a period of relative calm in your life: not a week with a big trip, a demanding work period, or a house full of guests. That sounds obvious, but in practice it can be hard to find, and it is easy to

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underestimate how much the transition will occupy your attention. I had to wait three weeks after deciding to switch before I found a window that felt manageable.

Beyond the physical dosage transition is a longer period of practical and psychological change when you get used to a new rhythm. I recommend taking this period into account in the planning too, because it is unrealistic to anticipate that after just a period of days you will feel 'back to normal'. I would assume a period of several weeks is needed to adjust.

2. Your bolus insulin is part of the story

This was the thing that most caught me out, and I have not seen it explained clearly anywhere. When you change your basal insulin, you are not just changing one part of your regime - you are changing the foundation on which everything else sits. Your bolus insulin - your rapid-acting mealtime insulin - has been calibrated against your existing basal. When the basal changes, that calibration no longer holds perfectly. Your diabetes team will have some idea how you can plan for this, but it is likely you'll need to do some fine tuning.

What this means in practice is that the basal and bolus insulin cannot be evaluated independently during a transition. If your overnight glucose is dropping, is that the basal insulin, or your evening bolus, or both? If your post-meal levels are higher than expected, is the basal insufficient, or is the bolus calculation that has always worked now landing differently? This is genuinely difficult to unpick, and it requires your team to look at the whole picture, not just the new insulin in isolation.

One practical tip that my clinician offered, which I found useful in theory even when hard to execute was to try some carb-free periods in the early weeks of the transition. With no mealtime insulin in the equation, you can observe what the basal insulin alone is doing to your glucose levels, especially overnight. It is not always possible, but where it is, it gives you much cleaner data to work with. The practical thing this requires is the lengthy post-transition window to allow yourself to experiment and adjust. It is like going back to the beginning again in a way.

3. What to monitor, and how closely

Your CGM data is your most important tool during a transition. Use it actively. Look at the overnight pattern in particular - this is where basal insulin behaviour is most visible, because food and bolus are not complicating the picture. Are you flat overnight? Dropping? Rising? How does the pattern change as the new insulin builds up?

Keep notes, even brief ones. You do not need a formal log, but a note that says '03:00 - low again, 3.8, ate 15g' gives you and your team something concrete to work with. Numbers without context are harder to act on.

Again, in this period if you can eliminate as many other potentially disruptive factors - stress, travel, difficult work commitments - that is a helpful thing to do because you then make the context as simple as possible for your own analysis.

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If things feel wrong, do not wait for a scheduled appointment. Call your team. The early weeks of a basal insulin transition are exactly the time for proactive contact, not passive waiting. In my case, I had already begun adjusting my own dose before my first formal review because the overnight lows were too severe to wait. That self-directed adjustment was probably right, but it would have been better to make it in consultation rather than alone. Contact your team early. The expectation that there will be a reaonable level of contact and hand-holding is a good planning assumption.

4. Signs that things are not settling - and what to do

Some disruption in the early weeks is expected. The question is how much, for how long, and whether it is improving. These are the signs that something more than normal adjustment may be happening:

Overnight lows that are persistent and not improving after two to three weeks, despite dose reduction. Lows that are happening at different times each night rather than at a consistent point. Blood glucose that is too high in general - suggesting under-dosing - while overnight lows are still occurring simultaneously. That contradictory picture was exactly what I experienced, and it is one of the harder things to resolve because the obvious response to each problem makes the other worse.

If you see these patterns, say so clearly to your team. Do not present it as 'things are a bit up and down'. Present it as: overnight lows are still happening on most nights, and daytime levels are running higher than I want. That specificity helps your team respond to the actual problem. This is where data and records really help.

And know that going back, or trying a different alternative, is a legitimate option. Equally, the first alternative you try may not be the right one - and if it is not, you can try another. This is not failure. It is how individual physiology works. That said, there are only a limited number of options in terms of actual insulin types, so you do need to give yourself time to accommodate the change and settle.

5. The emotional dimension

It is important to recognise that there is an emotional aspect to this because this can be a challenging experience. During my eight weeks on Tresiba, I felt tired, frustrated, and at times like a failure. This was supposed to be a better insulin. I had the experience and the knowledge to manage my condition well. And I could not make it work. It was an unexpected and heavy thing to process.

If you feel this way during a difficult transition, that is not a sign of weakness or incompetence. It is a sign that you are working hard to manage something difficult. Thirty years of reliable management does not make a difficult transition

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easier - if anything, the contrast makes it more jarring, because you know exactly what it feels like when things are going well.

If there is an overarching concern it is that the system might not have enough bandwidth to support everyone over forthcoming months. That means it is important t1ds have other people they can lean on, and that they are fully aware in advance of the things they can do to free up as much space in life as possible to manage this well, and look after their well-being.

5. How to give yourself the best chance

Choose your transition window carefully - a period of relative calm, not your busiest stretch of the year.

Ask your team for close monitoring in the first month: not just a six-week follow-up, but a real plan for early contact if things feel wrong. If they might not be able to offer that, look for other resources such as your GP surgery, charities, and pharmaceutical helplines.

Use carb-free or low-carb evenings where possible in the early weeks to observe the basal in isolation.

Keep brief notes on your patterns and data especially overnight. Documenting specifics can help your team act sensibly.

Do not try to make your bolus insulin compensate for problems caused by the basal. Address the basal first.

Give the transition a fair trial - several weeks, with active dose adjustment - before concluding it is not working. But also trust your own experience. If something feels consistently wrong after a genuine attempt, say so clearly. Going back or trying something different is not giving up. It is good management.

Based on Sarah's lived experience of switching basal insulin in 2023. Not medical advice. Every T1D is different and every transition is individual. Please work closely with your diabetes team throughout any insulin change.

Want to understand more?

Read Sarah's full personal account of her Tresiba switch: theablediabetic.com

See Able Guide No. 15 for a plain-English overview of the Levemir discontinuation and your alternatives.

Contact Sarah at sarah@theablediabetic.com

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