— THE WOLF TRACKER PRO

THE COMPLETE BLOOD DISCIPLINE *REFERENCE GUIDE*

Fact-checked science. Practical protocols. Built for T1D and T3c athletes who treat performance as non-negotiable.

T1D & T3C	FACT-CHECKED	9 MODULES	CLINICAL
Built for	Every claim	Complete system	Evidence-based

> "*The numbers are the language.*
> **The decisions are the power."**
> - DIABETIC WOLF

* Educational content only. Always consult your endocrinologist before changing insulin protocols.

— INTRODUCTION

How to Use This Guide

Nine modules. Pick the one most relevant to your current challenge. Apply one protocol at a time.

WHAT THIS IS

A reference guide built on clinical evidence, translated into practical protocols for T1D and T3c athletes. Every key claim is grounded in published research.

WHAT IT IS NOT

This is not medical advice. It does not replace your endocrinologist. Always discuss insulin changes with your care team before implementing new protocols.

HOW TO USE IT

Pick the module most relevant right now. Apply one change. Measure for 3-7 days. Move to the next. Stack knowledge slowly, not all at once.

NINE MODULES IN THIS GUIDE

* This guide is educational. Always consult your endocrinologist before changing insulin doses.

Aerobic vs Anaerobic: What Happens to Your Glucose

Based on RCT data from Riddell, Yardley et al. - adults with T1D.

THE MECHANISM

During aerobic exercise, muscles take up glucose via insulin-independent GLUT4 translocation - pulling glucose from the blood without insulin. During high-intensity/anaerobic exercise, adrenaline and noradrenaline are released, signalling the liver to dump glucose via glycogenolysis. Same person: can go low on a long run, then spike during heavy squats.

AEROBIC EXERCISE

Running · Cycling · Swimming · Rowing

Glucose effect:
Drops - avg ~3.9 mmol/L per 45 min at 60% VO2max

Primary risk:
Hypoglycemia during and up to 12 hours post-exercise

Why it drops:
No catecholamine brake - insulin-independent uptake

Pre-exercise target:
Start at 7–10 mmol/L. Below 5.5: eat 15–20g carbs first

Bolus strategy:
Reduce pre-workout meal bolus by 25–75% (pump users)

ANAEROBIC / HIIT

Sprints · Heavy lifting · HIIT · Intervals

Glucose effect:
Rises or stays flat - adrenaline can triple from a short sprint

Primary risk:
Post-exercise spike, then delayed nocturnal hypo risk

Why it rises:
Catecholamine surge drives hepatic glycogenolysis

Post-session:
May need small correction. Reduce overnight basal by 10–20%

Pro strategy:
10-sec sprint at end of aerobic session blunts glucose drop

KEY RCT FINDING - Yardley et al., Diabetes Care

Performing resistance exercise BEFORE aerobic exercise reduces glucose drop, cuts hypoglycemic episodes, and lowers nocturnal hypo severity vs doing aerobic first. Order matters.

Sources: Riddell et al. Canadian Journal of Diabetes; Yardley et al. Diabetes Care RCT; ADA Position Statement on Exercise

Pre · During · Post Protocols & The Late-Onset Low

01 PRE-EXERCISE

30–60 min before session

- Target glucose: 7–10 mmol/L before starting
- Below 5.5 mmol/L: eat 15–20g fast carbs before you begin
- Reduce bolus for pre-workout meal by 25–75% (pump users)
- Do not start if glucose >14 mmol/L with ketones present
- Aerobic: consider temporary basal reduction 90 min before

02 DURING

If session lasts >45 min

- Check CGM every 30 min (note: compression artifact is common)
- Glucose dropping below 6 mmol/L: 15g fast carbs immediately
- Aerobic sessions >60 min may need 30–60g carbs per hour
- HIIT and strength: glucose often rises - minimal carbs needed
- Confirm any suspected low with a finger stick before treating

03 POST-EXERCISE

First 2–6 hours

- Eat a mixed meal (carbs + protein) within 60 min of finishing
- Aerobic: reduce correction bolus - insulin sensitivity elevated
- Check at 2hr, 4hr, and before bed - hypo window extends overnight
- Resistance training: TIR improves significantly in 24hr post-session
- Do not combine heavy training with alcohol on the same day

THE LATE-ONSET LOW - Nocturnal Hypoglycemia After Exercise

This is the most dangerous and under-managed risk of exercise in T1D. Muscles replenish glycogen stores for 6–12 hours post-exercise, drawing glucose from the bloodstream during sleep - when your CGM alarm may not wake you. Risk is highest after aerobic and combined sessions.

PREVENTION PROTOCOL

- Reduce overnight basal by 10–20% after any session lasting more than 45 minutes
- Eat a slow-digesting snack before bed: oats + peanut butter, or cheese + crackers
- Set your CGM low alert to 5.5 mmol/L (not 4.0) - give yourself buffer while asleep
- If you trained AND drank alcohol on the same day: this risk compounds. The snack is not optional.

* Always consult your endocrinologist before adjusting basal rates.

Glycaemic Load vs Glycaemic Index: What Actually Matters

GI tells you speed. GL tells you impact. Only one should guide your bolus decisions.

GLYCAEMIC INDEX (GI)

Measures how FAST a food raises glucose (0–100 scale)

GI uses 50g of pure glucose as the reference. The problem: it ignores serving size. Watermelon has a GI of 72 - but a normal slice contains so few carbs it barely moves your glucose. GI alone is an incomplete picture for dosing.

GI below 55 = low 56–69 = medium 70+ = high

GLYCAEMIC LOAD (GL)

Measures how MUCH a real serving raises glucose

GL = GI x carbohydrate content (g) divided by 100. This accounts for actual portion size. A banana (GI 51, GL ~13) raises glucose significantly more than watermelon (GI 72, GL ~4). GL is the number that guides practical bolus decisions.

GL below 10 = low 11–19 = medium 20+ = high

REAL-WORLD EXAMPLES - SAME FOOD. DIFFERENT GLUCOSE IMPACT

Food	GI	Carbs/serve	GL	T1D Impact
White bread (2 slices)	75	30g	22	HIGH - fast spike, short tail
Basmati rice (1 cup cooked)	58	45g	26	HIGH - medium speed, long tail
Rolled oats (1 cup cooked)	55	27g	15	MEDIUM - slow, predictable
Watermelon (large slice)	72	6g	4	LOW - minimal impact despite high GI
Banana, ripe (medium)	51	25g	13	MEDIUM - fructose slows absorption
Sweet potato (medium)	70	25g	18	MEDIUM-HIGH - faster than expected
Whole milk (250ml)	27	12g	3	LOW - fat buffers the carb load
White rice (1 cup cooked)	73	44g	32	HIGH - one of the fastest spikes

Sources: Foster-Powell et al. International Table of GI and GL; Atkinson et al. Am J Clin Nutrition 2008

The Hidden Glucose Drivers: Protein · Fat · Alcohol

PROTEIN - The Delayed Spike (2-4 hours later)

Protein is gluconeogenic - the liver converts amino acids into glucose, typically 2-4 hours after a high-protein meal. The effect is modest (roughly 50% of the carbohydrate equivalent) but significant for athletes eating large protein meals around training. For meals with more than 40-50g protein, consider a small extended bolus.

Watch for:

- Post-workout protein shake (>50g): glucose can rise 2-3 hours later
- High-protein dinner, low carbs: check glucose before bed not just post-meal
- The rise is slow and gradual - it will not trigger your CGM alarm immediately

FAT - The Delayed Bomb (The Pizza Effect)

Fat slows gastric emptying, delaying carbohydrate absorption. A high-fat meal (pizza, burgers, creamy pasta) may show a modest 1-2 hour spike, then drive a large secondary spike at 3-5 hours - often while asleep. Your initial bolus covers the early phase but misses the delayed one.

Management:

- High-fat meals: use a dual-wave bolus - 50% upfront, 50% over 2-3 hours
- Set a CGM reminder at 3-4 hours post-meal if eating pizza, curry, or heavy food
- Do not chase a flat 90-min reading - the spike is often still building

ALCOHOL - The Invisible Threat to T1D Safety

The liver treats alcohol as a toxin and prioritises metabolising it above all else - including releasing glucose. This blocks hepatic gluconeogenesis for up to 8-12 hours. For T1D this means your liver - the normal backup against hypoglycemia - is offline. Peak hypo risk: 8-12 hours after drinking.

Initial effect:
Sugary mixers spike glucose first - then crashes hours later

Safe practice:
Always eat slow carbs before bed. Never drink on empty stomach

Peak hypo window:
8-12 hours post-drinking - often during sleep

Monitoring:
Check glucose before sleep. Set a 3am CGM alarm

Glucagon warning:
Emergency glucagon is less effective - liver cannot respond normally

Exercise + alcohol:
Combining on the same day significantly compounds hypo risk

Sources: Charlton et al. Practical Diabetes 2020; Breakthrough T1D; Beyond Type 1; NIH PMC

Why Your Glucose Rises While You Sleep

Affects approximately 50–54% of people with Type 1 diabetes. (Cleveland Clinic; StatPearls, NCBI)

WHAT IS THE DAWN PHENOMENON?

Between approximately 3am and 8am, the body releases a surge of hormones - cortisol and growth hormone - that signal the liver to increase glucose output, providing energy to wake up. In people without diabetes, the pancreas compensates with extra insulin. In T1D, no extra insulin is secreted - so glucose rises unchecked. This is physiology, not a management failure.

THE MECHANISM (3am to 8am)

1 **Cortisol & GH surge**
Hormones rise to prepare body

-> 2 **Liver gets the signal**
Hepatic glucose output increases

-> 3 **No extra insulin**
T1D pancreas cannot compensate

-> 4 **Glucose rises**
Typically 1–4 mmol/L above pre-sleep level

DAWN PHENOMENON

CGM pattern:
Steady rise from ~3am with no prior low

Cause:
Cortisol + GH surge → liver releases glucose

Prevalence:
Approx. 50–54% of T1D patients

Best treatment:
Insulin pump basal adjustment at 2–4am

SOMOGYI EFFECT - Now Largely Disputed

CGM pattern:
Low overnight, then rebound high by morning

Original theory:
Hypo triggers counterreg hormones - rebound

Current evidence:
Multiple studies fail to confirm this mechanism

Practical note:
Overnight low then high: reduce evening insulin first

FOUR MANAGEMENT STRATEGIES

01
Adjust Basal Rate

Program your pump to increase basal delivery between 2–4am by 10–20%. The most targeted fix for pump users.

02
Morning Exercise

A 20–30 min walk or light session burns the dawn glucose. Practical and free - works for MDI users too.

03
Delay Breakfast

Waiting until glucose plateaus naturally can prevent compounding the rise with meal carbs.

04
Bedtime Carb Review

Avoid carbohydrate snacks late at night. Late carbs add glucose on top of the dawn rise.

Sources: StatPearls (NCBI); Cleveland Clinic; ADA; Schmidt et al. N Engl J Med

8 Glucose Shapes: What They Mean & What to Do

01 Shark Fin — >10 spike

Rapid spike >10, then sharp fall

ACTION:
Late or missing bolus. Pre-bolus 15–20 min earlier next time.

02 Slow Creep — Delayed rise

Gradual rise over 2–4 hours

ACTION:
High-fat or high-protein meal. Consider extended/dual-wave bolus.

03 Double Peak — Two humps

Two bumps separated by 2–3 hours

ACTION:
Second-meal effect or gastroparesis. Review meal composition and bolus timing.

04 Flat Line — Target

Stable 4–8 mmol/L for several hours

ACTION:
Ideal control. Capture exact conditions: what did you eat, dose, and do?

05 Overnight Cliff — Nocturnal low

Steady drop from 10pm to 2am

ACTION:
Too much evening basal or insulin sensitivity elevated from exercise. Reduce basal.

06 Dawn Rise — 3–8am rise

Steady rise from approximately 3–8am

ACTION:
Dawn phenomenon. Adjust 2–4am basal rate or add morning exercise.

07 Roller Coaster — All-day swings

High highs and low lows throughout the day

ACTION:
Reactive dosing cycle. Simplify meals for 3 days. Remove variables. Reset.

08 Compression Dip — False low

Sudden sharp drop, rapid spontaneous recovery

ACTION:
Sensor pressed against mattress. Not a real low - always confirm with finger stick.

ALWAYS CONFIRM SUSPECTED LOWS WITH A FINGER STICK

CGM lags 5-15 minutes behind blood glucose. Rapid changes create a gap over 2 mmol/L.
Never correct a suspected low based on CGM alone. Always confirm with a finger stick first.

Managing T1D During Illness: The Six Rules

Never stop insulin during illness. This is the rule that prevents DKA.

WHY ILLNESS IS DANGEROUS FOR T1D

Even mild infections trigger cortisol, glucagon, and growth hormone - all of which drive significant insulin resistance. Your usual dose will not be enough. If left unmanaged, rising glucose and ketones can lead to diabetic ketoacidosis (DKA), a life-threatening emergency. The single most important rule: never stop insulin during illness, even if you cannot eat.

THE SIX NON-NEGOTIABLE RULES

01 Never stop insulin

Even if not eating. Stress hormones raise glucose regardless of food. Stopping insulin risks DKA.

02 Check glucose every 2–4 hours

Illness makes glucose behaviour unpredictable. Frequent monitoring is the only way to stay ahead.

03 Check ketones if glucose exceeds 14 mmol/L

Ketones signal fat breakdown due to insulin insufficiency - the early DKA warning sign.

04 Stay hydrated constantly

Dehydration concentrates blood glucose and worsens hyperglycemia. Sip fluids continuously, even if vomiting.

05 Expect to need 20–50% more insulin

Illness-driven insulin resistance is real. Work with your team on a sick-day correction factor in advance.

06 Know when to go to hospital

Vomiting >4 hours, ketones >1.5 mmol/L, confusion, or glucose >20 mmol/L unresponsive to correction: call for help now.

KETONE ACTION GUIDE

<0.6 mmol/L	0.6–1.5	1.5–3.0	>3.0 mmol/L
Normal	**Moderate**	**High**	**Dangerous**
Continue monitoring. Manage glucose.	Increase fluids, correct glucose, recheck in 2 hours.	Call your diabetes team immediately.	Go to emergency department now.

Always consult your diabetes care team. Develop a sick-day plan with your endocrinologist before you need it.

Heat · Altitude · Time Zones: The Complete Travel Protocol

Insulin, CGM, and glucose management across climates and time zones.

HEAT

Hot climates & summer

Insulin absorbs faster:
Heat causes vasodilation - subcutaneous insulin absorbs more quickly, increasing hypo risk

CGM accuracy:
Sensors can give inaccurate readings when overheated. Verify with finger sticks

Insulin storage:
Keep at 2-8 degrees C. Never leave in a car, beach bag in direct sun, or near a heat source

Hydration:
Dehydration raises blood glucose by concentrating it. Drink more water in heat

ALTITUDE

Above approx. 2,500m

Metabolic rate:
Higher altitude increases metabolic rate, which can raise glucose unpredictably

CGM accuracy:
Sensor accuracy may vary at altitude. Carry a glucometer and test strips

Physical exertion:
Hiking and trekking lower glucose significantly - pre-load carbs appropriately

Symptom overlap:
Altitude sickness symptoms mimic hypoglycemia - monitor, do not guess

Supplies:
Carry double fast-acting carbs. Mountain rescue is far from a pharmacy

TIME ZONES

Long-haul travel

Long-acting insulin:
Lantus, Tresiba timing must shift with your new time zone gradually

Basal shift rule:
Adjust injection time by 1-2 hours per day until aligned with local time

Direction matters:
East travel (shorter day) - slight hypo risk. West (longer) - slight hyper risk

Pump users:
Update pump clock immediately on arrival to local time

In-flight:
Flying disrupts meals, sleep, and activity - check glucose every 2 hours in-flight

NON-NEGOTIABLE TRAVEL PACKING LIST

- Double insulin supply (split carry-on and checked bag)
- Prescription and endo letter (English + local language)
- Ketone meter and strips
- Extra CGM sensors (bring 2x expected need)
- Fast carbs in carry-on, checked bag, AND day pack
- Medical ID bracelet or card
- Backup long-acting insulin pen (even if pump user)
- Letter explaining CGM/pump for airport security
- Emergency glucagon kit and companion who knows how to use it
- Glucometer and test strips as CGM backup

Marathon & Endurance Events: Glucose from Start to Finish

T1D-specific protocols for race day. Built from Binu's experience running sub-3:10 with a CGM.

WHY RACE DAY IS DIFFERENT FROM TRAINING

Race day adrenaline is real. Cortisol and catecholamines surge before the gun even fires, raising glucose 1–3 mmol/L before you take a single step. The excitement, the crowd, the nerves - they all activate the same hormonal response as a hard interval. Plan for it.

RACE DAY GLUCOSE TIMELINE

NIGHT BEFORE

18–12 hrs out

- Carb load moderately - avoid high-fat meals (pizza effect risk during the race)
- Set CGM low alarm to 6.0 mmol/L overnight - glycogen loading can shift sensitivity
- Aim to wake at 6.5–8.5 mmol/L. Too low or too high means a difficult morning adjustment

MORNING (2–3 HRS BEFORE)

Pre-race

- Target pre-race glucose: 8–10 mmol/L - higher than normal training target
- Eat a familiar, low-fat, moderate-carb breakfast (no experimenting on race day)
- Reduce long-acting insulin by 10–20% the night before (discuss with your endo first)

RACE START (0–5 KM)

Before the gun

- Check CGM at the start line - last chance for a calm, deliberate look
- Ideal: 8–10 mmol/L with a flat or slightly rising arrow
- Below 7: take 15g fast carbs before the gun - gel or glucose tabs

DURING RACE (5–35 KM)

Let alerts do the work

- You cannot safely check your CGM while racing - set alerts and trust them
- Low alert at 5.5 mmol/L, urgent low at 4.5 mmol/L - set these the night before
- Aid stations are your check point - glance at your watch CGM when you grab fuel

FINAL 5–7 KM

Head down, alerts on

- You are not checking anything - you are racing
- Your pre-set alerts will tell you if there is a problem - trust the system
- If your low alarm fires: take the gel in your hand. Do not stop unless urgent low

POST-RACE (0–24 HRS)

Recovery window

- Glucose can crash 4–12 hours post-marathon as muscles replenish glycogen - monitor closely
- Eat a mixed recovery meal (carbs + protein) within 45 min of finishing
- Reduce overnight basal by 20–30% - post-marathon insulin sensitivity is significantly elevated

This protocol is based on T1D endurance athlete experience and published glucose management guidelines for exercise. Always develop your personal race-day plan with

Why TIR Is the Better Metric

Both HbA1c and TIR matter. But only one tells the full story of your glucose control.

THE PROBLEM WITH RELYING ON HbA1c ALONE

Two people can have identical HbA1c of 7.0% - yet one spends 90% of their time in range with smooth, stable glucose, while the other swings violently between highs and lows that average to the same number. HbA1c cannot distinguish between them. Time in Range can.

HbA1c reflects average glucose over 3 months. It does not capture how often you go low, how high your spikes reach, how long you stay above range, or the variability that drives long-term complications.

HbA1c

Average blood glucose over 3 months

What it measures:
Average glucose - nothing more

What it misses:
Highs, lows, variability, time below range

Blind spot:
Two people, same HbA1c, completely different control

Check frequency:
Every 3 months at most - retrospective, not actionable

Clinical use:
Long-term complication risk assessment

TIME IN RANGE (TIR)

Percentage of time glucose is 3.9-10.0 mmol/L

What it measures:
Actual glucose distribution, 24/7

What it reveals:
Time low, time high, variability, overnight patterns

Why it is better:
Same HbA1c can hide 40% time-below-range or 60% time-above

Check frequency:
Daily on CGM - real-time and actionable

Clinical use:
Daily management, exercise, nutrition, and coaching decisions

TIR TARGETS AND APPROXIMATE HbA1c EQUIVALENTS

TIR %	HbA1c Approx.	Average Glucose	Classification	Wolf Standard
90–100%	~5.7–6.0%	~6.5 mmol/L	Exceptional	**Elite Wolf**
80–89%	~6.5–7.0%	~7.5 mmol/L	Excellent	**Wolf Standard**
70–79%	~7.0–7.5%	~8.3 mmol/L	Target met	**In progress**
50–69%	~7.5–8.5%	~9.5 mmol/L	Needs work	**Focus here**
<50%	>8.5%	>11 mmol/L	Urgent	**Start the discipline**

USE BOTH - BUT MANAGE BY TIR

HbA1c gives your long-term trend. TIR gives you today's lever. Use HbA1c to track 3-month progress with your endocrinologist. Use TIR daily to guide insulin, food, and exercise decisions. The goal: improve TIR and HbA1c follows.

Sources: Battelino et al. Diabetes Care 2019 (TIR consensus); ADA Standards of Medical Care; Danne et al. Diabetes Care 2017

Week 1 Review Template

Complete after Day 7. Look for patterns - not perfection.

WEEK 1 TIME IN RANGE

_____ % Target >=70% Elite >=80%

DAILY BLOOD DISCIPLINE SCORE - WEEK 1 (1–10 each day)

DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
/ 10	/ 10	/ 10	/ 10	/ 10	/ 10	/ 10

BIGGEST SPIKE CAUSE THIS WEEK

BEST PERIOD OF CONTROL

MOST REPEATED MISTAKE

WEEK 2 PLAN - ONE CHANGE TO TEST

WEEK 2 TIR TARGET: Current TIR + 5% = _____ %

QUICK PATTERN REFERENCE

- Breakfast spike -> Pre-bolus earlier · reduce fast carbs
- Morning highs -> Dawn phenomenon · adjust 2–4am basal
- Delayed highs -> Fat-heavy meal · extended/dual-wave bolus
- Night lows -> Reduce basal · slow-digesting snack before bed
- Workout spikes -> Resistance before aerobic · test exercise order

Discipline over diabetes. - diabeticwolf.com

Week 2 Review Template

Complete after Day 14. Identify what compounded week on week.

WEEK 2 TIME IN RANGE

_____ %

Week 1 TIR: _____ % | Improvement: _____ % | Target was: +5%

DAILY BLOOD DISCIPLINE SCORE - WEEK 2 (1–10 each day)

DAY 8	DAY 9	DAY 10	DAY 11	DAY 12	DAY 13	DAY 14
/ 10	/ 10	/ 10	/ 10	/ 10	/ 10	/ 10

BIGGEST IMPROVEMENT THIS WEEK

REMAINING CHALLENGE TO ADDRESS

FINAL ADJUSTMENT TO CARRY FORWARD

BEYOND 14 DAYS - THE NEXT STEP

- Continue The Blood Discipline - patterns take 30+ days to fully master
- Identify your next 14-day focus: exercise protocol, food quality, or CGM pattern work
- Share your wins with the community: @diabetic.wolf on Instagram

QUICK PATTERN REFERENCE

- Breakfast spike -> Pre-bolus earlier · reduce fast carbs
- Morning highs -> Dawn phenomenon · adjust 2–4am basal
- Delayed highs -> Fat-heavy meal · extended/dual-wave bolus
- Night lows -> Reduce basal · slow-digesting snack before bed
- Workout spikes -> Resistance before aerobic · test exercise order

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— QUICK REFERENCE

All the Key Numbers on One Page

Targets · Scores · Rules · Patterns - everything at a glance.

GLUCOSE TARGETS

Time in Range	Time Below Range	Time Above Range	Average Glucose	Std Deviation
>=70%	<4%	<25%	<8.5 mmol/L	<3.0 mmol/L
Standard	Standard	Standard	Standard	Standard
>=80%	<1%	<10%	5.5–7.5	<2.0 mmol/L
Elite	Elite	Elite	Elite	Elite

BLOOD DISCIPLINE SCORE

10	7–9	4–6	1–3
Controlled	**Good**	**Struggling**	**Unstable**
TIR >=80% · Stable	TIR 70–79% · Minor	TIR 50–69%	TIR <50% · Reactive

THE 8 WOLF RULES

Same spike 3x — Fix the meal or the bolus timing. The pattern is real.	**Lows repeat** — Reduce basal by 10–20%. Fix the cause, not just the symptom.
Morning highs — Check 2–4am CGM data. Likely dawn phenomenon.	**Workout spikes** — Resistance before aerobic. Sprint at end of aerobic sessions.
TIR below 60% — Simplify meals for 3 days. Remove variables. Reset the baseline.	**After alcohol** — Set 3am alarm. Eat slow carbs before bed. Glucagon may not work.
Sick day — Never stop insulin. Check ketones if >14 mmol/L. Know when to go.	**Travelling** — Double supplies. Shift basal 1–2 hrs/day across time zones.

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— THE WOLF STANDARD —

You don't need more *motivation.*

You need better *decisions.*

This guide is the map. The discipline is yours.

CONNECT WITH THE COMMUNITY

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