

Comorbidities Hit Older Diabetes Patients Hard

BY SHERRY BOSCHERT
San Francisco Bureau

SAN FRANCISCO — Managing blood sugar, lipids, and blood pressure levels in elderly patients with diabetes is important, but don't forget to address their quality of life, Dr. Hermes Florez said at a meeting sponsored by the American Diabetes Association.

Be aware of common geriatric syndromes that affect quality of life as well as morbidity and mortality rates in people with diabetes, urged Dr. Florez, an endocrinologist at the University of Miami and the Miami Veterans Affairs Medical Center.

Screen for and treat the following geriatric syndromes as part of your routine care, he suggested.

Cognitive decline. People with diabetes have an increased risk for vascular dementia or Alzheimer's dementia, compared with people who don't have diabetes. One large study found nearly a doubling in age-adjusted risk for dementia if diabetes is present. Separate data suggest that factors that may contribute to the increased risk include chronic hyperglycemia, repeated episodes of hypoglycemia, polypharmacy, and microvascular or macrovascular complications of diabetes. There seems to be a trend toward greater likelihood of dementia with longer duration of diabetes.

Do at least a quick test for cognitive decline, such as asking the patient to draw a clock face, Dr. Florez said. If you have more time, do a more formal evaluation such as the Mini-Mental State Examination.

Polypharmacy. Although polypharmacy commonly is described as the use of five or more medications, Dr. Florez prefers to think of it as any prescription for a medication that may interact with a medication being used or with a disease it was not intended to treat. Certain antimicrobial medications interact with sulfonylureas, for example. If a patient on an ACE inhibitor for hypertension is prescribed a nonsteroidal anti-inflammatory drug for complaints of pain and stays on the latter for a year or two, a drug-drug interaction can occur that will worsen their hypertension, Dr. Florez said.

One cohort study of 418 elderly patients in Los Angeles found that 13%

were taking 5 drugs and 14% were taking 10 or more drugs. Trying to intensify therapy for control of blood sugar, lipids, or blood pressure in these patients is a challenge. "Patients will be struggling to follow your instructions for additional medications," he said, and some patients will not be able to afford all these medications.

Depression. A common syndrome in older patients with diabetes, depression of even minimal severity increases the risk for microvascular complications, disability, and mortality, compared with nondepressed patients with diabetes. Diabetes patients with depression of any severity are more likely to have poor glycemic control (hemoglobin A_{1c} levels of 8% or higher), compared with nondepressed diabetes patients. "It's important always to ask about mood" and to assess with instruments such as the Geriatric Depression Scale, if indicated, he said.

Falls. It's also important to ask older patients about injurious falls. Frequent falls suggest that a diabetes patient is either having frequent hypoglycemic events or may have significant hyperglycemia and nocturia, increasing nighttime waking and the risk for falls on the way to the bathroom.

Look for reversible treatable causes of falls such as retinopathy, cataracts, and use of medications that can cause orthostatic hypotension, including thiazide diuretics for hypertension or α -2 blockers to treat benign prostatic hypertrophy. Ask about environmental factors in the home that may contribute to falls.

A quick, easy way to assess someone's risk for falling is to ask the patient to stand up from a chair without the use of arms. If you have more time, assessing gait and balance will provide more information.

Urinary incontinence. Poor glycemic control, heart failure, and some medications each can increase the risk of urinary incontinence. Behavioral modification can be helpful in some cases, Dr. Florez said. Poor eating habits and insufficient water intake may cause constipation that leads to urinary incontinence, which can be treated by increased intake of water and fiber.

Dr. Florez has received research funding from Merck & Co., which makes medications for diabetes. ■

Weigh Aggressive Diabetes Therapy Carefully in Elderly

BY SHERRY BOSCHERT
San Francisco Bureau

SAN FRANCISCO — The heterogeneous nature of diabetes in the elderly makes it imperative to assess each patient individually before choosing whether to use aggressive or more conservative therapy, Dr. Hermes Florez said.

Some older diabetes patients have newly diagnosed disease and are quite functional, while others have long-standing disease and significant functional decline. Older adults are more likely to have multiple comorbidities and to be taking multiple medications.

Life expectancy also is important to consider. "In a patient who has less than 5 years of life expectancy, can we be aggressive enough with intensive glycemic control to achieve a hemoglobin A_{1c} level of less than 6.5% when that will lead to increased risk of hypoglycemic events, frequent falls, or significant functional or cognitive decline?" he asked at a meeting sponsored by the American Diabetes Association.

Approximately 40% of adults with type 2 diabetes mellitus are 60 years or older, comprising roughly 40 million people, noted Dr. Florez, an endocrinologist at the University of Miami and the Miami Veterans Affairs Medical Center. Looked at another way, 13% of U.S. residents aged 60 years or older have been diagnosed with diabetes, and another 12% have undiagnosed diabetes.

To help chart an individual's management plan, balance the potential benefits of aggressive glycemic control against the risks from comorbidities, medication side effects, and geriatric syndromes such as dementia, incontinence, and depression, he advised.

Published data suggest that 46% of elderly patients with type 2 diabetes have five or more comorbidities, most commonly cardiovascular problems including hypertension, lipid disorders, or coronary atherosclerosis. Older patients with diabetes and five or more comorbidities are at increased risk for hospitalizations that could have been prevented and that are two to three

times longer, compared with hospitalizations of patients who have diabetes alone.

Dr. Florez described the following sample cases, which highlight treatment choices:

Low risk, high benefit. Aggressive treatment was an easy decision for a 70-year-old woman with a 20-year history of diabetes who also had hypertension, lipid abnormalities, and early appearance of retinopathy but who functioned well independently and had no other comorbidities. "She's low risk, with potential for high benefit" from aggressive glycemic control, he said.

High risk, low benefit. The opposite was true for a 68-year-old man with a 4-year history of diabetes who also had severe cardiomyopathy with ventricular tachycardia and was unable to walk. This

patient already was taking 14 medications. Intensifying treatment for better blood pressure, lipid levels, or blood-sugar control could pose greater risks than benefits. "Take a conservative approach," he said.

Low risk, low benefit. Less easy to manage was a 75-year-old woman with new-onset diabetes, none of the associated cardiovascular risk factors (no hypertension or dyslipidemia), no other comorbidities, and no functional impairment. She's at low risk, but would she benefit from intensive therapy to lower her HbA_{1c} level below 6.5%? "We don't have evidence yet that such a patient will benefit from intensive glycemic control," Dr. Florez said.

High risk, low benefit. Another tough call was a 72-year-old man with long-standing diabetes of 18 years' duration, a history of multiple hypoglycemic episodes, and complications related to diabetes, including recurrent foot ulcers and retinopathy. Intensive therapy for blood glucose levels, lipids, and blood pressure probably would seem indicated, except that he also had major cognitive deficits. Unless a spouse, or other caregiver can aggressively monitor therapy, intensive treatment poses too much risk for side effects, falls, or further cognitive decline. Treat conservatively, Dr. Florez advised.

Dr. Florez has received research funding from Merck & Co., which makes medications for diabetes. ■



DR. FLOREZ

Data From ADVANCE Trial Slated to Be Released Early

BY SARA FREEMAN
Contributing Writer

GLASGOW, SCOTLAND — Data from the intensive glucose-lowering arm of the ADVANCE trial will be released earlier than expected, during the American Diabetes Association's 68th Annual Scientific Sessions in June.

Study investigator Dr. Neil R. Poulter of the National Heart

and Lung Institute at Imperial College London, made the announcement during the annual professional conference of Diabetes U.K. The results had been planned for release at the European Association for the Study of Diabetes in September.

Only data from the intensive glucose-lowering arm of ADVANCE (Action in Diabetes and Vascular Disease: Preterax and

Diamicon MR Controlled Evaluation) will be released, and these data follow as a direct result of the recent closure of the intensive glucose-lowering arm of the ACCORD (Action to Control Cardiovascular Risk in Diabetes) trial.

Dr. Poulter said that the press statement issued by the data safety monitoring board for the ADVANCE trial still stood and that

there was no evidence of increased cardiovascular mortality in patients treated with an intensive glucose-lowering regimen as there had been in ACCORD. At the time this statement was released, the data analyses were 99% complete, so there is unlikely to be any change, he said.

"In terms of statistical robustness, ADVANCE is more powerful; it's got about twice as much

patient years of follow-up as ACCORD does," Dr. Poulter said. Commenting on the differences between the trials, and what they may mean, he added, "The difference in insulin use was really quite dramatic between the two [trials]."

Dr. Poulter is a member of the management committee and director of the north European region of the ADVANCE study. ■