Gerryatric Musings January 2013

As mentioned last month, I want to review new guidelines in diabetic management in long term care facilities.

There have been several studies that have shown an increase in mortality with more intensive glucose lowering (ACCORD). Vascular outcomes did not show any statically significant reduction in major cardiovascular events over a 5-year period of the studies (ADVANCE, VADT). UKPDS showed no reduction in CV deaths or overall deaths at 10 years except in the overweight patients on metformin. At 15 years the benefits from metformin persist and some benefit from sulfonylureas was now apparent despite no differences in A1c levels.

I think the main issue to consider in reducing risk in type II diabetes is that it takes 8 years of tight control to reduce vascular risk factors. However, in the frail elderly the life expectancy is less than 8 years with the median life expectancy in new nursing home patients is less than 2 ½ years.

So what do we do? I believe the goals should be to decrease symptomatic hyperglycemia, optimize cognition, avoid worsening of incontinence and avoid increasing the risk of infections. This can be done through moderate control.

A recent study by Meneilly published in the Canadian Journal of Diabetes in 2011 recommended the following goals:

- FPG < 10 mmol/L
- PPBG < 14 mmol/l
- A1c % <8.5

Hypoglycemia is the most common complication in the elderly type II diabetic. Symptoms may be absent or may include light-headedness or loss of balance. It is more likely with the use of sulfonylureas or insulin and unlikely with metformin. A Swedish study showed that residents with an A1c < 6 had a high incidence of nocturnal hypoglycemia. Seventy five percent could come off their medications and those on insulin could have their dose cut in half. Only 12 % needed their oral medications restarted.

What about GBM testing? I would suggested that it is not required except under the following circumstances:

- change of weight up or down by 10%
- when prednisone or an anti-psychotic medication are prescribed
- when the resident is acutely ill or
- when there is a sudden change in cognition or function.

Next month: statins in the frail elderly