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### Fostering a "Back to Basics" Model in Type 2 Diabetes Care

Narrator:

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Dr. Russell:

Welcome to **Diabetes Discourse** here on ReachMD. I'm your host, Dr. John Russell. Today I'm joined by Dr. Neil Skolnik, and we're going to talk about *Back to Basics with Diabetes*. Neil, welcome to the show.

Dr. Skolnik:

Thank you, John, looking forward to it.

Dr. Russell:

So, as a primary care doctor, how do you decide year over year what you're going to do to alter your care for your diabetic patients?

Dr. Skolnik:

I think the best resource out there in terms of staying up-to-date are the standards of care that are issued every year by the American Diabetes Association, and their process is really interesting. Beginning in the summer before, and then they meet in September, they begin looking at all of the new evidence from the previous year and reexamine all aspects of standard care from what should be the target A1c to how rigorously should we treat blood pressure, lipids and every other aspect of care, and in the January edition of *Diabetes Care* issue an update that really gives us all guidance.

Dr. Russell:

So, how would the average doctor access that?

Dr. Skolnik:

You can access that in one of two ways. One, it is free on the web if you go to diabetes.org on the professional section, and the American Diabetes Association now also makes a shortened version that I believe is accessible from the same website and also from a number of other places.

Dr. Russell:

So, for 2015, just going through some of the basics, has A1c target changed at all for guidelines?

Dr. Skolnik:

No, our A1c target hasn't changed, but I think it's important to re-emphasize the individualization of our setting of targets. So, we all remember for years the main target is an A1c less than 7%. What we don't remember is that for at least the last 5 years, the American Diabetes Association has said very clearly that we need to individualize our target A1cs; and what that means is that younger patients, meaning 40 to maybe even 60, people who are young with a relatively short duration of type 2 diabetes with few comorbidities, you can seek an even more rigorous control of A1c, close to 6.5 or as close to normal as you would feel is comfortable and safe to do without hypoglycemia. For the average patient with diabetes, we're looking at an A1c less than 7. But it's really important to remember that for patients who are older and/or patients who have multiple comorbidities, we want less rigorous control of A1c; 8, 8.5 is fine. That nursing home patient, you don't want to have tight control because the consequences of hypoglycemia are severe and we want to try to avoid them.

Dr. Russell:

How about the diagnosis of diabetes? Is there anything new in 2015 for establishing a diagnosis?

Dr. Skolnik:

No, our diagnosis remains the same. We want to screen patients who are at risk for diabetes, and those at risk are everyone over 45 and individuals younger than 45 who have risk factors for diabetes. Those risk factors being things like being sedentary, being overweight, having a family history of diabetes, having had gestational diabetes in the past. So, there's a large group of people who get screened. The best screening tool is an A1c so a patient doesn't have to have a fasting specimen. You can also screen with a fasting glucose, but of course, there's going to be more variability day-to-day there. And then an A1c above 6.5 is diabetes, and it ought to be repeated twice. It ought to be an initial one and then a second one to have the diagnosis of diabetes.

Dr. Russell:

Where should our blood pressure goals be for our diabetic patients?

Dr. Skolnik:

Our goals have changed over the last few years so that if we look back a few years ago, we were aiming for 130/80. Then it went to -- because of a lack of evidence showing that a blood pressure that was more rigorous than what we usually shoot for for patients was of any benefit, over the last few years the blood pressure goals have changed to be that which we are shooting for for most patients, which is 140/90.

Dr. Russell:

And I think that's based on the ACCORD trial, I think.

Dr. Skolnik:

That's a very good point, John, so that if we get more granular, dig deeper, it's based on the ACCORD blood pressure trial where there really wasn't a benefit of more rigorous blood pressure control.

Dr. Russell:

Now, I know there's been a lot of controversy for lipid guidelines over the last few years with the new release. Is there any clarity in the American Diabetes Association guidelines with regard to management of lipids?

Dr. Skolnik:

So, for years the guidelines had recommended an LDL cholesterol of less than 100 mg/dL because we want more rigorous control of cholesterol in patients with diabetes because of their elevated cardiovascular risk. Remember, in late 2013 the American Heart Association came out with new cholesterol guidelines that recommended using a statin in all high-risk patients and in high-risk patients using a highly potent statin but not to pay attention to a specific cutoff number in LDL, because none of the studies out there actually aim to get someone below an LDL of whatever that cutoff would be, 100 or 70. They all looked at decreasing someone's LDL by a certain percent, in the case of highly potent statins by about 30 to 50%. In 2015 the American Diabetes Association guidelines harmonized with those of the American Heart Association, so every patient over 50 or 45 with diabetes should have a statin on board and it should be a highly potent statin.

Dr. Russell:

And I think we saw in the arm of the ACCORD trial the addition of fibrates really did not make a huge difference in our folks with diabetes.

Dr. Skolnik:

That's right, and that's been a real change over the last few years because we used to think, because remember, patients with diabetes often have a low HDL and high triglycerides, that the addition of a fibric acid derivative would be beneficial. The ACCORD trial really didn't prove that to be so. There was some suggestion and in some subgroups that had low HDLs and high triglycerides that perhaps a fibric acid would help, but the guidelines putting it all together say that the focus is really LDL cholesterol, decreasing it with use of a statin and not focusing on HDL and triglycerides with the addition of a fibric acid.

Dr. Russell:

You're listening to **Diabetes Discourse** here on ReachMD. I'm your host, Dr. John Russell. I'm joined by Dr. Neil Skolnik, and we're talking about the basics, Diabetes Basics for 2015.

So, Neil, what should we be doing with regard to screening for renal disease?

Dr. Skolnik:

Screening for renal disease is really two things: one, periodically checking a basic metabolic panel looking at creatinine and BUN, and then also on an annual basis checking for an albumin to creatinine ratio in order to detect the first development and early development of microalbuminuria, which is often or usually the first manifestation of renal disease in patients with diabetes.

Dr. Russell:

So, in the newer guidelines, is there any change in our algorithms with regard to walking through medications?

Dr. Skolnik:

Well, walking through medications, in the standards of care they reference and agree with a different paper by Silvio Inzucchi, which was also published in this January's edition of *Diabetes Care* -- it isn't an every year update; it's about every 3 years -- where the algorithm for medications is one, an emphasis on individualization of treatment. Almost everyone gets metformin, but after that we want to assess patients based on what their needs are and how that meshes with what medicines can do and looking at risk for hypoglycemia, looking at efficacy of A1c reduction, looking at other side effects like GI side effects, looking at weight issues -- we want to, if possible, in our

patients who are overweight use a medicine that helps them lose weight rather than gain weight -- and looking at cost.

And when we put all of those together, really everything is on the map as second and third agents including the new classes of medicines, the SGLT-2s, incretinmimetics, the DPP-4 antagonists, the GLP-1 agonists, and TZDs which, in the past, there was a concern about an increase in bladder cancer, but more recent evidence from Kaiser Permanente and talked about in the Medical Management Update suggests that there actually isn't a real link there. So, really, everything is on the map.

Dr. Russell:

So, do you mind if we kind of break down and talk about some of these things that we look at and look at the different medicines? So, hypoglycemia, what are the medicines should I be worrying about with hypoglycemia?

Dr. Skolnik:

So, the medicines that rise to the top in terms of concern about hypoglycemia are, of course, insulin, which has a very high incidence of hypoglycemia; but in terms of medicines that we might use as first- or second- or third-line agents, the sulfonylureas. And sulfonylureas are tricky because on the one hand they have a much higher incidence of hypoglycemia compared to the newer medicines so in that way are unattractive, though they do have good A1c control; but remember, they are inexpensive and they're on many pharmacies' \$4 list. Sulfonylureas also can cause some gain in weight, but I don't want to -- while many people will throw them off the map in terms of being useful because of the weight gain and the hypoglycemia, I think we have to acknowledge from a patient's point of view a medicine that's \$4 a month if they don't have insurance is better than a medicine they can't afford.

Dr. Russell:

And certainly, I think we have learned in the last few years that hypoglycemia in seniors is not a trivial event.

Dr. Skolnik:

It's a huge event. If we look at aggregated data, we see that one incidence of hypoglycemia can increase cardiovascular outcomes and mortality by 2 to 2½-fold, so that's 200 to 250%. If we think about it logically, we can see why, particularly in older people, we need to stay away from this. If, John, you or I were to get hypoglycemic, we'd look a little dizzy, we might fall, someone would give us something to eat and we'd continue talking; but an older patient, particularly someone who lives alone, when they get hypoglycemic, they feel dizzy, they can't communicate effectively to someone what's going on, they might fall, they might break a hip, and that is a life-changing event.

Dr. Russell:

So, you mentioned weight. Can you kind of categorize the medicines on which ones are going to make me put weight on, which are weight neutral and which can cause me to lose some weight?

Dr. Skolnik:

Great point. So, in terms of weight on, that would be sulfonylureas, and insulin rises to the top. Weight neutral, metformin, sometimes makes you lose a little bit of weight often weight neutral. DPP-4s are essentially weight neutral in terms of weight loss. And also, weight gain would be the TZDs often by retention of water. In terms of weight loss, the two that really are exciting in this respect are the SGLT-2 inhibitors. Remember, the SGLT-2s make you lose glucose into the urine. Glucose contains calories. And there's often significant weight loss over the first year after starting an SGLT-2. It doesn't continue forever, but that weight loss sure beats weight gain. The other class of medicines is the GLP-1 agonists where you have a good deal of weight loss with their use.

Dr. Russell:

So next, if we're going to look at all these different medicines, could maybe you kind of give me kind of best to worse with regard to lowering of A1c?

Dr. Skolnik:

Sure. Now, one of the things to be aware of and something that's not incredibly well appreciated is when we look at the efficacy with regard to A1c lowering for these medicines, they are often related. The data we have is related, of course, to the studies that were done. The newer studies often enroll people who had A1cs close to 8, 8.5. The older studies had as point of entry A1cs of people who were 9 and 9.5. Therefore, sulfonylureas look a lot more effective than some of the new medicines. They're probably about equal efficacy.

Dr. Russell:

So, apples and oranges.

Dr. Skolnik:

Exactly, apples and oranges, so that what we see is that lowering of about a point, maybe a point almost a point and a half, are going to be medicines like the GLP-1 agonists, sulfonylureas, metformin, perhaps even the SGLT-2s because there there's something interesting where if you look at patients who come in with A1cs that are near goal, they're going to only drop their A1c by about half a percent; but if you look at people with higher excursions of A1c coming in at about 10, you can see drops of about 2% or more. And then, of course, insulin, which you can ramp up and on the average will give you -- people think of insulin as giving you an infinite control. That's not actually true with basal insulin alone. With basal insulin alone, you get about that point and a half of improvement in A1c. And for people who are way far away and who don't get control on basal insulin alone, you then, of course, add rapid-acting insulin before meals.

Dr. Russell:

So, Neil, for someone who spent over the last 25 years as a primary care educator, if you could talk to kind of young students, residents, to give them kind of one point that you think people are making mistakes on with diabetes care, what would that tip be?

Dr. Skolnik:

Boy, that's a tough one, John. I'll tell you my personal opinion here is the place where we stand to benefit patients the most with regard to diabetes is increased attention to prediabetes, that group of patients who have A1cs from 5.7 to 6.4 who are very high risk of going on to develop diabetes, and that's the group that's actually -- and I hate to use the term sweet spot here -- but that's the sweet spot where if you can intervene with vigorous lifestyle interventions -- and the data is robust from the Diabetes Prevention Program trial, *New England Journal* 2002 -- help them to be motivated to achieve weight loss of 7% or greater and exercise of 150 minutes a week or more, we can decrease their progression to diabetes by over 65% compared to usual care. And, in fact, that 65% is about twice as good as if you treat those people with 850 mg of metformin twice a day. So, I think that's our biggest area of both improvement and exciting potential for patient benefit.

Dr. Russell:

Thank you so much for being on the show.

Dr. Skolnik:

My pleasure.

Narrator:

You've been listening to **Diabetes Discourse** on ReachMD brought to you by AstraZeneca, pushing the boundaries of science to create life-changing medicines for people with diabetes. With a portfolio of 7 approved diabetes products and other compounds in development, AstraZeneca is ushering in a new era of innovative diabetes treatment options. AstraZeneca research aims to impact the burden of diabetes by researching the underlying mechanisms of the disease that could one day help lead to a cure. In addition, AstraZeneca offers resources for patients dealing with diabetes including the recently launched Fit2Me diabetes diet and lifestyle support program and is committed to supporting patient access to its diabetes treatments through the AZ&Me patient assistance program. AstraZeneca is pushing the boundaries of science with the hopes of creating life-changing medicines for people with diabetes.

To learn more about this diabetes diet and lifestyle support program from AstraZeneca, visit [fit2me.com](https://fit2me.com). That's fit, the number 2, me.com.