Best Evidence Goals for Type 2 Diabetes - Frankly Speaking EP 66

Transcript Details

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Dr. Frank Domino:

After seeing your last patient of the day, you hear on the car ride home about a new set of treatment guidelines for patients with type two diabetes. Before you even get a chance to read about it, you hear a second group has come forward denouncing these new guidelines and recommends a different set of rules in the management of type two diabetes. Hi, this is Frank Domino, and joining me today is Alan Ehrlich, Associate Professor in the Department of Family Medicine and Community Health at the University of Massachusetts Medical School, and Executive Editor at DynaMed. Thank you for coming, Alan.

Dr. Alan Ehrlich:

Thanks, Frank.

Dr. Domino:

So, we're talking about new guidelines for type two diabetes.

Dr. Ehrlich:

Yeah, I heard that the American College of Physicians has issued some new guidance. Can you elaborate on what they're recommending now?

Dr. Domino:

So the American College of Physicians, very large organization, undertook an evaluation of what the best data is regarding the treatment of type two diabetes. And they did so using a statistical method and a process where they looked at all the published guidelines that were available, many that you're commonly familiar with. And they tried to see if the best available data pointed us in a direction about how we should view treating type two diabetics. Their conclusions were pretty straightforward. There were four of them. And they're really informative, but controversial.

Dr. Ehrlich:

Well, what were they? Can you run us through them, Frank

Dr. Domino:

Sure. So the first was that we should set individualized goals for our patients with type two diabetes and discuss the pros and cons, the risks and benefits and harms of pharmacologic therapy. And also talk to them about their general health, their philosophy towards how long they wanna live and how they wanna live, and also discuss some issues around the adverse effects of chronic type two diabetes that's not well-controlled and the costs of their care.

Dr. Ehrlich:

That's sounds non-controversial.

Dr. Domino:

That was very well-received. But believe it or not, that's actually one of the sticking points of the controversy. The second statement was that clinicians should aim to achieve a hemoglobin A1C level between 7% and 8%. And as you can imagine, that's a real departure from previous recommendations and is also quite controversial. Their third statement was that we should consider de-intensifying, which means less treatment of patients with type two diabetes whose hemoglobin A1C was below 6.5. The rationale here being, that if you're getting them so low, you run the risk of inducing a hypoglycemic event. And we know that there's a real danger, an increase in mortality associated with hypoglycemia and very low A1C levels in type two diabetics. Their fourth recommendation was that we should become a little bit more patient-centered and realistic in how we treat patients with type two diabetes. They recommended avoiding even testing A1C levels in patients with limited life expectancy, which they defined as less than 10 years or being of age 80 or older. They also recommended that we become less aggressive or don't bother to check A1C levels in patients who live in nursing homes and have chronic severe conditions like dementia, cancer, end-stage kidney disease, chronic COPD, or severe heart failure.

So that was their four statements: Have a very personalized goal in a patient-centered discussion about treatment. Make your A1C goal between 7 and 8. Back off a bit in patients aggressively treated with lower A1C levels, and begin reducing the amount of testing we do on patients with limited life expectancy.

Dr. Ehrlich:

Well, I can imagine that that last one probably wasn't the big focus of controversy. It's those middle two that sound like they would be a departure from what we're often told by our endocrinologist colleagues. What did the American Academy of Clinical Endocrinologists have to say about all this?

Dr. Domino:

Well, their take was that, first of all, we're the clinicians in that we should have those patient-centered discussions, but we should get to choose the aggressiveness to care less so than having the patient's personal opinions play a great role. They really felt though, as you said, the middle two recommendations were the most controversial. They felt that getting hemoglobin A1C below 7, in their mind, lowered the risk of some of the microvascular complications of type two diabetes, and liberalizing this level was going to actually to have an adverse impact on patients. And they did qualify that by saying that they have very good data that if you take a newly diagnosed, highly motivated patient, and aggressively manage their A1Cs, they will have better outcomes. They didn't really talk about the patient who's got chronic type two diabetes that may or may not have been aggressively managed.

Dr. Ehrlich:

Yeah, that population, while I hear that often described, the highly motivated new type two diabetic, I think there's a certain percentage of patients who fit that description. But I think there's a large segment of patients with type two diabetes who are getting this partly as a basis of gaining weight over time, and partly just getting older and their pancreas becoming aging and being a little less effective. And these patients are often the ones who are more difficult to manage, and maybe these less aggressive treatments make sense there.

Dr. Domino:

I think they do. I totally agree with de-intensifying very aggressive A1C lowering, especially in a patient who's had the disease for more than a few years because we don't have any data that shows it's beneficial and we do have data that shows it's harmful. Likewise, I think everyone agrees that taking a more civil approach to patients with limited life expectancy is

the right way to go. Now, in the US, if you talk about not measuring hemoglobin A1C on a type two diabetic, someone's gonna worry about quality markers, someone's gonna worry about someone looking over your shoulder. Nonetheless, I think this guideline is a wonderful benefit to us because we can tell our patients who are over the age of 80 or have a life expectancy, or have a chronic disease that's gonna limit their life expectancy, that we don't need to worry about that as much. Let's keep them safe and, in particular, screen for hypoglycemic events and maybe change some of their medicines.

In particular, I feel like there are many good things about both the ACP guidelines and the AACE recommendations in contrast to it. They say, "Listen, focus where the disease is", which is really insulin resistance. The American Association of Clinical Endocrinologists strongly support aggressively treating our newly diagnosed type two diabetics with agents like Metformin and the SGLT2 inhibitors, as well as the GLP-1 agonists. Those three agents should probably be our first and second line approaches, which, although they didn't say so, certainly means backing away from insulin, in particular, short-acting insulin. As you pointed out though, if their pancreas has failed, you may need to add insulin as well, but for the newly diagnosed patient, I think we now have some agreement on a clear approach.

Dr. Ehrlich:

So, when I'm working with a patient with diabetes, how would you suggest I focus my efforts? What's the most important thing to tell the patient?

Dr. Domino:

Well, I think the television, all sorts of media, and us have for many years emphasized the A1C and I think we need to redirect that. We should talk to them about healthy eating. We should talk a great deal about weight loss and aerobic exercise. If they wanna lose weight, they should combine aerobic with some resistance training and then use agents that are

gonna help patients get to the end points that we consider important, not necessarily hemoglobin A1C level, but rather a healthy weight and a very reasonable A1C goal.

Dr. Ehrlich:

Sounds good, Frank.

Dr. Domino:

Alan, I think there's more agreement than disagreement here despite the controversy. I feel comfortable liberalizing and making an A1C goal of 7 and 8 and I think refocusing our efforts on proper health is ultimately gonna lead to our best outcomes with our type two diabetics.

Dr. Ehrlich:

This sounds very practical and it sounds certainly more realistic than the way we sometimes approach patient care.

Dr. Domino:

Thanks again, Alan. Practice pointer: Consider a hemoglobin A1C level between 7 and 8 for most patients with type two diabetes. Join us next time when we talk about the approach to acute sinusitis in the community-based setting.