This gets personal. Not only do I now reluctantly meet the definition of an older adult, I also have a family history of type 2 diabetes, which means I have at least a 25% chance of developing the disease any day now. But as an endocrinologist/diabetologist who has been working in this area for more than 20 years, I feel lucky. I know how to delay the onset of this disorder with a combination of diet and exercise, and if I do develop diabetes, I know what drugs I would want to take (metformin would be high on the list) and which ones I would decline (glyburide and thiazolidinediones). I also know that, at my age, keeping my A1C ≤ 7.5% would be a reasonable way of minimizing my risk for micro- and macrovascular complications, as well as mortality1 and, hopefully, the diabetes-associated risk for cognitive decline, which in some ways is of more concern than diabetes itself.2

But the personal extends beyond me. My father has had type 2 diabetes for more than 30 years. His doctor started him on glyburide when he was diagnosed—and he has been on this drug ever since.

To me, this is one of the worst diabetes medications he could take. The risk of hypoglycemia is higher with glyburide than with any other secretagogue or any other class of diabetes medications, including appropriately dosed insulin.3,4 Yet, I am not his physician, and I do not write his prescriptions.

He lives in another state and has conveyed my suggestions that glyburide be discontinued to his physicians. Like many patients young and old, he is reluctant to challenge his physicians beyond this.5 So he remains on glyburide.

And he does have hypoglycemia. It is only through our weekly phone calls that I have learned about this. When he was still playing golf in his eighth decade of life, he was wondering why he became so weak at the ninth hole, often needing to call it quits for the day. I told him that he should carry glucose tablets or some other food source with him and that he should cut back on his glyburide when he played golf. This worked. It was a revelation to him that his symptoms resulted from a low blood glucose reaction, and he was happy to learn about the relatively simple solution.

Fast forward another decade, when I received a worried phone call from my mother. She was concerned by how weak and listless my father was becoming. He was not worried and instead attributed these symptoms to old age. On further questioning, I learned that his A1C was 6%, and his morning glucose readings were ranging from 70 to 80 mg/dl. Once again, I suspected hypoglycemia, and told him directly to cut his dose of glyburide in half.

The next time I spoke with him, his voice sounded more energetic, and he reported feeling much better. However, he was concerned because he was now getting home glucose readings of 130–140 mg/dl. I recommended that he continue the lower dose of glyburide and con-
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Editorial

Vincent L. Pociask, MD

Most people do not have a daughter or son who is an endocrinologist with an interest in diabetes. My father’s physician was satisfied with his glycemic control and did not suspect hypoglycemia as the cause of his physical decline. However, even mild episodes of recurrent hypoglycemia are a significant risk factor for dementia. Fortunately, this has not been an issue for my father who, other than maintaining political leanings very different from mine, is cognitively strong with no signs of waning.

This story is a very personal one, but it illustrates the importance of improving the system of providing patients with enough information to take care of their diabetes while leading a satisfying life. It is important for those in the medical profession to either provide information or refer their older adult patients to someone who can provide sufficient education to guide their diabetes management.

There are several lessons to be learned from this story. One is that diabetes self-management education (DSME) is as important for older adults as it is for younger adults. Providing patients with information about the symptoms of both hypoglycemia and hyperglycemia improves their ability to determine when they need an adjustment in their medications. In the long run, this knowledge improves general well-being and quality of life and ultimately prevents hospitalizations for severe glycemic excursions that pose additional risks to older adults.

Another issue raised by this story relates to the medications used to treat diabetes in older adults. For some reason, glyburide remains one of the most frequently prescribed sulfonylureas in the United States, despite the fact that it is known to be associated with a high risk of prolonged hypoglycemia, particularly in the elderly. Glyburide has also been shown to interfere with the protective mechanism of ischemic preconditioning described in those with coronary artery disease. There is no good reason for glyburide to be used in anyone > 70 years of age. Other sulfonylureas are as inexpensive and effective at lowering blood glucose and have a lower risk for hypoglycemia without the adverse impact on ischemic preconditioning.

Scientific controversy, as well as personal opinion on the part of many medical providers, can cause confusion in the glycemic management of older adults with diabetes. Fortunately, some of this confusion and inconsistency in applying the American Diabetes Association (ADA) Standards of Care to older adults is now addressed in a recently published consensus statement from the ADA and the American Geriatrics Society. A discussion of the recommendations from this statement is beyond the scope of this editorial, but this important document is available free in full text online (http://care.diabetesjournals.org/site/includefiles/dc12-1801.full.pdf). I also encourage readers to be on the lookout for a Diabetes Spectrum From Research to Practice section on diabetes in older adults that is in preparation for future publication in this journal.

The final lesson that comes from this story is the importance of providing effective education to physicians about diabetes care and management. This is particularly important for internists, family practitioners, and geriatricians, who are most likely to encounter older adults with diabetes. These physicians are on the frontlines of providing diabetes care that, if done properly, can have a favorable impact on the lives of those with this disorder. Instead of focusing on pay-for-performance initiatives that reward prespecified A1C and blood pressure measures, perhaps we should reward physicians who make DSME a priority in the care of their patients.

References

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