

Case Study Responses

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Note: Readers are encouraged to visit www.InsulinJournal.com to review the details of a Case Study published in the January 2009 issue of *Insulin*.

This was the case of an 84-year-old woman with type 2 diabetes mellitus and increasingly difficult glycemic control, manifested by elevated glycosylated hemoglobin (A1C) with hypoglycemic episodes. The patient came to your office for comprehensive management.

Question 1. What are the possible reasons for her worsening glucose control?

Answer: e. All of the above (worsening renal function, poor adherence to medications, dietary changes, and decreasing physical activity)

Question 2. What is the first step that you would recommend to address this patient's glycemic control in the setting of her advancing age, chronic kidney disease, and history of hypoglycemia?

Answer: d. Assess ability to adhere to current medication regimen

Question 3. What additional conditions should you consider regarding an older person's ability to adhere to a medication regimen?

Answer: e. All of the above (finances, cognitive status, functional status, and multiple medications [polypharmacy])

Question 4. What is the target A1C in older adults with chronic conditions?

Answer: e. Depends on the patient's preferences, life expectancy, and chronic conditions

The American Geriatrics Society released a position paper in 2003, recommending that target A1C levels should be individualized. Although a goal of <7.0% would be reasonable for a functional, older adult with stable chronic conditions, a higher level might be acceptable in a frail, older adult with limited life expectancy.¹ Medication selection and dosage should be considered carefully, even with a "normal" creatinine level, because of the likelihood of chronic kidney disease and impaired renal clearance of medications in older patients.² In addition to the usual barriers to medication adherence, older adults may struggle with environmental, physical, or cognitive impairments that make adherence more difficult. Durso³ outlines a patient-centered plan on how to negotiate patient preferences, health status/burden of illness, benefits of therapy, and life expectancy. In addition, results of the Action to Control Cardiovascular Risk in Diabetes study⁴ suggest that mortality rates are higher with intensive therapy (A1C <6.0%). This framework is also supported by the American Diabetes Association in the 2008 Standards of Medical Care.⁵

REFERENCES

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3. Durso SC. Using clinical guidelines designed for older adults with diabetes mellitus and complex health status. *JAMA.* 2006;295:1935–1940.
4. Gerstein HC, Miller ME, Byington RP, et al, for the Action to Control Cardiovascular Risk in Diabetes Study Group. Effects of intensive glucose lowering in type 2 diabetes. *N Engl J Med.* 2008;358:2545–2559.
5. Standards of medical care in diabetes—2008. American Diabetes Association position statement. *Diabetes Care.* 2008;31(Suppl 1):S12–S54.

Additional Reading

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Schmittiel JA, Uratsu CS, Karter AJ, et al. Why don't diabetes patients achieve recommended risk factor targets? Poor adherence versus lack of treatment intensification. *J Gen Intern Med*. 2008;23:588–594.

Readers are invited to consider a new Case Study (see page 126) and submit responses to www.InsulinJournal.com before the deadline.