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# ELDER CARE

## A Resource for Providers



### Diabetes – Special Considerations for Older Adults

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Diabetes is common in older people. National data show that at least 1 in 7 older adults has diabetes, and in some racial and ethnic groups the rate is as high as 1 in 4.

Most clinicians are familiar with practice guidelines for glycemic control in diabetes, but there are many issues in diabetes care that require special considerations when dealing with geriatric patients. The American Geriatrics Society (AGS) has issued guidelines for improving the care of older people with diabetes, and this newsletter will highlight some of the key points in the AGS and other pertinent related guidelines.

#### Glycemic Control

The glycemic control target for otherwise healthy older adults with diabetes is a hemoglobin A<sub>1c</sub> (A1C) level  $\leq$  7%. However, the risks of hypoglycemic complications that accompany such tight control outweigh the potential benefits for frail older adults and people with a life expectancy of less than 5 years. For such individuals, a less-stringent goal of 8% is more appropriate.

A1C should be measured at least every 6 months for patients who are not at goal. For those with a stable A1C level, annual measurements are appropriate.

When prescribing diabetic medications to older adults, several specific issues must be considered. Metformin can cause metabolic acidosis, and is not recommended as a routine therapy for people over 80. If a sulfonylurea is used, glipizide is preferable to glyburide because glipizide has a shorter half life. Insulin therapy, the gold standard for glycemic control, is often not practical for older individuals due to vision problems or hand arthritis that limits the dexterity needed to draw up and inject the drug. Prefilled insulin pens are an excellent option for older adults, but often are not covered by insurance.

Inexpensive medications with simple dosing schedules, short half lives, and few side effects and drug-drug interactions are the best choices for older adults.

#### Blood Pressure and Lipid Control

Research has shown that it takes about 8 years of good glycemic control to reduce the rate of diabetes-related vascular complications. It only takes 2-3 years, however, to see a similar benefit from blood pressure and lipid control. The AGS guidelines thus emphasize blood pressure and lipid control as a way to reduce vascular complications in people with diabetes (Table 1).

**Blood Pressure Control** Current guidelines recommend a target blood pressure below 130/80 mm Hg for patients with diabetes. Many antihypertensive drugs are effective, including diuretics, angiotensin-converting enzyme (ACE) inhibitors, beta-blockers, calcium channel blockers, and angiotensin-receptor blockers (ARBs). Because of the renal-protective effective of ACE inhibitors, many experts recommend that the antihypertensive medication regimen for diabetic patients include these drugs. If ACE inhibitors, ARBs, or diuretics are prescribed, the AGS guidelines recommend that renal function and potassium levels be checked within 1-2 weeks after starting therapy. The guidelines also recommend checking these parameters 1-2 weeks after every dose increase, and at least yearly.

**Lipid Control** The AGS guidelines set a target low-density lipoprotein (LDL) level for diabetic patients, at  $<100$  mg/dL. For patients with diabetes or those with known coronary disease, the National Cholesterol Education Program recommends a goal of  $<70$  mg/dL. Liver function tests should be measured after 3 months on starting statin therapy and with dose increases.

#### TIPS FOR THE MANAGEMENT OF DIABETES IN OLDER ADULTS

Emphasize good blood pressure and lipid control. For older adults, good control of blood pressure and lipids has more benefit for reducing the risk of vascular disease than does tight glycemic control.

While the goal for glycemic control in most older adults is the same as for younger people (A1C  $<7\%$ ), accept less stringent glycemic control goals (eg. A1C  $\leq 8\%$ ) for frail older adults and those with limited life expectancy.

Unless contraindicated, most older diabetics should be on daily aspirin for cardiac protection, a statin for lipid control, and an ACE or ARB as part of their blood pressure control regimen.

Annual foot and eye exams, and screening for microalbuminuria, should be a part of all diabetic preventive care.

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**Diabetic Education** Data from randomized-controlled trials indicates that glycemic control is improved, and rates of hypoglycemic episodes are reduced, when older adults participate in multidisciplinary diabetes education. Annual diabetes education is covered under Medicare Part B.

**Aspirin** The rate of myocardial infarction is reduced in older adults with diabetes if they take a daily dose of aspirin. The AGS guidelines thus recommend that older adults who have diabetes should be offered daily aspirin therapy, assuming there are no contraindications to aspirin and the patient is not taking anticoagulant therapy. The optimal dose is uncertain, but there is no evidence that high doses are more effective than a dose of 81 mg per day.

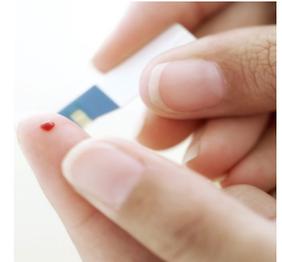
### Monitoring for Geriatric Syndromes

Older adults with diabetes have a higher risk of several common geriatric syndromes than older adults without this disease. Syndromes include falls, chronic pain, urinary incontinence, cognitive impairment, depression, and polypharmacy. Table 2 outlines the intervals at which the AGS guidelines recommend screening for these syndromes, along with the recommended screening tool.

As always in geriatrics, an individualized approach is the key to proper care. Blood pressure and lipid control are paramount. Relatively good control of blood sugar is important to prevent metabolic abnormalities, reduce infection, and hopefully stem the progression of end organ disease. Routine eye and foot exams are vital preventive care. Simple and inexpensive medication regimens should be the goal for the older patient, who might not be able to afford non-generic drugs or manage insulin. Take some extra thought with older diabetics—they are worth it.

**Table 1. Glycemic, Lipid, and Blood Pressure Goals for Older Adults who Have Diabetes**

< 7%	A1C goal for most older adults
≤ 8%	A1C goal for those who are frail or have limited life expectancy
< 130/80 mm Hg	Blood pressure goal for all people with diabetes
< 100 mg/dL	LDL goal for diabetics with no other heart disease risk factors
< 70 mg/dL	LDL goal for diabetes who have heart disease risks factors in addition to diabetes



**Table 2. Screening for Geriatric Syndromes in Older Adults with Diabetes**

Syndrome	When to Screen	Recommended Screening Method
Falls	Initial evaluation	History
Chronic Pain	Initial evaluation	History
Urinary Incontinence	Initial evaluation and annually	History
Cognitive Impairment	Initial evaluation and also later if there is an unexplained decline in status	Mini-Mental State Examination
Depression	Initial evaluation and also later if there is an unexplained decline in status	Geriatric Depression Scale
Polypharmacy	If patient experiences new onset of falls, urinary incontinence, cognitive impairment, or depression	Medication review

### References and Resources

- California Healthcare Foundation/American Geriatrics Society Panel on Improving Care for Elders with Diabetes. Guidelines for improving the care of the older person with diabetes. *Journal of the American Geriatrics Society*. 2003; 51:S265-280.
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