

Optimising control: Current views on managing acute and chronic complications in older people



Sara Da Costa

Nurse Consultant in Diabetes and Visiting Fellow, Western Sussex Hospitals NHS Trust and Visiting Fellow, University of Brighton

Having been involved in diabetes care for over 25 years, I, like my peers, have seen changes in recommendations regarding optimal glycaemic control for all our client groups, including, more recently, the elderly. Emerging evidence suggests there is a balance to be achieved between excessively tight control and control that is too lax, and both decisions have ramifications on the lives and quality of life of older individuals.

The debate is timely given that over half of people with diabetes are over 65 years of age, and we have a growing subgroup of frail elderly people, with specific issues and needs. We also have rising numbers of older people with dementia, who are unable to cope independently and rely on others to manage their daily living; this, of course, includes their diabetes medication, whether oral or injectable. The reduction in resources for community care places these vulnerable people at risk, often without the opportunity to optimise their glycaemic control. Resources often determine the choice of treatment more than individual need.

Despite this context of care, there remain many reasons why we should aim to improve glycaemic control on an individualised basis. We know from the ACCORD and ADVANCE trials that increased mortality arose from excessively tight control (Gerstein et al, 2008; Patel et al, 2008); however, at the same time, hyperglycaemia contributes to all diabetes complications, and we have people who remain active even in their nineties.

What are the factors that need considering when planning diabetes care to optimise control in the elderly? Two articles in this section inform the current debate and suggest considerations when planning glycaemic targets and strategies for reducing risk in elderly people with diabetes who are frail or suffering from cognitive

impairment or dementia.

In the first article, Andrew McGovern discusses the current evidence from clinical trials and observational studies for glycaemic targets in older people. Using this evidence as the context, he considers current guidelines and discusses the risks and benefits of tight glycaemic control, including the risks of hypoglycaemia and adverse medication effects. However, he cautions that undertreatment can also increase mortality and the risk of infection and cardiovascular, renal and eye disease. While it is not certain what level of glycaemia we should aim for in this client group, all the above factors should be considered when devising individualised targets for the older person with diabetes.

In the second article, Roger Gadsby and colleagues discuss how diabetes management increases in complexity with age, and how both clinicians and patients find it challenging to balance treatment benefits and risks. They consider the increasing risk of frailty and dementia in this elderly population, which in turn requires review of glycaemic control and associated medications. They also discuss frailty scales, which you may be familiar with. Our team is starting to use the Rockwood clinical measure of fitness and frailty to help us include these factors in our diabetes management (Rockwood et al, 2005). These scales can be useful to inform the aims of treatment according to clinical judgements about frailty, which in turn can yield useful predictive information.

In summary, the principle of individualising care according to factors including cognition, capability and comorbidities is clearly stated and remains important. It should be emphasised that de-prescribing, changing regimens and glycaemic targets, and regular medication review is necessary, and may be needed more frequently in the older person with diabetes. ■

References

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