

高齡糖尿病患血糖與血脂與血壓治療原則

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Older individuals with diabetes have higher rates of premature death, functional disability, and coexisting illnesses, such as hypertension, coronary heart disease, and stroke, than those without diabetes. Older adults with diabetes also are at a greater risk than other older adults for several common geriatric syndromes, such as polypharmacy, cognitive impairment, urinary incontinence, injurious falls, and persistent pain, so called geriatric syndrome. Therefore, they have unique and diverse needs and challenges, which should be considered when developing a management plan. The approach to management of diabetes in the elderly must be individualized and changed over time depending on the presence and progression of geriatric syndromes, comorbidities, and risk of hypoglycemia.

The approaches for diabetes management in old diabetic patients can include physical function assessment, vascular assessment, metabolic targeting, specific intervention for disability, and establishment of an individual diabetes self management plan with assessment of suitability. Older adults in excellent health, without functional or cognitive limitations, who desire good glycemic control, can follow guidelines developed for younger adults. Glycemic goals for older adults who are frail, functionally dependent, and have serious comorbidities should be individualized, using higher A1c goals that are acceptable to patients and caregivers, avoiding symptomatic hyperglycemia. According to some published consensus it is suggested that the goal of HbA1c in generally healthy older persons can be set between 7.0% and 7.5%. However, in frail or demented old patients, the goal of HbA1c should be adjusted, and quality of life is an important issue in any elderly patient, and aggressive treatment plans may not be reasonable because of complicated, costly, uncomfortable side effects from medical therapy, and an increased risk of hypoglycemia.

According to the 2016 American Diabetes Association (ADA) guideline, the goal for treatment of hypertension in healthy older adults and frail older adults without end-stage chronic illness who have T2DM is $< 140/90$ mmHg. Given the increased risks of CVD and progressive kidney disease in T2DM, lower targets (such as < 130 mm Hg) may be appropriate if the specific target can be achieved without an additional burden of treatment. As for blood pressure control, there is insufficient evidence regarding the benefits of hypertension treatment for frail polymedicated older patients, for whom treatment should be individualized. The ADA guidelines recommend a higher systolic and diastolic blood pressure target ($< 150/90$ mmHg) in older adults with poor health status, end-stage chronic illness, or short life expectancy. Of note, a recent study in diabetic patients showed that adults aged 75 years or older, treating to a systolic blood pressure target of less than 120mmHg compared with a systolic blood pressure target of less than 140mmHg resulted in significantly lower rates of fatal and nonfatal major

cardiovascular events and death from any cause, and exploratory analysis suggested that the benefit of intensive blood pressure control was consistent among persons in this age range who were frail or had reduced gait speed

Even though the data are not definitive, similar statin treatment approaches should be considered for older patients with type 2 diabetes, particularly in the presence of other cardiovascular risk factors, and the benefits of those interventions from primary and secondary prevention trials are likely to apply to older adults whose life expectancies equal or exceed the time frames seen in clinical trials. Of note, particular in the frail older diabetic patients, the clinical decision about their hypercholesterolemia therapy is a challenging issue. Generally, statin treatment should not be discontinued on the basis of increasing age and frailty only. Statins are generally safe, and even still helpful for cardiovascular benefits in frail older patients. The decision to discontinue statins should be made by judiciously taking into account the risk of vascular complications, life expectancy, serious adverse effects, and possible drug interactions, especially being considered if a statin has been prescribed for dyslipidemia in the absence of overt atherosclerotic disease.

In summary, approach to manage blood glucose, pressure and lipids in older subjects should be multifaceted and individualized. A comprehensive geriatric assessment of older people with diabetes should be designed to collect information on medical history, medication regimens, cognitive and mental health, and functional capabilities and how these may limit activities with special focus on surveillance rates of emergency room and hospital visits for hypoglycemia, medicine errors/overdose, use of agents with high risk of hypoglycemia, rate of falls, and quality of life. Management plans should focus on delivering individualized education plans, materials, and assessment for elderly diabetic patients.