

## Frequently Asked Questions About Oral Therapy For T2DM

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**Q.** Are there any disadvantages to using FDCs?

**A.** One disadvantage is the potential restriction in dose ranges within the combinations, although many OAD FDC's offer a full range of dosing possibilities. In addition, more care is required when initiating therapy with a combination tablet. While the FDC offers a well worked out, complementary combination of therapies, the clinician must be constantly aware of the potential side effects of all the constituent components. Some clinicians prefer to stabilize the patient on monotherapy prior to adding a second agent. In such cases, the FDC can be introduced to facilitate tolerability and adherence to therapy once the patient is tolerating combination therapy well.

**Q.** Do DPP-4 inhibitors cause gastrointestinal side effects?

**A.** The DPP-4 inhibitors generally do not cause any gastrointestinal side effects. In clinical trials, the rate of these side effects was very close to the placebo rate.

**Q.** Because SUs stimulate the pancreas to produce more insulin, do they hasten beta cell failure?

**A.** There is some debate regarding this. The SUs rapidly bring down blood glucose, and in so doing help prevent glucose toxicity to pancreatic beta cells. A Diabetes Outcome Progression Trial (ADOPT), however, showed SUs to have the least glycemic durability (ie, ability to maintain good glycemic control over time—a practical expression of beta cell failure) of most commonly used oral agents. There is no universally accepted evidence either way; the most compelling information, which was learned from UKPDS, is that over time, beta cell function progressively deteriorates regardless of the treatment used.

**Q.** Should an A1C ever be used for diagnosis?

**A.** The guidelines state that an A1C >6.5% is diagnostic for T2DM. It is important to realize that this determination should be made in a certified lab and not by a point-of-care determination. It always is desirable to have more than 1 criterion to firmly establish the diagnosis of diabetes—either a repeat abnormal test or an additional abnormal criterion such as FPG or 2-hour PPG.

**Q.** Can you comment on your thoughts about using certified diabetic educators (CDEs) in the treatment of the patient with T2DM?

**A.** Diabetes requires so many choices and decisions on the part of the patient. It's important to convey to the patient that it's their disease. A recent meta-analysis on the impact of having patients participate in an ongoing relationship with a CDE showed that such an interaction has a powerful impact on reduction of A1C and improvement in overall patient well-being. This study showed that ongoing contact with a CDE had the same impact on A1C lowering as most oral agents! Patients should be taught about diabetes care. It should be a requirement for all clinicians to teach their patients diabetes self-management in association with a CDE.

**Q.** In our practice, we are seeing morbidly obese teens with T2DM. In your opinion, what is the safest oral agent for these patients?

**A.** The safest strategy for teens who are obese is diet and exercise. Recent presentations at the ADA 71st Annual Scientific Session reported that weight loss and exercise can resolve hyperglycemia in recently diagnosed patients. The presenters used words like REMISSION of diabetes in those who exercise and reduce their weight. It is important to get patients exercising, get them dieting, get them moving, get them involved in sports. There is an obesity epidemic among our teens. When it comes to medication, there are few studies to confirm the efficacy of newer oral therapies in younger populations. This isn't to say newer drugs aren't efficacious in youthful populations, but they have not been studied and, thus, can't be freely recommended. If an intensive program of diet, exercise, and weight management is not effective, I would probably start the patient on metformin first. It has been around a long time and is well understood. There are good studies showing efficacy and safety in pregnancy. Beyond that, therapy must be individualized based on the patient.