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Glycemic Control in T2DM: Patient-Centric Approaches Case

Announcer:
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Here's your faculty Dr. John E. Anderson and Dr. Vivian Fonseca

Dr. Anderson:
Patient adherence is always a concern in practice, especially for those living with type 2 diabetes mellitus and its many comorbidities, including cardiovascular events and obesity. That's why this patient-centered discussion will focus on management strategies and novel pharmacologic treatment options we can use to help our patients with diabetes.

Welcome to CME on ReachMD. I'm Dr. John E. Anderson, and joining me today is Dr. Vivian Fonseca. Dr. Fonseca, thanks so much for joining us today.

Dr. Fonseca:
Pleasure, John, very happy to be working with you on this important topic.

Dr. Anderson:
Great, Vivian. So start us off. How do you incorporate patient-centered care models in your practice?

Dr. Fonseca:
So, patient-centered care is a very broad term. It involves many things. First of all, the whole concept started around having different goals for A1c. After the ACCORD trial, we realized that going very low can be risky for some individuals, so people with a lot of comorbidities you might have a higher goal than what we used to go for, which was 7% at that time, and there are some people who could get to 6% without much problem.

We also realized there are some people who may not be motivated enough or don't have the resources to get to very tight glycemic control, and to stigmatize them in some way is challenging, so you give them a goal, maybe 7.5, maybe up to 8%. We don't usually recommend higher than that because there's risk of more complications or infections, etc.

And for some people the goals might change. If your circumstances change, you might then go for a lower goal if things change terribly. And for some people who develop new comorbidities, you might relax the therapy. Much of this revolves around patient education of where they are, where they are headed, and shared decision-making with the patient. Tell the patient why you're choosing a particular goal and if they agree with that because that's what motivates them to choose that goal.

And then there are clinical characteristics. Do they have atherosclerotic disease or congestive heart failure, which has a very bad prognosis, or do they have chronic kidney disease where the A1c may not be reliable enough and you have to have other measures of

glycemia? So you may need to rethink the goals, and much more importantly, rethink the treatment, because some drugs need adjustment of dose or are contraindicated in advanced CKD.

There are now drugs that have very specific effects on reducing hospitalization for heart failure, so if the patient has CHF, that might be your appropriate choice. There are drugs that affect atherosclerosis favorably. There are drugs that either improve things in patients with stroke and peripheral vascular disease and some where you want to be cautious in people that have had prior amputations, so I think having a very precise approach helps get the right patients the right treatment.

Dr. Anderson:
Yes, I completely agree, Vivian, and I love the fact that it's about individualizing for each patient, looking at comorbidities, and also getting the patient buy-in, because we know that adherence improves when the patients are really involved in the decision-making.

You had mentioned earlier that early intensification is important for many patients with diabetes, so how do you introduce injectable therapy? And then how do you address ensuring patient adherence?

Dr. Fonseca:
So I think one of the important things in introducing something that many people don't like, which is an injectable, is how you dealt with the information about it in the past. I never tell people or threaten them with injections and tell them that it may be what they're going to get in the future in a negative way because then when they have to do it, they may think that I am pushing something negative on them. So, as part of education, even at the time of diagnosis, we tell them injectables are part of the treatment spectrum and that some people need it and it's not so hard to do—and emphasize the modern devices that we have. Pens, pen injectors, pumps for insulin are very fine needles, and part of this whole spectrum is also the monitoring devices, the continuous glucose monitoring. All this gets the patient very involved in their own care and might make things more acceptable to them.
Dr. Anderson:
For those just tuning in, you're listening to CME on ReachMD. I'm Dr. John Anderson, and here with me to talk about patient-centric approaches to glycemic control in type 2 diabetes is Dr. Vivian Fonseca.

Now, earlier, Dr. Fonseca, you gave us some insight into how you incorporate this kind of approach to your practice, but I'd like to switch roles and let you lead the discussion. So, without further adieu, Vivian, the floor is yours.

Dr. Fonseca:
So I'm very focused on being a little bit more precise in how I manage some of the complications of diabetes with data from many clinical trials that have reported giving us information on going beyond glucose control, and for that matter, also thinking about other comorbidities that people might have, such as chronic kidney disease and its progression, hospitalization for heart failure, etc. So we have very good data that allows us to target therapy appropriately for people. A good example would be reduction in hospitalization for heart failure with SGLT-2 inhibitors. So it becomes almost imperative that if we have a patient with diabetes that's uncontrolled and heart failure, that we use a drug that will reduce such hospitalization. The same applies for people who have generalized atherosclerosis. An SGLT-2 inhibitor has some benefit, but we're seeing a lot of benefit with GLP-1 receptor agonists. For people with prior stroke, for example, some of the older drugs like pioglitazone are very helpful, as is semaglutide, so we have to improve our knowledge about all these outcomes and tailor therapy to choose the right therapy for the right kind of patients.

In a way, focusing on what you see in your practice, Dr. Anderson, what's the place of these injectable GLP-1 receptor agonists for people with uncontrolled hyperglycemia who haven't yet got cardiovascular disease but you want to prevent it? And how do you approach use of that kind of therapy?

Dr. Anderson:
Well, it's a great question, Vivian, because when the GLP-1 receptor agonist class came out, I think everybody sort of used it as a last ditch effort before basal insulin. Now we know that in the AACE guidelines, the GLP-1 receptor agonist class is recommended as the second-line agent right behind metformin, and that was just for glucose lowering, because we know that they exhibit an effect on the beta cell to secrete insulin in a glucose-dependent fashion and they suppress glucagon after a meal.

They cause a delaying of gastric emptying, which slows carbohydrate absorption. There's even a central nervous system effect. And all of these things benefit weight reduction, some small systolic blood pressure reduction. They are very safe, because in and of themselves, unless you're using them with a secretagogue or insulin, they don't tend to cause hypoglycemia, so we've been being more aggressive with GLP-1 receptor agonists in diabetes over the last several years.

Now you have cardiovascular outcomes trials, and so it's not just the patient who's hyperglycemic and needs glucose lowering. I'm changing, just like you are, patients over to GLP-1 receptor agonists instead of other agents even if their glycemic control is at a target level if they have atherosclerotic cardiovascular disease because I'm now trying to limit future macrovascular risk, and so we're now

looking at medications this patient (inaudible)*9:02 we're looking at their comorbidities, and we're thinking very differently about using different medicines, not just because of hyperglycemia but also because of all the reduction in risk that we've seen in these latest trials.

Dr. Fonseca:
So, as I understand it, an oral GLP-1 receptor agonist has just been approved by the FDA. Can you tell us a little bit about that and the many trials that we've had, Dr. Anderson?

Dr. Anderson:
Right So oral semaglutide was just recently approved for use in the US by the Food and Drug Administration, and there were a series of trials with oral semaglutide called the PIONEER trials. And it's really unique because we know that peptides are usually rapidly broken down in the gut, and there's a unique MAC*9:43 technology that has been developed to allow this oral peptide to be absorbed. And what we see with the oral form of semaglutide is it looks just like our GLP-1 receptor agonists. It's got great efficacy. It looks very similar to other injectable GLP-1s. You still get the weight reduction, and, of course, GI side effects are part of it, and we easily have learned how to manage those patients. We even had a recent cardiovascular outcome trial, while a short trial with smaller numbers, still showed a cardiovascular benefit for the oral semaglutide.

Dr. Fonseca:
You know, that's really great. Most patients who come to see me are coming late in their disease, and although they have been reluctant to take injections before, when they come to see a specialist in a teaching hospital, they are more accepting about injections, but I wonder what it's like in primary care where people are early in their disease and they don't want to take injections. Do you think they prefer an oral agent to an injectable one? And how would they perceive this, I think, fantastic discovery of being able to have a peptide that's being absorbed? That's never happened before, and it opens up a whole bunch of possibilities in clinical medicine.

Dr. Anderson:
You know, it's interesting, Vivian. I'm probably much more aggressive as we do a lot of diabetes than the average primary care provider, and what we see is it's been very disappointing after 13 years in the marketplace that the GLP-1 receptor agonist class, while rising and getting more use, still isn't where it needs to be. And to your point, I think an offering of an oral GLP-1 like oral semaglutide is going to probably gain acceptance pretty quickly in primary care providers. I think that the DPP-4 inhibitors may see a real decrease in their use because this oral semaglutide has the potency of a GLP-1 receptor agonist. As we start to look at what's best for patients across this country with type 2 diabetes, I think you and I would both agree more GLP-1 receptor agonists need to make its way into therapy, and I think this is a real way for that to happen.

Dr. Fonseca:
I agree, and I think we need to see how this all plays out, having a peptide that was previously injectable, now available as an oral agent, but there are some limitations. People can't have other medications, they have to avoid food for about half an hour to an hour, so we have to educate people about how to really take this in a way that will get absorbed, and we need to wait and see how this will all pan out in practice in terms of adherence, not just to the medications but the correct way of taking it. And we're sort of used to it with thyroid hormones, and we need to educate our patients about that and avoid drug and food interactions.

I think it's really fascinating, very interesting to me to see how this has all developed, and I look forward to the future and what this holds for the whole GLP-1 receptor agonist class now that we have an oral one that will help us improve patient compliance, incorporate it into patient-centric approaches in diabetes management.

I want to thank Dr. John Anderson for sharing those strategies and uses in his practice. It was great speaking with you today, John.

Dr. Anderson:
Vivian, thank you, I really enjoyed it.

Announcer:
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