Question & Answer

Recorded August 12, 2020 from the live webinar:
Overcoming Therapeutic Inertia: What You Need to Know

Question:
I would value your thoughts on delays in starting prandial insulin or GLP-1 RA and continued titration of basal insulin beyond appropriate doses (i.e., overbasalization). I feel like this is a huge problem with few studies on defining optimal basal insulin dose before prandial coverage warranted.

Answer:
We have shown that there is a 3-year delay in starting prandial or GLP-1RA following basal insulin. There is also definitely an issue with overbasalization and that is why we often say fix fasting first. We are often asking to review patients after going to 0.5 units per kg.

-- Kamlesh Khunti, MD, PhD

Question:
How can we encourage more referrals to DSMES?

Answer:
Making the office aware of community availability of this service can facilitate referrals and reminding clinicians that Medicare pays for these visits on an annual basis is helpful. It is also important that clinicians refer multiple times and track follow through.

-- Stephen Brunton, MD

Question:
What are your thoughts on de-intensifying therapy? When is it warranted and appropriate? Any criteria besides just age and hypoglycemia to evaluate?

Answer:
This is a very important issue. Please see the 2019 paper below on de-intensification from Diabetes, Obesity and Metabolism. This paper concludes that available but limited evidence suggests that the benefits of deintensification outweigh the harm in older people with type 2 diabetes with or without comorbidities. Deintensification in older patients with type 2 diabetes: A systematic review of approaches, rates and outcomes

-- Kamlesh Khunti, MD, PhD

Question:
Both exercise and nutrition are so important? What is their role in addressing therapeutic inertia?

Answer:

YES! All algorithms have this as a foundational approach to self-management. They are a critical part of any comprehensive diabetes care and management plan.

--Stephen Brunton, MD

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Question:

Are any of the studies that show benefit of early control using a prospective and controlled model (either placebo or active controlled)?

Answer:

Here are two useful studies:

This study concludes that early intervention with a combination therapy of vildagliptin plus metformin provides greater and durable long-term benefits compared with the current standard-of-care initial metformin monotherapy for patients with newly diagnosed type 2 diabetes. *Glycemic durability of an early combination therapy with vildagliptin and metformin versus sequential metformin monotherapy in newly diagnosed type 2 diabetes (VERIFY): a 5-year, multicenter, randomized, double-blind trial.*

This study concludes that combination therapy with metformin/pioglitazone/exenatide in patients with newly diagnosed T2DM is more effective and results in fewer hypoglycemic events than sequential add-on therapy with metformin, sulfonylurea and then basal insulin. *Initial combination therapy with metformin, pioglitazone and exenatide is more effective than sequential add-on therapy in subjects with new-onset diabetes. Results from the Efficacy and Durability of Initial Combination Therapy for Type 2 Diabetes (EDICT): a randomized trial.*

--Kamlesh Khunti, MD, PhD

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Question:

What do you do when you probe their knowledge attempt to correct knowledge deficits, but the patient continues to not believe they are sick after this conversation?

Answer:

It can be helpful to understand WHY patients may feel this. Where do they get their information (family members, internet etc.)? It is helpful to not "fight" with the patient but acknowledge their beliefs and build upon that.

--Stephen Brunton, MD
**Question:**
Can you talk about de-intensifying treatment and what situations you typically are doing this for? DO you find that if you are trying to bring down A1c quickly to get that legacy effect, you end up trying to get them off some meds once under control?

**Answer:**
Usually we would not stop therapies unless there is hypoglycemia. As soon as you stop a therapy, glycemic control will get worse. Here is a good reference to answer this [Question: Factors influencing safe glucose-lowering in older adults with type 2 diabetes: A PeRsOn-centred ApproaCh To IndiVidualisEd (PROACTIVE) Glycemic Goals for older people: A position statement of Primary Care Diabetes Europe](http://example.com).

-- Kamlesh Khunti, MD, PhD

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**Question:**
You recommend setting diabetes only appointments with patients. Would you please comment on the role of and/or your experience with an ambulatory care pharmacist to assist the patient (and you) in reaching diabetes goals?

**Answer:**
A pharmacist can be a very important member of the management team and if available can certainly be part of the visit.

--Stephen Brunton, MD

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**Question:**
Are there any benefits to start metformin in patients with prediabetes in promoting the legacy and progression of diabetes?

**Answer:**
There are definite benefits seen in RCTs to starting metformin in those with prediabetes. Here is a systematic review on this topic: [Metformin’s Role in the Prevention of Type 2 Diabetes in Individuals Diagnosed with Prediabetes: A Systematic Literature Review](http://example.com).

-- Kamlesh Khunti, MD, PhD

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**Question:**
Racism seems to be embedded in therapeutic inertia but hasn't been discussed yet. Any thoughts?

**Answer:**
I think that endemic racism is an important issue in healthcare and needs to be addressed. I have written an editorial on this issue that will be published in *Clinical Diabetes* in Issue 4, 2020. It includes a link to a self-assessment questionnaire that can help evaluate racism in the provider.

--Stephen Brunton, MD
**Question:**

Is there more research on exercises that can improve Diabetes management? Exercises that can be done to target metabolic syndrome.

**Answer:**

There are a number of RCTs that show physical activity interventions lead to better glycemic control. These are included in this 2016 ADA position statement: [Physical Activity/Exercise and Diabetes: A Position Statement of the American Diabetes Association](https://care.diabetesjournal.org/content/13/3/439)

-- Kamlesh Khunti, MD, PhD