Prescriber Insights
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Simplify Diabetes Meds in Older Adults

You're in a key spot to **deprescribe diabetes meds in older adults**.

Intensive treatment can cause hypoglycemia...leading to falls, cognitive changes, and cardiac events.

Follow these 4 "S" steps to optimize diabetes meds in older adults.

Seek triggers. Look for red flags that may indicate a need to reevaluate treatment goals or strategies.

For example, consider whether unintended weight loss might be a side effect of a diabetes med, such as a GLP-1 agonist (semaglutide, etc).

Or ask patients with cognitive changes, excessive drowsiness, or sleep problems if they're having any low blood sugars, dizziness, etc.

Share decision-making. Work with the patient and their caregiver to weigh treatment benefits and risks.

Discuss why therapy changes may be needed (hypoglycemia, a recent fall, etc). Listen to concerns...and emphasize that you're considering med changes to keep them safe.

Set or reset goals. Reinforce individualizing blood sugar goals...and that a "one-size-fits-all" approach isn't safe or practical.

Explain that an A1c goal below 7% in older patients may lead to overtreatment...increasing adverse effects, interactions, falls, etc.

Adjust the A1c target to between 7% and 8.5% in older patients, especially if there's a history of recurrent severe hypoglycemia or hypoglycemia unawareness, limited life expectancy, frailty, etc.

Simplify and select safer treatment. Stop or reduce the dose of the most likely culprit med. For instance, stop or lower the dose of meds associated with hypoglycemia (sulfonylureas, insulin, etc) if needed.

Or switch the basal insulin dose to the morning instead of at bedtime if hypoglycemia is occurring overnight.

Monitor kidney function and reevaluate meds often. For example, avoid metformin in patients with eGFR below 30 mL/min/1.73 m^2. Use our *Drugs for Type 2 Diabetes* chart to help dose meds in kidney impairment.

Assess appetite and weight. For patients with poor appetite or at risk for weight loss, consider a DPP-4 inhibitor (sitagliptin, etc). They have fewer GI side effects and don't cause weight loss like other options, including GLP-1 agonists or SGLT2 inhibitors.

See our toolbox, *Chronic Meds in the Elderly: Taking a "Less Is More" Approach*, for tips on how to deprescribe for other conditions.

Key References:

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