

Understanding diabetes management in older people

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Description

Hypoglycemia in the elderly should be avoided. Avoidance of hypoglycemia is an important consideration when selecting therapeutic agents and setting glycemic targets. Insulin secretagogues, such as sulfonylureas and meglitinides, and all types of insulin should be used with caution in frail older people. In particular, older adults who have started a diet and/or exercise program and have blood sugar levels at or near target may need to empirically reduce insulin or insulin secretagogue doses to prevent hypoglycemia. Physical changes associated with aging include a tendency to decrease weight, muscle mass, and BMI. Therefore, older adults with diabetes, especially those with multiple medical conditions, such as long-term caregivers, may be more susceptible to age-related changes. People are more likely to be underweight than overweight. Weakness and muscle wasting are common. This, in addition to the usual complications of diabetes, may partially explain the disability and disability seen in older adults with diabetes. Susceptibility to hypoglycemia is significantly increased in the elderly.

In the elderly, neuroglycopenic symptoms of hypoglycemia (dizziness, weakness, delirium, confusion) are more common than adrenergic symptoms (tremors, sweating), and hypoglycemia may be delayed in detection. These symptoms of hypoglycemia can be overlooked or misinterpreted as primary neurological disorders resulting in patients under-reporting hypoglycemic episodes will be even mild episodes of hypoglycemia can lead to acute adverse outcomes such as falls and fractures in frail elderly patients. Elderly people with diabetes are at risk of developing macrovascular complications similar to those of young diabetic patients. However, their absolute risk of cardiovascular disease is much higher than that of young adults. As with young people with type 2 diabetes, risk reduction should focus on established risk factors. In elderly patients, reducing cardiovascular risk

by treating hypertension and lowering lipid levels with statin therapy is more likely to reduce morbidity and mortality than strict glycemic control.

Both diabetes and advanced age are major risk factors for Coronary Artery Disease (CAD). Few data specifically address optimal cardiovascular risk reduction in older patients. The benefits of lipid-lowering and blood pressure control were extracted from studies in older adults, not limited to diabetic patients, and studies in diabetic patients, including some older adults. As with glycemic control, the benefits of cardiovascular risk reduction depend on the patient's degree of frailty, general health, and expected survival. Smoking in people with diabetes mellitus is an independent risk factor for all-cause mortality, mostly due to cardiovascular disease. Despite the lack of high-quality research data, smoking cessation should be actively promoted. The relative beneficial effects of statins for lipid-lowering are similar in older and younger diabetic patients, and the absolute benefit is usually greater in older than in younger patients by target setting for glycemic control. Similarly, lipid management goals should be adjusted based on comorbidities, cognitive status, and personal preferences of older patients. Because event reduction with statin therapy can occur rapidly (within weeks to months), even in older patients, such treatment may reduce events over the patient's expected life span. Weight loss (if needed) through diet, exercise, and behavioral changes can be used to improve glycemic control, but most older people with type 2 diabetes will need medication as the disease progresses.

Acknowledgement

None

Conflict of interest

The author has nothing to disclose and also state no conflict of interest in the submission of this manuscript.

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Received: 02 January 2023, Manuscript No. ajdm-23-90358;

Editor assigned: 04 January 2023, Pre QC No ajdm-23-90358 (PQ); Reviewed: 18 January 2023, QC No ajdm-23-90358; Revised: 23 January 2023, Manuscript No. ajdm-23-90358 (R); Published: 30 January 2023