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## JAMA publishes review concluding A1c targets of 7.5%-9% are most appropriate for the majority of older adults - March 11, 2016

### Executive Highlights

- The latest issue of *JAMA* includes a [review](#) by Dr. Kasia Lipska (Yale University, New Haven, CT) et al. arguing that A1c targets of 7.5%-9% are most appropriate for the majority of older adults with diabetes.
- The main rationale for this recommendation is that the immediate risks of hypoglycemia often outweigh the long-term benefits of more intensive control for this population.
- While the authors emphasize the importance of individualizing therapy, we fear these recommendations could have unintended consequences if PCPs interpret them too broadly. We also point out that A1c targets do not necessarily need to change dramatically if the primary focus could be on reducing the risk of hypoglycemia through increased training and greater access to CGM and lower-risk medications. While these are obviously not available to all patients, we would like to see much broader advocacy in this realm.
- Five billion dollars a year is spent on hypoglycemia in the US alone each year and CGM in particular represents a most valuable tool to address this. [See more on this at the recent AACE consensus gathering.](#)

*The latest issue of JAMA includes a [review](#) by Dr. Kasia Lipska (Yale University, New Haven, CT) et al. arguing that A1c targets of 7.5%-9% are most appropriate for the majority of older adults (over age 65) with diabetes. Although we agree that slightly higher targets are appropriate for some, we really bristle at the idea of "the majority" of older adults, or of a target as high as 9% for almost anyone. The authors noted that the major trials used to support more intensive targets in the general population (UKPDS, ACCORD, ADVANCE, and VADT) excluded adults older than 80 years, in some cases specifically due to safety concerns (hypoglycemia - related safety concerns in trials today would be at least partially addressed by CGM). They also relied heavily on surrogate endpoints for clinical outcomes that may not be relevant for patients with limited life expectancy, and they provided little clarity on the benefits and risks of intensive control for specific subgroups, or on the comparative effects of different medications. In light of this uncertainty and limited evidence, the authors encouraged providers to choose individual glycemic targets based on an estimate of the benefits and harms of intensive control, while also aiming to minimize polypharmacy. They concluded that the risks of intensive control outweigh the benefits for many older adults, as the micro- and macrovascular benefits take at least eight to ten years to manifest but the immediate risk of severe hypoglycemia is 1.5- to 3-fold higher.*

*The authors were careful to emphasize that this recommendation was not intended for every patient (thanks!) and that decisions about individual A1c targets should incorporate factors including specific medications, life expectancy, and patient preferences. We believe this point about individualization of therapy is absolutely critical, and for experienced endocrinologists, we think the caution is well-placed. At the same time, we worry many PCPs may not have time to go through the specifics if they are hearing that "the majority" of older adults should not adhere to recommended targets for the general population. If that is the case, these well-intentioned recommendations could have the unintended consequence of leading to inappropriately lax targets for many adults with diabetes over 65. We acknowledge that higher A1c targets are appropriate for some older patients (such as very frail patients with limited life expectancy), but we believe the primary emphasis should be on reducing the risk of hypoglycemia to make intensive control*

*more feasible. This could be achieved through increased education, better access to CGM, and efforts to increase the use and affordability of newer medications that carry a lower risk of hypoglycemia.*

*Additionally, most 75-year olds can't predict if they will have longer than 8-10 years of life expectancy or more (many women in particular will) while most 65-year olds will have at least 8-10 years of life left - at any rate, "in real life" saying to a patient that they may as well "not bother" because they may die probably won't be a particularly satisfying conversation.*

- **Dr. Lipska was lead author on a similar article [published](#) in *JAMA Internal Medicine* last year arguing that the risks of intensive treatment outweigh the benefits for many older adults.** It was based on an analysis indicating a high degree of insulin and sulfonylurea use to achieve a target A1c of <7% in this population despite the high risk of hypoglycemia. As with this review, we believe the main conclusion of that study should be that there is a clear need for greater access to CGM and newer glycemic-dependent medications for older adults. We do acknowledge that we are not yet close to CGM representing standard of care but we're getting much closer and would certainly advocate HCPs fighting for it (as we believe has already been very successful) rather than just suggesting higher A1c targets.

*-- by Emily Regier and Kelly Close*