

*Here are some examples of the benefits of the Hypoglycemia Safety Initiative in our actual patients!*

Case #1:

An 88 year old male with end-stage HF from aortic stenosis (not a surgical candidate) presented to clinic. With the help of his wife, the provider was able to sort out what medications he was taking. The patient was on metoprolol 50mg twice daily, aspirin daily, simvastatin 20 mg daily, and glipizide 2.5 mg twice daily. His A1c was 6.4%.

BP 108/60, HR 56, Total cholesterol 81, and A1c 6.4.

The electronic medical record alerted me to the fact that he may be at risk of hypoglycemia due to his age, A1c<7%, and being on a sulfonylurea.

Simple screening revealed that he had been having mid-morning symptoms of hypoglycemia at least once per week resolved with orange juice. Fortunately, none of the episodes had yet resulted in hospitalization or third party rescue.

He and his wife were glad to be allowed to stop glipizide and allow his sugars to rise. The provider assured them that they would watch for problematic hyperglycemia, although unlikely to occur.

Case #2:

An 83 year old chronically ill woman came in for consultation because she had received a letter from her primary care provider stating that her fasting glucose was 128 and her A1c was 7.1% and that she now had gone from pre-diabetes to diabetes. In discussing what this would mean for her, we advised against initiating pharmacologic treatment for glycemia and, instead, focused the discussion on optimizing function and safety and reasonable monitoring of glucose to ensure this would not turn into symptomatic hyperglycemia.

Case #3:

An 80 year old male with Type 2 Diabetes for over 10 years was taking metformin, metoprolol, losartan, simvastatin and aspirin. Regular DFE were done showing moderate background retinopathy. His stated concerns were to avoid blindness, heart attack, or stroke. His BP = 128/68. His A1c was 7.7%. His specialist recommended he come to see me to initiate pioglitazone or glargine insulin in order to "get his blood sugar under control".

Discussion was had with the patient and his wife regarding the difference between macrovascular and microvascular complications. Along with this, discussion that the risk for macrovascular complications was being lowered by not smoking, using losartan, simvastatin and aspirin. Furthermore, that there is no proof that, for him,

lowering glucose will prevent microvascular disease but will increase his risk of hypoglycemia. After this discussion, the patient chose not to add more medication.

Case #4:

An 80 year old woman with longstanding diabetes and moderate cognitive impairment was sent by a specialist suggesting she should have better blood sugar control. She is taking galantamine, glyburide, simvastatin and once daily NPH insulin.

Her BP is 138/70 and her A1c over the past 2 years went from 11.6 to 7.3 with the treatment listed above.

She was advised by her provider that research informs us that she would not benefit from lower sugars than she already has. In fact, since she is on insulin and a sulfonylurea and has cognitive impairment, our main concern is that she is at very high risk of serious hypoglycemia and she agreed to a plan to carefully reduce her medications.