

# Addressing Comorbidities of Patients With Type 2 Diabetes

A Q&A With Philip Rabito, MD



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**AJMC®:** What are some general characteristics of your patients with type 2 diabetes (T2D)? Do you have any method of grouping or categorizing these patients in how you approach treatment?

**RABITO:** Patients with T2D are at higher risk for cardiovascular disease, as they're more likely to have cardiovascular risk factors such as hypertension and dyslipidemia. Obesity is obviously something that is prevalent in this patient population. As far as grouping patients with T2D, one can do this in so many ways. There are those with renal dysfunction and those without. Those at very high risk cardiovascular disease versus lower risk, those who are poorly controlled versus those who are generally better controlled. Then there are patients who can control T2D with diet versus those requiring medicine, and insulin-requiring patients with T2D versus those not requiring insulin.

**AJMC®:** With so much focus on T2D with the comorbidity of cardiovascular disease (CVD) risk, how are you identifying what treatment to start your patients on? What is your approach to treating patients who don't have elevated CVD risk?

**RABITO:** Generally speaking, lifestyle modifications and metformin are considered the gold standard, but the paradigm for the treatment of T2D paradigm is now changing with the availability of amazing new classes of meds that offer cardio-renal protection and dramatic CVD risk reduction. I generally start with metformin as first line, but often initiate polypharmacy if the  $A_{1c}$  is substantially higher. For patients with elevated cardiovascular risk, I am more inclined to start with a GLP1 receptor agonist and/or an SGLT2 inhibitor, based upon the amazing data that has come out over the last few years. These meds help with body weight and blood pressure reduction, and also lower insulin requirements in those on insulin, thus lowering the risk of hypoglycemia.

**AJMC®:** Can you describe the safety of the new drug class (DPP4 inhibitors, SGLT2 inhibitors, and GLP1 receptor agonists)? Have you had experience prescribing these to patients without having any major tolerability issues?

**RABITO:** As far as safety, DPP4 inhibitors are hands down the best tolerated and safest class. Occasional myalgias and rarely pancreatitis can occur, but this class is generally well tolerated. On the flip side, DPP4 inhibitors do not provide dramatic  $A_{1c}$  lowering, CVD risk reduction, weight loss or blood pressure reduction. In fact, some of the drugs in this class have been associated with congestive heart failure.

The GLP1 receptor agonists are an amazing class of drugs. On the upside, there is primary and secondary CVD risk reduction depending on the drug, and how the study was done. There is significant weight reduction and an  $A_{1c}$  reduction of up to 1.5. There is also excellent patient adherence, despite what I'm about to talk about. The side effects with this class are generally gastrointestinal [GI]. Many patients on this class can experience dyspepsia, diarrhea, constipation and nausea. These symptoms generally abate with time,

and most eventually do tolerate it well. There is always the risk of pancreatitis with this class, although it's rare. As physicians, we also need to mention to patients that in the seminal studies, mice and rats had a higher risk of medullary cell thyroid cancer. Thankfully this has not been an issue in humans it is something that should be discussed. Also to be considered is the added time required to educate the patient how to use the delivery device. Then there is the newest class, the SGLT2 inhibitors. There is incredible data for cardiovascular risk reduction, blood pressure lowering, renal protection, weight reduction and congestive heart failure reduction. On the downside there is an increased risk of diabetic ketoacidosis, particularly in those patients who have a significant reduction in their preexisting sulfonylurea or insulin dosing. Mycotic infections and urinary tract infections also occur more commonly with this class, as well as hypotension, as the drug is a weak diuretic. There's also a bit of education and counseling that has to go with this to encourage patients to stay hydrated and to understand all of the potential risks of the medicines.

**AJMC®:** Have you had experience prescribing these [new drug classes] to patients without having any major tolerability issues? Given these new classes of drugs with differences on tolerability, efficacy, and impact on CVD risk, are you starting to use them together in combination?

**RABITO:** Absolutely. If I have a patient who's on a steady dose of metformin, I will add these agents in combination. My ideal T2D cocktail is metformin, a SGLT2 inhibitor, and a GLP1 receptor agonist. This combination will offer dramatic reduction in cardiovascular events, congestive heart failure, body weight reduction, and A<sub>1c</sub> reduction. The risk of hypoglycemia is minimal when using those drugs in combination, as none of these drugs by themselves or in combination cause pathologic

hypoglycemia to any significant degree. That combination has been working amazingly well.

**AJMC®:** What are some of your biggest challenges with current pharmacologic treatment of T2D? What barriers do you see that are impacting their access and use of drug therapies?

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**RABITO:** Like most practitioners, I'm overburdened with paperwork as it is. Unfortunately, there are often hoops to jump through to get patients on these drug classes such as prior authorizations, appeals thereafter, and appeal phone calls for from the peers from the insurance companies. In a lot of cases, the drugs go right through, but in some instances it may take weeks to get the patients on. I do load up on samples. I like to get my patients initiated on samples, so at least they have something in the short term until we can rectify the coverage. In the end, as dedicated clinicians, we should be making every effort to get patients on the drugs that benefit them most. ♦