



Home Study Activity With Podcasts

Clinical Decision Points:
Profiles in Patient Care for Nurse Practitioners and Physician Assistants
Based on a Series of National CME/CE Symposia

Q&A: Type 2 Diabetes

What Your Colleagues Around the Country Want to Know...

Q: Should cost be a factor when considering prescribing exenatide? Are insurance companies covering it? At what tier level?

A: Exenatide is widely covered. It is not likely coverage would be denied to any patient who is failing on 2 oral agents. Tier level will depend on individual plans.

Q: Is it appropriate to prescribe exenatide before metformin for obese patients with type 2 diabetes mellitus (T2DM)?

A: Exenatide is indicated as adjunctive therapy to improve glycemic control in patients with T2DM who are prescribed monotherapy with metformin or another oral antidiabetic drug (OAD) or are taking 2 OADs and not reaching desired A1C levels. Exenatide is not approved as monotherapy. Moreover, it is not approved specifically for weight loss in any circumstance.

Q: How long should a patient be kept on exenatide before the decision can be made that it is not effective?

A: Efficacy usually can be determined within 2 or 3 months and change in A1C is going to be the measure of that efficacy. Weight loss is an important element of therapy with exenatide, but it's not the primary reason to prescribe the drug. The question of how long to continue therapy does raise another interesting point. Exenatide doesn't lower blood sugar; it works by stimulating insulin release. So, exenatide will tend to be more effective in newly diagnosed patients who have more robust insulin-secreting capacity remaining in the pancreas. It probably won't work as well in a patient who has had T2DM for a long time. Using exenatide soon after diagnosis definitely should be considered, and A1C is the measure of efficacy.



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Q: With the current precautions about thiazolidinediones (TZDs) and cardiovascular risk, is there a TZD that is safe to use?

A: The new consensus statement from the American Diabetes Association (ADA)/ European Association for the Study of Diabetes (EASD) on management of hyperglycemia in T2DM states that data are less than conclusive for cardiovascular disease (CVD) risk with rosiglitazone or a CVD benefit with pioglitazone. However, the statement goes on to say, "...given that other options are now recommended, the consensus group members unanimously advised against using rosiglitazone. Currently in the US, the TZDs are approved for use in combination with metformin, sulfonylureas, glinides, and insulin."¹

Q: Why is bone loss listed as a potential adverse event in the new ADA/EASD algorithm on treatment for T2DM?

A: Some studies suggest evidence of an association between TZDs and bone metabolism, resulting in reduced osteoblastic bone formation and accelerated bone loss. Current use of TZDs in women and men with T2DM may be associated with an approximately 2- to 3-fold increased risk of hip and nonvertebral osteoporotic fractures.² Ongoing trials are being conducted to shed more light on the situation.

Q: Can exenatide be used to treat the metabolic derangements and obesity in women with polycystic ovarian syndrome (PCOS)?

A: Current research has shown that diabetes management strategies targeting insulin resistance and hyperinsulinemia, such as weight reduction and use of oral antidiabetic medications, in women with PCOS not only can improve glucose and lipid metabolism, it can reverse testosterone abnormalities and restore the menstrual cycle. While exenatide is not FDA-approved for this use, a small pilot study³ found that combination treatment with metformin and exenatide improved reproductive function and normalized metabolic derangements in overweight women with PCOS. Combination



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treatment was more effective than either drug alone in improving menstrual cyclicity and ovulation rate and reducing body mass index, hyperandrogenism, insulin resistance, and weight. So, it's a promising treatment.

References

1. Nathan DM, Buse JB, Davidson MB, et al. Medical management of hyperlipidemia in type 2 diabetes: a consensus algorithm for the initiation and adjustment of therapy. *Diabetes Care*. 2008;31:1-11.
2. Meier C, Kraenzlin ME, Bodmer M, et al. Use of thiazolidinediones and fracture risk. *Arch Intern Med*. 2008;168:820-825.
3. Elkind-Hirsch J, Marrioneaux O, Bhushan M, Vernor D, Bhushan R. Comparison of single and combined treatment with exenatide and metformin on menstrual cyclicity in overweight women with polycystic ovary syndrome. *Clin Endocrinol Metab*. 2008;93:2670-2678.