Treatment of Diabetes in Older Adults

Screening, individualized glycemic targets, drug therapy, complication management, and special settings in adults ≥65 years.

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Treatment of Diabetes in Older Adults Guideline
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GRADE · 1 · Strong · 2 · Suggest For · 2- · Suggest Against · Ungraded / Best Practice

1 Screening & Assessment

1 **Screen** with fasting glucose and/or HbA1c in adults ≥65y without known diabetes; repeat every 2 years if normal. 2h post-OGTT glucose is an option for high-risk prediabetes phenotypes (2). **DPP-like lifestyle program** for prediabetes to delay progression — metformin not FDA-approved for prevention.

GPS **Assess overall health and personal values** before setting treatment goals. Periodic **cognitive screening** to detect undiagnosed impairment (2) — if impaired, **simplify regimens** and use more lenient glycemic targets (2).

1 **Assess nutritional status** to detect/manage malnutrition. Use diets rich in protein/energy if frail (2); if malnutrition risk limits glycemic control, avoid restrictive diets and instead limit simple sugars (2).

2 Glycemic Targets & Drug Therapy

1 **Design regimens to minimize hypoglycemia** — individualize glycemic targets to overall health category. Insulin-treated patients: frequent fingerstick and/or CGM monitoring in addition to HbA1c.

1 **Lifestyle modification** is first-line for ambulatory patients. **Metformin** is the initial oral agent (avoid if eGFR < 30 or GI intolerance); add other oral/injectable agents or insulin if targets aren't met — **avoid sulfonylureas/glinides**, use insulin sparingly, and keep regimens simple.

3 Managing Complications

COMPLICATION	MANAGEMENT
Hypertension	Target 140/90 mmHg (130/80 if prior stroke or progressive CKD; 145–160/90 if poor health) — ACEI or ARB first-line
Hyperlipidemia	Annual lipid profile + statin therapy; add ezetimibe/PCSK9i if inadequate; fish oil or fenofibrate if fasting TG >500 mg/dL
Heart failure	Treat per standard CHF guidelines; use glinides, rosiglitazone, pioglitazone, and DPP-4 inhibitors cautiously (may worsen HF)
ASCVD	Low-dose aspirin (75–162 mg/d) for secondary prevention after bleeding-risk assessment and shared decision-making
Eye disease	Annual comprehensive eye exam to detect retinal disease
Neuropathy & falls	Minimize sedative/orthostatic/hypoglycemic drugs; refer to PT or a falls-management program; refer to podiatry/vascular for foot-ulcer or amputation prevention
Chronic kidney disease	Annual eGFR + urine albumin-to-creatinine ratio (skip repeat ACR if poor health + prior normal); limit/dose-adjust diabetes medications as eGFR falls

4 Special Settings

1 **Hospital/nursing home:** target BG 100–140 mg/dL fasting, 140–180 mg/dL postprandial, avoiding hypoglycemia; build an explicit discharge plan to re-establish outpatient targets. Screen HbA1c on admission if diabetes status is unknown (2).

1 **Terminal illness or severe comorbidity:** simplify diabetes management strategies.

LeRoith D, Biessels GJ, Braithwaite SS, et al. Treatment of Diabetes in Older Adults: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab.* 2019;104(5):1520–1574.