

Insulin Regimens for Type 2 Diabetes Compared

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CHICAGO — When advancing a patient with type 2 diabetes to insulin therapy, the choice of whether to use mealtime insulin plus a basal insulin at bedtime or just a mealtime mix of rapid- and longer-acting insulin does not make a difference.

However, in a head-to-head trial of the two strategies, a slightly higher proportion of the patients given basal plus mealtime

insulin achieved a hemoglobin A_{1c} (HbA_{1c}) level below 7%, with a lower dose of insulin needed, Dr. Julio Rosenstock said at the annual scientific sessions of the American Diabetes Association.

“Basal-bolus therapy in our trial was associated with a slightly greater reduction in A_{1c} from baseline, a 2.1% reduction versus 1.9% reduction.” But “clinically meaningful achievements in glycemic control can be achieved with both basal-bolus therapy and prandial-premix therapy in com-

bination with oral agents in patients with type 2 diabetes previously treated with insulin glargine plus oral agents,” added Dr. Rosenstock, an endocrinologist in Dallas.

In the trial, one group of 187 adult patients who had been on insulin glargine plus oral agents but who were not well-controlled were put on a regimen of glargine insulin in the evenings together with lispro insulin at mealtime. A second group of 187 similar patients were put on a 50/50 mix of lispro insulin and NPL

(neutral protamine lispro) insulin.

At the end of 24 weeks, 50% of those on the regimen that included evening basal insulin glargine had an HbA_{1c} equal to or below 6.5%, compared with 35% of those on the mealtime-mix regimen. In addition, 69% and 54%, respectively, achieved an HbA_{1c} equal to or below 7%.

Overall, the mean HbA_{1c} levels of the groups dropped from 8.9% in both groups to 6.8% in the basal group and 7% in the mealtime-mix group. ■

In the treatment of very high triglycerides (≥500 mg/dL)

- **LOVAZA** dramatically lowered triglycerides by 45%¹
 - Treatment resulted in a median increase of 45% in LDL-C; treatment with **LOVAZA** resulted in an overall reduction of atherogenic cholesterol, as reflected by a 14% reduction in non-HDL-C ($P=0.0013$)¹⁻⁵
- **LOVAZA** demonstrates an excellent safety profile and proven tolerability¹
 - The most common adverse events reported were: eructation, infection, flu syndrome, dyspepsia, rash, taste perversion, and back pain

Indication:

LOVAZA™ (omega-3-acid ethyl esters) is indicated as an adjunct to diet to reduce very high (≥500 mg/dL) triglyceride (TG) levels in adult patients.

Usage Considerations:

In individuals with hypertriglyceridemia (HTG), address excess body weight and alcohol intake before initiating any drug therapy. Diet and exercise can be important ancillary measures. Look for and treat diseases contributory to hyperlipidemia, such as hypothyroidism or diabetes mellitus. Certain treatments (e.g., estrogen therapy, thiazide diuretics and beta blockers) are sometimes associated with very significant rises in serum triglyceride (TG) levels. Discontinuation of the specific agent may obviate the need for specific drug therapy for HTG.

Consider lipid-regulating agent use only when reasonable attempts have been made to obtain satisfactory results with non-drug methods. Advise patients that lipid-regulating agent use does not reduce the importance of adhering to diet. (See PRECAUTIONS section of full prescribing information.)

In patients with very high TG levels the effect of LOVAZA on the risk of pancreatitis has not been evaluated, nor has its effect on cardiovascular mortality and morbidity been determined.

Please see brief summary of full prescribing information on the adjacent page.

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The US Food and Drug Administration (FDA) has granted approval for the addition of new clinical data in the **LOVAZA** label. Please read our updated prescribing information for more details.

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