TOP TIPS FROM FAMILY PRACTICE

Diabetes Care, Stroke Risk, Migraine Guidelines

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UPDATED DIABETES STANDARDS OF CARE

The American Diabetes Association (ADA) has offered new guidance on broader use of continuous glucose monitoring (CGM), use of glucagon-like peptide-1 receptor agonists (GLP-1 RAs) beyond weight loss, management of metabolic dysfunction-associated fatty liver disease, plus a strong endorsement for drinking water. Among the newly published standards:

- Clinicians should consider use of CGM devices in adults with type 2 diabetes (T2D) who don't use insulin. Medicare and many other payers currently only cover CGM for people who use insulin or are otherwise at risk for hypoglycemia. However, some CGMs are now available over-the-counter.
- In the event of medication shortage, the ADA advises substituting a different GLP-1 RA if possible.
- Recommendations were revised to explicitly advise on choice of pharmacotherapy for individuals with T2D, based on new data about patients with established or high risk for atherosclerotic cardiovascular disease, heart failure with preserved ejection fraction, and chronic kidney disease.
- The ADA adopted new nomenclature: nonalcoholic fatty liver disease (NAFLD) and nonalcoholic steatohepatitis (NASH) are now metabolic dysfunction-associated fatty liver disease (MAFLD) and metabolic dysfunction-associated steatohepatitis (MASH). Resmetirom is a thyroid hormone receptor-beta agonist that shows promise in reducing progression to fibrosis.
- The ADA, in collaboration with the Obesity Society, advises that patients continue weight therapy beyond achieving weight-loss goals. Discontinuing weight-loss therapies is associated with weight regain and increased cardiovascular risk.
- Antibody-based screening for presymptomatic type 1 diabetes (T1D) should be considered in family members with T1D and others who may be at risk. Individuals with these autoantibodies should be provided with or referred for counseling and prevention. Specialized centers may provide further evaluation and/or access to clinical trials and approved therapies.
- People with diabetes should be screened for adjustment disorder, depression, anxiety, hypoglycemia, and disordered eating behaviors. People using insulin or sulfonylureas may be afraid of hypoglycemia, but feeling overwhelmed about the disorder, sometimes called "diabetes distress," can happen to anyone with diabetes. Caregivers and family members should be screened as well. The Centers for Disease Control and Prevention provides some guidance about how to help individuals cope.[1]

← Scan to access "10 Tips for Coping with Diabetes Distress" from the CDC

- In the nutrition section, an important new recommendation strongly advises drinking water instead of nutritive or nonnutritive-sweetened beverages. Nonnutritive sweeteners are preferred over other sweeteners, in moderation and for a brief duration, but water is always best.

REGULAR FLOSSING REDUCES ISCHEMIC STROKE RISK

Regular dental flossing is linked to a lower risk of ischemic stroke and atrial fibrillation (AF), according to new research presented at the International Stroke Conference in February 2025.[2] The reduced risk is primarily the result of reduced systemic inflammation and is independent of oral care, such as regular brushing and visits to the dentist.

This was studied in 6,278 participants who had no history of stroke or AF (mean age of 62 years). Participants were categorized as flossers (n = 4,092) and nonflossers (n = 2,186). Notably, more women flossed than did not floss; more men were nonflossers than were flossers.

Flossers had fewer relevant cardiovascular risk factors. For example, 31.5% of flossers had hypertension and 11.7% had diabetes versus 36.3% and 16.1%, respectively, of the nonflossers. Flossers also had significantly higher high-density lipoprotein levels and significantly lower levels of periodontal and dental caries.[3]

Participants had regular follow-ups for 25 years. During that time, 434 strokes were identified. Of those, 146 were thrombotic, 102 were cardioembolic, and 95 were lacunar subtypes. The investigators found that flossing was associated with a decreased risk for ischemic stroke (adjusted hazard ratio [HR], 0.79; 95% CI, 0.64-0.97), cardioembolic stroke subtype (adjusted HR, 0.56; 95 CI, 0.36-0.86), and AF (adjusted HR, 0.88; 95% CI, 0.78-1.00).

The analysis suggested that the stroke risk reduction was primarily driven by fewer cardioembolic strokes which is possibly linked to a reduced rate of atrial fibrillation. Flossing did not seem to reduce the risk of thrombotic stroke (adjusted HR, 0.91; 95% CI, 0.63-1.32) or lacunar stroke (adjusted HR, 1.14; 95% CI, 0.54-1.88). There was a significant dose-effect between the frequency of flossing and the incidence of ischemic stroke.

NEW MIGRAINE GUIDELINES

The American College of Physicians (ACP) indicates there is no clinical advantage to choosing newer, expensive medications to prevent migraines. Rather, the ACP recommends that to prevent episodic migraines in nonpregnant adults, monotherapy be used.[4] This may constitute use of a beta-adrenergic blocker (metoprolol or propranolol), the antiseizure medication valproate, the serotonin and norepinephrine reuptake inhibitor venlafaxine, or the tricyclic antidepressant amitriptyline.

If patients do not respond to or tolerate these, ACP recommends a monotherapy with a calcitonin gene-related peptide (CGRP) antagonist (atogepant or rimegepant) or a CGRP monoclonal antibody (eptinezumab, erenumab, fremanezumab, or galcanezumab). If patients still do not respond to or tolerate treatment, the guidelines recommend monotherapy with the antiseizure medication topiramate.

The guidelines stress the importance of a patient's adherence to a pharmacologic treatment since improvement may occur gradually, with effects manifesting after the first few weeks of treatment.

Newer, more expensive medications, such as ubrogepant ($1,045/month) and dihydroergotamine mesylate nasal spray ($269/month) — the lowest available costs reported by GoodRx® — were not mentioned in the guidelines.

Migraine, characterized by recurrent episodes of moderate-to-severe intensity headache lasting 4 to 72 hours, is the second leading cause of global disability in adults and the top cause in females aged 15-49 years. Approximately 16% of people in the United States have migraine, and migraines account for about 4 million emergency department visits and more than 4.5 million office visits per year. The condition creates a substantial economic burden of over $78 billion annually in medical expenses.

ACP reports that their analysis did not demonstrate any clinical difference when comparing these treatments, therefore investigators looked at the economics of therapy. Initial recommended treatments — metoprolol ($123), propranolol ($393), valproate ($274), venlafaxine ($378), and amitriptyline ($67) — had substantially lower annual mean costs.

As a result, the ACP Clinical Guidelines Committee suggests that clinicians and patients try a β-blocker (metoprolol or propranolol), the antiseizure medication valproate, the serotonin-norepinephrine reuptake inhibitor venlafaxine, or the tricyclic antidepressant amitriptyline to prevent episodic migraine headache in nonpregnant adults before moving to a CGRP-mAb or a CGRP antagonist-gepant.

Choosing Wisely

Originally published in the Summer 2015 issue of JLGH *in conjunction with the American Board of Internal Medicine's now-complete Choosing Wisely campaign, this edited reprint is offered to remind physicians of the importance of talking with patients about what tests, treatments, and procedures are needed — and which ones are not.*

RECOMMENDATIONS FROM THE INFECTIOUS DISEASES SOCIETY OF AMERICA

❶ **Asymptomatic bacteriuria (ASB) should not be treated with antibiotics.** ASB, the asymptomatic presence of a significant number of bacteria in the urine, is a major contributor to antibiotic overuse. Antibiotics are appropriate for ASB in pregnant patients, patients undergoing prostate or other invasive urologic surgery, and kidney or pancreas transplant patients in the first year after receiving their transplant. Otherwise, antibiotics for ASB are not beneficial and do not improve morbidity or mortality. Not only is overtreatment of ASB costly, but it can lead to *C-difficile* infection and resistant pathogens.[5]

❷ **Stasis dermatitis of the lower extremities should not be treated with antibiotics.** Unfortunately, stasis dermatitis is sometimes misdiagnosed and antibiotics are used, but they do not improve healing rates for stasis dermatitis.[6] Proper treatment consists of leg elevation and compression.

❸ **In the absence of diarrhea, do not test for *Clostridium difficile*.** Only perform this test on unformed diarrheal stool, unless this organism is suspected to be causing ileus. If there is no diarrhea, the presence of *C-difficile* indicates a carrier state that should not be treated or tested for.

❹ **Do not give prophylactic antibiotics for mitral valve prolapse.** Prophylaxis is no longer recommended in patients with mitral valve prolapse for the prevention of infective endocarditis. The risk exceeds any potential benefit. Antibiotics increase resistant strains and perhaps the occurrence of *C-difficile*-associated colitis.[7]

GERIATRIC CARE PRIORITIES

Comprehensive geriatric assessment (CGA) is a way to consider the medical, psychosocial, cognitive, physical, and functional needs of older adults. A rapid assessment, known as the "Geriatric 5 Ms," can be practical and efficient for physicians to use in time-constrained settings.[8] The 5Ms are:

1. Mind. Numerous tests are available to assess cognitive function. A single test cannot validate a diagnosis, but it can indicate whether a patient deserves further evaluation. The Mini-Cog test is a quick screening tool for dementia that, when used correctly, has 76% sensitivity and 89% specificity. The test consists of having the patient repeat and remember three unrelated words, draw a clock, and remember the initial three words. It may be easily performed in less than five minutes; the Mini-Mental State Examination may take twice as long.

Depression and delirium can mimic dementia and should also be considered. Depression is common in older adults and may represent an exacerbation of a previously diagnosed mood disorder or a newly developed condition. The Patient Health Questionnaire-2 Screening Tool has nearly 100% sensitivity for detecting depression in noninstitutionalized older adults.

2. Mobility. The risk of falling contributes to the degree of mobility impairment. The STEADI (Stopping Elderly Accidents, Deaths, and Injuries) test helps assess fall risks in older adults using a three-question survey:

1. Have you fallen in the past year?
2. Do you feel unsteady when standing or walking?
3. Are you afraid of falling?

A single "yes" response indicates a positive test result and warrants further evaluation. Several functional tests are available, but two are particularly quick and easy to perform: the Timed Up and Go (TUG) Test and the 4-Step Balance Test. The TUG Test involves asking the patient to stand up from a chair, walk three meters, turn around, return to the chair, and sit down. A recorded time of more than 12 seconds is associated with an increased fall risk.

3. Medications. Various factors elevate the risk for adverse drug events from polypharmacy, including advanced age, female sex, cognitive impairment, multiple prescribers, low body weight, creatinine clearance <50 mL/min, frailty, limited medical knowledge, and concomitant use of nine or more medications.

Deprescribing plays a critical role in optimizing polypharmacy management. This involves reducing the dose of a medication, tapering it off, discontinuing it, or switching to a safer alternative when the risks outweigh the benefits. Family physicians should allocate time during visits to review and reconcile patients' medications.

4. What Matters Most. This step begins with a personalized patient assessment to align medical decisions with individual care preferences, goals, and meaningful health outcomes. Shared decision-making between the patient and the physician should guide diagnostic tests and treatment options, ensuring that indications, benefits, risks, and burdens are carefully considered.

Advance care planning is an essential component of this discussion, helping patients express their values and preferences for future medical care.

5. Multicomplexity. This encompasses both the care challenges posed by multiple chronic conditions (multimorbidity) and the broader biopsychosocial complexities affecting older adults. In this context, caregiving plays a fundamental role in supporting patients in daily activities. At this stage, the role of a clinician extends to supporting caregivers, offering guidance and assistance as they navigate the challenges of providing care for their loved ones.

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