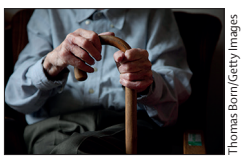
Diabetes and frailty in an ageing world



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Global life expectancy continues to rise, with the latest Eurostat report confirming that the EU has surpassed pre-pandemic levels. With an ageing population comes an increased burden of chronic health conditions. One in five people aged 65 years and older have type 2 diabetes, with numbers predicted to grow in the coming years. This increase is largely driven by lifestyle factors, increasing obesity rates, and improved survival rates of people with diabetes. Managing diabetes in older adults presents distinct challenges that demand a fundamental shift in health-care strategies to optimise outcomes and improve quality of life.

A major difficulty in the management of diabetes in this population is a heightened vulnerability to hypoglycaemia, which significantly increases the risk of falls, dementia, cognitive decline, stroke, and cardiovascular events. Given these risks, adapting diabetes management to account for age-related changes should be a priority. In this issue of *The Lancet Diabetes & Endocrinology*, Medha Munshi and colleagues discuss recommendations from the Deprescribing Consensus Initiative, which aims to guide health-care providers in realigning treatment strategies when current management is insufficient. Their framework outlines a four-step approach that considers clinical and functional status, lifestyle and social factors, available support systems, and personal preferences to optimise care for older adults with diabetes.

Given the complexities involved in diabetes in older people, treatment must be tailored to not only the demographic but also to the individual. HbA_{1c} targets should be relaxed (7·5–8·5%) to reduce hypoglycaemia and used alongside glucose monitoring data. A comprehensive geriatric assessment should also be obtained to evaluate both physical and cognitive abilities for self-management.

Older adults with diabetes often have multiple comorbidities that require complex medication regimens. If not carefully managed, these medications can do more harm than good, substantially increasing the risk of severe hypoglycaemia due to drug interactions or through prolonging physiological effects. Thus, regular medication review and adjustments are essential for optimal care in older patients. This might involve reducing the number of medications, discontinuing high-risk drugs, or replacing them with newer and safer alternatives to minimise adverse effects and improve overall health outcomes. However, cost constraints often limit access to newer, lower-risk drugs. Reducing the number of medications prescribed requires clinicians to take a holistic view of their patient and to perform frequent risk assessments due to the dynamic nature of diabetes management. Yet, this is not regularly done. Primary care teams often face time pressures or lack confidence in modifying established treatment plans, leading to patients most at risk not being screened for hypoglycaemia history or provided with anticipatory guidance—let alone having their hypoglycaemia-inducing medications adjusted or de-intensified.

In parallel with these challenges, the rise of type 2 diabetes in people younger than 40 years is accelerating frailty worldwide and leading to related complications at younger ages. Diabetes contributes to frailty through muscle loss, inflammation, and hypoglycaemia, while frailty, in turn, worsens diabetes management. In this issue of the journal, Maltese and colleagues examine this bidirectional relationship, highlighting the growing recognition of frailty in younger individuals with type 2 diabetes. Frailty in this population has been linked to hypoglycaemia, hospitalisations, disability, cognitive impairment, and mortality. To mitigate these risks, efforts to prevent or reverse frailty should be prioritised wherever possible. Also in this issue, Henson and colleagues emphasise the need to understand muscle tissue-specific mechanisms and the clinical consequences of accelerated ageing in type 2 diabetes. By doing so, strategies to prevent skeletal muscle loss—one of the key drivers of frailty—can be developed and integrated into routine patient care.

Nearly 67% of all diabetes-related health-care costs are attributed to adults aged 65 and older, while in the UK, frailty adds an extra £5·8 billion in annual health-care expenses. As we age, health complexities multiply, with conditions intertwining and impacting overall wellbeing. For older adults with diabetes, treatment should be personalised, considering functional status, life expectancy, and individual health goals to ensure better outcomes and quality of life. If not, we risk not only a greater economic burden but, more importantly, a profound effect on the wellbeing and quality of life of older adults. ■ *The Lancet Diabetes & Endocrinology*

For more on **life expectancy in the European Union** see https://ec.europa.eu/eurostat/web/population-demography/demography-population-stock-balance/database?node_code=demo_r_mlifexp

For more on **diabetes in older people** see https://diabetesatlas.org/atlas/tenth-edition/

For more on **severe hypoglycaemia older adults** see *Diabet Epidemiol Manag* 2023; **12:** 100162

For more on **realigning diabetes regimens in older adults** see **Review** page 427

For more on **assessment and prevention of hypoglycaemia** in primary care see **Articles** *Lancet Reg Health Am* 2023; **28:** 100641

For more on **type 2 diabetes in younger people** see **Review** *Lancet Diabetes Endocrinol* 2023; **11:** 768–82

For more on **early onset typ'e 2 diabetes and frailty** see **Correspondence** page 370

For more on **type 2 diabetes and skeletal muscle** see **Comment** page 362

For more on **diabetes health-care costs** see *Diabetes Care* 2018; **41:** 917–928

For more on the **impact of frailty on health-care resource use** see *Age Ageing* 2019; **48:** 665–71