The Daily Walk or the Daily Pill?

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Healthy nutrition, weight control, and physical activity—if your patients are like mine, it is an ongoing battle, and often a losing one, to induce them to include these cornerstones of treatment in their diabetes management. All too often, patients rely on their medications to maintain glycemic control and disregard the potential benefits of making lifestyle changes. Developing better daily habits and routines offers the promise of more benefits than just improved glycemic control, including enhanced cardiovascular fitness and reduced cardiovascular risk.

For patients who are at particular risk for diabetes, is the possibility of preventing or delaying the disease a sufficient motivator to exercise and eat right? The results of the Diabetes Prevention Program (DPP) for type 2 diabetes were published last year and are reviewed in this issue’s “Landmark Studies” department (p. 91). They demonstrate convincingly that in an ethnically diverse population with impaired glucose tolerance (IGT), the onset of diabetes can be significantly delayed or prevented across a spectrum of ages by lifestyle changes including a routine of moderate physical activity and modest weight loss. But the risk for developing diabetes is rarely enough, in my experience, to motivate people to change their lifestyles.
The DPP demonstrated that the drug metformin (Glucophage) also reduced the incidence of diabetes in at-risk individuals, but less effectively than did lifestyle changes. Other studies\(^2\)–\(^6\) have suggested that diabetes may be prevented by other drug interventions. Inzucchi and Sherwin, in our “Landmark Studies” review, pose the question, “At what point, if any, do we proceed from encouraging lifestyle change to pharmacotherapy?” If given the opportunity, what choice would your patients make? Take a pill, or exercise, eat right, and lose weight?

Realistically, lifestyle interventions such as those in the DPP may not be translatable to real-world health care. In most practice settings, the realities of time limitations, poor reimbursement, costs, lack of expertise, and limited resources undermine efforts directed at such change. But although taking a pill may in fact reduce the risk of diabetes development, we don’t know if pharmacotherapy will have the same effect as lifestyle changes in terms of extraglycemic benefits (a point also made in our review). I suspect it won’t, although the answer is unknown. I also suspect that our patients who opt for pills rather than better diet and regular activity may miss out on becoming generally healthier. In fact, our patients may avoid diabetes, but develop heart disease anyway!

Does this mean we shouldn’t try? Does the possibility of pills to prevent diabetes mean that we should be less concerned with our diets, our weights, and our activity levels? Should we just take the easy way out if it works? Should we give patients a pill and feel that we have provided adequate treatment? In the future, there may be drugs that will not only treat and/or prevent all maladies, but also keep us healthy and fit. One day, our genes may be altered so that we remain in good physical condition with no energy expenditure. That day is not here, or even near, by any stretch of the imagination. Thus, I agree with Inzucchi and Sherwin that advice to our patients regarding lifestyle changes is still indicated.

Whether our patients choose to follow that advice is another issue. But even if we don’t have a lot of time to spend, we need to continue to emphasize the importance of a healthy lifestyle. We also need to work toward social and public health changes that allow and encourage adults and children to get out and walk and to avoid unhealthy fast foods. Even if we can’t achieve the magnitude of the results of the DPP in our practices, or prevent cardiovascular disease in all our patients, we can still make a difference.

REFERENCE


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