

Conferencias y Simposios

Debate: ¿Algo más que insulina para el tratar la diabetes mellitus tipo 1?

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Por el No

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El agregado de metformina en pacientes adultos con diabetes mellitus tipo 1 (DM1) favoreció pequeños descensos de peso y de los niveles lipídicos, pero no ha mejorado la HbA1c.

Los estudios de ARGLP-1 en DM1 se desarrollaron con liraglutida y demostraron modestas reducciones de la HbA1c (0,3-0,4%), descenso de peso (5 kg) y reducción de la dosis de insulina (10-12%). Como efectos adversos, también se observó mayor presentación de náuseas y vómitos, con el riesgo que supone en un paciente insulinotratado. La tasa de hipoglucemia sintomática aumentó con liraglutida 1,8 mg y 1,2 mg vs placebo. La tasa de episodios de hiperglucemia con cetosis (>1,5 mmol/L) fue mayor con liraglutida 1,8 mg. También se estudiaron los diferentes iSGLT-2 en DM1, demostrando mejoría de la HbA1c, de la TA y reducción de peso, sin embargo se asoció a un aumento de la tasa de cetoacidosis diabética e infecciones micóticas genitales.

No está definido si los beneficios de asociar los nuevos fármacos a las personas con DM1 son lo suficientemente importantes como para correr el riesgo de presentar los efectos adversos que pueden generar complicaciones severas. No hay estudios que demuestren los beneficios cardiovasculares de los iSGLT-2 y de los ARGLP-1 en pacientes con DM1.

La *Food and Drug Administration* (FDA) solamente aprobó el uso de pramlitide en DM1. La *European Medicines Agency* (EMA) aprobó la sotagliflozina como complemento de la terapia con insulina para mejorar el control glucémico en adultos DM1 que no lograron un control glucémico adecuado a pesar de la terapia óptima con insulina. Los pacientes considerados para este tratamiento deben cumplir ciertos requisitos y deben tener un índice de masa corporal (IMC) superior a 27 kg/m².

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Palabras clave: diabetes mellitus; insulina.

Debate: anything else than insulin to treat type 1 diabetes mellitus?

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The addition of metformin in adults with type 1 diabetes caused small reductions in body weight and lipid levels but did not improve HbA1c.

The trials of glucagon-like peptide 1 receptor agonists (GLP-1 RAs) in type 1 diabetes have been conducted with liraglutide, showing modest HbA1c reductions (0.3 - 0.4%), decreases in weight (5 kg), and reductions in insulin doses (10 – 12%). The most frequent AEs with liraglutide were nausea and vomiting. The rate of symptomatic hypoglycemic episodes was increased with liraglutide 1.8 mg and 1.2 mg versus placebo. The rate of hyperglycemic episodes accompanied by ketosis was increased with liraglutide 1.8 mg

Sodium –glucose cotransporter 2 (SGLT2) inhibitors have been studied in clinical trials in people with type 1 diabetes, showing improvements in HbA1c, reduced body weight, and improved blood pressure; however, SGLT2 inhibitor use in type 1 diabetes is associated with an increased rate of diabetic ketoacidosis and genital fungal infections.

The risks and benefits of adjunctive agents continue to be evaluated, with consensus statements providing guidance on patient selection and precautions.

There are no studies that demonstrate the cardiovascular benefits of SGLT-2i and GLP-1 RAs in patients with DM1

The FDA only approved pramlintide for treatment of type 1 diabetes.

EMA approved sotagliflozin as an adjunct to insulin therapy to improve glycaemic control in adults with type 1 diabetes mellitus who have failed to achieve adequate glycaemic control despite optimal insulin therapy. Patients considered for this treatment should fulfill certain requirements and should have a body mass index (BMI) higher than 27 kg/m².

Key words: diabetes mellitus; insulin.