

Preface



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Guest Editor

Life is not over because you have diabetes. Make the most of what you have, be grateful.

—Dale Evans Rogers

The last issue of *Clinics in Geriatric Medicine* on diabetes mellitus was published nearly 10 years ago [1]. In the last 10 years there have been dramatic advances in our understanding of diabetes and its treatment. There has been an exponential increase in articles on diabetes mellitus in the elderly [2,3]. Diabetes occurs in nearly 20% of people older than 65 years of age and insulin resistance occurs in half of older individuals [4,5]. Diabetes is now recognized to cause sarcopenia, frailty, falls, and hip fractures [6–8]. These issues, along with the dramatic advances in the diagnosis and treatment of diabetic neuropathy, are discussed in the first articles.

Thomas Willis in the 18th century suggested that “Diabetes is caused by melancholy [9].” In the last decade there has been increasing awareness of the effects of depression and cognitive dysfunction on the ability of individuals to control their diabetes [10,11]. The role of HbA_{1c} monitoring in nursing homes has been questioned [12,13]. The importance of managing lipids and blood pressure along with blood glucose has become more emphasized [14–16]. This emphasis has increased the problem of polypharmacy in older people who have diabetes [17]. All these concerns are discussed in detail in this issue.

Finally, there has been an explosion of new therapies for diabetes mellitus over the last 10 years [18,19]. The use of these new therapies has to be balanced against their potential ill effects, as was demonstrated with the negative cardiovascular effects of rosiglitazone [20]. The difficulties in how aggressively to control diabetes in older people were highlighted by the early stoppage of the Action to Control Cardiovascular Risk in Diabetes (ACCORD) trial because of increased cardiovascular mortality. The role of medical nutrition therapy in older people remains controversial with questions concerning the potential negative consequences of weight loss [21] and the role of therapeutic diets [22].

This issue highlights the complexities of diabetes in older people and the difficulties and uncertainties in its management. When Nell Carter was first diagnosed with diabetes she denied it. It is clear that the one thing that neither the patient nor the physician can afford to do is to ignore diabetes.

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