



COMMENT ON HAN ET AL.

Comparative Effectiveness of Diabetic Oral Medications Among HIV-Infected and HIV-Uninfected Veterans.

Diabetes Care 2017;40:218–225

Diabetes Care 2018;41:e6 | <https://doi.org/10.2337/dc17-1006>

María Dolores García de Lucas and
Julián Olalla Sierra

Regarding the article by Han et al. (1), we would like to add the following comments.

As the article points out, diagnosis, control objectives, and therapy in the patient with HIV and type 2 diabetes are similar to those in the non-HIV patient (2). At present the approach in patients with HIV and type 2 diabetes who are overweight or obese should be treatment with antidiabetic medications that, in addition to improving metabolic control, produce weight loss without increasing the risk of hypoglycemia; the only such drugs available are the glucosuric agents sodium–glucose cotransporter 2 inhibitors (SGLT2Is) and glucagon-like peptide 1 receptor agonists (GLP-1 RAs). During the period described in the study (1999–2010), in which 74% of the HIV patients with diabetes were overweight or obese, there were commercially available GLP-1 RAs whose efficacy in HIV patients has been demonstrated for the control of HbA_{1c} and weight loss (3). In addition,

reduction in cardiovascular mortality was demonstrated with liraglutide in the Liraglutide Effect and Action in Diabetes: Evaluation of Cardiovascular Outcome Results (LEADER) study (4). On the other hand, since 2011 three SGLT2Is—canagliflozin, dapagliflozin, and empagliflozin—have become available that improve HbA_{1c} between 0.8 and 1%, decrease weight between 2 and 3.5 kg, and reduce systolic blood pressure. We have recently published a series of eight cases of obese patients with HIV and type 2 diabetes showing statistically significant improvement of HbA_{1c} and weight loss after 24 weeks of treatment with 300 mg/day canagliflozin, without interference with highly active antiretroviral therapy and with no significant undesirable effects (5).

Therefore, we consider that in overweight or obese patients with HIV and type 2 diabetes, as in non-HIV patients, therapy with an SGLT2I and/or a GLP-1 RA

should be initiated after metformin because of the efficacy and safety of these drugs.

Duality of Interest. No potential conflicts of interest relevant to this article were reported.

References

1. Han JH, Gordon K, Womack JA, et al. Comparative effectiveness of diabetic oral medications among HIV-infected and HIV-uninfected veterans. *Diabetes Care* 2017;40:218–225
2. Monroe AK, Glesby MJ, Brown TT. Diagnosing and managing diabetes in HIV-infected patients: current concepts. *Clin Infect Dis* 2015;60:453–462
3. García de Lucas MD, Olalla Sierra J, Piña Fernández J. Liraglutide treatment in a patient with HIV, type 2 diabetes and sleep apnoea-hypopnoea syndrome. *Diabetes Metab* 2015;41:102–103
4. Marso SP, Daniels GH, Brown-Frandsen K, et al.; LEADER Steering Committee; LEADER Trial Investigators. Liraglutide and cardiovascular outcomes in type 2 diabetes. *N Engl J Med* 2016;375:311–322
5. García de Lucas MD, Olalla J. Experience of using ISGLT-2 in patients with DM2 and HIV infection. *Eur J Intern Med* 2017;41:e29

Department of Internal Medicine, Hospital Costa del Sol, Marbella, Málaga, Spain

Corresponding author: María Dolores García de Lucas, gdelucaslola@gmail.com.

The authors of the cited article did not respond.

© 2017 by the American Diabetes Association. Readers may use this article as long as the work is properly cited, the use is educational and not for profit, and the work is not altered. More information is available at <http://www.diabetesjournals.org/content/license>.