Sulfonylureas: Asset or liability?

Sir,

We read with great interest the editorial on the role of sulphonylureas (SUs) in the present day scenario by Kalra *et al*.[1] SUs are fast falling out of favor in many western countries, however they continue to be essential medications in the fight against diabetes in developing countries like India, because of its lower cost, unquestionable efficacy, and easy accessibility. As fellow crusaders in the fight against diabetes, we generally disfavor the use of SUs in our own clinical practice for reasons we shall point out in the letter.

There are broadly two aspects of use of SUs in current clinical practice. One is use of SUs as first-line therapy in treatment naïve type 2 diabetics (in addition to diet and exercise) and second being the role of SUs as add-on therapy to metformin in those poorly controlled on metformin monotherapy.

Most international guidelines advocate the use of metformin as the first-line therapy over other agents like SUs.[2,3] Metformin offers a wide range of benefits over SUs which are familiar to most physicians. In addition, metformin monotherapy is as cost effective as SUs monotherapy and hence ideal for a developing nation like India. Many of the studies (including the controversial University Group Diabetes Program study which was pointed out by Kalra *et al*.), which have questioned the cardiovascular safety of SUs, are studies where SUs is used as monotherapy or

first-line therapy.[4,5] From our own personal experience, we have seen many general physicians prescribing SU monotherapy to treatment naïve patients. In the light of the strong position of metformin as first-line therapy, we believe the use of SUs as monotherapy should end, and this should be important part of physician and patient education.

The second question is the use SUs as add on therapy in cases where metformin monotherapy fails. There is also a question of using double or triple drugs combinations having metformin + SUs in treatment naïve patients. SUs are a fair choice as a second line therapy considering cost constraints and efficacy. As the authors of article Kalra *et al.* pointed out, the focus should be on the patient-oriented approach. We have often seen indiscriminate use of SUs in patients who are high risk for hypoglycemia. Again, physician education would be key in such a case, and physicians should be trained to use the appropriate second-line agent in appropriate situations depending on the clinical condition of the patient.

In the end, we would like to thank Kalra *et al.* for an important editorial that lays the premise for a healthy debate on the current role of SUs in clinical practice.

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References

1. Kalra S, Madhu S, Bajaj S. Sulfonylureas: Assets in the past, present and future. Indian J Endocrinol Metab 2015;19:314-6.
2. Inzucchi SE, Bergenstal RM, Buse JB, Diamant M, Ferrannini E, Nauck M, *et al.* Management of hyperglycaemia in type 2 diabetes, 2015: A patient-centred approach. Update to a Position Statement of the American Diabetes Association and the European Association for the Study of Diabetes. Diabetologia 2015;58:429-42.
3. Garber AJ, Abrahamson MJ, Barzilay JI, Blonde L, Bloomgarden ZT, Bush MA, *et al.* AACE comprehensive diabetes management algorithm 2013. Endocr Pract 2013;19:327-36.
4. Meinert C. UGDP Trial. Wiley Encyclopedia of Clinical Trials. New Jersey: John Wiley & Sons, Inc.; 2007.
5. Johnson JA, Majumdar SR, Simpson SH, Toth EL. Decreased mortality associated with the use of metformin compared with sulfonylurea monotherapy in type 2 diabetes. Diabetes Care 2002;25:2244-8.

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