Triple Therapy
Definitions, application, and treating to target

In this issue of Diabetes Care, Strowig, Avilés-Santa, and Raskin (1) evaluated the glycemic response to “triple therapy” in a small number of patients. Their study of triple therapy involved adding metformin to type 2 diabetic patients receiving >30 units of insulin plus troglitazone or adding troglitazone to similar patients receiving >30 units of insulin plus metformin. The added oral antidiabetes medications were titrated upward over 1 month to maximal doses and the patients followed for another 3 months without further changes in their doses. Insulin doses were not allowed to be increased but could be decreased in response to hypoglycemia. Although these patients were well controlled at baseline, their control improved even further with this triple therapy. A1C levels in patients in whom troglitazone was added with this triple therapy. A1C levels in patients receiving >30 units of insulin plus metformin or adding troglitazone to similar patients followed for another 3 months over 1 month to maximal doses and the other medication was added. In this manner, patients did not remain out of control for long periods of time. Before glitazones became available, the next step was to add bedtime NPH insulin. If the cost of glitazones is a factor, this still remains an attractive option. In our institution (9), glitazones have been added to the formulay to be used for either triple oral therapy (metformin, glipizide or glyburide, glitazone) (11) (or if patients take >80 units insulin/day and remain in poor control). If triple oral therapy fails, bedtime insulin is substituted for the glitazone.

Since triple oral therapy (metformin =2,000 mg/day, glyburide 20 mg/day, pioglitazone 45 mg/day) was as effective as triple therapy with insulin (metformin =2,000 mg/day, glyburide 20 mg/day, bedtime NPH) (12), cost and lifestyle considerations may be the deciding factors when dual therapy fails. Of course, the bottom line is to treat to target, regardless of how one gets there. The approach described above is a cost-effective way to do just that.

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References
2. Poulsen MK, Henriksen JE, Hother-


