Exenatide Twice Daily Versus Premixed Insulin Aspart 70/30 in Metformin-Treated Patients With Type 2 Diabetes

A randomized 26-week study on glycemic control and hypoglycemia

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OBJECTIVE—Hypoglycemia causes recurrent morbidity in patients with type 2 diabetes. This study evaluated if exenatide twice daily (BID) was noninferior to premixed insulin aspart 70/30 BID (PIA) for glycemic control and associated with less hypoglycemia.

RESEARCH DESIGN AND METHODS—In this open-label study, metformin-treated adults with type 2 diabetes were randomized to 26-week treatment with exenatide BID (4 weeks 5 μg, then 10 μg) or PIA.

RESULTS—Exenatide BID (n = 181) was noninferior to PIA (n = 173) for A1C control (least squares [LS] mean change −1.0 vs. −1.4%; difference [95% CI] 0.14 [−0.003 to 0.291]) and associated with a lower risk for hypoglycemia (8.0 vs. 20.5%, P < 0.003 to 0.05). LS mean weight decreased by 4.1 kg and increased by 1.0 kg with PIA (P < 0.001). A total of 39.2 vs. 20.8% of patients reached the composite end point of A1C <7.0%, no weight gain, and no hypoglycemia (P < 0.001; post hoc analysis).

CONCLUSIONS—In metformin-treated patients, exenatide BID was noninferior to PIA for glycemic control but superior for hypoglycemia and weight control.

The well-known limitations of insulin therapy are weight gain and increased risk of hypoglycemia (1,2). Results of cardiovascular outcome trials (3,4) have triggered a discussion about the association between hypoglycemia and increased mortality (5). The American Diabetes Association defines the prevention of hypoglycemia as a critical component of diabetes management (6). This study was specifically designed to compare hypoglycemia with exenatide twice daily (BID) versus premixed insulin aspart 70/30 BID (PIA) (70% protamin crystallized, 30% soluble) at a noninferior level of glycemic control in type 2 diabetic patients on metformin treatment. An additional smaller patient cohort previously treated with metformin plus sulphonylurea or meglitinides was enrolled into an exploratory arm; data have been published separately (7).

RESEARCH DESIGN AND METHODS—This 26-week randomized open-label study was conducted at 68 sites in Germany. Metformin-treated adults with type 2 diabetes (A1C 6.5–10.0%) received exenatide BID (4 weeks, 5 μg, then 10 μg) or PIA. PIA was titrated to glucose targets of 5.0–7.2 mmol/L (fasting) and <10 mmol/L (2 h postprandial) after each main meal (8), without a structured insulin dosing algorithm. Metformin was continued unchanged. Randomization was stratified by baseline A1C (<8.0 or >8.0%).

Hypoglycemia causes recurrent morbidity in patients with type 2 diabetes. This study evaluated if exenatide twice daily (BID) was noninferior to premixed insulin aspart 70/30 BID (PIA) for glycemic control and associated with less hypoglycemia. This randomized 26-week study on glycemic control and hypoglycemia associated with a lower risk for hypoglycemia (8.0 vs. 20.5%, P < 0.001) and associated with a lower risk for hypoglycemia (8.0 vs. 20.5%, P < 0.001). LS mean weight decreased by 4.1 kg and increased by 1.0 kg with PIA (P < 0.001). A total of 39.2 vs. 20.8% of patients reached the composite end point of A1C <7.0%, no weight gain, and no hypoglycemia (P < 0.001; post hoc analysis).

CONCLUSIONS—In metformin-treated patients, exenatide BID was noninferior to PIA for glycemic control but superior for hypoglycemia and weight control.

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RESULTS—Of 363 randomized patients (exenatide/PIA 182/181), 354 (181/173) received study drug (full analysis population); 272 (135/137) completed the study. Patient characteristics were similar in both groups (exenatide/PIA mean ± SD): age 57 ± 10/57 ± 9.9 years, BMI 33.4 ± 4.2/32.9 ± 4.4 kg/m², diabetes duration 5 ± 4/5 ± 5 years, baseline A1C 7.9 ± 0.8%/7.9 ± 0.9%.

After 26 weeks, LS mean A1C had decreased by −1.00% with exenatide BID and −1.14% with PIA (Fig. 1A); exenatide BID was noninferior (group difference 0.14; 95% CI −0.003 to 0.291). A1C targets of <7.0% (<6.5%) were achieved by 49.2% (27.6%) of exenatide BID patients and 56.6% (24.9%) of PIA patients. The risk for the first hypoglycemic episode (blood glucose ≤3.9 mmol/L or severe) was significantly lower with exenatide BID than with PIA (P < 0.05); 8.0% (95% CI 4.7–13.4%) vs. 20.5% (15.0–27.7%) of patients experienced at least one episode (Fig. 1B). There was no severe hypoglycemia. Nocturnal episodes were reported for 3.9% of exenatide BID and 7.0% of PIA patients. Hypoglycemic episodes with blood glucose ≤3.0 mmol/L were also less frequent with exenatide BID (1.8 vs. 6.3%, Fig. 1B).

After 26 weeks, exenatide BID patients had lost 4.1 ± 0.22 kg of weight, while PIA patients had gained 1.0 ± 0.22 kg (LS mean ± SEM; P < 0.001 for group difference).

The mean final total insulin dose (PIA) was 28.4 IU/day (0.29 IU/kg/day). Metformin doses remained unchanged in both groups (median 2,000 mg/day).

Most common adverse events (≥5% of patients) with the exenatide BID group were nausea (18.8%), nasopharyngitis (14.9%), diarrhea (10.5%), vomiting (9.9%), headache (8.3%), and dyspepsia (6.1%). With PIA, nasopharyngitis (19.1%), headache (13.3%), diarrhea (8.1%), and back pain (5.2%) were reported most frequently. More patients on exenatide BID discontinued because of adverse events (7.2 vs. 0.6%; P = 0.0014). The main reasons for discontinuation of exenatide BID were nausea (3.9%) and diarrhea (1.1%).

CONCLUSIONS—In metformin-treated type 2 diabetic patients, exenatide BID was noninferior to PIA in terms of glycemic control and superior in terms of hypoglycemia. In addition, exenatide patients achieved significant mean weight reduction. With exenatide BID, twice as many patients reached the clinically relevant composite end point of A1C <7.0%, no weight gain, and no hypoglycemia (post hoc analysis). Two previous studies had also compared exenatide BID versus PIA. The 52-week trial by Nauck et al. (9) showed that in a similar patient population, exenatide BID was noninferior to PIA for glycemic control, but without any difference in hypoglycemia. The mean final daily insulin dose was lower than in our trial (24.4 vs. 28.4 IU/day). Patients received concomitant sulfonylurea, and this may explain the lower insulin dose and lack of differences in hypoglycemia.

In contrast, the 24-week trial by Bergenstal et al. (10) showed superior glycemic control with PIA versus exenatide BID in poorly controlled patients with advanced disease (baseline A1C 10.2%,
diabetes duration 10 years). In late-stage diabetes, insulin may improve glycemic control better; GLP-1 therapy may have limited effects because of the impaired β-cell function (10). Hypoglycemia was less frequent with exenatide BID (20.2 vs. 52.1%) in spite of concomitant sulfonylurea, possibly because of aggressive insulin titration (mean final dose 96.1 IU/day).

In our study, sulfonylurea treatment was excluded, decreasing the risk of hypoglycemia in both arms and enabling us to assess the full benefit of exenatide on the risk of hypoglycemia. The hierarchical testing required noninferior glycemic control before testing for hypoglycemia. Insulin titration might be criticized as not being aggressive enough (11). The mean final insulin dose (28.4 IU/day) was higher than in the study by Nauck et al. (9), but lower than in the two studies using other premixed insulins (12,13). However, A1C reductions were similar to previous trials, and a mean end point A1C of 6.8% was among the best results reported (12,13).

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