

MANAGEMENT OF METABOLIC SYNDROME

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In Singapore, the prevalence of obesity and type 2 diabetes mellitus (T2DM) have risen to 10.8% and 11.6% respectively in 2010. This steep increase in these metabolic disorders contribute to atherosclerosis and end-organ complications such as coronary heart disease, stroke and peripheral vascular disease. Increasingly these chronic and complex patients will be managed by primary care physicians, as continuity of care for them is vital to ensure good outcomes.

This issue of SFP provides an insight and update on new developments in areas of therapeutics and surgery. In treating dyslipidemia, Niacin in extended formulations and in combination with prostaglandin D2 receptor antagonist (Laropiprant) are available to reduce its side-effects. CETP inhibitors are new class of drugs for raising HDL-cholesterol, which show promise when used with simvastatin.

Recent studies have thrown more light on the role of dual renin-angiotensin-aldosterone system (RAAS) blockade, the effect of ARB on the development of T2DM and the efficiency of the single pill combination drugs in anti-hypertensive treatment.

Incretin mimetics and DPP-4 are now added to our armamentarium to combat T2DM. Incretin-based therapy has been introduced into the treatment algorithms in European and American guidelines. With lesson learnt from the previous use of rosiglitazone, we have to watch the safety data of these new drugs diligently.

Metabolic surgery is an increasingly popular treatment option, targeting at those patients with both obesity (BMI \geq 32.5 kg/m²) and metabolic disorders. This bariatric surgery includes both restrictive and by-pass type of procedures. Notwithstanding the remarkable effects of metabolic surgery on T2DM, hypertension, dyslipidemia, non-alcoholic fatty liver disease (NAFLD), obstructive sleep apnoea and even on cancer and mortality, they are invasive, life-changing procedure with known risks and complications. Patients should be informed about the restriction on eating ability and their commitment to regular reviews and surveillance for nutritional deficiencies.

Primary care physicians (PCP) should interpret the data from these recent clinical trials carefully, inform their patients of the options available locally and offer to share what is known about the advantages of these new treatments and their potential adverse effects and complications. It is important for PCP to negotiate with patients on mutually agreed goals of treatment, so as to treat these diseases to evidence-based targets. Only with such productive interactions between the prepared and proactive PCP and the informed activated patients, that we expect the outcomes of managing these metabolic disorders to be favorable. With that, we are confident that PCP in Singapore will be capable of delivering effective chronic care to these patients at risk and trim the burden of these diseases.

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