長輩患者血糖控制知多少

邱外科醫院 神經內科醫師 陳琮華

在老年人口之中，糖尿病是非常普遍的健康狀況，統計顯示，65 歲以上的長者超過四分之一罹患糖尿病，而且超過一半的長者患有前期糖尿病。患有糖尿病的長輩也會有更多共病需要注意，包括**心臟、腎臟疾病、腦中風、肌少症以及高血壓**等等；另外，台灣的長者病患多半服用多種藥物，除了治療慢性病之外，常見的包括睡眠、情緒控制、泌尿疾病或是失智藥物等，因此在面對年紀超過 65 歲以上的個案時，醫藥護人員都必須特別留意個案的病史以及用藥史。

1. 神經科醫師會先評估個案的認知能力，例如是否有失智、認知障礙等現象，並且每年需評估至少一次。
2. 治療高血糖的時候，特別注意長輩是否出現低血糖的症狀，衛教時也必須特別教導低血糖的處理方式。針對第一型糖尿病個案更需要嚴密監測血糖變化。
3. 第二型糖尿病個案使用胰島素者也需要連續監測血糖變化，避免低血糖出現。

「低血糖」是治療糖尿病個案中最需要謹慎避免的情況，因此我們可以將長輩略分成三個部分：

- **健康良好族群（鮮少共病，認知能力正常）**：糖化血色素控制在 7~7.5%以下，空腹血糖大約 80~130mg/dl。
- **中等健康族群（有共病，輕度認知障礙）**：糖化血色素控制在 8%以下，空腹血糖大約 90~150mg/dl。
- **健康嚴重不良族群（共病多、認知功能差）**：糖化血色素不再重要，而是注意有無發生低血糖的情況，空腹血糖可以維持在 100~180mg/dl。

根據 2023 年版的血糖治療指引中，對於長者病患的建議個別強調要避開低血糖的情況，因此在治療過程中一但有發生心悸、頭暈、冒冷汗、精神恍惚、身體虛弱等疑似低血糖症狀時，務必要趕緊服用含糖食物或飲料，並且原地休息直到恢復，或是到醫院檢查。

另外針對血壓與血脂肪的控制也有一併建議的指引，尤其是血壓控制標準建議居家血壓落在 130/80 mmHg（不管年齡），除非個案健康條件很差、認知能力不足者才會把控制標準些微提升到 140/90 mmHg。而且建議服用抗高血脂藥物(statin 類藥物)來減少腦心血管疾病的發生。

隨著台灣人民壽命逐年延長，面對糖尿病的時候不必太過恐慌，只要與您的醫藥護人員保持良好的溝通，關於日常生活的情況、飲食、運動與用藥作息反覆評估檢討，相信還是可以獲得極大的改善，減少共病的發生！

Table 13.1—Framework for considering treatment goals for glycemia, blood pressure, and dyslipidemia in older adults with diabetes

Patient characteristics/ health status	Rationale	Reasonable A1C goal‡	Fasting or preprandial glucose	Bedtime glucose	Blood pressure	Lipids
Healthy (few coexisting chronic illnesses, intact cognitive and functional status)	Longer remaining life expectancy	<7.0–7.5% (53–58 mmol/mol)	80–130 mg/dL (4.4–7.2 mmol/L)	80–180 mg/dL (4.4–10.0 mmol/L)	<130/80 mmHg	Statin, unless contraindicated or not tolerated
Complex/intermediate (multiple coexisting chronic illnesses* or two or more instrumental ADL impairments or mild-to-moderate cognitive impairment)	Intermediate remaining life expectancy, high treatment burden, hypoglycemia vulnerability, fall risk	<8.0% (64 mmol/mol)	90–150 mg/dL (5.0–8.3 mmol/L)	100–180 mg/dL (5.6–10.0 mmol/L)	<130/80 mmHg	Statin, unless contraindicated or not tolerated
Very complex/poor health (LTC or end-stage chronic illnesses** or moderate-to-severe cognitive impairment or two or more ADL impairments)	Limited remaining life expectancy makes benefit uncertain	Avoid reliance on A1C; glucose control decisions should be based on avoiding hypoglycemia and symptomatic hyperglycemia	100–180 mg/dL (5.6–10.0 mmol/L)	110–200 mg/dL (6.1–11.1 mmol/L)	<140/90 mmHg	Consider likelihood of benefit with statin

This table represents a consensus framework for considering treatment goals for glycemia, blood pressure, and dyslipidemia in older adults with diabetes. The patient characteristic categories are general concepts. Not every patient will clearly fall into a particular category. Consideration of patient and caregiver preferences is an important aspect of treatment individualization. Additionally, a patient's health status and preferences may change over time. ADL, activities of daily living; LTC, long-term care. ‡A lower A1C goal may be set for an individual if achievable without recurrent or severe hypoglycemia or undue treatment burden. *Coexisting chronic illnesses are conditions serious enough to require medications or lifestyle management and may include arthritis, cancer, heart failure, depression, emphysema, falls, hypertension, incontinence, stage 3 or worse chronic kidney disease, myocardial infarction, and stroke. "Multiple" means at least three, but many patients may have five or more (66). **The presence of a single end-stage chronic illness, such as stage 3–4 heart failure or oxygen-dependent lung disease, chronic kidney disease requiring dialysis, or uncontrolled metastatic cancer, may cause significant symptoms or impairment of functional status and significantly reduce life expectancy. Adapted from Kirkman et al. (3).

American Diabetes Association

Standards of Care in Diabetes-2023

地址：高雄市苓雅區成功一路137號　　預約專線：(07)331-9966