For Latino patients with limited English proficiency (LEP), switching to a primary care provider who speaks Spanish is associated with improved control of type 2 diabetes, report authors in a study published in *JAMA Internal Medicine.*

Using data from the Kaiser Permanente Northern California healthcare system from 2007 through 2013, the researchers analyzed the effects of language-concordant (LC) versus language-discordant (LD) care on risk factor control among LEP Latino patients with type 2 diabetes. Of 1605 patients age 60.5 years, 26% switched from LD to LC care—i.e., from a primary care provider who spoke English only to one who spoke Spanish. Measures of diabetes control were compared to those of patients who remained in LC care (26%), remained in LD care (38%), or switched from an LC to an LD provider (19%).

Patients who switched from LD to LC care had greater improvement in glycemic control and low-density lipoprotein (LDL) cholesterol, compared to those who remained in LD care. On adjusted analysis accounting for secular trends, the rate of glycemic control (defined as HbA1c less than 8%) increased by 10% among the LD to LC group, while the rate of poor glycemic control (HbA1c greater than 9%) decreased by 4%. Switching from an English-only to a Spanish-speaking primary care provider was also associated with a 9% decrease in the rate of LDL control (less than 100 mg/dL). Language concordance had no effect on BP control. There was also a 15% increase in LDL control among patients who switched from LC to LD care. None of the four groups had a reduction in risk factor control after switching from one primary care provider to another.

There are more than 50 million Latinos in the US, 30% to 40% of whom may have LEP. Language discordance between these patients and their healthcare practitioners may pose challenges in providing culturally competent care. This pre-post study of LEP Latino patients in a large California healthcare system suggests improvements in diabetes risk factor control after switching from a PCP who speaks English only to one who speaks Spanish. Findings include a 10% increase in the prevalence of glycemic control among patients who switch from LD to LC care. Facilitating LC care may be an effective strategy for improving disease control for LEP Latino patients with diabetes (Parker MM, et al. Association of patient-physician language concordance and glycemic control for limited-English proficiency Latinos with type 2 diabetes. *JAMA Intern Med* 2017; 177:380–387).

“The Language-Concordant” Care Improves Diabetes Control in Latino Patients

### Increased Creatinine after Starting ACEIs/ARBs May Increase Cardiorenal Risk

Patients who have even relatively small increases in creatinine after starting angiotensin-converting enzyme inhibitor/angiotensin receptor blocker (ACEI/ARB) treatment are at increased risk of adverse cardio-renal events, suggests a study in the *British Medical Journal.*

Using linked UK primary care and hospital databases, the researchers identified 122,363 patients who initiated treatment with ACEIs or ARBs between 1997 and 2014. Of these, 1.7% had creatinine increases of 30% or more after starting ren-angiotensin system blockade. Rates of end stage renal disease, myocardial infarc- tion, heart failure, and death were compared for patients with and without a 30% increase in creatinine, with adjustment for patient characteristics and clinical factors.

Up to 30% of patients who had a 30% or greater increase in creatinine had diabetes. Rates of all adverse cardio-renal outcomes were significantly higher for the pa-tients with a 30% or greater increase in cre-atinine, compared to those with increases of less than 30%. Adjusted incidence rate ratios were 3.43 for ESRD, 1.46 for myo-cardial infarction, 1.37 for heart failure, and 1.87 for death. These increases were greatest in the year after starting ACEI/ ARB treatment. Among those with lesser increases in creatinine, all risks increased in graduated fash-ions. In patients with creatinine increases of 10% to 19% up to 40% or higher, IRBs increased steadily: from 1.73 to 4.04 for ESRD, 1.12 to 1.59 for myocardial infarc-tion, 1.14 to 1.42 for heart failure, and 1.15 to 2.11 for mortality (compared to creatinine increases of less than 10%).

For patients and their healthcare providers, the data may indicate that risk stratification for patients with smaller creatinine increases should be considered.

### Liraglutide Reduces Diabetes Risk in Prediabetic Patients

Added to diet and exercise, once-daily treat-ment with subcutaneous liraglutide reduces the risk of developing diabetes among obese adults with prediabetes, concludes a trial in *The Lancet.*

The multicenter trial included 2254 obese adults (body mass index <30 kg/m² or higher, or ≥27 kg/m² or higher with co-morbid conditions) meeting criteria for prediabetes. In a 2:1 ratio, patients were randomly assigned to receive once-daily liraglutide, 3.0 mg sc, or matching placebo. Both groups received a diet and exercise in-tervention. The main outcome of interest was time to onset of type 2 diabetes over 3 years’ follow-up.

Fifty percent of patients completed the study; withdrawal rates were 47% in the liraglutide group versus 55% in the placebo group. During double-blind follow-up, type 2 diabetes was diagnosed in 2% of pa-tients in the liraglutide group versus 6% in the placebo group. Mean time to diabetes diagnosis was 99 versus 87 weeks, respec-tively.

After accounting for differences in diabetes frequency, time to diabetes onset in all randomized patients was 2.7 times longer with liraglutide versus placebo. The associated hazard ratio for type 2 diabetes was 0.21. After 3 years, mean weight loss was 6.1% of body weight in the liraglutide group versus 1.9% with placebo. Liraglu-tide was also associated with a higher rate of depression from prediabetes to normoglyce-mia; odds ratio 3.6, with a number needed to treat of 3. Adverse events, including seri-ous events, were similar between groups.

In obese adults with prediabetes, daily treatment with liraglutide appears to reduce the risk of developing type 2 diabetes over 3 years’ follow-up, as an adjunct to lifestyle changes. Liraglutide is also associated with greater weight loss, reduced glycemic control, and reduced car-diovascular risk factors. The auth-ors note that their study did not include follow-up data on the large proportion of patients who did not complete the study (le Roux CW, et al. 3 years of liraglutide versus placebo in 2 type 2 diabetes risk reduction and weight management in individuals with prediabetes: a randomised, double-blind trial. *Lancet.* 2017; DOI: http://dx.doi.org/10.1016/S0140-6736(17)30669-7).

The authors sought to determine the long-term implications of increased creatinine, including increases of less than 30%.

The results suggest significant increases in cardio-renal events and mortality for patients with increases in creatinine after starting ACEI/ARB treatment. The increased risks are apparent even under the 30% threshold, in “dose–response” fashion. The investigators conclude, “In-creases in creatinine after starting ACEI/ ARB treatment identify a high risk group needing close monitoring and in whom the risks and benefits of ACEI/ARB pre-scribing should be considered” (Schmidt M, et al. Serum creatinine elevation after renin-angiotensin system blockade and long-term cardio-renal risks: cohort study. *BMJ* 2017; 356: j791).