Risk of Fatal and Nonfatal Lactic Acidosis With Metformin Use in Type 2 Diabetes Mellitus

Systematic Review and Meta-analysis

Shelley R. Salpeter, MD; Elizabeth Greyber, MD; Gary A. Pasternak, MD; Edwin E. Salpeter, PhD

Background: Metformin therapy for type 2 diabetes mellitus has been shown to reduce total mortality rates compared with other antihyperglycemic treatments but is thought to increase the risk of lactic acidosis. The true incidence of fatal and nonfatal lactic acidosis associated with metformin use is not known.

Methods: A comprehensive search was performed to identify all comparative trials or observational cohort studies published between January 1, 1959, and March 31, 2002, that evaluated metformin therapy, alone or in combination with other treatments, for at least 1 month. The incidence of fatal and nonfatal lactic acidosis was recorded as cases per patient-years for metformin treatment and for placebo or other treatments. In a second analysis, lactate levels were measured as a net change from baseline or as mean treatment values for metformin and comparison groups.

Results: Pooled data from 194 studies revealed no cases of fatal or nonfatal lactic acidosis in 36893 patient-years in the metformin group or in 30109 patient-years in the nonmetformin group. Using Poisson statistics with 95% confidence intervals, the probable upper limit for the true incidence of lactic acidosis in the metformin and nonmetformin groups was 8.1 and 9.9 cases per 100000 patient-years, respectively. There was no difference in lactate levels for metformin compared with placebo or other nonbiguanide therapies.

Conclusion: There is no evidence to date that metformin therapy is associated with an increased risk of lactic acidosis or with increased levels of lactate compared with other antihyperglycemic treatments if the drugs are prescribed under study conditions, taking into account contraindications.

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METFORMIN hydrochloride is a biguanide that has been used to treat type 2 diabetes mellitus for more than 40 years. Aside from its effect on carbohydrate metabolism, metformin treatment is thought to have other positive effects, such as weight loss or stabilization of weight gain. In addition, results of the UK Prospective Diabetes Study indicate that metformin monotherapy leads to reductions in diabetes mellitus–related end points, in the diabetes mellitus–related mortality rate, and in the total mortality rate compared with insulin use, sulfonylurea therapy, or diet alone.

Lactic acidosis is a rare, potentially fatal metabolic condition that can occur whenever substantial tissue hypoperfusion and hypoxia exist. Lactic acidosis is characterized by an elevated blood lactate concentration (>45.0 mg/dL, >5.0 mmol/L), decreased blood pH (<7.35), and electrolyte disturbances with an increased anion gap. An earlier biguanide, phenformin hydrochloride, was withdrawn from the market because it was associated with a reported rate of lactic acidosis of 40 to 64 cases per 100000 patient-years. Metformin, however, differs from phenformin in molecular structure and pharmacokinetics and, unlike phenformin, is thought to enhance glucose oxidation without substantially affecting fasting lactate production in peripheral tissues.

The true incidence of metformin-associated lactic acidosis is not known. Population-based studies have estimated a rate of 2 to 9 cases of lactic acidosis in metformin users per 100000 person-years. However, most of the reported cases have occurred in patients with severe acute conditions, such as renal failure, that could in themselves have caused the lactic acidosis. To estimate the risk specifically attributable to metformin use, the background rate of lactic acidosis in patients with type 2 diabetes mellitus who are not treated with metformin was assessed and was found...
to be 9 cases per 100,000 person-years. This raises the question of whether patients with type 2 diabetes mellitus have an increased risk for developing lactic acidosis with metformin use compared with other glucose-lowering treatments.

Metformin use is now considered to be contraindicated in many chronic conditions that may increase the risk of tissue anoxia and the development of lactic acidosis, such as cardiovascular, renal, pulmonary, and liver disease. These restrictions significantly reduce the number of patients who could benefit from metformin treatment. The objective of this review is to assess the risk of fatal and nonfatal lactic acidosis associated with metformin use in persons with type 2 diabetes mellitus compared with placebo or other glucose-lowering therapies. Another objective is to evaluate levels of blood lactate, measured at baseline and during treatment, for metformin treatment compared with placebo or other hypoglycemic therapies. An earlier version of this analysis was published as a review on The Cochrane Library.

**METHODS**

**TRIAL SEARCH AND SELECTION**

A comprehensive search through March 31, 2002, was performed of the Cochrane Library (including the Cochrane Controlled Trials Database), MEDLINE, OLDMEDLINE, Database of Abstracts of Reviews of Effectiveness, Reactions, and EMBASE using the terms “diabetes mellitus,” “non-insulin-dependent,” “NIDDM,” “non insulin* dep*,” “noninsulin* dep*,” “non insulin dep*,” “typ* II diabet*,” “typ* 2 diabet*,” “diabet* typ* 2,” “diabet* typ* II,” “biguanides,” “biguanid*,” “metform*,” “glucophag*,” and “metformin*.” Studies published in any language were included. The search was further augmented by scanning references of identified articles and reviews, abstracts at clinical symposia, and the Cumulated Index Medicus. In addition, attempts were made to contact authors of identified studies and manufacturers of metformin to obtain additional information.

Two independent reviewers (G.A.P. and S.R.S.) reviewed every record found in the search, and articles on metformin use in patients with diabetes mellitus were retrieved. Two investigators (S.R.S. and E.G.) independently evaluated studies for inclusion, and the observed percentage agreement between raters was measured using the k statistic.

Prospective clinical trials of at least 1 month in duration were included if they evaluated metformin use, alone or in combination with other treatments, compared with placebo or compared with any other glucose-lowering therapy for type 2 diabetes mellitus. In addition, all observational cohort studies evaluating at least 1 month of metformin use were included in the analysis if they provided the number of patients and the duration of treatment. The excluded trials lasting less than 1 month were evaluated separately to see whether there were any cases of lactic acidosis.

Interventions studied included metformin, alone or in combination with other treatments, vs placebo or another antihyperglycemic intervention, such as diet, insulin, or sulfonylureas. Data on participants treated with phenformin were not included in the analysis for lactic acidosis but were included in measurements of lactate levels.

**VALIDITY ASSESSMENT**

The methodological quality of each study was evaluated based on the quality criteria modified from Schulz, Jadad, and Stroup and their colleagues. Studies were divided into 5 categories that characterize the treatment of metformin in the trials. A score of A, B, or C was given to randomized controlled trials using the following factors: (1) Was the study randomized? If so, was the randomization procedure adequate? (2) Were the patients and people administering the treatment masked to the intervention? (3) Were withdrawals and dropouts described? A score of D was given to open-label nonrandomized controlled trials, and a score of E was given to observational cohort studies.

Each trial was assessed independently by 2 reviewers (S.R.S. and E.G.), and consensus was reached in cases of disagreement. Interrater agreement before consensus was calculated using the k statistic.

**DATA EXTRACTION AND DATA SYNTHESIS**

Two independent reviewers (S.R.S. and E.G.) extracted data from the selected articles, reconciling differences by consensus. Outcomes measured were (1) death described as due to lactic acidosis; (2) reported cases of nonfatal lactic acidosis, as defined by the investigator; and (3) blood lactate levels for metformin compared with placebo or other nonbiguanide therapies and compared with phenformin.

The treatment effect for fatal and nonfatal lactic acidosis was expressed as a risk difference by taking the incidence of events during metformin, alone or in combination with other treatments, and then subtracting the incidence of events during placebo or alternative treatments. As no cases of lactic acidosis were found, the probable upper limits for the true incidence of lactic acidosis in the metformin and nonmetformin groups were calculated separately using Poisson statistics. Information was obtained on how many patients were older than 65 years or were thought to have concomitant hypoxic conditions.

Once pooled results revealed no cases of lactic acidosis, it was decided to report on randomized controlled trials that measured blood lactate levels for metformin use compared with placebo or nonbiguanide treatments and also compared with phenformin use. Three outcomes were analyzed for the metformin group compared with the comparison groups: (1) the change in lactate levels from baseline to treatment, (2) the mean lactate levels recorded during treatment, and (3) the change in treatment lactate levels from a basal state to peak stimulation with either food or exercise. The results were recorded as the weighted mean difference (WMD) and were pooled using the fixed-effects model for continuous data.

**RESULTS**

The electronic database search identified 638 articles, 191 of which were potentially relevant studies on metformin use in patients with type 2 diabetes mellitus. After scanning abstracts from symposia and references from selected articles, an additional 70 studies were identified. Of these 261 studies, 193 met the inclusion criteria. One additional unpublished trial (2001) was received from Evertine Abbink, MD. The k score for Interrater agreement in trial selection was 0.87 (95% confidence interval [CI], 0.76-0.98), indicating good agreement, and consensus was reached on the remaining trials.

Of the 194 studies included in the analysis, 126 were prospective comparative trials, 56 were prospective cohort studies, and 12 were retrospective cohort studies. A
total of 56692 participants were followed for 67 002 patient-years, with 18 689 participants (36 893 patient-years) in the metformin group and 38 003 participants (30 109 patient-years) in the nonmetformin group. The mean±SD age of the participants in the metformin group was 57.1±8.9 years, and 61% were men. In the nonmetformin group, the mean±SD age was 57.2±9.1 years, and 61% were men. The mean trial duration was 2.1 years (range, 0.08–10.7 years). The mean study size in the metformin group was 76 participants (range, 8–1362). The dropout rate was estimated to be 9.3%.

Metformin was given in daily doses of 1 to 3 g, with the dosage titrated clinically. Comparison treatments included placebo, diet, insulin, glyburide, gliclazide, glipti-zide, glibenclamide, gliclperide, chloropropamide, tolbutamide, acarbose, nateglinide, repaglinide, miglitol, troglitazone, rosiglitazone maleate, and guar gum.

No trial was specifically designed to assess the incidence of lactic acidosis, but adverse effects or adverse events were described in almost all of the trials. Attempts were made to reach the authors of the trials, and those who responded confirmed that there were no known cases of fatal or nonfatal lactic acidosis in their trials. Serum bicarbonate or lactate levels were measured in 96 of the included studies (49%). Of the comparative trials, 26 measured lactate levels during metformin and nonmetformin treatment.

Studies were excluded for the following reasons: 2 were retrospective and 13 were prospective cohort studies that did not give information on the number of patients or the length of treatment, 39 prospective comparative trials were less than 1 month in duration, and 13 were retrospective analyses or reviews.

### METHODOLOGICAL QUALITY OF INCLUDED STUDIES

Of the trials analyzed, 3 received a score of A; 40, a score of B; 55, a score of C; 28, a score of D; and 68, a score of E. The κ score for interrater agreement was 0.83 (95% CI, 0.75-0.91), indicating good agreement.

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**QUANTITATIVE DATA SYNTHESIS**

### Incidence of Lactic Acidosis

When combining the data from cohort studies with the prospective comparative trials (including data from the unpublished data from E. J. Abbink, MD, 2001) \(^6,10,21-211\), there were no cases of fatal or nonfatal lactic acidosis reported in the metformin group (36 893 patient-years) or in the nonmetformin group (30 109 patient-years). Using Poisson statistics with 95% CIs, the probable upper limit for the true incidence of lactic acidosis in the metformin group is 0.1 cases per 100 000 patient-years and in the nonmetformin group is 0.9 cases per 100 000 patient-years.

Of the 182 prospective studies, \(^*\) 80 (44%) allowed for the inclusion of renal insufficiency, following 16 233 patient-years of metformin use, and 174 (96%) allowed for the inclusion of at least 1 of the contraindications listed herein. It was estimated from the available data that 16% of the participants in the studies were older than 65 years, and they were followed for approximately 59 031 patient-years of metformin use.

### Blood Lactate Levels

For randomized controlled trials† that provided the data, the baseline lactate level measured before metformin treatment was 10.2±2.3 mg/dL (1.1±0.2 mmol/L). There was no difference in the net change in lactate levels from baseline for metformin treatment compared with placebo or nonbiguanide therapies, with a WMD of 1.0 mg/dL (0.11 mmol/L) (95% CI, −0.1 to 2.2 mg/dL [−0.01 to 0.24 mmol/L]) (Figure 1). The mean±SD lactate level during metformin treatment was 11.2±2.8 mg/dL (1.2±0.3 mmol/L), which was not significantly different from nonbiguanide comparisons (WMD, 0.5 mg/dL [0.06 mmol/L]; 95% CI, 0 to 1.2 mg/dL [0 to 0.1

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\(^\)References 10, 36, 38, 44, 47, 58, 94, 112, 117, 178.

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**Figure 1.** Net treatment effect of lactate levels for metformin treatment compared with nonmetformin treatments. To convert lactate (and weighted mean difference) from milligrams per deciliter to micromoles per liter, multiply milligrams per deciliter by 0.1110. CI indicates confidence interval.

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<table>
<thead>
<tr>
<th>Source</th>
<th>Treatment Group</th>
<th>Control Group</th>
<th>Weight, %</th>
<th>Weighted Mean Difference (95% CI)</th>
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<tr>
<td></td>
<td>Patients, No.</td>
<td>Lactate Level, Mean±SD, mg/dL</td>
<td>Lactate Level, Mean±SD, mg/dL</td>
<td>mg/dL</td>
</tr>
<tr>
<td></td>
<td>24</td>
<td>0.5±3.8</td>
<td>24</td>
<td>1.5±3.9</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>−1.8±4.1</td>
<td>10</td>
<td>0±4.1</td>
</tr>
<tr>
<td></td>
<td>25</td>
<td>2.7±6.6</td>
<td>29</td>
<td>−1.0±5.9</td>
</tr>
<tr>
<td></td>
<td>20</td>
<td>0±6.3</td>
<td>20</td>
<td>−0.5±4.5</td>
</tr>
<tr>
<td></td>
<td>20</td>
<td>0.2±5.1</td>
<td>10</td>
<td>0±2.3</td>
</tr>
<tr>
<td></td>
<td>16</td>
<td>2.4±7.1</td>
<td>16</td>
<td>−1.0±7.1</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>4.0±8.6</td>
<td>10</td>
<td>−2.7±8.8</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>0.5±2.9</td>
<td>9</td>
<td>−0.4±3.1</td>
</tr>
<tr>
<td>Total*</td>
<td>134</td>
<td>128</td>
<td>100</td>
<td>1.0 (−0.1-2.2)</td>
</tr>
</tbody>
</table>

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*Test for heterogeneity, \(\chi^2=5.48; P=.60\). Test for overall effect, \(Z=1.79; P=.07\).
and was 6.8 mg/dL (0.8 mmol/L) lower than with phenformin use (95% CI, −7.9 to −5.9 mg/dL [−0.9 to −0.6 mmol/L]) (Figure 2). The mean ± SD lactate level during metformin treatment, measured before and after stimulation by a meal or strenuous exercise, was 20.7 ± 15.3 mg/dL (2.3 ± 1.7 mmol/L) (Figure 3). This value was not significantly different from that of the metformin group vs the nonbiguanide group (WMD, 0.8 mg/dL [0.1 mmol/L]; 95% CI, −0.3 to 2.0 mg/dL [−0.03 to 0.2 mmol/L]) or the phenformin group (WMD, −3.3 mg/dL [−0.4 mmol/L]; 95% CI, −9.5 to 2.9 mg/dL [−1.1 to 0.3 mmol/L]). Five trials that measured lactate levels did not provide data to be analyzed but reported levels to be normal during metformin and nonmetformin treatment.

Possible heterogeneity was noted in the 3 trials that measured lactate levels after stimulation by food or exercise. The results were not significantly different when the random-effects model was used (WMD, 0.4 mg/dL [0.04 mmol/L]; 95% CI, −4.1 to 4.8 mg/dL [−0.4 to 0.5 mmol/L]). In addition, some heterogeneity was noted in the 3 trials measuring mean lactate levels for metformin treatment compared with phenformin treatment. When the random-effects model was used, the difference was no longer statistically significant (−5.8 mg/dL [−0.6 mmol/L]; 95% CI, −14.7 to 3.2 mg/dL [−1.6 to 0.4 mmol/L]).

To evaluate the risk of lactic acidosis attributed to metformin use, pooled data from all known prospective comparative trials and observational cohort studies lasting longer than 1 month were analyzed. No cases were found in 194 trials with 36893 patient-years of metformin treatment. In fact, on review of 56 additional trials that were excluded from analysis (those that lasted <1 month or were of unclear duration), no cases of lactic acidosis were found.

### Table: Mean Treatment Lactate Levels for Metformin Compared with Nonmetformin Treatments and for Metformin Compared with Phenformin

<table>
<thead>
<tr>
<th>Source</th>
<th>Patients, No.</th>
<th>Lactate Level, Mean ± SD, mg/dL</th>
<th>Weight, %</th>
<th>Weighted Mean Difference (95% CI, Fixed), mg/dL</th>
<th>Weighted Mean Difference and 95% CI (Fixed), mg/dL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metformin Minus Nonmetformin</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Botha29 1977</td>
<td>21</td>
<td>10.9 ± 3.4</td>
<td></td>
<td>6.0</td>
<td>−0.3 (−2.3 to 1.8)</td>
</tr>
<tr>
<td>Campbell et al44 1994</td>
<td>24</td>
<td>8.9 ± 3.2</td>
<td></td>
<td>11.0</td>
<td>0.8 (−0.7 to 2.3)</td>
</tr>
<tr>
<td>Cosic et al207 2001</td>
<td>48</td>
<td>15.9 ± 16.4</td>
<td></td>
<td>0.9</td>
<td>0.4 (−4.9 to 5.6)</td>
</tr>
<tr>
<td>Cusi et al11 1996</td>
<td>10</td>
<td>9.0 ± 2.9</td>
<td></td>
<td>4.0</td>
<td>−0.9 (−3.2 to 1.6)</td>
</tr>
<tr>
<td>Dambo et al118 1998</td>
<td>9</td>
<td>7.2 ± 1.9</td>
<td></td>
<td>8.4</td>
<td>1.2 (−0.5 to 2.9)</td>
</tr>
<tr>
<td>De Silva et al116 1979</td>
<td>21</td>
<td>9.6 ± 5.5</td>
<td></td>
<td>2.1</td>
<td>−0.9 (−4.4 to 2.6)</td>
</tr>
<tr>
<td>Eri et al119 1999</td>
<td>20</td>
<td>10.8 ± 5.4</td>
<td></td>
<td>2.7</td>
<td>0.5 (−2.5 to 3.6)</td>
</tr>
<tr>
<td>Gregoria et al110 1999</td>
<td>20</td>
<td>8.4 ± 4.1</td>
<td></td>
<td>6.2</td>
<td>0.2 (−1.9 to 2.3)</td>
</tr>
<tr>
<td>Hother-Neilson et al105 1989</td>
<td>9</td>
<td>14.1 ± 4.3</td>
<td></td>
<td>2.2</td>
<td>1.2 (−2.3 to 4.6)</td>
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<tr>
<td>Jackson et al208 1987</td>
<td>10</td>
<td>14.1 ± 1.7</td>
<td></td>
<td>11.5</td>
<td>0.0 (−1.5 to 1.5)</td>
</tr>
<tr>
<td>Josephkutty and Potter112 1990</td>
<td>10</td>
<td>15.9 ± 7.3</td>
<td></td>
<td>0.8</td>
<td>2.6 (−2.8 to 8.4)</td>
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<tr>
<td>Klein117 1991</td>
<td>16</td>
<td>14.2 ± 5.8</td>
<td></td>
<td>1.5</td>
<td>1.0 (−3.2 to 5.1)</td>
</tr>
<tr>
<td>McAlpine et al129 1988</td>
<td>21</td>
<td>16.2 ± 5.0</td>
<td></td>
<td>2.9</td>
<td>2.7 (−0.3 to 5.7)</td>
</tr>
<tr>
<td>Nattress et al131 1977</td>
<td>6</td>
<td>8.3 ± 3.1</td>
<td></td>
<td>3.2</td>
<td>0.5 (−2.4 to 3.3)</td>
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<tr>
<td>Pederson et al136 1989</td>
<td>10</td>
<td>16.2 ± 3.2</td>
<td></td>
<td>3.4</td>
<td>1.8 (−1.0 to 4.6)</td>
</tr>
<tr>
<td>Teupe and Bergis176 1991</td>
<td>25</td>
<td>13.0 ± 5.0</td>
<td></td>
<td>3.6</td>
<td>1.1 (−1.4 to 3.8)</td>
</tr>
<tr>
<td><strong>Total1</strong></td>
<td>360</td>
<td>358</td>
<td></td>
<td>100.0</td>
<td>−1.6 (−2.1 to −1.1)</td>
</tr>
</tbody>
</table>

Figure 2. Mean treatment lactate levels for metformin compared with nonmetformin treatments and for metformin compared with phenformin. To convert lactate (and weighted mean difference) from milligrams per deciliter to micromoles per liter, multiply milligrams per deciliter by 0.1110. CI indicates confidence interval.

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‡Test for heterogeneity, phenformin treatment. To convert lactate (and weighted mean difference) from milligrams per deciliter to micromoles per liter, multiply milligrams per deciliter by 0.001. CI indicates confidence interval.

*Test for heterogeneity, \( \chi^2 = 22.54; P < .001 \). Test for overall effect, \( z = 1.45; P = .15 \).
†Test for heterogeneity, \( \chi^2 = 0.30; P > .99 \). Test for overall effect, \( z = 1.05; P = .30 \).
‡Test for heterogeneity, \( \chi^2 = 24.21; P < .001 \). Test for overall effect, \( z = 1.23; P = .20 \).

Figure 3. Peak stimulated lactate levels for metformin treatment compared with nonmetformin treatments and for metformin treatment compared with phenformin treatment. To convert lactate (and weighted mean difference) from milligrams per deciliter to micromoles per liter, multiply milligrams per deciliter by 0.001. CI indicates confidence interval.

†Test for heterogeneity, \( \chi^2 = 22.54; P < .001 \). Test for overall effect, \( z = 1.45; P = .15 \).
†Test for heterogeneity, \( \chi^2 = 0.30; P > .99 \). Test for overall effect, \( z = 1.05; P = .30 \).
‡Test for heterogeneity, \( \chi^2 = 24.21; P < .001 \). Test for overall effect, \( z = 1.23; P = .20 \).
Now, the only evidence to indicate that metformin use is associated with lactic acidosis comes from reports of approximately 330 cases that have occurred in patients taking metformin.\(^2\)\(^3\)\(^-\)\(^2\)\(^0\) Lactic acidosis has also been reported in patients with diabetes mellitus not treated with metformin, typically under conditions in which there is significant tissue hypoperfusion or hypoxia.\(^2\)\(^1\) One study,\(^1\)\(^5\) found that the rate of confirmed lactic acidosis in the United States, measured before the introduction of metformin and after the withdrawal of phenformin, was approximately 10 per 100,000 patient-years, which is equivalent to that thought to be associated with metformin treatment. Another study,\(^2\)\(^1\)\(^3\) evaluated all cases of nonketotic metabolic acidosis in patients with type 2 diabetes mellitus that occurred during 600 emergency admissions to a university hospital. The rates of nonketotic acidosis per 1000 emergency admissions were 29 for sulfonylurea use, 32 for sulfonylurea plus phenformin use, 48 for insulin use, and 0 for metformin treatment. All cases of nonketotic metabolic acidosis found were associated with severe precipitant disease that could have caused lactic acidosis. The investigators conclude that it is the underlying systemic dysfunction and not the particular treatment that is the main determinant for the appearance of lactic acidosis. In support of that conclusion, the results of this review reveal that there is no evidence of an increased risk of lactic acidosis associated with metformin use if it is prescribed under the study conditions, taking into account contraindications.

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Corresponding author and reprints: Shelley R. Salpeter, MD, Santa Clara Valley Medical Center, 751 S Bascom Ave, San Jose, CA 95128 (e-mail: salpeter@stanford.edu).

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