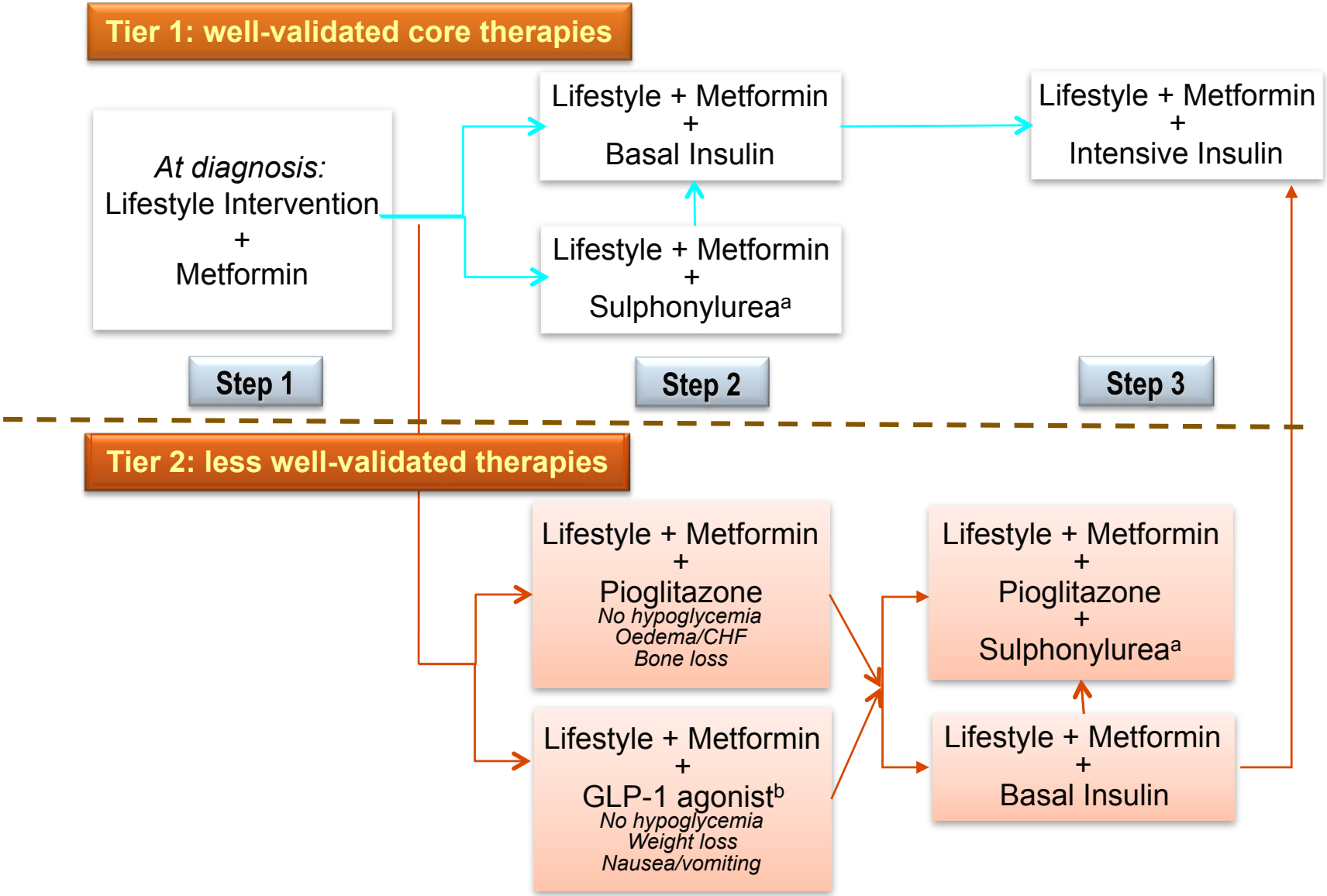
# Management of Hyperglycemia in T2DM: ADA/EASD Consensus Algorithm 2009




[a] *Sulphonylureas other than glybenclamide or clorpropamide*

[b] *Insufficient clinical use to be confident regarding safety*

Nathan DM et al, *Diabetes Care*, 2008

# Algoritmo ADA/EASD 2009

## Novità

- Istruzioni sull'uso della metformina
- Terapie "ben validate" (I livello) vs terapie "meno ben validate" (II livello)
- "Apertura" agli analoghi del GLP-1
- Esclusione/inclusione di molecole specifiche nell'ambito della stessa classe farmacologica

## Criticità

- Non "Evidence based"
- Non importanza del ruolo dell'ìperglicemia post-prandiale e della variabilità glicemica
- Esclusione di glinidi e DPP4-inibitori
- Terapie con associazione di farmaci v*s step-wise*
- Non riferimenti a target inferiori di A1c, non personalizzazione

Annals of Internal Medicine

# Individualizing Glycemic Targets in Type 2 Diabetes Mellitus: Implications of Recent Clinical Trials

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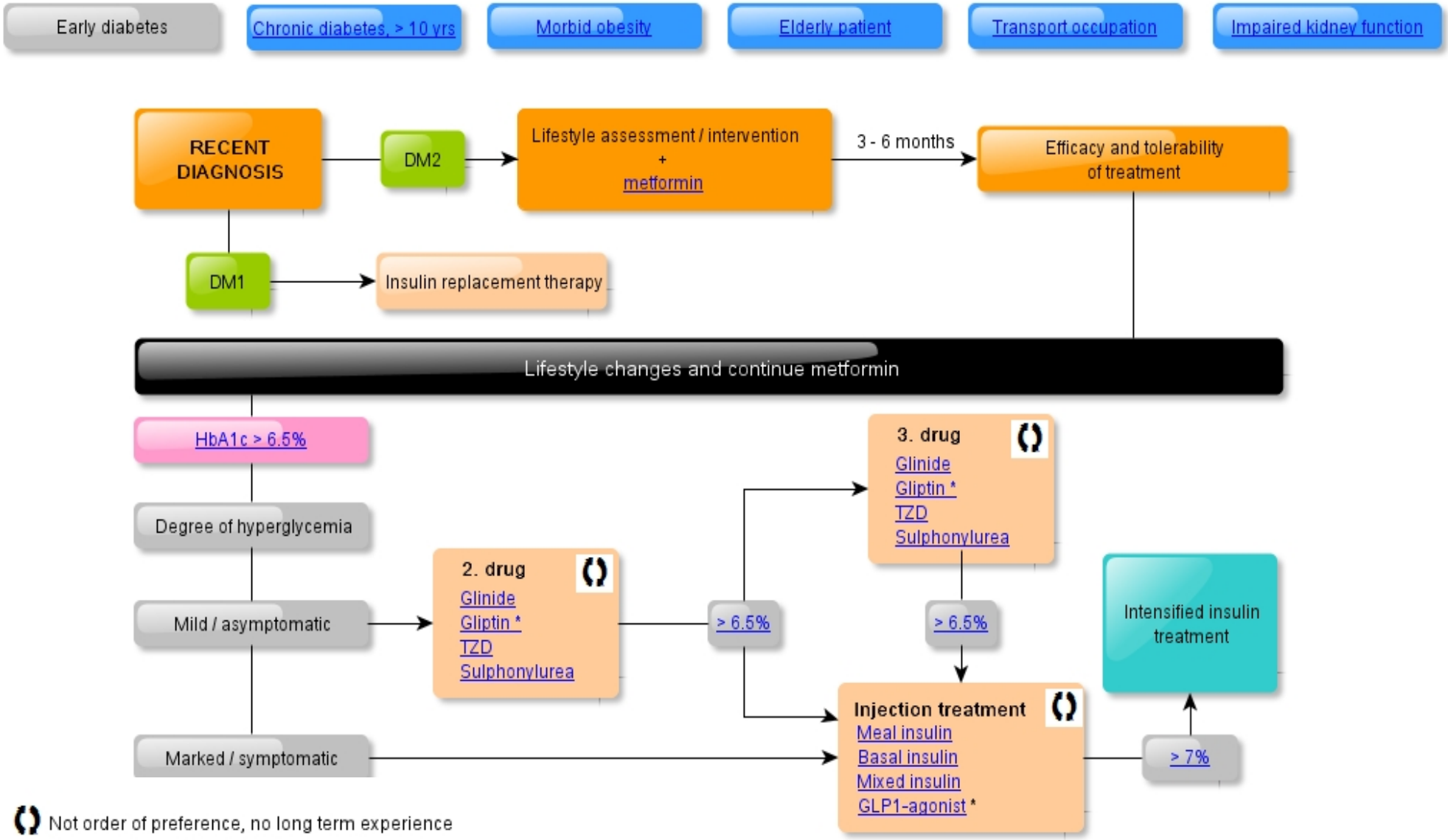
One of the first steps in the management of patients with type 2 diabetes mellitus is setting glycemic goals. Professional organizations advise setting specific hemoglobin $A_{1c}$ ($HbA_{1c}$) targets for patients, and individualization of these goals has more recently been emphasized. However, the operational meaning of glycemic goals, and specific methods for individualizing them, have not been well-described. Choosing a specific $HbA_{1c}$ target range for a given patient requires taking several factors into consideration, including an assessment of the patient's risk for hyperglycemia-related complications versus the risks of therapy, all in the context of the overall clinical setting. Comorbid conditions, psychological status, capacity for self-care, economic considerations, and family and social support systems also play a key role in the intensity of therapy. The individualization of $HbA_{1c}$ targets has gained more traction after recent clinical trials in older patients with established type 2 diabetes mellitus failed to show a benefit from intensive glucose-lowering therapy on cardiovascular disease (CVD) outcomes. The limited available evidence suggests that near-normal glycemic targets should be the standard for younger patients with relatively recent onset of type 2 diabetes mellitus and little or no micro- or macrovascular complications, with the aim of preventing complications over the many years of life. However, somewhat higher targets should be considered for older patients with long-standing type 2 diabetes mellitus and evidence of CVD (or multiple CVD risk factors). This review explores these issues further and proposes a framework for considering an appropriate and safe $HbA_{1c}$ target range for each patient.

*Ann Intern Med.* 2011;154:554-559. www.annals.org

For author affiliations, see end of text.

# Diabetes treatment algorithm from the Diabetes Current Care Guideline. Working group set up by the Finnish Medical Society Duodecim and the Finnish Society of Internal Medicine.

**Available from: www.terveysportti.fi/xmedia/ccs/varhainen_diabetes_en.html**




( ) Not order of preference, no long term experience

* No long term experience

Glucose lowering effect of different oral medications is rather similar

# Individual HbA1c target range