

# **ADA-EASD vs IDF 2011**

## ***Algoritmi a confronto***

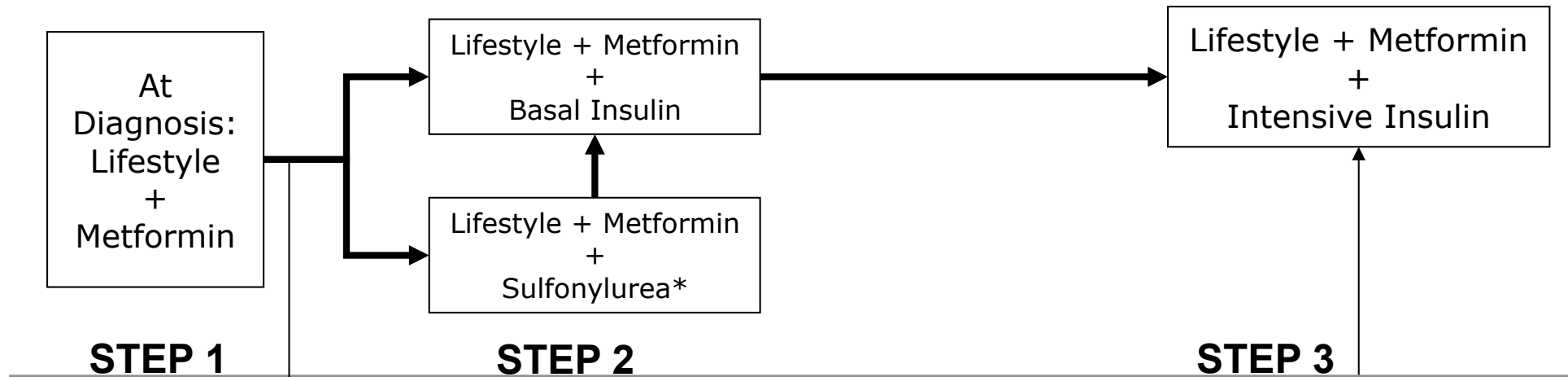
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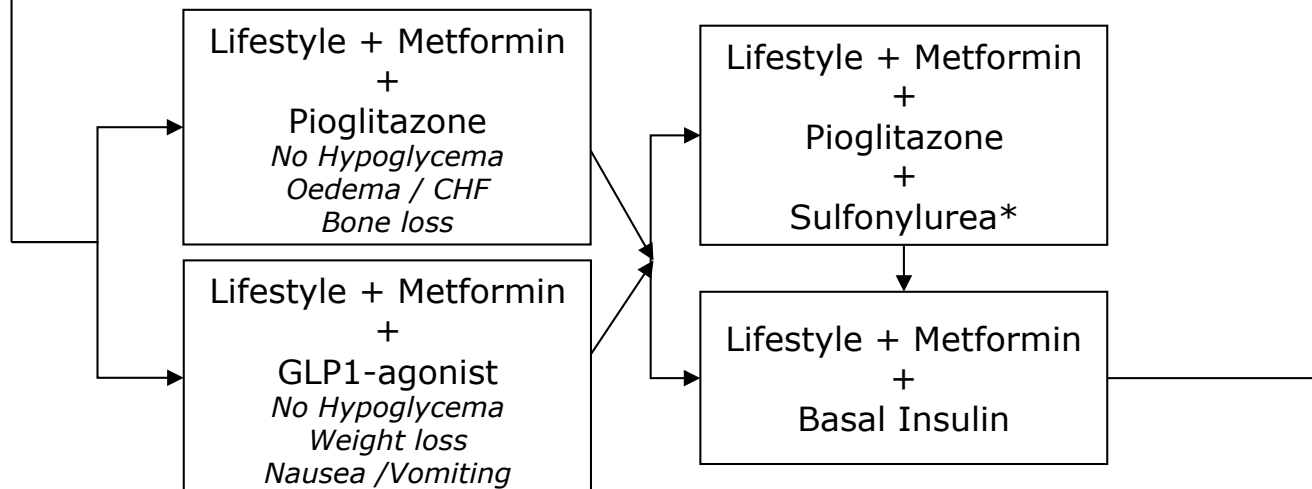
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# ADA / EASD consensus Management of hyperglycaemia in type 2 diabetes

## Tier 1: Well validated core therapies

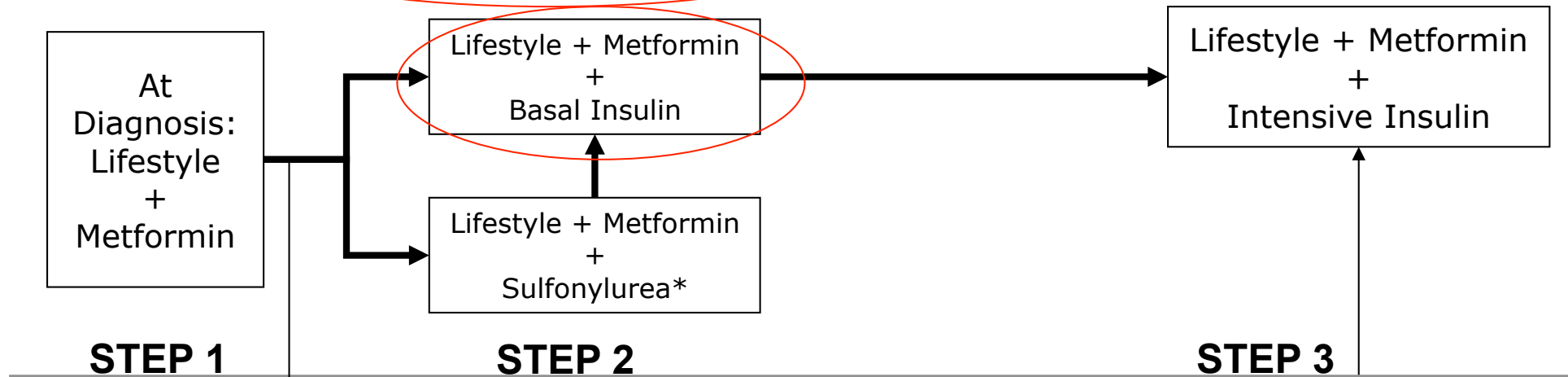


## Tier 2: Less well validated therapies

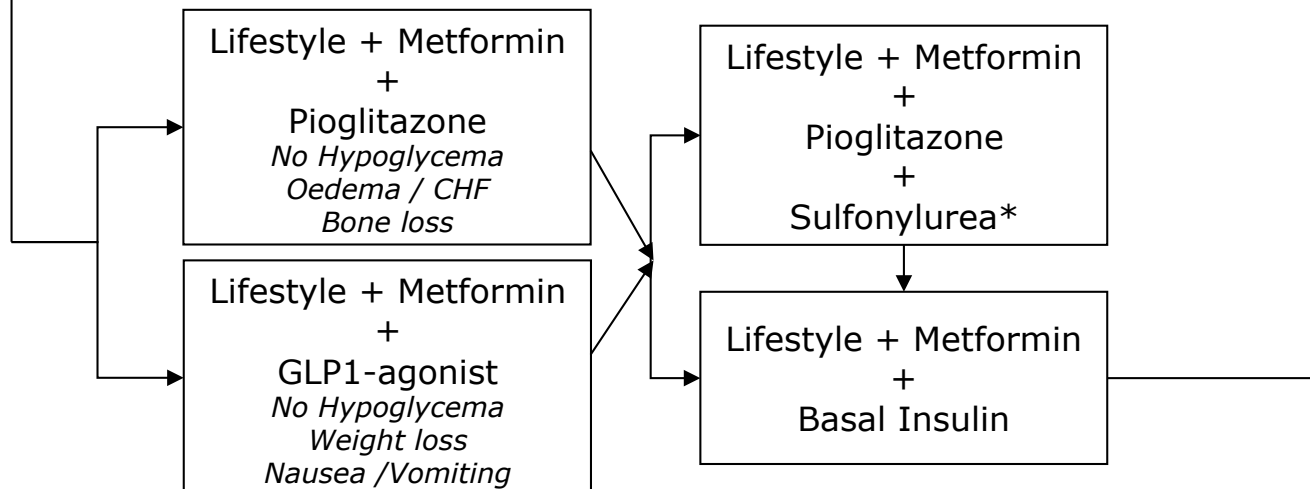


# ADA / EASD consensus Management of hyperglycaemia in type 2 diabetes

## Tier 1: Well validated core therapies



## Tier 2: Less well validated therapies



# Basal Analogues Approach

Start with 10 IU/day bedtime basal insulin and adjust weekly

Mean of self-monitored FPG values from preceding 2 days	Increase of insulin dosage (IU/day)
$\geq 180$ mg/dl (10 mmol/l)	8
140–180 mg/dl (7.8–10.0 mmol/l)	6
120–140 mg/dl (6.7–7.8 mmol/l)	4
100–120 mg/dl (5.6–6.7 mmol/l)	2

**Target FPG-Value < 100mg/dl (< 5.6 mmol/l)**

# Insulin Glargine vs NPH Insulin Added to Oral Therapy (Treat to Target Trial)

## Results

ITT Analysis	Insulin Glargine	NPH
FPG, mg/dL	117	120
mM	6.5	6.68
A1C, %	6.96	6.97
Final A1C $\leq$ 7% (% patients)	57	57
Nocturnal hypoglycemia		
Patients,* %	40	49
Events,† no.	532	886
Severe hypoglycemia		
Patients, %	2.5	2.3

\* $P < 0.01$ ; † $P < 0.002$

Riddle MC, et al., *Diabetes Care* 2003; 26: 3080-3086.

# Basal Insulin to OHA

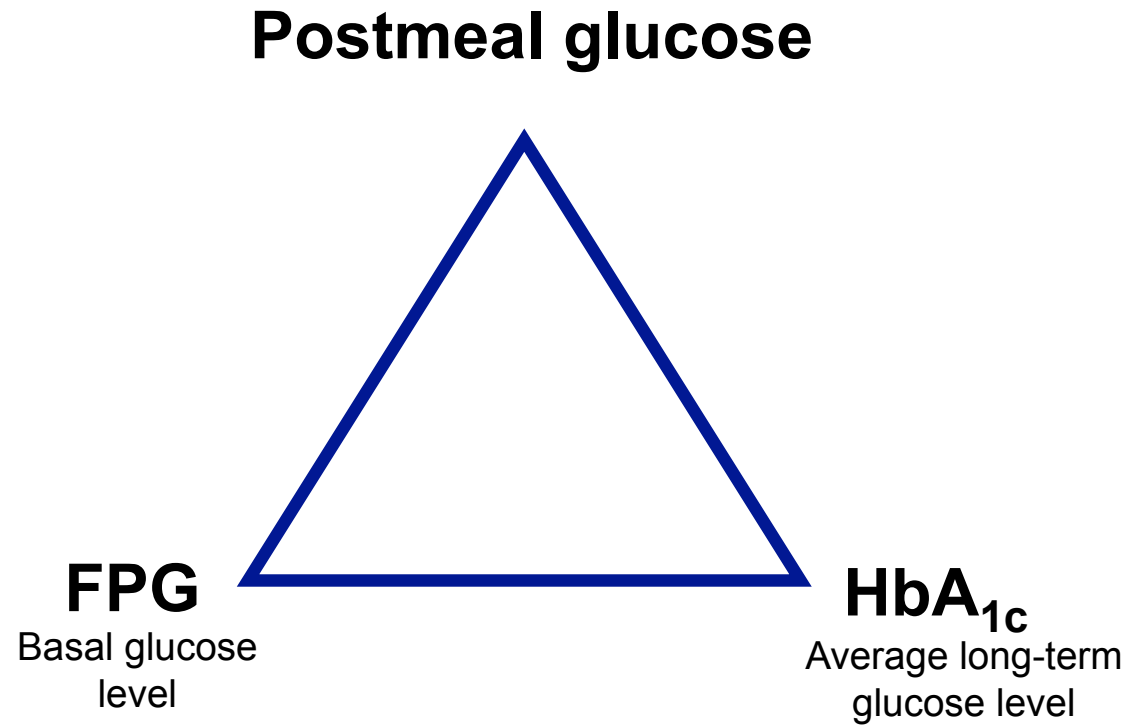
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Basal insulin to continued OHA therapy (including metformin) is a simple and effective means of introducing insulin therapy.

It is not clear whether this initiation regimen will prove durable in maintaining longer-term glycaemic control.

→ **Clinical experience suggests not**

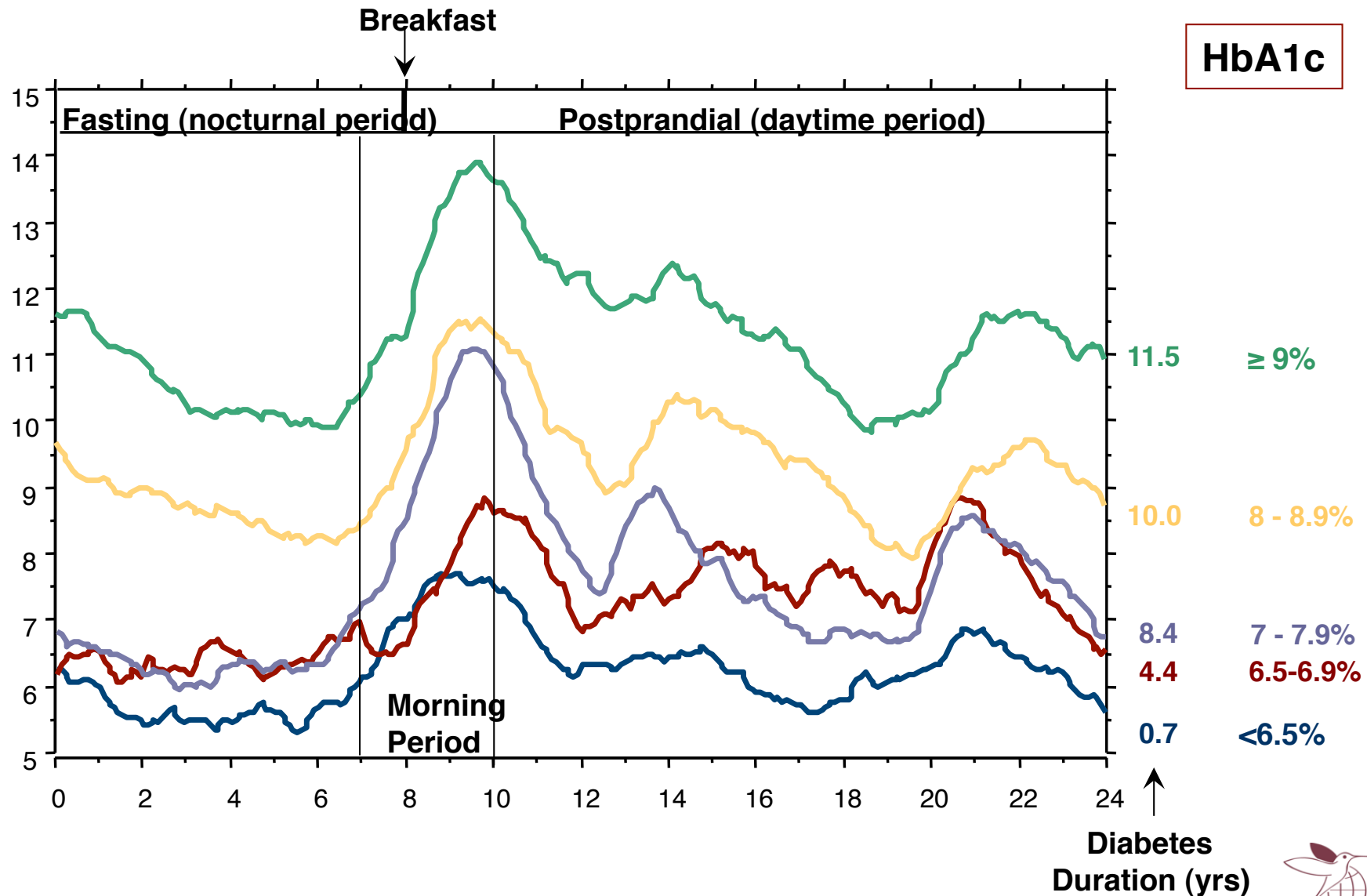
# 'Glucose triad' of diabetes management



HbA<sub>1c</sub> = glycated haemoglobin  
FPG = fasting plasma glucose



# Daily glycaemic variation (mmol/L) with worsening glycaemic control in type 2 diabetes





# Optimal Insulin Regimens in Type 2 Diabetes mellitus: systematic review and meta-analyses

## CONCLUSIONS/INTERPRETATION:

Greater HbA(1c) reduction may be obtained in type 2 diabetes when insulin is initiated using biphasic or prandial insulin rather than a basal regimen, but with an unquantified risk of hypoglycaemia.

Studies with longer follow-up are required to determine the clinical relevance of this finding.

Lasserson D.S. et al. Diabetologia 2009; 52:1990-2000.

# Efficacy of insulin analogs in achieving the hemoglobin A1c target of <7% in type 2 diabetes: meta-analysis of randomized controlled trials.

## **CONCLUSIONS:**

A greater proportion of type 2 diabetic patients can achieve the HbA(1c) goal <7% with biphasic or prandial insulin compared with basal insulin; in absolute terms, the basal-bolus regimen was best for the attainment of the HbA(1c) goal.

Giugliano D. et al. Diabetes Care 2011; 34:510-517..

**Consensus algorithm of the American  
Diabetes Association and the European  
Association for the Study of Diabetes: some  
concerns.**

**A. Ceriello**

Diabetologia 2009; 52:1696-1697

Is the ADA/EASD algorithm for the  
management of type 2 diabetes (January 2009)  
based on evidence or opinion?  
*A critical analysis.*

G. Schernthaner, A. H. Barnett, D. J. Betteridge, R. Carmena,  
A. Ceriello, B. Charbonnel, M. Hanefeld, R. Lehmann,  
M. T. Malecki, R. Nesto, V. Pirags, A. Scheen, J. Seufert,  
A. Sjöholm, A. Tsatsoulis, and R. DeFronzo

*Diabetologia* 2010; 53: 1258–1269

Is the ADA/EASD algorithm for the  
management of type 2 diabetes (January 2009)  
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In our view, this algorithm does not offer physicians and patients the appropriate selection of options to individualise and optimise care with a view to sustained control of blood glucose and reduction both of diabetes complications and cardiovascular risk. This paper critically assesses the basis of the ADA/EASD algorithm and the resulting tiers of treatment options.

*Diabetologia* 2010; 53: 1258–1269

# The New IDF Therapeutic Algorithm

