The 2023 ADA Standards of Care: What's new?

The American Diabetes Association (ADA)'s Standards of Care in Diabetes are "living guidelines" and are updated throughout the year as significant new evidence becomes available, with a full update published each January. This At a glance factsheet highlights key changes that were published in January 2023. Although some sections of the Standards reflect US practice, diabetes care is becoming more globally unified, so most recommendations are relevant to healthcare professionals in the UK. Where these differ, comparisons are made with UK recommendations.

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General changes

The summary of revisions section helps to identify where changes to care delivery may be needed.

The 2022 ADA/EASD joint consensus on hyperglycaemia[1], including the updated management algorithm, has been fully incorporated into the 2023 Standards. See our previously published resources for concise summaries of these recommendations:

- Summary of Consensus Report changes.
- Summary of nutrition and lifestyle advice.

Emphasis on weight loss throughout

Throughout the guidance and within the treatment algorithms, weight loss is now given equal importance to glycaemic control, CVD, heart failure and renal disease. Encouragement to lose weight should underpin type 2 diabetes care:

- Relatively small weight loss (approximately 3–7% of baseline weight) improves glycaemia and other intermediate cardiovascular risk factors.
- Larger, sustained weight loss (10–15%), achievable with total diet replacements or current pharmacotherapy, usually confers greater benefits, including disease-modifying effects and possible remission of type 2 diabetes, and may improve long-term cardiovascular outcomes and mortality.

Language matters

The term behaviour change has been updated to **"positive health behaviours"** to highlight the importance of positive language. Other sections remind us of the importance of the language we use, including the need to ensure that consultations and resources are available in the person's own language whenever possible.

- In the author's experience, although consultations via LanguageLine take longer, this is more than compensated by the benefits of allowing the person to discuss their health in their chosen language.

Limited literacy and numeracy skills may detrimentally impact understanding when sharing results, interpreting self-monitoring results or agreeing targets.

Nutrition

Table 5.1 of the Standards (based on Evert et al[2]) summarises ADA guidance on nutrition.

No single dietary pattern is best for all people with type 2 diabetes, hence there is freedom to individualise advice.

Time-restricted eating (TRE) and intermittent fasting are included, and are supported by studies demonstrating a short-term weight loss of 3–8%, similar to that achieved with daily calorie restriction.

- In the author's personal practice, as dietitian access remains limited, TRE is quick and easy to discuss since no calorie counting is required.
- However, there are also books and online resources to guide calorie restriction, meaning we can also make rapid recommendations if we have identified suitable resources.

The Mediterranean diet still has the strongest evidence for delaying progression to type 2 diabetes, and for primary and secondary CVD prevention. There are long-term secondary CVD prevention benefits compared with a low-fat diet: type of fat and other nutrients is important, rather than total fat intake (see CORDIOPREV study[3]).

Food insecurity

Since the beginning of the pandemic, food insecurity has become a greater issue. The ADA recommends formal questioning, and to consider households at risk if the person confirms one or both of the following statements:

"Within the past 12 months:

- *"we worried whether our food would run out before we got money to buy more."* **or**
- *"the food we bought just didn't last, and we didn't have money to get more."*

Lifestyle advice

The **"5S framework"** in Figure 5.1 of the Standards summarises the importance of 24-hour physical behaviours, including **S**tepping, **S**weating (moderate-to-vigorous activity), **S**trengthening, **S**itting (broken up by movement) and **S**leep. The figure facilitates brief discussions on positive health behaviours, and can be supplemented by our At-a-glance lifestyle factsheets.

Complications – CVD, CKD and NAFLD

CVD is common and causes most mortality in people with type 2 diabetes. The UK CVD treatment landscape has changed, with the updated NICE type 2 diabetes guideline recommending early combination therapy with metformin and an SGLT2 inhibitor in those with or at high risk of CVD. This is in line with the 2022 ADA/EASD consensus.

However, LDL-cholesterol targets remain important, and there is clear guidance from the ESC and EAS on individualising targets to the level of CVD risk.

Achieving 50% LDL reductions and statin intolerance and non-adherence remain significant challenges. Despite studies suggesting that statin intolerance rates are around 10%, real-world data suggest much higher discontinuation rates. NHS England's statin intolerance pathway is useful in ensuring best practice assessment and action.

- Combination therapy with moderate-potency statins plus ezetimibe may be better tolerated than high-potency statin monotherapy.
- It may be sensible to think of lipid lowering in the same way as blood pressure management: adding additional therapies until target LDL reductions are achieved. This may be a significant change from current practice.

NICE has published a draft update to its 2014 CG181 guideline on CVD, making new recommendations on risk assessment tools, cardioprotective diets and statin treatment. The new guideline is expected in May 2023.

CKD

In the UK, NICE and other guidelines on chronic kidney disease (CKD) and hypertension in type 2 diabetes should inform our practice, and these differ from those in the ADA Standards.

NAFLD and NASH

The 2023 Standards section on diagnosis and management of non-alcoholic fatty liver disease (NAFLD) has been updated, in the face of a predicted epidemic of non-alcoholic steatohepatitis (NASH).[4]

Around 25% of the UK adult population is believed to have NAFLD, and diabetes is a risk factor for worse outcomes, including progression to fibrosis and cirrhosis,[5] as well as increased mortality from cardiovascular disease, liver disease and hepatocellular carcinoma.

The ADA reminds us that normal liver function tests (LFTs) do not rule out NAFLD. Those with persistently elevated LFTs should be investigated, and fatty liver on ultrasound or abnormal LFTs should prompt non-invasive fibrosis assessment using FIB-4 or NAFLD fibrosis scores, with further investigation or referral for intermediate fibrosis risk and referral for high risk scores.

- For those at low fibrosis risk, 5–10% weight loss and CVD risk reduction strategies (smoking cessation, lipid and blood pressure control) are recommended in primary care, with reassessment of fibrosis risk every 3 years.
  - ➤ Those with type 2 diabetes should be treated with SGLT2 inhibitors or GLP-1 receptor agonists, which facilitate weight loss and reduce CVD risk.

It is likely we all have a large undiagnosed burden of NAFLD/NASH and fibrosis in our practice, and the British Association for the Study of the Liver and the British Society of Gastroenterology have developed quality standards for the management of NAFLD which could facilitate useful audits and improve care.

Other sections

Pregnancy

The pregnancy update includes strengthened guidance on nutrition, tighter blood pressure recommendations and breastfeeding actively encouraged. Weight loss following gestational diabetes (GDM) reduces the risk of GDM in subsequent pregnancies and the risk of future type 2 diabetes (each unit of BMI increase from pre-pregnancy weight increases type 2 diabetes risk by 16%).

Autonomic neuropathy and foot care

We are reminded to screen for autonomic neuropathy by asking about and looking for orthostatic hypotension, syncope or dry cracked skin on the extremities, as well as to exclude peripheral arterial disease by assessing lower-extremity pulses, capillary refill time, rubor on dependency, pallor on elevation and venous filling time.

Use of ankle–brachial index and vascular assessment, as well as ensuring multidisciplinary foot care assessment and management for those with high-risk feet, may reduce ulceration and amputation risk and ensure access to the full range of therapies and bespoke footwear.

Care of older people

In older people, the ADA strongly encourages holistic assessment of geriatric syndromes such as polypharmacy, cognitive impairment, depression, urinary incontinence, falls, persistent pain and frailty, as these may interfere with self-management and should influence treatment choices and targets.

Agreeing individualised glycaemic targets between 53 and 64 mmol/mol, avoiding hypoglycaemia or osmotic symptoms, simplification of drug regimens and de-escalation of treatment, where appropriate, are key recommendations.

CGM

We are reminded to consider whether people using insulin may benefit from continuous glucose monitoring (CGM). The potential benefits of agreeing specific glycaemic targets in the consultation are highlighted, based on a recent meta-analysis.[6]

UK guidance on CGM has recently been reviewed in this journal.

References

References can be viewed in the online version of this article.