



The ADA/EASD type 2 diabetes consensus 2026: What's new?

The 2026 consensus report on the management of type 2 diabetes by the American Diabetes Association (ADA) and European Association for the Study of Diabetes (EASD) takes a broader view than their previous consensus documents, focusing more widely than just on hyperglycaemia. The consensus now covers holistic management of type 2 diabetes, its complications and associated multiple long-term conditions. The document was launched at the EASD Annual Meeting and simultaneously published open-access in [Diabetologia](#) and [Diabetes Care](#). Pam Brown summarises the key changes to the guidance, and readers are particularly recommended to view the figures and tables linked in this summary.

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The 2026 guideline takes a wider view than the previous ADA/EASD consensus reports. Beyond hyperglycaemia management, the consensus now covers holistic management of type 2 diabetes, its complications and associated multiple long-term conditions (MLTCs).

Two key areas are highlighted:

- Promoting healthy lifestyle behaviours – healthy eating, 24-hour physical behaviours (including sleep, avoiding tobacco and substance use), psychological support and weight management.
- Earlier use – potentially from diagnosis – of SGLT2 inhibitors and/or GLP-1-based therapies is recommended to provide organ protection and improve long-term outcomes.
 - Earlier combination therapy with these two drug classes should be considered in people with cardiovascular disease (CVD), chronic kidney disease (CKD) and heart failure.
 - Throughout the consensus, recommendations are for use of specific drugs within the classes which have **proven benefit**.
 - GLP-1-based therapy includes GLP-1 receptor agonists and the dual GIP/GLP-1 receptor agonist tirzepatide, **except where semaglutide is stated**.

The terms “should” and “could” are used to distinguish between **recommended** and **optional** therapeutic guidance.

Key changes – what's new?

- Rigorous evaluation of new evidence regarding type 2 diabetes management published in English since 2022.
- Broader focus on holistic type 2 diabetes management rather than only hyperglycaemia, including associated complications such as metabolic dysfunction-associated steatotic liver disease/steatohepatitis (MASLD/MASH) and obstructive sleep apnoea.
- Incorporation and updating of detailed guidance on medical nutrition therapy and the “5S” 24-hour lifestyle behaviours, previously published separately.
- Focus on weight management, particularly in those with early-onset type 2 diabetes and for remission.
- Review of evidence and implementation of cardio-kidney-metabolic benefits of drug therapies.

- Early use of SGLT2 inhibitors and GLP-1-based therapies, ideally from diagnosis.
- Less certainty about the requirement for metformin first-line to support SGLT2 inhibitors and GLP-1-based therapies.
- Semaglutide recommended for people with CKD, HFpEF with obesity, and/or peripheral arterial disease.
- Consideration of semaglutide and SGLT2 inhibitors for those at high risk of atrial arrhythmias.
- Consider secondary causes such as hypercortisolism in those with apparent drug-resistant hyperglycaemia.

Overview framework

A holistic, anticipatory, integrated care approach to addressing type 2 diabetes and its associated long-term conditions, [available here](#), includes three important considerations: complex pathophysiology, across the life course, and environmental and social determinants of health. The management overview highlights four key processes:

Improving detection and diagnostic accuracy

- Risk-based screening, including in those with overweight/obesity, to identify the 25–50% of people with diabetes who are undiagnosed.
- Diagnostic accuracy: If atypical phenotype, consider autoantibody screening or C-peptide testing. Consider alternative diagnoses, including secondary diabetes.

Integrated diagnosis and surveillance for diabetes complications and associated long-term conditions

- Longitudinal surveillance for traditional complications and MLTCs.
- Additional surveillance for obesity-related complications, physical function, psychological and mental health conditions, periodontal disease, men's and women's health needs, and vaccination status.

Goals of care – outcomes beyond glycaemic management

- Addressing broader care goals, including cardio-kidney protection, physical function, wellbeing and quality of life, weight management and obesity-related complications.

Holistic, person-centred interventions in type 2 diabetes

- Medical nutrition therapy, 24-hour physical behaviours (5Ss), diabetes self-management education and support programmes (DSMES).
 - DSMES programmes should be offered to everyone, and self-management education should be revisited regularly.
- Evidence-based pharmacological interventions that provide management of glycaemia and weight, provide organ protection, prevent MLTCs and optimise cardiovascular risk factors.
- Prevent complications by incorporating SGLT2 inhibitor and/or GLP-1-based therapy early to modify disease and complication risk.

Therapeutic options: Healthy lifestyle behaviours, weight management and pharmacotherapy

Medical nutrition therapy (personalised dietary interventions)

Available dietary patterns and their metabolic effects are [summarised here](#).

- A healthy-eating plan resulting in an energy deficit should be used with medications and/or metabolic surgery.
- Mediterranean, low-energy, intermittent-fasting, ketogenic and low-carbohydrate diets may help support energy deficit for weight loss.
- Recognition that no single ratio of carbohydrate, protein and fat intake is optimal for every person. Quality and quantity are important to achieve calorie deficit.
- Personalised eating patterns should be encouraged, minimising harmful foods, aiming to develop healthy, feasible and sustainable long-term dietary habits.
- Consider a Mediterranean pattern for people with atherosclerotic CVD, if feasible and acceptable.
- Consider offering intensive lifestyle therapy to achieve 10–15% weight loss and remission.
- Supplements are not recommended for glucose management.

24-hour physical behaviours

The 5S framework, previously published and now incorporated in the consensus, is [summarised here](#), alongside **actionable guidance on prescribing 24-hour behaviours**:

- Standing as much as possible, Stepping, Sweating (aerobic activity), Strengthening (resistance exercise), Sleeping (quantity, quality and timing).
- Encourage resistance exercise during weight-loss interventions to preserve skeletal muscle mass and strength.
- Progressively encourage increased volume and intensity of physical activity when feasible and safe.
- Consider MLTCs and frailty when recommending physical activity.

Pharmacotherapy for treatment of type 2 diabetes

The [algorithm for use of glucose-lowering medications](#) in type 2 diabetes has been updated. SGLT2 inhibitors and/or GLP-1-based therapies are recommended early in care to prevent complications associated with type 2 diabetes.

- Continues to highlight lifestyle behaviour therapy, DSMES and addressing social determinants of health alongside drug therapy.
- Importance of avoiding therapeutic inertia and regular reviews.
- Personalised approach, with six tracks based on individual characteristics and associated long-term conditions:
 - Achieve and maintain glycaemic goals.
 - Weight management.
 - Atherosclerotic cardiovascular disease.
 - Chronic kidney disease.
 - Heart failure
 - MASLD or MASH.

Evidence of benefits for glucose-lowering drugs are summarised in *Box 1* (overleaf). Within the consensus report, these benefits and the clinical considerations for the different drug classes are [summarised here](#).

Weight and body composition management beyond lifestyle interventions

- Semaglutide and tirzepatide most effective.
- Tirzepatide leads to greater weight loss but has not been compared with high-dose semaglutide (subcutaneous or oral) or orforglipron.
- Metabolic surgery **could** be considered for people with type 2 diabetes and a BMI ≥ 30 kg/m² and **should** be considered for people with a BMI ≥ 35 (reduce BMI thresholds by 2.5 kg/m² for people of Asian ancestry).

Personalised approach to treatment based on individual characteristics and MLTCs

[This is summarised here](#). **Note:** Medication choices should not differ by race, ethnicity (although earlier initiation or intensification may be required after assessment) or sex.

Glucose-lowering therapies

- Along with DSMES and health behaviour interventions, most people will benefit from early introduction of SGLT2 inhibitor and/or GLP-1-based therapy, potentially from diagnosis.
- Choice of glucose-lowering therapy should be based on weight, other long-term conditions, adverse event profile, preferences and personal circumstances.
- When insulin is indicated (usually in addition to GLP-1-based therapies), initiate basal insulin. Maintain other glucose-lowering therapies with CVD and CKD benefits.
- De-intensify if there is hypoglycaemia risk – especially in frailty.
- Screen for secondary causes of hyperglycaemia (e.g. hypercortisolism) in adults with treatment-resistant type 2 diabetes despite multiple agents.

Cardiorenal-protective glucose-lowering medications

Cardiovascular disease:

- SGLT2 inhibitors and GLP-1-based therapies provide CVD benefits independent of metformin and should be considered first-line, individualised based on absolute cardio-kidney risk at baseline.

- If established CVD, use GLP-1-based therapies and/or an SGLT2 inhibitor, as in previous consensus.
- Combination therapy with SGLT2 inhibitor and GLP-1-based therapies could be considered in those at **high CVD risk** (age ≥ 55 years, obesity, hypertension, smoking, dyslipidaemia, albuminuria) or established CVD or CKD – irrespective of HbA_{1c} levels.
- If **peripheral arterial disease**, consider semaglutide (to improve symptoms).
- If **no CVD but multiple risk factors** (see above), GLP-1-based therapy and/or an SGLT2 inhibitor could be considered.
- Any **heart failure (irrespective of ejection fraction)**: SGLT2 inhibitors recommended.
 - HFpEF with obesity: semaglutide or tirzepatide.
 - HFpEF or HF with mildly reduced ejection fraction: a non-steroidal MRA should be used.
- **CKD with albuminuria**: add a non-steroidal MRA if eGFR is over 25 mL/min/1.73 m².
- **Atrial arrhythmias**: semaglutide associated with a 27% reduction in atrial fibrillation risk and a 78% reduction in AV block in type 2 diabetes. SGLT2 inhibitors have anti-arrhythmic benefits and reduce new-onset atrial fibrillation compared with GLP-1-based therapy or DPP-4 inhibitors.

Chronic kidney disease:

- SGLT2 inhibitors **should** be used irrespective of uACR or albuminuria. Continue until renal replacement therapy.
- GLP-1-based therapies **could** be added to improve kidney, HFpEF and MACE outcomes; semaglutide is indicated to reduce risk of CKD progression.
- If **CKD and uACR >3 mg/mmol**, add a non-steroidal MRA to improve kidney and heart failure outcomes.
- Early combination therapy if CVD, CKD and heart failure.
- Choose individual SGLT2 inhibitors and GLP-1-based therapies based on:
 - Country-specific availability.
 - Efficacy, safety and outcome evidence.

Individualise treatment based on cardio–kidney risk and time horizon; absolute benefit is substantially greater in people at higher cardio–kidney risk.

Younger people

- Interventions targeting weight reduction are essential in early-onset type 2 diabetes.
- Early use of SGLT2 inhibitors and GLP-1-based therapies, alone

Box 1. Benefits of glucose-lowering drugs demonstrated in clinical trials.

SGLT2 inhibitors:

- Reduce HbA_{1c} in type 2 diabetes.
- Reduce risk of major adverse cardiovascular events (MACE), cardiovascular death, myocardial infarction, hospitalisation for heart failure and all-cause mortality in people with type 2 diabetes and established or high risk of CVD.
- Improve kidney outcomes, including development of kidney failure and cardiovascular mortality, in people with type 2 diabetes and CKD.
- Longer-term studies have not confirmed significant increased risks of acute kidney injury, dehydration, orthostatic hypotension, amputation or fractures suggested in early studies.

GLP-1 RAs:

- Reduce HbA_{1c} in type 2 diabetes.
- Reduce MACE in type 2 diabetes and established CVD (dulaglutide, liraglutide, subcutaneous and oral semaglutide) or multiple CVD risk factors (dulaglutide).
- Reduce CKD progression risk in people with type 2 diabetes and CKD (subcutaneous semaglutide).
- Improve heart failure symptoms in people with HFpEF, type 2 diabetes and obesity (subcutaneous semaglutide).
- Improve liver histology in people with MASLD and moderate or advanced liver fibrosis (subcutaneous semaglutide).
- Higher doses available for chronic weight management (subcutaneous liraglutide 3 mg daily; subcutaneous semaglutide 1.7 mg, 2.4 mg or 7.2 mg weekly; oral semaglutide 25 mg daily; oral orforglipron 9.0 mg, 14.5 mg or 17.2 mg daily).

Tirzepatide (GIP/GLP-1 RA):

- Reduces HbA_{1c} in type 2 diabetes.
- Improves liver fat content and visceral and subcutaneous fat volume.
- Improves symptoms in obstructive sleep apnoea with obesity, and in HFpEF with obesity.
- In SURPASS-CVOT study in people with type 2 diabetes and atherosclerotic CVD, tirzepatide was non-inferior to dulaglutide, which had previously been shown to reduce MACE, resulting in regulatory approval to reduce MACE in adults with type 2 diabetes at high risk of cardiovascular events.

Metformin:

- High efficacy in lowering HbA_{1c}.
- Weight-neutral and potential for modest weight loss.
- However, sub-analyses suggest that CVD and CKD benefits with SGLT2 inhibitors and incretin therapies may be independent of metformin use; therefore, the consensus makes its use optional.

DPP-4 inhibitors:

- Weight-neutral.
- Cardiovascular safety but no risk reduction.
- No benefit on eGFR.

or in combination, should be prioritised due to faster glycaemic deterioration and earlier onset of complications.

- Explicit counselling in women of reproductive potential regarding contraception and avoidance of pregnancy while taking these drugs.

Older people and frailty

- Medication choice should not differ in older people, but modify if appropriate for MLTCs or frailty.
- Be aware of potential for increased adverse effects of medications.

People with obesity-related conditions

MASLD and MASH:

- Weight reduction important – lifestyle interventions, including physical activity.
- Obesity, MASLD and type 2 diabetes, or type 2 diabetes and biopsy-proven MASH: GLP-1-based therapies should be preferred. Pioglitazone or tirzepatide could be used.
- Consider combination with pioglitazone and GLP-1-based therapies and continue other glucose-lowering drugs as required.
- If decompensated cirrhosis, use insulin.
- If moderate or advanced liver fibrosis (stages 2 or 3), refer to hepatology to consider treatment with a thyroid hormone receptor beta-agonist (e.g. resmetirom).

Obstructive sleep apnoea:

- If obesity, type 2 diabetes and OSA, tirzepatide or a GLP-1 RA with proven benefit could be prioritised.

Cognitive decline

- Insufficient evidence to support specific glucose-lowering drugs. Prioritise safety and simplicity.

Technology

- Consider evidence-based diabetes technologies with proven benefit in people with type 2 diabetes as adjunctive tools within a comprehensive, integrated diabetes management plan. Individualise based on clinical need, preferences and skill level.
- Consider continuous glucose monitoring in people living with type 2 diabetes, especially those on insulin.

Organisation of care

A “learning health system framework for quality and outcomes in type 2 diabetes” is recommended, [summarised here](#).

- Healthcare systems should be organised to deliver individualised care, integrated into the daily lives of people with type 2 diabetes.
- Care should be individualised with consideration of clinical risks, personal preferences and social determinants of health, including food security, housing stability and access to care.

- Management plans should incorporate all MLTCs and be informed by overall disease burden.
- Care delivery should use innovative models, including digital health tools and interprofessional team-based care, to expand access and support self-management.
- Establish mechanisms to identify and address inequities in evidence-based care delivery, ensuring care is affordable and accessible to all.

Knowledge gaps

Thirteen key knowledge gaps are identified. These are listed in Box 2.

Box 2. Knowledge gaps.

- Consensus on early intensive therapy, but no evidence base for HbA_{1c} targets <53 mmol/mol and CGM targets.
- Should the definition of remission be broadened beyond glycaemia, to include modification of associated long-term conditions, whether or not this requires medication?
- Need to develop optimal strategies to maintain remission over time.
- How can available treatments be optimally sequenced – when is enough enough?
- How should GLP-1-based therapies be used in those who do not require weight loss but do require cardiovascular and kidney protection?
- Trial evidence needed on early-onset type 2 diabetes and when to de-intensify in later life.
- How should GLP-1-based treatments be used in relation to pregnancy?
- How should adiposity be measured to best reflect the metabolic impact; what should targets be for medical and surgical weight-loss programmes?
- What are optimal lifestyle programmes to support GLP-1-based therapy to reach weight targets and preserve fat-free mass and function?
- Understand whether high doses of moderately effective weight-loss agents are equivalent to modest doses of highly effective agents. What are the optimum approaches for maintenance of weight loss?
- What should the evaluation strategy be for people with inadequate responses to generally effective therapies?
- A better understanding of the role of cortisol-directed therapy in type 2 diabetes is needed.
- Evidence needed for benefits of combining GLP-1-based therapy and SGLT2 inhibitors, and if there is an optimal sequence.

[Read the consensus statement in full here](#)