ADA/EASD Consensus Report update 2022: What's new?

he European Association for the Study of Diabetes (EASD) and the American Diabetes Association (ADA) have launched their updated <u>Consensus Report on the</u> <u>Management of Hyperglycaemia in Type 2 Diabetes</u>, which updates the previous consensus report (2018) and its update (2019). The latest iteration has an increased focus on managing weight loss, on person-centred care and on equity of care. In this short commentary, I outline the changes to the guidance.

What's new?

- Updated algorithm: Use of glucose-lowering medications and lifestyle in type 2 diabetes management. Features two sections:
 - ➤ A cardiorenal risk reduction section for high-risk patients, including those with or at high risk of atherosclerotic cardiovascular disease; heart failure; and chronic kidney disease. Treatment recommendations focus on SGLT2 inhibitors and GLP-1 receptor agonists, independent of metformin use.
 - ➤ A section on achieving and maintaining glycaemic control and weight management goals, focusing on drug efficacy (and including metformin) for the former and on lifestyle benefits and efficacy of weightreduction drugs for the latter.
- Use of the term "organ-protection" when using SGLT2 inhibitors and GLP-1 RAs for cardiorenal benefits.
- Increased focus on weight reduction, giving it equal status to glucose management in the treatment algorithm.
- More detailed guidance on lifestyle and healthy behaviour, including discussion of dietary patterns, time-restricted eating, physical activity and sleep.
 - Includes a figure (shown alongside) summarising the importance of 24-hour physical behaviours, including Stepping, Sweating (moderate-to-vigorous activity),

Strengthening, Sitting (broken up by movement) and Sleep.

- Updated summary of the cardiorenal outcome studies, including early data and updated meta-analyses on the potential benefits of using combinations of SGLT2 inhibitors and GLP-1 RAs. Network meta-analyses comparing the efficacy of different drug classes are also included.
- Specific guidance is outlined for older people, younger people, and those from different race and ethnicity groups, as well as summarising the impact of sex differences.

Practical tips for clinicians: Strategies for implementation

• **Integrated care:** Due to the life-long nature of the condition, aim for an integrated team and use technology where appropriate – know local resources.

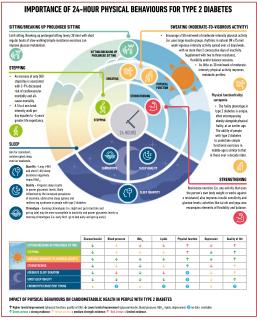
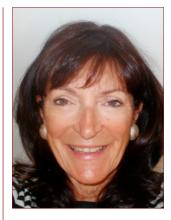
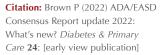


Figure. The importance of 24-hour physical behaviours for type 2 diabetes.

Image courtesy of *Diabetologia*. Click on the figure to access.



Pam Brown GP in Swansea



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Management of hyperglycaemia in typ	e 2 diab	rtes, 2022.
A consensus report by the American Di		
and the European Association for the S	tudy of I	Diabetes (EASD)
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- <u>Language matters</u> in all communications.
- Individualisation of care: Involve the person living with diabetes in all decision-making. Monitor and address inequity of care delivery and assess social determinants of health. Consider co-morbidities in management plans.
- Diabetes self-management education and support (DSMES): This is as important as drug treatments, so recommend to everyone. Know what is available locally and how to access; refer at diagnosis and at care transitions.
- Facilitate healthy behaviours and weight management: Ensure shared decision-making and agree goals; emphasise self-monitoring and review all data in consultations; discuss all aspects of hypoglycaemia in those taking sulfonylureas or insulin, ensure DSMES and medical nutrition therapy.
- Glucose-lowering therapies: Stay updated on efficacy and side effects of medications; identify and incorporate relevant co-morbidities; assess profile (younger, frail, cognitive impairment, social determinants of health); consider risk factors for adverse events; prioritise organprotective therapies (SGLT2is, GLP-1 RAs, TZDs) if the person has or is at high risk of cardiorenal disease or non-alcoholic steatohepatitis.
- Avoid therapeutic inertia: Consider initial combination therapy, especially if HbA_{1c} is >70 mmol/mol, in younger people and to avoid delay in access to cardiorenal protection; evaluate health behaviours, medication-taking and side effects at each visit; add therapies with complementary glucose-lowering actions; use fixed-dose combinations to reduce pill burden; de-intensify therapy as soon as appropriate (e.g. frail elderly, risk of hypoglycaemia).

- Insulin positioning: Consider a GLP-1 RA first; start with basal insulin; intensify in a timely way and titrate to the agreed fasting target; continue organ-protective glucoselowering medications and metformin; ensure DSMES when initiating or changing to basal-bolus regimens.
- **Technology:** Consider continuous glucose monitoring if on insulin; adapt clinic system to support behaviour change with self-monitoring.
- **Delivering improved care:** Ensure continuing education activities for all team members; use a team-based approach; incorporate continuous quality improvement interventions.

New and updated figures and resources

- Table 1: Summary of glucose-lowering medication characteristics, including clinical considerations.
- Figure 2: Importance of 24-hour physical behaviours for type 2 diabetes.
- Figure 3: Updated algorithm for use of glucose-lowering medications.
- Figure 4: Holistic patient-centred approach in type 2 diabetes management summarises and integrates the management recommendations from the whole document.
- Figure 5: Place of insulin (including how to initiate and titrate).

Additional resources are included in the Supplementary Materials linked to the online versions published in both *Diabetes Care* and *Diabetologia*.

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