# Diabetes ProTips

**The American Diabetes Association Standards of Medical Care in Diabetes (the Standards) is updated and published annually (in January) in Diabetes Care, with an abridged version for primary care providers published in Clinical Diabetes.**

Both of these important documents can be found online and downloaded free of charge at care.diabetesjournals.org.

The Standards is a "living document" and is updated on an ongoing basis when important new information (e.g., clinical evidence, regulatory approval/update) that may affect clinical care becomes available.

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**There are several updates in the 2022 Standards that may affect your clinical practice. Some of these, as well as some key previous recommendations, are listed below.**

## Glucose Management

Glycemic status (with A1C or other glycemic measurement such as time in range or glucose management indicator) should be assessed at least 2-times per year in patients meeting individualized treatment goals and at least quarterly (every 3 months) if therapy has recently been changed and/or treatment goals have not been achieved.

When choosing glucose-lowering medications for people with type 2 diabetes and overweight or obesity, the medication's effect on body weight should be considered.

In patients with type 2 diabetes, a GLP-1 receptor agonist is preferred to insulin, when possible.

For the treatment of type 2 diabetes, first-line therapy should be based on the individual patient's comorbidities (especially cardiovascular and renal disease), patient-centered treatment factors, and management needs and generally include metformin and comprehensive lifestyle modification.

In individuals with type 2 diabetes who have atherosclerotic cardiovascular disease (ASCDV) or who are at high risk for ASCVD, with heart failure and/or chronic kidney disease, a GLP-1 receptor agonist and/or SGLT2 inhibitor (with or without metformin) are appropriate initial therapies.

In persons with type 2 diabetes with these conditions, a GLP-1 receptor agonist and/or SGLT2 inhibitor is recommended independent of the A1C level.

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## Diagnosing and Preventing Diabetes and its Complications

For women who are planning pregnancy, screening for diabetes should be conducted in those with risk factors. It should also be considered for ALL women, regardless of risk factors, to detect undiagnosed diabetes prior to conception.

Persons with prediabetes should be monitored for the development of type 2 diabetes at least annually. This can be done with a fasting plasma glucose, an A1C (not point-of-care A1C), or 2-hr 75-gm oral glucose tolerance test (OGTT).

Persons with prediabetes should be considered for metformin therapy to help prevent type 2 diabetes. Particularly persons with prediabetes 25-59 years old with a BMI ≥35 kg/m$^2$, higher fasting plasma glucose (e.g., ≥110 mg/dL), and higher A1C (e.g., ≥6.0%), and women with prior history of gestational diabetes.

For all people, regardless of risk factors for type 2 diabetes, screening for prediabetes and diabetes should begin at age 35 years (previously, the recommendation was 45 years).

Prediabetes is associated with higher cardiovascular risk, so treating modifiable cardiovascular risk factors (e.g., hypertension, dyslipidemia, obesity, tobacco abuse), if they exist, is important in this patient population.

The goals of treatment for diabetes are to prevent or delay complications and optimize quality of life.

Non-alcoholic fatty liver disease (NAFLD) is more common and more progressive in persons with type 2 diabetes. Patients with indications of NAFLD (e.g., elevated liver enzymes or fatty liver on ultrasound) should be assessed for non-alcoholic steatohepatitis (NASH) and hepatic fibrosis.

We should be aware of the impact cost-related medication nonadherence may have on clinical outcomes, and cost should be a focus of treatment goals.

Chronic kidney disease (CKD) is the leading cause of end-stage renal disease (ESRD) in the United States. In people with type 1 or type 2 diabetes, the presence of CKD markedly increases cardiovascular risk.

A multifactorial approach must be used to reduce risk of diabetes complications including glycemic management, blood pressure management, lipid management, and use of agents with cardiovascular and kidney benefit (e.g., GLP-1 receptor agonist and/or SGLT2 inhibitor) when appropriate. All of these should be addressed on a foundation of lifestyle modification and diabetes education.

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## Self-Care Behaviors

The term “self-monitoring of blood glucose (SMGB)” has been replaced by “blood glucose monitoring (BGM)” and “smart pens” are referred to as “connected insulin pens.”

“Emerging evidence demonstrated the benefit of telemedicine or internet-based diabetes self-management education and support (DSMES) services for diabetes prevention and the management of type 2 diabetes.”

## Research and Other Recommendations

Immunization recommendations specific to person with diabetes should be followed, including COVID-19 immunization. These can be found at www.cdc.gov/vaccines/

Glucagon should be prescribed to all persons with diabetes at increased risk of level 2 (<54 mg/dL) or level 3 (severe) hypoglycemia.

Semaglutide 2.4mg once weekly was added to the table reviewing FDA approved medications for the treatment of obesity in adults.

A NAFLD special report was recently developed by the American Gastroenterological Association, with representatives of the ADA, entitled “Preparing for the NASH Epidemic: A call to Action” is available at https://doi.org/10.2337/dci21-0020

For patients with chronic kidney disease (CKD) at increased risk of cardiovascular events or CKD progression who cannot use a SGLT2 inhibitor, a nonsteroidal mineralocorticoid receptor agonist (finerenone) is recommended.

Become a member of the LifeScan Diabetes Institute here: **www.lifescandiabetesinstitute.com** to have full access to all of our resources for healthcare professionals.