
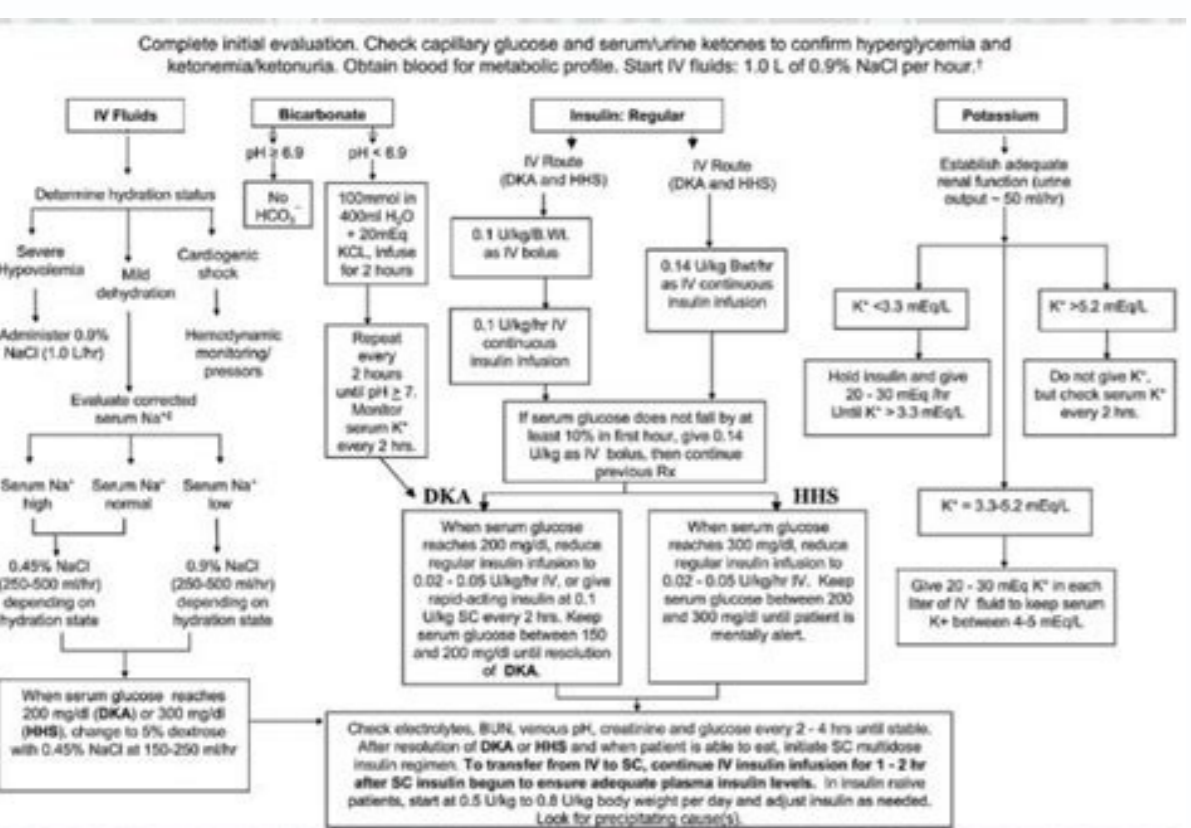


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Kitach AE, Umpeze GE, Miles JM, et al. Hyperglycemic crises in adult patients with diabetes: a consensus statement from the American Diabetes Association. *Diabetes Care*. 2009;32:1335-1345.

American Diabetes Association (ADA) 2014 Guidelines Summary Recommendations from NDD

Source: American Diabetes Association. Standards of medical care in diabetes—2014. *Diabetes Care*. 2014;37(suppl 1):S14-S80. Refer to source document for full recommendations, including level of evidence rating.

ODS Screening and Treatment

Screening: Screen for ODS in all patients with type 2 diabetes at diagnosis and in all patients with type 1 diabetes at diagnosis and every 2-4 years thereafter. Screen for ODS in all patients with type 2 diabetes at diagnosis and in all patients with type 1 diabetes at diagnosis and every 2-4 years thereafter.

Management of High Blood Pressure

Screening: Screen for high blood pressure in all patients with diabetes at diagnosis and every 2-4 years thereafter.

Management: Treat high blood pressure to a goal of < 130/80 mmHg. In patients with diabetes and high blood pressure, treatment should be initiated when blood pressure is > 130/80 mmHg. In patients with diabetes and high blood pressure, treatment should be initiated when blood pressure is > 130/80 mmHg.

American Diabetes Association (ADA) 2014 Guidelines Summary Recommendations from NDD

Source: American Diabetes Association. Standards of medical care in diabetes—2014. *Diabetes Care*. 2014;37(suppl 1):S14-S80. Refer to source document for full recommendations, including level of evidence rating.

Criteria for Diabetes Diagnosis

A1C ≥ 6.5%
 FPG ≥ 126 mg/dL (7.0 mmol/L)
 2-hr PG ≥ 200 mg/dL (11.1 mmol/L) during OGTT (75g)
 Random PG ≥ 200 mg/dL (11.1 mmol/L) with symptoms of hyperglycemia

Frequency of A1C Testing

Perform A1C test

At least 2 times each year in patients who are meeting treatment targets and have stable glycemic control

Quarterly in patients whose therapy has changed or who are not meeting glycemic targets

Point-of-care A1C testing allows for more timely treatment changes

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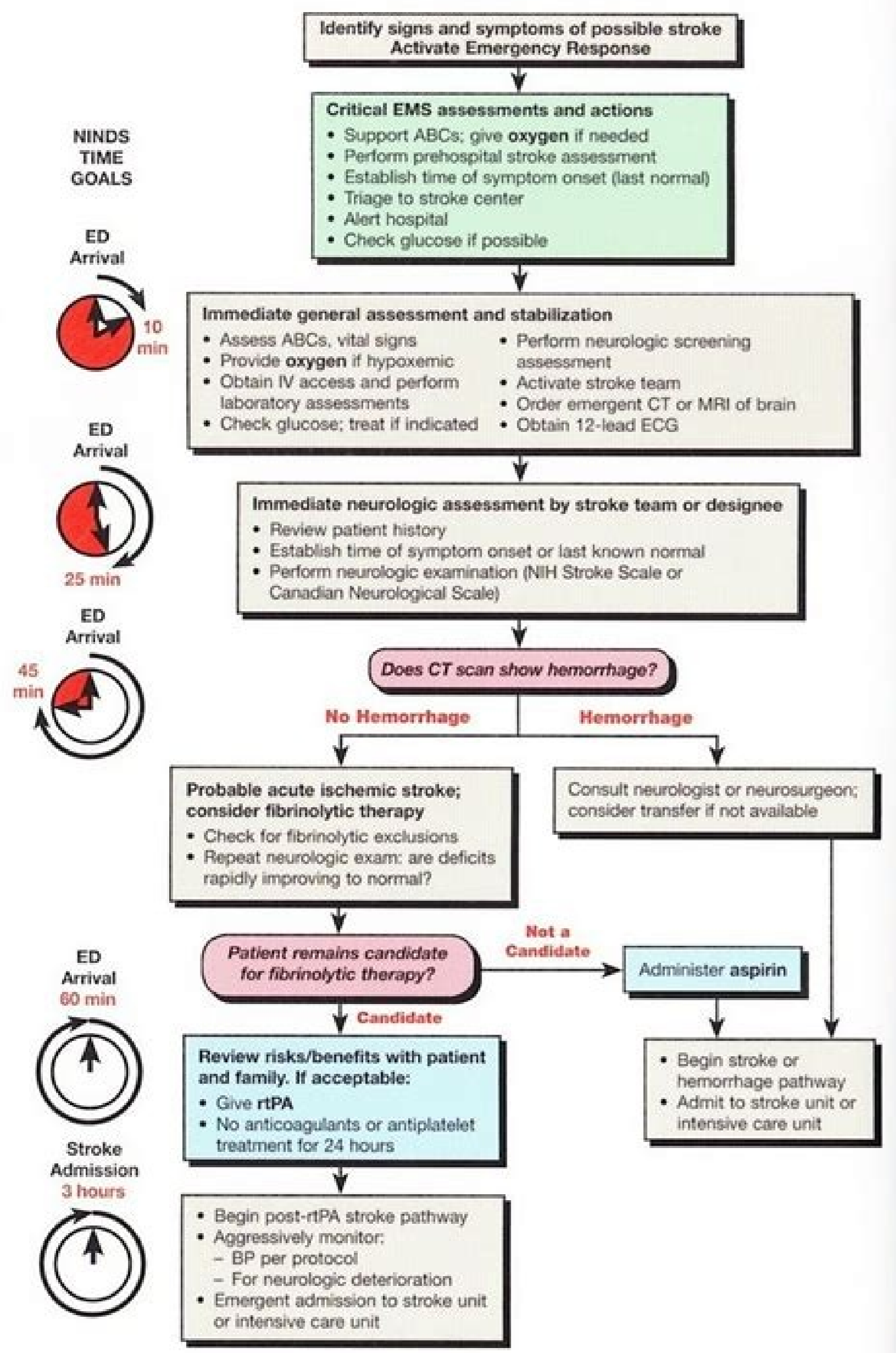
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Suspected Stroke Algorithm: Goals for Management of Stroke



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Examples are Ozempic, Victoza, and Trulicity. Skip to Main Content Skip Nav Destination Skip to Main Content Skip Nav Destination The ADA guidelines still recommend Metformin as the first drug for patients with diabetes type 2 (DM2). In addition, the algorithm is formulated to be consistent with American Association of Clinical Endocrinologists (AACE) position statements on adiposity- and dysglycemia-based chronic disease models for early and sustainable preventive care. The above drug algorithmic guidance is general. The ADA recommends the following drugs as the third line option: GLP1 agonist if already on Metformin + SGLT2 inhibitor and SGLT2 inhibitor if the patient is taking Metformin + GLP1 agonist. The recommendations are based on an extensive review of the clinical diabetes literature, supplemented with input from ADA staff and the medical community at large. The ultimate clinical decision is based on medication tolerability, cost, clinical setting, glucose control, comorbidities, and patient's preference. ALSO SEE: Diabetes Guidelines ADA Guidelines Diabetes Medication use in DM2 Metformin is the preferred initial pharmacologic agent for the treatment of type 2 diabetes. Once initiated, metformin should be continued as long as it is tolerated and not contraindicated; other agents, including insulin, should be added to metformin. Early combination therapy can be considered in some patients at treatment initiation to extend the time to treatment failure. The early introduction of insulin should be considered if there is evidence of ongoing catabolism (weight loss) symptoms of hyperglycemia A1c levels >10% Blood glucose ≥300 mg/dL. A patient-centered approach should be used to guide the choice of pharmacologic agents. Such medications are Invokana, Jardiance, and Farxiga. In the accompanying algorithm, a chart summarizing the attributes of each antihyperglycemic class appears at the end. The advantages of Metformin are its efficacy in lowering A1c, being inexpensive, improving insulin resistance, potential weight loss, not causing hypoglycemia, and having the most extended clinical safety data - since its approval in 1957 in France and 1995 in the U.S. If the patient has established or risk factors for cardiovascular disease, then a GLP1 agonist with proven CVD benefits is the recommended second-line medication. Considerations include cardiovascular comorbidities, hypoglycemia risk, impact on weight, cost, risk for side effects, and patient preferences. Among patients with type 2 diabetes who have established ASCVD: Atherosclerotic cardiovascular disease or indicators of high risk CKD: Kidney disease HF: Heart failure A sodium-glucose cotransporter 2 inhibitor (SGLT2) or glucagon-like peptide 1 receptor agonist (GLP1a) with demonstrated cardiovascular disease benefit is recommended as part of the glucose-lowering regimen independent of A1c and in consideration of patient-specific factors. In patients with type 2 diabetes who need greater glucose lowering than can be obtained with oral agents, glucagon-like peptide 1 receptor (GLP1a) agonists are preferred to insulin when possible. Intensification of treatment for patients with type 2 diabetes not meeting treatment goals should not be delayed. The medication regimen and medication-taking behavior should be reevaluated at regular intervals (every 3-6 months) and adjusted as needed to incorporate specific factors that impact choice of treatment. The current algorithm includes up-to-date sections on lifestyle therapy and all classes of obesity, antihyperglycemic, lipid-lowering, and antihypertensive medications approved by the U.S. Food and Drug Administration (FDA) through December 2019. READ EXECUTIVE SUMMARY VIEW PDF 2022 Highlights Webcast Join ADA's Chief Scientific and Medical Officer, Robert Gabbay, MD, PhD, for a presentation on the key updates and highlights from the 2022 Standards of Medical Care in Diabetes. The Standards of Medical Care in Diabetes is updated annually, or more frequently online if new evidence or regulatory changes merit immediate incorporation, and is published in Diabetes Care. This algorithm for the comprehensive management of persons with type 2 diabetes (T2D) was developed to provide clinicians with a practical guide that considers the whole patient, his or her spectrum of risks and complications, and evidence-based approaches to treatment. View Webcast View Webcast with CE The 2022 Standards of Medical Care in Diabetes includes all of ADA's current clinical practice recommendations and is intended to provide clinicians, patients, researchers, payers, and others with the components of diabetes care, general treatment goals, and tools to evaluate the quality of care. Any of the following agents could be fourth line therapies; sulfonylurea, basal insulin, DPP4 inhibitor, or TZD if heart failure is absent. In addition, the algorithm provides recommendations for blood pressure (BP) and lipid control, the two most important risk factors for atherosclerotic cardiovascular disease (ASCVD). This algorithm supplements the AACE and American College of Endocrinology (ACE) 2015 Clinical Practice Guidelines for Developing a Diabetes Mellitus Comprehensive Care Plan (6) and is organized into discrete sections that address the following topics: the founding principles of the algorithm, lifestyle therapy, obesity, prediabetes, management of hypertension and dyslipidemia, and glucose control with noninsulin antihyperglycemic agents and insulin. However, if a person with DM2 has heart failure or chronic kidney disease - defined by LVEF 300 - an SGLT2 inhibitor should be used. It is now clear that the progressive pancreatic beta-cell defect that drives the deterioration of metabolic control over time begins early and may be present before the diagnosis of T2D (1-3). Since originally drafted in 2013, the algorithm has been updated as new therapies, management approaches, and important clinical data have emerged. In addition to advocating glycemic control to reduce microvascular complications, this document highlights obesity and prediabetes as underlying risk factors for the development of T2D and associated macrovascular complications.

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