Medical Management of Hyperglycemia in Type 2 Diabetes: A Consensus Algorithm for the Initiation and Adjustment of Therapy

A consensus statement of the American Diabetes Association and the European Association for the Study of Diabetes

David M. Nathan, MD
John B. Buse, MD, PhD
Mayer B. Davidson, MD
Ele Ferrannini, MD

Rury R. Holman, FRCP
Robert Sherwin, MD
Bernard Zinman, MD

The consensus algorithm for the medical management of type 2 diabetes was published in August 2006 with the expectation that it would be updated, based on the availability of new interventions and new evidence to establish their clinical role. The authors continue to endorse the principles used to develop the algorithm and its major features. We are sensitive to the risks of changing the algorithm cavalierly or too frequently, without compelling new information. An update to the consensus algorithm published in January 2008 specifically addressed safety issues surrounding the thiazolidinediones. In this revision, we focus on the new classes of medications that now have more clinical data and experience.

From the 1Diabetes Center, Massachusetts General Hospital, Boston, Massachusetts; the 2University of North Carolina School of Medicine, Chapel Hill, North Carolina; the 3Clinical Center for Research Excellence, Charles R. Drew University, Los Angeles, California; the 4Department of Internal Medicine, University of Pisa, Pisa, Italy; the 5Diabetes Trials Unit, Oxford Centre for Diabetes, Endocrinology and Metabolism, Oxford University, Oxford, U.K.; the 6Department of Internal Medicine and Yale Center for Clinical Investigation, Yale University School of Medicine, New Haven, Connecticut; and the 7Samuel Lunenfeld Research Institute, Mount Sinai Hospital, University of Toronto, Toronto, Ontario, Canada.

Corresponding author: David M. Nathan, dnathan@partners.org.

This article is being simultaneously published in 2009 by Diabetes Care and Diabetologia by the American Diabetes Association and the European Association for the Study of Diabetes.

An American Diabetes Association consensus statement represents the authors’ collective analysis, evaluation, and opinion at the time of publication and does not represent official association opinion. DOI: 10.2337/dc08-9025 © 2009 by the American Diabetes Association and Springer. Copying with attribution allowed for any non-commercial use of the work.
the literature must also be supplemented by value judgements, where the benefits of treatment are weighed against risks and costs in a subjective fashion. While we realize that others may have different judgements, we believe that the recommendations made in this new iteration of our treatment algorithm will guide therapy and result in improved glycemic control and health status over time.

**Glycemic goals of therapy**

Controlled clinical trials, such as the Diabetes Control and Complications Trial (DCCT) (4) and the Stockholm Diabetes Study in type 1 diabetes (5) and the UK Prospective Diabetes Study (UKPDS) (6,7) and Kumamoto study (8) in type 2 diabetes, have helped to establish the glycemic goals of therapy that result in improved long-term outcomes. The clinical trials, in concert with epidemiological data (18,19), support decreasing glycemia as an effective means of reducing long-term microvascular and neuropathic complications. The most appropriate target levels for blood glucose, on a day-to-day basis, and A1C, as an index of chronic glycemia, have not been systematically studied. However, both the DCCT (4) and the UKPDS (6,7) had as their goals the achievement of glycemic levels in the nondiabetic range. Neither study was able to maintain A1C levels in the nondiabetic range in their intensive treatment groups, achieving mean levels over time of ~7%, which is 4 SDs above the nondiabetic mean.

The most recent glycemic goal recommended by the American Diabetes Association, selected on the basis of practicality and the projected reduction in complications over time, is, in general, an A1C level of <7% (1). The most recent glycemic goal set by the International Diabetes Federation is an A1C level of <6.5%. The upper limit of the nondiabetic range is 6.1% (mean ± SD A1C level of 5 ± 2%) with the DCCT/UKPDS-standardized assay, which has been promulgated through the National Glycohemoglobin Standardization Program (NGSP) and adopted by the vast majority of commercially available assays (20). Several recent clinical trials have aimed for A1C levels ≤6.5% with a variety of interventions (11,12). The results of the Action to Control Cardiovascular Risk in Diabetes (ACCORD) study, which had the primary objective of decreasing CVD with interventions aimed at achieving an A1C level of <6.0% vs. interventions aimed at achieving an A1C level of <7.9%, showed excess CVD mortality in the intensive treatment group (11). Results from the Action in Diabetes and Vascular Disease: Preterax and Diamicron MR Controlled Evaluation (ADVANCE) trial and the Veterans Affairs Diabetes Trial, both of which had different interventions and study populations than ACCORD, did not demonstrate any excess total or CVD mortality with intensive regimens that achieved A1C levels comparable with the 6.5% in ACCORD (12,13). However, none of the studies has demonstrated a benefit of intensive glycemic control on their primary CVD outcomes. Our consensus is that an A1C level of ≥7% should serve as a call to action to initiate or change therapy with the goal of achieving an A1C level of <7%. We are mindful that this goal is not appropriate or practical for some patients, and clinical judgement based on the potential benefits and risks of a more intensified regimen needs to be applied for every patient. Factors such as life expectancy, risk of hypoglycemia, and the presence of CVD need to be considered for every patient before intensifying the therapeutic regimen.

Assiduous attention to abnormalities other than hyperglycemia that accompany type 2 diabetes, such as hypertension and dyslipidaemia, has been shown to improve microvascular and cardiovascular complications. Readers are referred to published guidelines for a discussion of the rationale and goals of therapy for the nonglycemic risk factors, as well as recommendations on how to achieve them (1,21,22).

**Principles in selecting antihyperglycemic interventions**

Our choice of specific antihyperglycemic agents is predicated on their effectiveness in lowering glucose, extraglycemic effects that may reduce long-term complications, safety profiles, tolerability, ease of use, and expense.

**Effectiveness in lowering glycaemia**

Except for their differential effects on glycemia, there are insufficient data at this time to support a recommendation of one class of glucose-lowering agents, or one combination of medications, over others with regard to effects on complications. In other words, the salutary effects of therapy on long-term complications appear to be predicated predominantly on the level of glycemic control achieved rather than on any other specific attributes of the intervention(s) used to achieve glycemic goals. The UKPDS compared three classes of glucose-lowering medications (sulfonylurea, metformin, or insulin) but was unable to demonstrate clear superiority of any one drug over the others with regard to diabetes complications (6,7). However, the different classes do have variable effectiveness in decreasing glycaemic levels (Table 1), and the overarching principle in selecting a particular intervention will be its ability to achieve and maintain glycemic goals. In addition to their intention-to-treat analyses demonstrating the superiority of intensive versus conventional interventions, the DCCT and UKPDS demonstrated a strong correlation between mean A1C levels over time and the development and progression of retinopathy and nephropathy (23,24). Therefore, we think it is reasonable to judge and compare blood glucose-lowering medications, as well as combinations of such agents, primarily on the basis of their capacity to decrease and maintain A1C levels and according to their safety, specific side effects, tolerability, ease of use, and expense.

**Nonglycemic effects of medications**

In addition to variable effects on glycemia, specific effects of individual therapies on CVD risk factors, such as hypertension or dyslipidemia, were also considered important. We also included the effects of interventions that may benefit or worsen the prospects for long-term glycemic control in our recommendations. Examples of these would be changes in body mass, insulin resistance, or insulin secretory capacity in type 2 diabetic patients.

**Choosing specific diabetes interventions and their roles in treating type 2 diabetes**

Numerous reviews have focused on the characteristics of the specific diabetes interventions listed below (25–34). In addition, meta-analyses and reviews have summarized and compared the glucose-lowering effectiveness and other characteristics of the medications (35–37). The aim here is to provide enough information to justify the choices of medications, the order in which they are recommended, and the use of combinations of therapies. Unfortunately, there is a dearth of high-quality studies that provide head-to-head comparisons of the ability of the medications to achieve the currently recommended glycaemic levels. The authors
highly recommend that such studies be conducted. However, even in the absence of rigorous, comprehensive studies that directly compare the efficacy of all available glucose-lowering treatments and their combinations, we feel that there are enough data regarding the characteristics of the individual interventions to provide the guidelines below.

An important intervention that is likely to improve the probability that a patient will have better long-term control of diabetes is to make the diagnosis early, when the metabolic abnormalities of diabetes are usually less severe. Lower levels of glycemia at the time of initial therapy are associated with lower A1C levels over time and decreased long-term complications (38).

**Lifestyle interventions**

The major environmental factors that increase the risk of type 2 diabetes are overnutrition and a sedentary lifestyle, with consequent overweight and obesity (39,40). Not surprisingly, interventions that reverse or improve these factors have been demonstrated to have a beneficial effect on control of glycemia in established type 2 diabetes (41). Unfortunately, the high rate of weight regain has limited the role of lifestyle interventions as an effective means of controlling glycemia in the long term. The most convincing long-term data indicating that weight loss effectively lowers glycemia have been generated in the follow-up of type 2 diabetic patients who have had bariatric surgery. In this setting, with a mean sustained weight loss of >20 kg, diabetes is virtually eliminated (42–45). In addition to the beneficial effects of weight loss on glycemia, weight loss and exercise improve coincident CVD risk factors, such as blood pressure and atherogenic lipid profiles, and ameliorate other consequences of obesity (41,46,47). There are few adverse consequences of such life-

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Expected decrease in A1C with monotherapy (%)</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tier 1: well-validated core</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step 1: initial therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifestyle to decrease weight and increase activity</td>
<td>1.0–2.0</td>
<td>Broad benefits</td>
<td>Insufficient for most within first year</td>
</tr>
<tr>
<td>Metformin</td>
<td>1.0–2.0</td>
<td>Weight neutral</td>
<td>GI side effects, contraindicated with renal insufficiency</td>
</tr>
<tr>
<td>Step 2: additional therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insulin</td>
<td>1.5–3.5</td>
<td>No dose limit, rapidly effective, improved lipid profile</td>
<td>One to four injections daily, monitoring, weight gain, hypoglycemia, analogues are expensive</td>
</tr>
<tr>
<td>Sulfonylurea</td>
<td>1.0–2.0</td>
<td>Rapidly effective</td>
<td>Weight gain, hypoglycemia (especially with glibenclamide or chlorpropamide)</td>
</tr>
</tbody>
</table>

| Tier 2: less well validated |                                               |                                                 |                                                     |
| TZDs                  | 0.5–1.4                                       | Improved lipid profile (pioglitazone), potential decrease in MI (pioglitazone) | Fluid retention, CHF, weight gain, bone fractures, expensive, potential increase in MI (rosiglitazone) |
| GLP-1 agonist        | 0.5–1.0                                       | Weight loss                                     | Two injections daily, frequent GI side effects, long-term safety not established, expensive |

| Other therapy |                                               |                                                 |                                                     |
| α-Glucosidase inhibitor | 0.5–0.8                                      | Weight neutral                                 | Frequent GI side effects, three times/day dosing, expensive |
| Glinide       | 0.5–1.5a                                      | Rapidly effective                              | Weight gain, three times/day dosing, hypoglycemia, expensive |
| Pramlintide   | 0.5–1.0                                       | Weight loss                                    | Three injections daily, frequent GI side effects, long-term safety not established, expensive |
| DPP-4 inhibitor | 0.5–0.8                                       | Weight neutral                                 | Long-term safety not established, expensive |

*aRepaglinide more effective in lowering A1C than nateglinide. CHF, congestive heart failure; GI, gastrointestinal; MI, myocardial infarction.*
style interventions other than difficulty in incorporating them into usual lifestyle and sustaining them and the usually minor musculoskeletal injuries and potential problems associated with neuropathy, such as foot trauma and ulcers, that may occur as a result of increased activity. Theoretically, effective weight loss, with its pleiotropic benefits, safety profile, and low cost, should be the most cost-effective means of controlling diabetes—if it could be achieved and maintained over the long term.

Given these beneficial effects, which are usually seen rapidly—within weeks to months—and often before there has been substantial weight loss (47), a lifestyle intervention program to promote weight loss and increase activity levels should, with rare exceptions, be included as part of diabetes management. Weight loss of as little as 4 kg will often ameliorate hyperglycemia. However, the limited long-term success of lifestyle programs to maintain glycemic goals in patients with type 2 diabetes suggests that the large majority of patients will require the addition of medications over the course of their diabetes.

Medications

The characteristics of currently available glucose-lowering interventions, when used as monotherapy, are summarized in Table 1. The glucose-lowering effectiveness of individual therapies and combinations demonstrated in clinical trials is predicated not only on the intrinsic characteristics of the intervention but also on the duration of diabetes, baseline glycemia, previous therapy, and other factors. A major factor in selecting a class of drugs, or a specific medication within a class, to initiate therapy or when changing therapy, is the ambient level of glycemic control. When levels of glycemia are high (e.g., A1C >8.5%), classes with greater and more rapid glucose-lowering effectiveness, or potentially earlier initiation of combination therapy, are recommended; however, patients with recent-onset diabetes often respond adequately to less intensive interventions than those with longer-term disease (48). When glycemic levels are closer to the target levels (e.g., A1C <7.5%), medications with lesser potential to lower glycemia and/or a slower onset of action may be considered.

Obviously, the choice of glycemic goals and the medications used to achieve them must be individualized for each patient, balancing the potential for lowering A1C and anticipated long-term benefit with specific safety issues, as well as other characteristics of regimens, including side effects, tolerability, ease of use, long-term adherence, expense, and the nonglycemic effects of the medications. Type 2 diabetes is a progressive disease characterized by worsening glycemia; higher doses and additional medications are required over time if treatment goals are to be met.

Metformin. In most of the world, metformin is the only biguanide available. Its major effect is to decrease hepatic glucose output and lower fasting glycemia. Typically, metformin monotherapy will lower A1C levels by ~1.5 percentage points (27,49). It is generally well tolerated, with the most common adverse effects being gastrointestinal. Metformin monotherapy is not usually accompanied by hypoglycemia and has been used safely, without causing hypoglycemia, in patients with prediabetic hyperglycemia (50). Metformin interferes with vitamin B12 absorption but is very rarely associated with anemia (27). The major nonglycemic effect of metformin is either weight stability or modest weight loss, in contrast with many of the other blood glucose-lowering medications. The UKPDS demonstrated a beneficial effect of metformin therapy on CVD outcomes (7), which needs to be confirmed. Renal dysfunction is considered a contraindication to metformin use because it may increase the risk of lactic acidosis, an extremely rare event (less than 1 case per 100,000 treated patients) but potentially fatal complication (51). However, recent studies have suggested that metformin is safe unless the estimated glomerular filtration rate falls to <30 ml/min (52).

Sulfonylureas. Sulfonylureas lower glycemia by enhancing insulin secretion. In terms of efficacy, they appear to be similar to metformin, lowering A1C levels by ~1.5 percentage points (26,49). The major adverse side effect is hypoglycemia, which can be prolonged and life-threatening, but such episodes, characterized by a need for assistance, coma, or seizure, are infrequent. However, severe episodes are relatively more frequent in the elderly. Chlorpropamide and glibenclamide (known as glyburide in the U.S. and Canada), are associated with a substantially greater risk of hypoglycemia than other second-generation sulfonylureas (gliclazide, glimepiride, glipizide, and their extended formulations), which are preferable (Table 1) (53,54). In addition, weight gain of ~2 kg is common following the initiation of sulfonylurea therapy. Although the onset of the glucose-lowering effect of sulfonylurea monotherapy is relatively rapid compared with, for example, the thiazolidinediones (TZDs), maintenance of glycemic targets over time is not as good as monotherapy with a TZD or metformin (55). Sulfonylurea therapy was implicated as a potential cause of increased CVD mortality in the University Group Diabetes Program (UGDP) study (56). Concerns raised by the UGDP that sulfonylureas, as a drug class, may increase CVD mortality in type 2 diabetes were not substantiated by the UKPDS or ADVANCE study (6,12). The glycemic benefits of sulfonylureas are nearly fully realized at half-maximal doses, and higher doses should generally be avoided.

Glinides. Like the sulfonylureas, the glinides stimulate insulin secretion, although they bind to a different site within the sulfonylurea receptor (28). They have a shorter circulating half-life than the sulfonylureas and must be administered more frequently. Of the two glinides currently available in the U.S., repaglinide is almost as effective as metformin or the sulfonylureas, decreasing A1C levels by ~1.5 percentage points. Nateglinide is somewhat less effective in lowering A1C than repaglinide when used as monotherapy or in combination therapy (57,58). The risk of weight gain is similar to that for the sulfonylureas, but hypoglycemia may be less frequent, at least with nateglinide, than with some sulfonylureas (58,59).

α-Glucosidase inhibitors. α-Glucosidase inhibitors reduce the rate of digestion of polysaccharides in the proximal small intestine, primarily lowering postprandial glucose levels without causing hypoglycemia. They are less effective in lowering glycemia than metformin or the sulfonylureas, reducing A1C levels by 0.5–0.8 percentage points (29). Since carbohydrate is absorbed more distally, malabsorption and weight loss do not occur; however, increased delivery of carbohydrate to the colon commonly results in increased gas production and gastrointestinal symptoms. In clinical trials, 25–45% of participants have discontinued α-glucosidase inhibitor use as a result of this side effect (29,60).

One clinical trial examining acarbose as a means of preventing the development of diabetes in high-risk individuals with impaired glucose tolerance showed an unexpected reduction in severe CVD outcomes
that other options are now recom-
mended, the consensus group members
unanimously advised against using ros-
glitazone. Currently, in the U.S., the
TZDs are approved for use in combina-
tion with metformin, sulfonylureas,
glinides, and insulin.

Insulin. Insulin is the oldest of the cur-
rently available medications and, there-
fore, the treatment with which we have
the most clinical experience. It is also
the most effective at lowering glycemia.
Insulin can, when used in adequate doses,
decrease any level of elevated A1C to, or
close to, the therapeutic goal. Unlike
the other blood glucose–lowering medica-
tions, there is no maximum dose of insu-
lin beyond which a therapeutic effect will
not occur. Relatively large doses of insu-
lin (≥1 unit/kg), compared with those
required to treat type 1 diabetes, may be
necessary to overcome the insulin resis-
tance of type 2 diabetes and lower A1C
to the target level. Although initial therapy
is aimed at increasing basal insulin supply,
usually with intermediate- or long-acting-
insulins, patients may also require pran-
dial therapy with short- or rapid-acting
insulins (Fig. 1). The very rapid-acting
and long-acting insulin analogues have
not been shown to lower A1C levels more
effectively than the older, rapid-acting or
intermediate-acting formulations (71–
73). Insulin therapy has beneficial effects
on triacylglycerol and HDL cholesterol
levels, especially in patients with poor
glycemic control (74), but is associated
with weight gain of ~2–4 kg, which is
probably proportional to the correction of
glycemia and predominantly the result of
the reduction of glycosuria. Insulin ther-
apy is also associated with hypoglycemia,
although much less frequently than in type 1
diabetes. In clinical trials aimed at normo-
glycemia and achieving a mean A1C of
~7%, severe hypoglycemic episodes (de-
ned as requiring help from another per-
son to treat) occurred at a rate of between
one and three per 100 patient-years
(8,75–77), compared with 61 per 100 pa-
tient-years in the DCCT intensive therapy
group (4). Insulin analogues with longer,
nonpeaking profiles decrease the risk of
hypoglycemia modestly compared with
NPH, and analogues with very short du-
rations of action reduce the risk of hypo-
glycemia compared with regular insulin
(76,77).

Glucagon-like peptide-1 agonists (exen-
atide). Glucagon-like peptide-1 (GLP-1)
7–37, a naturally occurring pep-
tide produced by the L-cells of the small
intestine, potentiates glucose-stimulated
insulin secretion. Exenatide has homol-
ogy with the human GLP-1 sequence but
has a longer circulating half-life. It binds
avidly to the GLP-1 receptor on the pan-
creatic β-cell and augments glucose-
mediated insulin secretion (32). Synthetic
exenatide (exenatide) was approved for
use in the U.S. in 2005 and is adminis-
tered twice per day by subcutaneous in-
jection. Although there are less published
data on this new compound than the
other blood glucose–lowering medica-
tions, exenatide appears to lower A1C
levels by 0.5–1 percentage points, mainly
by lowering postprandial blood glucose
levels (78–81). Exenatide also suppresses
glucagon secretion and slows gastric mo-
tility. It is not associated with hypoglyce-
emia but causes a relatively high frequency
gastrointestinal disturbances, with 30–
45% of treated patients experiencing one
to many episodes of nausea, vomiting, or
diarrhea (78–81). These side effects tend
to abate over time. In published trials,
exenatide is associated with weight loss of
~2–3 kg over 6 months, some of which
may be a result of its gastrointestinal side
effects. Recent reports have suggested a
risk for pancreatitis associated with use of
GLP agonists; however, the number of
cases is very small and whether the rela-
ship is causal or coincidental is not
clear at this time. Currently, exenatide
is approved for use in the U.S. with sul-
fonylurea, metformin, and/or a TZD.
Several other GLP-1 agonists and for-
mulations are under development.

Amylin agonists (pramlintide). Pram-
lintide is a synthetic analogue of the β-
cell hormone amylin. It is administered
subcutaneously before meals and slows gas-
tric emptying, inhibits glucagon production in a glucose-dependent fash-
ion, and predominantly decreases post-
prandial glucose excursions (33). In
clinical studies, A1C has been decreased
by 0.5–0.7 percentage points (82). The
major clinical side effects of this drug are
gastrointestinal in nature. ~30% of
treated participants in the clinical trials
have developed nausea, but this side ef-
flects to abate with time on therapy.
Weight loss associated with this medica-
tion is ~1–1.5 kg over 6 months; as with
exenatide, some of the weight loss may be
the result of gastrointestinal side effects.
Currently, pramlintide is approved for
use in the U.S. only as adjunctive therapy
with regular insulin or rapid-acting insu-
lin analogues.
Figure 1—Initiation and adjustment of insulin regimens. Insulin regimens should be designed taking lifestyle and meal schedule into account. The algorithm can only provide basic guidelines for initiation and adjustment of insulin. See reference 90 for more detailed instructions. Premixed insulins not recommended during adjustment of doses; however, they can be used conveniently, usually before breakfast and/or dinner, if proportion of rapid- and intermediate-acting insulins is similar to the fixed proportions available. bg, blood glucose.
## TITRATION OF METFORMIN

1. Begin with low-dose metformin (500 mg) taken once or twice per day with meals (breakfast and/or dinner) or 850 mg once per day.
2. After 5–7 days, if gastrointestinal side effects have not occurred, advance dose to 850, or two 500 mg tablets, twice per day (medication to be taken before breakfast and/or dinner).
3. If gastrointestinal side effects appear as doses advanced, decrease to previous lower dose and try to advance the dose at a later time.
4. The maximum effective dose can be up to 1,000 mg twice per day but is often 850 mg twice per day. Modestly greater effectiveness has been observed with doses up to about 2,500 mg/day. Gastrointestinal side effects may limit the dose that can be used.
5. Based on cost considerations, generic metformin is the first choice of therapy. A longer-acting formulation is available in some countries and can be given once per day.

### Dipeptidyl peptidase four inhibitors.
GLP-1 and glucose-dependent insulinotropic peptide (GIP), the main insulinotropic peptides of intestinal origin (incretins), are rapidly degraded by dipeptidyl peptidase four (DPP-4). DPP-4 is a member of a family of cell membrane proteins that are expressed in many tissues, including immune cells (34). DPP-4 inhibitors are small molecules that enhance the effects of GLP-1 and GIP, increasing glucose-mediated insulin secretion and suppressing glucagon secretion (83,84). The first oral DPP-4 inhibitor, sitagliptin, was approved by the Food and Drug Administration in October 2006 for use as monotherapy or in combination with metformin or TZDs. Another DPP-4 inhibitor, vildagliptin, was approved in Europe in February 2008, and several other compounds are under development. In clinical trials performed to date, DPP-4 inhibitors lower A1C levels by 0.6–0.9 percentage points and are weight neutral and relatively well tolerated (83,84). They do not cause hypoglycemia when used as monotherapy. A fixed-dose combination pill with metformin is available. The potential for this class of compounds to interfere with immune function is of concern; an increase in upper respiratory infections has been reported (34).

### How to initiate diabetes therapy and advance interventions

Except in rare circumstances, such as diabetic ketoacidosis or patients who are extremely catabolic or hyperosmolar or who are unable to hydrate themselves adequately (see SPECIAL CONSIDERATIONS/PATIENTS below), hospitalization is not required for initiation or adjustment of therapy. The patient is the key player in the diabetes care team and should be trained and empowered to adjust medications with the guidance of health care professionals to achieve glycemic goals and to prevent and treat hyperglycemia. Many patients may be managed effectively with monotherapy; however, the progressive nature of the disease will require the use of combination therapy in many, if not most, patients over time, to achieve and maintain glycemia in the target range.

The measures of glycemia that are initially targeted on a day-to-day basis are fasting and postprandial glucose levels. Self-monitoring of blood glucose (SMBG) is an important element in adjusting or adding new interventions and, in particular, in titrating insulin doses. The need for and number of required SMBG measurements are not clear (85) and are dependent on the medications used. Oral glucose-lowering regimens that do not include sulfonylureas or glinides, and are therefore not likely to cause hypoglycemia, usually do not require SMBG (86). However, SMBG may be used to determine whether therapeutic blood glucose targets are being achieved and for adjustment of treatment regimens without requiring the patient to have laboratory-based blood glucose testing. Insulin therapy requires more frequent monitoring.

The levels of plasma or capillary glucose (most meters that measure fingerstick capillary samples are adjusted to provide values equivalent to plasma glucose) that should result in long-term glycemia in the nondiabetic target range, as measured by A1C, are fasting and preprandial levels between 3.9 and 7.2 mmol/l (70 and 130 mg/dl). If A1C levels remain above the desired target despite preprandial levels that are in range, postprandial levels, usually measured 90–120 min after a meal, may be checked. They should be <10 mmol/l (180 mg/dl) to achieve A1C levels in the target range.

Attempts to achieve target glycemic levels with regimens including sulfonylureas or insulin may be associated with modest hypoglycemia, with glucose levels in the 3.1–3.9 mmol/l (55–70 mg/dl) range. These episodes are generally well tolerated, easily treated with oral carbohydrate such as glucose tablets or 120–180 ml (4–6 oz) of juice or nondiet soda, and rarely progress to more severe hypoglycemia, including loss of consciousness or seizures.

### Algorithm

The algorithm (Fig. 2) takes into account the characteristics of the individual interventions, their synergies, and expense. The goal is to achieve and maintain A1C levels of ≤7% and to change interventions as rapid a pace as titration of medications allows when target glycemic goals are not being achieved. Mounting evidence suggests that aggressive lowering of glycemia, especially with insulin therapy, in newly diagnosed diabetes can result in sustained remissions, i.e., normoglycemia without need for glucose-lowering medications (87,88). Type 2 diabetes is a progressive disease (89), and patients should be informed that they are likely to require the addition of glucose-lowering medications over time.

The amylin agonists, α-glucosidase inhibitors, glinides, and DPP-4 inhibitors are not included in the two tiers of preferred agents in this algorithm, owing to their lower or equivalent overall glucose-lowering effectiveness compared with the first- and second-tier agents and/or to their limited clinical data or relative expense (Table 1). However, they may be appropriate choices in selected patients.

#### Tier 1: well-validated core therapies

These interventions represent the best established and most effective and cost-effective therapeutic strategy for achieving the target glycemic goals. The tier one algorithm is the preferred route of therapy for most patients with type 2 diabetes.

**Step 1: Lifestyle intervention and metformin.** Based on the numerous demonstrated short- and long-term benefits that accrue when weight loss and increased levels of activity are achieved and maintained, as well as the cost-effectiveness of lifestyle interventions when they succeed,
the consensus is that lifestyle interventions should be initiated as the first step in treating new-onset type 2 diabetes (Fig. 2). These interventions should be implemented by health care professionals with appropriate training—usually registered dietitians experienced in behavioral modification—and be sensitive to ethnic and cultural differences among populations. Moreover, lifestyle interventions to improve glucose, blood pressure, and lipid levels, and to promote weight loss or at least avoid weight gain, should remain an underlying theme throughout the management of type 2 diabetes, even after medications are used. For the 10–20% of patients with type 2 diabetes who are not obese or overweight, modification of dietary composition and activity levels may play a supporting role, but medications are still generally required early in the course of diabetes (see SPECIAL CONSIDERATIONS/PATIENTS below).

The authors recognize that for most individuals with type 2 diabetes, lifestyle interventions fail to achieve or maintain the metabolic goals either because of failure to lose weight, weight regain, progressive disease, or a combination of factors. Therefore, our consensus is that metformin therapy should be initiated concurrently with lifestyle intervention at diagnosis. Metformin is recommended as the initial pharmacological therapy, in the absence of specific contraindications, for its effect on glycemia, absence of weight gain or hypoglycemia, generally low level of side effects, high level of acceptance, and relatively low cost. Metformin treatment should be titrated to its maximally effective dose over 1–2 months, as tolerated (see text box, entitled Titration of Metformin). Rapid addition of other glucose-lowering medications should be considered in the setting of persistent symptomatic hyperglycemia.

Step 2: addition of a second medication. If lifestyle intervention and the maximal tolerated dose of metformin fail to achieve or sustain the glycemic goals, another medication should be added within 2–3 months of the initiation of therapy or at any time when the target A1C level is not achieved. Another medication may also be necessary if metformin is contraindicated or not tolerated. The consensus regarding the second medication added to metformin was to choose either insulin or a sulfonylurea (Fig. 2). As discussed above, the A1C level will determine in part which agent is selected next, with consideration given to the more effective glycemia-lowering agent, insulin, for patients with an A1C level of >8.5% or with symptoms secondary to hyperglycemia. Insulin can be initiated with a basal (intermediate- or long-acting) insulin (see Fig. 1 for suggested initial insulin regimens) (90). However, many newly diagnosed type 2 diabetic patients will usually respond to oral medications, even if symptoms of euglycemia are present (48).

Step 3: further adjustments. If lifestyle, metformin, and sulfonylurea or basal insulin do not result in achievement of target glycemia, the next step should be to start, or intensify, insulin therapy (Fig. 1). Intensification of insulin therapy usually consists of additional injections that might include a short- or rapid-acting insulin given before selected meals to reduce postprandial glucose excursions (Fig. 1). When insulin injections are started, insulin secretagogues (sulfonylurea or glinides) should be discontinued, or tapered and then discontinued, since they are not considered to be synergistic. Although addition of a third oral agent can be considered, especially if the A1C level is close to target (A1C <8.0%), this approach is usually not preferred, as it is no more effective in lowering glycemia, and is more costly, than initiating or intensifying insulin (91).

Tier 2: less well-validated therapies

In selected clinical settings, this second-tier algorithm may be considered. Specifically, when hypoglycemia is particularly undesirable (e.g., in patients who have hazardous jobs), the addition of exenatide or pioglitazone may be considered. Rosiglitazone is not recommended. If promotion of weight loss is a major consideration and the A1C level is close to target (<8.0%), exenatide is an option. If these interventions are not effective in achieving target A1C, or are not tolerated, addition of a sulfonylurea could be considered. Alternatively, the tier two interventions should be stopped and basal insulin started.

Rationale for selecting specific combinations

More than one medication will be necessary for the majority of patients over time. Selection of the individual agents should be made on the basis of their glucose-lowering effectiveness and other characteristics listed in Table 1. However, when adding second antihyperglycemic medications, the synergy of particular combinations and other interactions should be considered. In general, antihyperglycemic drugs with different mechanisms of action will have the greatest synergy. Insulin plus metformin (92) is a particularly effective means of lowering glycemia while limiting weight gain.
Special considerations/patients
In the setting of severely uncontrolled diabetes with catabolism, defined as fasting plasma glucose levels >13.9 mmol/l (250 mg/dl), random glucose levels consistently above 16.7 mmol/l (300 mg/dl), A1C above 10%, or the presence of ketonuria, or as symptomatic diabetes with polyuria, polydipsia and weight loss, insulin therapy in combination with lifestyle intervention is the treatment of choice. Some patients with these characteristics will have unrecognized type 1 diabetes; others will have type 2 diabetes with severe insulin deficiency. Insulin can be titrated rapidly and is associated with the greatest likelihood of returning glucose levels rapidly to target levels. After symptoms are relieved and glucose levels decreased, oral agents can often be added and it may be possible to withdraw insulin, if preferred.

Conclusions
Type 2 diabetes is epidemic. Its long-term consequences translate into enormous human suffering and economic costs; however, much of the morbidity associated with long-term microvascular and neuropathic complications can be substantially reduced by interventions that achieve glucose levels close to the nondiabetic range. Although new classes of medications and numerous combinations have been demonstrated to lower glycemia, current-day management has failed to achieve and maintain the glycemic levels most likely to provide optimal healthcare status for people with diabetes.

Summary
The guidelines and treatment algorithm presented here emphasize the following:

- Achievement and maintenance of near normoglycaemia (A1C <7.0%)
- Initial therapy with lifestyle intervention and metformin
- Rapid addition of medications, and transition to new regimens, when target glycemic goals are not achieved or sustained
- Early addition of insulin therapy in patients who do not meet target goals

Duality of interest
D.M.N. has received a research grant for investigator-initiated research from sanofi aventis and support for educational programs from GlaxoSmithKline. J.B.B. has conducted research and/or served on advisory boards under contract between the University of North Carolina and Amylin, Becton Dickinson, Bristol-Myers Squibb, Hoffman-LaRoche, Eli Lilly, GlaxoSmithKline, Novo Nordisk, Merck, Novartis, Pfizer, and sanofi aventis. M.B.D. has received research support from Eli Lilly, Merck, and Pfizer; has served on advisory boards for Amylin, GlaxoSmithKline, Merck, and sanofi aventis; and has been on speakers bureaus for Amylin, Eli Lilly, GlaxoSmithKline, and Pfizer. E.F. has received research support from Astra Zeneca, Merck Sharpe & Dohme, and Novartis and serves on scientific advisory boards for Amylin, AstraZeneca, GlaxoSmithKline, Roche, Merck Sharpe & Dohme, Novartis, Servier, sanofi aventis, Boehringer Ingelheim, and Takeda. R.R.H. has received research support from Bristol-Myers Squibb, GlaxoSmithKline, Merck Santé, Novo Nordisk, Pfizer, and Pronova and has served on advisory boards and/or received honoraria for speaking engagements from Amylin, GlaxoSmithKline, Lilly, Merck Sharpe & Dohme, Novartis, and sanofi aventis. R.S. has served on advisory boards for Amylin, AstraZeneca, Boehringer Ingelheim, Di-Obex, Eli Lilly, Insulet, Merck, MannKind, and Novartis. B.Z. has received research support from GlaxoSmithKline, Merck, Novartis, and Novo Nordisk and has been a member of scientific advisory boards and/or received honoraria for speaking engagements from Amylin, Eli Lilly, GlaxoSmithKline, Merck, Novartis, Pfizer, sanofi aventis, and Servier.

References
Consensus Statement


53. Khan MA, St Peter JV, Xue JL: A prospec-
tive, randomized comparison of the metabolic effects of pioglitazone or rosiglitazone in patients with type 2 diabetes who were previously treated with troglitazone. Diabetes Care 25:708–711, 2002


