The Scientific Times

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ADA Guidelines 2023

Standards of Medical Care in Diabetes

The American Diabetes Association (ADA) is one of the leading voluntary health organization fighting to bend the curve on the diabetes epidemic and help people living with diabetes thrive. For nearly 80 years the ADA has been driving discovery and research to treat, manage and prevent diabetes, while working relentlessly for a cure.

The ADA has developed and provided diabetes care standards, guidelines and related documents since 1989, and its clinical practice recommendations serve as an integral resources for health care professionals.

ADA ANNOUNCES NEW EVIDENCE-BASED GUIDELINES AND RECOMMENDATIONS

The ADA has released new guidelines outlining new standards for diabetes care. This year's guideline has amended some stricter recommendations for blood pressure and lipid control in diabetic individuals.

It also emphasizes the importance of weight control advocating for higher weight loss (up to 15%) based on efficacy and accessibility of newer medications.

Some notable updates and additions to the ***Standards of Medical Care in Diabetes—2023*** are highlighted in this issue.

*For **Full Text** click link below:*

https://diabetesjournals.org/care/issue/46/Supplement_1

CONTENTS

WAYS DIABETES CARE WILL CHANGE IN 2023

Revised Hypertension Definition & Treatment Goals

New hypertension diagnosis cut-off
Hypertension is now defined as blood pressure **≥ 130 / 80 mmHg** in diabetic individuals.
(Earlier it was ≥ 140/90 mmHg)

Treatment Goals

ADA 2022

BP Goal

- T2DM + 10 yr ASCVD risk >15% → **BP < 130/80 mmHg**
- T2DM + 10 yr ASCVD risk <15% → **BP < 140/90 mmHg**

Therapy Initiation

- **At BP >140/90** mmHg – Single pill
- **Initial BP >160/100** mmHg– use 2 agents of different class

ADA 2023

BP Goal

- The on-treatment target blood pressure goal is **<130/80 mmHg**, if it can be safely attained.

Therapy Initiation

- **At BP >130/80** mmHg – Single pill
- **Initial BP >160/100** mmHg– Use 2 agents of different class, preferably single pill combination

New Lipid Lowering Recommendations Suggests Lower LDL Goals for High-risk Individuals

Treatment Goals

ADA 2022

- **T2DM** (age 40–75 yrs) with higher **CV risk**

  ↓

  reduce LDLc to target LDLc goal of **<100 mg/dL**

- **T2DM** with **ASCVD**

  ↓

  reduce LDLc to target LDLc goal of **<70 mg/dL**

* Add Ezetimibe / PCSK9 inhibitors to max dose Statin Therapy to reach goals

ADA 2023

- T2DM (age 40–75 yrs) with higher **CV risk**

  ↓

  reduce LDLc by >50% to target LDLc goal of **<70 mg/dL**

- **T2DM** with **ASCVD**

  ↓

  reduce LDLc by >50% to target LDLc goal of **<55 mg/dL**

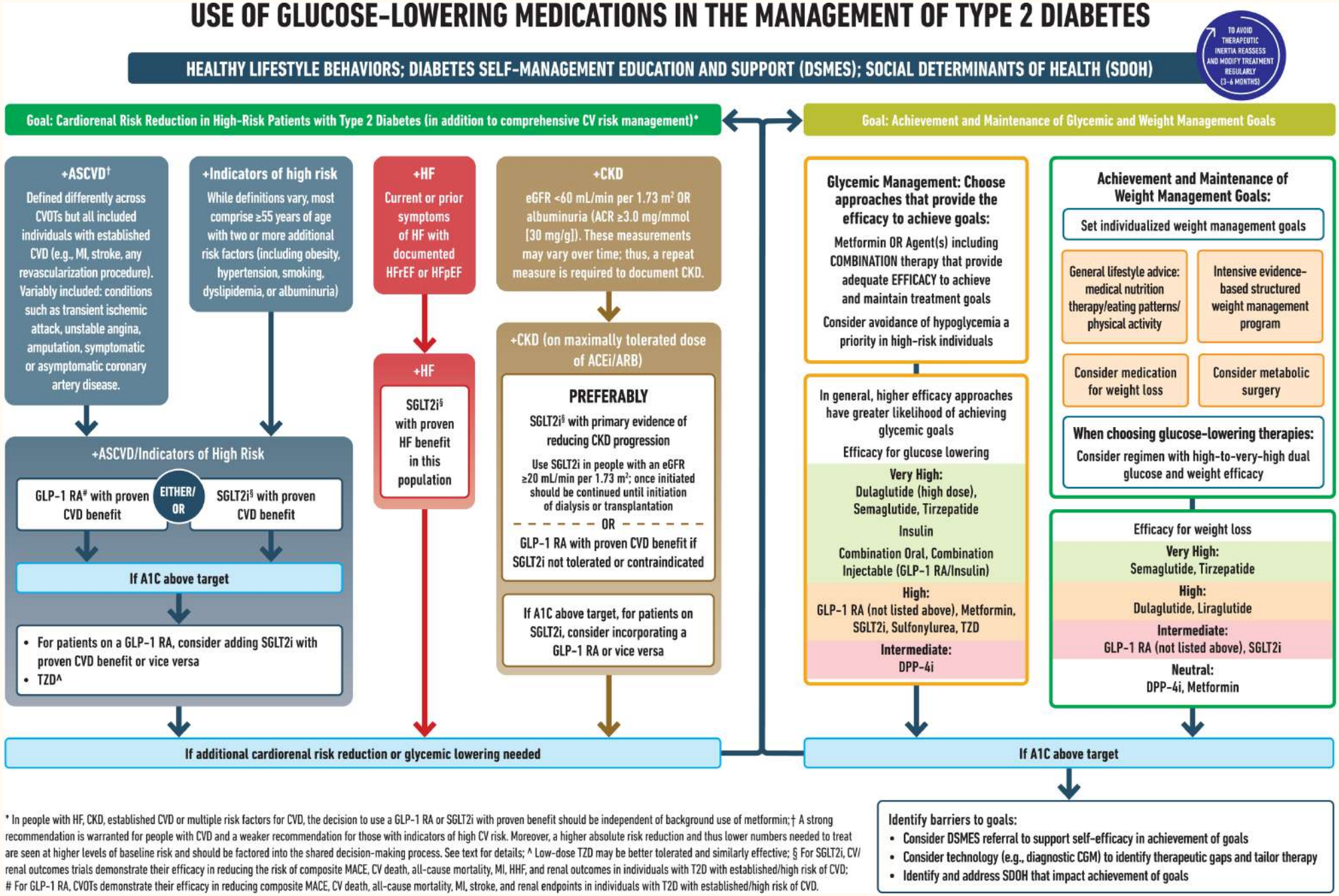
* Add Ezetimibe / PCSK9 inhibitors to max dose Statin Therapy to reach goals

Emphasis on Supporting Higher Weight Loss

- The recommended weight loss for patients with diabetes has been increased to **15%** of their body weight instead of **5%**.
- **Larger (10% or more)** weight loss may have disease-modifying effects, including DM remission & improve long-term CV outcomes.
- **Tirzepatide** – dual GLP-1 / GIP receptor agonist is added as a glucose lowering option with the potential for weight loss.

ASCVD: Atherosclerotic Cardiovascular Disease; GLP-1: Glucagon like Peptide; GIP: Glucose-dependent insulinotropic polypeptide; LDL: Low Density Lipoprotein; PCSK9: Proprotein convertase subtilisin/kexin type 9

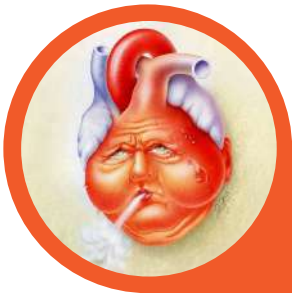
USE OF GLUCOSE-LOWERING MEDICATIONS IN THE MANAGEMENT OF TYPE 2 DIABETES



* In people with HF, CKD, established CVD or multiple risk factors for CVD, the decision to use a GLP-1 RA or SGLT2i with proven benefit should be independent of background use of metformin;† A strong recommendation is warranted for people with CVD and a weaker recommendation for those with indicators of high CV risk. Moreover, a higher absolute risk reduction and thus lower numbers needed to treat are seen at higher levels of baseline risk and should be factored into the shared decision-making process. See text for details; ^ Low-dose TZD may be better tolerated and similarly effective; § For SGLT2i, CV/renal outcomes trials demonstrate their efficacy in reducing the risk of composite MACE, CV death, all-cause mortality, MI, HHF, and renal outcomes in individuals with T2D with established/high risk of CVD; # For GLP-1 RA, CVOTs demonstrate their efficacy in reducing composite MACE, CV death, all-cause mortality, MI, stroke, and renal endpoints in individuals with T2D with established/high risk of CVD.

Use of Glucose-lowering Medications in the Management of T2DM

The Expanded Role of SGLT2 inhibitor Use in Heart Failure with Preserved and Reduced Ejection Fraction



Sodium –glucose cotransporter 2 (SGLT2) inhibitor with proven benefit is now recommended in T2DM patients with heart failure with either preserved (HFpEF) or reduced ejection fraction (HFrEF).

(Earlier recommended in HFrEF only)

Diabetes & Kidney Disease Guidance Updated

- **Guidelines also advocate for aggressive treatment to prevent CKD since diabetes causes progression & worsening of this condition.**
- **Finerenone - a novel nonsteroidal Mineralocorticoid Receptor Antagonists (MRA) is recommended in T2DM patients with CKD with albuminuria to improve CV outcomes & reduce CKD progression.**
- **Threshold for initiating an SGLT2 inhibitor for kidney protection has changed.**

For any scientific queries on above topic

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