Overview of ADA standards 2022

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Table 2.2—Criteria for the diagnosis of diabetes

FPG ≥126 mg/dL (7.0 mmol/L). Fasting is defined as no caloric intake for at least 8 h.*
OR
2-h PG ≥200 mg/dL (11.1 mmol/L) during OGTT. The test should be performed as described by WHO, using a glucose load containing the equivalent of 75 g anhydrous glucose dissolved in water.*
OR
A1C ≥6.5% (48 mmol/mol). The test should be performed in a laboratory using a method that is NGSP certified and standardized to the DCCT assay.*
OR
In a patient with classic symptoms of hyperglycemia or hyperglycemic crisis, a random plasma glucose ≥200 mg/dL (11.1 mmol/L).

DCCT, Diabetes Control and Complications Trial; FPG, fasting plasma glucose; OGTT, oral glucose tolerance test; WHO, World Health Organization; 2-h PG, 2-h plasma glucose. *In the absence of unequivocal hyperglycemia, diagnosis requires two abnormal test results from the same sample or in two separate test samples.

Classification and Diagnosis of Diabetes:
Standards of Medical Care in Diabetes - 2022. Diabetes Care 2022;45(Suppl. 1):S17-S38

American Diabetes Association.
Connected for Life

Table 4.3—Assessment of hypoglycemia risk

Factors that increase risk of treatment-associated hypoglycemia

- Use of insulin or insulin secretagogues (i.e., sulfonylureas, meglitinides)
- Impaired kidney or hepatic function
- Longer duration of diabetes
- Frailty and older age
- Cognitive impairment
- Impaired counterregulatory response, hypoglycemia unawareness
- Physical or intellectual disability that may impair behavioral response to hypoglycemia
- Alcohol use
- Polypharmacy (especially ACE inhibitors, angiotensin receptor blockers, nonselective β-blockers)
- History of severe hypoglycemic event

In addition to individual risk factors, consider use of comprehensive risk prediction models (105).

See references 106–110.

Obesity and Weight Management for the Treatment of Type 2 Diabetes

SGLT2 inhibitor	0.5 to 0.7	Weight loss, reduction in systolic blood pressure, reduced cardiovascular mortality in patients with established CVD, improved renal outcomes in patients with nephropathy	Vulvovaginal candidiasis, urin tract infections, bone fracture lower limb amputations, DKA
DPP-4 inhibitor	0.5 to 0.8	Weight neutral	Possible increased risk of HF with saxagliptin, expensive
Alpha-glucosidase inhibitor	0.5 to 0.8	Weight neutral	Frequent GI side effects, 3 times/day dosing
Pramlintide	0.5 to 1.0	Weight loss	3 injections daily, frequent GI side effects, long-term safety not established, expensive

A1C: glycated hemoglobin; GI: gastrointestinal; eGFR: estimated glomerular filtration rate; GLP-1: glucagon-like peptide-1; CVD: cardiovascular disease; MI: myocardial infarction; HF: heart failure; SGLT: sodium-glucose co-transporter 2; DKA: diabetic ketoacidosis; DPP-4: dipeptidyl peptidase 4.

* Initiation is contraindicated with eGFR <30 mL/min/1.73 m^2 and not recommended with eGFR 30 to 45 mL/min/1.73 m^2.

¶ The order of listing of additional therapies does not indicate a preferred order of selection. The choice of additional therapy should be based on criteria discussed in the UpToDate topics on the management of hyperglycemia in diabetes mellitus.

Δ Repaglinide is more effective in lowering A1C than nateglinide.

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