

Transcript Details

This is a transcript of an educational program accessible on the ReachMD network. Details about the program and additional media formats for the program are accessible by visiting: <https://reachmd.com/programs/medical-industry-feature/overviewing-glycemic-control-algorithm-2020-american-college-endocrinology-consensus-statement/11828/>

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Overview of the Glycemic Control Algorithm from the 2020 AACE/ACE Consensus Statement

Announcer:

Welcome to ReachMD.

This medical industry feature, titled "Overview of the Glycemic Control Algorithm from the 2020 AACE/ACE Consensus Statement," is sponsored by Novo Nordisk. This program is intended for physicians.

To view the 2020 AACE/ACE Consensus Statement, visit AACE.com and select Disease State Resources - Diabetes.

Dr. Mora:

Good afternoon. My name is Dr. Pablo Mora. I'm a Clinical Professor in the Division of Endocrinology at University of Texas Southwestern Medical Center of Dallas. I am also a Clinical Investigator at the Dallas Diabetes Research Center, located in Medical City Dallas, Texas. Today, I'm going to walk you through the glycemic control algorithm that is part of the American College of Endocrinology consensus's statement for 2020.

The American College of Endocrinology algorithm and consensus statements have consistently made a point of differentiating A1C goals based on individual patient characteristics. An A1C of less than or equal to 6.5 percent is a recommended goal for patients without concurrent serious illness or relatively low risk of hypoglycemia, while an A1C greater than 6.5 percent is recommended for patients with other comorbid conditions and are at risk for hypoglycemia. In addition to making sure that our patients are continuing to make optimal lifestyle modifications, we identify the individualized goals for each of our patients. Additionally, it is now recommended to use technological advances, including continuous glucose monitoring, or CGM, in its various forms to identify what happens overnight and throughout the day, especially after meals.

The consensus statement now recommends that, independent of glycemic control, you consider initiating long-acting GLP-1 receptor agonists and SGLT2 inhibitors with proven efficacy, if your patients have established atherosclerotic cardiovascular disease or at a high risk for cardiovascular disease or have a history of chronic kidney disease (CKD).

According to the ACE consensus statement, entry A1C value can assist in therapy decisions. Under the left-hand side, you can see the category for A1C that is less than 7.5 percent. The middle of the algorithm covers when the A1C is equal to or greater than 7.5 percent but no higher than 9.0 percent, and on the right-hand side, you can see a category for when the patient is poorly controlled with an A1C greater than 9.0 percent.

On the left-hand side, monotherapy is recommended for patients with an entry A1C of less than 7.5 percent. Please note the order of medications represent a suggested hierarchy of usage, and the length of line reflects strength of recommendation. If patients have established atherosclerotic cardiovascular disease or at a high risk for atherosclerotic cardiovascular disease, have CKD of stage 3, or the presence of heart failure with reduced ejection fraction independent of glycemic control, the consensus's statement recommend a long-acting GLP-1 receptor agonist or an SGLT2 inhibitor with proven efficacy.

Let's move to the middle section for patients with A1C greater than or equal to 7.5 percent but no higher than 9 percent. So, in this A1C range, the majority of patients are recommended to receive dual or triple therapy, and as you can see, the GLP-1 receptor agonists and SGLT2 are options included for both dual and triple therapy recommendations based on the hierarchy and the strength of recommendation. One thing that is very important for these patients is that, as much possible, to stay on metformin at the maximum tolerable daily dose if that is what the previous treatment being received, and if the patient doesn't achieve their A1C goal after three months, then you'll consider adding a third agent if you started with dual therapy, or you can add or intensify insulin as depicted on the

right-hand side. Re-evaluating therapy every three months helps reduce delays in treatment intensification for patients not at goal.

And the last category on the right-hand side, an entry A1C level greater than 9 percent, it is recommended to provide treatment based on the presence of symptoms. If symptoms are present, insulin therapy is recommended plus or minus other agents. The consensus statement supports individualizing therapy based on the patient's symptoms and comorbid conditions. If the patient has an A1C greater than 9 percent but has no symptoms, then you can try to optimize dual or triple therapy, and, once again, if in three months the patient is not achieving their A1C goal, then it's recommended to add or intensify insulin.

In addition to glycemic control, returning to an important point I made earlier, at any given time treatments can also be dictated by whether the patient has established atherosclerotic cardiovascular disease or is at high risk for atherosclerotic cardiovascular disease and/or has chronic kidney disease at stage 3 independent of glycemic control.

With that, I want to thank you for your attention today.

Announcer:

You've been listening to this Medical Industry Feature, sponsored by Novo Nordisk. If you missed any part of this discussion visit reachmd.com/heartoft2d. To access the full 2020 AACE/ACE Consensus Statement, go to [AACE.com](https://aace.com) and select Disease State Resources Diabetes. This is ReachMD. Be part of the knowledge.

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