

**Drug Therapy Choices for Type 2 DM in Primary Care: ACP vs ADA Updated Recommendations**

	<b><u>ADA</u></b>			<b><u>ACP</u></b>		
<b>A1C GOAL:</b>	< 7% if can be achieved safely			Between 7 and 8% for most adults with Type 2 De-intensify for A1C < 6.5%		
<b><u>Drug Therapy Recommendations</u></b>						
<b>First Line for Glycemic Management</b>	Metformin plus lifestyle modifications PLUS GLP1-RA or SGLT2-I if indicated			Metformin plus lifestyle modifications (unless contra-indicated)		
<b>When to ADD an SGLT2-I or GLP1-RA</b>	Initially, consider dual therapy for cardiorenal risk reduction for persons with established ASCVD or at high risk (GLP1-RA or SGLT2-I) <i>independent of A1C</i>			Add new meds ONLY if glycemic goals aren't met with lifestyle and Metformin alone.		
<b><u>WHICH CLASS TO PRIORITIZE by RISK REDUCTION:</u></b>						
<b>Risk Reduction:</b>	All-cause mortality	MACE	Progression of CKD	Hospitalization due to CHF	Stroke	Weight management
<b>SGLT2-I</b>	Yes	Yes	Yes	Yes	No	No
<b>GLP1-RA</b>	Yes	Yes	No	No	Yes	Yes
<b>OTHER DRUG THERAPY CHOICES:</b>	<b><u>ADA</u></b>			<b><u>ACP</u></b>		
<b>Use of DPP4-Inhibitors</b>	Not prioritized			Recommends <u>AGAINST</u> adding to regimen due to no evidence to reduce morbidity and all-cause mortality		
<b>Use of Sulfonylureas</b>	Not prioritized due to risk of HYPOGLYCEMIA and weight gain					
<b>Use of Basal Insulin</b>	Caution due to risk of HYPOGLYCEMIA Recommends GLP1-RA initiation <i>before</i> basal insulin			Inferior to SGLT2-I and GLP1-RAs to reduce morbidity/mortality, yet some limited value for glycemic control		

**References:**

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  - LINK to visual clinical guideline: <https://www.acpjournals.org/doi/full/10.7326/M24-0803>
- Drake T, Landsteiner A, Langsetmo L, et al. Newer pharmacologic treatments in adults with type 2 diabetes: a systematic review and network meta-analysis for the American College of Physicians. Ann Intern Med. 19 April 2024. [Epub ahead of print]. doi:10.7326/M23-1490
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