COMMENTS AND RESPONSES

Comment on: Inzucchi et al. Management of Hyperglycemia in Type 2 Diabetes: A Patient-Centered Approach. Position Statement of the American Diabetes Association (ADA) and the European Association for the Study of Diabetes (EASD). Diabetes Care 2012;35: 1364–1379

Management of hyperglycemia in type 2 diabetes is certainly one of the most debated fields in medicine (1). Although poor possibilities in drug choice for years maintained the discussion only on what glucose target should be reached, the recent introduction of new drugs playing on different mechanisms of action compelled the debate on what drug should be chosen. Unfortunately, most drugs share similar efficacy, and this generated several comments and recommendations usually based on experts' opinion rather than on evidence-based medicine (2,3). A clear demonstration of the subjectivity of the previous and the present consensus statements by the American Diabetes Association and the European Association for the Study of Diabetes is the profound changes observed between them (1–3). For example, dipeptidyl peptidase 4 inhibitors, previously excluded (3) for lower efficacy, are now included in the flowchart (1); certainly their efficacy has been known since their market launch. Glyburide (European glibenclamide) was banned for increased risk of severe hypoglycemia (3); in this last consensus it is included again, with the suggestion of particular care in prescribing it in patients with moderate to severe renal insufficiency (strange again—such contraindication is shared by almost all sulfonylureas). Strong evidence can hardly change in such a short period of time.

The two Italian scientific diabetes societies (Società Italiana di Diabetologia and Associazione Medici Diabetologi) have provided specific recommendations (4) for the diagnosis and treatment of diabetes and its complications, including recommendations for oral medications for type 2 diabetes. An original processing system was used to create these recommendations: the document prepared by the editorial team was published online for 20 days, and the suggestions and criticisms of all of the members were evaluated and integrated with those from a panel of specialists and members of other health care professions committed to diabetes care, as well as lay members, including patient representatives. More importantly, each statement is accompanied by a predefined 6-scale grade of force and evidence for the recommendation, which helps the reader in distinguishing between opinion and proof.

We hereby recognize that the last (1) consensus statement is based on evidence more than the previous ones. Actually, we are glad to observe that the proposed flowchart is almost identical to what has been proposed in the Italian document (4). Further, the choice between different therapeutic opportunities is predominantly based on well-known possible side effects (or absence of side effects) instead of pathophysiological wishes, with an attempt to cope with the patients' needs. Nevertheless, the absence of any grade of evidence (the only grade is the eventual presence of a question mark) still leaves the readers too free to interpret them, assuring the false perception that their prescription/interpretation is following the American Diabetes Association and the European Association for the Study of Diabetes proposed consensus. Guidelines should serve as reference (5). A nonexpert practitioner can be particularly puzzled by the unexplained mix of evidence and opinions, especially if the latter change profoundly between the various consensus versions; the experts will read these consensus just to stimulate (successful) debates.

We hope, for the future, that other models of reporting graded evidences, as ours (4), will be taken into account.

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