ONLINE LETTERS

COMMENTS AND RESPONSES

Response to **Comments 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

e read the comments of Rodbard and Jellinger (1) with interest, but we feel that perhaps the very problem that the position statement of the American Diabetes Association and the European Association for the Study of Diabetes (2) was trying to circumvent comes across strongly in their communication. We have been cautious of certainty on the basis of the variety of clinical situations, the heterogeneity of response, the disparities of resource, the complexity of social or cultural environments, and the manifold wishes of each of our patients. Indeed, the primary care physician may be best placed to implement a proper individualized and successful therapeutic strategy.

Our position statement is not, and was not designed to be, an algorithm. The rationale for this is that we felt that expressing "strong preferences" and a belief that a "specific prescriptive approach ... should be advantageous" (1) may be misplaced. Such robust views meld poorly with the concept of a patient-centered approach.

More explicitly, we do not think that being "much closer to" a previously published algorithm is, of itself, a marker of "dramatic" improvement. Yet we have been careful to cite and embrace the work of others upon whose shoulders we stand. Nor do we recognize "a three-pronged approach," which seems to carry with it the concept of a coercing trident. We have been careful to avoid any dogmatic therapeutic propositions based on HbA_{1c} levels above or below thresholds alone. Indeed, we are trying to encourage the process of decision making on a flexible basis, individualizing patient-centered care on criteria other than those simply obtained from a laboratory—without denying the profound importance of such measures.

In the case of the choice of therapy, our statement that the order "is not meant to denote any specific preference" should be read as meaning that! The English seems clear to us. Then, on matters of cost, it is imperative to recognize that resource may be paramount—both to governments and to those who need to use their own money to buy pharmaceutical agents. In some countries, it is possible to fund 16.7 years of sulfonylurea for the cost of one month's supply of a glucagonlike peptide 1 agonist. For some, especially in the U.S., costs may make the difference between no treatment and some treatment. But as costs change, so will the choices

We have also carefully read the comments of Giaccari et al. (3). We applaud the work of those who take care in grading evidence, and we did not intend that our article should sideline such work. But we need to emphasize that the best randomized controlled trial evidence base for our treatment of newly diagnosed patients still rests largely on the UK Prospective Diabetes Study (4). Strict observance of the absolute high-quality evidence base (5) can lead to restrictive, less-than-helpful headline recommendations to 1) treat beyond diet and exercise, 2) treat with metformin, and then 3) treat with something else as well

We need to use all our international collegiate combined medical knowledge, skill, and wisdom if we are to serve our patients beyond the mathematics of greater-than and less-than signs and the self-imposed statistical fundamentalism that implies that we cannot decide anything beyond the constraints of a *P* value.

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References

- 1. Rodbard HW, Jellinger PS. 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 (Letter). Diabetes Care 2012;35:e70. DOI: 10.2337/dc12-0768
- Inzucchi SE, Bergenstal RM, Buse JB, et al.; American Diabetes Association (ADA); European Association for the Study of Diabetes (EASD). Management of hyperglycemia in type 2 diabetes: a patientcentered 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
- Giaccari A, Giorda CB, Riccardi G, et al. Comment on: Inzucchi et al. Management of hyperglycemia in type 2 diabetes:

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- 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 (Letter). Diabetes Care 2012;35:e71. DOI: 10.2337/dc12-0784
- 4. UK Prospective Diabetes Study (UKPDS) Group. Intensive blood-glucose control with sulphonylureas or insulin compared with conventional treatment and risk of complications in patients with type 2 diabetes (UKPDS 33). Lancet 1998;352: 837–853
- 5. Qaseem A, Humphrey LL, Sweet DE, Starkey M, Shekelle P; Clinical Guidelines Committee of the American College of Physicians. Oral pharmacologic treatment of type 2 diabetes mellitus: a clinical practice guideline from the American College of Physicians. Ann Intern Med 2012;156:218–231