no difference in T1DM duration across groups. There were also no differences in body mass index, TDD, TDD/weight (units/kg/day), nor in the rates of retinopathy or neuropathy. Multiple regression analysis identified %B/T as an independent predictor of the HbA1c concentration. A difference in the rates of hypoglycemic episodes per month was found among individuals with a %B/T ≤50%: 2 (1–5) versus 6 (2.5–12) episodes per month in those having a higher %BT (p=0.002). There are limitations in our study, including the retrospective nature of the analysis, no data about meal content and a low usage of CGM (thus relying on variable self-monitoring of blood glucose). Therefore, we cannot asseverate that lowering the %B/T would improve glycemic and microvascular outcomes. Nevertheless, our findings indicate that the %B/T correlates with HbA1c levels and are consistent with those previously described. It also suggests a relationship with hypoglycemia and to the best of our knowledge, it is the first time that an association between %B/T and nephropathy has been noted.

Diabetes Mellitus and Glucose Metabolism

TYPE 1 DIABETES

Should Target Glucose Values Be Increased to Avoid Severe Hypoglycemia? Real-World Data Say "No."

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Early studies such as the Diabetes Control and Complications Trial showed a strong inverse relationship between A1C and the risk of severe hypoglycemia in type 1 diabetes. This risk has historically limited insulin therapy intensification efforts, and some treatment guidelines (e.g., Rosenzweig et al., J Clin Endocrinol Metab 105:969, 2020) suggest that A1C values <7% confer an increased risk of hypoglycemia. Nowadays, real-time continuous glucose monitoring (CGM) systems can flatten and attenuate the relationship between overall glucose control and hypoglycemia (Oliver et al., Diabetes Care 43:53, 2020). The glucose management indicator (GMI) is an estimate of A1C derived from the CGM system's mean estimated glucose value (EGV) (Bergenstal et al., Diabetes Care 41:2275, 2018). We analyzed real-world evidence of the relationship between the GMI and exposure to hypoglycemia. Data were from an anonymized convenience sample of US-based users of the G6 CGM system (Dexcom, Inc., San Diego, CA) who used a mobile device to upload EGVs in the third quarter of 2020. Only data from people who had uploaded ≥80% of possible values were included. Each person's GMI was calculated as GMI = 3.31 + (0.02392 × mean EGV [mg/dL]). Each person's exposure to hypoglycemia was estimated as the percentage of EGVs <70 mg/dL or <54 mg/dL (%<70 and %<54, respectively). Patients were grouped into 6 categories according to GMI values <6.5%, 6.5 to 6.9%, 7.0 to 7.4%, 7.5 to 7.9%, 8.0 to 8.4%, and ≥8.5%. Mean %<70 mg/dL and %<54 mg/dL were both inversely correlated with GMI, decreasing monotonically as the GMI category increased. GMI category, %<70, and %<54 are as follows: (<6.5%: 5.27%, 1.13%); (6.5 to 6.9%: 2.84%, 0.59%); (7.0 to 7.4%: 1.95%, 0.41%); (7.5 to 7.9%: 1.46%, 0.31%); (8.0 to 8.4%: 1.14%, 0.25%); (≥8.5%: 0.69%, 0.17%). However, in all GMI categories except for the "<6.5%" category, the extent of hypoglycemic exposure was below the consensus targets proposed by Battelino et al. (Diabetes Care 42:1593, 2019) of <4% for EGVs <70 mg/dL and <1% for EGVs <54 mg/dL. The approach of elevating A1C targets to reduce hypoglycemia risk is not supported by real-world evidence for CGM users who have GMI or A1C values ≥6.5%. CGM users can safely strive for A1C values <7.0%.

Diabetes Mellitus and Glucose Metabolism

TYPE 1 DIABETES

The CGM Experience of Minority Adults With Type 1 Diabetes in the South Bronx

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Objective: To describe the state of type 1 diabetes (T1D) in minority adults in the South Bronx, and their experience with continuous glucose monitoring (CGM). **Introduction:** In a recent analysis of data from the Type 1 Diabetes Exchange Registry, one notable finding was the difference in metabolic control and use of diabetes technology in patients of different socioeconomic status and racial/ethnic backgrounds. With limited data available on Hispanic and Black patients, we sought to examine the use of and experience with continuous glucose monitoring (CGM) in our hospital system, which primarily serves a low-income, minority population in the South Bronx. **Methods:** 68 adults with T1D who attended the Endocrinology clinic at our hospital from 2017 to 2019 were identified. Patients were contacted by telephone to complete a questionnaire regarding CGM use and satisfaction. A retrospective chart review was conducted to obtain additional demographic and clinical information. **Results:** Out of 68 patients with T1D in the hospital database who were contacted, 47 patients completed the questionnaire. The age range was 23 to 63 years. 42.6% were male. 59.6% were Hispanic, 19.1% Black/African American (AA), 4.3% Caucasian, and 17% not specified. 87.2% had public insurance. Overall, 48.9% of patients were actively using CGM, 19.1% had discontinued use of CGM, and 31.9% had never used CGM. In Hispanic patients using CGM, mean HbA1C was 8.2% compared to 10.1% in Hispanic non-users. In Black/AA patients using CGM, mean HbA1C was 9.2% compared to 9.9% in Black/AA non-users. Hospitalizations for acute diabetes complications were lower in CGM users (4.3%) compared to non-CGM users (16.7%). Among active CGM users, 74% rated their satisfaction as "extremely satisfied" or "very satisfied." Perceived benefits included the prevention of hypoglycemia and awareness of inappropriate food intake. **Discussion:** Our study population, mainly comprised of Hispanic and Black T1D adults, showed a higher CGM utilization rate than previously reported. After stratification by socioeconomic status, CGM utilization was reported to be as low as 16% in Hispanic and 10% in Black patients with household income <$50,000/year in the T1D Exchange Registry. By comparison, 49% of our studied population possessing similar demographics was