American College of Physicians Guidance Statement: HbA1c targets for pharmacologic therapy of non-pregnant adults with type 2 diabetes

Devan Kansagara MD MCR FACP
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Disclosure of Financial Relationships

Devan Kansagara, MD, MCR, FACP

Has no relationships with any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients.
ACP and guidelines

- Evidence-based guidelines since 1981
- Clinical Guidelines Committee
  - Standing committee of 12 physicians with different areas of expertise
    - Primary care, hospitalist, subspecialty
    - EBM methods, health services research, epidemiology
  - 2 non-physician public members
  - 7 additional public members on “citizen jury”
- Primary care is a key target audience
Guidance statement

- Rigorously review existing guidelines and their evidence base
  - UKPDS (33 +34), VADT, ACCORD, ADVANCE
- Recommendations based on consideration of:
  - Benefits
  - Harms
  - Values and preferences
  - Cost

Qaseem A, Wilt T, Kansagara D et al, Ann Int Med, 2018
The balance

How big? Magnitude of benefit and harm (in absolute terms)?
How certain? Quality, consistency, applicability of the evidence?
How important? Clinical importance of the outcomes measured?
Recommendation 1

- Clinicians should personalize goals for glycemic control in patients with type 2 diabetes on the basis of a discussion of benefits and harms of pharmacotherapy, patients’ preferences, general health and life expectancy, treatment burden, and costs of care.
 Recommendation 2

- Clinicians should aim to achieve an HbA1c level between 7% and 8% in most patients with type 2 diabetes.
Rationale for target 7-8%

- Ideal balance of benefit and harm
- Little evidence of benefit for lower A1c
- Where there is evidence of benefit it is inconsistent, mostly in surrogate outcome measures, and small in absolute terms
- Consistent evidence for increased risk of severe hypoglycemia
- Increased risk of death with A1c target < 6.5%
Clinical considerations

- Lifestyle interventions to lower targets are supported
- “Most” is not all
- Targets closer to 7% may be appropriate for patients with >15 year life expectancy and who prioritize more intensive control over risk, cost, burden
- Smoking cessation, lipid management, BP control are important and, for many patients, may take priority over glycemic control
- Clinical effects of using newer meds to treat to lower targets: no data
Recommendation 3

- Clinicians should consider deintensifying pharmacologic therapy in patients with type 2 diabetes who achieve HbA1c levels less than 6.5%.
Rationale for recommendation 3

- Harms/cost/burden outweigh benefit for many of these patients
- In practice, de-intensification is uncommon and overtreatment is common
- Providers worry about not meeting performance measures
- Without an explicit recommendation, de-intensification is often not considered or prioritized

McCoy R, JAMA IM, 2016
Caverly TJ, JAMA IM, 2015
Recommendation 4

Clinicins should treat patients with type 2 diabetes to minimize symptoms related to hyperglycemia and avoid targeting an HbA1c level in patients with life expectancy less than 10 years due to advanced age (80 years or older), residence in a nursing home, or chronic conditions such as dementia, cancer, end-stage kidney disease, severe chronic obstructive pulmonary disease or congestive heart failure because the harms outweigh the benefits in this population.