Diabetes Management Guide

American Diabetes Association (ADA) and American Association of Clinical Endocrinologists (AACE) Summary of Recommendations for Adults With Diabetes

This tool is designed as a quick reference guide to help healthcare providers identify guideline-based target ranges for their patients with diabetes. Although multiple guidelines are available for the management of patients with diabetes, the information summarized here is based on the ADA and AACE guidelines. Please refer to the full guidelines for more information.

Glycemic control[1-3]

ADA recommendations[1]:

A1C (for many nonpregnant adults)	<7.0%
Preprandial capillary plasma glucose	70-130 mg/dL (3.9-7.2 mmol/L)
Peak postprandial capillary plasma glucose*	<180 mg/dL (<10.0 mmol/L)

AACE recommendations[2,3]:

A1C (for most nonpregnant adults)	≤6.5%†
Preprandial capillary plasma glucose	<110 mg/dL
Peak postprandial capillary plasma glucose	<140 mg/dL

*Postprandial glucose measurements should be made 1-2 hours after the beginning of the meal, which are generally peak levels in patients with diabetes.
†For healthy patients without concurrent illness at low hypoglycemic risk. Individualize goals for patients with concurrent illness and at risk for hypoglycemia.

Lipids[1]

ADA recommendations[1]:

LDL	<100 mg/dL (<2.6 mmol/L)
Triglycerides	<150 mg/dL (<1.7 mmol/L)
HDL	>40 mg/dL for men (>1.0 mmol/L) >50 mg/dL for women (>1.3 mmol/L)

Hypertension[1]

ADA recommendation[1]:

Blood pressure ... <140/80 mm Hg

Key concepts in setting glycemic goals

- A1C is a primary target for glycemic control[1]
  - Postprandial glucose may be targeted if A1C goals are not met despite reaching preprandial glucose goals
- Goals should be individualized based on duration of diabetes, age/life expectancy, comorbid conditions, known cardiovascular disease or advanced microvascular complications, hypoglycemia unawareness, and individual patient considerations[1]
  - More or less stringent glycemic goals may be appropriate for individual patients
- If patients do not meet goals, step up therapy or refer to a specialist[1,3]

References: 1. American Diabetes Association. Standards of medical care in diabetes—2013. *Diabetes Care.* 2013;36(suppl 1):S11-S66. **2.** Handelsman Y, Mechanick JI, Blonde L, et al; AACE Task Force for Developing Diabetes Comprehensive Care Plan. American Association of Clinical Endocrinologists Medical Guidelines for Clinical Practice for Developing a Diabetes Mellitus Comprehensive Care Plan. *Endocr Pract.* 2011;17(suppl 2):1-53. **3.** Abrahamson MJ, Barzilay JI, Blonde L, et al. American Association of Clinical Endocrinologists Comprehensive Diabetes Management Algorithm—2013. *Endocr Pract.* 2013;19(2):327-336.

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