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Management of Hyperglycemia in Type 2 Diabetes: A Consensus Algorithm for the Initiation and Adjustment of Therapy: A Consensus Statement From the American Diabetes Association and the European Association for the Study of Diabetes

Response to Nathan et al.

Although stating that lifestyle interventions “should [. . .] be included as part of diabetes management,” the American Diabetes Association/European Association for the Study of Diabetes consensus (1) on managing hyperglycemia in type 2 diabetes dismisses lifestyle interventions because of their “limited long-term success”; hence, the recommendation to immediately start newly diagnosed patients on lifestyle intervention plus metformin. The consensus even suggests that increased physical activity may lead to “potential problems associated with neuropathy,

such as foot trauma and ulcers” (a statement not supported by a reference) and that “the most convincing long-term data that weight loss effectively lowers glycemia have been generated in [. . .] type 2 diabetic patients who have had bariatric surgery,” which is hardly a model of lifestyle intervention.

A growing body of literature shows that lifestyle intervention is both feasible and effective in achieving and reinforcing the goals sought by pharmacological means (2–4). It cannot, however, be prescribed. Health operators, who are mainly trained to treat acute conditions, should stop thinking of their chronically ill patients as pill-popping automata who are “noncompliant” when they fail to ingest 10–15 tablets, walk 30 min, and perform other tedious tasks everyday. Adults learn and apply new concepts if they perceive them as reasonable, useful, and related to personal experience. Realistic self-management plans can only stem from alliances between patients and operators within reorganized working practices.

Some recent *Cochrane Database System Review* studies suggest that lifestyle intervention in type 2 diabetes is especially effective when implemented by interactive group education (2–4). Group education is far superior to the individual approach because of peer-to-peer relationships, dynamics, and other positive aspects of group education that are impossible to elicit in traditional one-to-one, usually top-down consultations. Group education also generates higher satisfaction in patients and operators. In our experience, substituting individual visits with group visits in routine care of type 2 diabetic patients achieved long-term (5 years) sustained weight loss, stabilization of A1C, and amelioration of cardiovascular risk factors while reducing prescribed medication (5). Over the first 4 years, group care cost an additional 56.7 U.S. dollars per patient to keep A1C one percentage point lower and 2.12 U.S. dollars per point gained in the quality-of-life score.

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Recently, a joint consensus statement by the American Diabetes Association/European Association for the Study of Diabetes (1) recommended starting insulin therapy for type 2 diabetes with basal insulin and increasing doses until a fasting glucose <130 mg/dl was