

Actotalk In Tabriz

Sept, 2021



Together for a healthy future

ACTtalk

Sharing Best Practices



Case (1)

- 52 y/o man
- Truck driver (12 h/day)
- Middle income
- First visit to the Clinic
- CC: Frequent urination and excessive thirst
- **PMHx:**
 - Confirmed T2DM family history on both sides
 - Sedentary life style
- **PE:**
 - BW: 85.5 kg
 - BH: 185 cm
 - BMI: 26.2
 - Thyroid exam.: Normal
- Cardiovascular exam.: Normal
- Lung hearing: Normal
- Peripheral pulses are full and symmetrical

Lab Tests

Lab Test
HbA1c: 9.1%; FBS: 185 mg/dL, 2hPPBS: 310 mg/dL
Cr: 0.7 mg/dL
TSH: Normal
LFT: Normal
TG: 147 mg/dL , Chol: 177 mg/dL, HDL: 46 mg/dL , LDL: 102 mg/dL
U/A Albumin: Negative

A1C Goal of Therapy



Summary of glycemic recommendations for many nonpregnant adults with diabetes

A1C

<7.0%

More or less stringent glycemic goals may be appropriate for individual patients. CGM may be used to assess glycemic target. Goals should be **individualized** based on [duration of diabetes](#), [age/life expectancy](#), [comorbid conditions](#), [known CVD](#) or [advanced microvascular complications](#), [hypoglycemia unawareness](#), and [individual patient considerations](#)

Preprandial capillary plasma glucose

80–130 mg/dL

More or less stringent glycemic goals may be appropriate for individual patients. CGM may be used to assess glycemic target. Goals should be **individualized** based on [duration of diabetes](#), [age/life expectancy](#), [comorbid conditions](#), [known CVD](#) or [advanced microvascular complications](#), [hypoglycemia unawareness](#), and [individual patient considerations](#)

Peak postprandial capillary plasma glucose

<180 mg/dL

[Postprandial glucose may be targeted if A1C goals are not met despite reaching preprandial glucose goals](#). Postprandial glucose measurements should be made 1–2 h after the beginning of the meal, generally peak levels in patients with diabetes.

More or less stringent glycemic goals may be appropriate for individual patients. CGM may be used to assess glycemic target. Goals should be **individualized** based on [duration of diabetes](#), [age/life expectancy](#), [comorbid conditions](#), [known CVD](#) or [advanced microvascular complications](#), [hypoglycemia unawareness](#), and [individual patient considerations](#)

Which one is better for the start?

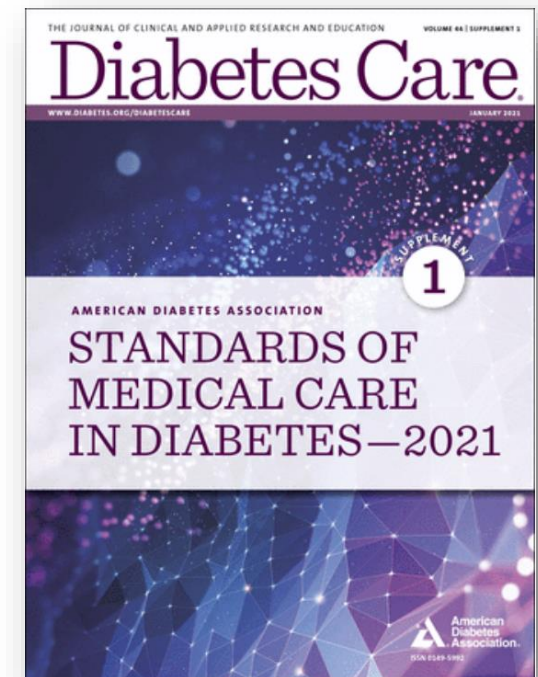
Along side of life style modification (calorie restriction and increasing physical activity):

1. Start Metformin 500 mg BD then increase to 1000 mg BD
2. Start with Metformin 1000 mg BD then add Sitagliptin (Glysta) 100 mg or change to Metformin/Sitagliptin (Sigomet) (1000/50) BD
3. Start Sigomet (500/50) BD then increase to Sigomet (1000/50) BD
4. Start with Sigomet (1000/50) BD then add 1000 mg Metformin in the evening
5. Start with Metformin 500 mg BD and Liraglutide
6. Start with Metformin 1000 mg BD then add Pioglitazone
7. Start with Glibenclamide 5 mg/day
8. Start with Gliclazide MR (Glicover) 30 mg/day then increase the dose or add Metformin
9. Start with Liraglutide
10. Start with Metformin 500 mg BD and Empagliflozin 10 mg/day then increase Metformin dose
11. Other options?

9. Pharmacologic Approaches to Glycemic Treatment: *Standards of Medical Care in Diabetes—2021*

American Diabetes Association

Diabetes Care 2021;44(Suppl. 1):S111–S124 | <https://doi.org/10.2337/dc21-S009>



FIRST-LINE Therapy is Metformin and Comprehensive Lifestyle (including weight management and physical activity)



INDICATORS OF HIGH-RISK OR ESTABLISHED ASCVD, CKD, OR HF†

CONSIDER INDEPENDENTLY OF BASELINE A1C, INDIVIDUALIZED A1C TARGET, OR METFORMIN USE*

+ASCVD/Indicators of High Risk

- Established ASCVD
- Indicators of high ASCVD risk (age >55 years with coronary, carotid, or lower-extremity artery stenosis or LVH)

EITHER/ OR

GLP-1 RA with proven CVD benefit¹

SGLT2i with proven CVD benefit¹

If A1C above target

If further intensification required or patient is unable to tolerate GLP-1 RA and/or SGIT2i, choose agents demonstrating CV benefit and/or safety:

- For patients on a GLP-1 RA, consider adding SGLT2i with proven CVD benefit and vice versa⁴
- TZD²
- Dpp-4i if not on GLP-1 RA
- Basal insulin³
- SU⁴

+HF

Particularly HFREF (LVEF <45%)

SGLT2i with proven benefit in this population^{5,6,7}

- Proven CVD benefit means it has label indication of reducing CVD events
- Low dose may be better tolerated though less well studied for CVD effects
- Degludec or U-100 glargine have demonstrated CVD safety
- Choose later generation SU to lower risk of hypoglycemia; glimepiride has shown similar CV safety to DPP-4i
- Be aware that SGLT2i labelling varies by region and individual agent with regard to indicated level of eGFR for initiation and continued use
- Empagliflozin, canagliflozin, and dapagliflozin have shown reduction in HF and to reduce CKD progression in CVOTs. Canagliflozin and dapagliflozin have primary renal outcome data. Dapagliflozin and empagliflozin have primary heart failure outcome data
- Proven benefit means it has label indication of reducing heart failure in this population
- Refer to Section 11 : Microvascular Complications and Foot Care
- Degludec / glargine U-300 < glargine U-100 / detemir < NPH insulin
- Semaglutide > liraglutide > dulaglutide > exenatide > lixisenatide
- If no specific comorbidities (i.e., no established CVD, low risk of hypoglycemia, and lower priority to avoid weight gain or no weight-related comorbidities)
- Consider country- and region-specific cost of drugs. In some countries TZDs are relatively more expensive and DPP-4i are relatively cheaper.

+CKD

DKD and Albuminuria⁸

PREFERABLY SGLT2i with primary evidence of CKD progression

OR SGLT2i with evidence of reducing CKD progression in CVOT^{5,6,8}

OR GLP-1RA with proven CVD benefit if SGIT2i not tolerated or contraindicated

For patients with TZD and CKD⁹ (e.g., eGFR <60 mL/min/1.73m²) and thus at increased risk of cardiovascular events

EITHER/ OR

GLP-1 RA with proven CVD benefit¹

SGLT2i with proven CVD benefit^{1,7}

NO

IF A1C ABOVE INDIVIDUALIZED TARGET PROCEED AS BELOW

COMPELLING NEED TO MINIMIZE HYPOGLYCEMIA

DPP-4i

GLP-1 RA

SGLT2i²

TZD

if HbA_{1c} above target

if HbA_{1c} above target

if HbA_{1c} above target

if HbA_{1c} above target

SGLT2i² OR TZD

SGLT2i² OR TZD

GLP-1 RA OR DPP-4i OR TZD

SGLT2i OR DPP-4i OR GLP-1 RA

if HbA_{1c} above target

Continue with addition of other agents as outlined above

if HbA_{1c} above target

Consider the addition of SU⁴ OR basal insulin:
 ■ Choose later generation SU with lower risk of hypoglycemia
 ■ Consider basal insulin with lower risk of hypoglycemia⁹

COMPELLING NEED TO MINIMIZE WEIGHT GAIN OR PROMOTE WEIGHT LOSS

EITHER/ OR

GLP-1 RA with good efficacy for weight loss¹⁰

SGLT2i²

if HbA_{1c} above target

SGLT2i²

GLP-1 RA with good efficacy for weight loss¹⁰

if HbA_{1c} above target

If quadruple therapy required or SGLT2i and/or GLP-1 RA not tolerated or contraindicated regimen with lowest risk of weight gain
PREFERABLY
 DPP-4i (if not on GLP-1 RA) based on weight neutrality

If DPP-4i not tolerated or contraindicated or patient already on GLP-1 RA, cautious addition of:

•SU⁴ •TZD² •Basal insulin

COST IS A MAJOR ISSUE^{11,12}

SU⁴

TZD¹²

if HbA_{1c} above target

TZD¹²

SU⁴

if HbA_{1c} above target

Insulin therapy basal insulin with lowest acquisition cost
 OR
 Consider other therapies based on cost

† Actioned whenever these become new clinical considerations regardless of background glucose-lowering medications.

*Most patients enrolled in the relevant trials were on metformin at baseline as glucose-lowering therapy.

چرخه تصمیم گیری برای مدیریت هیپرگلیسمی بیمار محور در دیابت نوع ۲

مرور دوره ای مجدد رویه درمان تایید آن در صورت

مان
س تغییرات لازم در رویه درمان
شدن تغییرات توافق شده درمانی به صورت زمان بندی شده به
تفاوتی به روند درمان
س یک یا دو بار در سال فرآیند چرخه تصمیم گیری بازنگری شده

نظارت و پشتیبانی مستمر شامل موارد زیر خواهد بود:

- دستیابی به احساس درونی تندرستی
- قابلیت تحمل داروهای مصرفی را ارزیابی کنید
- وضعیت گلیسمی را پایش کنید
- با ارزیابی مواردی نظیر اندازه گیری خانگی قند خون (SMBG)، وزن، شمارش تعداد قدم های پیموده شده، HbA1C، فشار خون، چربی های خون بازخوردهای تشویقی به بیمار بدهید (بیوفیدبک)

مدیریت درمان طراحی شده

فادر به دستیابی به اهداف درمان نمی شوند معمولاً تا
قتی دیده می شود باید حداقل هر ۳ ماه یکبار ویزیت
غلب مطلوبتر است فواصل ویزیت ها کمتر باشد تا برنامه
(DSM) پیاده شود.

ویژگی های اصلی بیمار را ارزیابی کنید

- شیوه زندگی فعلی
- بیماری های همراه نظیر بیماری قلبی عروقی آترواسکلروز
- کلیه و نارسایی قلب
- ویژگی های بالینی، به عنوان مثال، سن، HbA1C، و
- مسائلی مانند انگیزه و افسردگی
- زمینه فرهنگی و اجتماعی و اقتصادی

فاکتورهای خاصی که انتخاب شیوه درمان را تحت تاثیر قرار میدهد را در نظر بگیرید

- هدف فردی HbA1C
- تاثیر درمان بر وزن و هیپوگلیسمی
- طیف اثرات جانبی دارو
- پیچیدگی رژیم درمانی، یعنی دفعات و روش مصرف
- شیوه درمانی را انتخاب کنید تا بیشترین امکان به دست آوردن پایداری و پایداری در ادامه درمان را فراهم سازد.
- هزینه و امکان در دسترس بودن دارو را ارزیابی کنید.

طراحی شیوه درمان با لحاظ نظر بیمار و/یا مراقب

- شامل یک بیمار (و خانواده / مراقب یا پرستار) آموزش دیده و آگاه خواهد بود.
- ترجیحات بیمار را دنبال می کند
- مشاوره موثر شامل مصاحبه انگیزشی، تنظیم هدف و تصمیم گیری مشترک خواهد بود.
- بیمار را توانمند می سازد.
- دسترسی به DSMES (آموزش مدیریت بیماری خوشتن در دیابت و پشتیبانی مستمر) تضمین می کند.

ASCVD = Atherosclerotic Cardiovascular Disease

CKD = Chronic Kidney Disease

HF = Heart Failure

DSMES = Diabetes Self-Management Education and Support

SMBG = Self- Monitored Blood Glucose

Achievable - قابل دستیابی

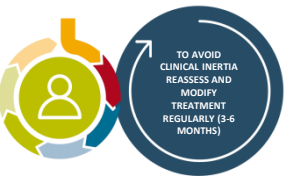
Realistic - واقع بینانه

Time limited - زمان بندی شده باشد.

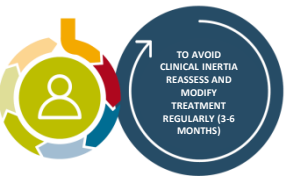


**TO AVOID CLINICAL
INERTIA REASSESS
AND MODIFY
TREATMENT
REGULARLY (3-6
MONTHS)**

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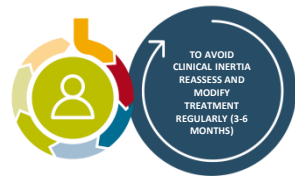
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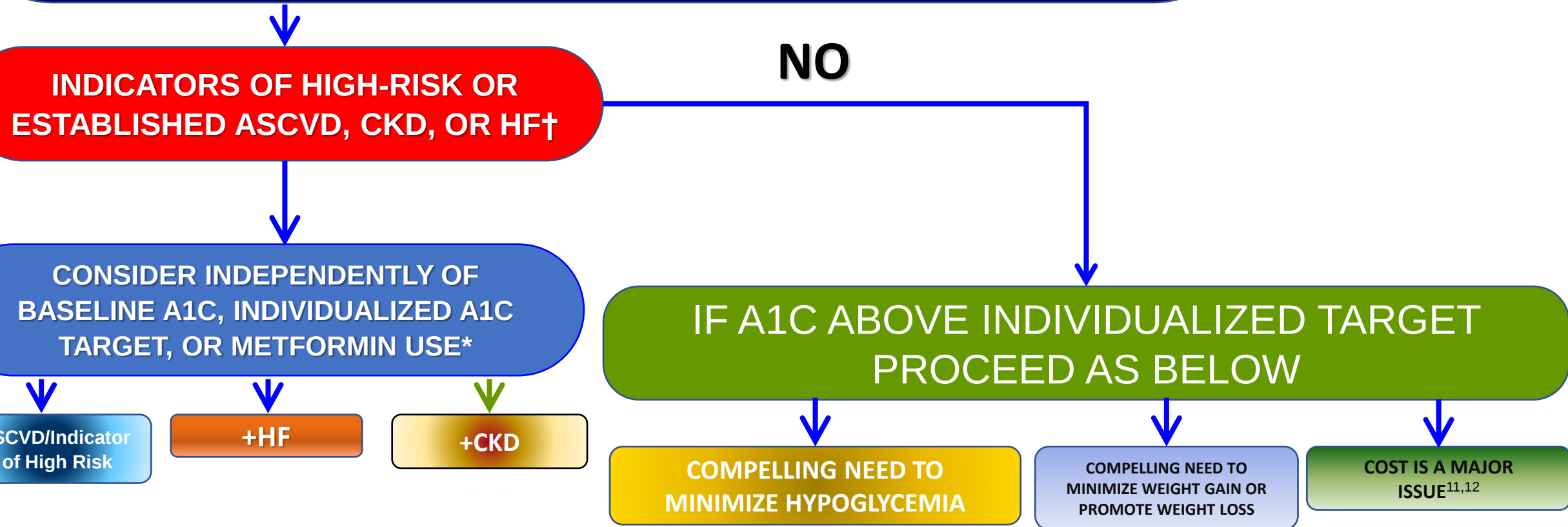
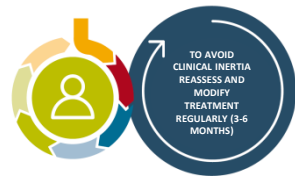
+ASCVD/Indicators of High Risk

+HF

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- Established ASCVD
- Indicators of high ASCVD risk (age >55 years with coronary, carotid, or lower-extremity artery stenosis or LVH)

EITHER/OR

GLP-1 RA
with proven
CVD benefit¹

SGLT2i with
proven CVD
benefit¹

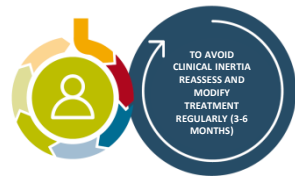
If A1C above target

If further intensification required or patient is unable to tolerate GLP-1 RA and/or SGLT2i, choose agents demonstrating CV benefit and/or safety:

- For patients on a GLP-1 RA, consider adding SGLT2i with proven CVD benefit and vice versa¹
- TZD²
- Dpp-4i if not on GLP-1 RA
- Basal insulin³
- SU⁴

- 1.Proven CVD benefit means it has label indication of reducing CVD events
- 2.Low dose may be better tolerated though less well studied for CVD effects
- 3.Degludec or U-100 glargine have demonstrated CVD safety
- 4.Choose later generation SU to lower risk of hypoglycemia; glimepiride has shown similar CV safety to DPP-4i

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IF A1C ABOVE INDIVIDUALIZED TARGET PROCEED AS BELOW

+HF

Particularly HFrEF (LVEF <45%)

SGLT2i with proven benefit in this population^{5,6,7}

5. Be aware that SGLT2i labelling varies by region and individual agent with regard to indicated level of eGFR for initiation and continued use

6. Empagliflozin, canagliflozin, and dapagliflozin have shown reduction in HF and to reduce CKD progression in CVOTs. Canagliflozin and dapagliflozin have primary renal outcome data. Dapagliflozin and empagliflozin have primary heart failure outcome data

7. Proven benefit means it has label indication of reducing heart failure in this population

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NO

IF A1C ABOVE INDIVIDUALIZED TARGET PROCEED AS BELOW

+CKD

DKD and Albuminuria⁸

NO

PREFERABLY SGLT2i with primary evidence of CKD progression

OR

SGLT2i with evidence of reducing CKD progression in CVOT^{5,6}.

OR

GLP-1 RA with proven CVD benefit if SGLT2i not tolerated or contraindicated

For patients with T2D and CKD (e.g., eGFR <60 mL/min/1.73m²) and thus at increased risk Of cardiovascular events

EITHER/OR

GLP-1 RA with proven CVD benefit¹

SGLT2i with proven CVD benefit^{1,7}

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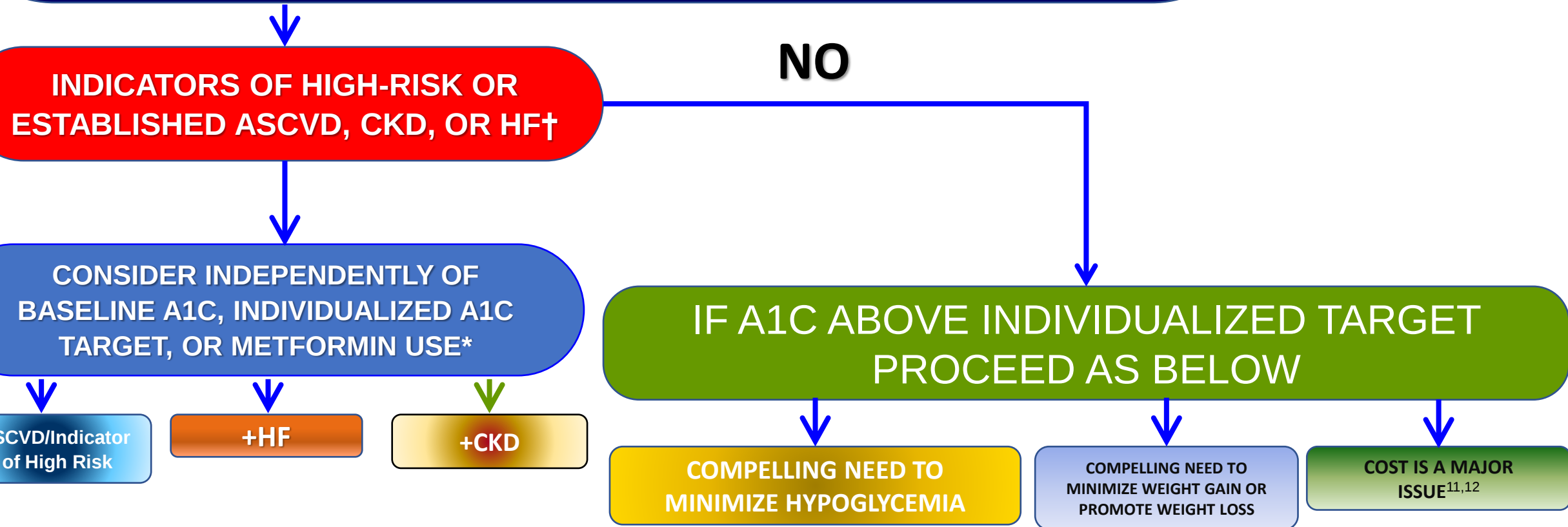
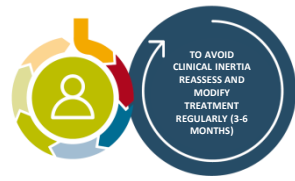
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8. Refer to Section 11 : Care



Microvascular Complications and Foot

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NO

IF A1C ABOVE INDIVIDUALIZED TARGET PROCEED AS BELOW

COMPELLING NEED TO MINIMIZE HYPOGLYCEMIA

DPP-4i

if HbA_{1c} above target

SGLT2i²
OR
TZD

GLP-1 RA

if HbA_{1c} above target

SGLT2i²
OR
TZD

SGLT2i²

if HbA_{1c} above target

GLP-1 RA
OR
DPP-4i
OR
TZD

TZD

if HbA_{1c} above target

SGLT2i
OR
DPP-4i
OR
GLP-1 RA

if HbA_{1c} above target

Continue with addition of other agents as outlined above

if HbA_{1c} above target

Consider the addition of SU⁴ **OR** basal insulin: ■ Choose later generation SU with lower risk of hypoglycemia
■ Consider basal insulin with lower risk of hypoglycemia⁹

- 2. Low dose may be better tolerated though less well studied for CVD effects
- 4. Choose later generation SU to lower risk of hypoglycemia; glimepiride has shown similar CV safety to DPP-4i
- 9. Degludec / glargine U-300 < glargine U-100 / detemir < NPH insulin

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IF A1C ABOVE INDIVIDUALIZED TARGET PROCEED AS BELOW

COMPELLING NEED TO MINIMIZE WEIGHT GAIN OR PROMOTE WEIGHT LOSS

EITHER/ OR

GLP-1 RA with good efficacy for weight loss¹⁰

SGLT2i²

if HbA_{1c} above target

SGLT2i²

GLP-1 RA with good efficacy for weight loss¹⁰

if HbA_{1c} above target

If quadruple therapy required or SGLT2i and/or GLP-1 RA not tolerated or contraindicated regimen with lowest risk of weight gain

PREFERABLY

DPP-4i (if not on GLP-1 RA) based on weight neutrality

If DPP-4i not tolerated or contraindicated or patient already on GLP-1 RA, cautious addition of: •SU⁴ •TZD² •Basal insulin

2.Low dose may be better tolerated though less well studied for CVD effects
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10. Semaglutide > liraglutide > dulaglutide > exenatide > lixisenatide

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COST IS A MAJOR ISSUE^{11,12}

SU⁴

TZD¹²

if HbA_{1c} above target

TZD¹²

SU⁴

if HbA_{1c} above target

Insulin therapy basal insulin with lowest acquisition cost
OR
Consider other therapies based on cost

4. Choose later generation SU to lower risk of hypoglycemia; glimepiride has shown similar CV safety to DPP-4i

12. Consider country- and region-specific cost of drugs. In some countries TZDs are relatively more expensive and DPP-4i are relatively cheaper.

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DKD and Albuminuria⁸

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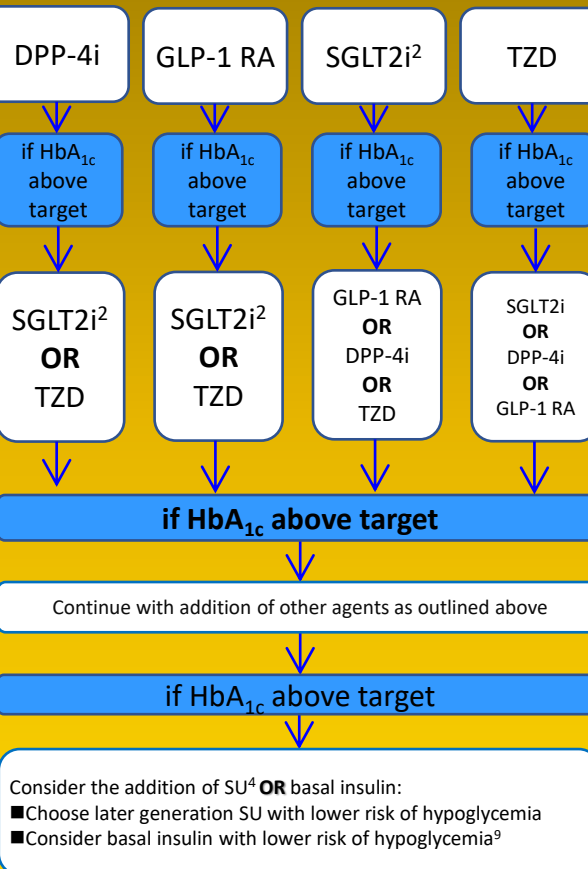
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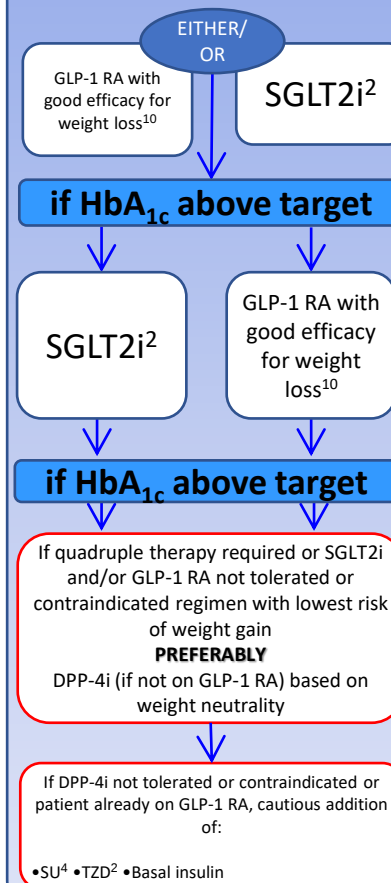
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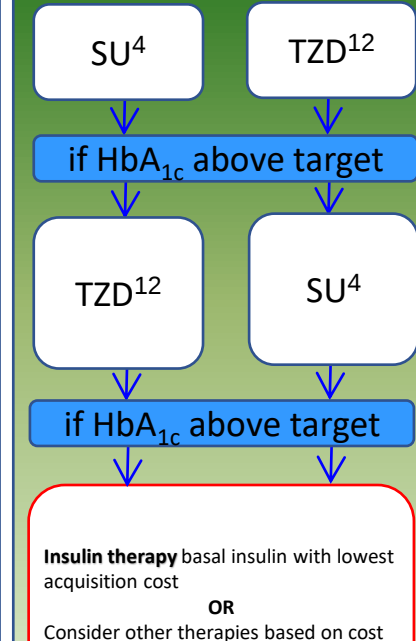
COMPELLING NEED TO MINIMIZE HYPOGLYCEMIA



COMPELLING NEED TO MINIMIZE WEIGHT GAIN OR PROMOTE WEIGHT LOSS



COST IS A MAJOR ISSUE^{11,12}



† Actioned whenever these become new clinical considerations regardless of background glucose-lowering medications.
 *Most patients enrolled in the relevant trials were on metformin at baseline as glucose-lowering therapy.

FIRST-LINE Therapy is Metformin and Comprehensive Lifestyle (including weight management and physical activity)



INDICATORS OF HIGH-RISK OR ESTABLISHED ASCVD, CKD, OR HF†

CONSIDER INDEPENDENTLY OF BASELINE A1C, INDIVIDUALIZED A1C TARGET, OR METFORMIN USE*

+ASCVD/Indicators of High Risk

- Established ASCVD
- Indicators of high ASCVD risk (age >55 years with coronary, carotid, or lower-extremity artery stenosis or LVH)

EITHER/
OR

GLP-1
RA with
proven
CVD
benefit¹

SGLT2i
with
proven
CVD
benefit¹

If A1C above
target

If further intensification required or patient is unable to tolerate GLP-1 RA and/or SGIT2i, choose agents demonstrating CV benefit and/or safety:

- For patients on a GLP-1 RA, consider adding SGLT2i with proven CVD benefit and vice versa⁴
- TZD²
- Dpp-4i if not on GLP-1 RA
- Basal insulin³
- SU⁴

+HF

Particularly HFrEF (LVEF <45%)

SGLT2i with proven benefit in this population^{5,6,7}

- Proven CVD benefit means it has label indication of reducing CVD events
- Low dose may be better tolerated though less well studied for CVD effects
- Degludec or U-100 glargine have demonstrated CVD safety
- Choose later generation SU to lower risk of hypoglycemia; glimepiride has shown similar CV safety to DPP-4i
- Be aware that SGLT2i labelling varies by region and individual agent with regard to indicated level of eGFR for initiation and continued use
- Empagliflozin, canagliflozin, and dapagliflozin have shown reduction in HF and to reduce CKD progression in CVOTs. Canagliflozin and dapagliflozin have primary renal outcome data. Dapagliflozin and empagliflozin have primary heart failure outcome data
- Proven benefit means it has label indication of reducing heart failure in this population
- Refer to Section 11 : Microvascular Complications and Foot Care
- Degludec / glargine U-300 < glargine U-100 / detemir < NPH insulin
- Semaglutide > liraglutide > dulaglutide > exenatide > lixisenatide
- If no specific comorbidities (i.e., no established CVD, low risk of hypoglycemia, and lower priority to avoid weight gain or no weight-related comorbidities)
- Consider country- and region-specific cost of drugs. In some countries TZDs are relatively more expensive and DPP-4i are relatively cheaper.

+CKD

DKD and Albuminuria⁸

PREFERABLY SGLT2i with primary evidence of CKD progression

OR SGLT2i with evidence of reducing CKD progression in CVOT^{5,6,8}

OR GLP-1RA with proven CVD benefit if SGIT2i not tolerated or contraindicated

For patients with TZD and CKD³ (e.g., eGFR <60 mL/min/1.73m²) and thus at increased risk of cardiovascular events

EITHER/
OR

GLP-1
RA with
proven
CVD
benefit¹

SGLT2i
with
proven
CVD
benefit^{1,7}

NO

IF A1C ABOVE INDIVIDUALIZED TARGET PROCEED AS BELOW

COMPELLING NEED TO MINIMIZE HYPOGLYCEMIA

DPP-4i

GLP-1 RA

SGLT2i²

TZD

if HbA_{1c} above target

if HbA_{1c} above target

if HbA_{1c} above target

if HbA_{1c} above target

SGLT2i²
OR
TZD

SGLT2i²
OR
TZD

GLP-1 RA
OR
DPP-4i
OR
TZD

SGLT2i
OR
DPP-4i
OR
GLP-1 RA

if HbA_{1c} above target

Continue with addition of other agents as outlined above

if HbA_{1c} above target

Consider the addition of SU⁴ OR basal insulin:

- Choose later generation SU with lower risk of hypoglycemia
- Consider basal insulin with lower risk of hypoglycemia⁹

COMPELLING NEED TO MINIMIZE WEIGHT GAIN OR PROMOTE WEIGHT LOSS

EITHER/
OR

GLP-1 RA with good efficacy for weight loss¹⁰

SGLT2i²

if HbA_{1c} above target

SGLT2i²

GLP-1 RA with good efficacy for weight loss¹⁰

if HbA_{1c} above target

If quadruple therapy required or SGLT2i and/or GLP-1 RA not tolerated or contraindicated regimen with lowest risk of weight gain
PREFERABLY
DPP-4i (if not on GLP-1 RA) based on weight neutrality

If DPP-4i not tolerated or contraindicated or patient already on GLP-1 RA, cautious addition of:

•SU⁴ •TZD² •Basal insulin

COST IS A MAJOR ISSUE^{11,12}

SU⁴

TZD¹²

if HbA_{1c} above target

TZD¹²

SU⁴

if HbA_{1c} above target

Insulin therapy basal insulin with lowest acquisition cost

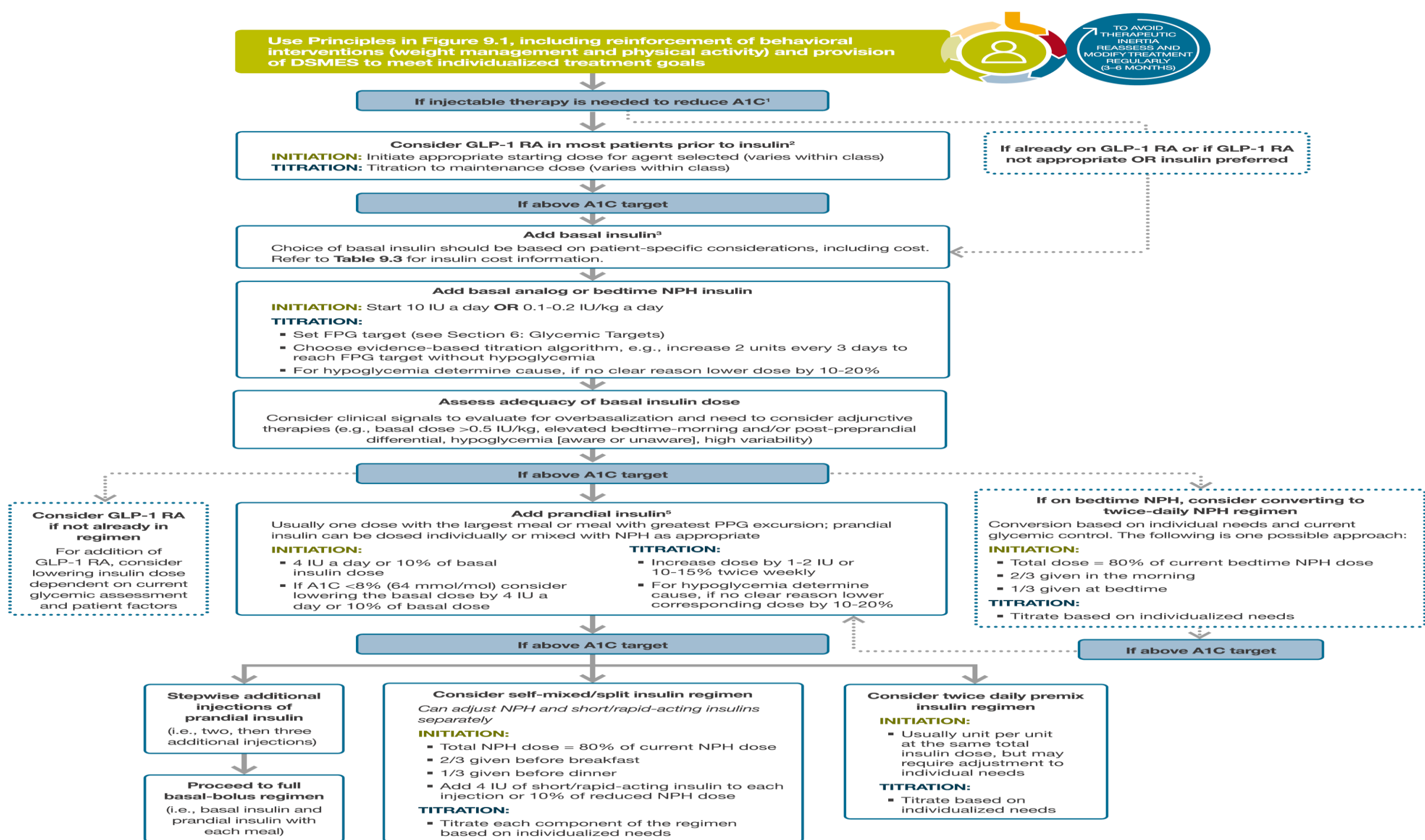
OR

Consider other therapies based on cost

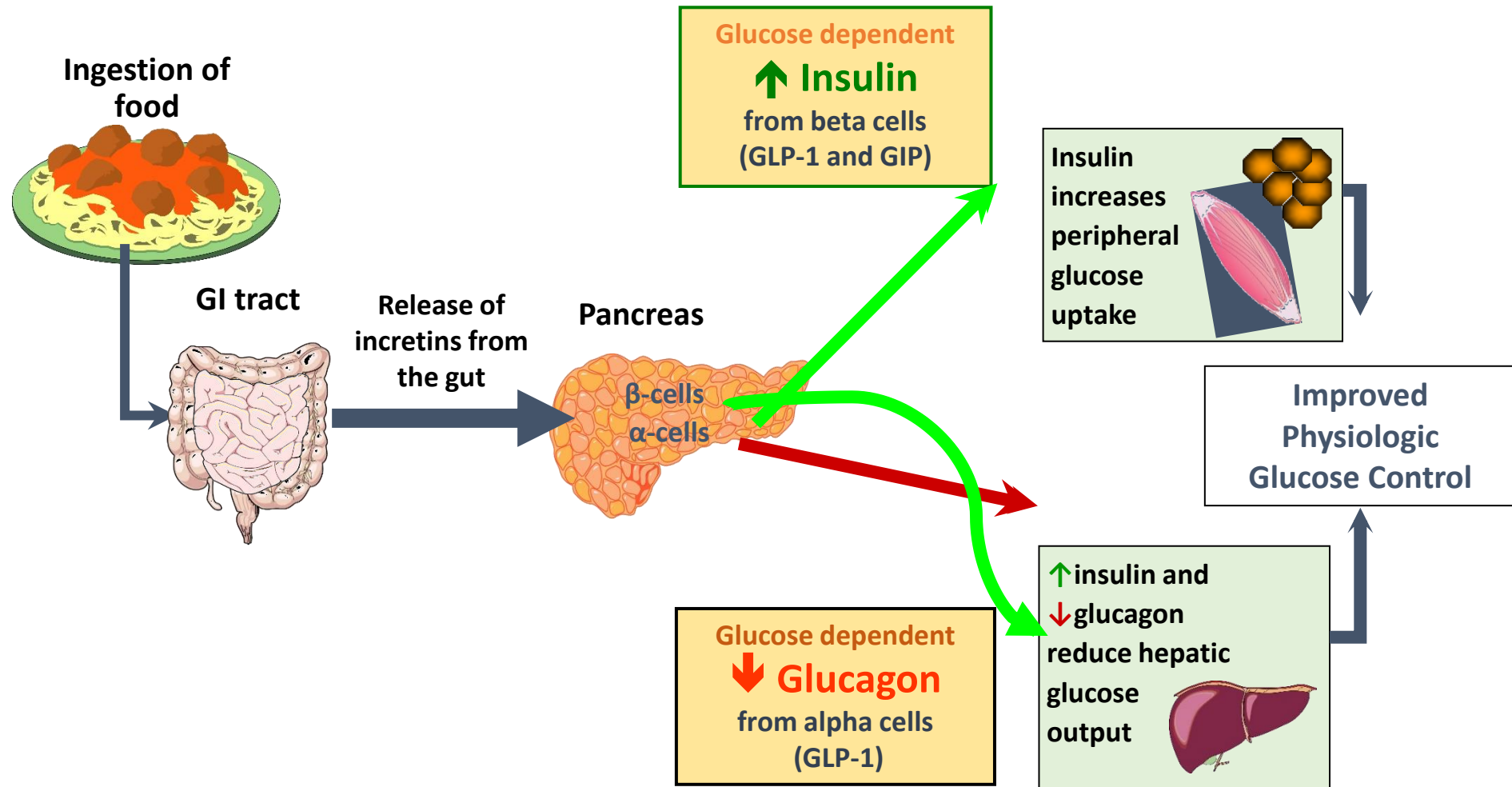
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Intensifying to injectable therapies



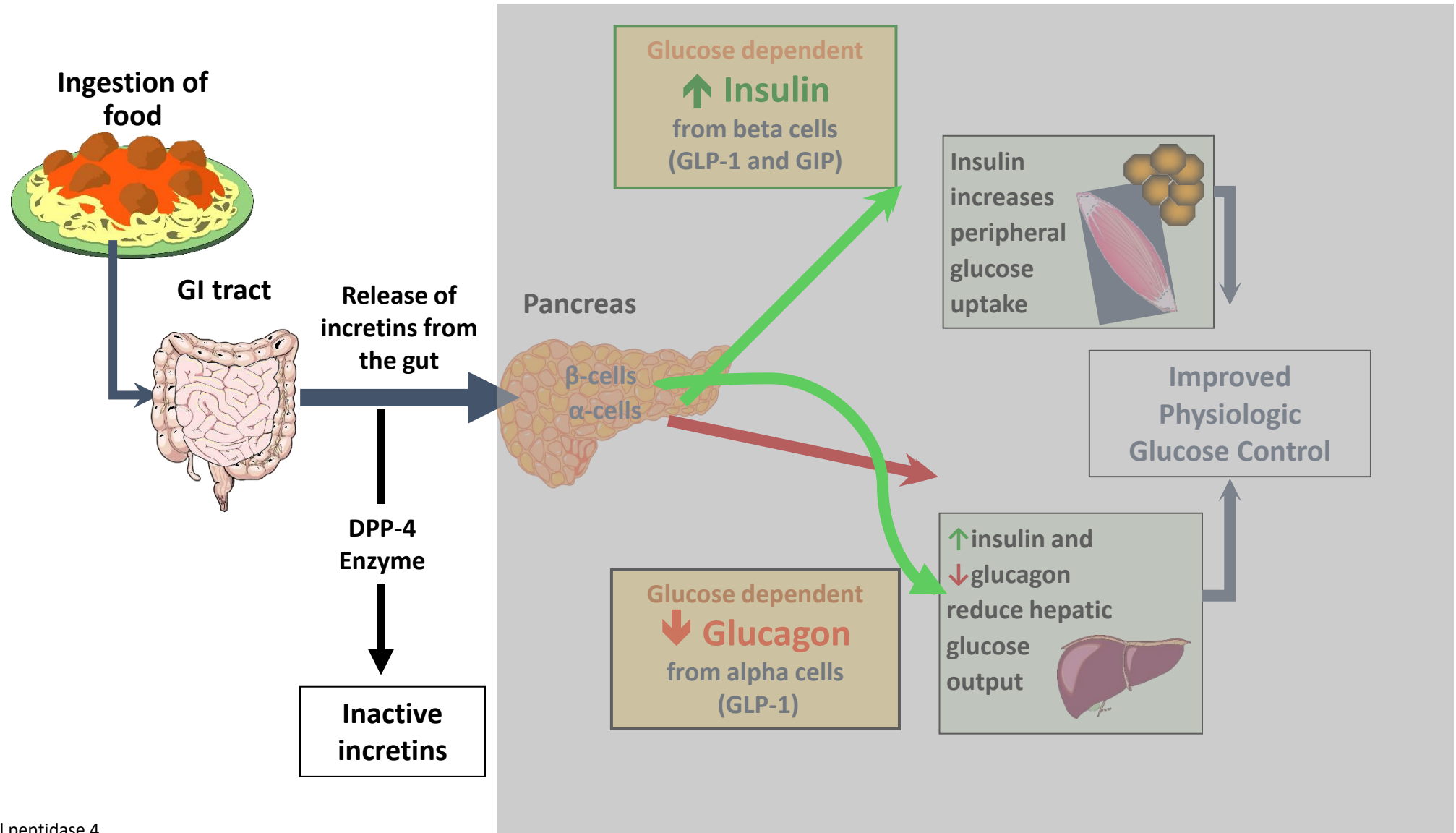
DPP-4 Inhibitors Improve Glucose Control by Increasing Incretin Levels in Type 2 Diabetes¹⁻⁴



DPP-4 = dipeptidyl peptidase 4

1-Endocrinology. 2004 ;145(6):2653-9. 2- Lancet. 2002 ;359(9309):824-30; 3-Curr Diab Rep. 2003;3(5):365-72; 4-Buse JB et al. In *Williams Textbook of Endocrinology*. 10th ed., 2003:1427–1483.

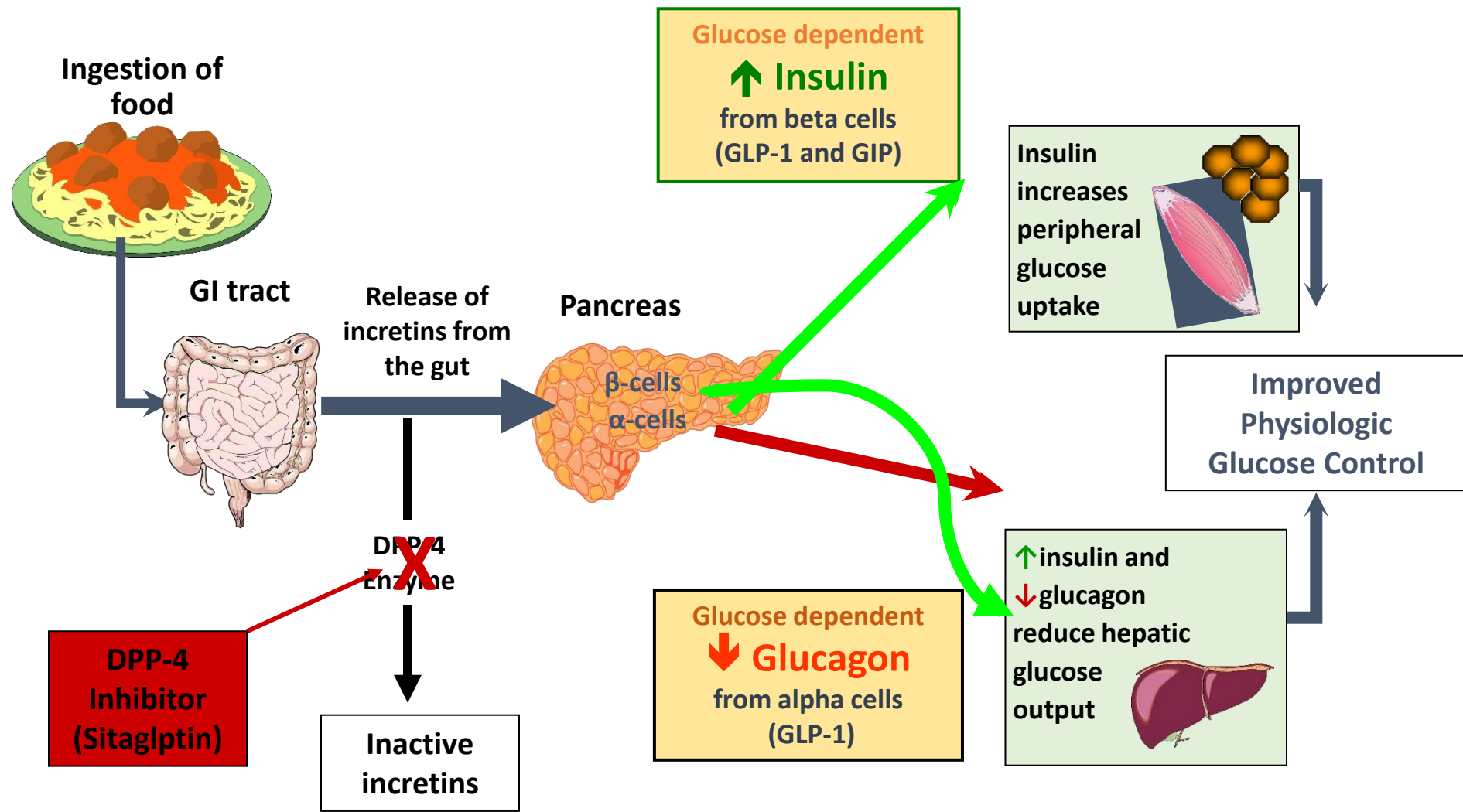
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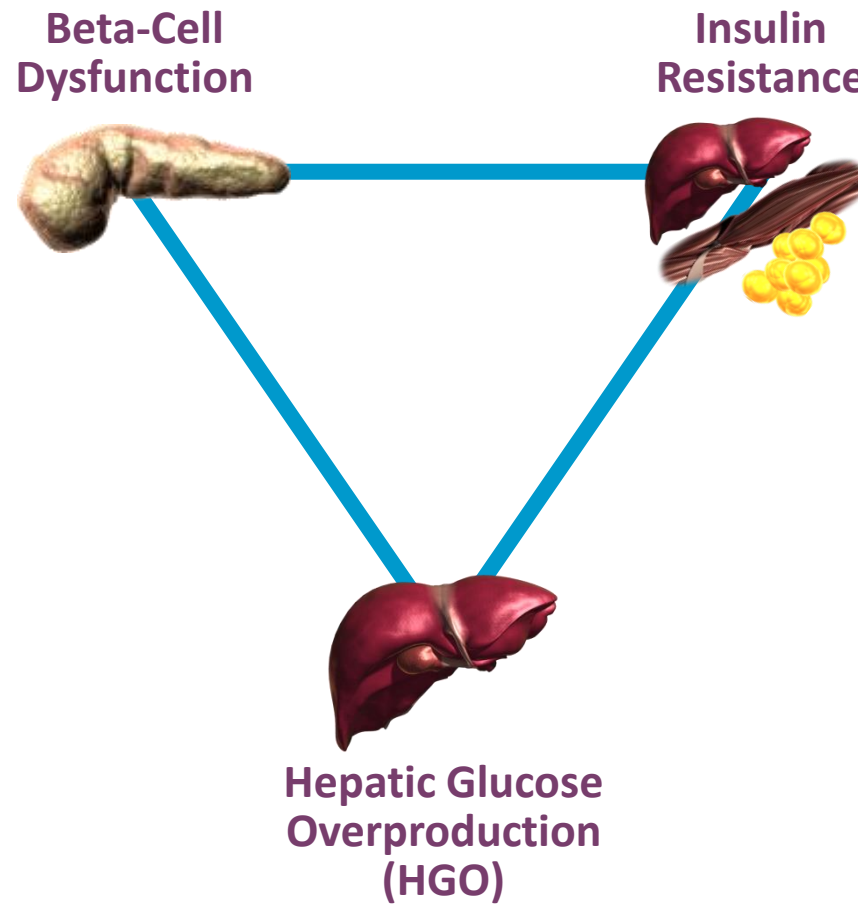
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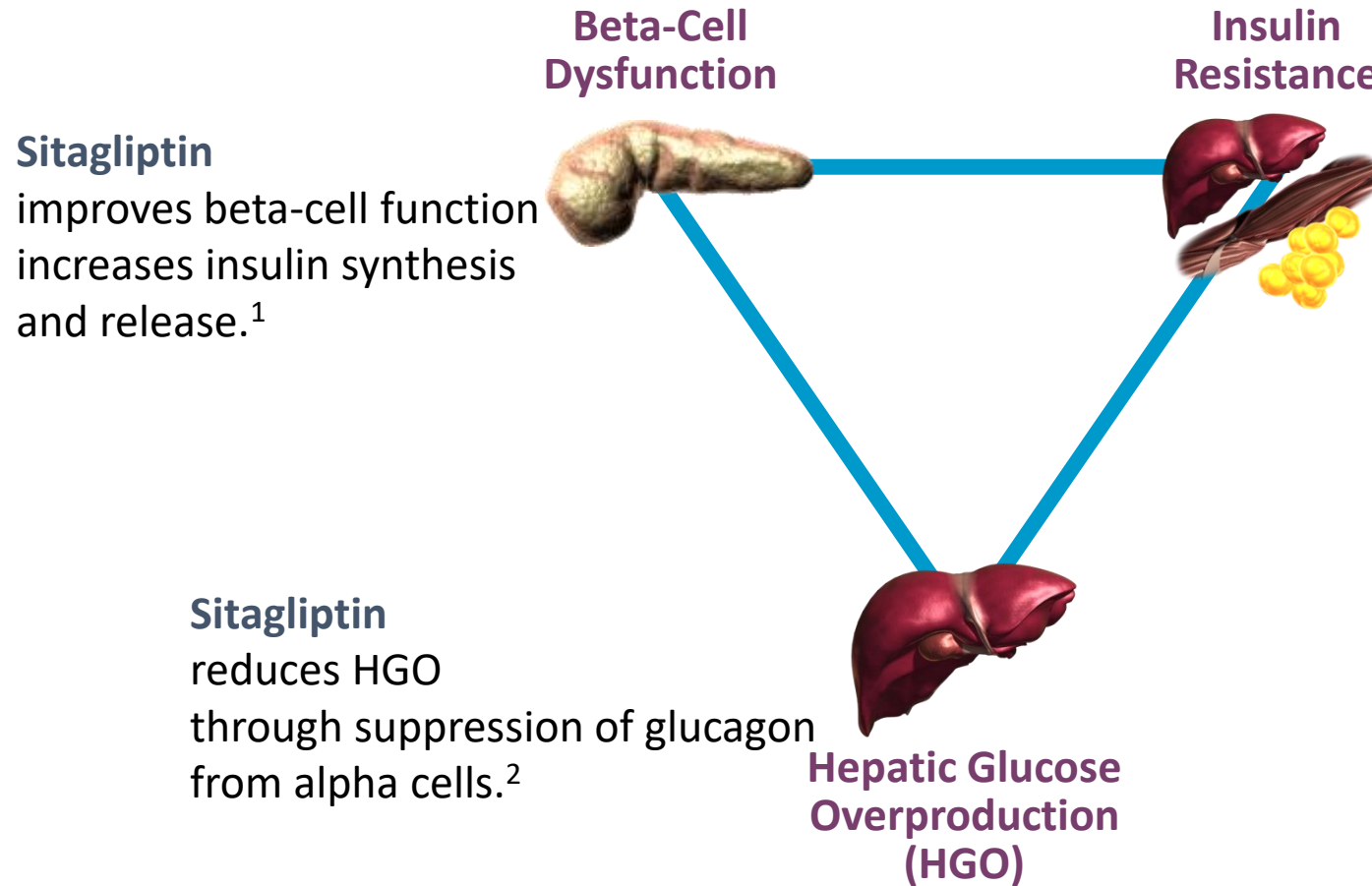
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Sitagliptin and Metformin Target the Core Metabolic Defects of Type 2 Diabetes



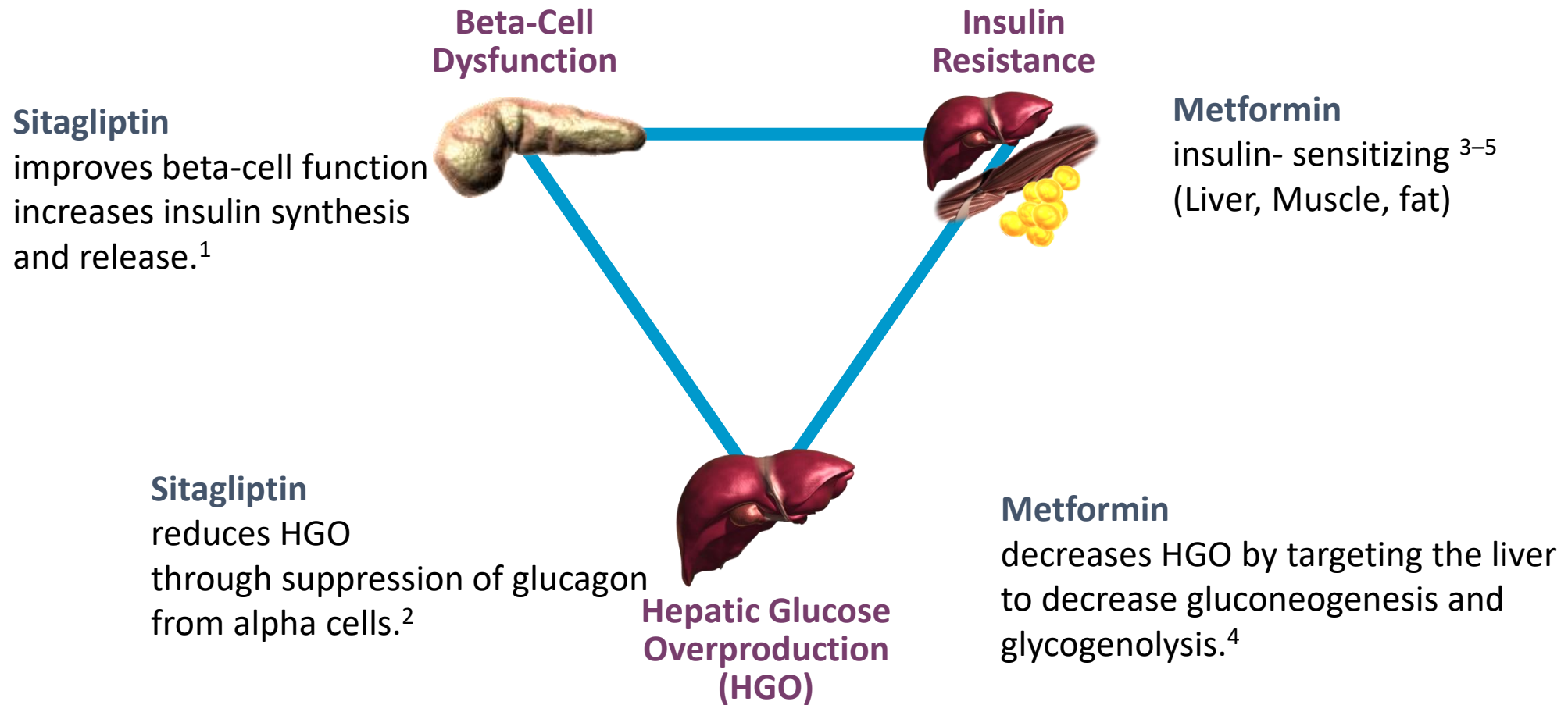
Sitagliptin

Target the Core Metabolic Defects of Type 2 Diabetes



1. Diabetes Care; 2006;29(12):2632–2637. 2- Data on file. 3- Diabetes Care. 1998;21(8):1301–1305. 4- Ann Intern Med. 2002;137(1):25–33. 5- J Clin Invest. 2001;108(8):1167–1174.

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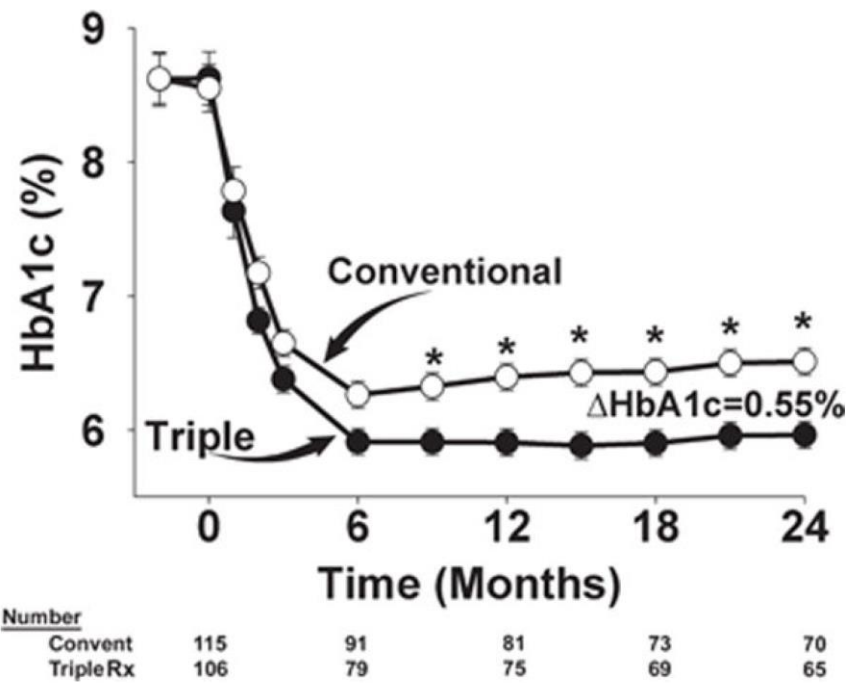
Initial combination therapy with metformin, pioglitazone and exenatide is more effective than sequential add-on therapy in subjects with new-onset diabetes. Results from the Efficacy and Durability of Initial Combination Therapy for Type 2 Diabetes (EDICT): a randomized trial

M. A. Abdul-Ghani¹, C. Puckett¹, C. Triplitt¹, D. Maggs², J. Adams¹, E. Cersosimo¹, and R. A DeFronzo¹

¹Diabetes Division, University of Texas Health Science Center at San Antonio, San Antonio, TX, USA

²GI Dynamics, Lexington, MA, USA

Conclusion—The results of this exploratory study show that combination therapy with metformin/pioglitazone/exenatide in patients with newly diagnosed T2DM is more effective and results in fewer hypoglycaemic events than sequential add-on therapy with metformin, sulfonylurea and then basal insulin.



Time-related change in glycated haemoglobin (HbA1c) in participants receiving conventional (convent) therapy and initial triple combination (Rx) therapy during the 24-month follow-up period. *p < 0.01.

Glycaemic durability of an early combination therapy with vildagliptin and metformin versus sequential metformin monotherapy in newly diagnosed type 2 diabetes (VERIFY): a 5-year, multicentre, randomised, double-blind trial



David R Matthews, Päivi M Paldanius, Pieter Proot, YannTong Chiang, Michael Stumvoll, Stefano Del Prato, for the VERIFY study group

Interpretation

Early intervention with a combination therapy of vildagliptin plus metformin provides greater and durable long-term benefits compared with the current standard-of-care initial metformin monotherapy for patients with newly diagnosed type 2 diabetes.

Which one is better for the start?

Along side of life style modification (calorie restriction and increasing physical activity):

1. Start Metformin 500 mg BD then increase to 1000 mg BD
2. Start with Metformin 1000 mg BD then add Sitagliptin (Glysta) 100 mg or change to Metformin/Sitagliptin (Sigomet) (1000/50) BD
3. Start Sigomet (500/50) BD then increase to Sigomet (1000/50) BD
4. Start with Sigomet (1000/50) BD then add 1000 mg Metformin in the evening
5. Start with Metformin 500 mg BD and Liraglutide
6. Start with Metformin 1000 mg BD then add Pioglitazone
7. Start with Glibenclamide 5 mg/day
8. Start with Gliclazide MR (Glicover) 30 mg/day then increase the dose or add Metformin
9. Start with Liraglutide
10. Start with Metformin 500 mg BD and Empagliflozin 10 mg/day then increase Metformin dose
11. Other options?

{special}
THANKS

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