Diabetes, a worldwide epidemic, has become a huge health burden in most countries and calls for prompt and appropriate management to avoid long-term complications. Globally, appropriate diabetes care is particularly important at the primary care level, where most people with type 2 diabetes (T2D) are treated and therefore, where a healthcare team trained on best practice for T2D is vital for success.

The task is not easy, since the limited amount of time to solve a great variety of medical problems makes it very difficult for the primary care physician (PCP) to personalize care for every patient with T2D considering individual needs and barriers. It becomes even more difficult when having to choose among the increasing number of new medications which may have added benefits, but also risks.

Although there are special cases, particularly among patients whose T2D is recognized after they have already developed complications such as cardiovascular disease (CVD) or renal failure, there are general recommendations for treatment and goals which facilitate decision making. Currently, there are numerous global, regional and local Clinical Practice Guidelines (CPG) developed for this purpose which is why the IDF determined investigating the current CPG environment was critical. It was important to assess and understand how surveyed PCPs responded to the most common questions that address daily care of people with T2D and identify common ground in terms of T2D diagnosis, management, goal-setting and different levels of prevention. When there were clear discrepancies, the IDF Working Group made the effort to explain the reason and help facilitate the PCP towards the best choice of action.

Unfortunately, the degree of rigorousness varies greatly between current CPGs, ranging from a set of recommendations given by a group of leading medical professionals based on their expertise to an evidence-based CPG using the methodology developed by the Grading of Recommendations Assessment, Development and Evaluation (GRADE) working group. The GRADE working group has produced a common, sensible and transparent approach to grading quality of evidence and strength of recommendations which has now become the standard for developing CPG. The IDF Working Group decided to select the best CPG by assessing methodological rigor and transparency with the Appraisal of Guidelines for Research & Evaluation (AGREE) Instrument, developed to address the issue of variability in the quality of practice guidelines in order to be confident of the resulting recommendations. This tool has also become the standard for appraising CPG.

The IDF Working Group selected twelve CPGs for the treatment of T2D and included additional versions focused on specific populations such as the elderly with T2D. We identified around 40 clinical practice questions which we tried to answer by analyzing the rationale and recommendations provided by those selected CPGs and discussing the results in an International Consensus Group.

Our work resulted in the new IDF Clinical Practice Recommendations for Managing Type 2 Diabetes in Primary Care where we offer around 78 practical and applicable recommendations for the PCP and his or her team covering all the fields of T2D management. The Recommendations will be published with their rationale and methodology in July 2017.

Appropriate diabetes care is particularly important at the primary care level, where most people with type 2 diabetes are treated.

Screening, diagnosis and targets

In brief, we recommend screening people at high risk for diabetes attending the local healthcare facilities, if possible with a validated screening test, and then use the diagnostic tests and criteria currently proposed by the WHO and IDF. We strongly recommend early treatment of those who are newly diagnosed with T2D and enrolling people with intermediate hyperglycemia (pre diabetes) in a diabetes prevention program.

The general target for blood glucose (BG) control should be an HbA1c<7 percent but we included special considerations in some conditions such as old age. We emphasize the role of diabetes education at the primary care level and the fundamental role of the diabetes educator. Lifestyle changes, including diet, physical activity and avoiding unhealthy habits, are the cornerstone of diabetes control and patients should be referred to a structured diabetes education program, but meanwhile we provide helpful tips that the PCP can offer to the patient at the initial visit with
particular attention to the management of obesity.

**Pharmacological treatment**

Practically all the CPGs under review recommend starting pharmacological treatment with metformin monotherapy, but under certain circumstances initial combination therapy with metformin and another glucose lowering drug (GLD) and/or basal insulin may be a better option. If the initial treatment is not enough to achieve or maintain BG control, there are different approaches to the use of other GLDs depending on priorities such as the patient’s characteristics and preferences, the generalizability of the medications, their effect on weight and/or their effect on CVD. Nevertheless, we offer the PCP the best choices for dual and triple therapy, including recommendations on when to start injectables (insulin and GLP-1 receptor agonists).

**Cardiovascular risk and complications**

A special section was assigned to the management of cardiovascular risk factors. High blood pressure should be lowered to a diastolic target of 80 mmHg and a systolic target between 130 and 140 mmHg. Smoking should be stopped. Statins should be given to most patients with T2D, particularly if they have other cardiovascular risk factors and/or a high cardiovascular risk score. In those with documented CVD, the statin should be selected and up-titrated to reach an LDL cholesterol target <70 mg/dL (1.8 mmol/L). New add-on therapies to statins are also considered. We included smoking cessation and antiplatelet treatment.

The last section was dedicated to screening for complications, including retinopathy, nephropathy, neuropathy, coronary disease, peripheral artery disease and depression. We ended by addressing referral and cost-effectiveness.

Although the recommendations presented in the new guidance are derived from more comprehensive and well-conducted guidelines, we hope to facilitate the optimal utilization of the available medications and monitoring tools at the primary care level and ultimately reduce the health burden attributable to diabetes and its complications.

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