Comment on: Nathan DM, Buse JB, Davidson MB et al (2006) Management of hyperglycaemia 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. Diabetologia 49:1711–1721

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To the Editor: In contrast with previous policy, the European Association for the Study of Diabetes has now produced professional guidelines or statements. They have published a joint position statement with the American Diabetes Association (ADA) on the metabolic syndrome [1], a consensus algorithm with the ADA on the management of hyperglycaemia in type 2 diabetes [2], and more recently, guidelines with the European Society of Cardiology (ESC) on diabetes, prediabetes and cardiovascular diseases [3].

These three position statements are not harmonised. We find at least three contradictions that will puzzle the practitioner. First, the interest of defining the metabolic syndrome in clinical practice. The ADA/EASD statement [1] stated that, until much-needed research is completed, clinicians should evaluate and treat all risk factors for

cardiovascular disease (CVD), regardless of whether a patient meets the criteria for the diagnosis of the metabolic syndrome. This seems to be in disagreement with the ESC/EASD Task Force guidelines [3], which still mention the metabolic syndrome as a potentially valuable approach for prediction of the risk of cardiovascular disease, even though they recognise that classical scores may be equal or superior. We would like to point out that, as shown in a recent study [4], in some groups, the presence of the metabolic syndrome may add to classical scores: in men with an estimated 10 year risk of cardiovascular mortality of <5%, the metabolic syndrome conferred a relative risk of cardiovascular mortality of 2.5 [4].

Another point of apparent contradiction is the statement by the ESC/EASD Task Force [3] that the OGTT should play an important role in screening for type 2 diabetes, in particular, in patients with CVD. This is in opposition to the current worldwide accepted recommendation that the OGTT has a minimal place, if any, in the diagnosis of diabetes [5].

The third, and not least, point concerns postprandial blood glucose control and CVD prevention. The most recent guidelines [3] clearly indicate that improved control of postprandial glycaemia may lower cardiovascular risk and mortality, while the ADA/EASD, in their consensus on type 2 diabetes treatment, have deliberately excluded from their algorithm almost all pharmaceutical means of correcting variations in postprandial blood glucose [2]. According to the ADA/EASD consensus, ‘Pramlintide, exenatide, α -glucosidase inhibitors and the glinides are not included in this algorithm, owing to their generally lower overall glucose-lowering effectiveness, limited clinical data and/or

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relative expense. However, they may be appropriate choices in selected patients.’ This therefore leaves one possibility, the use of short-acting regular insulin or insulin analogues to correct postprandial glycaemia. This would imply that postprandial variations in blood glucose are not worthy of focused attention. This point has already been debated in a recent letter to the Editor [6].

Better harmonisation is needed if the general practitioner, the diabetologist and the cardiologist are to use these recommendations.

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