ADA/EASD position statement of the treatment of type 2 diabetes: Reply to Rodbard HW and Jellinger PS [letter], Scheen AJ [letter] and Ceriello A, Gallo M, Gentile S et al [letter]

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Abbreviation

DPP-4 Dipeptidyl peptidase IV

To the Editor: We read the comments of Rodbard and Jellinger [1] with interest, but we feel that perhaps the very problem that the position statement of the ADA/EASD [2] was trying to circumvent comes across strongly in their communication. We have been cautious of certainty on the

The ADA/EASD position statement was published simultaneously in *Diabetologia* and *Diabetes Care*. Both journals are publishing correspondence relating to the position statement and hence some of the text in this letter is also published in *Diabetes Care*.

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basis of the variety of clinical situations, the heterogeneity of response, the disparities of resource, the complexity of social or cultural environments and the manifold wishes of each of our patients. Indeed, the primary care physician may be best placed to implement a proper individualised and successful therapeutic strategy.

Our position statement is not, and was not designed to be, an algorithm. The rationale for this is that we felt that expressing ‘strong preferences’ would not be correct, and think that the authors’ belief that specific prescriptive approach(es) are highly advantageous may be misplaced. Such robust views meld poorly with the concept of a patient-centred approach.

More explicitly we do not think that ‘moving closer to’ a previously published algorithm is, of itself, a marker of dramatic improvement. Rather, we have been careful to cite and embrace the work of others upon whose shoulders we stand. Nor do we recognise ‘a three-pronged approach’, which seems to carry with it the concept of a coercing trident. We have been careful to avoid any dogmatic therapeutic propositions based on HbA_{1c} levels above or below thresholds alone. Indeed, we are trying to encourage the process of decision-making on a flexible basis, individualising patient-centred care on criteria other than those simply obtained from a laboratory—without denying the profound importance of such measures.

In the case of the choice of therapy, our statement that the ‘order is not meant to denote any specific preference’ should be read as meaning that! The English seems clear to us. Then, on matters of cost, it is imperative to recognise that resources may be paramount—both to governments and to those who need to use their own money to buy pharmaceutical agents. In some countries it is possible to fund 16.7 years of sulfonylurea treatment for the cost of one

month's supply of a GLP-1 agonist. For some, especially in the USA, costs may make the difference between no treatment and some treatment. But as costs change so the choices will change.

Professor Scheen devotes nearly 1,000 words to the distinction between 'high' and 'intermediate' [3]. For particular agents, the effects are often reported as less with dipeptidyl peptidase IV (DPP-4) inhibitors. For example, a comparison paper from Foley et al suggests that 'the mean reduction in HbA_{1c} from baseline to week 104 was −0.5% in the vildagliptin group and −0.6% in the gliclazide group' [4]. A recent meta-analysis of 27 reports of 19 studies including 7,136 patients randomised to a DPP-4 inhibitor and 6,745 patients randomised to another hypoglycaemic drug showed that, compared with metformin as monotherapy, DPP-4 inhibitors were associated with a smaller decline in HbA_{1c} (weighted mean difference 0.20, 95% CI 0.08, 0.32). As a second-line treatment, DPP-4 inhibitors had no advantage over sulfonylureas in the attainment of the HbA_{1c} goal (risk ratio in favour of sulfonylureas 1.06, 95% CI 0.98, 1.14) [5]. Nevertheless, we would not wish to suggest that these small biochemical differences would make a noticeable clinical difference, so the debate over using the word 'high' or 'intermediate' is ultimately one of lexical semantics.

We have also carefully read the comments of Ceriello et al [6]. We entirely agree that there can be many ways to help with clinical decision-making—and that computers can be of particular help in analysing complexities and guiding the physician in other ways.

We are aware, of course, of the International Diabetes Federation (IDF) guidelines on postmeal glucose [7], which state that 'uncertainties remain about a causal association between postmeal plasma glucose and complications and additional research is needed to clarify our understanding in this area. Logic and clinical judgment remain critical components of diabetes care and implementation of any guideline recommendations'. It is unclear to us how this can be read as 'acknowledging the fundamental importance of targeting...postprandial plasma glucose' [6].

Short-acting insulin usually needs more injections than basal insulin therapy, but we would not wish to argue for the primacy of one approach above another.

Enthusiasm for self-monitoring glucose may not be wrong, but the costs can also be high. Only when therapeutic decisions (or lifestyle decisions) flow directly from these data can there be full justification for undertaking this. In practice many patients on oral agents are finger-pricking frequently for no clearly justifiable outcome.

Finally, we would urge a continuing debate on how best to serve our patients unencumbered by monocular enthusiasms. One agent will be good for one patient, another for the next. An individual's motivation may or may not be improved by finger-prick glucose monitoring. He or she might, for

example, prefer not to have sore fingers and be able play the cello unimpaired. The skill of the physician cannot be codified into any rigid or mathematical formula. We need to use all our international collegiate combined medical knowledge, skill and wisdom if we are to serve our patients beyond the mathematics of greater-than and less-than signs and the self-imposed statistical fundamentalism that implies that we cannot decide anything beyond the constraints of a *p* value.

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