

Table 2 (continued)

R 1.7	Clinicians should consider evaluation for monogenic DM in any child or young adult with an atypical presentation, clinical course, or response to therapy. Monogenic DM includes neonatal diabetes and nonautoimmune diabetes of multiple genetic causes, also known as maturity-onset diabetes of the young. Most children with DM occurring under age 6 mo of age have a monogenic cause as autoimmune T1D rarely occurs before 6 mo of age. Other monogenic forms of diabetes are characterized by mutation of genes of transcription factors, genes regulating pancreatic development or atrophy, abnormal insulin genes, genes related to endoplasmic reticulum stress that impair insulin secretion or abnormal glucokinase genes that cause impaired insulin signaling. Grade B; BEL 2
Q 2: What are the glycemic treatment goals for persons with diabetes mellitus?	
2.1 Outpatient Glucose Targets for Nonpregnant Adults	
R 2.1.1	An A1C level of $\leq 6.5\%$ is recommended for most nonpregnant adults, if it can be achieved safely. To achieve this target A1C level, FPG may need to be <110 mg/dL, and the 2-h postprandial glucose (PPG) may need to be <140 mg/dL (Table 6). Glucose targets should be individualized with consideration for life expectancy, disease duration, presence or absence of micro- and macrovascular complications, cardiovascular disease (CVD) risk factors, comorbid conditions, and risk for hypoglycemia, as well as a person's cognitive and psychological status. Grade A; BEL 1
R 2.1.2	Adopt less stringent glycemic goals (A1C 7% to 8%) in persons with a history of severe hypoglycemia, hypoglycemia unawareness, limited life expectancy, advanced renal disease, extensive comorbid conditions, or long-standing DM in which the A1C goal has been difficult to attain despite intensive efforts, so long as the person remains free of hyperglycemia-associated symptoms. Grade A; BEL 1
2.2 Inpatient Glucose Targets for Nonpregnant Adults	
R 2.2	For most hospitalized persons with hyperglycemia in both the intensive care unit (ICU) and non-ICU settings, a glucose range of 140 to 180 mg/dL is recommended, provided this target can be safely achieved (Table 6). Grade A; BEL 1
2.3 Outpatient Glucose Targets for Pregnant Women	
R 2.3	In women with GDM, the following glucose goals are recommended: fasting and preprandial glucose concentration ≤ 95 mg/dL and either a 1-h postmeal glucose value ≤ 140 mg/dL or a 2-h postmeal glucose value ≤ 120 mg/dL. In women with preexisting T1D or T2D who become pregnant, it is recommended that glucose be controlled to meet the following goals, but only if the goals can be safely achieved: premeal, bedtime, and overnight glucose values between 60 and 95 mg/dL; a 1-h PPG value between 110 and 140 mg/dL; a 2-h glucose 100 to 120 mg/dL. A secondary target would be an A1C level of $<6\%$ if it can be accomplished without significant hypoglycemia. Grade A; BEL 1
Q 3: When and how should glucose monitoring be used?	
R 3.1	A1C should be measured at least semiannually in all persons with DM and at least quarterly in persons not at their glycemic target. Grade B; BEL 2
R 3.2	All persons who use insulin should use continuous glucose monitoring (CGM) or perform blood glucose monitoring (BGM) a minimum of twice daily and ideally before any insulin injection. More frequent BGM may be needed by persons who are taking multiple daily injections (MDI) injections, persons not at A1C targets, or those with history of hypoglycemia. Persons who do not require insulin or insulin secretagogue therapy may often benefit from BGM, especially to provide feedback about the effects of their lifestyle choices (diet and physical activity), and to assess response to pharmacologic therapy. Grade A; BEL 1
R 3.3	Real-time continuous glucose monitoring (rtCGM) or intermittently scanned continuous glucose monitoring (isCGM) is recommended for all persons with T1D, regardless of insulin delivery system, to improve A1C levels and to reduce the risk for hypoglycemia and DKA (see Fig. 6). Grade A; BEL 1
R 3.4	rtCGM or isCGM is recommended for persons with T2D who are treated with insulin therapy, or who have high risk for hypoglycemia and/or with hypoglycemia unawareness (see Figure 6). Grade A; BEL 1
Section 2. Comorbidities and Complications	
Q 4: How should hypertension be managed in persons with diabetes mellitus?	
R 4.1	The recommended blood pressure (BP) goal for most persons with T1D, T2D, or prediabetes is $<130/80$ mm Hg (Table 7). Grade A; BEL 1
R 4.2	Therapeutic lifestyle interventions in persons with hypertension are recommended to include consultation with a registered dietitian for education about an overall healthy diet (such as the Mediterranean diet), weight management, reduced sodium intake (such as the Dietary Approaches to Stop Hypertension [DASH] diet), daily physical activity and regular exercise (several times a week), and as-needed consultation with a psychologist or certified diabetes care and education specialist (CDCES) to support long-term behavior change. (See also R 11.2 to R 11.4 and R 12.1.1 to R 12.1.5 on nutrition and lifestyle.) Grade A; BEL 1
R 4.3	If BP goals are unattained with therapeutic lifestyle changes, use antihypertensive pharmacotherapy to achieve individual BP treatment goals. Grade A; BEL 1
R 4.4	Select antihypertensive agents based on their ability to reduce BP to goal and prevent or slow the progression of micro- and macrovascular disease. Use either an angiotensin-converting enzyme (ACE) inhibitor or angiotensin II receptor blocker (ARB) for BP control and to delay the progression of DKD or chronic kidney disease (CKD) in DM (see also R 6.1 to R 6.6 on DKD or CKD in DM). Grade A; BEL 1
R 4.5	Intensify pharmacotherapy as needed to achieve BP goals. Antihypertensive therapy may include combinations of either an ACE inhibitor or an ARB plus any of the following agents: diuretics, calcium channel antagonists, combined alpha-beta blockers, and newer-generation beta blockers. Consider a mineralocorticoid receptor antagonist for resistant hypertension. Grade A; BEL 1
Q 5: How should dyslipidemia be managed in persons with diabetes mellitus?	
R 5.1	All persons with prediabetes, T1D over the age of 40, or T2D should have a lipid panel (fasting or nonfasting) checked at diagnosis and annually to assess cardiovascular (CV) and metabolic disease risks, and at additional intervals as needed to monitor treatment to achieve lipid goals. Grade B; BEL 2
R 5.2	Therapeutic lifestyle interventions for dyslipidemia are recommended for all persons with prediabetes, T1D over the age of 40, or T2D, to include education with a registered dietitian about a healthy diet with emphasis on weight management, daily physical activity, and regular exercise (several times a week). Consultation with a psychologist or CDCES is recommended to support long-term behavior change. Grade A; BEL 1

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