The "Evidence" Is In! It Does Get Better!

William T. Cefalu

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With the January 2015 issue, our editorial team is now well past the halfway point of its tenure in overseeing the scientific aspects of *Diabetes Care*. Throughout the process, it has been our goal to keep you up to date and informed on our progress, initiatives, special issues, and thoughts. Specifically, in July 2014 (the actual midterm point of our tenure), our editorial team provided a very comprehensive and positive update, stating that we, as an editorial team, and *Diabetes Care*, as a journal, continue to evolve (1). We were also contemplating that at some future point (i.e., July 2015), we would still be asking, "Can it possibly get any better than this?" Though surprisingly earlier than expected, we believe this question has been answered in the affirmative. We feel the level of articles we publish that report data from scientific investigation and innovative medical care and treatments continues to be extremely high as exemplified by articles in this issue of *Diabetes Care*. Specifically, given the changing evidence base of studies, there is steady progress being made in the form of updated recommendations for management of hyperglycemia. In addition, there are now data providing more validation of the recommended American Diabetes Association (ADA) Standards of Care for management of diabetes.

At this point in time, there is no need to restate the changes we made to the journal or the initiatives put in place over the last 2.5 years. These have been adequately covered in prior Editorials. However, the initiatives put in place continue to grow and expand.

For example, our signature event at the ADA Scientific Sessions has been our *Diabetes Care* Symposium (we recently held our 3rd Annual Symposium in June 2014). This year we experimented with the format of the symposium by dividing it into two 1-h sessions and selecting a predetermined umbrella topic. The first segment introduced a novel twist with a presentation entitled "Best of *Diabetes Care*." Its purpose was to provide brief overviews of the most noteworthy original articles published in *Diabetes Care* during the prior year as chosen by the Associate Editors. The topics included imaging updates, clinical highlights for microvascular complications, diabetes and cancer, and artificial pancreas developments. The session was then followed with presentation of the four selected Original Articles focusing on "New Drug Therapies, Innovative Management Strategies, and Novel Drug Targets." These articles were published in a special section in the July 2014 issue (2–5). The response to this format change was overwhelmingly positive as demonstrated by a standing-room-only attendance at the session. Given the favorable approval, this format is planned to continue for the 4th Annual *Diabetes Care* Symposium scheduled at the 75th Scientific Sessions in June 2015 (Boston, MA).

Our journal is also charged with dissemination of important updates from the ADA in the form of Position Statements or Consensus Conferences. For example, in the July 2014 issue, the ADA's position statement "Type 1 Diabetes Through the Life Span" was published, which summarized available data specific to the comprehensive care of individuals with type 1 diabetes (6). In October, we published the ADA's position statement "Care of Young Children With Diabetes in the Child Care Setting" (7), the ADA and American Heart Association's scientific statement "Type 1 Diabetes Mellitus and Cardiovascular Disease" (8), and the report from an ADA Consensus Conference "Diabetic Kidney Disease" (9).

Our journal continues to enlighten readers on many diverse topics as evidenced from our invited Reviews, Perspectives, and Commentaries. In the August 2014 issue, we featured a Perspective in Care that reported on the National Institute

Pennington Biomedical Research Center, Louisiana State University System, Baton Rouge, LA

Corresponding author: William T. Cefalu, cefaluwt@pbrc.edu.

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of Diabetes and Digestive and Kidney Diseases' international conference report on diabetes and depression (10). We have also featured a very novel review reporting on the challenges for people with diabetes at high altitude (11); published a comprehensive review updating our readers on new findings and future developments in the area of natriuretic peptides (12); provided a historical accounting and clinical evaluation of hyperosmolar hyperglycemic state, a condition that has not been recently reviewed in such a detailed manner (13); and provided an update and review on dipeptidyl peptidase-4 inhibitors and microvascular complications (14).

In addition, we were honored to publish a comprehensive review on the SEARCH for Diabetes in Youth study for which major findings were highlighted and future directions identified for this incredibly important cohort (15). In specific regard to treating adolescents with type 2 diabetes, we were proactive in publishing a thought-provoking editorial about the challenges of drug therapy investigation in adolescents (16). Specifically, Karres et al. (16) commented on the need for collaboration between clinical research funding bodies, health care professionals, and professional societies as required to develop a robust pediatric type 2 diabetes clinical research infrastructure and to inform pediatric use of new drugs to treat type 2 diabetes.

In September, we published our third annual *Diabetes Care* Editors' Expert Forum held at the ADA Scientific Sessions that evaluated safety considerations in the decision-making process when a choice of a second agent is needed on metformin background (17). Our most recent forum, dedicated to obesity and type 2 diabetes, will be published later this year. One initiative put in place over the last few years that is gaining extreme popularity has been our Profiles in Progress category. The Profiles narrative specifically recognizes a researcher or provider in the field of diabetes whose contributions and discoveries were noteworthy and remarkable. We are truly honored to feature these individuals as every investigator we have featured to date and the ones currently planned for future issues have served as role models and mentors for many of the readers of *Diabetes Care* and have truly advanced the field. Interestingly, these individuals may not be readily known to most individuals with diabetes, but patients are the real winners because of the research done to better their lives. Thus, we were pleased to honor Frederick C. Goetz (18) in the September issue and Oscar B. Crofford (19) in our December issue.

Our journal continues to provide vitally important data on the burden of diabetes that needs to be known by policy makers. Clearly, all stakeholders (i.e., public, policy makers, and payers) continue to struggle with rising costs of health care in general, but the rising costs associated with diabetes and prediabetes in particular are concerning as evidenced by the report by Dall et al. (20) in the December issue. The authors reported that the economic burden associated with diagnosed and undiagnosed diabetes, gestational diabetes mellitus, and prediabetes was 48% higher than the estimate reported in 2007. This amount exceeded $322 billion in 2012 and consisted of $244 billion in excess medical costs and $78 billion in reduced productivity. To put this in perspective, the authors state that this "amounts to an economic burden exceeding $1,000 for each American in 2012" (20). Our stated concern is the fact that for prediabetes in particular, these are conditions that currently are very prevalent at the primary care level, but there may not be a heightened awareness regarding the need to adequately address this condition.

Given the new data on the burden of diabetes, we can take comfort in the fact that our treatment strategies are changing and evolving in the effort to keep apace. Specifically, in this month's issue of *Diabetes Care*, and coordinated with a release in *Diabetologia*, is an update to the ADA and the European Association for the Study of Diabetes 2012 position statement on the management of hyperglycemia in patients with type 2 diabetes (21). As reported by the authors, this update was needed based simply on the growing number of new agents and "growing uncertainty regarding their proper selection and sequence" (21). The main updates to the position statement in regards to the approach to the patient are clearly outlined in Fig. 1; there is now separation of those factors felt to be "modifiable" (i.e., patient attitude, resources, support system, etc.) as opposed to those that usually are not (i.e., disease duration, life expectancy, comorbidities, etc.). The position statement identifies the major change in treatment options since publication of the 2012 statement—namely, that sodium–glucose cotransporter 2 inhibitors are now available. Thus, there is no change in the recommendation that metformin remain the optimal drug for monotherapy, but as outlined in Fig. 2 of the update, sodium–glucose cotransporter 2 inhibitors, given the efficacy and clinical research experience to date, are now considered as reasonable options as second- or third-line agents. The updated statement also recognizes the data to date over the last 3 years on the effectiveness of combining GLP-1 receptor agonists with basal insulin and states that when glucose control remains poor that combination of either a GLP-1 receptor agonist or prandial insulin could be used in this setting "with the former arguably safer, at least for short-term outcomes" (21). In brief, the update is needed and timely, recognizes advances in the field, and provides a concise, yet focused management approach.

Finally, also in this issue of *Diabetes Care*, a report examines the ADA Standards of Care recommendations and trends in the quality of evidence supporting the recommendations (22). The recommendations made in the Standards of Care are assigned ratings of A, B, C, or E depending on the quality of evidence. The authors evaluated trends over the past decade for the "higher-level evidence" (combined A- and B-level recommendations) as opposed to the "lower-level evidence" (combined C- and E-level recommendations) category. They then calculated the proportion of overall recommendations that were based on higher-level evidence each year. Over the 9-year period spanning from 2005 to 2014, the total number of annual bulleted recommendations increased by 51% (from 154 to 232). During this time, the proportion of recommendations per year that were based on higher-level evidence increased from 39 to 51%. In the narrative, it was stated that 2014 appears to be the first year in which the majority of recommendations were based on this higher evidence level. Thus, for those who are providing care for individuals with diabetes, it is reassuring that the

recommendations for care are increasingly based on hard evidence. We applaud the ADA for the process they have put in place over the years to provide, update, and grade the recommendations . . . clearly the process is working!

In summary, as an editorial team, we provide "evidence" that since our last update 6 months ago, the quality of published articles continues to be high and our standards at *Diabetes Care* for consideration of publication are increasing. We are very pleased with the outcome to date. Since our last report in July 2014, there has been reason to celebrate as we received our highest impact factor ever given to the journal. So, the "evidence" continues to accumulate . . . evidence that *Diabetes Care* as a journal continues to get better . . . evidence that the recommended standards of care for those with diabetes are at the highest level ever. So, we ask you . . . Can it possibly get any better than this?

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