novo nordisk®

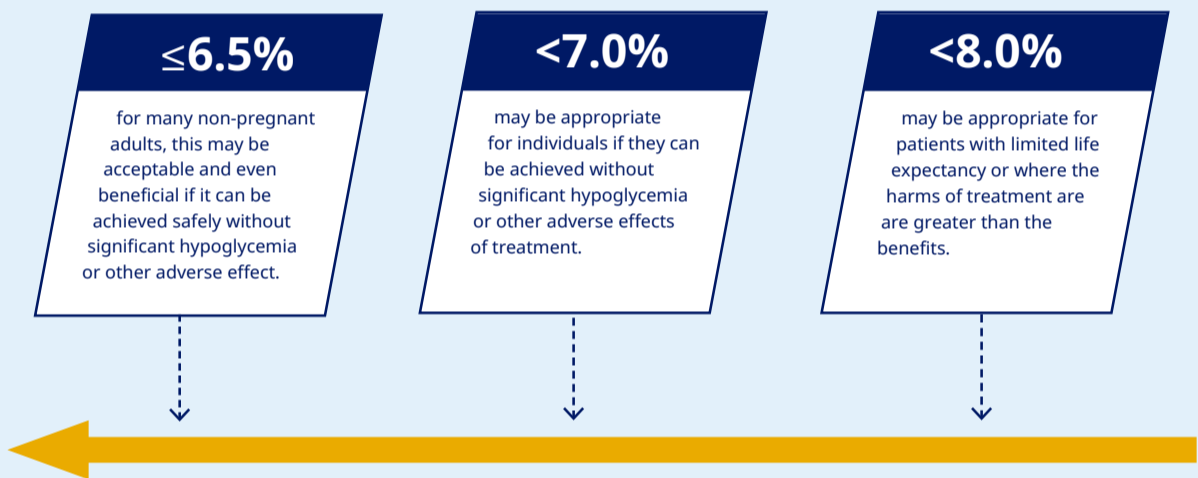# With uncontrolled HbA$_{1c}$, how high is too high?

Treatment plans still center around an individualised target HbA$_{1c}$ for each patient, but greater consideration is now given to the impact of additional patient characteristics and comorbidities.

It can therefore be difficult to know how to set the right target for the right patient.

For illustration purposes only - not a real patient.

Setting HbA$_{1c}$ targets in patients with type 2 diabetes

≤6.5%
for many non-pregnant adults, this may be acceptable and even beneficial if it can be achieved safely without significant hypoglycemia or other adverse effect.

<7.0%
may be appropriate for individuals if they can be achieved without significant hypoglycemia or other adverse effects of treatment.

<8.0%
may be appropriate for patients with limited life expectancy or where the harms of treatment are are greater than the benefits.

Other factors affecting selection of target HbA$_{1c}$

⚠️ High risk of hypoglycaemia or adverse drug effects

📅 Longer duration of diabetes or shorter life expectancy

Presence of severe or multiple key comorbidities (obesity, hypertension, CKD, CVD, HF)

The complexity of the regimen and treatment burden should also be considered, as these factors can affect patient adherence and persistence, and thus the long-term efficacy of any treatment plan.

💧 Established vascular complications

Additional agents should be added as required to maintain glycemic control, and should be selected based on a patient-centered approach.

Abbreviations: CKD, chronic kidney disease; CVD, cardiovascular disease; HF, heart failure.

Reference: American Diabetes Association; Standards of Care in Diabetes—2023 Abridged for Primary Care Providers. Clin Diabetes. 2023;41(1):4–31.