The American Diabetes Association 2017 Guidelines are already out. There are some important changes which need to be highlighted.

1. The guidelines will now be called **Standards of Care** although the document is still named Standards of Medical Care in Diabetes-2017 (1).

2. **Use of Metformin**:
   a) Metformin use has been encouraged in patients with DM even in those who have mild to moderate decrease in eGFR (upto 30ml/min). That is in view of observation by USFDA that lactic acidosis is very rare in patients on Metformin.
   b) Supplements of vitamin B12 have been advised to be used in patients on long term Metformin use. Periodic checking of vitamin B12 levels and supplementation in case of deficiency has been advised. Since biochemical deficiency is more common we do not have to wait for symptoms of Vitamin B12 deficiency to develop.

3. **Psychological assessment** at entry level and subsequently at various stages of the disease especially when complications develop as well as change in life circumstance has been stressed. Indications of referring to a psychiatrist have also been mentioned.

4. Consider **cost of treatment** as an important factor while prescribing drugs. So the cost of various tablets and insulins are mentioned. Here in India we get a tablet of Metformin 500 mg or a tablet of Glimepiride 1 or 2 mg for an average of 2-4 rupees. However just one tablet of an SGLT2 inhibitor Canagliflozin or Empagliflozin costs around 50 rupees. So the doctor has to be judicious in selecting drugs for his patients.

5. **Gestational Diabetes**:
   a) Lifestyle modification may suffice for many women (70-85%) with GDM (2).
   b) Insulin is the treatment of choice and Metformin and Glibenclamide must be second choice as these drugs do not have long term safety data (3).
   c) Metformin should be stopped in patients who are taking it for inducing ovulation in polycystic ovary disease once pregnancy is confirmed.
   d) HbA1c of <6.5% is ideal to minimize the chances of congenital anomalies.
   e) Eye examination to detect retinopathy or check its progress should be conducted preconception or in the first trimester in all GDM.
   f) In the interest of simplicity, fasting and postprandial targets for pregnant women with GDM and preexisting DM have been unified.
   g) Targets for blood sugars for GDM: Fasting <95, 1-hr PP <140, and 2-hr PP <120 mg/dL.

6. A **big baby** (9 pounds or more) born to a lady is no more an independent risk factor to develop prediabetes or T2DM in the future.

7. **Anti hypertensive drugs in DM**:
   a) The choice of use has been extended to all four major groups. Now we can prescribe ACE inhibitors, ARBs, dihydropyridine Calcium Channel Blockers or thiazide-like diuretics as per our wish.
   b) Only when a patient has proteinuria use of ACE inhibitors or ARBs is recommended.
   c) Like previous recommendations do not combine ACEI with ARBs.
8. Use of Insulin:
a) Now we can use a combination of regular and long acting insulin like 30/70 in a twice or thrice daily dose.
b) An alert about hypoglycemia has been inserted in the algorithm of insulin use. Stress has been made on identifying and addressing the cause of hypoglycemia.
c) The definition of hypoglycemia has been renewed: Clinically Significant Hypoglycemia if blood glucose level is <54 mg/dL irrespective of symptom or signs of hypoglycemia; Glucose Alert Value is glucose level 55-70 mg/dL.

9. For Cardiovascular benefit, two drugs namely Empagliflozin and Liraglutide have been recommended to be used. This is in view of the EMPA-REG and LEADER trials respectively (4,5)

10. Bariatric surgery to be called Metabolic Surgery and BMI lowered to 30 as an indication.

11. Medical evaluation to assess Sleep Quality and diagnosis of Obstructive Sleep Apnea to be entertained and treated if present.

12. Screening of DM in dental practices has been emphasized.

13. A new section has been added on post-transplantation diabetes mellitus.

14. Finally prolonged sitting should be interrupted every 30 minutes with short bouts of physical activity.

Let us try to apply as much as possible in our daily management of DM and hope this would help us in treating diabetes mellitus in a much better way.

References:
1. Standards of Medical Care in Diabetes. Diabetes Care 2017;40(Suppl. 1-132)

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