FP Essentials
Call for Authors – February 2026

Type 2 Diabetes Update

We are seeking an author or author group to write a manuscript for this edition of *FP Essentials* that will update family physicians about type 2 diabetes. This edition will cover four topics:

1. Screening, Prevention, and Team-Based Care
2. Nonpharmacologic Treatment and Continuous Glucose Monitoring
3. Pharmacologic Treatment
4. Preventing and Managing Retinopathy, Nephropathy, and Neuropathy

The main text of the manuscript should be approximately 10,000 words in length, divided into four sections of approximately 2,500 words each, plus an abstract of approximately 200 words for each section. In addition, there should be key practice recommendations, a maximum of 15 tables/figures total, and up to 200 references to provide support for all recommendations and factual statements in the manuscript. References must be numbered sequentially by section, with each new section starting over at "1."

This edition should focus on what is new in each topic and should answer the key questions listed for each section. Each section should begin with an illustrative case, similar to the examples provided, with modifications to emphasize key points; each case should have a conclusion that demonstrates resolution of the clinical situation. The references provided here include information that should be considered in preparation of this edition of *FP Essentials*. However, these should be used only as a starting point in identifying the most current guidelines and references to include in the edition.

Needs Assessment

In the United States, nearly 15% of adults, 1 in 5 adolescents, and 1 in 11 pregnant individuals have diabetes. Its prevalence is expected to double in the coming decades. Care for patients with type 2 diabetes incur direct and indirect medical costs of up to $300 billion, and it remains one of the most common diagnoses made and managed by family physicians. Use of newer medications with evidence of cardiovascular, renal, weight loss, and mortality benefits have gained traction in recent years, but management decisions have become more nuanced and complicated, with various medical guidelines providing different recommendations for first-line treatment and subsequent management of type 2 diabetes. Therapeutic decisions are further complicated by evidence that social determinants of health and unequal access to care and resources lead to different health outcomes among patients. This edition of *FP Essentials* will review type 2 diabetes screening and prevention recommendations, explore the evidence behind nonpharmacologic and pharmacologic therapies, and evaluate effective preventive and therapeutic interventions for diabetic retinopathy, nephropathy, and neuropathy.

Section 1: Screening, Prevention, and Team-Based Care

Example Case

CS is a 59-year-old with type 2 diabetes (T2D), hypertension, and obesity who visits your clinic with a superficial diabetic foot ulcer that appears to be responding well to offloading. You notice, however, that his dressing is saturated, and his socks and boots are dirty. With curiosity and openness, you discover he has been living in his car since he lost his job and apartment and has no access to running water. You quickly take action by notifying your clinic social worker and care management team to begin engaging the patient and assessing his needs.

Key Questions to Consider

Prevalence, Disease Burden, Health Disparities

- How prevalent are prediabetes and type 2 diabetes among adults in the United States and worldwide (based upon current diagnostic definitions and criteria)? How is the prevalence projected to change in coming years?
- What are the economic, personal, and societal impacts of T2D?
- What social determinants affect the prevalence of T2D, and what health disparities exist in the provision of care and outcomes for patients with T2D?

Screening

- What are the United States Preventive Services Task Force (USPSTF) recommendations regarding screening for prediabetes and T2D in adults? How do they compare to the American Diabetes Association (ADA) and American Association of Clinical Endocrinology (AACE) recommendations? When should screening begin in person from groups at high risk of diabetes?
- Does screening asymptomatic patients improve health outcomes (eg, all-cause mortality, disease-specific mortality or morbidity, quality of life)?
- What screening tests (and laboratory criteria/cutoffs) are used to diagnose prediabetes and T2D (eg, fasting plasma glucose, hemoglobin A1c, oral glucose tolerance test)? How often should screening be done? What are the current limitations of using hemoglobin A1c for screening patients for T2D, and what medical conditions will limit its use?

Prevention

- How effective are the following interventions for preventing or delaying the progression from prediabetes to T2D? How well do they improve health outcomes (mortality, morbidity, quality of life) in patients with prediabetes?
- Lifestyle interventions: diet, physical activity, weight loss or maintenance of healthy body weight, smoking cessation/abstinence
- Medications: metformin, dipeptidyl peptidase-4 inhibitors (pioglitazone, rosiglitazone), glucagon-like peptide-1 receptor agonists, or dual glucose-dependent insulinotropic polypeptide agonists/glucagon-like peptide-1 receptor agonists. *Note: Please add statement in the discussion that none of these medications are currently FDA-approved for prevention.*
- Complementary treatments: vitamin D, omega-3, omega-6, polyunsaturated fat
- For older adults, what is the prognosis/natural history of prediabetes? What percentage of patients with prediabetes will eventually develop T2D? What are the benefits and harms of preventive interventions?

Team-Based Care

Please include medical (eg, pharmacists, dietician, nurses, subspecialists) and nonmedical team members (eg, social worker, peer support, community health workers)

- What is team-based care and how can it enhance the management of patients with prediabetes and T2D? How effective is it compared to usual care? Is it cost-effective?
- What are the barriers and facilitators to effective team-based care?

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Section 2: Nonpharmacologic Treatment and Continuous Glucose Monitoring

Example Case

NJ is a 70-year-old with type 2 diabetes (T2D), stage 3 chronic kidney disease, hypertension, and obesity, who has struggled to keep her hemoglobin A1c below 9% despite being on empagliflozin, semaglutide, and basal plus prandial insulin. She is fairly sedentary and struggles to make adequate nutritional changes. Her brother suggested she talk to you about obtaining a continuous glucose monitoring (CGM) device, as this has been a game-changer for him in tracking his glucose as it relates to his diet and insulin doses.

Key Questions to Consider

Lifestyle Interventions

- What is the role of diet, physical activity, weight loss, and behavioral interventions in the management of T2D? How well do they improve health outcomes (mortality, morbidity, quality of life)?
- How has the emphasis from professional guidelines on medical nutrition therapy shifted away from macronutrients and micronutrients toward a focus on eating patterns (dietary or food patterns), the totality of consumption of food and beverages, and nutrient-dense food choices? How should patients with diabetes be counseled on nutrition with this in mind? What are the best diets to recommend to diabetic patients? Consider individualized nutrition education that may include carbohydrate counting for patients on insulin regimens, while emphasizing broader dietary patterns. *Note: An upcoming monograph on obesity management will be published in April 2026, so please keep your discussions focused on diabetes.*

Behavioral Interventions, Including Self-Management

- How well do group-based and individual diabetes self-management educational interventions improve T2D health outcomes?
- How effective are educational interventions provided by formally trained diabetes educators (eg, nurses, dieticians, pharmacists) vs brief in-office physician advice? At what level of diabetes control (ie, hemoglobin A1c) should patients be referred for these services? Is there benefit for individuals with good control or prediabetes to see a diabetic educator?
- How effective are mobile, virtual, artificial intelligence, or other technology-based behavioral interventions and self-management tools in improving health outcomes in patients with diabetes? Consider a table or algorithm for readers as a "how to" implement in practice and provide specific examples/links/resources of these interventions.

Surgical Interventions

- With increasing availability of safe, effective pharmacologic treatment of obesity and T2D, when should metabolic bariatric surgery be considered? For which patients should both therapies be considered? What are the eligibility criteria for Medicare? *Note: A brief discussion should be sufficient since this topic will be thoroughly covered in the monograph on obesity management.*

Complementary Treatments

- Which complementary and alternative therapies are effective for T2D treatment or as adjunctive therapy?

Continuous Glucose Monitoring

- What is continuous glucose monitoring (CGM)? Which patients are good candidates for CGM / what are the common insurance requirements for patients to qualify? How does it affect health outcomes for patients with T2D (ie, benefits, harms)?
- Which CGM devices are available (both prescription and over-the-counter)? Using a table, please provide a summary of the following CGM device features:
    - Approved ages
    - Frequency of readings
    - Bluetooth range
    - Compatibility with mobile phone vs use of a separate reader (for patients without mobile phone)
    - Body location for sensor placement
    - Sensor life
    - Warm-up time
- What are the common restrictions on coverage (eg, insulin use, hypoglycemia unawareness)? For patients paying out of pocket, what are the retail prices for the sensors (and readers if applicable)? Please use tables to summarize key information.
- How should ambulatory glucose profile in CGM reports be interpreted (eg, average glucose, time in range, time above range, time below range, glycemic variability)? If appropriate, consider tables to summarize key information.
- Given the time constraints in clinical practice, how can family physicians effectively and efficiently incorporate CGM in caring for patients with T2D (eg, CGM integration with electronic health records, pharmacists within team-based care)?

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Section 3: Pharmacologic Treatment

Example Case
JT is a 52-year-old male with type 2 diabetes (T2D), hypertension, obesity (BMI 40 kg/m^2), and sleep apnea. His diabetes has been well-controlled on metformin and empagliflozin for 5 years, but he has struggled with his diet for the past 2 years due to his frequent travels to assist his aging parents. He averages 12,000 steps per day, yet his hemoglobin A1c has been around 8.5% for the past 12 months. He knows he can probably make dietary changes but is realistic about his family's circumstances, so he asks you about the possibility of adding another medication.

Figures/algorithms and tables are extremely helpful for busy clinicians and should be included when appropriate. Additionally, preventing and treating diabetic complications will be thoroughly covered in Section 4, so please minimize discussion in this section and refer readers to Section 4 when appropriate.

Key Questions to Consider:
Noninsulin Pharmacologic Treatment

- How should physicians approach individualized glycemic goals for patients with T2D? Please review variations in recommendations/guidelines from the American Diabetes Association (ADA), American College of Physicians (ACP), etc., and provide a summary of evidence from landmark trials (ACCORD, ADVANCE, UKPDS 33 and 34, VADT, etc.).
- When is metformin considered first-line oral treatment for T2D?
- Based on individual patient risks and comorbidities (ie, cardiovascular disease, chronic kidney disease, obesity), when are sodium-glucose cotransporter-2 inhibitors and glucagon-like peptide-1 receptor agonists (GLP-1RA) indicated? How effective are these newer medications in treating diabetes? When should GLP-1RA be used instead of insulin? How should family physicians titrate the doses of these medications? What are common adverse events and contraindications to their use? Please provide tables of different pharmacological agents divided by class, and hemoglobin A1c reduction by each.
- When are dipeptidyl peptidase-4 inhibitors, sulfonylureas, thiazolidinediones, alpha-glucosidase inhibitors, and meglitinides indicated? How effective are these medications in treating diabetes? How should family physicians titrate the doses of these medications? What are common adverse events and contraindications to their use? Please provide table of different pharmacological agents divided by class, and hemoglobin A1c reduction by each.

Insulin Therapy

- When should insulin be considered in the outpatient treatment of T2D? How effective is insulin in treating T2D? What are common adverse events and how should they be managed?
- When is basal (long-acting) vs bolus (short-acting) insulin indicated? When should basal insulin be split into 2 times/day dosing instead of once daily? What types of basal insulins are there (ultra-long-acting, long-acting/intermediate-acting insulin)? What types of bolus insulins are there (rapid-acting, short-acting)? When would premixed insulin (basal + bolus) be used? Please provide a table summarizing insulin types,

concentrations, brand names, onset, peak, and duration. An accompanying figure comparing the onset, peak, and duration profiles across insulin types would also be helpful.

- Which patients should self-monitor blood glucose? What are the recommended fasting, premeal, and postprandial blood glucose targets? How often should regimens be adjusted? Aside from self-monitored blood glucose testing, when should continuous glucose monitoring be considered? *Note: continuous glucose monitoring is thoroughly covered in Section 2.*
- When should concentrated insulins (eg U-200, U-300, U-500) be prescribed?
- If space allows, include practical guidance on initiating and adjusting insulin therapy, including total daily dose calculation, use of insulin-to-carbohydrate ratios, correction factors, when to start insulin pump.
- Should oral diabetic medications be continued when the patient is on insulin therapy? Which ones could be held or discontinued? When should insulin therapy be discontinued? How should insulin be adjusted when adding GLP-1RA therapy?
- Which factors affect individualized goals of insulin therapy (eg, age, life expectancy, comorbid conditions, duration of diabetes, risk of hypoglycemia, cost, patient motivation and preferences, quality of life)?

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Section 4: Preventing and Managing Retinopathy, Nephropathy, and Neuropathy

Example Case

JS is a 63-year-old with uncontrolled type 2 diabetes (T2D), hypertension, dyslipidemia, stable angina, stage 2 chronic kidney disease, and neuropathy, who has been fearful of needles all her life. Despite a healthy diet, regular exercise, and multiple oral diabetic medications (metformin, acarbose, glipizide, empagliflozin), her hemoglobin A1c has ranged from 8.7% to 9.5% and she remains averse to the thought of insulin and semaglutide injections. You refer her to your clinical pharmacist who suggested trying oral semaglutide to improve her glycemic control and for its added mortality benefits.

Figures/algorithms and tables are extremely helpful for busy clinicians and should be included when appropriate. Additionally, preventing onset of T2D among patients with prediabetes will be thoroughly covered in Section 1, so please minimize discussion in this section and refer readers to Section 1 when appropriate.

Key Questions to Consider

Overview, Screening

- What is the prevalence of microvascular complications (ie, retinopathy, nephropathy, neuropathy) in patients with T2D? How are they diagnosed and classified relative to quality metrics?
- What are the recommended screening intervals for retinopathy, nephropathy, and neuropathy? And when present, how frequently should these patients be seen?

Prevention

- Among patients with T2D *without* microvascular complications, how well do the following interventions prevent these complications?
    - Sodium-glucose cotransporter-2 inhibitors
    - Glucagon-like peptide-1 receptor agonists, or dual glucose-dependent insulinotropic polypeptide agonists/glucagon-like peptide-1 receptor agonists
    - Blood pressure control: intensive vs standard
    - Glycemic control: intensive vs standard/conventional

Retinopathy

- Among patients with T2D and retinopathy, how well do the following interventions improve disease-specific outcomes? How well do they prevent progression or worsening of retinopathy?
    - Laser photocoagulation
    - Intravenous injections of anti-vascular endothelial growth factor
    - Blood pressure control: intensive vs standard
    - Glycemic control: intensive vs standard/conventional

Nephropathy

- Among patients with T2D and nephropathy, how well do the following interventions improve disease-specific and global outcomes? How well do they prevent progression or worsening of nephropathy?
    - Blood pressure control: intensive vs standard
    - Glycemic control: intensive vs standard/conventional

    - Angiotensin-converting enzyme inhibitors, angiotensin receptor blockers, calcium channel blockers
    - Sodium-glucose cotransporter-2 inhibitors
    - Glucagon-like peptide-1 receptor agonists, or dual glucose-dependent insulinotropic polypeptide agonists/glucagon-like peptide-1 receptor agonists Statins
    - Dietary interventions: protein intake, sodium intake

- Among patients with advanced diabetic nephropathy, when should renal replacement therapy vs conservative kidney management be considered? Please briefly differentiate and focus on health outcomes of home hemodialysis, in-center hemodialysis, peritoneal dialysis, and kidney transplantation. Consider a table for this.

Neuropathy

- Among patients with T2D and neuropathy, how well do the following interventions improve outcomes? How well do they prevent progression or worsening of neuropathy
    - Glycemic control: intensive vs standard/conventional
    - Antidepressants: tricyclic antidepressants, serotonin-norepinephrine reuptake inhibitors
    - Gabapentinoids: gabapentin, pregabalin
    - Sodium channel blockers: lamotrigine, lacosamide, carbamazepine, oxcarbazepine, valproic acid
    - Topical treatments: capsaicin, lidocaine
    - Lifestyle interventions: weight management
    - Opioids, tapentadol, tramadol

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