In order to improve the quality of life and to prevent chronic complications related to diabetes mellitus, intensive lifestyle modification and proper medication are needed from the early stage of diagnosis of type 2 diabetes mellitus (T2DM). When using the first medication for diabetic patients, the appropriate treatment should be selected considering the clinical characteristics of the patient, efficacy of the drug, side effects, and cost. In general, the use of metformin as the first treatment for oral hypoglycemic monotherapy is recommended because of its excellent blood glucose-lowering effect, relatively low side effects, long-term proven safety, low risk of hypoglycemia, and low weight gain. If metformin is difficult to use as a first-line treatment, other appropriate medications should be selected in view of the clinical situation. If the goal of achieving glycemic control is not achieved by monotherapy, a combination therapy with different mechanisms of action should be initiated promptly.

Keywords: Diabetes mellitus, type 2; Hypoglycemic agents; Metformin; Practice guideline
INTRODUCTION

Many studies have shown that intensive control of blood glucose can significantly prevent diabetes-related chronic complications [1,2]. These results are the theoretical basis for explaining the need for active blood glucose management to improve the clinical course of diabetic patients. However, recent studies have reported that overly rigorous blood glucose control may lead to a negative clinical course in patients [3-5]. Individualized blood glucose control goals that take into account the diverse clinical situations of diabetic patients are required [6,7].

Lifestyle modification (LSM) is the first treatment for successful diabetes management. The effects of LSM on the clinical course of diabetes have been demonstrated in several studies [8,9]. However, due to the pathophysiological nature of type 2 diabetes mellitus (T2DM), where β-cell function is gradually diminishing, it is difficult to maintain adequate blood glucose control with LSM alone [10]. Therefore, in many patients, medication should be administered from the beginning of the treatment for proper blood glucose control.

This article was written to provide the rationale for the update of the position statement of the Korean Diabetes Association (KDA), and the contents of oral hypoglycemic agent monotherapy were described.

RECOMMENDATIONS

Principles of initial management after diagnosis of type 2 diabetes mellitus

1. Active lifestyle modification and appropriate pharmacotherapy are needed from the initial diagnosis of diabetes [A].
2. An appropriate selection of pharmacotherapy should be made after considering the clinical characteristics of the patient and drug efficacy, side effects, mechanism of action, risk of hypoglycemia, effect on body weight, and patient preference and combined morbidity [E].

Principles of treatment with antihyperglycemic agents

1. Metformin is the preferred initial oral hypoglycemic agent [A].
2. If metformin is contraindicated or not well tolerated as the initial treatment, another class of hypoglycemic agent can be used depending on the clinical situation [E].
3. If monotherapy fails to achieve the glycemic target, combination therapy with a second agent with a different mechanism of action should be initiated [A].

METHODS

Selection of topics, organization of the working group, and determination of methods

In March 2017, the Clinical Practice Guideline (CPG) update was discussed at the Committee of Clinical Practice Guideline in the KDA. The committee decided to carry out an amendment in this revision that reflects the new diabetes medications. For this task, the committee formed a working group for revising the relevant content of the CPG. The guidelines were revised based on a systematic review of the newly published literature, along with the other national and international CPG contents. The details of this process are described in detail in other documents [11].

Key question selection

The task of the authors of the current article was evaluating the monotherapy of oral hypoglycemic agents for the working group. We have determined the key questions for revising the CPG according to the results of the discussion within the group. The first question is whether metformin is appropriate as a first-line choice for Korean patients with T2DM. The second question is how to choose the other first-line agent if metformin is not available. Finally, cardiovascular outcome with metformin or other monotherapy was determined to be the third key question.

Literature review

For the purpose of revising the guidelines, various domestic and international guidelines have been referred to. We referred to the KDA guidelines and the Korea National Diabetes Program (KNPD) guidelines as domestic guidelines [12,13] and referred to the guidelines of the American Diabetes Association (ADA), National
Institute for Health and Care Excellence (NICE), International Diabetes Federation (IDF), Canadian Diabetes Association (CDA), and American Association of Clinical Endocrinologists and American College of Endocrinology (AACE) as foreign guidelines [14-18]. References that meet our key questions were adopted. In addition, a systematic review was conducted to obtain the latest evidence. A master database for systematic review was built by professional librarians and delivered to group members. The evidence levels of the articles in the database were evaluated according to individual reviews of the group members. Thereafter, a list of articles was prepared by mutual review and agreement of group members. A final list was established by independent committee members separate from the working group [11].

Drafting, public hearing, and final approval of board of directors

The revised recommendations were circulated and evaluated by members of the committee other than the working group. Based on peer review, a draft CPG update was prepared. In July 2017, an initial draft was released at a public hearing. A final draft of the CPG update was prepared in accordance with the opinions gathered at the hearing. In August 2017, the final manuscript was approved by the Board of Directors, KDA.

COMMENTS ON RECOMMENDATIONS

Oral hypoglycemia agent as a monotherapy

For patients with T2DM who have not satisfactorily met therapeutic goals with LSM, a first-line oral hypoglycemic monotherapy should be administered. In monotherapy, approximately 0.5% to 1.5% of glycosylated hemoglobin (HbA1c) reduction is observed depending on the medication [19]. Although there are some differences depending on the class, the maximal effect of the drug is usually observed 4 to 6 months after treatment [20]. In general, the higher the patient’s HbA1c, the greater the extent of HbA1c reduction with medication [19]. Postprandial glucose control becomes more important for further improvement of HbA1c when blood glucose approaches the generally recommended level (less than 7.3% of HbA1c) [21]. Some studies have shown that postprandial glucose is an independent risk factor for cardiovascular disease and death regardless of fasting glucose [22,23]. However, the evidence for whether postprandial improvement of blood glucose is effective in improving additional cardiovascular disease outcomes is not yet clear.

Metformin as an initial treatment regimen

Metformin is recommended as the drug for initial treatment in most diabetes-related CPGs worldwide [12-18]. Metformin is recommended as the first choice for patients with T2DM because of its excellent blood glucose-lowering effect, relatively low adverse effects, long-term safety, low risk of hypoglycemia, and low weight gain. These recommendations are based on a cohort study in which metformin monotherapy in overweight T2DM patients was associated with more marked blood glucose-lowering effects and less weight gain and hypoglycemia compared to sulfonylurea or insulin monotherapy [24]. Potential cardiovascular disease prevention effect is also included in the reason for choosing metformin as the initial treatment [24,25]. However, the preventive effect of metformin on cardiovascular disease has yet to be ascertained.

In several subsequent observational studies and meta-analyses, there was evidence that metformin could be the drug of choice for initial treatment of diabetes patients compared to sulfonylurea, thiazolidinedione, and dipeptidyl peptidase 4 (DPP4) inhibitor, from the aspects of HbA1c reduction, side effects, weight gain, hypoglycemia, economic feasibility, and cardiovascular disease prevention [26-29]. In a prospective, multicenter clinical trial conducted in Korea, the effect of metformin monotherapy on HbA1c was similar to that of sulfonylurea or thiazolidinedione monotherapy [30]. Based on the above evidence, we also recommend metformin as an initial first-line medication in this CPG.

Clinical situations such as hepatic failure, chronic kidney disease (caution in estimated glomerular filtration rate [eGFR] < 60 mL/min/1.73 m², contraindication in eGFR < 30 mL/min/1.73 m²), severe infection, dehydration, and heart failure are contraindications of metformin use and it should be used with caution [14,17]. Recently, a study suggesting that metformin use may be associated with vitamin B12 deficiency and anemia was published [31]. Vitamin B12 measurements may be considered for metformin users with peripheral neuropa-
thy or anemia.

**Monotherapy using other oral hypoglycemic agents**

For patients who are contraindicated for metformin or who experience difficulties with metformin use, monotherapy of other hypoglycemic agents is considered as an initial treatment. Recently, as new drugs have been launched, various oral hypoglycemic agents have become available in clinical practice (Table 1) [11]. These drugs differ not only in their mechanism of action, but also in terms of cardiovascular disease prevention, side effects, contraindications, and price.

The DPP4 inhibitors have been widely used as a substitute for patients who have difficulty in using metformin monotherapy; these inhibitors are used because of their low incidence of side effects such as hypoglycemia. Recently, a meta-analysis has been reported by Korean researchers that suggests the effect of DPP4 inhibitors on Asians may be superior to other ethnicities [32]. The effects of the DPP4 inhibitors on cardiovascular disease have been reported to be neutral according to multicenter, prospective, randomized controlled trials performed recently performed trials [33-35]. Although some DPP4 inhibitor have been reported to increase the risk of heart failure, systematic reviews have shown that the risk is not significant, and there is a slight difference in the risk of heart failure resulting from the use of DPP4 inhibitors [36,37].

The use of sodium-glucose cotransporter 2 (SGLT2) inhibitors has recently led to a significant reduction in the risk of cardiovascular disease and mortality in patients with diabetes in multicenter, prospective, randomized controlled trials, and the frequency of use of these inhibitors is increasing in clinical settings [38-41]. However, due to possible side effects such as urogenital infection, dehydration, and hypotension, care should be taken with the use of drugs that are high likely to cause hypoglycemia.

**CONCLUSIONS**

Diabetes treatment should be individualized according to the patient’s needs and preferences, and drugs should be selected taking into account the specific advantages and disadvantages of each drug [7]. For a reasonable choice of medication, various clinical conditions should be considered including age, Hba1c, fasting and post-prandial glucose, obesity or metabolic syndrome, insulin secretory capacity, risk of hypoglycemia, liver, cardiac or renal dysfunction, and patient preference.

Recently, new drugs have been introduced, and various clinical trials related to these drugs have been introduced. Different opinions on the selection of the initial treatment for patients with T2DM have been raised. We have yet to come to a complete conclusion as to which oral hypoglycemic agent should be the first choice for a particular patient, and which medication should be added next. In addition, we have not yet reached a consensus that it is reasonable to choose a particular medication for each of the various clinical situations. However, it is clinically more important to know what drug should control blood glucose, than what goal should blood glucose be controlled [17]. Even if blood glucose and Hba1c levels do not reach the target, the prognosis of the patient can be significantly improved depending
| Table 1. Oral antihyperglycemic agents for patients with type 2 diabetes mellitus used in Korea |
|------------------------------|------------------------------|------------------------------|------------------------------|------------------------------|
| **Mechanism and common use** | **Weight gain** | **Hypoglycemia**<sup>a</sup> | **HbA1c reduction, %**<sup>a</sup> | **Side effects** | **Caution** |
| Biguanide (metformin) | ↓ Hepatic glucose production | Neutral or decrease | No | 1.0–2.0 | GI side effects (anorexia, nausea, vomiting, diarrhea, cramping), vitamin B12 deficiency, lactic acidosis (rare) | Contraindication in severe hepatic or renal insufficiency (eGFR < 30 mL/min/1.73 m<sup>2</sup>), severe infection, dehydration, heart failure. Major operation or iodine-contrast use within 48 hours |
| | Start with lower dose and titrate upward slowly | | | | | |
| Sulfonlurea (gliclazide, glipizide, glimepiride, glibenclamide) | ↑ Insulin secretion from β-cells | Yes | Yes | 0.5–1.5 | Severe hepatic or renal insufficiency, secondary failure |
| | Before meal | | | | | |
| Meglitinide (repaglinide, nateglinide, mitiglinide) | ↑ Insulin secretion from β-cells, ↓ postprandial hyperglycemia | Yes | Yes | 0.5–1.0 | Severe hepatic or renal insufficiency |
| | Before each meal | | | | | |
| DPP4 inhibitor (sitagliptin, vildagliptin, saxagliptin, linagliptin, gemigliptin, alogliptin, teneligliptin, anaagliptin) | ↑ Postprandial incretin (GLP-1, GIP), ↑ glucose-dependent insulin secretion, ↓ postprandial glucagon secretion, ↓ postprandial hyperglycemia, use regardless of mealtime | No | No | 0.5–1.0 | Angioedema, urticaria |
| | | | | | Acute pancreatitis |
| | | | | | Risk for heart failure (saxagliptin, alogliptin) |
| | | | | | Dose titration in severe hepatic or renal insufficiency |
| Thiiazolidinedione (pioglitazone, lobeglitazone) | ↑ Insulin sensitivity (muscle, adipose tissue), ↓ hepatic glucose production, once daily regardless of mealtime | Yes | No | 0.5–1.4 | Edema, anemia, bone fracture, heart failure |
| | | | | | Heart failure, severe hepatic or renal insufficiency |
| SGLT2 inhibitor (dapagliflozin, ipragliflozin, empagliflozin) | ↓ Renal glucose reabsorption, ↑ glucosuria | No | No | 0.5–1.0 | Genitourinary tract infections, polyuria, dehydration, DKA |
| | Once daily regardless of mealtime | | | | | |
| α-Glucosidase inhibitor (acarbose, voglibose) | ↓ Upper intestinal glucose absorption, ↓ postprandial hyperglycemia | No | No | 0.5–1.0 | GI side effects (flatulence, diarrhea, bloating) |
| | Before each meal | | | | | |

<sup>a</sup>Monotherapy.

Adapted Ko et al. [11].

HbA1c, glycosylated hemoglobin; GI, gastrointestinal; eGFR, estimated glomerular filtration rate; DPP4, dipeptidyl peptidase 4; GLP-1, glucagon-like peptide 1; GIP, gastric inhibitory polypeptide; CKD, chronic kidney disease; SGLT2, sodium-glucose cotransporter 2; DKA, diabetic ketoacidosis.
REFERENCES

1. UK Prospective Diabetes Study (UKPDS) Group. Intensive blood-glucose control with sulphonylureas or insulin compared with conventional treatment and risk of complications in patients with type 2 diabetes (UKPDS 33). Lancet 1998;352:837-853.

2. Holman RR, Paul SK, Bethel MA, Matthews DR, Neil HA. 10-Year follow-up of intensive glucose control in type 2 diabetes. N Engl J Med 2008;359:1577-1589.

3. Action to Control Cardiovascular Risk in Diabetes Study Group, Gerstein HC, Miller ME, et al. Effects of intensive glucose lowering in type 2 diabetes. N Engl J Med 2008;358:2545-2559.

4. ADVANCE Collaborative Group, Patel A, MacMahon S, et al. Intensive blood glucose control and vascular outcomes in patients with type 2 diabetes. N Engl J Med 2008;358:2560-2572.

5. Duckworth W, Abraira C, Moritz T, et al. Glucose control and vascular complications in veterans with type 2 diabetes. N Engl J Med 2009;360:129-139.

6. Ismail-Beigi F, Moghissi E, Tiktin M, Hirsch IB, Inzucchi SE, Genuith S. Individualizing glycemic targets in type 2 diabetes mellitus: implications of recent clinical trials. Ann Intern Med 2011;154:554-559.

7. Inzucchi SE, Bergenstal RM, Buse JB, et al. Management of hyperglycemia in type 2 diabetes, 2015: a patient-centered approach: update to a position statement of the American Diabetes Association and the European Association for the Study of Diabetes. Diabetes Care 2015;38:140-149.

8. Look AHEAD Research Group, Wing RR, Bolin P, et al. Cardiovascular effects of intensive lifestyle intervention in type 2 diabetes. N Engl J Med 2013;369:145-154.

9. Pillay J, Armstrong MJ, Butalia S, et al. Behavioral programs for type 2 diabetes mellitus: a systematic review and network meta-analysis. Ann Intern Med 2015;163:848-860.

10. Turner RC, Cull CA, Frighi V, Holman RR. Glycemic control with diet, sulfonylurea, metformin, or insulin in patients with type 2 diabetes mellitus: progressive requirement for multiple therapies (UKPDS 49). UK Prospective Diabetes Study (UKPDS) Group. JAMA 1999;281:2005-2012.

11. Ko SH, Hur KY, Rhee SY, et al. Antihyperglycemic agent therapy for adult patients with type 2 diabetes mellitus.
2017: a position statement of the Korean Diabetes Association. Diabetes Metab J 2017;41:347-348.
12. The Korea National Diabetes Program (KNDP) Investigators. Clinical Practice Guideline for the Prevention and Management of Diabetes in Korea. Seoul (KR): Medbook, 2014.
13. Korean Diabetes Association. 2015 Treatment Guidelines for Diabetes. Seoul (KR): Korean Diabetes Association, 2015.
14. American Diabetes Association. 8. Pharmacologic approaches to glycemic treatment. Diabetes Care 2017;40(Suppl 1):S64-S74.
15. McGuire H, Longson D, Adler A, Farmer A, Lewin I; Guideline Development Group. Management of type 2 diabetes in adults: summary of updated NICE guidance. BMJ 2016;353:i1575.
16. International Diabetes Federation Guideline Development Group. Global guideline for type 2 diabetes. Diabetes Res Clin Pract 2014;104:1-52.
17. Canadian Diabetes Association Clinical Practice Guidelines Expert Committee, Harper W, Clement M, et al. Pharmacologic management of type 2 diabetes. Can J Diabetes 2013;37 Suppl 1:S61-S68.
18. Garber AJ, Abrahamson MJ, Barzilay JI, et al. Consensus statement by the American Association of Clinical Endocrinologists and American College of Endocrinology on the comprehensive type 2 diabetes management algorithm: 2017 executive summary. Endocr Pract 2017;23:207-238.
19. Bloomgarden ZT, Dodis R, Viscoli CM, Holmboe ES, Inzucchi SE. Lower baseline glycemia reduces apparent oral agent glucose-lowering efficacy: a meta-regression analysis. Diabetes Care 2006;29:2137-2139.
20. Sherifali D, Nerenberg K, Pullenayegum E, Cheng JE, Gerstein HC. The effect of oral antidiabetic agents on A1C levels: a systematic review and meta-analysis. Diabetes Care 2006;32:2137-2139.
21. Monnier L, Lapinski H, Colette C. Contributions of fasting and postprandial plasma glucose increments to the overall diurnal hyperglycemia of type 2 diabetic patients: variations with increasing levels of HbA1c. Diabetes Care 2003;26:881-885.
22. Bonora E, Muggeo M. Postprandial blood glucose as a risk factor for cardiovascular disease in type II diabetes: the epidemiological evidence. Diabetologia 2001;44:2107-2114.
23. Glucose tolerance and mortality: comparison of WHO and American Diabetes Association diagnostic criteria. The DECODE study group. European Diabetes Epidemiology Group. Diabetes epidemiology: collaborative analysis of diagnostic criteria in Europe. Lancet 1999;354:617-621.
24. UK Prospective Diabetes Study (UKPDS) Group. Effect of intensive blood-glucose control with metformin on complications in overweight patients with type 2 diabetes (UKPDS 34). Lancet 1998;352:854-865.
25. Goldberg RB, Aroda VR, Bluemke DA, et al. Effect of long-term metformin and lifestyle in the diabetes prevention program and its outcome study on coronary artery calcium. Circulation 2017;135:52-64.
26. Bennett WL, Maruthur NM, Singh S, et al. Comparative effectiveness and safety of medications for type 2 diabetes: an update including new drugs and 2-drug combinations. Ann Intern Med 2011;154:662-663.
27. Tam J, Deerochanawong C, Shera AS, et al. Role of metformin in the initiation of pharmacotherapy for type 2 diabetes: an Asian-Pacific perspective. Diabetes Res Clin Pract 2007;75:255-266.
28. Maruthur NM, Tseng E, Huffman S, et al. Diabetes medications as monotherapy or metformin-based combination therapy for type 2 diabetes: a systematic review and meta-analysis. Ann Intern Med 2016;164:740-751.
29. Palmer SC, Mavridis D, Nicolucci A, et al. Comparison of clinical outcomes and adverse events associated with glucose-lowering drugs in patients with type 2 diabetes: a meta-analysis. JAMA 2016;316:313-324.
30. Yoon KH, Shin JA, Kwon HS, et al. Comparison of the efficacy of glimepiride, metformin, and rosiglitazone monotherapy in Korean drug-naive type 2 diabetic patients: the practical evidence of antidiabetic monotherapy study. Diabetes Metab J 2011;35:26-33.
31. Aroda VR, Edelstein SL, Goldberg RB, et al. Long-term metformin use and vitamin B12 deficiency in the diabetes prevention program outcomes study. J Clin Endocrinol Metab 2016;101:3754-3761.
32. Kim YG, Hahn S, Oh TJ, Kwak SH, Park KS, Cho YM. Differences in the glucose-lowering efficacy of dipeptidyl peptidase-4 inhibitors between Asians and non-Asians: a systematic review and meta-analysis. Diabetologia 2013;56:769-768.
33. Scirica BM, Bhatt DL, Braunwald E, et al. Saxagliptin and cardiovascular outcomes in patients with type 2 diabetes
mellitus. N Engl J Med 2013;369:1317-1326.
34. White WB, Cannon CP, Heller SR, et al. Alogliptin after acute coronary syndrome in patients with type 2 diabetes. N Engl J Med 2013;369:1327-1335.
35. Green JB, Bethel MA, Armstrong PW, et al. Effect of sitagliptin on cardiovascular outcomes in type 2 diabetes. N Engl J Med 2015;373:232-242.
36. Abbas AS, Dehbi HM, Ray KK. Cardiovascular and non-cardiovascular safety of dipeptidyl peptidase-4 inhibition: a meta-analysis of randomized controlled cardiovascular outcome trials. Diabetes Obes Metab 2016;18:295-299.
37. Kongwatcharapong J, Dilokthornsakul P, Nathisuwan S, Phrommintikul A, Chaiyakunapruk N. Effect of dipeptidyl peptidase-4 inhibitors on heart failure: a meta-analysis of randomized clinical trials. Int J Cardiol 2016;211:88-95.
38. Zinman B, Wanner C, Lachin JM, et al. Empagliflozin, cardiovascular outcomes, and mortality in type 2 diabetes. N Engl J Med 2015;373:232-242.
39. Monami M, Dicembrini I, Mannucci E. Effects of SGLT-2 inhibitors on mortality and cardiovascular events: a comprehensive meta-analysis of randomized controlled trials. Acta Diabetol 2017;54:1-36.
40. Kaku K, Lee J, Mattheus M, et al. Empagliflozin and cardiovascular outcomes in Asian patients with type 2 diabetes and established cardiovascular disease: results from EMPA-REG OUTCOME(R). Circ J 2017;81:227-234.
41. Neal B, Perkovic V, Mahaffey KW, et al. Canagliflozin and cardiovascular and renal events in type 2 diabetes. N Engl J Med 2017;377:644-657.
42. Varvaki Rados D, Catani Pinto L, Reck Remonti L, Bauermann Leitao C, Gross JL. The association between sulfonylurea use and all-cause and cardiovascular mortality: a meta-analysis with trial sequential analysis of randomized clinical trials. PLoS Med 2016;13:e1001992.
43. Kim SY, Kim HJ, Han KA, et al. Efficacy and safety of mitiglinide in Korean type 2 diabetic patients: prospective randomised multicenter comparative phase III study. J Korean Diabetes Assoc 2007;31:163-174.
44. Joshi SR, Standl E, Tong N, Shah P, Kalra S, Rathod R. Therapeutic potential of α-glucosidase inhibitors in type 2 diabetes mellitus: an evidence-based review. Expert Opin Pharmacother 2015;16:1959-1981.
45. Dormandy JA, Charbonnel B, Eckland DJ, et al. Secondary prevention of macrovascular events in patients with type 2 diabetes in the PROActive study (PROspective pioglitA-zone Clinical Trial In macroVascular Events): a randomized controlled trial. Lancet 2005;366:1279-1289.
46. Lincoff AM, Wolski K, Nicholls SJ, Nissen SE. Pioglitazone and risk of cardiovascular events in patients with type 2 diabetes mellitus: a meta-analysis of randomized trials. JAMA 2007;298:1180-1188.
47. Chiasson JL, Josse RG, Hunt JA, et al. The efficacy of acarbose in the treatment of patients with non-insulin-dependent diabetes mellitus: a multicenter controlled clinical trial. Ann Intern Med 1994;121:928-933.
48. Hoffmann J, Spengler M. Efficacy of 24-week monotherapy with acarbose, glibenclamide, or placebo in NIDDM patients. The Essen Study. Diabetes Care 1994;17:561-566.
49. Holman RR, Cull CA, Turner RC. A randomized double-blind trial of acarbose in type 2 diabetes shows improved glycemic control over 3 years (U.K. Prospective Diabetes Study 44). Diabetes Care 1999;22:946-964.
50. Black C, Donnelly P, McIntyre L, Royle PL, Shepherd JP, Thomas S. Meglitinide analogues for type 2 diabetes mellitus. Cochrane Database Syst Rev 2007;(2):CD004654.
51. Chin SO, Rhee SY, Chon S, et al. Hypoglycemia is associated with dementia in elderly patients with type 2 diabetes mellitus. Diabetes Metab J 2016;40:202-210.
52. Rhee SY, Hong SM, Chon S, et al. Hypoglycemia and medical expenses in patients with type 2 diabetes mellitus: an analysis based on the Korea National Diabetes Program Cohort. Diabetes Res Clin Pract 2016;122:54-61.
53. Cha SA, Yun JS, Lim TS, et al. Severe hypoglycemia and cardiovascular or all-cause mortality in patients with type 2 diabetes. Diabetes Metab J 2016;40:262-270.
54. Yun JS, Ko SH. Risk factors and adverse outcomes of severe hypoglycemia in type 2 diabetes mellitus. Diabetes Metab J 2016;40:423-432.