



Physical Activity/Exercise and Diabetes: A Position Statement of the American Diabetes Association

Diabetes Care 2016;39:2065–2079 | DOI: 10.2337/dc16-1728

Sheri R. Colberg,¹ Ronald J. Sigal,²
Jane E. Yardley,³ Michael C. Riddell,⁴
David W. Dunstan,⁵ Paddy C. Dempsey,⁵
Edward S. Horton,⁶ Kristin Castorino,⁷ and
Deborah F. Tate⁸

The adoption and maintenance of physical activity are critical foci for blood glucose management and overall health in individuals with diabetes and prediabetes. Recommendations and precautions vary depending on individual characteristics and health status. In this Position Statement, we provide a clinically oriented review and evidence-based recommendations regarding physical activity and exercise in people with type 1 diabetes, type 2 diabetes, gestational diabetes mellitus, and prediabetes.

Physical activity includes all movement that increases energy use, whereas exercise is planned, structured physical activity. Exercise improves blood glucose control in type 2 diabetes, reduces cardiovascular risk factors, contributes to weight loss, and improves well-being (1,2). Regular exercise may prevent or delay type 2 diabetes development (3). Regular exercise also has considerable health benefits for people with type 1 diabetes (e.g., improved cardiovascular fitness, muscle strength, insulin sensitivity, etc.) (4). The challenges related to blood glucose management vary with diabetes type, activity type, and presence of diabetes-related complications (5,6). Physical activity and exercise recommendations, therefore, should be tailored to meet the specific needs of each individual.

TYPES AND CLASSIFICATIONS OF DIABETES AND PREDIABETES

Physical activity recommendations and precautions may vary by diabetes type. The primary types of diabetes are type 1 and type 2. Type 1 diabetes (5%–10% of cases) results from cellular-mediated autoimmune destruction of the pancreatic β -cells, producing insulin deficiency (7). Although it can occur at any age, β -cell destruction rates vary, typically occurring more rapidly in youth than in adults. Type 2 diabetes (90%–95% of cases) results from a progressive loss of insulin secretion, usually also with insulin resistance. Gestational diabetes mellitus occurs during pregnancy, with screening typically occurring at 24–28 weeks of gestation in pregnant women not previously known to have diabetes. Prediabetes is diagnosed when blood glucose levels are above the normal range but not high enough to be classified as diabetes; affected individuals have a heightened risk of developing type 2 diabetes (7) but may prevent/delay its onset with physical activity and other lifestyle changes (8).

TYPES OF EXERCISE AND PHYSICAL ACTIVITY

Aerobic exercise involves repeated and continuous movement of large muscle groups (9). Activities such as walking, cycling, jogging, and swimming rely primarily on aerobic energy-producing systems. Resistance (strength) training includes exercises with free weights, weight machines, body weight, or elastic resistance bands. Flexibility exercises improve range of motion around joints (10). Balance exercises benefit gait and prevent falls (11). Activities like tai chi and yoga combine flexibility, balance, and resistance activities.

¹Department of Human Movement Sciences, Old Dominion University, Norfolk, VA

²Departments of Medicine, Cardiac Sciences, and Community Health Sciences, Faculties of Medicine and Kinesiology, University of Calgary, Calgary, Alberta, Canada

³Department of Social Sciences, Augustana Campus, University of Alberta, Camrose, Alberta, Canada

⁴School of Kinesiology and Health Science, York University, Toronto, Ontario, Canada

⁵Baker IDI Heart & Diabetes Institute, Melbourne, Victoria, Australia

⁶Harvard Medical School and Joslin Diabetes Center, Boston, MA

⁷William Sansum Diabetes Center, Santa Barbara, CA

⁸Department of Health Behavior, Gillings School of Global Public Health, University of North Carolina, Chapel Hill, NC

Corresponding author: Sheri R. Colberg, scolberg@odu.edu.

This position statement was reviewed and approved by the American Diabetes Association Professional Practice Committee in June 2016 and ratified by the American Diabetes Association Board of Directors in September 2016.

© 2016 by the American Diabetes Association. Readers may use this article as long as the work is properly cited, the use is educational and not for profit, and the work is not altered. More information is available at <http://www.diabetesjournals.org/content/license>.

BENEFITS OF EXERCISE AND PHYSICAL ACTIVITY

Aerobic Exercise Benefits

Aerobic training increases mitochondrial density, insulin sensitivity, oxidative enzymes, compliance and reactivity of blood vessels, lung function, immune function, and cardiac output (12). Moderate to high volumes of aerobic activity are associated with substantially lower cardiovascular and overall mortality risks in both type 1 and type 2 diabetes (13). In type 1 diabetes, aerobic training increases cardiorespiratory fitness, decreases insulin resistance, and improves lipid levels and endothelial function (14). In individuals with type 2 diabetes, regular training reduces A1C, triglycerides, blood pressure, and insulin resistance (15). Alternatively, high-intensity interval training (HIIT) promotes rapid enhancement of skeletal muscle oxidative capacity, insulin sensitivity, and glycemic control in adults with type 2 diabetes (16,17) and can be performed without deterioration in glycemic control in type 1 diabetes (18,19).

Resistance Exercise Benefits

Diabetes is an independent risk factor for low muscular strength (20) and accelerated decline in muscle strength and functional status (21). The health benefits of resistance training for all adults include improvements in muscle mass, body composition, strength, physical function, mental health, bone mineral density, insulin sensitivity, blood pressure, lipid profiles, and cardiovascular health (12). The effect of resistance exercise on glycemic control in type 1 diabetes is unclear (19). However, resistance exercise can assist in minimizing risk of exercise-induced hypoglycemia in type 1 diabetes (22). When resistance and aerobic exercise are undertaken in one exercise session, performing resistance exercise first results in less hypoglycemia than when aerobic exercise is performed first (23). Resistance training benefits for individuals with type 2 diabetes include improvements in glycemic control, insulin resistance, fat mass, blood pressure, strength, and lean body mass (24).

Benefits of Other Types of Physical Activity

Flexibility and balance exercises are likely important for older adults with diabetes. Limited joint mobility is frequently

present, resulting in part from the formation of advanced glycation end products, which accumulate during normal aging and are accelerated by hyperglycemia (25). Stretching increases range of motion around joints and flexibility (10) but does not affect glycemic control. Balance training can reduce falls risk by improving balance and gait, even when peripheral neuropathy is present (11). Group exercise interventions (resistance and balance training, tai chi classes) may reduce falls by 28%–29% (26). The benefits of alternative training like yoga and tai chi are less established, although yoga may promote improvement in glycemic control, lipid levels, and body composition in adults with type 2 diabetes (27). Tai chi training may improve glycemic control, balance, neuropathic symptoms, and some dimensions of quality of life in adults with diabetes and neuropathy, although high-quality studies on this training are lacking (28).

BENEFITS OF AND RECOMMENDATIONS FOR REDUCED SEDENTARY TIME

Recommendations

- All adults, and particularly those with type 2 diabetes, should decrease the amount of time spent in daily sedentary behavior. **B**
- Prolonged sitting should be interrupted with bouts of light activity every 30 min for blood glucose benefits, at least in adults with type 2 diabetes. **C**
- The above two recommendations are additional to, and not a replacement for, increased structured exercise and incidental movement. **C**

Sedentary behavior—waking behaviors with low energy expenditure (TV viewing, desk work, etc.)—is a ubiquitous and significant population-wide influence on cardiometabolic health (29,30). Higher amounts of sedentary time are associated with increased mortality and morbidity, mostly independent of moderate-to-vigorous physical activity participation (31–35). In people with or at risk for developing type 2 diabetes, extended sedentary time is also associated with poorer glycemic control and clustered metabolic risk (36–39). Prolonged sitting

interrupted by brief (≤ 5 min) bouts of standing (40–42) or light-intensity ambulation (41,43,44) every 20–30 min improves glycemic control in sedentary overweight/obese populations and in women with impaired glucose regulation. In adults with type 2 diabetes, interrupting prolonged sitting with 15 min of postmeal walking (45) and with 3 min of light walking and simple body-weight resistance activities every 30 min (46) improves glycemic control. The longer-term health efficacy and durability of reducing and interrupting sitting time remain to be determined for individuals with and without diabetes.

PHYSICAL ACTIVITY AND TYPE 2 DIABETES

Recommendations

- Daily exercise, or at least not allowing more than 2 days to elapse between exercise sessions, is recommended to enhance insulin action. **B**
- Adults with type 2 diabetes should ideally perform both aerobic and resistance exercise training for optimal glycemic and health outcomes. **C**
- Children and adolescents with type 2 diabetes should be encouraged to meet the same physical activity goals set for youth in general. **C**
- Structured lifestyle interventions that include at least 150 min/week of physical activity and dietary changes resulting in weight loss of 5%–7% are recommended to prevent or delay the onset of type 2 diabetes in populations at high risk and with prediabetes. **A**

Insulin Action and Physical Activity

Insulin action in muscle and liver can be modified by acute bouts of exercise and by regular physical activity (47). Acutely, aerobic exercise increases muscle glucose uptake up to fivefold through insulin-independent mechanisms. After exercise, glucose uptake remains elevated by insulin-independent (~ 2 h) and insulin-dependent (up to 48 h) mechanisms if exercise is prolonged (48), which is linked with muscle glycogen repletion (49,50). Improvements in insulin action may last for 24 h following shorter duration activities (~ 20 min) if the intensity is elevated to near-maximal effort

intermittently (51,52). Even low-intensity aerobic exercise lasting ≥ 60 min enhances insulin action in obese, insulin-resistant adults for at least 24 h (53). If enhanced insulin action is a primary goal, then daily moderate- or high-intensity exercise is likely optimal (54).

Regular training increases muscle capillary density, oxidative capacity, lipid metabolism, and insulin signaling proteins (47), which are all reversible with detraining (55). Both aerobic and resistance training promote adaptations in skeletal muscle, adipose tissue, and liver associated with enhanced insulin action, even without weight loss (56,57). Regular aerobic training increases muscle insulin sensitivity in individuals with prediabetes (58) and type 2 diabetes (59) in proportion to exercise volume (60). Even low-volume training (expending just 400 kcal/week) improves insulin action in previously sedentary adults (60). Those with higher baseline insulin resistance have the largest improvements, and a dose response is observed up to about 2,500 kcal/week (60). Resistance training enhances insulin action similarly (56), as do HIIT and other modes (2,15–17). Combining endurance exercise with resistance exercise may provide greater improvements (61), and HIIT may be superior to continuous aerobic training in adults with diabetes (16).

Physical Activity in Adults With Type 2 Diabetes

The Look AHEAD (Action for Health in Diabetes) trial (62) was the largest randomized trial evaluating a lifestyle intervention in older adults with type 2 diabetes compared with a diabetes support and education control group. The intensive lifestyle intervention group targeted weight loss of at least 7% through a modest dietary energy deficit and at least 175 min/week of unsupervised exercise. Major cardiovascular events were the same in both groups, possibly in part due to greater use of cardioprotective medications in the diabetes support and education group (62). However, as reviewed by Pi-Sunyer (63), the intensive lifestyle intervention group achieved significantly greater sustained improvements in weight loss, cardiorespiratory fitness, blood glucose control, blood pressure, and lipids with fewer medications; less sleep apnea, severe

diabetic kidney disease and retinopathy, depression, sexual dysfunction, urinary incontinence, and knee pain; and better physical mobility maintenance and quality of life, with lower overall health care costs. This trial provided very strong evidence of profound health benefits from intensive lifestyle intervention. Moreover, aerobic exercise clearly improves glycemic control in type 2 diabetes, particularly when at least 150 min/week are undertaken (64). Resistance exercise (free weights or weight machines) increases strength in adults with type 2 diabetes by about 50% (24) and improves A1C by 0.57% (64). A meta-analysis of 12 trials in adults with type 2 diabetes reported a greater reduction (difference of -0.18%) in A1C following aerobic compared with resistance training but no difference in cardiovascular risk marker reduction (65). For glycemic control, combined training is superior to either type of training undertaken alone (61,66). Therefore, adults with type 2 diabetes should ideally perform both aerobic and resistance exercise training for optimal glycemic and health outcomes.

Physical Activity in Youth With Type 2 Diabetes

Randomized trials evaluating exercise interventions in youth with type 2 diabetes are limited and inconclusive, although benefits are likely similar to those in adults. In the Treatment Options for Type 2 Diabetes in Adolescents and Youth (TODAY) study (67), youth aged 10–17 years with type 2 diabetes were stabilized on metformin and then randomized to metformin plus placebo, metformin plus rosiglitazone, or metformin plus lifestyle intervention and followed for a mean of 3.86 years. The lifestyle intervention included modest weight loss achieved through dietary energy restriction and increased physical activity (minimum 200 min/week of moderate to vigorous activity for most; >300 min/week for already active youth), along with metformin use. The rate of glycemic failure (A1C $>8.0\%$ or need to initiate insulin) was not significantly reduced in the lifestyle plus metformin group compared with metformin only or metformin plus rosiglitazone. Given the limited data in youth with type 2 diabetes, it is recommended that children and adolescents with type 2 diabetes meet the same

physical activity goals set for youth in general (<http://www.cdc.gov/physicalactivity/basics/children>): a minimum 60 min/day of moderate-to-vigorous physical activity, including strength-related exercise at least 3 days/week.

Prevention and Treatment of Type 2 Diabetes With Lifestyle Intervention

Structured lifestyle intervention trials that include physical activity at least 150–175 min/week and dietary energy restriction targeting weight loss of 5%–7% have demonstrated reductions of 40%–70% in the risk of developing type 2 diabetes in people with impaired glucose tolerance (66). A recent systematic review of 53 studies (30 of diet and physical activity promotion programs vs. usual care, 13 of more intensive vs. less intensive programs, and 13 of single programs) that evaluated 66 lifestyle intervention programs reported that, compared with usual care, diet and physical activity promotion programs reduced type 2 diabetes incidence, body weight, and fasting blood glucose while improving other cardiometabolic risk factors (68). Trials evaluating less resource-intensive lifestyle interventions have also shown effectiveness (3), and adherence to guidelines is associated with a greater weight loss (69).

PHYSICAL ACTIVITY AND TYPE 1 DIABETES

Recommendations

- Youth and adults with type 1 diabetes can benefit from being physically active, and activity should be recommended to all. **B**
- Blood glucose responses to physical activity in all people with type 1 diabetes are highly variable based on activity type/timing and require different adjustments. **B**
- Additional carbohydrate intake and/or insulin reductions are typically required to maintain glycemic balance during and after physical activity. Frequent blood glucose checks are required to implement carbohydrate intake and insulin dose adjustment strategies. **B**
- Insulin users can exercise using either basal-bolus injection regimens or insulin pumps, but there

are advantages and disadvantages to both insulin delivery methods. **C**

- Continuous glucose monitoring during physical activity can be used to detect hypoglycemia when used as an adjunct rather than in place of capillary glucose tests. **C**

Physical Activity and Sports in Youth and Adults With Type 1 Diabetes

Youth experience many health benefits from physical activity participation (9). A meta-analysis of 10 trials in youth <18 years of age with type 1 diabetes found significant improvements in A1C in exercisers (70), and exercising more than three sessions/week for longer (>1 h/session) and doing both aerobic and resistance exercise may be beneficial (70). In adults, regular physical activity has been associated with decreased mortality (71). There is insufficient evidence on the ideal type, timing, intensity, and duration of exercise for optimal glycemic control.

Effects of Activity Type and Timing on Glycemic Balance

Blood glucose responses to physical activity in type 1 diabetes are highly variable (72). In general, aerobic exercise decreases blood glucose levels if performed during postprandial periods with the usual insulin dose administered at the meal before exercise (73), and prolonged activity done then may cause exaggerated decreases (74–76). Exercise while fasting may produce a

lesser decrease or a small increase in blood glucose (77). Very intense activities may provide better glucose stability (22) or a rise in blood glucose if the relative intensity is high and done for a brief duration (≤ 10 min) (78). Mixed activities, such as interval training or team/individual field sports, are associated with better glucose stability than those that are predominantly aerobic (18,79–82), although variable results have been reported for intermittent, high-intensity exercise (80).

Management of Food and Insulin With Physical Activity

Variable glycemic responses to physical activity (72) make uniform recommendations for management of food intake and insulin dosing difficult. To prevent hypoglycemia during prolonged (≥ 30 min), predominantly aerobic exercise, additional carbohydrate intake and/or reductions in insulin are typically required. For low- to moderate-intensity aerobic activities lasting 30–60 min undertaken when circulating insulin levels are low (i.e., fasting or basal conditions), ~ 10 –15 g of carbohydrate may prevent hypoglycemia (83). For activities performed with relative hyperinsulinemia (after bolus insulin), 30–60 g of carbohydrate per hour of exercise may be needed (84), which is similar to carbohydrate requirements to optimize performance in athletes with (85) or without (86) type 1 diabetes.

As recommended in Table 1, blood glucose concentrations should always be checked prior to exercise undertaken

by individuals with type 1 diabetes. The target range for blood glucose prior to exercise should ideally be between 90 and 250 mg/dL (5.0 and 13.9 mmol/L). Carbohydrate intake required will vary with insulin regimens, timing of exercise, type of activity, and more (87), but it will also depend on starting blood glucose levels. As an alternative or a complement to carbohydrate intake, reductions in basal and/or bolus insulin dose should be considered for exercise-induced hypoglycemia prevention; lowering insulin levels adequately during activity may reduce or eliminate the need for carbohydrate intake. For example, a 20% reduction in basal insulin for individuals on multiple daily injections (MDI) can be made for doses both before and after exercise, but this strategy may not fully attenuate the decline in glucose during the activity (89). Continuous subcutaneous insulin infusion (CSII) users can reduce (90) or suspend (91) insulin delivery at the start of exercise, but this strategy does not always prevent hypoglycemia (91,92). Performing basal rate reductions 30–60 min before exercise may reduce hypoglycemia due to pharmacokinetics of rapid-acting insulin analogs used in CSII (93). For exercise performed within 2–3 h after bolus insulin via CSII or MDI, 25%–75% reductions in insulin may limit hypoglycemia (Table 2). Frequent blood glucose checks are required when implementing insulin and carbohydrate adjustments.

Table 1—Suggested carbohydrate intake or other actions based on blood glucose levels at the start of exercise

Pre-exercise blood glucose	Carbohydrate intake or other action
<90 mg/dL (<5.0 mmol/L)	<ul style="list-style-type: none"> • Ingest 15–30 g of fast-acting carbohydrate prior to the start of exercise, depending on the size of the individual and intended activity; some activities that are brief in duration (<30 min) or at a very high intensity (weight training, interval training, etc.) may not require any additional carbohydrate intake. • For prolonged activities at a moderate intensity, consume additional carbohydrate, as needed (0.5–1.0 g/kg body mass per h of exercise), based on blood glucose testing results.
90–150 mg/dL (5.0–8.3 mmol/L)	<ul style="list-style-type: none"> • Start consuming carbohydrate at the onset of most exercise (~ 0.5–1.0 g/kg body mass per h of exercise), depending on the type of exercise and the amount of active insulin.
150–250 mg/dL (8.3–13.9 mmol/L)	<ul style="list-style-type: none"> • Initiate exercise and delay consumption of carbohydrate until blood glucose levels are <150 mg/dL (<8.3 mmol/L).
250–350 mg/dL (13.9–19.4 mmol/L)	<ul style="list-style-type: none"> • Test for ketones. Do not perform any exercise if moderate-to-large amounts of ketones are present. • Initiate mild-to-moderate intensity exercise. Intense exercise should be delayed until glucose levels are <250 mg/dL because intense exercise may exaggerate the hyperglycemia.
≥ 350 mg/dL (≥ 19.4 mmol/L)	<ul style="list-style-type: none"> • Test for ketones. Do not perform any exercise if moderate-to-large amounts of ketones are present. • If ketones are negative (or trace), consider conservative insulin correction (e.g., 50% correction) before exercise, depending on active insulin status. • Initiate mild-to-moderate exercise and avoid intense exercise until glucose levels decrease.

Adapted from Zaharieva and Riddell (88).

Table 2—Suggested initial pre-exercise meal insulin bolus reduction for activity started within 90 min after insulin administration

Exercise intensity	Exercise duration	
	30 min	60 min
Mild aerobic (~25% VO_{2max})	–25%*	–50%
Moderate aerobic (~50% VO_{2max})	–50%	–75%
Heavy aerobic (70%–75% VO_{2max})	–75%	N-A
Intense aerobic/anaerobic (>80% VO_{2max})	No reduction recommended	N-A

Recommendations compiled based on four studies (94–97). N-A, not assessed as exercise intensity is too high to sustain for 60 min. *Estimated from study (95).

Use of CSII and MDI for Activity

Individuals using CSII or MDI as a basal-bolus regimen can exercise with few restrictions. CSII offers some advantages over MDI due to greater flexibility in basal rate adjustments and limiting postexercise hyperglycemia (98), with some limitations. For example, aerobic exercise may accelerate basal insulin absorption from the subcutaneous depot (74), whereas basal insulin glargine absorption is largely unaffected (99). Skin irritation, pump tubing, and wearing a pump that is visible to others can be concerns (100). In certain sports, such as basketball or contact sports, wearing pumps and other devices may be prohibited during competition. Frustration with CSII devices and exercise may lead to discontinuation of pump therapy (100).

Use of Continuous Glucose Monitoring With Activity

Continuous glucose monitoring (CGM) may decrease the fear of exercise-induced hypoglycemia in type 1 diabetes by providing blood glucose trends that allow users to prevent and treat hypoglycemia sooner (83). Although a few studies have found acceptable CGM accuracy during exercise (101–104), others have reported inadequate accuracy (105) and other problems, such as sensor filament breakage (103,104), inability to calibrate (102), and time lags between the change in blood glucose and its detection by CGM (106). Differences in sensor performance have also been noted (107–109). Although it is a potentially useful tool during and after exercise (110), CGM values have traditionally required confirmation by finger-stick glucose testing prior to making regimen changes, but approval of non-adjunctive use is likely forthcoming in the near future.

RECOMMENDED PHYSICAL ACTIVITY PARTICIPATION FOR PEOPLE WITH DIABETES

Recommendations

- Pre-exercise medical clearance is generally unnecessary for asymptomatic individuals prior to beginning low- or moderate-intensity physical activity not exceeding the demands of brisk walking or everyday living. **B**
- Most adults with diabetes should engage in 150 min or more of moderate-to-vigorous intensity activity weekly, spread over at least 3 days/week, with no more than 2 consecutive days without activity. Shorter durations (minimum 75 min/week) of vigorous-intensity or interval training may be sufficient for younger and more physically fit individuals. **B** for type 2 diabetes, **C** for type 1 diabetes
- Children and adolescents with type 1 or type 2 diabetes should engage in 60 min/day or more of moderate or vigorous intensity aerobic activity, with vigorous, muscle-strengthening, and bone-strengthening activities included at least 3 days/week. **C**
- Adults with diabetes should engage in 2–3 sessions/week of resistance exercise on nonconsecutive days. **B** for type 2 diabetes, **C** for type 1 diabetes
- Flexibility training and balance training are recommended 2–3 times/week for older adults with diabetes. Yoga and tai chi may be included based on individual preferences to increase flexibility, muscular strength, and balance. **C**
- Individuals with diabetes or prediabetes are encouraged to increase

their total daily incidental (non-exercise) physical activity to gain additional health benefits. **C**

- To gain more health benefits from physical activity programs, participation in supervised training is recommended over nonsupervised programs. **B**

Pre-exercise Health Screening and Evaluation

The American College of Sports Medicine (ACSM) recently proposed a new model for exercise preparticipation health screening on the basis of 1) the individual's current physical activity levels; 2) the presence of signs or symptoms and/or known cardiovascular, metabolic, or renal disease; and 3) the desired exercise intensity, all of which are risk modulators of exercise-related cardiovascular events (111). The ACSM no longer includes risk factor assessment in the exercise preparticipation health screening process. However, their recommendation is that anyone with diabetes who is currently sedentary and desires to begin physical activity at any intensity (even low intensity) should obtain prior medical clearance from a health care professional (111). We believe this recommendation is excessively conservative.

Physical activity does carry some potential health risks for people with diabetes, including acute complications like cardiac events, hypoglycemia, and hyperglycemia. In low- and moderate-intensity activity undertaken by adults with type 2 diabetes, the risk of exercise-induced adverse events is low. In individuals with type 1 diabetes (any age) the only common exercise-induced adverse event is hypoglycemia. No current evidence suggests that any screening protocol beyond usual diabetes care reduces risk of exercise-induced adverse events in asymptomatic individuals with diabetes (112,113). Thus, pre-exercise medical clearance is not necessary for asymptomatic individuals receiving diabetes care consistent with guidelines who wish to begin low- or moderate-intensity physical activity not exceeding the demands of brisk walking or everyday living.

However, some individuals who plan to increase their exercise intensity or who meet certain higher-risk criteria

may benefit from referral to a health care provider for a checkup and possible exercise stress test before starting such activities (6). In addition, most adults with diabetes may also benefit from working with a diabetes-knowledgeable exercise physiologist or certified fitness professional to assist them in formulating a safe and effective exercise prescription. A combination of careful consideration of multiple factors and sound clinical judgment based on the individual's medical history and physical examination will determine their degree of risk of acute complications and identify the most appropriate physical activities to avoid or limit.

Aerobic Exercise Training

People with diabetes should perform aerobic exercise regularly. Aerobic activity bouts should ideally last at least 10 min, with the goal of ~30 min/day or more, most days of the week for adults with type 2 diabetes. Daily

exercise, or at least not allowing more than 2 days to elapse between exercise sessions, is recommended to decrease insulin resistance, regardless of diabetes type (16,19). Over time, activities should progress in intensity, frequency, and/or duration to at least 150 min/week of moderate-intensity exercise. Adults able to run at 6 miles/h (9.7 km/h) for at least 25 min can benefit sufficiently from shorter-duration vigorous-intensity activity (75 min/week). Many adults, including most with type 2 diabetes, would be unable or unwilling to participate in such intense exercise and should engage in moderate exercise for the recommended duration (Table 3).

Youth with type 1 or type 2 diabetes should follow general recommendations for children and adolescents. These include 60 min/day or more of moderate- or vigorous-intensity aerobic activity, with vigorous, muscle-strengthening, and bone-strengthening activities at least 3 days/week (9).

Low-volume HIIT, which involves short bursts of very intense activity interspersed with longer periods of recovery at low to moderate intensity, is an alternative approach to continuous aerobic activity (16,19). However, its safety and efficacy remain unclear for some adults with diabetes (114,115). Those who wish to perform HIIT should be clinically stable, have been participating at least in regular moderate-intensity exercise, and likely be supervised at least initially (116). The risks with advanced disease are unclear (116), and continuous, moderate-intensity exercise may be safer (117). The optimal HIIT training protocol has yet to be determined.

Resistance Exercise Training

Adults with diabetes should engage in 2–3 sessions/week of resistance exercise on nonconsecutive days (Table 3) (9). Although heavier resistance training with free weights and weight

Table 3—Exercise training recommendations: types of exercise, intensity, duration, frequency, and progression

	Aerobic	Resistance	Flexibility and Balance
Type of exercise	<ul style="list-style-type: none"> • Prolonged, rhythmic activities using large muscle groups (e.g., walking, cycling, and swimming) • May be done continuously or as HIIT 	<ul style="list-style-type: none"> • Resistance machines, free weights, resistance bands, and/or body weight as resistance exercises 	<ul style="list-style-type: none"> • Stretching: static, dynamic, and other stretching; yoga • Balance (for older adults): practice standing on one leg, exercises using balance equipment, lower-body and core resistance exercises, tai chi
Intensity	<ul style="list-style-type: none"> • Moderate to vigorous (subjectively experienced as “moderate” to “very hard”) 	<ul style="list-style-type: none"> • Moderate (e.g., 15 repetitions of an exercise that can be repeated no more than 15 times) to vigorous (e.g., 6–8 repetitions of an exercise that can be repeated no more than 6–8 times) 	<ul style="list-style-type: none"> • Stretch to the point of tightness or slight discomfort • Balance exercises of light to moderate intensity
Duration	<ul style="list-style-type: none"> • At least 150 min/week at moderate to vigorous intensity for most adults with diabetes • For adults able to run steadily at 6 miles per h (9.7 km/h) for 25 min, 75 min/week of vigorous activity may provide similar cardioprotective and metabolic benefits 	<ul style="list-style-type: none"> • At least 8–10 exercises with completion of 1–3 sets of 10–15 repetitions to near fatigue per set on every exercise early in training 	<ul style="list-style-type: none"> • Hold static or do dynamic stretch for 10–30 s; 2–4 repetitions of each exercise • Balance training can be any duration
Frequency	<ul style="list-style-type: none"> • 3–7 days/week, with no more than 2 consecutive days without exercise 	<ul style="list-style-type: none"> • A minimum of 2 nonconsecutive days/week, but preferably 3 	<ul style="list-style-type: none"> • Flexibility: ≥ 2–3 days/week • Balance: ≥ 2–3 days/week
Progression	<ul style="list-style-type: none"> • A greater emphasis should be placed on vigorous intensity aerobic exercise if fitness is a primary goal of exercise and not contraindicated by complications • Both HIIT and continuous exercise training are appropriate activities for most individuals with diabetes 	<ul style="list-style-type: none"> • Beginning training intensity should be moderate, involving 10–15 repetitions per set, with increases in weight or resistance undertaken with a lower number of repetitions (8–10) only after the target number of repetitions per set can consistently be exceeded • Increase in resistance can be followed by a greater number of sets and finally by increased training frequency 	<ul style="list-style-type: none"> • Continue to work on flexibility and balance training, increasing duration and/or frequency to progress over time

machines may improve glycemic control and strength more (118), doing resistance training of any intensity is recommended to improve strength, balance, and ability to engage in activities of daily living throughout the life span.

Flexibility, Balance, and Other Training

Completing flexibility exercises for each of the major muscle-tendon groups on 2 or more days/week maintains joint range of movement (Table 3) (12). Although flexibility training may be desirable for individuals with all types of diabetes, it should not substitute for other recommended activities (i.e., aerobic and resistance training), as flexibility training does not affect glucose control, body composition, or insulin action (6). Adults with diabetes (ages 50 years and older) should do exercises that maintain/improve balance 2–3 times/week (Table 3) (11,12), particularly if they have peripheral neuropathy (11). Many lower-body and core-strengthening exercises concomitantly improve balance and may be included. Yoga and tai chi can be included based on individual preferences to increase flexibility, strength, and balance.

Daily Movement

Increasing unstructured physical activity (e.g., errands, household tasks, dog walking, or gardening) increases daily energy expenditure and assists with weight management (119–121). Unstructured activity also reduces total daily sitting time. Increasing nonexercise activity, even in brief (3–15 min) bouts, is effective in acutely reducing postprandial hyperglycemia and improving glycemic control in those with prediabetes and type 1 and type 2 diabetes, most prominently after meals (41,43–46,75,122–124). Increasing unstructured physical activity should be encouraged as part of a whole-day approach, or at least initially as a stepping stone for individuals who are sedentary and unable/reluctant to participate in more structured exercise.

Supervised Versus Nonsupervised Training

Supervised aerobic or resistance training reduces A1C in adults with type 2 diabetes whether or not they include dietary cointervention, but

unsupervised exercise only reduces A1C with a concomitant dietary intervention (64). Similarly, individuals undertaking supervised aerobic and resistance exercise achieve greater improvements in A1C, BMI, waist circumference, blood pressure, fitness, muscular strength, and HDL cholesterol (125). Thus, supervised training is recommended when feasible, at least for adults with type 2 diabetes.

PHYSICAL ACTIVITY AND PREGNANCY WITH DIABETES

Recommendations

- Women with preexisting diabetes of any type should be advised to engage in regular physical activity prior to and during pregnancy. **C**
- Pregnant women with or at risk for gestational diabetes mellitus should be advised to engage in 20–30 min of moderate-intensity exercise on most or all days of the week. **B**

Physical activity and exercise during pregnancy have been shown to benefit most women by improving cardiovascular health and general fitness while reducing the risk of complications like preeclampsia and cesarean delivery (126). Regular physical activity during pregnancy also lowers the risk of developing gestational diabetes mellitus (127,128). Exercise programs including at least 20–30 min of moderate-intensity exercise on most or all days of the week are recommended (126). Once gestational diabetes mellitus is diagnosed, either aerobic or resistance training can improve insulin action and glycemic control (129). In women with gestational diabetes mellitus, particularly those who are overweight and obese, vigorous-intensity exercise during pregnancy may reduce the odds of excess gestational weight gain (130). Ideally, the best time to start physical activity is prior to pregnancy to reduce gestational diabetes mellitus risk (131), but it is safe to initiate during pregnancy with very few contraindications (126). Any pregnant women using insulin should be aware of the insulin-sensitizing effects of exercise and increased risk of hypoglycemia, particularly during the first trimester (129).

MINIMIZING EXERCISE-RELATED ADVERSE EVENTS IN PEOPLE WITH DIABETES

Recommendations

- Insulin regimen and carbohydrate intake changes should be used to prevent exercise-related hypoglycemia. Other strategies involve including short sprints, performing resistance exercise before aerobic exercise in the same session, and activity timing. **B**
- Risk of nocturnal hypoglycemia following physical activity may be mitigated with reductions in basal insulin doses, inclusion of bedtime snacks, and/or use of continuous glucose monitoring. **C**
- Exercise-induced hyperglycemia is more common in type 1 diabetes but may be modulated with insulin administration or a lower-intensity aerobic cooldown. Exercising with hyperglycemia and elevated blood ketones is not recommended. **C**
- Some medications besides insulin may increase the risks of exercise-related hypoglycemia and doses may need to be adjusted based on exercise training. **C**
- Older adults with diabetes or anyone with autonomic neuropathy, cardiovascular complications, or pulmonary disease should avoid exercising outdoors on very hot and/or humid days to prevent heat-related illnesses. **C**
- Exercise training should progress appropriately to minimize risk of injury. **C**

Hypoglycemia

Exercise-induced hypoglycemia is common in people with type 1 diabetes and, to a lesser extent, people with type 2 diabetes using insulin or insulin secretagogues. In addition to insulin regimen and carbohydrate intake changes, a brief (10 s) maximal intensity sprint performed before (132) or after (133) a moderate-intensity exercise session may protect against hypoglycemia (134). Performing high-intensity bouts intermittently during moderate aerobic exercise also slows blood glucose declines (81,135,136), as can resistance exercise done immediately prior to aerobic (23).

Exercise-induced nocturnal hypoglycemia is a major concern (137). Hypoglycemic events occur typically within 6–15 h postexercise (138), although risk can extend out to 48 h (139). The risk of nocturnal hypoglycemia may be minimized through ~20% reductions of daily basal insulin dose with reduced prandial bolus insulin and low glycemic index carbohydrate feeding following evening exercise for those on MDI (89). For CSII users, basal rate reductions of 20% at bedtime for 6 h after afternoon exercise may limit nocturnal hypoglycemia (140). Inclusion of a bedtime snack, glucose checks overnight, and/or use of CGM with alarms and automatic pump suspension may also be warranted (141,142).

Hyperglycemia

Exercise-induced hyperglycemia is more common in type 1 diabetes. Purposeful insulin omission before exercise can promote a rise in glycemia, as can malfunctioning infusion sets (143). Individuals with type 2 diabetes may also experience increases in blood glucose after aerobic or resistance exercise, particularly if they are insulin users and

administer too little insulin for meals before activity (144). Overconsumption of carbohydrates before or during exercise, along with aggressive insulin reduction, can promote hyperglycemia during any exercise (89).

Very intense exercise such as sprinting (134), brief but intense aerobic exercise (145), and heavy powerlifting (146,147) may promote hyperglycemia, especially if starting blood glucose levels are elevated (145). Hyperglycemia risk is mitigated if intense activities are interspersed between moderate-intensity aerobic ones (82,148). Similarly, combining resistance training (done first) with aerobic training (second) optimizes glucose stability in type 1 diabetes (23). To correct postexercise hyperglycemia, a conservative (50% of usual) correction can be administered (77) or an aerobic cooldown may be done to lower it (I.S. Millán, personal communication). Excessive insulin corrections after exercise increase nocturnal hypoglycemia risk, which can result in mortality (149).

Individuals with type 1 diabetes should test for blood ketones if they have unexplained hyperglycemia (≥ 250 mg/dL). Exercise should be postponed or suspended

if blood ketone levels are elevated (≥ 1.5 mmol/L), as blood glucose levels and ketones may rise further with even mild activity.

Medication Effects

Adults with diabetes are frequently treated with multiple medications for diabetes and other comorbid conditions. Some medications (other than insulin) may increase exercise risk and doses may need to be adjusted (150,151). Although appropriate changes should be individualized, Table 4 lists general considerations and guidelines for medications.

Heat-Related Illness During Physical Activity

Physical activity increases bodily heat production and core temperature, leading to greater skin blood flow and sweating. In relatively young adults with type 1 diabetes, temperature regulation is only impaired during high-intensity exercise (152,153). With increasing age, poor blood glucose control, and neuropathy, skin blood flow and sweating may be impaired in adults with type 1 (152,154) and type 2 (155) diabetes, increasing the risk of heat-related

Table 4—Exercise considerations for diabetes, hypertension, and cholesterol medications and recommended safety and dose adjustments

Type/class of medication	Exercise considerations	Safety/dose adjustments
Diabetes		
Insulin	<ul style="list-style-type: none"> Deficiency: hyperglycemia, ketoacidosis Excess: hypoglycemia during and after exercise 	<ul style="list-style-type: none"> Increase insulin dose pre- and postexercise for deficiency Decrease prandial and/or basal doses for excess insulin
Insulin secretagogues	<ul style="list-style-type: none"> Exercise-induced hypoglycemia 	<ul style="list-style-type: none"> If exercise-induced hypoglycemia has occurred, decrease dose on exercise days to reduce hypoglycemia risk
Metformin	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> Generally safe; no dose adjustment for exercise
Thiazolidinediones	<ul style="list-style-type: none"> Fluid retention 	<ul style="list-style-type: none"> Generally safe; no dose adjustment for exercise
Dipeptidyl peptidase 4 inhibitors	<ul style="list-style-type: none"> Slight risk of congestive heart failure with saxagliptin and alogliptin 	<ul style="list-style-type: none"> Generally safe; no dose adjustment for exercise
Glucagon-like peptide 1 receptor agonists	<ul style="list-style-type: none"> May increase risk of hypoglycemia when used with insulin or sulfonylureas but not when used alone 	<ul style="list-style-type: none"> Generally safe; no dose adjustment for exercise but may need to lower insulin or sulfonylurea dose
Sodium–glucose cotransporter 2 inhibitors	<ul style="list-style-type: none"> May increase risk of hypoglycemia when used with insulin or sulfonylureas but not when used alone 	<ul style="list-style-type: none"> Generally safe; no dose adjustment for exercise
Hypertension		
β -Blockers	<ul style="list-style-type: none"> Hypoglycemia unawareness and unresponsiveness; may reduce maximal exercise capacity 	<ul style="list-style-type: none"> Check blood glucose before and after exercise; treat hyperglycemia with glucose
Other agents	<ul style="list-style-type: none"> Regular exercise training may lower blood pressure; some agents increase risk of dehydration 	<ul style="list-style-type: none"> Doses may need to be adjusted to accommodate the improvements from training and avoid dehydration
Cholesterol		
Statins	<ul style="list-style-type: none"> Muscle weakness, discomfort, and cramping in a minority of users 	<ul style="list-style-type: none"> Generally safe; no dose adjustment for exercise
Fibric acid derivatives	<ul style="list-style-type: none"> Rare myositis or rhabdomyolysis; risk increased with gemfibrozil and statin combination 	<ul style="list-style-type: none"> Avoid exercise if these muscle conditions are present

Table 5—Physical activity consideration, precautions, and recommended activities for exercising with health-related complications

Health complication	Exercise considerations	Physical activity recommendations/precautions
Cardiovascular diseases		
Coronary artery disease	<ul style="list-style-type: none"> • Coronary perfusion may actually be enhanced during higher-intensity aerobic or resistance exercise. 	<ul style="list-style-type: none"> • All activities okay. • Consider exercising in a supervised cardiac rehabilitation program, at least initially.
Exertional angina	<ul style="list-style-type: none"> • Onset of chest pain on exertion, but exercise-induced ischemia may be silent in some with diabetes. 	<ul style="list-style-type: none"> • All activities okay, but heart rate should be kept ≥ 10 bpm below onset of exercise-related angina.
Hypertension	<ul style="list-style-type: none"> • Both aerobic and resistance training may lower resting blood pressure and should be encouraged. • Some blood pressure medications can cause exercise-related hypotension. 	<ul style="list-style-type: none"> • Ensure adequate hydration during exercise. • Avoid Valsalva maneuver during resistance training.
Myocardial infarction	<ul style="list-style-type: none"> • Stop exercise immediately should symptoms of myocardial infarction (such as chest pain, radiating pain, shortness of breath, and others) occur during physical activity and seek medical attention. 	<ul style="list-style-type: none"> • Restart exercise after myocardial infarction in a supervised cardiac rehabilitation program. • Start at a low intensity and progress as able to more moderate activities. • Both aerobic and resistance exercise are okay.
Stroke	<ul style="list-style-type: none"> • Diabetes increases the risk of ischemic stroke. • Stop exercise immediately if symptoms of a stroke (occurring suddenly and often affecting only one side of the body) happen during exercise. 	<ul style="list-style-type: none"> • Restart exercise after stroke in a supervised cardiac rehabilitation program. • Start at a low intensity and progress as able to more moderate activities. • Both aerobic and resistance exercise are okay.
Congestive heart failure	<ul style="list-style-type: none"> • Most common cause is coronary artery disease and frequently follows a myocardial infarction. 	<ul style="list-style-type: none"> • Avoid activities that cause an excessive rise in heart rate. • Focus more on doing low- or moderate-intensity activities.
Peripheral artery disease	<ul style="list-style-type: none"> • Lower-extremity resistance training improves functional performance (161). 	<ul style="list-style-type: none"> • Low- or moderate-intensity walking, arm ergometer, and leg ergometer preferred as aerobic activities (162). • All other activities okay.
Nerve disease		
Peripheral neuropathy	<ul style="list-style-type: none"> • Regular aerobic exercise may also prevent the onset or delay the progression of peripheral neuropathy in both type 1 and type 2 diabetes (163). 	<ul style="list-style-type: none"> • Proper care of the feet is needed to prevent foot ulcers and lower the risk of amputation (6). • Keep feet dry and use appropriate footwear, silica gel or air midsoles, and polyester or blend socks (not pure cotton). • Consider inclusion of more non-weight-bearing activities, particularly if gait altered.
Local foot deformity	<ul style="list-style-type: none"> • Manage with appropriate footwear and choice of activities to reduce plantar pressure and ulcer risk (164). 	<ul style="list-style-type: none"> • Focus more on non-weight-bearing activities to reduce undue plantar pressures. • Examine feet daily to detect and treat blisters, sores, or ulcers early.
Foot ulcers/amputations	<ul style="list-style-type: none"> • Moderate walking is not likely to increase risk of foot ulcers or reulceration with peripheral neuropathy (165). 	<ul style="list-style-type: none"> • Weight-bearing activity should be avoided with unhealed ulcers. • Examine feet daily to detect and treat blisters, sores, or ulcers early. • Amputation sites should be properly cared for daily. • Avoid jogging.
Autonomic neuropathy	<ul style="list-style-type: none"> • May cause postural hypotension, chronotropic incompetence, delayed gastric emptying, altered thermoregulation, and dehydration during exercise (6). • Exercise-related hypoglycemia may be harder to treat in those with gastroparesis. 	<ul style="list-style-type: none"> • With postural hypotension, avoid activities with rapid postural or directional changes to avoid fainting or falling. • With cardiac autonomic neuropathy, obtain physician approval and possibly undergo symptom-limited exercise testing before commencing exercise (166). • With blunted heart rate response, use heart rate reserve and ratings of perceived exertion to monitor exercise intensity (167). • With autonomic neuropathy, avoid exercise in hot environments and hydrate well.

Continued on p. 2074

Table 5—Continued

Health complication	Exercise considerations	Physical activity recommendations/precautions
Eye diseases		
Mild to moderate nonproliferative retinopathy	<ul style="list-style-type: none"> Individuals with mild to moderate nonproliferative changes have limited or no risk for eye damage from physical activity. 	<ul style="list-style-type: none"> All activities okay with mild, but annual eye exam should be performed to monitor progression. With moderate nonproliferative retinopathy, avoid activities that dramatically elevate blood pressure, such as powerlifting.
Severe nonproliferative and unstable proliferative retinopathy	<ul style="list-style-type: none"> Individuals with unstable diabetic retinopathy are at risk for vitreous hemorrhage and retinal detachment. 	<ul style="list-style-type: none"> Avoid activities that dramatically elevate blood pressure, such as vigorous activity of any type. Avoid vigorous exercise; jumping, jarring, and head-down activities; and breath holding (6). No exercise should be undertaken during a vitreous hemorrhage.
Cataracts	<ul style="list-style-type: none"> Cataracts do not impact the ability to exercise, only the safety of doing so due to loss of visual acuity. 	<ul style="list-style-type: none"> Avoid activities that are more dangerous due to limited vision, such as outdoor cycling. Consider supervision for certain activities.
Kidney diseases		
Microalbuminuria	<ul style="list-style-type: none"> Exercise does not accelerate progression of kidney disease even though protein excretion acutely increases afterward (6,159). Greater participation in moderate-to-vigorous leisure time activity and higher physical activity levels may actually moderate the initiation and progression of diabetic nephropathy (168–170). 	<ul style="list-style-type: none"> All activities okay, but vigorous exercise should be avoided the day before urine protein tests are performed to prevent false positive readings.
Overt nephropathy	<ul style="list-style-type: none"> Both aerobic and resistance training improve physical function and quality of life in individuals with kidney disease. Individuals should be encouraged to be active. 	<ul style="list-style-type: none"> All activities okay, but exercise should begin at a low intensity and volume if aerobic capacity and muscle function are substantially reduced.
End-stage renal disease	<ul style="list-style-type: none"> Doing supervised, moderate aerobic physical activity undertaken during dialysis sessions may be beneficial and increase compliance (171). 	<ul style="list-style-type: none"> Exercise should begin at a low intensity and volume if aerobic capacity and muscle function are substantially reduced. Electrolytes should be monitored when activity done during dialysis sessions.
Orthopedic limitations		
Structural changes to joints	<ul style="list-style-type: none"> Individuals with diabetes are more prone to structural changes to joints that can limit movement, including shoulder adhesive capsulitis, carpal tunnel syndrome, metatarsal fractures, and neuropathy-related joint disorders (Charcot foot) (25). 	<ul style="list-style-type: none"> In addition to engaging in other activities (as able), do regular flexibility training to maintain greater joint range of motion (10,12). Stretch within warm-ups or after an activity to increase joint range of motion best (172). Strengthen muscles around affected joints with resistance training. Avoid activities that increase plantar pressures with Charcot foot changes.
Arthritis	<ul style="list-style-type: none"> Common in lower-extremity joints, particularly in older adults who are overweight or obese. Participation in regular physical activity is possible and should be encouraged. Moderate activity may improve joint symptoms and alleviate pain. 	<ul style="list-style-type: none"> Most low- and moderate-intensity activities okay, but more non-weight-bearing or low-impact exercise may be undertaken to reduce stress on joints. Do range-of-motion activities and light resistance exercise to increase strength of muscles surrounding affected joints. Avoid activities with high risk of joint trauma, such as contact sports and ones with rapid directional changes.

illness. Chronic hyperglycemia also increases risk through dehydration caused by osmotic diuresis, and some medications that lower blood pressure may also impact hydration and electrolyte balance. Older adults with diabetes or anyone with autonomic neuropathy, cardiovascular complications, or pulmonary disease should avoid exercising

outdoors on very hot and/or humid days.

Orthopedic and Overuse Injuries

Active individuals with type 1 diabetes are not at increased risk of tendon injury (156), but this may not apply to sedentary or older individuals with diabetes. Given that diabetes may lead to

exercise-related overuse injuries due to changes in joint structures related to glycemic excursions (157), exercise training for anyone with diabetes should progress appropriately to avoid excessive aggravation to joint surfaces and structures, particularly when taking statin medications for lipid control (158).

MANAGING PHYSICAL ACTIVITY WITH HEALTH COMPLICATIONS

Recommendations

- Physical activity with vascular diseases can be undertaken safely but with appropriate precautions. **B**
- Physical activity done with peripheral neuropathy necessitates proper foot care to prevent, detect, and prevent problems early to avoid ulceration and amputation. **B**
- The presence of autonomic neuropathy may complicate being active; certain precautions are warranted to prevent problems during activity. **C**
- Vigorous aerobic or resistance exercise; jumping, jarring, head-down activities; and breath holding should be avoided in anyone with severe nonproliferative and unstable proliferative diabetic retinopathy. **E**
- Exercise does not accelerate progression of kidney disease and can be undertaken safely, even during dialysis sessions. **C**
- Regular stretching and appropriate progression of activities should be done to manage joint changes and diabetes-related orthopedic limitations. **C**

Macrovascular and microvascular diabetes-related complications can develop and worsen with inadequate blood glucose control (159,160). Vascular and neural complications of diabetes often cause physical limitation and varying levels of disability requiring precautions during exercise, as recommended in Table 5.

PROMOTING THE ADOPTION AND MAINTENANCE OF PHYSICAL ACTIVITY

Recommendations

- Targeted behavior-change strategies should be used to increase physical activity in adults with type 2 diabetes. **B**
- When using step counters, adults with type 2 diabetes should initially set tolerable targets for steps/day before progressing toward higher goals. **C**
- For adults with type 2 diabetes, Internet-delivered interventions

for physical activity promotion may be used to improve outcomes. **C**

Behavior-Change Strategies

Behavioral interventions can significantly increase physical activity in adults with type 2 diabetes (173), and A1C reductions produced by such interventions have been sustained to 24 months (174). Five key techniques have been identified: 1) prompt focus on past success, 2) barrier identification/problem-solving, 3) use of follow-up prompts, 4) provision of information on where/when to perform the behavior, and 5) prompt review of behavioral goals (175). However, motivational interviewing is not significantly better than usual care (176), and other intervention factors associated with weight loss, such as number and duration of contacts, have been inconsistent or not associated with greater participation (177).

Step counters/pedometers have been widely studied as a behavior-change tool. Wearing the device may prompt activity, and it provides feedback for self-monitoring. Pedometer use in adults with type 2 diabetes increased their daily steps by 1,822, but did not improve A1C (178). Using a daily steps goal (e.g., 10,000) was predictive of increased participation, even using self-selected step goals (178). Thus, adults with type 2 diabetes should initially set feasible/achievable targets for steps/day before progressing toward higher goals. Adults should avoid taking <5,000 steps/day (179–181) and to strive for $\geq 7,500$ steps/day (182). The positive findings for pedometers are not universal (175), however, and some individuals may require greater support to realize benefits. Longer-term efficacy and determination of which populations can benefit from pedometers and other wearable activity trackers (183) require further evaluation.

Technology-Based Strategies

Given that the majority of individuals with type 2 diabetes have access to the Internet, technology-based support is appealing for extending clinical intervention reach. For adults with type 2 diabetes, Internet-delivered physical activity promotion interventions may be more effective than usual care (184). Effective Internet-based programs

included monitoring of physical activity, feedback, goal setting, and support from a coach via phone/e-mail (184). More evidence is needed regarding social media approaches, given the importance of social and peer support in diabetes self-management (185).

CONCLUSIONS

Physical activity and exercise should be recommended and prescribed to all individuals with diabetes as part of management of glycemic control and overall health. Specific recommendations and precautions will vary by the type of diabetes, age, activity done, and presence of diabetes-related health complications. Recommendations should be tailored to meet the specific needs of each individual. In addition to engaging in regular physical activity, all adults should be encouraged to decrease the total amount of daily sedentary time and to break up sitting time with frequent bouts of activity. Finally, behavior-change strategies can be used to promote the adoption and maintenance of lifetime physical activity.

Duality of Interest. No potential conflicts of interest relevant to this article were reported.

References

1. Chen L, Pei JH, Kuang J, et al. Effect of lifestyle intervention in patients with type 2 diabetes: a meta-analysis. *Metabolism* 2015;64:338–347
2. Lin X, Zhang X, Guo J, et al. Effects of exercise training on cardiorespiratory fitness and biomarkers of cardiometabolic health: a systematic review and meta-analysis of randomized controlled trials. *J Am Heart Assoc* 2015;4:4
3. Schellenberg ES, Dryden DM, Vandermeer B, Ha C, Korownyk C. Lifestyle interventions for patients with and at risk for type 2 diabetes: a systematic review and meta-analysis. *Ann Intern Med* 2013;159:543–551
4. Yardley JE, Hay J, Abou-Setta AM, Marks SD, McGavock J. A systematic review and meta-analysis of exercise interventions in adults with type 1 diabetes. *Diabetes Res Clin Pract* 2014;106:393–400
5. American Diabetes Association. Foundations of care and comprehensive medical evaluation. Sec. 6. In *Standards of Medical Care in Diabetes—2016*. *Diabetes Care* 2016;39(Suppl. 1):S23–S35
6. Colberg SR, Sigal RJ, Fernhall B, et al.; American College of Sports Medicine; American Diabetes Association. Exercise and type 2 diabetes: the American College of Sports Medicine and the American Diabetes Association: joint position statement. *Diabetes Care* 2010;33:e147–e167
7. American Diabetes Association. Classification and diagnosis of diabetes. Sec. 2. In *Standards of Medical Care in Diabetes—2016*. *Diabetes Care* 2016;39(Suppl. 1):S13–S22

8. American Diabetes Association. Prevention or delay of type 2 diabetes. Sec. 4. In *Standards of Medical Care in Diabetes—2016*. Diabetes Care 2016;39(Suppl. 1):S36–S38
9. Physical Activity Guidelines Advisory Committee. *Physical Activity Guidelines Advisory Committee Report*. Washington, DC, U.S. Department of Health and Human Services, 2008, p. 683
10. Herriott MT, Colberg SR, Parson HK, Nunnold T, Vinik AI. Effects of 8 weeks of flexibility and resistance training in older adults with type 2 diabetes. *Diabetes Care* 2004;27:2988–2989
11. Morrison S, Colberg SR, Mariano M, Parson HK, Vinik AI. Balance training reduces falls risk in older individuals with type 2 diabetes. *Diabetes Care* 2010;33:748–750
12. Garber CE, Blissmer B, Deschenes MR, et al.; American College of Sports Medicine. American College of Sports Medicine position stand. Quantity and quality of exercise for developing and maintaining cardiorespiratory, musculoskeletal, and neuromotor fitness in apparently healthy adults: guidance for prescribing exercise. *Med Sci Sports Exerc* 2011;43:1334–1359
13. Sluik D, Buijse B, Muckelbauer R, et al. Physical activity and mortality in individuals with diabetes mellitus: a prospective study and meta-analysis. *Arch Intern Med* 2012;172:1285–1295
14. Chimen M, Kennedy A, Nirantharakumar K, Pang TT, Andrews R, Narendran P. What are the health benefits of physical activity in type 1 diabetes mellitus? A literature review. *Diabetologia* 2012;55:542–551
15. Snowling NJ, Hopkins WG. Effects of different modes of exercise training on glucose control and risk factors for complications in type 2 diabetic patients: a meta-analysis. *Diabetes Care* 2006;29:2518–2527
16. Jelleyman C, Yates T, O'Donovan G, et al. The effects of high-intensity interval training on glucose regulation and insulin resistance: a meta-analysis. *Obes Rev* 2015;16:942–961
17. Little JP, Gillen JB, Percival ME, et al. Low-volume high-intensity interval training reduces hyperglycemia and increases muscle mitochondrial capacity in patients with type 2 diabetes. *J Appl Physiol* (1985) 2011;111:1554–1560
18. Dubé MC, Lavoie C, Weisnagel SJ. Glucose or intermittent high-intensity exercise in glargine/gulinsine users with T1DM. *Med Sci Sports Exerc* 2013;45:3–7
19. Tonoli C, Heyman E, Roelands B, et al. Effects of different types of acute and chronic (training) exercise on glycaemic control in type 1 diabetes mellitus: a meta-analysis. *Sports Med* 2012;42:1059–1080
20. Nishitani M, Shimada K, Sunayama S, et al. Impact of diabetes on muscle mass, muscle strength, and exercise tolerance in patients after coronary artery bypass grafting. *J Cardiol* 2011;58:173–180
21. Anton SD, Karabetian C, Naugle K, Buford TW. Obesity and diabetes as accelerators of functional decline: can lifestyle interventions maintain functional status in high risk older adults? *Exp Gerontol* 2013;48:888–897
22. Yardley JE, Kenny GP, Perkins BA, et al. Resistance versus aerobic exercise: acute effects on glycemia in type 1 diabetes. *Diabetes Care* 2013;36:537–542
23. Yardley JE, Kenny GP, Perkins BA, et al. Effects of performing resistance exercise before versus after aerobic exercise on glycemia in type 1 diabetes. *Diabetes Care* 2012;35:669–675
24. Gordon BA, Benson AC, Bird SR, Fraser SF. Resistance training improves metabolic health in type 2 diabetes: a systematic review. *Diabetes Res Clin Pract* 2009;83:157–175
25. Abate M, Schiavone C, Pelotti P, Salini V. Limited joint mobility in diabetes and ageing: recent advances in pathogenesis and therapy. *Int J Immunopathol Pharmacol* 2010;23:997–1003
26. Gillespie LD, Robertson MC, Gillespie WJ, et al. Interventions for preventing falls in older people living in the community. *Cochrane Database Syst Rev* 2012;9:CD007146
27. Innes KE, Selfe TK. Yoga for adults with type 2 diabetes: a systematic review of controlled trials. *J Diabetes Res* 2016;2016:6979370
28. Ahn S, Song R. Effects of tai chi exercise on glucose control, neuropathy scores, balance, and quality of life in patients with type 2 diabetes and neuropathy. *J Altern Complement Med* 2012;18:1172–1178
29. Owen N, Sugiyama T, Eakin EE, Gardiner PA, Tremblay MS, Sallis JF. Adults' sedentary behavior determinants and interventions. *Am J Prev Med* 2011;41:189–196
30. Dempsey PC, Owen N, Biddle SJ, Dunstan DW. Managing sedentary behavior to reduce the risk of diabetes and cardiovascular disease. *Curr Diab Rep* 2014;14:522
31. Biswas A, Oh PI, Faulkner GE, et al. Sedentary time and its association with risk for disease incidence, mortality, and hospitalization in adults: a systematic review and meta-analysis. *Ann Intern Med* 2015;162:123–132
32. Chau JY, Grunseit AC, Chey T, et al. Daily sitting time and all-cause mortality: a meta-analysis. *PLoS One* 2013;8:e80000
33. Hu FB, Leitzmann MF, Stampfer MJ, Colditz GA, Willett WC, Rimm EB. Physical activity and television watching in relation to risk for type 2 diabetes mellitus in men. *Arch Intern Med* 2001;161:1542–1548
34. Hu FB, Li TY, Colditz GA, Willett WC, Manson JE. Television watching and other sedentary behaviors in relation to risk of obesity and type 2 diabetes mellitus in women. *JAMA* 2003;289:1785–1791
35. Wilmut EG, Edwardson CL, Achana FA, et al. Sedentary time in adults and the association with diabetes, cardiovascular disease and death: systematic review and meta-analysis. *Diabetologia* 2012;55:2895–2905
36. Dunstan DW, Salmon J, Healy GN, et al.; AusDiab Steering Committee. Association of television viewing with fasting and 2-h postchallenge plasma glucose levels in adults without diagnosed diabetes. *Diabetes Care* 2007;30:516–522
37. Healy GN, Dunstan DW, Salmon J, et al. Objectively measured light-intensity physical activity is independently associated with 2-h plasma glucose. *Diabetes Care* 2007;30:1384–1389
38. Healy GN, Dunstan DW, Salmon J, et al. Breaks in sedentary time: beneficial associations with metabolic risk. *Diabetes Care* 2008;31:661–666
39. Fritschi C, Park H, Richardson A, et al. Association between daily time spent in sedentary behavior and duration of hyperglycemia in type 2 diabetes. *Biol Res Nurs* 2016;18:160–166
40. Buckley JP, Mellor DD, Morris M, Joseph F. Standing-based office work shows encouraging signs of attenuating post-prandial glycaemic excursion. *Occup Environ Med* 2014;71:109–111
41. Henson J, Davies MJ, Bodicoat DH, et al. Breaking up prolonged sitting with standing or walking attenuates the postprandial metabolic response in postmenopausal women: a randomized acute study. *Diabetes Care* 2016;39:130–138
42. Thorp AA, Kingwell BA, Sethi P, Hammond L, Owen N, Dunstan DW. Alternating bouts of sitting and standing attenuate postprandial glucose responses. *Med Sci Sports Exerc* 2014;46:2053–2061
43. Dunstan DW, Kingwell BA, Larsen R, et al. Breaking up prolonged sitting reduces postprandial glucose and insulin responses. *Diabetes Care* 2012;35:976–983
44. Larsen RN, Kingwell BA, Robinson C, et al. Breaking up of prolonged sitting over three days sustains, but does not enhance, lowering of postprandial plasma glucose and insulin in overweight and obese adults. *Clin Sci (Lond)* 2015;129:117–127
45. van Dijk JW, Venema M, van Mechelen W, Stehouwer CD, Hartgens F, van Loon LJ. Effect of moderate-intensity exercise versus activities of daily living on 24-hour blood glucose homeostasis in male patients with type 2 diabetes. *Diabetes Care* 2013;36:3448–3453
46. Dempsey PC, Larsen RN, Sethi P, et al. Benefits for type 2 diabetes of interrupting prolonged sitting with brief bouts of light walking or simple resistance activities. *Diabetes Care* 2016;39:964–972
47. Roberts CK, Hevener AL, Barnard RJ. Metabolic syndrome and insulin resistance: underlying causes and modification by exercise training. *Compr Physiol* 2013;3:1–58
48. Magkos F, Tsekouras Y, Kavouras SA, Mittendorfer B, Sidossis LS. Improved insulin sensitivity after a single bout of exercise is curvilinearly related to exercise energy expenditure. *Clin Sci (Lond)* 2008;114:59–64
49. Wang X, Patterson BW, Smith GI, et al. A ~60-min brisk walk increases insulin-stimulated glucose disposal but has no effect on hepatic and adipose tissue insulin sensitivity in older women. *J Appl Physiol* (1985) 2013;114:1563–1568
50. Wojtaszewski JF, Nielsen JN, Richter EA. Invited review: effect of acute exercise on insulin signaling and action in humans. *J Appl Physiol* (1985) 2002;93:384–392
51. Gillen JB, Little JP, Punthakee Z, Tarnopolsky MA, Riddell MC, Gibala MJ. Acute high-intensity interval exercise reduces the postprandial glucose response and prevalence of hyperglycaemia in patients with type 2 diabetes. *Diabetes Obes Metab* 2012;14:575–577
52. Manders RJ, Van Dijk JW, van Loon LJ. Low-intensity exercise reduces the prevalence of hyperglycemia in type 2 diabetes. *Med Sci Sports Exerc* 2010;42:219–225
53. Newsom SA, Everett AC, Hinko A, Horowitz JF. A single session of low-intensity exercise is sufficient to enhance insulin sensitivity into the next day in obese adults. *Diabetes Care* 2013;36:2516–2522

54. Hawley JA, Lessard SJ. Exercise training-induced improvements in insulin action. *Acta Physiol (Oxf)* 2008;192:127–135
55. Olsen RH, Krogh-Madsen R, Thomsen C, Booth FW, Pedersen BK. Metabolic responses to reduced daily steps in healthy nonexercising men. *JAMA* 2008;299:1261–1263
56. Bacchi E, Negri C, Targher G, et al. Both resistance training and aerobic training reduce hepatic fat content in type 2 diabetic subjects with nonalcoholic fatty liver disease (the RAED2 Randomized Trial). *Hepatology* 2013;58:1287–1295
57. Hallsworth K, Fattakhova G, Hollingsworth KG, et al. Resistance exercise reduces liver fat and its mediators in non-alcoholic fatty liver disease independent of weight loss. *Gut* 2011;60:1278–1283
58. Dubé JJ, Amati F, Toledo FG, et al. Effects of weight loss and exercise on insulin resistance, and intramyocellular triacylglycerol, diacylglycerol and ceramide. *Diabetologia* 2011;54:1147–1156
59. Kirwan JP, Solomon TP, Wojta DM, Staten MA, Holloszy JO. Effects of 7 days of exercise training on insulin sensitivity and responsiveness in type 2 diabetes mellitus. *Am J Physiol Endocrinol Metab* 2009;297:E151–E156
60. Dubé JJ, Allison KF, Rousson V, Goodpaster BH, Amati F. Exercise dose and insulin sensitivity: relevance for diabetes prevention. *Med Sci Sports Exerc* 2012;44:793–799
61. Sigal RJ, Kenny GP, Boulé NG, et al. Effects of aerobic training, resistance training, or both on glycemic control in type 2 diabetes: a randomized trial. *Ann Intern Med* 2007;147:357–369
62. Wing RR, Bolin P, Brancati FL, et al.; Look AHEAD Research Group. Cardiovascular effects of intensive lifestyle intervention in type 2 diabetes. *N Engl J Med* 2013;369:145–154
63. Pi-Sunyer X. The Look AHEAD trial: a review and discussion of its outcomes. *Curr Nutr Rep* 2014;3:387–391
64. Umpierre D, Ribeiro PA, Kramer CK, et al. Physical activity advice only or structured exercise training and association with HbA1c levels in type 2 diabetes: a systematic review and meta-analysis. *JAMA* 2011;305:1790–1799
65. Yang Z, Scott CA, Mao C, Tang J, Farmer AJ. Resistance exercise versus aerobic exercise for type 2 diabetes: a systematic review and meta-analysis. *Sports Med* 2014;44:487–499
66. Church TS, Blair SN, Cocroham S, et al. Effects of aerobic and resistance training on hemoglobin A1c levels in patients with type 2 diabetes: a randomized controlled trial. *JAMA* 2010;304:2253–2262
67. Zeitler P, Hirst K, Pyle L, et al.; TODAY Study Group. A clinical trial to maintain glycemic control in youth with type 2 diabetes. *N Engl J Med* 2012;366:2247–2256
68. Balk EM, Earley A, Raman G, Avendano EA, Pittas AG, Remington PL. Combined diet and physical activity promotion programs to prevent type 2 diabetes among persons at increased risk: a systematic review for the community preventive services task force. *Ann Intern Med* 2015;163:437–451
69. Dunkley AJ, Bodicoat DH, Greaves CJ, et al. Diabetes prevention in the real world: effectiveness of pragmatic lifestyle interventions for the prevention of type 2 diabetes and of the impact of adherence to guideline recommendations: a systematic review and meta-analysis. *Diabetes Care* 2014;37:922–933
70. MacMillan F, Kirk A, Mutrie N, Matthews L, Robertson K, Saunders DH. A systematic review of physical activity and sedentary behavior intervention studies in youth with type 1 diabetes: study characteristics, intervention design, and efficacy. *Pediatr Diabetes* 2014;15:175–189
71. Moy CS, Songer TJ, LaPorte RE, et al. Insulin-dependent diabetes mellitus, physical activity, and death. *Am J Epidemiol* 1993;137:74–81
72. Biankin SA, Jenkins AB, Campbell LV, Choi KL, Forrest QG, Chisholm DJ. Target-seeking behavior of plasma glucose with exercise in type 1 diabetes. *Diabetes Care* 2003;26:297–301
73. Tansey MJ, Tsalikian E, Beck RW, et al.; Diabetes Research in Children Network (DirecNet) Study Group. The effects of aerobic exercise on glucose and counterregulatory hormone concentrations in children with type 1 diabetes. *Diabetes Care* 2006;29:20–25
74. Mallad A, Hinshaw L, Schiavon M, et al. Exercise effects on postprandial glucose metabolism in type 1 diabetes: a triple-tracer approach. *Am J Physiol Endocrinol Metab* 2015;308:E1106–E1115
75. Manohar C, Levine JA, Nandy DK, et al. The effect of walking on postprandial glycemic excursion in patients with type 1 diabetes and healthy people. *Diabetes Care* 2012;35:2493–2499
76. Dubé MC, Weisnagel SJ, Prud'homme D, Lavoie C. Is early and late post-meal exercise so different in type 1 diabetic lispro users? *Diabetes Res Clin Pract* 2006;72:128–134
77. Turner D, Luzio S, Gray BJ, et al. Algorithm that delivers an individualized rapid-acting insulin dose after morning resistance exercise counters post-exercise hyperglycaemia in people with type 1 diabetes. *Diabet Med* 2016;33:506–510
78. Mitchell TH, Abraham G, Schiffrin A, Leiter LA, Marliss EB. Hyperglycemia after intense exercise in IDDM subjects during continuous subcutaneous insulin infusion. *Diabetes Care* 1988;11:311–317
79. Bally L, Zueger T, Buehler T, et al. Metabolic and hormonal response to intermittent high-intensity and continuous moderate intensity exercise in individuals with type 1 diabetes: a randomised crossover study. *Diabetologia* 2016;59:776–784
80. García-García F, Kumareswaran K, Hovorka R, Hernando ME. Quantifying the acute changes in glucose with exercise in type 1 diabetes: a systematic review and meta-analysis. *Sports Med* 2015;45:587–599
81. Maran A, Pavan P, Bonsembiante B, et al. Continuous glucose monitoring reveals delayed nocturnal hypoglycemia after intermittent high-intensity exercise in nontrained patients with type 1 diabetes. *Diabetes Technol Ther* 2010;12:763–768
82. Guelfi KJ, Ratnam N, Smythe GA, Jones TW, Fournier PA. Effect of intermittent high-intensity compared with continuous moderate exercise on glucose production and utilization in individuals with type 1 diabetes. *Am J Physiol Endocrinol Metab* 2007;292:E865–E870
83. Riddell MC, Milliken J. Preventing exercise-induced hypoglycemia in type 1 diabetes using real-time continuous glucose monitoring and a new carbohydrate intake algorithm: an observational field study. *Diabetes Technol Ther* 2011;13:819–825
84. Francescato MP, Stel G, Stenner E, Geat M. Prolonged exercise in type 1 diabetes: performance of a customizable algorithm to estimate the carbohydrate supplements to minimize glycemic imbalances. *PLoS One* 2015;10:e0125220
85. Adolfsson P, Mattsson S, Jendle J. Evaluation of glucose control when a new strategy of increased carbohydrate supply is implemented during prolonged physical exercise in type 1 diabetes. *Eur J Appl Physiol* 2015;115:2599–2607
86. Baker LB, Rollo I, Stein KW, Jeukendrup AE. Acute effects of carbohydrate supplementation on intermittent sports performance. *Nutrients* 2015;7:5733–5763
87. Colberg SR, Laan R, Dassau E, Kerr D. Physical activity and type 1 diabetes: time for a rewire? *J Diabetes Sci Technol* 2015;9:609–618
88. Zaharieva DP, Riddell MC. Prevention of exercise-associated dysglycemia: a case study-based approach. *Diabetes Spectr* 2015;28:55–62
89. Campbell MD, Walker M, Bracken RM, et al. Insulin therapy and dietary adjustments to normalize glycemia and prevent nocturnal hypoglycemia after evening exercise in type 1 diabetes: a randomized controlled trial. *BMJ Open Diabetes Res Care* 2015;3:e000085
90. Franc S, Daoudi A, Pochat A, et al. Insulin-based strategies to prevent hypoglycaemia during and after exercise in adult patients with type 1 diabetes on pump therapy: the DIABRASPORT randomized study. *Diabetes Obes Metab* 2015;17:1150–1157
91. Tsalikian E, Kollman C, Tamborlane WB, et al.; Diabetes Research in Children Network (DirecNet) Study Group. Prevention of hypoglycemia during exercise in children with type 1 diabetes by suspending basal insulin. *Diabetes Care* 2006;29:2200–2204
92. Admon G, Weinstein Y, Falk B, et al. Exercise with and without an insulin pump among children and adolescents with type 1 diabetes mellitus. *Pediatrics* 2005;116:e348–e355
93. Heinemann L, Nosek L, Kapitza C, Schweitzer MA, Krinkel L. Changes in basal insulin infusion rates with subcutaneous insulin infusion: time until a change in metabolic effect is induced in patients with type 1 diabetes. *Diabetes Care* 2009;32:1437–1439
94. Campbell MD, Walker M, Trenell MI, et al. Metabolic implications when employing heavy pre- and post-exercise rapid-acting insulin reductions to prevent hypoglycaemia in type 1 diabetes patients: a randomised clinical trial. *PLoS One* 2014;9:e97143
95. Rabasa-Lhoret R, Bourque J, Ducros F, Chiasson JL. Guidelines for premeal insulin dose reduction for postprandial exercise of different intensities and durations in type 1 diabetic subjects treated intensively with a basal-bolus insulin regimen (ultralente-lispro). *Diabetes Care* 2001;24:625–630
96. Moser O, Tschakert G, Mueller A, et al. Effects of high-intensity interval exercise versus moderate continuous exercise on glucose homeostasis and hormone response in patients with type 1 diabetes mellitus using novel ultra-long-acting insulin. *PLoS One* 2015;10:e0136489

97. Shetty VB, Fournier PA, Davey RJ, et al. Effect of exercise intensity on glucose requirements to maintain euglycaemia during exercise in type 1 diabetes. *J Clin Endocrinol Metab* 2016;101:972–980
98. Yardley JE, Iscoe KE, Sigal RJ, Kenny GP, Perkins BA, Riddell MC. Insulin pump therapy is associated with less post-exercise hyperglycemia than multiple daily injections: an observational study of physically active type 1 diabetes patients. *Diabetes Technol Ther* 2013;15:84–88
99. Peter R, Luzzio SD, Dunseath G, et al. Effects of exercise on the absorption of insulin glargine in patients with type 1 diabetes. *Diabetes Care* 2005;28:560–565
100. Binek A, Rembierz-Knoll A, Polańska J, Jarosz-Chobot P. Reasons for the discontinuation of therapy of personal insulin pump in children with type 1 diabetes. *Pediatr Endocrinol Diabetes Metab* 2016;21:65–69
101. Yardley JE, Sigal RJ, Kenny GP, Riddell MC, Lovblom LE, Perkins BA. Point accuracy of interstitial continuous glucose monitoring during exercise in type 1 diabetes. *Diabetes Technol Ther* 2013;15:46–49
102. Bally L, Zueger T, Pasi N, Carlos C, Paganini D, Stettler C. Accuracy of continuous glucose monitoring during differing exercise conditions. *Diabetes Res Clin Pract* 2016;112:1–5
103. Fayolle C, Brun JF, Bringer J, Mercier J, Renard E. Accuracy of continuous subcutaneous glucose monitoring with the GlucoDay in type 1 diabetic patients treated by subcutaneous insulin infusion during exercise of low versus high intensity. *Diabetes Metab* 2006;32:313–320
104. Radermecker RP, Fayolle C, Brun JF, Bringer J, Renard E. Accuracy assessment of on-line glucose monitoring by a subcutaneous enzymatic glucose sensor during exercise in patients with type 1 diabetes treated by continuous subcutaneous insulin infusion. *Diabetes Metab* 2013;39:258–262
105. Herrington SJ, Gee DL, Dow SD, Monosky KA, Davis E, Pritchett KL. Comparison of glucose monitoring methods during steady-state exercise in women. *Nutrients* 2012;4:1282–1292
106. Iscoe KE, Davey RJ, Fournier PA. Is the response of continuous glucose monitors to physiological changes in blood glucose levels affected by sensor life? *Diabetes Technol Ther* 2012;14:135–142
107. Matuleviciene V, Joseph JJ, Andelin M, et al. A clinical trial of the accuracy and treatment experience of the Dexcom G4 sensor (Dexcom G4 system) and Enlite sensor (Guardian REAL-time system) tested simultaneously in ambulatory patients with type 1 diabetes. *Diabetes Technol Ther* 2014;16:759–767
108. Kropff J, Bruttomesso D, Doll W, et al. Accuracy of two continuous glucose monitoring systems: a head-to-head comparison under clinical research centre and daily life conditions. *Diabetes Obes Metab* 2015;17:343–349
109. Leelarathna L, Nodale M, Allen JM, et al. Evaluating the accuracy and large inaccuracy of two continuous glucose monitoring systems. *Diabetes Technol Ther* 2013;15:143–149
110. Cauza E, Hanusch-Enserer U, Strasser B, et al. Continuous glucose monitoring in diabetic long distance runners. *Int J Sports Med* 2005;26:774–780
111. Riebe D, Franklin BA, Thompson PD, et al. Updating ACSM's recommendations for exercise preparticipation health screening. *Med Sci Sports Exerc* 2015;47:2473–2479
112. Lièvre MM, Moulin P, Thivolet C, et al.; DYNAMIT Investigators. Detection of silent myocardial ischemia in asymptomatic patients with diabetes: results of a randomized trial and meta-analysis assessing the effectiveness of systematic screening. *Trials* 2011;12:23
113. Young LH, Wackers FJ, Chyun DA, et al.; DIAD Investigators. Cardiac outcomes after screening for asymptomatic coronary artery disease in patients with type 2 diabetes: the DIAD study: a randomized controlled trial. *JAMA* 2009;301:1547–1555
114. Biddle SJ, Batterham AM. High-intensity interval exercise training for public health: a big HIT or shall we HIT it on the head? *Int J Behav Nutr Phys Act* 2015;12:95
115. Mitranun W, Deerochanawong C, Tanaka H, Suksom D. Continuous vs interval training on glycemic control and macro- and microvascular reactivity in type 2 diabetic patients. *Scand J Med Sci Sports* 2014;24:e69–e76
116. Levinger I, Shaw CS, Stepto NK, et al. What doesn't kill you makes you fitter: a systematic review of high-intensity interval exercise for patients with cardiovascular and metabolic diseases. *Clin Med Insights Cardiol* 2015;9:53–63
117. Holloway TM, Spriet LL. CrossTalk opposing view: High intensity interval training does not have a role in risk reduction or treatment of disease. *J Physiol* 2015;593:5219–5221
118. Willey KA, Singh MA. Battling insulin resistance in elderly obese people with type 2 diabetes: bring on the heavy weights. *Diabetes Care* 2003;26:1580–1588
119. Levine JA, McCrady SK, Lanningham-Foster LM, Kane PH, Foster RC, Manohar CU. The role of free-living daily walking in human weight gain and obesity. *Diabetes* 2008;57:548–554
120. Levine JA, Lanningham-Foster LM, McCrady SK, et al. Interindividual variation in posture allocation: possible role in human obesity. *Science* 2005;307:584–586
121. Levine JA, Eberhardt NL, Jensen MD. Role of nonexercise activity thermogenesis in resistance to fat gain in humans. *Science* 1999;283:212–214
122. DiPietro L, Gribok A, Stevens MS, Hamm LF, Rumpler W. Three 15-min bouts of moderate postmeal walking significantly improves 24-h glycemic control in older people at risk for impaired glucose tolerance. *Diabetes Care* 2013;36:3262–3268
123. Nygaard H, Tomten SE, Høstmark AT. Slow postmeal walking reduces postprandial glycemia in middle-aged women. *Appl Physiol Nutr Metab* 2009;34:1087–1092
124. Colberg SR, Zarrabi L, Bennington L, et al. Postprandial walking is better for lowering the glycemic effect of dinner than pre-dinner exercise in type 2 diabetic individuals. *J Am Med Dir Assoc* 2009;10:394–397
125. Balducci S, Zanuso S, Nicolucci A, et al.; Italian Diabetes Exercise Study (IDES) Investigators. Effect of an intensive exercise intervention strategy on modifiable cardiovascular risk factors in subjects with type 2 diabetes mellitus: a randomized controlled trial: the Italian Diabetes and Exercise Study (IDES). *Arch Intern Med* 2010;170:1794–1803
126. The American College of Obstetricians and Gynecologists Committee on Obstetric Practice. Physical activity and exercise during pregnancy and the postpartum period. *Obstet Gynecol* 2015;126:e135–e142
127. Sanabria-Martínez G, García-Hermoso A, Poyatos-León R, Álvarez-Bueno C, Sánchez-López M, Martínez-Vizcaino V. Effectiveness of physical activity interventions on preventing gestational diabetes mellitus and excessive maternal weight gain: a meta-analysis. *BJOG* 2015;122:1167–1174
128. Russo LM, Nobles C, Ertel KA, Chasan-Taber L, Whitcomb BW. Physical activity interventions in pregnancy and risk of gestational diabetes mellitus: a systematic review and meta-analysis. *Obstet Gynecol* 2015;125:576–582
129. Colberg SR, Castorino K, Jovanović L. Prescribing physical activity to prevent and manage gestational diabetes. *World J Diabetes* 2013;4:256–262
130. Ehrlich SF, Sternfeld B, Krefman AE, et al. Moderate and vigorous intensity exercise during pregnancy and gestational weight gain in women with gestational diabetes. *Matern Child Health J* 2016;20:1247–1257
131. Zhang C, Solomon CG, Manson JE, Hu FB. A prospective study of pregravid physical activity and sedentary behaviors in relation to the risk for gestational diabetes mellitus. *Arch Intern Med* 2006;166:543–548
132. Bussau VA, Ferreira LD, Jones TW, Fournier PA. A 10-s sprint performed prior to moderate-intensity exercise prevents early post-exercise fall in glycaemia in individuals with type 1 diabetes. *Diabetologia* 2007;50:1815–1818
133. Bussau VA, Ferreira LD, Jones TW, Fournier PA. The 10-s maximal sprint: a novel approach to counter an exercise-mediated fall in glycaemia in individuals with type 1 diabetes. *Diabetes Care* 2006;29:601–606
134. Fahey AJ, Paramalingam N, Davey RJ, Davis EA, Jones TW, Fournier PA. The effect of a short sprint on postexercise whole-body glucose production and utilization rates in individuals with type 1 diabetes mellitus. *J Clin Endocrinol Metab* 2012;97:4193–4200
135. Iscoe KE, Riddell MC. Continuous moderate-intensity exercise with or without intermittent high-intensity work: effects on acute and late glycaemia in athletes with type 1 diabetes mellitus. *Diabet Med* 2011;28:824–832
136. Campbell MD, West DJ, Bain SC, et al. Simulated games activity vs continuous running exercise: A novel comparison of the glycemic and metabolic responses in T1DM patients. *Scand J Med Sci Sports* 2015;25:216–222
137. Frier BM. Hypoglycaemia in diabetes mellitus: epidemiology and clinical implications. *Nat Rev Endocrinol* 2014;10:711–722
138. Tsalikian E, Mauras N, Beck RW, et al.; Diabetes Research in Children Network DirecNet Study Group. Impact of exercise on overnight glycemic control in children with type 1 diabetes mellitus. *J Pediatr* 2005;147:528–534
139. MacDonald MJ. Postexercise late-onset hypoglycemia in insulin-dependent diabetic patients. *Diabetes Care* 1987;10:584–588

140. Taplin CE, Cobry E, Messer L, McFann K, Chase HP, Fiallo-Scharer R. Preventing post-exercise nocturnal hypoglycemia in children with type 1 diabetes. *J Pediatr* 2010;157:784–788.e1
141. Garg SK, Brazg RL, Bailey TS, et al. Hypoglycemia begets hypoglycemia: the order effect in the ASPIRE in-clinic study. *Diabetes Technol Ther* 2014;16:125–130
142. Wilson D, Chase HP, Kollman C, et al.; Diabetes Research in Children Network (DirecNet) Study Group. Low-fat vs. high-fat bedtime snacks in children and adolescents with type 1 diabetes. *Pediatr Diabetes* 2008;9:320–325
143. Yardley JE, Zaharieva DP, Jarvis C, Riddell MC. The “ups” and “downs” of a bike race in people with type 1 diabetes: dramatic differences in strategies and blood glucose responses in the Paris-to-Ancaster Spring Classic. *Can J Diabetes* 2015;39:105–110
144. Gordon BA, Bird SR, Maclsaac RJ, Benson AC. Does a single bout of resistance or aerobic exercise after insulin dose reduction modulate glycaemic control in type 2 diabetes? A randomised cross-over trial. *J Sci Med Sport*. 10 February 2016 [Epub ahead of print] DOI: 10.1016/j.jsams.2016.01.004
145. Marliss EB, Vranic M. Intense exercise has unique effects on both insulin release and its roles in glucose regulation: implications for diabetes. *Diabetes* 2002;51(Suppl. 1):S271–S283
146. Turner D, Gray BJ, Luzio S, et al. Similar magnitude of post-exercise hyperglycemia despite manipulating resistance exercise intensity in type 1 diabetes individuals. *Scand J Med Sci Sports* 2016;26:404–412
147. Turner D, Luzio S, Gray BJ, et al. Impact of single and multiple sets of resistance exercise in type 1 diabetes. *Scand J Med Sci Sports* 2015;25:e99–e109
148. Guelfi KJ, Jones TW, Fournier PA. The decline in blood glucose levels is less with intermittent high-intensity compared with moderate exercise in individuals with type 1 diabetes. *Diabetes Care* 2005;28:1289–1294
149. Tanenberg RJ, Newton CA, Drake AJ. Confirmation of hypoglycemia in the “dead-in-bed” syndrome, as captured by a retrospective continuous glucose monitoring system. *Endocr Pract* 2010;16:244–248
150. Larsen JJ, Dela F, Madsbad S, Vibe-Petersen J, Galbo H. Interaction of sulfonylureas and exercise on glucose homeostasis in type 2 diabetic patients. *Diabetes Care* 1999;22:1647–1654
151. McDonnell ME. Combination therapy with new targets in type 2 diabetes: a review of available agents with a focus on pre-exercise adjustment. *J Cardiopulm Rehabil Prev* 2007;27:193–201
152. Carter MR, McGinn R, Barrera-Ramirez J, Sigal RJ, Kenny GP. Impairments in local heat loss in type 1 diabetes during exercise in the heat. *Med Sci Sports Exerc* 2014;46:2224–2233
153. Stapleton JM, Yardley JE, Boulay P, Sigal RJ, Kenny GP. Whole-body heat loss during exercise in the heat is not impaired in type 1 diabetes. *Med Sci Sports Exerc* 2013;45:1656–1664
154. Yardley JE, Stapleton JM, Carter MR, Sigal RJ, Kenny GP. Is whole-body thermoregulatory function impaired in type 1 diabetes mellitus? *Curr Diabetes Rev* 2013;9:126–136
155. Yardley JE, Stapleton JM, Sigal RJ, Kenny GP. Do heat events pose a greater health risk for individuals with type 2 diabetes? *Diabetes Technol Ther* 2013;15:520–529
156. Wong AM, Docking SI, Cook JL, Gaida JE. Does type 1 diabetes mellitus affect Achilles tendon response to a 10 km run? A case control study. *BMC Musculoskelet Disord* 2015;16:345–357
157. Ranger TA, Wong AM, Cook JL, Gaida JE. Is there an association between tendinopathy and diabetes mellitus? A systematic review with meta-analysis. *Br J Sports Med* 2016;50:982–989
158. de Oliveira LP, Vieira CP, Guerra FD, Almeida MS, Pimentel ER. Structural and biomechanical changes in the Achilles tendon after chronic treatment with statins. *Food Chem Toxicol* 2015;77:50–57
159. American Diabetes Association. Microvascular complications and foot care. Sec. 9. In *Standards of Medical Care in Diabetes—2016*. *Diabetes Care* 2016;39(Suppl. 1):S72–S80
160. American Diabetes Association. Cardiovascular disease and risk management. Sec. 8. In *Standards of Medical Care in Diabetes—2016*. *Diabetes Care* 2016;39(Suppl. 1):S60–S71
161. McDermott MM, Ades P, Guralnik JM, et al. Treadmill exercise and resistance training in patients with peripheral arterial disease with and without intermittent claudication: a randomized controlled trial. *JAMA* 2009;301:165–174
162. Pena KE, Stopka CB, Barak S, Gertner HR Jr, Carmeli E. Effects of low-intensity exercise on patients with peripheral artery disease. *Phys Sportsmed* 2009;37:106–110
163. Balducci S, Iacobellis G, Parisi L, et al. Exercise training can modify the natural history of diabetic peripheral neuropathy. *J Diabetes Complications* 2006;20:216–223
164. Barn R, Waaijman R, Nollet F, Woodburn J, Bus SA. Predictors of barefoot plantar pressure during walking in patients with diabetes, peripheral neuropathy and a history of ulceration. *PLoS One* 2015;10:e0117443
165. Lemaster JW, Mueller MJ, Reiber GE, Mehr DR, Madsen RW, Conn VS. Effect of weight-bearing activity on foot ulcer incidence in people with diabetic peripheral neuropathy: feet first randomized controlled trial. *Phys Ther* 2008;88:1385–1398
166. Colberg SR, Vinik AI. Exercising with peripheral or autonomic neuropathy: what health care providers and diabetic patients need to know. *Phys Sportsmed* 2014;42:15–23
167. Colberg SR, Swain DP, Vinik AI. Use of heart rate reserve and rating of perceived exertion to prescribe exercise intensity in diabetic autonomic neuropathy. *Diabetes Care* 2003;26:986–990
168. Wadén J, Tikkanen HK, Forsblom C, et al.; FinnDiane Study Group. Leisure-time physical activity and development and progression of diabetic nephropathy in type 1 diabetes: the FinnDiane Study. *Diabetologia* 2015;58:929–936
169. Robinson-Cohen C, Littman AJ, Duncan GE, et al. Physical activity and change in estimated GFR among persons with CKD. *J Am Soc Nephrol* 2014;25:399–406
170. Look AHEAD Research Group. Effect of a long-term behavioural weight loss intervention on nephropathy in overweight or obese adults with type 2 diabetes: a secondary analysis of the Look AHEAD randomised clinical trial. *Lancet Diabetes Endocrinol* 2014;2:801–809
171. Koh KP, Fassett RG, Sharman JE, Coombes JS, Williams AD. Effect of intradialytic versus home-based aerobic exercise training on physical function and vascular parameters in hemodialysis patients: a randomized pilot study. *Am J Kidney Dis* 2010;55:88–99
172. Behm DG, Blazevich AJ, Kay AD, McHugh M. Acute effects of muscle stretching on physical performance, range of motion, and injury incidence in healthy active individuals: a systematic review. *Appl Physiol Nutr Metab* 2016;41:1–11
173. Avery L, Flynn D, van Wersch A, Sniehotta FF, Trenell MI. Changing physical activity behavior in type 2 diabetes: a systematic review and meta-analysis of behavioral interventions. *Diabetes Care* 2012;35:2681–2689
174. Müller N, Stengel D, Kloos C, Ristow M, Wolf G, Müller UA. Improvement of HbA(1c) and stable weight loss 2 years after an outpatient treatment and teaching program for patients with type 2 diabetes without insulin therapy based on urine glucose self-monitoring. *Int J Gen Med* 2012;5:241–247
175. Avery L, Flynn D, Dombrowski SU, van Wersch A, Sniehotta FF, Trenell MI. Successful behavioural strategies to increase physical activity and improve glucose control in adults with type 2 diabetes. *Diabet Med* 2015;32:1058–1062
176. Ekong G, Kavookjian J. Motivational interviewing and outcomes in adults with type 2 diabetes: a systematic review. *Patient Educ Couns* 2016;99:944–952
177. Greaves CJ, Sheppard KE, Abraham C, et al.; IMAGE Study Group. Systematic review of reviews of intervention components associated with increased effectiveness in dietary and physical activity interventions. *BMC Public Health* 2011;11:119
178. Qiu S, Cai X, Chen X, Yang B, Sun Z. Step counter use in type 2 diabetes: a meta-analysis of randomized controlled trials. *BMC Med* 2014;12:36
179. Tudor-Locke C, Craig CL, Brown WJ, et al. How many steps/day are enough? For adults. *Int J Behav Nutr Phys Act* 2011;8:79
180. Tudor-Locke C, Craig CL, Aoyagi Y, et al. How many steps/day are enough? For older adults and special populations. *Int J Behav Nutr Phys Act* 2011;8:80
181. Tudor-Locke C, Craig CL, Thyfault JP, Spence JC. A step-defined sedentary lifestyle index: <5000 steps/day. *Appl Physiol Nutr Metab* 2013;38:100–114
182. Tudor-Locke C, Leonardi C, Johnson WD, Katzmarzyk PT, Church TS. Accelerometer steps/day translation of moderate-to-vigorous activity. *Prev Med* 2011;53:31–33
183. Lyons EJ, Lewis ZH, Mayrsohn BG, Rowland JL. Behavior change techniques implemented in electronic lifestyle activity monitors: a systematic content analysis. *J Med Internet Res* 2014;16:e192
184. Connelly J, Kirk A, Masthoff J, MacRury S. The use of technology to promote physical activity in type 2 diabetes management: a systematic review. *Diabet Med* 2013;30:1420–1432
185. Merolli M, Gray K, Martin-Sanchez F. Health outcomes and related effects of using social media in chronic disease management: a literature review and analysis of affordances. *J Biomed Inform* 2013;46:957–969