Introduction: For vast majority of Georgian people the cost of healthcare is mostly paid by private insurance or services out-of-pocket. The costs associated with this pattern of payment vastly reduce the access to healthcare for people with chronic diseases.

Clinical Case: This is the case study of one of the ordinary Georgian patient. Mr. B is 64 years old man, who was diagnosed type 2 diabetes 15 years ago. He has medical history of myocardial infarction (MI) at the age 58 and arterial hypertension II degree from the age 51. His last visit to endocrinologist was 3 years ago. Since then he is taking metformin 2000 mg/day, glimepiride 2 mg/day and prescription from cardiologist: atorvastatin, ACE inhibitors and cardioaspirin. He came to the clinic with several complaints, such as: fatigue and excessive sweeting during nighttime. As the patient has low income we could not perform all necessary blood tests, but choose the ones with greater informational value. The lab answers revealed that patient’s HbA1c was 7.3%; he had elevated transaminase levels ($1.5$ fold from ULN) and microalbumin and glucose in the urinalysis. According to HbA1c levels glycaemia goal was achieved for this patient, but we wondered why he had excessive sweeting and glucose in urine if everything was normal?! We asked for the glucose profile, which showed glycemic variability during the whole day and night. Glycemic variability explained the false normal HbA1c level. The next step was to choose the appropriate treatment that will individually fit our patient. What does the modern international guidelines recommend for this particular situation? Unfortunately nothing! This case is an example that every diabetes is different from each other and individual treatment is important in achieving goal for each patient. We pay attention on long duration of the disease, glucose variability, elevated risk factors of cardio-vascular disease, impaired liver function tests, mild diabetic nephropathy and low income. According to all this factors we choose low doses of basal insulin (that is paid by government) and SU with lower risks. After 2 weeks patient showed glucose profile without any significant improvement. After 1 month we prescribed DPP-4 inhibitors instead SU and the results were much more better after 2 weeks. Importantly patient did not feel any discomfort with this regimen and was happy with chosen treatment in spite of high price of this new antihyperglycemic agents.

Conclusion: Guidelines not always show the right treatment direction and individual based approach is very important for each patient with type 2 diabetes.