

Summary of Standards of Medical Care in Diabetes – 2010

Key concepts in setting glycemic controls: Goals should be individualized; certain populations (children, pregnant women, and elderly) require special considerations; less intensive glycemic goals may be indicated in patients with severe or frequent hypoglycemia; more intensive glycemic goals may further reduce microvascular complications at the cost of increasing hypoglycemia; postprandial glucose may be targeted if A1C goals are not met despite reaching preprandial glucose goals. A1C screening: To test for diabetes or to assess risk of future diabetes, either A1C, FPG, or 2-h 75-g OGTT are appropriate. An A1C level of 5.7% to 6.4% indicates increased risk for diabetes. An A1C level of 6.5% or higher indicates the presence of diabetes.

Minimal standards

| Exam/test | Type 1 | Type 2 |
|---|---|---|
| Complete exam | To classify the patient, detect complications, develop a management plan, and provide a basis for continuing care | |
| Office visits | Quarterly, but dictated by severity of condition and response to treatment | |
| A1C Goal: A1C <7.0% | Quarterly, then 2x/year when stable; more stringent goals (<6.0%) may further reduce complications at the cost of increased risk of hypoglycemia and may be considered in individual patients. | |
| Weight | Each visit | |
| Foot examination | Visual inspection at each visit – comprehensive exam annually | |
| Blood pressure: systolic <130mm Hg, diastolic <80 mm Hg | Each visit; ACE-I or ARB recommended for treatment of hypertension | |
| Dilated eye exam by an ophthalmologist or optometrist who is knowledgeable and experienced in diagnosing the presence of diabetic retinopathy and is aware of its management. | Within 3-5 years after onset of diabetes once patient is age 10 years or older, then annually; less frequent exams (q2-3 years) may be considered when eye exam normal. | Shortly after diagnosis, then annually; less frequent exams (q2-3 years) may be considered when eye exam normal. |
| Lipid profile goals: <100 mg/dl LDL if high risk, <70 mg/dl LDL if very high risk, ¹ >40 mg/dl HDL in men, >50 mg/dl HDL in women may be appropriate, <150 mg/dl triglycerides | Annually – more often if needed to achieve goals. Every 2 years if low risk (LDL <100, HDL >50, triglycerides <150). In people with diabetes over the age of 40 with a total cholesterol ≥135 mg/dl, statin therapy to achieve an LDL reduction of ~30% regardless of baseline LDL levels may be appropriate. Statin therapy should be added to lifestyle therapy, regardless of baseline lipid levels, for diabetic patients: <ul style="list-style-type: none"> • With overt CVD • Without CVD who are over the age of 40 years and have one or more other CVD risk factors | |
| Urine microalbumin/creatinine (random testing is preferred method) 24-h collection: <30 mg/24h Timed collection: <20 mcg/min Spot collection: <30 mg/g Cr | Should begin after five years' duration, then annually; ACE-I or ARB recommended for treatment of microalbuminuria when 2 of 3 tests are elevated within a 6-month period. | At diagnosis and annually; ACE-I or ARB recommended for treatment of microalbuminuria when 2 of 3 tests are elevated within a 6-month period. |
| Influenza immunization | Annually after 6 months of age | |
| Pneumonia immunization | Once unless given more than 5 years before age 65 or immunocompromised | |
| Preconception and family-planning counseling | As needed. Women with gestational diabetes should be screened for diabetes 6 or 12 weeks postpartum and should have a subsequent screening for the development of diabetes or prediabetes. | |
| Self-care education | At least once, update as needed | |
| Self-monitored blood glucose Goals for plasma values ² Preprandial glucose 90-130 mg/dl Peak post-prandial glucose <180 mg/dl | Three or more times daily for patients using multiple insulin injections or insulin pump therapy | As needed to maintain glycemic control; may need to check postprandially for glucose |
| Aspirin therapy 75-162 mg/day | For all ≥ 40 years old or for all ≥ 30 years old for secondary prevention ³ or those with cardiovascular risk factors. ⁴ For all with type 1 or type 2 with increased cardiovascular risk for primary prevention, including men > age 50 and women > age 60; as secondary prevention for all with history of CVD. | |
| Smoking cessation | Aid patient in nicotine cessation each visit, if indicated | |
| Review self-management goals | Each visit | |
| Hypothyroidism screening | Screen for thyroid peroxidase and thyroglobulin antibodies at diagnosis. TSH should be rechecked every 1-2 years or with symptoms of thyroid dysfunction. Free T4 should be measured if TSH abnormal. | |

1 Level of Evidence B

2 Individual patient goals may vary based on the patient's ability to understand and carry out the treatment regimen, risk for hypoglycemia, and other factors such as very young or old age, end-stage renal disease, advanced cardiovascular or cerebrovascular disease, or other coexisting diseases that will shorten life expectancy.

3 Use for secondary prevention in diabetic men and women who have evidence of large vessel disease. This includes those with history of myocardial infarction, vascular bypass procedure, stroke or transient ischemic attack, peripheral vascular disease, claudication, and/or angina.

4 High risk: Family history of coronary artery disease, cigarette smoking, hypertension, obesity, albuminuria, hyperlipidemia, and/or age > 40 years.

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