

JOSLIN DIABETES CENTER & JOSLIN CLINIC
CLINICAL GUIDELINE FOR ADULTS WITH DIABETES
4/3/09

The Joslin Clinical Guideline for Adults with Diabetes is designed to assist primary care physicians and specialists individualize the care of, and set goals for adult, non-pregnant patients with diabetes. This Guideline focuses on the unique needs of the patient with diabetes. It is not intended to replace sound medical judgment or clinical decision-making and may need to be adapted for certain patient care situations where more or less stringent interventions are necessary. The objectives of the Joslin Clinical Diabetes Guidelines are to support clinical practice and to influence clinical behaviors in order to improve clinical outcomes and assure that patient expectations are reasonable and informed. Guidelines are developed and approved through the Clinical Oversight Committee that reports to the Medical Director of Joslin Diabetes Center. The Clinical Guidelines are established after careful review of current evidence, medical literature and sound clinical practice. This Guideline will be reviewed periodically and modified as clinical practice evolves and medical evidence suggests.

Joslin's Guidelines are evidence-based; in order to allow the user to evaluate the quality of the evidence used to support each standard of care, a modification of the GRADE system has been adopted. The table provided on page 10 describes the categories in which methodological quality and strength of recommendations have been classified. Evidence levels are graded 1A through 2C, as indicated in brackets.

A1C

Screen:

Check hemoglobin A1C (A1C) 2-4 times a year as part of the scheduled medical visit, with frequency dependent upon revision of treatment program and the need to reinforce behavior changes. Increase frequency when therapy has changed and/or when glycemic goals are not met. Having the A1C result at the time of the visit can be useful in making timely treatment decisions. [1C]

Goal:

The true goal of care is to bring the A1C as close to normal as safely possible. [1C]

A goal of < 7% is chosen as a practical level for most patients using medications that may cause hypoglycemia to avoid the risk of that complication. Achieving normal blood glucose is recommended if it can be done practically and safely. [1B]

Patients should be educated in the translation of their A1C level into their estimated average glucose level (eAG), based upon the work of the A1C Derived Average Glucose Study (ADAG).

Joslin's A1C goal is consistent with that of the ADA. Other expert panels, such as AACE/IDF suggested in August 2001, that the goal of treatment should be $\leq 6.5\%$.

A1C target goal should be individualized for each patient; aiming to achieve the lowest possible level may be modified based upon presence or absence of microvascular and/or cardiovascular complications, cognitive status and life expectancy. [1A]

For patients with longstanding type 2 diabetes with pre-existing CVD, or high CAD risk (diabetes + 2 or more

additional risk factors), consider loosening A1C goals to maintain safety [1B]. (See section on *Glucose Monitoring*)

Treatment:

If A1C is $\geq 7\%$ and $< 8\%$, or above the individualized goal for 6 or more months:

- Review and clarify the management plan with the patient with attention to:
 - meal plan [1B]
 - activity program [1A]
 - medication administration schedule, technique and practices [1A]
 - self-monitoring blood glucose (SMBG) schedule and technique [1A]
 - treatment for hypoglycemia and hyperglycemia
 - sick day management practices
- Reassess goals and adjust medication as needed [1A]
- Communicate individualized glycemic goals to patient
- Consider referring patient to diabetes educator (DE) for evaluation, diabetes self-management education (DSME) and ongoing consultation [2A]
- Consider referral to registered dietitian (RD) for medical nutrition therapy (MNT) [2B]
- Schedule follow-up appointment within 3-4 months or more frequently as situation dictates

If A1C is $\geq 8\%$

- Review and clarify the plan as previously noted [1B]
- Assess for psychosocial stress [1C]
- Refer patient to DE for evaluation, DSME and ongoing consultation. Document reason if no referral initiated. [1A]
- Intensify therapy
- Refer patient to RD for MNT [1B]
- Communicate individualized glycemic goals to patient

If history of severe hypoglycemia or hypoglycemia unawareness (a condition in which the patient is unable to recognize symptoms of hypoglycemia until they become severe):

- Assess for changes in daily routine such as decreased food intake or increased activity [1C]
- Refer to DE for evaluation, DSME and hypoglycemia prevention; encourage family/friend attendance
- Review use of glucagon
- Consider loosening A1C goal [2C]
- Communicate goals to patient
- Adjust medications accordingly
- If insulin-treated, consider use of a more physiologic insulin replacement program [1C]
- Consider and screen for other medical causes [1C]
- Consider referral for blood glucose awareness training, if available [1B]
- Schedule follow-up appointment within 1-2 months. If history of recent, severe hypoglycemia or change in pattern of hypoglycemia, recommend increase in frequency of communicating blood glucose levels to provider or diabetes educator [1B]

GLUCOSE MONITORING

Self-monitoring of blood glucose (SMBG) is an important component of the treatment program for all people with diabetes. Its use is to gauge treatment efficacy, help in treatment design, provide feedback on the impact of nutritional intake and activity, provide patterns that assist in medication selection, and for those on insulin, assist in daily dose adjustments. [1A]

Goals for glycemic control for people with diabetes are:

- Fasting plasma glucose: 70-130 mg/dl
- 2- hour postprandial plasma glucose: <180 mg/dl
- Bedtime glucose: 90-150 mg/dl

The frequency of SMBG is highly individualized and should be based on such factors as glucose goals, medication changes and patient motivation. Most patients with type 1 diabetes should monitor at least 3 times per day [1A]; for patients with type 2 diabetes, the frequency of monitoring is dependent upon such factors as mode of treatment and level of glycemic control. [1C]

To obtain meaningful data for treatment decisions, it is helpful for the patient to monitor for several consecutive days (e.g., 2-4 days). In addition to obtaining fasting and preprandial glucose levels, consider glucose readings 2-3 hours postprandially, as postprandial hyperglycemia has been implicated as a cardiovascular risk factor. [1B]

Postprandial monitoring is particularly recommended for patients who:

- Have an elevated A1C but fasting glucose is at target.

- Are initiating intensive (physiologic) insulin treatment programs
- Are experiencing problems with glycemic control
- Are using glucose-lowering agents targeted at postprandial glucose levels
- Are making meal planning or activity adjustments

1-hour postprandial glucose monitoring should be considered:

- During pregnancy
- For those patients using alpha-glucosidase inhibitors

Encourage the patient to bring SMBG results (written record or meter for downloading) to each visit for review with provider/educator.

Alternate Site Monitoring

Blood glucose levels from sites such as the upper arm, forearm, and thigh may lag behind samples taken from the fingertips particularly when glucose levels are changing rapidly. Glucose levels may change rapidly with exercise, eating, after insulin administration or with hypoglycemia. For this reason, alternate site testing is not recommended in the following situations:

- When the blood glucose may be changing rapidly
- For patients using intensive insulin treatment programs
- If hypoglycemia is suspected
- In patients with hypoglycemia unawareness

HYPOGLYCEMIA

Prompt action is recommended for the treatment of hypoglycemia. When possible, the patient should confirm symptoms with SMBG to document hypoglycemia. All patients with type 1 diabetes should ensure that a family member /companion/caregiver knows how to administer a glucagon injection in the event the patient is unable or unwilling to take carbohydrate orally. [1C]

Symptoms of hypoglycemia include: sweating, tremor, palpitations, dizziness, confusion, tiredness, inability to concentrate, difficulty speaking.

Treatment:

- Treat as mild-moderate hypoglycemia if patient is symptomatic or unable to confirm hypoglycemia with SMBG, or if blood glucose levels are < 70 mg/dl (< 90 mg/dl at bedtime or overnight).
- Caution patient to avoid alternate site monitoring with blood glucose meter when hypoglycemic.
- For mild to moderate hypoglycemia (plasma glucose 51-70 mg/dl most times of the day and < 90 mg/dl bedtime or overnight), begin with 15-20 grams carbohydrate (1/2 cup juice or regular soft drink, 3-4 glucose tabs, or 8-10 hard candies). If glucose level is ≤ 50 mg/dl, consume 20 – 30 grams carbohydrate. [1C]

- Recheck blood glucose after 15 minutes. [1B]
- Repeat hypoglycemia treatment if blood glucose does not return to normal range after 15 minutes. [1C]
- Follow with additional carbohydrate or snack if next meal is more than one hour away. [1C]
- If hypoglycemia persists after second treatment, patient or companion should be instructed to contact healthcare provider.
- In event of severe hypoglycemia (altered consciousness, unable to take carbohydrate orally, or requiring the assistance of another person) treat with glucagon and/or intravenous glucose. [1C]
- For patients with hypoglycemia unawareness, the threshold for treatment of hypoglycemia needs to be individualized. [2C]
- For patients using real-time continuous glucose monitoring, check 15 minutes post treatment using a finger stick and not the sensor reading. Due to the physiologic lag between blood and interstitial glucose, the sensor will yield a lower result and can lead to over-treatment.

Education:

- Instruct patient to obtain and wear or carry diabetes identification.
- Inform patient of need to check blood glucose before driving, periodically during a long drive, and when operating heavy machinery. [1B]
- Instruct patient to carry treatment for hypoglycemia at all times.
- Identify possible causes of hypoglycemia in order to prevent it. [1C]
- Be clear in communicating modified treatment goals in individuals with hypoglycemia unawareness (see section in guideline on *Hypoglycemia Unawareness*). [1C]

DIABETES SELF-MANAGEMENT EDUCATION (DSME) and MEDICAL NUTRITION THERAPY (MNT)

Individuals with newly diagnosed diabetes should receive:

- DSME according to National Standards for Diabetes Self-Management Education [1A]
- Individualized Medical Nutrition Therapy (MNT) [1A]
- Multiple visits to evaluate progress towards goals [1A]

Individuals with existing diabetes should receive:

- An annual assessment of the need for DSME and MNT, and referral, as appropriate, to a trained Diabetes Educator (DE) [2B]
- Initial and ongoing assessment of psychosocial issues [1C]

PHYSICAL ACTIVITY

Physical activity should be an integral component of the diabetes care plan to optimize glucose control, decrease cardiovascular risk factors, and achieve or maintain optimal body weight.[1B]

A minimum of 150-175 minutes of moderate intensity physical activity/week should be achieved unless contraindicated. A target of 60-90 minutes, 6-7 days per week is encouraged, to lose weight. [1B]

To increase lean body mass, resistance training should be incorporated into the activity plan every other day, and include upper, core and lower body strengthening exercises using free weights, resistance machines or resistance bands. Stretching exercises should be done when muscles are warm or at the end of the activity plan to loosen muscles and prevent soreness.[1B]

RENAL DISEASE AND MICRO-MACRO ALBUMINURIA

Screen:

Measure serum creatinine at least annually to estimate glomerular filtration rate (GFR) regardless of degree of urine albumin excretion. (See *Guideline for Specialty Consultation/Referral*). [1C]

Estimate GFR (eGFR) using the MDRD equation. If eGFR is <60 ml/min, evaluate for complications of kidney disease (anemia, hyperparathyroidism, and vitamin D deficiency).

Consider referral to nephrologist to:

- Assess cause(s) of impaired kidney function including assessing for nondiabetes kidney disease.
- Maximize therapies aimed at slowing progression of kidney disease (e.g., blood pressure control and reduction of urine protein level)
- Treat complications of kidney disease.

Screen for micro/macro albuminuria by checking urine albumin/creatinine (A/C) ratio as follows:

- Type 1 patients within 5 years after diagnosis and then yearly [1C]
- Type 2 patients at diagnosis (after glucose has been stabilized) and then yearly [1C]
- Annually in all patients up to age 70 years [2C]
- As clinically indicated in patients > 70 years of age

Micro/macro albuminuria is recognized as a major independent risk factor for CAD in patients with diabetes. Albuminuria may be measured with a spot or timed urine collection. Spot urine is preferred for simplicity.

Continue use of routine urinalysis as clinically indicated. [2C]

Treatment:**If A/C ratio < 30 mcg/mg or timed urine < 30 mg/24 hr**

- Recheck in 1 year

If A/C ratio 30-300 mcg/mg or timed urine 30-300 mg/24 hr

- Confirm presence of microalbuminuria with at least 2 of 3 positive collections done within 3-6 months. In the process, rule out confounding factors that cause a false-positive such as UTI, pregnancy, excessive exercise, menses or severe hypoglycemic event. [1C] Consider testing first morning urine.
- Consider consult with nephrology team for blood pressure control, successive increases in microalbumin and other issues (i.e., GFR < 60 ml/min) [2C]

Once confirmed:

- Evaluate BP and initiate/modify aggressive blood pressure treatment to achieve a BP of < 130/80 mmHg [1A]
- Recommend patient self-monitor BP with portable cuff and maintain a record/log. The monitoring schedule should be determined with the healthcare provider and is based on patient circumstance.
- Strive to improve glycemic control with an optimal goal A1C of < 7% or as otherwise clinically indicated for individual patients [1A]
- Refer to diabetes educator for glucose management
- Initiate/ modify ACE inhibitor or angiotensin II antagonist treatment if microalbuminuria persists. Check K⁺ and creatinine 1-2 weeks after making changes. [1A]
- Repeat A/C ratio at least every 6 months. Consider increase in frequency when changes in medication are made. [2C]

If A/C ratio > 300 mcg/mg (> 300 mg/24 hr) or proteinuria (positive dipstick for protein or ≥ 30 mg/dl)

- Follow all guidelines as stated for A/C ratio 30-300 mcg/mg
- Consider BP goal of < 125/75 mmHg [2B]
- Consult with nephrologist if: [1C]
 - 1) Rapid rise in serum creatinine, abnormal sediment, or sudden increase in proteinuria
 - 2) eGFR < 60 ml/min. Estimated GFR is calculated by using the serum creatinine level and applying it to an accepted formula (e.g, MDRD Equation).
 - 3) Need to refine treatment program to prevent further deterioration
 - 4) Problems with ACE inhibitors, difficulties in management of high BP, or hyperkalemia
 - 5) Etiology of nephropathy is questionable
 - 6) Management of hyperphosphatemia presents difficulties
 - 7) Anemia due to renal disease
- Consider reducing protein in the diet [1B]

CARDIOVASCULAR HEALTH

(Also see sections on *Lipids, Blood Pressure, Physical Activity and Smoking*)

Treatment:

A daily enteric-coated ASA (75-325 mg unless contraindicated **) as a primary prevention strategy for everyone > 40 years of age [2B] and for men and women ≥ 30 years of age [2B] with ONE or more of the following risk factors:

- Family history of premature* CAD or stroke
- HTN
- Current cigarette smoker
- Micro/macro albuminuria
- Hyperlipidemia

*Premature – 1st degree male relatives younger than 55; 1st degree female relatives younger than 65

Recommend a daily enteric-coated ASA (75-325 mg) or clopidogrel (75 mg, if aspirin intolerant) as a secondary prevention strategy for anyone with ONE or more of the following:[1A]

- History of MI, angina, or documented CAD
- Vascular bypass
- Non-hemorrhagic stroke
- TIA
- PVD

**Possible contraindications for antiplatelet therapy may include allergy, bleeding tendency, anticoagulant therapy, recent gastrointestinal bleeding and clinically active hepatic disease. Eye disease is usually not a contraindication for ASA therapy.

Consider using beta-blocker in all patients with a history of MI or with documented CAD unless contraindicated. [1A]

Consider recommending aerobic exercise if not clinically contraindicated and a weight-loss program if patient is overweight or obese. [1A]

Consider using ACE inhibitors (or ARBs if ACE inhibitors not tolerated) in patients with known CAD or cardiovascular risk factors and age 55 or greater. [1A]

Thiazolidinediones (pioglitazone, rosiglitazone) are contraindicated in patients with NYHA class 3 and 4 and conditions of fluid overload (i.e., CHF).

A meta-analysis of clinical studies showed rosiglitazone to be associated with an increased risk of myocardial ischemic events such as angina or myocardial infarction. Other studies comparing rosiglitazone to some other approved oral antidiabetic agents or placebo, have not confirmed or excluded this risk. The available data on the risk of myocardial ischemia are inconclusive.

LIPIDS

Screen:

Adults should be screened annually for lipid disorders with measurements of serum cholesterol, triglycerides, and LDL and HDL cholesterol, preferably fasting. [1C]

Lipid Goals: (mg/dl)

LDL-Cholesterol (LDL-C):

- < 100 if no diagnosed CVD [1A];
- < 70 if diagnosed CVD [1B]

HDL-Cholesterol (HDL-C):

- >40 (men); >50 (women) [2C]

Triglycerides: < 150 (fasting) [2C]

Treatment:

All patients should receive information about a meal plan designed to lower blood glucose and improve lipids, physical activity recommendations, and risk reduction strategies. Consultation with appropriate education discipline is preferred. [1A]

Institute therapy after abnormal values are confirmed.

For patients in whom CVD is not yet diagnosed:

If LDL-C \geq 100 mg/dl

- Optimize glycemic control [1A]
- Refer to RD for intensive dietary modification and therapeutic lifestyle changes (TLC) [1A]
- Consider referral to exercise specialist or DE for exercise prescription
- Recheck lipids within 6 weeks
- If LDL-C remains >100, initiate medication with goal of lowering LDL-C to < 100, preferably with a statin, or by ~ 30-40% if goal not achieved by maximally tolerated statin therapy
- Consider bile acid sequestrant or cholesterol absorption inhibitors or niacin (alone, or in combination therapy) for patients with statin intolerance or unacceptable adverse event.

If LDL-C < 100 mg/dl:

Consider statin therapy if age > 40 yrs and one more CVD risk factor is present (hypertension, smoking, albuminuria or family history of premature CVD). [1A]

Patients with LDL-C < 100 mg/dl and fasting triglycerides \geq 150 mg/dl or HDL-C \leq 40 mg/dl

- Optimize glycemic control [1A]
- Refer to RD for dietary modification and therapeutic lifestyle changes (TLC) [1A]
- Consider referral to exercise specialist for exercise prescription
- Recheck lipids within 6 weeks
- Consider medication if fasting triglycerides >200 mg/dl and/or HDL-C \leq 40 mg/dl (fibrate preferred if fasting triglycerides > 500 mg/dl) [2C]

- In patients with fasting triglyceride levels 200-499 mg/dl, calculate non-HDL-C (total cholesterol minus HDL-C) and consider starting or titrating statin if non-HDL-C >130 [1C]
- Consider adding fibrate or niacin if fasting triglycerides > 200 and/or HDL-C \leq 40 mg/dl, and LDL/non-HDL-C is at goal. [2C]
- Initiate treatment with very low fat diet and fibrate if triglycerides > 1000 mg/dl for prophylaxis against acute pancreatitis; rule-out other secondary causes; reassess lipid status when triglycerides < 500 mg/dl. [1A]
- If triglycerides remain > 500 after initiation of fibrates and/or niacin, consider the addition of fish oil.

Patients with cardiovascular disease (CVD):

If LDL-C \geq 70 mg/dl:

- Optimize glycemic control [1A]
- Refer to RD for intensive dietary modification and therapeutic lifestyle changes (TLC) [1A]
- Consider referral to exercise specialist or DE for exercise prescription [1A]
 - The decision for the specific level or type of exercise may depend upon the results of cardiac stress tests or specific clearance by a cardiologist
- Consider starting lipid lowering agent (preferably statin) immediately if LDL-C is > 100. [1A]
- Recheck lipids within 6 weeks.
- If LDL-C remains > 70, initiate medication (preferably a statin) with goal of lowering LDL-C to < 70, or by ~ 30-40% if goal not achieved by maximally tolerated statin therapy [1A]. May require combination of statin with another lipid lowering agent to achieve this goal. [1B]
- Consider bile acid sequestrant or cholesterol absorption inhibitors or niacin, alone, or in combination therapy, for patients with statin intolerance or unacceptable adverse event
- Consider adding niacin or fibrate if triglycerides >200 and/or HDL-C < 40mg/dl, and LDL at goal.

BLOOD PRESSURE

Screen:

- Check BP at all routine visits with patient sitting for 5 minutes. Use proper-sized cuff and arm position. Postural BP should be checked initially, and as clinically indicated, and if orthostatic (defined as a fall in SBP of 20-30 mmHg or DBP of 10-15 mmHg upon change in position) check at each follow-up visit. [1C]
- Consider initiating pharmacologic therapy if initial blood pressure is over 160-180/100.

Goal:

- BP goal for each patient >18 years old is <130/80 mmHg and modified for comorbidities [1B]
- BP goals for patients with proteinuria > 1 gm is < 125/75 mmHg [1C]

- Initial goal for patients with isolated systolic HTN (SBP >180 mmHg & DBP < 80 mmHg) is a SBP <160 mmHg
- Initial goal for patients with SBP 160-179 mmHg is to lower SBP by 20 mmHg. If well tolerated, lower BP goals may be indicated. [1B]
- Strong evidence suggests significant benefits to be gained if BP < 130/80 mmHg [1B]

Treatment:

If SBP 130-139 mmHg or DBP 80-89 mmHg, a 3-month trial of behavioral therapy is warranted as follows: [1C]

- Counsel about meal plan, activity, weight loss, sodium reduction, alcohol and stress reduction
- Consider referral to RD for medical nutrition therapy (MNT)
- Encourage home BP monitoring
- Instruct patient to have BP checked on 3 separate occasions before next appointment
- Follow-up with healthcare provider within 2-4 weeks
- Initiate or adjust therapy with antihypertensive agents as clinically indicated if BP remains above goals.
- Studies have shown that aggressive management and control of blood pressure may result in long-term benefits.

If BP remains > 130/80 mmHg after 3 months of attempted lifestyle modification, or if BP > 140/90 mmHg at initial visit, add a pharmacological agent to behavioral modification.

Drug therapy –Efficaciousness is the most important consideration in choosing an initial anti-hypertensive drug. In that sense, any available antihypertensive drug can be an appropriate choice, however, other considerations (presence of proteinuria, co-existing CAD, or cost) dictate a preference for ACE inhibitors, ARBs, beta-blockers and diuretics. [1A]

ACE inhibitors or ARBs are the drugs of choice, after achieving A1C and blood pressure goals, for patients with urine protein ≥ 30mcg/mg These drugs require monitoring of serum creatinine and K⁺ within 1-2 weeks of starting therapy and periodically thereafter. [1A] (See section on *Renal Disease and Micro-Macro Albuminuria*)

SMOKING

Assess patient’s smoking status on a routine basis.

Treatment: (If patient smokes)

- Discuss rationale for and strongly recommend smoking cessation [1A]
- Review options available to assist in smoking cessation, including medications and cessation programs [1B]

FEET and PERIPHERAL NEUROPATHY

Screen:

Screening should include:

- Questions about loss of sensation in the limbs, or symptoms of pain, tingling or other paresthesia
- Foot evaluation for sensorimotor (monofilament), skin and soft tissues integrity, nail condition, vascular sufficiency (pedal pulses) and biomechanical integrity
- Examination of shoes for wear

Frequency:

- For patients with type 1 and 2 diabetes without complications, conduct foot screen at time of diagnosis and at least annually thereafter [1C]
- For the “at-risk patients,” check feet at all routine interval visits [1C]

“*At-Risk Patients*” include patients who smoke, have vascular insufficiency, neuropathy, retinopathy, nephropathy, history of ulcers or amputations, structural deformities, infections, skin/nail abnormality, are on anticoagulation therapy or who cannot see, feel or reach their feet.

Treatment:

For patients with acute problems or who are “at risk”:

- Refer to podiatrist for routine care and evaluation [1B]
- Refer to DE for foot care training* [1C]
- Consider referral to neurologist for:
 - Atypical neuropathy
 - Rapidly progressive symptoms
 - Severe pain unresponsive to first line therapy
 - Weakness suggestive of diabetic amyotrophy

* *Foot care training* will include information about:

- avoidance of foot trauma
- daily foot inspection
- nail care
- proper footwear
- impact of loss of protective sensation on morbidity
- need to stop smoking
- action to take when problems arise
- importance of glucose control on disease progression

For current ulcer or infection: mild** [1C]

** *Mild Infection or Ulcer*

Superficial (no foul odor)	No significant ischemia
No bone or joint involvement	No systemic toxicity
Minimal or no cellulitis (< 2 cm)	

- Instruct patient in non-weight bearing, if appropriate
- Apply local dressings
- Consider baseline x-ray to evaluate for bone integrity and possible osteomyelitis
- Consider systemic antibiotic therapy
- Refer to podiatrist for debridement or further treatment
- Refer for foot care training
- Ensure follow-up appointments are kept

For limb-threatening* ulcer or infection:** [1C]

*** Limb-threatening:

Deep ulcer	Bone or joint involvement
Gangrene	Lymphangitis
> 2 cm cellulitis	Systemic toxicity
Significant ischemia	No social support system
Immunocompromised	Foul odor in ulcer
Osteomyelitis, presumed to be present if probed to the bone.	

- Consider hospitalization
- Refer to a podiatrist and vascular surgeon for immediate evaluation and treatment

EYES

Exam Schedule:

Refer patient for comprehensive dilated eye exam or validated retinal imaging to determine level of retinopathy.

- Type 1: initial eye exam within 3 years after diagnosis of diabetes once patient is 9 years of age or older and annually thereafter. [1B]
- Type 2: at diagnosis and annually thereafter [1B]
- Pregnancy in pre-existing diabetes: prior to conception and during first trimester with follow-up as determined by first trimester exam and 6-12 weeks post partum. [1B]

For physiologic insulin therapy (pump therapy or multiple daily injections): consult with patient's eye doctor or evaluate retinal status with validated retinal imaging to determine level of retinopathy and appropriate follow-up care prior to initiating physiologic insulin therapy.

Treatment:

Aggressively treat known medical risk factors for retinopathy: [1A]

- Strive to improve glycemic control with optimal A1C goal of < 7%
- Monitor eye disease carefully when intensifying glycemic control
- Strive for BP <130/80 mmHg
- Treat micro/macro albuminuria
- Strive to maintain total cholesterol, LDL, HDL and triglyceride levels as per the recommendations outlined in the *Lipids* Section of the Clinical Guideline
- Treat anemia

Revise activity program depending on the level of retinopathy. Consider consultation with exercise physiologist.

Reinforce follow-up with eye care provider for any level of retinopathy including no apparent retinopathy. The frequency of follow-up is dependent upon the level of retinopathy and is determined by the eye care provider.

- For high-risk proliferative diabetic retinopathy, scatter (panretinal) photocoagulation is indicated promptly [1A]
- For clinically significant macular edema (CSME), focal laser is generally indicated regardless of level of retinopathy [1A]

- The level of diabetic retinopathy and diabetic macular edema (DME) generally determines follow-up* [1A]

If No Diabetic Retinopathy

12 months

If Mild Nonproliferative Diabetic Retinopathy

Without DME 12 months

With DME** 3-4 months

If Moderate Nonproliferative Diabetic Retinopathy

Without DME 6-9 months

With DME** 3-4 months

If Severe - Very Severe Nonproliferative Diabetic Retinopathy

Without DME*** 3-4 months

With DME** 3 months

If Proliferative Diabetic Retinopathy less than High-Risk

Without DME** * 1 week – 3-4 months

With DME** 1 week – 3-4 months

If High-Risk Proliferative Diabetic Retinopathy

With or without DME – scatter laser surgery with follow-up in 3 months

*The presence of known risk factors for onset and progression of retinopathy may suggest follow-up at shorter intervals for all levels of retinopathy

** Focal laser surgery is generally indicated for CSME

*** Scatter laser surgery may be indicated, especially for type 2 diabetes or type 1 diabetes of long duration

Intravitreal steroid and intravitreal anti-VEGF injections are sometimes used in clinical practice to treat macular edema despite no definitive studies on their effectiveness or safety to date. These modalities are currently under rigorous investigation to further define their role.

MENTAL HEALTH

A psychosocial evaluation should be an integrated component of the initial assessment and the ongoing care of all patients with diabetes and should be strongly considered in the following situations:

Newly diagnosed diabetes:

Assess at least the following:

- Ability to cope with the emotional impact and lifestyle changes of diabetes
- Level of social support
- Type and degree of non-diabetes related stress

When changes in treatment, self-care, or metabolic stability as evidenced by:

- Diabetes burnout or lack of adherence with treatment regimen: Consider using PAID as a screening tool.

- Symptoms of depression: Consider using PHQ-9 or PHQ-2 as a screening tool.
- Symptoms of anxiety e.g., compulsive SMBG
- A1C >10% and inquiry indicates insulin mismanagement by the patient (omission or under-dosing)
- Exaggerated fear of hypoglycemia
- Recurrent DKA
- Family conflict related to diabetes
- Substance abuse: Consider use of CAGE alcohol screening tool.

Newly diagnosed complications from diabetes:

Assess at least the following:

- Ability to cope with the emotional impact and lifestyle changes
- Level of social support
- Type and quantity of non-diabetes related stress

IMMUNIZATIONS

Recommend the following vaccines

- Influenza vaccine - yearly for all adult patients with diabetes [1B]
- Pneumococcal vaccine – once for all patients with diabetes. [1B] Patients ≥ 65 years of age should receive a second dose of pneumococcal vaccine if:
 - they received the previous dose ≥ 5 years earlier *and*
 - they were < 65 years of age when they received the previous dose

WOMEN'S HEALTH

(Refer to Joslin's *Guideline for Detection and management of Diabetes in Pregnancy* for more details)

- Counsel women with the potential for conception about contraception use and relationship of blood glucose control to fetal development and pregnancy outcomes [1C]
- Follow appropriate guidelines for pap/pelvic and mammography screening for primary care patients [1A]
- Individualize approach to bone health for women with risk factors for osteoporosis, including surgical and natural menopause [1B]

- Assess for infections or hormonal, psychological, or structural etiologies if sexual dysfunction exists. Refer to specialist as indicated. [1C]

MEN'S HEALTH

- At initial and annual visit, discuss sexual function.
- Assess for hormonal, psychological, or structural etiologies if dysfunction exists. [1C]
- For men with type 2 diabetes, screen for secondary hypogonadism. [2B]
- Refer to specialist as indicated.

DENTAL CARE

At initial visit and annually, discuss need for dental exams at least every six months. If evidence of gingivitis, may need dental evaluation/treatment every 3-4 months.

Refer to dental specialist if oral symptoms such as sore, swollen, or bleeding gums, loose teeth or persistent mouth ulcers occur. [1C]

UTILIZATION: VISIT ATTENDANCE

If patient fails to keep scheduled appointments, has frequent hospitalizations or missed days of work/school:

Since many factors contribute to patients' ability to manage their care, the provider should:

- Engage patient in identifying and resolving contributing factors or barriers to under-utilization or over-utilization of healthcare services
- Consider referral to DE, social service or mental health professional to address possible underlying psychosocial problems
- Establish a process for follow-up communication regarding lapsed services

List of Abbreviations

Page 1

A1C: glycohemoglobin (hemoglobin A_{1c})
 AACE: American Association of Clinical Endocrinologists
 ADA: American Diabetes Association
 ADAG A1c-Derived Average Glucose study
 CAD: coronary artery disease
 CVD: cardiovascular disease
 DCCT: Diabetes Control and Complication Trial
 DE: diabetes educator
 DSME: diabetes self-management education
 eAG: estimated average blood glucose
 eGFR: estimated glomerular filtration rate
 IDF: International Diabetes Federation
 IFCC: International Federation of Clinical Chemistry and Laboratory Medicine
 MNT: medical nutrition therapy
 NGSP: National Glycohemoglobin Standardization Program
 RD: registered dietitian
 SMBG: self-monitoring of blood glucose

Page 3

A/C Ratio: albumin/creatinine ratio
 GFR: glomerular filtration rate
 MDRD: Modification of diet in renal disease study equation
http://nkdep.nih.gov/professionals/gfr_calculators/orig_con.htm

Page 4

ACE inhibitor: angiotensin-converting enzyme inhibitor
 ARBs: angiotensin receptor blockers
 ASA: aspirin
 BP: blood pressure
 CHF: Congestive heart failure
 CVD: cardiovascular disease, including coronary heart disease, peripheral vascular disease, and cerebrovascular disease
 HDL-C: high-density lipoprotein cholesterol
 HTN: hypertension
 K⁺: potassium
 LDL-C: low-density lipoprotein cholesterol
 MI: myocardial infarction
 NYHA: New York Heart Association
 PVD: peripheral vascular disease
 TIA: transient ischemic attack
 TLC: therapeutic lifestyle changes
 UTI: urinary tract infection

Page 5

DBP: diastolic blood pressure
 SBP: systolic blood pressure

Page 7

CSME: clinically significant macular edema
 DME: diabetic macular edema
 CAGE: Alcohol screening questionnaire
 DKA: diabetic ketoacidosis
 PAID: Problem Areas in Diabetes
 PHQ-9: Patient Health Questionnaire, 9 questions
 PHQ-2: Patient Health Questionnaire 2 questions
 VEGF: vascular endothelial growth factor

Approved by the Joslin Clinical Oversight Committee on 04/03/2009

The Joslin Clinical Oversight Committee gratefully acknowledges: Elena Savoia, MD, MPH, Acting Director, Center for Public Health Preparedness, Harvard School of Public Health, Boston, in the supervision of the grading process; and Peter Polewski, graduate student, for his assistance with the literature search and review.

Joslin Clinical Oversight Committee	
Om Ganda, MD - Chairperson	Melinda Maryniuk, MEd, RD, CDE
Richard Beaser, MD	Medha Munshi, MD
Elizabeth Blair, MS, ANP-BC, CDE	Jo- Anne Rizzotto, MEd, RD, CDE
Patty Bonsignore, MS, RN, CDE	Kristi Silver, MD
Amy Campbell, MS, RD, CDE	Susan Sjostrom, JD
Cathy Carver, ANP-BC, CDE	Kenneth Snow, MD
Jerry Cavallerano, OD, PhD	Robert Stanton, MD
David Feinbloom, MD	William Sullivan, MD
Richard Jackson, MD	Howard Wolpert, MD
Lori Laffel, MD, MPH	Martin J. Abrahamson, MD (<i>ex officio</i>)

Grading System Used in Guideline

Grade of Recommendation	Clarity of risk/benefit	Quality of supporting evidence
1A Strong recommendation High quality of evidence	Benefits clearly outweigh risk and vice versa.	Consistent evidence from well performed randomized, controlled trials or overwhelming evidence of some other form. Further research is unlikely to change our confidence in the estimate of benefit and risk.
1B Strong recommendation Moderate quality of evidence	Benefits clearly outweigh risk and burdens, or vice versa.	Evidence from randomized, controlled trials with important limitations (inconsistent results, methodological flaws, indirect or imprecise), or very strong evidence of some other research design. Further research is likely to have an impact on our confidence in the estimate of the benefit and risk and may change the estimate.
1C Strong recommendation Low quality of evidence	Benefits outweigh risk and burdens, or vice versa.	Evidence from observational studies, unsystematic clinical experience, or from randomized controlled trials with serious flaws. Any estimate of effect is uncertain.
2A Weak recommendation High quality of evidence	Benefits closely balanced with risks and burdens.	Consistent evidence from well performed randomized controlled trials or overwhelming evidence of some other form. Further research is unlikely to change our confidence in the estimate of benefit and risk.
2B Weak recommendation Moderate quality of evidence	Benefits closely balanced with risks and burdens; some uncertainty in the estimates of benefits, risks and burdens.	Evidence from randomized controlled trials with important limitations (inconsistent results, methodological flaws, indirect or imprecise), or very strong evidence of some other research design. Further research is likely to have an impact on our confidence in the estimate of benefit and risk and may change the estimate.
2C Weak recommendation Low quality of evidence	Uncertainty in the estimates of benefits, risks and burdens; benefits may be closely balanced with risks and burdens.	Evidence from observational studies, unsystematic clinical experience, or from randomized controlled trials with serious flaws. Any estimate of effect is uncertain.

Evidence graded less than “A” is acceptable to support clinical recommendations in a guideline. It is also assumed that for many important clinical recommendations, it would be unlikely that level A evidence be obtained because appropriate studies may never be performed.

¹Guyatt G et al. Grading strength of recommendations and quality of evidence in clinical guidelines: Report from an American College of Physicians Task Force. *Chest* 129:174-181, 2006.