

Executive Summary: Standards of Medical Care in Diabetes—2011

Current criteria for the diagnosis of diabetes

- A1C $\geq 6.5\%$. The test should be performed in a laboratory using a method that is National Glycohemoglobin Standardization Program (NGSP)-certified and standardized to the Diabetes Control and Complications Trial (DCCT) assay
- fasting plasma glucose (FPG) ≥ 126 mg/dl (7.0 mmol/l). Fasting is defined as no caloric intake for at least 8 h, or
- 2-h plasma glucose ≥ 200 mg/dl (11.1 mmol/l) during an oral glucose tolerance test (OGTT). The test should be performed as described by the World Health Organization, using a glucose load containing the equivalent of 75 g anhydrous glucose dissolved in water
- in a patient with classic symptoms of hyperglycemia or hyperglycemic crisis, a random plasma glucose ≥ 200 mg/dl (11.1 mmol/l)
- in the absence of unequivocal hyperglycemia, result should be confirmed by repeat testing.

Testing for diabetes in asymptomatic patients

- Testing to detect type 2 diabetes and assess risk for future diabetes in asymptomatic people should be considered in adults of any age who are overweight or obese (BMI ≥ 25 kg/m²) and who have one or more additional risk factors for diabetes (see Table 4 of the “Standards of Medical Care in Diabetes—2011”). In those without these risk factors, testing should begin at age 45 years. (B)
- If tests are normal, repeat testing carried out at least at 3-year intervals is reasonable. (E)
- To test for diabetes or to assess risk of future diabetes, A1C, FPG, or 2-h 75-g OGTT are appropriate. (B)
- In those identified with increased risk for future diabetes, identify and, if ap-

propriate, treat other cardiovascular disease (CVD) risk factors. (B)

Detection and diagnosis of gestational diabetes mellitus (GDM)

- Screen for undiagnosed type 2 diabetes at the first prenatal visit in those with risk factors, using standard diagnostic criteria. (B)
- In pregnant women not known to have diabetes, screen for GDM at 24–28 weeks of gestation, using a 75-g 2-h OGTT and the diagnostic cut points in Table 6 of the “Standards of Medical Care in Diabetes—2011”. (B)
- Screen women with GDM for persistent diabetes 6–12 weeks postpartum. (E)
- Women with a history of GDM should have lifelong screening for the development of diabetes or prediabetes at least every 3 years. (E)

Prevention/delay of type 2 diabetes

- Patients with impaired glucose tolerance (IGT) (A), impaired fasting glucose (IFG) (E), or an A1C of 5.7–6.4% (E) should be referred to an effective ongoing support program targeting weight loss of 7% of body weight and increasing physical activity to at least 150 min/week of moderate activity such as walking.
- Follow-up counseling appears to be important for success. (B)
- Based on potential cost-savings of diabetes prevention, such programs should be covered by third-party payors. (E)
- Metformin therapy for prevention of type 2 diabetes may be considered in those at highest risk for developing diabetes, such as those with multiple risk factors, especially if they demonstrate progression of hyperglycemia (e.g. A1C $\geq 6\%$) despite lifestyle interventions. (B)
- Monitoring for the development of di-

abetes in those with prediabetes should be performed every year. (E)

Glucose monitoring

- Self-monitoring of blood glucose (SMBG) should be carried out three or more times daily for patients using multiple insulin injections or insulin pump therapy. (A)
- For patients using less-frequent insulin injections, non-insulin therapies, or medical nutrition therapy (MNT) alone, SMBG may be useful as a guide to the success of therapy. (E)
- To achieve postprandial glucose targets, postprandial SMBG may be appropriate. (E)
- When prescribing SMBG, ensure that patients receive initial instruction in, and routine follow-up evaluation of, SMBG technique and their ability to use data to adjust therapy. (E)
- Continuous glucose monitoring (CGM) in conjunction with intensive insulin regimens can be a useful tool to lower A1C in selected adults (age ≥ 25 years) with type 1 diabetes. (A)
- Although the evidence for A1C-lowering is less strong in children, teens, and younger adults, CGM may be helpful in these groups. Success correlates with adherence to ongoing use of the device. (C)
- CGM may be a supplemental tool to SMBG in those with hypoglycemia unawareness and/or frequent hypoglycemic episodes. (E)

A1C

- Perform the A1C test at least two times a year in patients who are meeting treatment goals (and who have stable glycemic control). (E)
- Perform the A1C test quarterly in patients whose therapy has changed or who are not meeting glycemic goals. (E)
- Use of point-of-care testing for A1C allows for timely decisions on therapy changes, when needed. (E)

Glycemic goals in adults

- Lowering A1C to below or around 7% has been shown to reduce microvascular and neuropathic complications of

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diabetes and, if implemented soon after the diagnosis of diabetes, is associated with long-term reduction in macrovascular disease. Therefore, a reasonable A1C goal for many nonpregnant adults is <7%. (B)

- Because additional analyses from several randomized trials suggest a small but incremental benefit in microvascular outcomes with A1C values closer to normal, providers might reasonably suggest more stringent A1C goals for selected individual patients, if this can be achieved without significant hypoglycemia or other adverse effects of treatment. Such patients might include those with short duration of diabetes, long life expectancy, and no significant cardiovascular disease. (B)
- Conversely, less stringent A1C goals may be appropriate for patients with a history of severe hypoglycemia, limited life expectancy, advanced microvascular or macrovascular complications, extensive comorbid conditions, and those with longstanding diabetes in whom the general goal is difficult to attain despite diabetes self-management education, appropriate glucose monitoring, and effective doses of multiple glucose-lowering agents including insulin. (C)

Diabetes self-management education (DSME)

- People with diabetes should receive DSME according to national standards when their diabetes is diagnosed and as needed thereafter. (B)
- Effective self-management and quality of life are the key outcomes of DSME and should be measured and monitored as part of care. (C)
- DSME should address psychosocial issues, since emotional well-being is associated with positive diabetes outcomes. (C)
- Because DSME can result in cost-savings and improved outcomes (B), DSME should be adequately reimbursed by third-party payors. (E)

Medical nutrition therapy (MNT)

General recommendations

- Individuals who have prediabetes or diabetes should receive individualized MNT as needed to achieve treatment goals, preferably provided by a registered dietitian familiar with the components of diabetes MNT. (A)
- Because MNT can result in cost-savings and improved outcomes (B), MNT

should be adequately covered by insurance and other payors. (E)

Energy balance, overweight, and obesity

- In overweight and obese insulin-resistant individuals, modest weight loss has been shown to reduce insulin resistance. Thus, weight loss is recommended for all overweight or obese individuals who have or are at risk for diabetes. (A)
- For weight loss, either low-carbohydrate, low-fat calorie-restricted, or Mediterranean diets may be effective in the short term (up to 2 years). (A)
- For patients on low-carbohydrate diets, monitor lipid profiles, renal function, and protein intake (in those with nephropathy) and adjust hypoglycemic therapy as needed. (E)
- Physical activity and behavior modification are important components of weight loss programs and are most helpful in maintenance of weight loss. (B)

Recommendations for primary prevention of diabetes

- Among individuals at high risk for developing type 2 diabetes, structured programs that emphasize lifestyle changes that include moderate weight loss (7% of body weight) and regular physical activity (150 min/week), with dietary strategies including reduced calories and reduced intake of dietary fat, can reduce the risk for developing diabetes and are therefore recommended. (A)
- Individuals at high risk for type 2 diabetes should be encouraged to achieve the U.S. Department of Agriculture (USDA) recommendation for dietary fiber (14 g fiber/1,000 kcal) and foods containing whole grains (one-half of grain intake). (B)

Recommendations for management of diabetes: macronutrients in diabetes management

- The best mix of carbohydrate, protein, and fat may be adjusted to meet the metabolic goals and individual preferences of the person with diabetes. (E)
- Monitoring carbohydrate, whether by carbohydrate counting, choices, or experience-based estimation, remains a key strategy in achieving glycemic control. (A)
- For individuals with diabetes, the use of the glycemic index and glycemic load

may provide a modest additional benefit for glycemic control over that observed when total carbohydrate is considered alone. (B)

- Saturated fat intake should be <7% of total calories. (A)
- Reducing intake of *trans* fat lowers LDL cholesterol and increases HDL cholesterol (A); therefore, intake of *trans* fat should be minimized. (E)

Other nutrition recommendations

- If adults with diabetes choose to use alcohol, daily intake should be limited to a moderate amount (one drink per day or less for adult women and two drinks per day or less for adult men). (E)
- Routine supplementation with antioxidants, such as vitamins E and C and carotene, is not advised because of lack of evidence of efficacy and concern related to long-term safety. (A)
- Individualized meal planning should include optimization of food choices to meet recommended daily allowance (RDA)/dietary reference intake (DRI) for all micronutrients. (E)

Physical activity

- People with diabetes should be advised to perform at least 150 min/week of moderate-intensity aerobic physical activity (50–70% of maximum heart rate). (A)
- In the absence of contraindications, people with type 2 diabetes should be encouraged to perform resistance training three times per week. (A)

Psychosocial assessment and care

- Assessment of psychological and social situation should be included as an ongoing part of the medical management of diabetes. (E)
- Psychosocial screening and follow-up should include, but is not limited to, attitudes about the illness, expectations for medical management and outcomes, affect/mood, general and diabetes-related quality of life, resources (financial, social, and emotional), and psychiatric history. (E)
- Screen for psychosocial problems such as depression and diabetes-related distress, anxiety, eating disorders, and cognitive impairment when self-management is poor. (C)

Hypoglycemia

- Glucose (15–20 g) is the preferred treatment for the conscious individual

with hypoglycemia, although any form of carbohydrate that contains glucose may be used. If SMBG 15 min after treatment shows continued hypoglycemia, the treatment should be repeated. Once SMBG glucose returns to normal, the individual should consume a meal or snack to prevent recurrence of hypoglycemia. (E)

- Glucagon should be prescribed for all individuals at significant risk of severe hypoglycemia, and caregivers or family members of these individuals should be instructed in its administration. Glucagon administration is not limited to health care professionals. (E)
- Individuals with hypoglycemia unawareness or one or more episodes of severe hypoglycemia should be advised to raise their glycemic targets to strictly avoid further hypoglycemia for at least several weeks, to partially reverse hypoglycemia unawareness and reduce the risk of future episodes. (B)

Bariatric surgery

- Bariatric surgery may be considered for adults with BMI >35 kg/m² and type 2 diabetes, especially if the diabetes or associated comorbidities are difficult to control with lifestyle and pharmacologic therapy. (B)
- Patients with type 2 diabetes who have undergone bariatric surgery need lifelong lifestyle support and medical monitoring. (E)
- Although small trials have shown glycemic benefit of bariatric surgery in patients with type 2 diabetes and BMI of 30–35 kg/m², there is currently insufficient evidence to generally recommend surgery in patients with BMI <35 kg/m² outside of a research protocol. (E)
- The long-term benefits, cost-effectiveness, and risks of bariatric surgery in individuals with type 2 diabetes should be studied in well-designed controlled trials with optimal medical and lifestyle therapy as the comparator. (E)

Immunization

- Annually provide an influenza vaccine to all diabetic patients ≥ 6 months of age. (C)
- Administer pneumococcal polysaccharide vaccine to all diabetic patients ≥ 2 years of age. A one-time revaccination is recommended for individuals >64 years of age previously immunized when they were <65 years of age if the

vaccine was administered >5 years ago. Other indications for repeat vaccination include nephrotic syndrome, chronic renal disease, and other immunocompromised states, such as after transplantation. (C)

Hypertension/blood pressure control

Screening and diagnosis

- Blood pressure should be measured at every routine diabetes visit. Patients found to have systolic blood pressure ≥ 130 mmHg or diastolic blood pressure ≥ 80 mmHg should have blood pressure confirmed on a separate day. Repeat systolic blood pressure ≥ 130 mmHg or diastolic blood pressure ≥ 80 mmHg confirms a diagnosis of hypertension. (C)

Goals

- A goal systolic blood pressure <130 mmHg is appropriate for most patients with diabetes. (C)
- Based on patient characteristics and response to therapy, higher or lower systolic blood pressure targets may be appropriate. (B)
- Patients with diabetes should be treated to a diastolic blood pressure <80 mmHg. (B)

Treatment

- Patients with a systolic blood pressure of 130–139 mmHg or a diastolic blood pressure of 80–89 mmHg may be given lifestyle therapy alone for a maximum of 3 months and then, if targets are not achieved, be treated with the addition of pharmacological agents. (E)
- Patients with more severe hypertension (systolic blood pressure ≥ 140 or diastolic blood pressure ≥ 90 mmHg) at diagnosis or follow-up should receive pharmacologic therapy in addition to lifestyle therapy. (A)
- Lifestyle therapy for hypertension consists of: weight loss, if overweight; DASH (Dietary Approaches to Stop Hypertension)-style dietary pattern, including reducing sodium and increasing potassium intake; moderation of alcohol intake; and increased physical activity. (B)
- Pharmacologic therapy for patients with diabetes and hypertension should be with a regimen that includes either an ACE inhibitor or an ARB. If one class is not tolerated, the other should be substituted. If needed to achieve blood pressure targets, a thiazide diuretic should be added to those with an esti-

mated glomerular filtration rate (GFR) ≥ 30 ml/min/1.73 m² and a loop diuretic for those with an estimated GFR <30 ml/min/1.73 m². (C)

- Multiple drug therapy (two or more agents at maximal doses) is generally required to achieve blood pressure targets. (B)
- If ACE inhibitors, ARBs, or diuretics are used, kidney function and serum potassium levels should be monitored. (E)
- In pregnant patients with diabetes and chronic hypertension, blood pressure target goals of 110–129/65–79 mmHg are suggested in the interest of long-term maternal health and minimizing impaired fetal growth. ACE inhibitors and ARBs are contraindicated during pregnancy. (E)

Dyslipidemia/lipid management

Screening

- In most adult patients, measure fasting lipid profile at least annually. In adults with low-risk lipid values (LDL cholesterol <100 mg/dl, HDL cholesterol >50 mg/dl, and triglycerides <150 mg/dl), lipid assessments may be repeated every 2 years. (E)

Treatment recommendations and goals

- Lifestyle modification focusing on the reduction of saturated fat, *trans* fat, and cholesterol intake; the increase of omega-3 fatty acids, viscous fiber, and plant stanols/sterols; weight loss (if indicated); and increased physical activity should be recommended to improve the lipid profile in patients with diabetes. (A)
- Statin therapy should be added to lifestyle therapy, regardless of baseline lipid levels, for diabetic patients:
 - with overt CVD (A)
 - without CVD who are over the age of 40 years and have one or more other CVD risk factors (A)
- For patients at lower risk than above (e.g. without overt CVD and under the age of 40 years), statin therapy should be considered in addition to lifestyle therapy if LDL cholesterol remains >100 mg/dl or in those with multiple CVD risk factors. (E)
- In individuals without overt CVD, the primary goal is an LDL cholesterol <100 mg/dl (2.6 mmol/l). (A)
- In individuals with overt CVD, a lower LDL cholesterol goal of <70 mg/dl (1.8 mmol/l), using a high dose of a statin, is an option. (B)
- If drug-treated patients do not reach the

above targets on maximal tolerated statin therapy, a reduction in LDL cholesterol of ~30–40% from baseline is an alternative therapeutic goal. (A)

- Triglyceride levels <150 mg/dl (1.7 mmol/l) and HDL cholesterol >40 mg/dl (1.0 mmol/l) in men and >50 mg/dl (1.3 mmol/l) in women are desirable. However, LDL cholesterol-targeted statin therapy remains the preferred strategy. (C)
- If targets are not reached on maximally tolerated doses of statins, combination therapy using statins and other lipid-lowering agents may be considered to achieve lipid targets but has not been evaluated in outcome studies for either CVD outcomes or safety. (E)
- Statin therapy is contraindicated in pregnancy. (E)

Antiplatelet agents

- Consider aspirin therapy (75–162 mg/day) as a primary prevention strategy in those with type 1 or type 2 diabetes at increased cardiovascular risk (10-year risk >10%). This includes most men >50 years of age or women >60 years of age who have at least one additional major risk factor (family history of CVD, hypertension, smoking, dyslipidemia, or albuminuria). (C)
- Aspirin should not be recommended for CVD prevention for adults with diabetes at low CVD risk (10-year CVD risk <5%, such as in men <50 years of age and women <60 years of age with no major additional CVD risk factors), since the potential adverse effects from bleeding likely offset the potential benefits. (C)
- In patients in these age-groups with multiple other risk factors (e.g. 10-year risk 5–10%), clinical judgment is required. (E)
- Use aspirin therapy (75–162 mg/day) as a secondary prevention strategy in those with diabetes with a history of CVD. (A)
- For patients with CVD and documented aspirin allergy, clopidogrel (75 mg/day) should be used. (B)
- Combination therapy with ASA (75–162 mg/day) and clopidogrel (75 mg/day) is reasonable for up to a year after an acute coronary syndrome. (B)

Smoking cessation

- Advise all patients not to smoke. (A)
- Include smoking cessation counseling and other forms of treatment as a routine component of diabetes care. (B)

Coronary heart disease (CHD) screening and treatment

Screening

- In asymptomatic patients, routine screening for CAD is not recommended, as it does not improve outcomes as long as CVD risk factors are treated. (A)

Treatment

- In patients with known CVD, ACE inhibitor (C) and aspirin and statin therapy (A) (if not contraindicated) should be used to reduce the risk of cardiovascular events.
- In patients with a prior myocardial infarction, β -blockers should be continued for at least 2 years after the event. (B)
- Longer-term use of β -blockers in the absence of hypertension is reasonable if well tolerated, but data are lacking. (E)
- Avoid thiazolidinedione (TZD) treatment in patients with symptomatic heart failure. (C)
- Metformin may be used in patients with stable congestive heart failure (CHF) if renal function is normal. It should be avoided in unstable or hospitalized patients with CHF. (C)

Nephropathy screening and treatment

General recommendations

- To reduce the risk or slow the progression of nephropathy, optimize glucose control. (A)
- To reduce the risk or slow the progression of nephropathy, optimize blood pressure control. (A)

Screening

- Perform an annual test to assess urine albumin excretion in type 1 diabetic patients with diabetes duration of ≥ 5 years and in all type 2 diabetic patients starting at diagnosis. (E)
- Measure serum creatinine at least annually in all adults with diabetes regardless of the degree of urine albumin excretion. The serum creatinine should be used to estimate GFR and stage the level of chronic kidney disease (CKD), if present. (E)

Treatment

- In the treatment of the nonpregnant patient with micro- or macroalbuminuria, either ACE inhibitors or ARBs should be used. (A)
- While there are no adequate head-to-head comparisons of ACE inhibitors

and ARBs, there is clinical trial support for each of the following statements:

- In patients with type 1 diabetes, with hypertension and any degree of albuminuria, ACE inhibitors have been shown to delay the progression of nephropathy. (A)
- In patients with type 2 diabetes, hypertension, and microalbuminuria, both ACE inhibitors and ARBs have been shown to delay the progression to macroalbuminuria. (A)
- In patients with type 2 diabetes, hypertension, macroalbuminuria, and renal insufficiency (serum creatinine >1.5 mg/dl), ARBs have been shown to delay the progression of nephropathy. (A)
- If one class is not tolerated, the other should be substituted. (E)
- Reduction of protein intake to $0.8\text{--}1.0\text{ g}\cdot\text{kg body wt}^{-1}\cdot\text{day}^{-1}$ in individuals with diabetes and the earlier stages of CKD and to $0.8\text{ g}\cdot\text{kg body wt}^{-1}\cdot\text{day}^{-1}$ in the later stages of CKD may improve measures of renal function (urine albumin excretion rate, GFR) and is recommended. (B)
- When ACE inhibitors, ARBs, or diuretics are used, monitor serum creatinine and potassium levels for the development of acute kidney disease and hyperkalemia. (E)
- Continued monitoring of urine albumin excretion to assess both response to therapy and progression of disease is recommended. (E)
- When estimated GFR (eGFR) is <60 ml.min/1.73 m², evaluate and manage potential complications of CKD. (E)
- Consider referral to a physician experienced in the care of kidney disease when there is uncertainty about the etiology of kidney disease (heavy proteinuria, active urine sediment, absence of retinopathy, rapid decline in GFR), difficult management issues, or advanced kidney disease. (B)

Retinopathy screening and treatment

General recommendations

- To reduce the risk or slow the progression of retinopathy, optimize glycemic control. (A)
- To reduce the risk or slow the progression of retinopathy, optimize blood pressure control. (A)

Screening

- Adults and children aged 10 years or older with type 1 diabetes should have an initial dilated and comprehensive

eye examination by an ophthalmologist or optometrist within 5 years after the onset of diabetes. (B)

- Patients with type 2 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist shortly after the diagnosis of diabetes. (B)
- Subsequent examinations for type 1 and type 2 diabetic patients should be repeated annually by an ophthalmologist or optometrist. Less-frequent exams (every 2–3 years) may be considered following one or more normal eye exams. Examinations will be required more frequently if retinopathy is progressing. (B)
- High-quality fundus photographs can detect most clinically significant diabetic retinopathy. Interpretation of the images should be performed by a trained eye care provider. While retinal photography may serve as a screening tool for retinopathy, it is not a substitute for a comprehensive eye exam, which should be performed at least initially and at intervals thereafter as recommended by an eye care professional. (E)
- Women with pre-existing diabetes who are planning a pregnancy or who have become pregnant should have a comprehensive eye examination and be counseled on the risk of development and/or progression of diabetic retinopathy. Eye examination should occur in the first trimester with close follow-up throughout pregnancy and for 1 year postpartum. (B)

Treatment

- Promptly refer patients with any level of macular edema, severe nonproliferative diabetic retinopathy (NPDR), or any proliferative diabetic retinopathy (PDR) to an ophthalmologist who is knowledgeable and experienced in the management and treatment of diabetic retinopathy. (A)
- Laser photocoagulation therapy is indicated to reduce the risk of vision loss in patients with high-risk PDR, clinically significant macular edema, and some cases of severe NPDR. (A)
- The presence of retinopathy is not a contraindication to aspirin therapy for cardioprotection, as this therapy does not increase the risk of retinal hemorrhage. (A)

Neuropathy screening and treatment

- All patients should be screened for distal symmetric polyneuropathy (DPN) at diagnosis and at least annually thereafter, using simple clinical tests. (B)
- Electrophysiological testing is rarely needed, except in situations where the clinical features are atypical. (E)
- Screening for signs and symptoms of cardiovascular autonomic neuropathy should be instituted at diagnosis of type 2 diabetes and 5 years after the diagnosis of type 1 diabetes. Special testing is rarely needed and may not affect management or outcomes. (E)
- Medications for the relief of specific symptoms related to DPN and autonomic neuropathy are recommended, as they improve the quality of life of the patient. (E)

Foot care

- For all patients with diabetes, perform an annual comprehensive foot examination to identify risk factors predictive of ulcers and amputations. The foot examination should include inspection, assessment of foot pulses, and testing for loss of protective sensation (10-g monofilament plus testing any one of: vibration using 128-Hz tuning fork, pinprick sensation, ankle reflexes, or vibration perception threshold). (B)
- Provide general foot self-care education to all patients with diabetes. (B)
- A multidisciplinary approach is recommended for individuals with foot ulcers and high-risk feet, especially those with a history of prior ulcer or amputation. (B)
- Refer patients who smoke, have loss of protective sensation and structural abnormalities, or have history of prior lower-extremity complications to foot care specialists for ongoing preventive care and life-long surveillance. (C)
- Initial screening for peripheral arterial disease (PAD) should include a history for claudication and an assessment of the pedal pulses. Consider obtaining an ankle-brachial index (ABI), as many patients with PAD are asymptomatic. (C)
- Refer patients with significant claudication or a positive ABI for further vascular assessment and consider exercise, medications, and surgical options. (C)

Children and adolescents

Glycemic control

- Consider age when setting glycemic goals in children and adolescents with type 1 diabetes. (E)

Screening and management of chronic complications in children and adolescents with type 1 diabetes

Nephropathy

- Annual screening for microalbuminuria, with a random spot urine sample for albumin-to-creatinine ratio (ACR), should be considered once the child is 10 years of age and has had diabetes for 5 years. (E)
- Confirmed, persistently elevated ACR on two additional urine specimens from different days should be treated with an ACE inhibitor, titrated to normalization of albumin excretion if possible. (E)

Hypertension

- Treatment of high-normal blood pressure (systolic or diastolic blood pressure consistently above the 90th percentile for age, sex, and height) should include dietary intervention and exercise, aimed at weight control and increased physical activity, if appropriate. If target blood pressure is not reached with 3–6 months of lifestyle intervention, pharmacologic treatment should be considered. (E)
- Pharmacologic treatment of hypertension (systolic or diastolic blood pressure consistently above the 95th percentile for age, sex, and height or consistently >130/80 mmHg, if 95% exceeds that value) should be initiated as soon as the diagnosis is confirmed. (E)
- ACE inhibitors should be considered for the initial treatment of hypertension, following appropriate reproductive counseling due to its potential teratogenic effects. (E)
- The goal of treatment is a blood pressure consistently <130/80 or below the 90th percentile for age, sex, and height, whichever is lower. (E)

Dyslipidemia

Screening

- If there is a family history of hypercholesterolemia (total cholesterol >240 mg/dl) or a cardiovascular event before age 55 years, or if family history is unknown, then a fasting lipid profile should be performed on children >2 years of age soon after diagnosis (after glucose control has been established). If family history is not of concern, then the first lipid screening should be considered at puberty (≥ 10 years). All children diagnosed with diabetes at or after

puberty should have a fasting lipid profile performed soon after diagnosis (after glucose control has been established). (E)

- For both age-groups, if lipids are abnormal, annual monitoring is recommended. If LDL cholesterol values are within the accepted risk levels (<100 mg/dl [2.6 mmol/l]), a lipid profile should be repeated every 5 years. (E)

Treatment

- Initial therapy should consist of optimization of glucose control and MNT using a Step 2 American Heart Association diet aimed at a decrease in the amount of saturated fat in the diet. (E)
- After the age of 10 years, the addition of a statin in patients who, after MNT and lifestyle changes, have LDL cholesterol >160 mg/dl (4.1 mmol/l), or LDL cholesterol >130 mg/dl (3.4 mmol/l) and one or more CVD risk factors, is reasonable. (E)
- The goal of therapy is an LDL cholesterol value <100 mg/dl (2.6 mmol/l). (E)

Retinopathy

- The first ophthalmologic examination should be obtained once the child is ≥10 years of age and has had diabetes for 3–5 years. (E)
- After the initial examination, annual routine follow-up is generally recommended. Less frequent examinations may be acceptable on the advice of an eye care professional. (E)

Celiac disease

- Children with type 1 diabetes should be screened for celiac disease by measuring tissue transglutaminase or anti-endomysial antibodies, with documentation of normal total serum IgA levels, soon after the diagnosis of diabetes. (E)
- Testing should be repeated in children with growth failure, failure to gain weight, weight loss, diarrhea, flatulence, abdominal pain, or signs of malabsorption or in children with frequent unexplained hypoglycemia or deterioration in glycemic control. (E)
- Children with positive antibodies should be referred to a gastroenterologist for evaluation with endoscopy and biopsy. (E)
- Children with biopsy-confirmed celiac disease should be placed on a gluten-free diet and have consultation with a

dietitian experienced in managing both diabetes and celiac disease. (E)

Hypothyroidism

- Children with type 1 diabetes should be screened for thyroid peroxidase and thyroglobulin antibodies at diagnosis. (E)
- TSH concentrations should be measured after metabolic control has been established. If normal, they should be rechecked every 1–2 years, or if the patient develops symptoms of thyroid dysfunction, thyromegaly, or an abnormal growth rate. (E)

Preconception care

- A1C levels should be as close to normal as possible (<7%) in an individual patient before conception is attempted. (B)
- Starting at puberty, preconception counseling should be incorporated in the routine diabetes clinic visit for all women of child-bearing potential. (C)
- Women with diabetes who are contemplating pregnancy should be evaluated and, if indicated, treated for diabetic retinopathy, nephropathy, neuropathy, and CVD. (E)
- Medications used by such women should be evaluated prior to conception, since drugs commonly used to treat diabetes and its complications may be contraindicated or not recommended in pregnancy, including statins, ACE inhibitors, ARBs, and most non-insulin therapies. (E)
- Since many pregnancies are unplanned, consider the potential risks and benefits of medications that are contraindicated in pregnancy in all women of child-bearing potential, and counsel women using such medications accordingly. (E)

Older adults

- Older adults who are functional, cognitively intact, and have significant life expectancy should receive diabetes care using goals developed for younger adults. (E)
- Glycemic goals for older adults not meeting the above criteria may be relaxed using individual criteria, but hyperglycemia leading to symptoms or risk of acute hyperglycemic complications should be avoided in all patients. (E)
- Other cardiovascular risk factors should be treated in older adults with consideration of the time frame of ben-

efit and the individual patient. Treatment of hypertension is indicated in virtually all older adults, and lipid and aspirin therapy may benefit those with life expectancy at least equal to the time frame of primary or secondary prevention trials. (E)

- Screening for diabetes complications should be individualized in older adults, but particular attention should be paid to complications that would lead to functional impairment. (E)

Diabetes care in the hospital

- All patients with diabetes admitted to the hospital should have their diabetes clearly identified in the medical record. (E)
- All patients with diabetes should have an order for blood glucose monitoring, with results available to all members of the health care team. (E)
- Goals for blood glucose levels:
 - Critically ill patients: Insulin therapy should be initiated for treatment of persistent hyperglycemia starting at a threshold of no greater than 180 mg/dl (10 mmol/l). Once insulin therapy is started, a glucose range of 140–180 mg/dl (7.8 to 10 mmol/l) is recommended for the majority of critically ill patients. (A)
 - More stringent goals, such as 110–140 mg/dl (6.1–7.8 mmol/l) may be appropriate for selected patients, as long as this can be achieved without significant hypoglycemia. (C)
 - Critically ill patients require an intravenous insulin protocol that has demonstrated efficacy and safety in achieving the desired glucose range without increasing risk for severe hypoglycemia. (E)
 - Non-critically ill patients: There is no clear evidence for specific blood glucose goals. If treated with insulin, the pre-meal blood glucose target should generally be <140 mg/dl (7.8 mmol/l) with random blood glucose <180 mg/dl (10.0 mmol/l), provided these targets can be safely achieved. More stringent targets may be appropriate in stable patients with previous tight glycemic control. Less stringent targets may be appropriate in those with severe comorbidities. (E)
- Scheduled subcutaneous insulin with basal, nutritional, and correction components is the preferred method for achieving and maintaining glucose control in non-critically ill patients. (C) Using correction dose or “supple-

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mental” insulin to correct pre-meal hyperglycemia in addition to scheduled prandial and basal insulin is recommended. (E)

- Glucose monitoring should be initiated in any patient not known to be diabetic who receives therapy associated with high risk for hyperglycemia, including high-dose glucocorticoid therapy, initiation of enteral or parenteral nutrition, or other medications such as octreotide or immunosup-

pressive medications. (B) If hyperglycemia is documented and persistent, treatment is necessary. Such patients should be treated to the same glyce-mic goals as patients with known di-abetes. (E)

- A hypoglycemia management protocol should be adopted and implemented by each hospital or hospital system. A plan for treating hypoglycemia should be established for each patient. Epi-sodes of hypoglycemia in the hospital

should be documented in the medial record and tracked. (E)

- All patients with diabetes admitted to the hospital should have an A1C ob-tained if the result of testing in the previous 2–3 months is not available. (E)
- Patients with hyperglycemia in the hos-pital who do not have a diagnosis of diabetes should have appropriate plans for follow-up testing and care docu-mented at discharge. (E)