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*Dakota Diabetes Coalition is proud to offer this column on diabetes and related concerns every other Friday.*



Dr. Johnson is a family practice doctor in Grand Forks with a special interest in diabetes -- and a special knack for writing. As a member of the Dakota Diabetes Coalition, he has generously made himself available to answer questions through our listserv. If you have comments, or questions for Dr. Johnson to address in future columns, please contact [gailhand@q.com](mailto:gailhand@q.com)



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## ADA's 2009 Guidelines Changes, additions to Clinical Care

It's January, so in addition to wrapping up the holidays, celebrating the New Year, and over-indulging in food and football, it's time for the updated American Diabetes Association Clinical Practice Recommendations.

Last year, we discussed statin therapy to lower cardiovascular risk in diabetes patients, including children, as well as inpatient glycemic management goals, screening for thyroid disease and at-risk populations for diabetes screening. To see that discussion, click here: <http://tinyurl.com/8ns9vd>

Get ready to bookmark this handy site. Here's the current revision for 2009:

[http://care.diabetesjournals.org/cgi/content/full/32/Supplement\\_1/S3](http://care.diabetesjournals.org/cgi/content/full/32/Supplement_1/S3)

**A1C less than 7 still primary goal**

In brief review of some notable changes, let's get started with A1C goals. Even with some of the data presented at ADA in June of 2008 regarding A1C and macrovascular complications (the ACCORD, ADVANCE, and VADT studies), an **A1C goal of <7% is still considered reasonable** for most non-pregnant adults with diabetes. Although these studies did not show clear benefit for reduction of macrovascular, which includes heart disease, stroke and peripheral arterial disease, complications with an A1C of <7%, substantial data exists for reduction of microvascular complications, eye, kidney, and nerve disease.

## **Weight loss surgery**

A new section on the role of **Bariatric Surgery** has been added for 2009. Bariatric surgery should be considered for patients with a BMI  $\geq 35$  and type 2 diabetes, particularly if control issues are evident. These patients will need **life-long support and medical monitoring** to increase their chances of success.

## **Known coronary risks and meds**

Management of coronary artery disease risk has been modified as well, with attention to statin therapy. In diabetes patients with **known CVD, use aspirin, ACE inhibitor, or statin therapy** to reduce further risk of events. Note that there is **no prerequisite for abnormal blood pressure or cholesterol** with these recommendations.

In addition, in those 40 and older, aspirin and statin therapy may be considered with diabetes patients with additional cardiovascular risk factors -- even in the absence of overt CVD. These **risk factors include hypertension, family history, dyslipidemia, microalbuminuria, cardiac autonomic neuropathy, or smoking.** Note that either hypertension or microalbuminuria would be indications for ACE inhibitors.

## **Type 1 youth, hypertension and celiac risk**

Two important updates have occurred for type 1 diabetes management in children. One regards **blood pressure** management. If a child with type 1 diabetes has a blood pressure greater than that of the 90-95<sup>th</sup> percentile for age, sex, and height, **lifestyle management** should be started and followed. If that does not prove adequate, **medication** intervention should be considered within six to 12 months.

**Adolescents with blood pressure** >130/>80 should be considered for **medication** management, similar to adults. The other recommendation with regard to type 1 patients involves screening for celiac disease. As **celiac disease** is a relatively high risk condition in type 1 patients (4-10% incidence), screening should be done at diagnosis with serologic markers, as well as periodically after that. Re-screening should also occur with any symptoms of celiac disease, which include growth failure, failure to gain weight, weight loss, or gastroenterologic symptoms.

## **Big changes at work, school and day care**

Other sections with substantial modifications are “**Diabetes and Employment**” and “**Diabetes in the School and Day Care Settings.**” We can’t cover them adequately here, but to see the entire **revised Clinical Practice Recommendations**, click on this link:

[http://care.diabetesjournals.org/content/vol32/Supplement\\_1/](http://care.diabetesjournals.org/content/vol32/Supplement_1/)

## **More support for more monitoring**

Of course, new treatments and medications are on the market now, or will be later in 2009. The new guidelines make a fairly strong **endorsement for the use of continuous glucose monitoring systems**, based on data accumulated over the last few years, particularly the JDRF study covered in one of our 2008 columns.

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We’ll attempt to keep you updated and informed throughout 2009, and, as always, we welcome any questions you have regarding diabetes treatment!

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[ADA's 2009 Clinical Guidelines, Dr. Johnson's Column #36, Jan. 9, 2009](#)