Guidelines for Diabetes Care Overview

INITIAL VISIT

TYPE OF TEST	TARGET / TEST	*COMMENTS*
Weight / BMI	**BMI**	***Measure initially and each routine visit***
Normal	**18.5–24.9**	If obese, determine level of obesity and assess to identify: ▪ potential medical causes/metabolic co-morbidities ▪ psychological status/potential barriers to treatment Possible options to treat obesity when other options fail: ▪ weight loss drugs (BMI ≥30) (with lifestyle modification) ▪ bariatric surgery (BMI ≥40)
Overweight	**25.0–29.9**	
Obesity (I)	**30.0–34.9**	
Obesity (II)	**35.0–39.9**	
Severe obesity (III)	**≥ 40**	
Waist Circumference		***Measure at initial visit and periodically thereafter***
Measure waist	**Men ≤40 in (102 cm) Women ≤35 in (88 cm)**	Persons with larger waist circumference are at greater disease risk
Nutrition		***Review at each routine visit***
Refer for Medical Nutrition Therapy (MNT) Counselling	▪ **Follow an individualized meal plan to improve glycaemic control** ▪ **Weight loss as required**	▪ Assess for readiness to change at initial visit and refer ▪ Discuss ongoing nutrition and weight goals / celebrate successes ▪ Goals should be realistic and achievable ▪ Assess compliance to MNT plan at follow-ups ▪ Key points: portion size/number servings/ limit food high in sugar/reduce high fat foods /increase fruit and vegetable intake
Physical activity		***Review each routine visit***
Aerobic exercise	▪ **30-60 minutes 5 times a week**	▪ Assess patient for level of activity (see physical activity section) ▪ Aerobic Exercise should be of moderate intensity ▪ Exercise can be in 10 minute blocks of time
Resistance exercise	▪ **3 times a week**	▪ If not contraindicated, patients with type 2 diabetes are recommended to perform resistance exercises ▪ Initial instruction by an exercise specialist is recommended
Smoking		***Review each routine visit***
	▪ **Ask if smoker** ▪ **Advise to quit** ▪ **Assess readiness** ▪ **Assist - refer** ▪ **Arrange – follow-up**	**Brief advice by medical providers to quit smoking is effective** ▪ Use "5A's" – of motivational interviewing ▪ More intensive interventions (individual, group or telephone counselling) that provide social support and training in problem-solving skills are effective ▪ Use approved smoking cessation drugs to assist with smoking cessation

Refer for	**Routine well persons tests**
▪ Diabetes education	▪ Mammogram / Clinical Breast exam
▪ Nutrition counselling	▪ PAP or PSA /Prostate exam
▪ Psychological counselling	▪ Faecal occult blood
▪ Lifestyle/ behaviour changes counselling	▪ Colonoscopy
▪ Annual blood glucose meter accuracy assessment	▪ Bone density
Immunizations	▪ Other tests as required
▪ Annual influenza	
▪ Pneumococcus	

EVERY VISIT

TYPE OF TEST	TARGET / TEST	*COMMENTS*
Blood glucose		***Measure / review every 3-6 months***
FPG	**72- 126 mg/dL**	**T2DM** - primary objective is to achieve and maintain glycaemic levels as close to non diabetic level as possible. 1. Introduce **oral Metformin** with lifestyle changes **If glycaemic levels are not maintained then:** 1. Add a **second medicine**: oral medicine or insulin 2. Add **third medicine**: insulin (basal or intensified therapy)
2 hour Plasma Glucose	**T1DM 90-180 mg/dL** **T2DM 90-144 mg/dL**	
HbA1c		***Measure every 3-6 months***
	< 7%	HbA1c reductions of even 1% reduces the risk of CVD by 10-15%
Hypertension		***Measure each routine visit***
	130/ 80 mg	To treat hypertension, maintain lifestyle modification and: ▪ Prescribe any agent **except alpha-adrenergic blockers** ▪ Can use ACEI, A2RBs, DHP, CCBs or thiazide diuretics ▪ If **intolerant** to ACEI use A2RB (3 or more drugs may be required to reach target)
Foot care		***Visual foot exam at each visit***
	Review by foot-care team: ▪ At risk - 6 monthly ▪ High risk – 3-6 months ▪ Foot ulceration – refer to foot-care team	▪ Refer to chiropodist at diagnosis of T2DM Ensure patients at high risk of foot ulceration receive: ▪ Foot care education, professionally fitted footwear ▪ Smoking cessation strategies if they are smokers ▪ Early referral to professionals trained in foot care management if problems occur ▪ Aggressive treatment for any infection of a diabetic foot

ANNUALLY

TYPE OF TEST	TARGET / TEST	*COMMENTS*
Lipids	*In most adult patients measure fasting lipid profile annually or every two years if low risk.*	
LDL cholesterol	**< 100 mg/dL**	For established CVD in addition lifestyle intervention, prescribe: ▪ Statin drugs ▪ ACE-inhibitors ▪ ASA
HDL cholesterol	**> 50 mg/dL**	
Triglycerides	**< 150 mg/dL**	
Neuropathy	***Type 1 Diabetes:*** *screen 5 yrs after diagnosis then quarterly or as required* ***Type 2 Diabetes:*** *screen at diagnosis and then quarterly or as required*	
Screening method	▪ Prick sensation ▪ 1.10 g monofilament ▪ Vibration sensitivity of big toe with tuning fork ▪ Assessment of ankle reflexes	▪ Intensive glycaemic control important for **T1DM** ▪ In **T2DM, lower blood glucose levels** are associated with reduced frequency of neuropathy ▪ Treatment / management of autonomic neuropathy will vary depending on severity and nerves affected ▪ Refer for **pain management** as required
Retinopathy	***Type 1 Diabetes:*** *screen 5 yrs after diagnosis & annually if no/minimal unchanged retinopathy* ***Type 2 Diabetes:*** *screen at diagnosis & annually if no or minimal unchanged retinopathy*	
Screening method	▪ Visual acuity assessment ▪ Dilated fundoscopy ▪ Retinal photography through dilated pupil	▪ Diagnose the severity of retinopathy and establish appropriate monitoring intervals ▪ Treat sight-threatened retinopathy with photocoagulation ▪ Screen for other complications
Renal/ kidney	***Type 1 Diabetes:*** *screen 5 yrs after diagnosis, then annually if no CKD* ***Type 2 Diabetes:*** *screen at diagnosis and then annually if no CKD*	
Normal ACR ratio: **Normal eGFR:**	**<18 mg/g (men)** **<25 mg/g (women)** **> 60 ml/min**	***If DKD measure:*** *ACR and eGFR at least every 6 months* **Refer patient to a nephrologist or an internist** if there is chronic progressive loss of kidney function: ▪ **eGFR** is **<30 ml/min** ▪ **ACR** is persistently **> 530 mg/g** ▪ **>30%** increase creatinine within 3 mos of starting **ACE**