

# Diabetes Newsletter



1600 North Second Street

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## American Diabetes Association Revises Diabetes Guidelines

Laurie Barclay, MD  
Dec 31, 2009

**December 29, 2009** - The American Diabetes Association (ADA) revised clinical practice recommendations for diabetes diagnosis promote hemoglobin A1c (A1c) as a faster, easier diagnostic test that could help reduce the number of undiagnosed patients and better identify patients with prediabetes. The new recommendations are published December 29 in the January supplement of *Diabetes Care*. "We believe that use of the A1c, because it doesn't require fasting, will encourage more people to get tested for type 2 diabetes and help further reduce the number of people who are undiagnosed but living with this chronic and potentially life-threatening disease," Richard M. Bergenstal, MD, ADA president-elect of medicine & science, said in a news release. "Additionally, early detection can make an enormous difference in a person's quality of life. Unlike many chronic diseases, type 2 diabetes actually can be prevented, as long as lifestyle changes are made while blood glucose levels are still in the pre-diabetes range."

The A1c test, which measures average blood glucose levels for a period of up to 3 months, was previously used only to evaluate diabetic control with time. An A1c level of approximately 5% indicates the absence of diabetes, and according to the revised evidence-based guidelines, an A1c score of 5.7% to 6.4% indicates prediabetes, and an A1c level of 6.5% or higher indicates the presence of diabetes. For optimal diabetic control, the recommended ADA target for most people with diabetes is an A1c level no greater than 7%. It is hoped that achieving this target would help prevent serious diabetes-related complications including nephropathy, neuropathy, retinopathy, and gum disease. Unlike fasting plasma glucose testing and the oral glucose tolerance test, A1c testing does not require overnight fasting. Compliance with screening may therefore be improved through use of the A1c test, which can be determined from a single nonfasting blood sample.

### **Recommendation Changes for 2010**

Specific changes in the 2010 Clinical Practice Recommendations are as follows:

- A section on diabetes related to cystic fibrosis has been added to "Standards of Medical Care in Diabetes." New evidence has shown that early diagnosis of cystic fibrosis-related diabetes and aggressive treatment with [insulin](#) have narrowed the gap in mortality between patients with cystic fibrosis with and without diabetes and have eliminated the sex difference in mortality rates. New recommendations for the clinical management of cystic fibrosis-related diabetes, based on a 2009 consensus conference, will be published in 2010 in a consensus report.
- Revision of the section "Diagnosis of Diabetes" now includes the use of the A1c level for diabetes diagnosis, with a cutoff point of 6.5%.
- The section formerly named "Diagnosis of Pre-diabetes" is now named "Categories of Increased Risk for Diabetes." Categories suggesting an increased risk for future diabetes now include an A1c range of 5.7% to 6.4%, as well as impaired fasting glucose and impaired glucose

## 2010 Diabetes Walk

The 2010 Diabetes Walk will be held on Saturday, March 27, 2010 at the Golden Valley Memorial HealthCare Medical Plaza in Clinton. We are in need of team captains. Team captains are in charge of getting participants to walk with you. A team can be anywhere from 2 people to 20 people (or more). Remember that the money that is raised stays locally and helps in anyone in the service area. This money can be used to buy prescriptions, help pay for educations, diabetic shoes, diabetic eye exam or dental exams. So please come out and support this cause. Call me if you would like to be a team captain.

If you do not want to be a team captain you can still come that day and walk.

The theme this year will be: A number worth knowing.

Call 660-885-2253, Ext. 6081, if you have any questions.

## Clinton Support Group

### TOPIC

Enhanced Fitness

### DATE

Thursday,  
March 11, 2010

### TIME

10:30—11:30 a.m.

### PLACE

GVMH Medical Plaza Classroom

### Presented By:

Teresa Lillibridge, BSW, MA

This is a 12 week exercise program that is designed for seniors. You don't have to have diabetes to come, anyone is welcome. So bring a friend.

## Hometown Turkey Meatloaf—From *The Heart-Smart Diabetes Kitchen*, p. 159

Servings: 4; Serving size: 1 mini loaf

### Ingredients

2 Tbsp ketchup  
1 can (8 oz) tomato sauce with Italian seasonings, divided  
3 tsp canola oil, divided  
3/4 lb lean ground turkey  
3/4 cup finely chopped green pepper  
1/2 cup finely chopped onion  
2 egg whites  
1 tsp Worcestershire sauce  
1/2 tsp dried Italian seasoning  
1/4 tsp salt  
1/2 cup quick-cooking oats

### Preparation

Preheat oven to 350°F. Line a baking sheet with foil. Combine ketchup, 2 Tbsp tomato sauce and 1 tsp canola oil in a small bowl and set aside.

Combine remaining ingredients in a large bowl. On a baking sheet, shape turkey mixture into four individual meatloaf ovals, about 3 x 4 1/2 in. Bake 30 minutes or until meat thermometer inserted into thickest part of meatloaf registers 165°F. Remove from oven. Using the back of spoon, evenly spread over the top and sides. Let stand 5 minutes before serving.

**Flavorful tip:** Read labels when buying ground turkey because some varieties can be quite high in saturated fat. Look for the words "lean" and/or "breast meat" to find the leaner versions.

### Nutrition Information:

Exchanges/Choices

1 Carbohydrate  
3 Lean Meat  
1 Fat

Calories: 245

Calories from Fat: 90

Total Fat: 10 g

Saturated Fat: 2.3 g

Trans Fat: 0 g

Dietary Fiber: 3 g

Cholesterol: 60 mg

Sodium: 630 mg

Total Carbohydrate: 17g

Dietary Fiber: 3 g

Sugars: 4g

Protein: 21 g

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tolerance levels.

- Revisions to the section "Detection and Diagnosis of GDM [Gestational Diabetes Mellitus]" now include a discussion of possible future changes in this diagnosis, according to international consensus. Screening recommendations for gestational diabetes are to use risk factor analysis and an oral glucose tolerance test, if appropriate. Women diagnosed with gestational diabetes should be screened for diabetes 6 to 12 weeks postpartum and should have subsequent screening for the development of diabetes or prediabetes.
- Extensive revisions to the section "Diabetes Self-Management Education" are based on new evidence. Goals of diabetes self-management education are to improve adherence to standard of care, to educate patients regarding appropriate glycemic targets, and to increase the percentage of patients achieving target A1c levels. Extensive revisions to the section "Antiplatelet Agents" now reflect evidence from recent trials suggesting that in moderate- or low-risk patients, aspirin is of questionable benefit for primary prevention of cardiovascular disease. The revised recommendation is to consider aspirin treatment as a primary prevention strategy in patients with diabetes who are at increased cardiovascular risk, defined as a 10-year risk greater than 10%. Patients at increased cardiovascular risk include men older than 50 years or women older than 60 years with at least 1 additional major risk factor.
- Fundus photography is now recommended as a screening strategy for retinopathy, as described in the section "Retinopathy Screening and Treatment."
- Extensive revisions to the section "Diabetes Care in the Hospital" now question the benefit of very tight glycemic control goals in critically ill patients, based on new evidence.
- Extensive revisions to the section "Strategies for Improving Diabetes Care" are based on newer evidence. Successful strategies to improve diabetes care, which have resulted in improved process measures such as measurement of A1c levels, lipid levels, and blood pressure, include the following:
  - Delivery of diabetes self-management education.
  - Adoption of practice guidelines developed with participation of healthcare professionals and having them readily accessible at the point of service.
  - Use of checklists mirroring guidelines, which help improve adherence to standards of care.
  - Systems changes, including providing automated reminders to healthcare professionals and patients and audit and feedback of process and outcome data to providers.
  - Quality improvement programs, in which continuous quality improvement or other cycles of analysis and intervention are combined with provider performance data.
  - Practice changes, which may include access to point-of-care A1c testing, scheduling planned diabetes visits, and clustering dedicated diabetes visits into specific times.
  - Tracking systems with either an electronic medical record or patient registry to improve adherence to standards of care.
  - Availability of case or (preferably) care management services using nurses, pharmacists, and other non-physician healthcare professionals following detailed algorithms under physician supervision.

"The most successful practices have an institutional priority for quality of care, involve all of the staff in their initiatives, redesign their delivery system, activate and educate their patients, and use electronic health record tools," the guidelines authors conclude. "It is clear that optimal diabetes management requires an organized, systematic approach and involvement of a coordinated team of dedicated health care professionals working in an environment where quality care is a priority."

## Warsaw Support Group

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