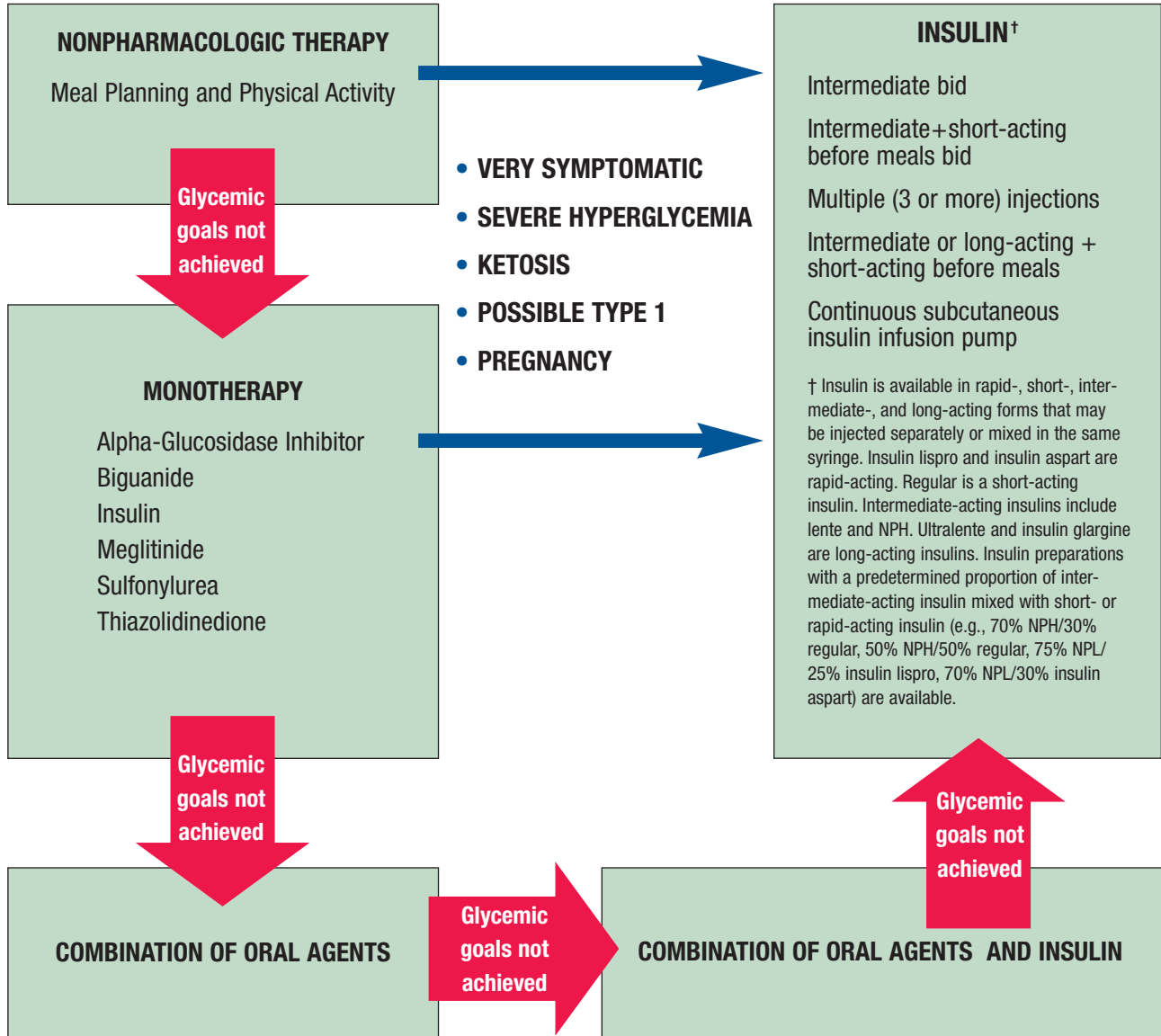


AMERICAN DIABETES ASSOCIATION TREATMENT GUIDELINES

THERAPY FOR TYPE 2 DIABETES MELLITUS*



* For detailed information on therapy for type 2 diabetes, refer to Zimmerman (Ed): *Medical Management of Type 2 Diabetes*, Fourth edition, Alexandria VA, American Diabetes Association, 1998. Oral agents should not be used in individuals with type 1 diabetes or during pregnancy. For information on therapy for type 1 diabetes, refer to Skyler (Ed): *Medical Management of Type 1 Diabetes*, Third edition, Alexandria, VA, American Diabetes Association, 1998. For more information on diabetes and pregnancy, see Jovanovic (Ed): *Medical Management of Pregnancy Complicated by Diabetes*, Third edition, Alexandria, VA, American Diabetes Association, 2000.

CRITERIA FOR THE DIAGNOSIS OF DIABETES MELLITUS

1. Symptoms of diabetes plus casual plasma glucose concentration ≥ 200 mg/dl (11.1 mmol/l). Casual is defined as any time of day without regard to time since last meal. The classic symptoms of diabetes include polyuria, polydipsia, and unexplained weight loss.

OR

2. Fasting plasma glucose (FPG) ≥ 126 mg/dl (7.0 mmol/l). Fasting is defined as no caloric intake for at least 8 hours.

OR

3. 2-hour PG ≥ 200 mg/dl (11.1 mmol/l) during an 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 the absence of unequivocal hyperglycemia with acute metabolic decompensation, these criteria should be confirmed by repeat testing on a different day. The OGTT is not recommended for routine clinical use but may be required in the evaluations of patients with IFG or when diabetes is still suspected despite normal FPG. Different criteria are used to diagnose gestational diabetes in pregnant women.

KEY TESTS/EXAMS

TEST/EXAM	FREQUENCY
A1C.....	<ul style="list-style-type: none"> Quarterly if treatment changes or not meeting goals At least 2 times/year if stable
Dilated eye exam.....	Yearly
Comprehensive foot exam	At least yearly (more often in patients with high-risk foot conditions)
Lipid profile	Yearly (less frequently if normal)
Microalbumin measurement	Yearly
Blood pressure	Each regular diabetes visit
Weight	Each regular diabetes visit

RECOMMENDATIONS FOR GLYCEMIC CONTROL

A1C	<7.0%*
Preprandial plasma glucose	90-130 mg/dl
Peak postprandial plasma glucose	<180 mg/dl

Key concepts in setting glycemic goals:

- Goals should be individualized.
- Certain populations (children, pregnant women, and elderly) require special considerations.
- Less intensive glycemic goals may be indicated in patients with severe or frequent hypoglycemia.
- More intensive glyceic goals may further reduce microvascular complications at the cost of increasing hypoglycemia.
- Postprandial glucose may be targeted if A1C goals are not met despite reaching preprandial glucose goals.

*Referenced to a nondiabetic range of 4.0-6.0% using a DCCT-based assay.

Source: Adapted from Key Tests/Exams, 2003 Clinical Practice Recommendations, American Diabetes Association. Standards of Medical Care for Patients with Diabetes Mellitus. *Diabetes Care*. 2003;26(Suppl. 1):S33-S50.

