

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: <ul style="list-style-type: none"> potential medical causes/metabolic co-morbidities psychological status/potential barriers to treatment Possible options to treat obesity when other options fail: <ul style="list-style-type: none"> weight loss drugs (BMI \geq30) (with lifestyle modification) bariatric surgery (BMI \geq40)
Overweight	25.0–29.9	
Obesity (I)	30.0–34.9	
Obesity (II)	35.0–39.9	
Severe obesity (III)	\geq 40	
Waist Circumference		Measure at initial visit and periodically thereafter
Measure waist	Men \leq 40 in (102 cm) Women \leq 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	<ul style="list-style-type: none"> Follow an individualized meal plan to improve glycaemic control Weight loss as required 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 30-60 minutes 5 times a week 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 3 times a week 	<ul style="list-style-type: none"> 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
	<ul style="list-style-type: none"> Ask if smoker Advise to quit Assess readiness Assist - refer Arrange – follow-up 	Brief advice by medical providers to quit smoking is effective <ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> Diabetes education 	<ul style="list-style-type: none"> Mammogram / Clinical Breast exam
<ul style="list-style-type: none"> Nutrition counselling 	<ul style="list-style-type: none"> PAP or PSA /Prostate exam
<ul style="list-style-type: none"> Psychological counselling 	<ul style="list-style-type: none"> Faecal occult blood
<ul style="list-style-type: none"> Lifestyle/ behaviour changes counselling 	<ul style="list-style-type: none"> Colonoscopy
<ul style="list-style-type: none"> Annual blood glucose meter accuracy assessment 	<ul style="list-style-type: none"> Bone density
Immunizations	<ul style="list-style-type: none"> Other tests as required
<ul style="list-style-type: none"> Annual influenza 	
<ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> At risk - 6 monthly High risk – 3-6 months Foot ulceration – refer to foot-care team 	<ul style="list-style-type: none"> Refer to chiropodist at diagnosis of T2DM Ensure patients at high risk of foot ulceration receive: <ul style="list-style-type: none"> 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		<i>In most adult patients measure fasting lipid profile annually or every two years if low risk.</i>
LDL cholesterol	< 100 mg/dL	For established CVD in addition lifestyle intervention, prescribe: <ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Prick sensation 1.10 g monofilament Vibration sensitivity of big toe with tuning fork Assessment of ankle reflexes 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Visual acuity assessment Dilated fundoscopy Retinal photography through dilated pupil 	<ul style="list-style-type: none"> 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:	<18 mg/g (men) <25 mg/g (women)	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: <ul style="list-style-type: none"> eGFR is <30 ml/min ACR is persistently > 530 mg/g >30% increase creatinine within 3 mos of starting ACE
Normal eGFR:	> 60 ml/min	

