NATIONAL DIABETES EDUCATION PROGRAM (NDEP)

# Diabetes

## Numbers At-a-Glance 2012†

**For non-pregnant adults**

### Criteria for Diagnosis of Diabetes*

(1) A1C †† ≥ 6.5% **or**
(2) Fasting plasma glucose ≥ 126 mg/dl **or**
(3) 2-hr plasma glucose ≥ 200 mg/dl post 75g oral glucose challenge **or**
(4) Random plasma glucose ≥ 200 mg/dl with symptoms (polyuria, polydypsia, and unexplained weight loss)

*For criteria 1-3: Repeat test to confirm unless symptoms are present. It is preferable that the same test be repeated for confirmation. If two different tests are used (e.g., FPG and A1C) and both indicate diabetes, consider the diagnosis confirmed. If the two different tests are discordant, repeat the test above the diagnostic cut point.

### Criteria for Prediabetes**

(1) Fasting plasma glucose 100 – 125 mg/dl [Impaired fasting glucose (IFG)] **or**
(2) 2-hr post 75g oral glucose challenge 140 – 199 mg/dl [Impaired glucose tolerance (IGT)] **or**
(3) A1C †† 5.7 % – 6.4 %

**For all tests, risk of diabetes is continuous, extending below the lower limit of the range and becoming disproportionately greater at higher ends of the range.

### Treatment Goals: the ABCs of Diabetes***

**A1C††** < 7 % for many people
Preprandial capillary plasma glucose 70 – 130 mg/dl
Peak postprandial capillary plasma glucose < 180 mg/dl
*(usually 1 to 2 hr after the start of a meal)*

**Blood pressure** (mmHg)
Systolic < 130 for most people
Diastolic < 80

**Cholesterol – Lipid Profile** (mg/dl)
LDL Cholesterol < 100
HDL Cholesterol Men > 40, Women > 50
Triglycerides < 150

### ***Individualize target levels. For example, consider:

- A1C target as close to normal as possible without significant hypoglycemia in people with short duration of diabetes, little comorbidity, and long life expectancy.
- Less stringent A1C target for people with severe hypoglycemia, limited life expectancy, extensive comorbid conditions, advanced complications, or longstanding diabetes where the general goal is difficult to attain despite optimal efforts.
- Higher or lower systolic blood pressure targets may be appropriate based on patient characteristics and response to therapy.

See source materials for treatment recommendations.

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† While utilizing American Diabetes Association Standards of Medical Care, *Diabetes Care* 35 (Suppl.1): S11-S63, 2012, NDEP recognizes that guidelines from other groups may vary, reflecting the limitations and complexity of the evidence base.

†† A1C testing for diagnostic purposes should be performed in a laboratory using a method that is NGSP certified. Point of care A1C tests should not be used for diagnosis. Be alert to the impact of hemoglobin variants on A1C values. See www2.niddk.nih.gov/variants for information.

# Diabetes Management Schedule

Adults with diabetes should receive medical care from a physician-coordinated team of health care professionals. Referrals to team members should be made as appropriate.

## At each regular diabetes visit:

- Measure weight and blood pressure.
- Inspect feet if one or more high-risk foot conditions are present.
- Review self-monitoring glucose record.
- Review/adjust medications to control glucose, blood pressure, and lipids. Consider low-dose aspirin for CVD prevention.
- Review self-management skills, dietary needs, and physical activity.
- Assess for depression or other mood disorder.
- Counsel on smoking cessation and alcohol use.

## Quarterly:

- Obtain A1C in patients whose therapy has changed or who are not meeting glycemic goals (twice a year if at goal with stable glycemia).

## Annually:

- Obtain fasting lipid profile (every 2 years if patient has low-risk lipid values).
- Obtain serum creatinine to estimate glomerular filtration rate and stage the level of chronic kidney disease.
- Perform urine test for albumin-to-creatinine ratio in patients with type 1 diabetes >5 years and in all patients with type 2 diabetes.
- Refer for dilated eye exam (if normal, an eye care specialist may advise an exam every 2–3 years).
- Perform comprehensive foot exam.
- Refer for dental/oral exam at least once a year.
- Administer influenza vaccination.
- Review need for other preventive care or treatment.

## Lifetime:

- Administer pneumococcal vaccination (repeat if over age 64 or immunocompromised and last vaccination was more than 5 years ago).
- Administer hepatitis B vaccination to patients aged 19 to 59 (use clinical discretion for patients ≥60 years).*

*CDC Morbidity and Mortality Weekly Report. Use of hepatitis B vaccination for adults with diabetes mellitus: recommendations of the Advisory Committee on Immunization Practices. December 23, 2011/60(50);1709-1711.

NDEP
National Diabetes Education Program

**To order NDEP materials visit www.YourDiabetesInfo.org or call 1-888-693-NDEP (1-888-693-6337).**

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

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