Joslin Diabetes Center | Affiliated with Harvard Medical School

Joslin Diabetes Center and Joslin Clinic
Clinical Guideline for Adults with Diabetes

Summary of Revisions 3/19/2008

Section	Specific Changes
A1C	• Statement added that Joslin's clinical recommendations are the same whether the average blood glucose is derived from the NGSP calculation or from the ADAG.
Glucose Monitoring	• Goals for glycemic control for people with diabetes were added • Section on frequency and timing of glucose monitoring was expanded to include considerations for checking glucose levels at 1 hr as well as 2-3hrs post prandial • Section added on alternate site monitoring
Hypoglycemia	• Statement added re need for patients using real-time continuous glucose monitoring to check finger stick 15 minutes after treatment of hypoglycemia rather than relying on CGM due to the physiologic lag between blood and interstitial glucose
Diabetes Self-Management Education (DSME) and medical Nutrition Therapy (MNT)	• Title change to section • Expanded statement for individuals with diabetes to receive an annual assessment of DSME and MNT and referral, as appropriate, to a trained diabetes educator
Physical Activity	• This is a new section
Renal Disease and Micro-Macro Albuminuria	Statements added re: • Use of MDRD equation to estimate GFR • If GFR <60ml/min, evaluate for complications of kidney disease • Indications for referring patients to nephrology
Cardiovascular Health	Statements added on: • Contraindications for use of thiazolidinediones • The inconclusive risk of myocardial ischemic events with the use of rosiglitazone.
Lipids	• For patients in whom CVD is not yet diagnosed and who have an LDL-C ≥100mg/dl, the following was changed **from**: If LDL-C remains >100, initiate medication with goal of lowering LDL-C by at least **30%** or to < 100, whichever is lower, preferably with a statin **to**: If LDL-C remains >100, initiate medication with goal of lowering LDL-C by at least **40%** or to < 100, whichever is lower, preferably with a statin • For patients in whom CVD is not yet diagnosed and who have an LDL-C ≥100mg/dl, the following was added: Consider bile acid sequestrants or cholesterol absorption inhibitors or niacin

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	(alone or in combination) for patients with statin intolerance or unacceptable adverse events. • For patients in whom CVD is not yet diagnosed and who have an LDL-C <100mg/dl and fasting triglycerides ≥150 mg/dl or HDL-C ≤ 40mg/dl, the following was added: if triglycerides remain >500 after initiation of fibrates and/or niacin, consider the addition of fish oil • For patients **with** CVD, if LDL-C ≥70mg/dl, the following was added: the decision for the specific level or type of exercise may depend upon the results of cardiac stress tests or specific clearance by a cardiologist. • For patients **with** CVD, if LDL-C ≥70mg/dl, the following was changed **from**: If LDL-C remains > 70, initiate medication (preferably a statin) with goal of lowering LDL-C to < 70 **to:** If LDL-C remains > 70, initiate medication (preferably a statin) with goal of lowering LDL-C to < 70 or by at least 40% from baseline. • For patients **with** CVD, if LDL-C ≥70mg/dl, the following added: o Consider bile acid sequestrant or cholesterol absorption inhibitors or niacin, alone, or in combination therapy, for patients with statin intolerance or unacceptable adverse event o Consider adding niacin or fibrate if triglycerides >200 and/or HDL-C ≤ 40mg/dl, and LDL at goal.
Blood Pressure	• The following was added: Consider initiating pharmacologic therapy if initial blood pressure is over 160-180/100
Feet and Peripheral Neuropathy	• New title for section • Expanded screening section • New section on when to consider referral to neurology • Under section on foot care training: The importance of glucose control on disease progression was added.
Eyes	• Under exam schedule: information on postpartum ophthalmologic follow was added • Under treatment follow up of proliferative diabetic retinopathy less than high risk **without** DME: changed **from**1-4 months **to** 1 week to 3-4 months. • Under treatment follow up of proliferative diabetic retinopathy less than high risk **with** DME: changed **from** 1-3 months **to** 1 week to 3-4 months • Statement on intravitreal steroid injection changed **from**: "Intravitreal steroid and periorbital steroid injections are sometimes used in clinical practice to treat macular edema despite no definitive studies on their effectiveness or safety to date" **to** "Intravitreal steroid and intravitreal ant-VEGF injections are sometimes used in clinical practice to treat macular edema despite no definitive studies on their effectiveness or safety to date".
Mental Health	• New section added