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We run through hundreds of articles every day to find the most clinically relevant, practice-changing articles in your specialty delivered to you via WhatsApp. This transcript has been edited for clarity. Every year, the American Diabetes Association (ADA) updates its medical care standards[1] for people with diabetes. Let's discuss what's new and interesting this year. Section 1 focuses on improving health care in populations. One of the recommendations I personally like is the discussion of telemedicine. In many places, telemedicine is not well funded. I think it's a great idea for our diabetes patients because it allows us to connect with them between visits to the clinic. Much of diabetes care does not involve face-to-face interactions with the patient regarding a physical exam, but rather involves discussing values from their meters or sensors. Telemedicine is a great way to go when it comes to managing our diabetes patients, and I'm hoping that this will become something that's done more often. Section 2 is about the classification and diagnosis of diabetes. Previous recommendations have suggested that we diagnose diabetes based on blood samples that have been taken a week or two apart. You will check your blood sugar level and if it is high, you will check it for a second time to confirm the first abnormal finding. We can make the diagnosis of diabetes based on two abnormal results from the same blood sample. We can measure the level of fasting glucose and A1c level on the same visit, and if both are elevated, make the diagnosis of diabetes. This section is called comprehensive medical assessment and evaluation of concomitant diseases and is one that everyone should know about. The most important thing in this section are the tables that show what is expected in a basic physical examination and evaluation – the laboratory tests to be carried out, the frequency of testing, evaluation and planning with the patient. Each of these units discusses the patient's commitment to care standards so that the patient and the doctor can be on the same page. The new table lists the risks of treatment-related hypoglycemia, which is useful for review because we all use many different drugs in our diabetes patients. Finally, the standards recommend that we use the 10-year-old atherosclerotic cardiovascular risk tool as part of the patient's assessment to calculate a patient's 10-year risk for a cardiovascular event. The individual management of lifestyle 5 section is for lifestyle management. Many things are addressed in this section, but most importantly, there is no one universal, best lifestyle for patients with diabetes. The key is that we customize the approach. Talk to the patient, determine what is best for the individual, and then work with the patient to be successful with this approach. A recommendation I would like to is one that states that patients not only consume less than 100% of the beverages, but also less non-food sweetened beverages. In general, ADA standards recommend that patients drink plenty of water, which is a very good idea. Remember that it's a complete [cola] and [cola diet] that patients should avoid instead of drinking water. Section 7 is about diabetes technology. This is an entirely new section that tries to cover everything related to technology, from insulin syringes and pens, to self-control of blood glucose, to pumps and sensors. There are a few important things to take home. In this section is the emphasis that education is key, that you can not just give the patient a device and expect that it is successful. Instead, the devices should be used with an integrated educational program and integrated clinical care. Self-monitoring blood sugar levels is obviously important for patients who take insulin, but these standards say that patients who do well with oral agents and do not have any problems, especially with hypoglycemia, and are followed by routine care may not need to self-control blood glucose levels. When people follow - and there are patients who like to get feedback about their levels - that data should be used to shape the patient and integrate the care plan. This section covers a lot about the use of pumps and sensors in people with type 1 diabetes. People with type 1 diabetes should be able to use either a pump or several daily insulin injection regimens, depending on the patient's preferences, and should have access to continuous glucose monitoring technology. The data are less strong in patients with type 2 diabetes, but those with type 2 diabetes who are on insulin may benefit from continuous glucose monitoring. Section 8 discusses obesity. There are no major changes here, although ADA standards align recommendations for metabolic surgery with the latest guidelines. Section 9 is on pharmacological therapy in people with type 2 diabetes. This section provides an overview of all newly issued ADA/EASD guidelines (European Association for the Study of Diabetes). I definitely recommend getting acquainted with them, because this is a very important part of how we approach our patients and the treatment of type 2 diabetes. Section 10 discusses cardiovascular disease and risk management. This section was first approved by the American Cardiologist. I strongly believe that it is important that all major health organizations begin to agree to these guidelines. I don't think it's going to help one group say one thing and another group say another, so that's very good news. This section discusses more about the treatment and evaluation of congestive heart failure and provides new information on the use of aspirin. Section 11 covers microvascular complications and foot care. The standards discuss the use of telemedicine for retinal screening and suggest that each visit requires in advance foot checks feet high-risk legs. Annual foot checks are considered necessary for everyone, but descending shoes and socks to look at the feet on each visit is necessary only for patients with high-risk legs or those who have concerns about something happening with their feet. Finally, section 12 is of older adults. I like this section quite a lot because it clarifies a lot of things that are not well defined. Comprehensive tables and discussions are included on how to categorize the risk of a patient who is older and how to categorize the benefit in terms of better glycemic control. We all see patients in their 80s. Some may have 10 or 15 years to live, and some may not be many years. This section looks at how to look at the human being before you – of their comorbidities, expectations of life and risks – and the benefits of different blood sugar levels and A1c targets, and how to use those in clinical practice. It includes a mass for de-de-treatment of insulin therapy. I've never seen this table, and I love it. We all have patients who come on complex insulin regimens; this table shows how to facilitate it. This is very important when treating our older population, especially as they may have little of dementia and problems managing their diabetes. These are some of the major changes in the new edition of diabetes standards of care. I recommend that you read as soon as possible the document you are interested in, but look at the section on the evaluation and evaluation of our patients, as well as the guidelines for the treatment of patients with type 2 diabetes. If you are familiar with these things and share them with your colleagues, this will help improve the lives of your diabetes patients. Thank you. Medscape Diabetes © 2019 WebMD, LLC All reviews expressed above are the author of own and do not necessarily reflect the views of WebMD or Medscape. Quote: Anne L. Peters. What's new in the standards of medical care for diabetes in 2019 - Medscape - February 07, 2019. 2020 focuses on Webcast Join ADA for the Chairman of the Professional Practice Commission, Joshua J. Saunders, Neumiller, Farm, CDE, FASCP, for presentation of the main updates and highlights of the 2020 Diabetes Medical Care Standards. View Webcast Webcast with CE 2020 Diabetes Medical Care Standards includes all up-to-date recommendations for ADA clinical practice and is designed to provide clinicians, patients, researchers, payers and other components of diabetes care with common treatment goals and tools to evaluate the quality of care. The recommendations are based on an extensive review of the literature on clinical diabetes, complemented by contributions from ADA staff and the medical community at large. Diabetes medical care standards are updated annually, or more frequently online, if new evidence or regulatory changes merit immediate inclusion, and published in Diabetes Care. Association of Diabetes released 2019 Diabetes Medical Care Standards (Care Standards), which include new and revised clinical practice recommendations that provide a roadmap for therapeutic approaches and drug choice based on each patient's overall health status. The AAS approved the new standards, which include updates aimed at reducing heart attacks, strokes, heart failure and other manifestations of cardiovascular disease. The latest evidence-based research continues to provide important information that can optimise treatment options and improve patient outcomes and quality of life. The new care standards for 2019 underscore a patient-centered approach that addresses the many health and life factors of anyone living with diabetes, said ADA's chief scientific, medical and missionary officer, William T. Cefalu, MD. We are also pleased with the close cooperation with the ACC, aligning ADA's recommendations with the ACC for the first time. Care standards include several important updates and additions, including recommendations for greater personalisation of care and the need for constant assessment and shared decision-making; advanced treatment recommendations for children and adolescents with type 2 diabetes; a new section on diabetes and technology, including the use of telemedicine; information on healthy eating, as well as pharmacological approaches and glycaemic purposes. The cardiovascular aet highlights from the cardiovascular disease management chapter include: New language for recognizing heart failure as the main cause of cardiovascular morbidity and mortality in people with diabetes and the need to take heart failure into account when determining optimal diabetic care Updated recommendations, describing the use of sodium-glucose co-transporter inhibitors of glt-2 or glucagon-like peptide 1 (GLP-1) receptor agonists New recommendation outlining the benefits of GLP-1 receptor agonists and SGLT-2 inhibitors for people with type 2 diabetes and chronic kidney disease. Approval of the risk calculator for ACC atherosclerotic cardiovascular disease (ASCVD) of ASCVD Risk Estimator Plus, for a routine assessment of ascvd's 10-year risk in people with diabetes. The American College of Cardiology and the American Diabetes Association share their goal of reducing the burden of cardiovascular disease, which too often follows the diagnosis of diabetes, said AS Vice President Richard Kovacs, MD, FACC. The ACC is proud to stand behind this important document, which will provide a roadmap for clinicians to effectively assess and manage cardiovascular disease in patients with diabetes and, in turn, save lives. Read the full document. Clinical topics: Dyslipidemia, heart failure and cardiomyopathies, lipid metabolism, acute heart failure Keywords: Diabetes mellitus, type 2, quality of life, Standard of care, blood atherosclerosis, stroke, heart failure, myocardial infarction, renal failure, chronic, telemedicine, Decision Sodium-glucose transport proteins, Glucagon-like peptide 1 &t; back to lists