

Know Your Number

Belinda P. Childs, ARNP, MN, CDE, Editor

KNOW YOUR NUMBER was an information campaign to increase the public's awareness about the hemoglobin A_{1c} (A1C) test several years ago. Today, there is confusion about what that number should be. According to the American Diabetes Association, the goal should be 7% or less.¹ A panel from the American Association of Clinical Endocrinologists says it should be 6.5% or less.² So what is THE NUMBER today?

I initially became aware of this discrepancy in recommendations as I attended national diabetes meetings where diabetes care professionals were asking "What do we tell patients?" Then, my patients began to ask about their A1C goal after receiving educational materials from pharmaceutical companies noting the goal of 6.5% or less. The question most often came from patients with type 1 diabetes on insulin pumps or multiple daily injections, who know the challenge of achieving and maintaining an A1C result less than 7%, let alone less than 6.5%.

The United Kingdom Prospective Diabetes Study (UKPDS) and the Diabetes Control and Complications Trial (DCCT) confirmed that the lower the A1C, the lower the risk of complications.^{3,4} But we also know from the DCCT/Epidemiology of Diabetes Interventions and Complications (EDIC) Study data that it is extremely difficult to maintain even a 7.2% A1C over the long term.⁵ The EDIC data are showing that even seemingly short-term improvements have long-term implications. Those in the intensive control group still have fewer complications even as their A1C results have increased over time.

Yes, the state of diabetes care and

control in the United States is awful. Change must occur. Health care practitioners, people with diabetes, government agencies, health care organizations, and third-party payers must recognize that diabetes and the associated dysmetabolic syndrome must be treated more aggressively. But more is necessary than just deciding on THE NUMBER.

Multiple challenges are before us. Challenges for people with diabetes, health care providers, and our government.

I contend that just saying something is so is not sufficient to make it happen. We must remember that individual patients make up the population of people with diabetes. These patients make choices about how they live with diabetes, and their choices change from day to day and year to year.

Some patients consciously make choices about their degree of glycemic control. Today, we have better medications; we have better technology. But in some ways, our advances may only contribute to earlier diabetes burnout.

Many people with diabetes still receive inadequate treatment options and information from their providers. Encouraging providers to be more aggressive with their treatment strategies is not new. But without professional education and tools to help people with diabetes achieve their goals, that achievement isn't likely to happen. Changing the target by 0.5% isn't going to provide the skills, tools, or treatment strategies to help patients reach it. Too many people with diabetes just don't know that a lower A1C is better. They still have not received the information that lower is better.

Having enough money to pay for all the available treatment tools is another very real issue. Can people afford to treat their diabetes with multiple medications—not only for diabetes itself, but also for high blood pressure and dyslipidemias? If not, how should patients prioritize their expenditures? If you had to pick, would you treat a patient's high blood glucose or high blood pressure? According to the UKPDS, it may be more important to treat the blood pressure if the patient has type 2 diabetes.

Above all, let's remember that a goal is a goal. As a practitioner who sees people with diabetes every day, I have to remember the individual. Patients ultimately must set their own goals. Prescriptions alone are not going to make THE NUMBER (whatever it may be) happen.

I am the coach. I use a risk reduction graph to show people with diabetes the value of glucose control in relation to complication reductions. The graph illustrates that for every percent reduction in A1C, there is a corresponding reduction in the risk of complications. When a person with diabetes in my practice decreases his or her A1C results from 11 to 8%, I appreciate the effort that has gone into achieving that reduction. Would a 6.5% A1C result be better? Of course. Would we continue to evaluate strategies to lower A1C results more? Yes. But at what price? Is that my decision or the decision of the person with diabetes?

For patients with type 1 diabetes, the incidence of hypoglycemia with tighter control may be such that it affects their daily living. Yes, new therapies may reduce this problem,

but I imagine that hypoglycemia and fear of hypoglycemia will still keep the majority from achieving this level of control. People with type 2 diabetes may well be able to reach this target early in the disease if they are medicated aggressively and coached appropriately. But they will develop the same risk of hypoglycemia later in their disease, and, as shown in the UKPDS, the longer the duration of disease, the more difficult it will be to maintain the lower A1C levels. Diabetes is a progressive disease.

Let's be cautious with the messages that we send, especially those to people with diabetes. They are the ones who live with this disease of many details and inconveniences every day. Let's not overlook what they are doing day-to-day.

And let's not confuse the provider community with a game of "What's THE NUMBER?" when our overriding and ongoing message should be, "We need to be doing better." The national A1C average is 9.2%. Every percent decrease improves outcomes and reduces the personal and financial burden of diabetes.

We need to promote the message of reducing the risks—that lowering glucose, lowering lipids, lowering blood pressure all improves outcomes. Our focus should be KNOW YOUR NUMBERS, not "What is THE NUMBER?"

References

¹American Diabetes Association: Standards of medical care for patients with diabetes mellitus

(Position Statement). *Diabetes Care* 25 (Suppl. 1):S33–S49, 2002

²American College of Endocrinology: American College of Endocrinology consensus statement on guidelines for glycemic control. *Endocrine Practice* 8 (Suppl. 1):5–11, 2002

³UKPDS Study Group: Intensive blood-glucose control with sulphonylureas or insulin compared to conventional treatment and risk complications in patients with type 2 diabetes (UKPDS 33). *Lancet* 352:837–853, 1998

⁴The DCCT Research Group: The effect of intensive treatment of diabetes on the development and progression of long-term complications in insulin-dependent diabetes mellitus. *New Engl J Med* 329:977–986, 1993

⁵The DCCT/EDIC Research Group: Retinopathy and nephropathy in patients with type 1 diabetes four years after a trial of intensive insulin therapy. *New Engl J Med* 342:381–389, 2000

Downloaded from <http://diabetesjournals.org/spectrum/article-pdf/15/2/69/57570/0069.pdf> by guest on 14 July 2024