

Summary of Revisions for the 2006 Clinical Practice Recommendations

Beginning with the 2005 supplement, the Clinical Practice Recommendations contained only the “Standards of Medical Care in Diabetes” and selected other position statements. This change was made to emphasize the importance of the “Standards” as the best source to determine ADA recommendations. The position statements in the supplement are updated yearly. Position statements not included in the supplement will be updated as necessary and republished when completed. A list of the position statements not included in this supplement appears on p. S75.

Format changes

- Page numbers now appear in the “Contents” for ease in locating particular sections
- Recommendations are now listed at the beginning of each section

Additions to the Standards of Medical Care in Diabetes

- Medical nutrition therapy (MNT)—extensively enhanced

- Diabetes self-management education (DSME)
- Physical activity
- Neuropathy

Summary of Revisions to Standards of Medical Care for Diabetes

- Assessment of glycemic control
 - Use of point-of-care testing for HbA_{1c} (A1C) allows for timely decisions on therapy changes, when needed (E)
- Glycemic goals
 - The A1C goal *for patients in general* is <7% (B)
 - The A1C goal *for the individual patient* is an A1C as close to normal (<6%) as possible without significant hypoglycemia (E)
- Nephropathy
 - To reduce the risk of nephropathy, protein intake should be limited to the Recommended Dietary Allowance (RDA) (0.8 g/kg) in those with any degree of chronic kidney disease (CKD) (B)
 - Serum creatinine should be measured at least annually for the estima-

tion of glomerular filtration rate (GFR) in all adults with diabetes regardless of the degree of urine albumin excretion. The serum creatinine alone should not be used as a measure of kidney function but rather used to estimate GFR and stage the level of CKD (E)

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