

Break through common nutrition myths, see what's trending, catch up on latest research, and get great tips from our team of Registered Dietitians.

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Top 10 Changes in the Canada's Diabetes 2018 Guidelines

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MANAGEMENT: ABCDES3 (3 = cubed) of Diabetes Care:

A = A1C: Aim for target within 3-6 months

- $\leq 6.5\%$ target for adults with type 2 diabetes to reduce the risk of CKD and retinopathy if at low risk of hypoglycemia; $\leq 7\%$ target for most adults with type 1 or type 2 diabetes; 7.1 – 8.5% target for frail elderly, or those with dementia, limited life expectancy or hypoglycemia unawareness

B = BP: $<130/80$ (no change)

C = Cholesterol: LDL < 2.0 (used to be $< \text{or} =$)

D = Drugs: Choose based on if clinical CVD is present or not.

E = Eating and exercise: Follow healthy dietary pattern (i.e. Mediterranean diet, low glycemic index); Follow exercise guidelines (no changes).

S = Screening for complications: ECG every 3-5 years if age > 40 OR diabetes complications; S= smoking cessation; S= self- management, stress

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TREATMENT DECISIONS: Recommendations for therapies are based on three categories

A1c $<1.5\%$ above target, $>1.5\%$ above target or symptomatic hyperglycemia and/or metabolic decompensation.

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MEDICATIONS:

Medication table is now listed by ability to improve CVD outcomes.

- If clinical CVD present (angina, MI, CHF, TIA, PAD= 15% of patients) add GLP-1 agonist Liraglutide or SGLT-2 canagliflozin (Invokana) or empagliflozin (Jardiance).
- If no clinical CVD present, then pick best agent based on other clinical considerations eg. hypoglycemia, weight neutral, degree of hyperglycemia, reduced eGFR.

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TIGHTEN UP:

If A1c is $> 7\%$ aim for fasting glucose = 4 – 5.5 mmol/L.

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VASCULAR PROTECTION

- Macrovascular disease = statin + ACE/ARB + ASA
- Microvascular disease or patient is ≥ 55 years old with additional CV risk factors = statin + ACE/ARB
- No macro/microvascular disease and patient is aged ≥ 40 or aged ≥ 30 with diabetes >15 years = statin



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HYPOGLYCEMIA:

Ask about hypoglycemia at each visit, assess impact, screen for unawareness and provide education on appropriate treatment and prevention.

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DEHYDRATION PREVENTION PROTOCOL FOR VOMITING/DIARRHEA

Rehydrate appropriately and hold **SADMANS** meds: **S** sulfonylureas, **A** ace inhibitors, **D** diuretics and direct renin inhibitors, **M** metformin, **A** angiotensin receptor blockers, **N** non-steroidal anti-inflammatory, **S** SGLT2 inhibitors.

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DIABETES AND DRIVING

- Keep fast acting sugar and snacks accessible.
- Test BG before driving and every 4 hours during long drives. If BG is below 4 mmol/L, treat. **If a patient is unaware of symptoms of hypoglycemia, he/she must check BG before driving and every 2 hours while driving, or wear a real-time continuous glucose monitor.
- If symptoms of low BG appear, stop driving and treat. After treating, wait until glucose is above 5 mmol/L before resuming driving.
- Commercial drivers need documented diabetes education minimum twice a year.

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DIABETES AND PREGNANCY

Pre-Existing Diabetes: Plan Ahead

- Aim for preconception A1c $\leq 7.0\%$ (ideally $\leq 6.5\%$)
- Stop ACE/ARB and statin prior to or upon detection of pregnancy
- For pre-existing type 1 or 2 diabetes aim for A1c of $\leq 6.5\%$ ($\leq 6.1\%$ if possible) during pregnancy if can be achieved safely
- Continue metformin/glyburide until conception, and then switch to insulin. Stop all other oral hyperglycemic agents
- Start folic acid 1 mg/day X 3 months prior to pregnancy and first 3 months of pregnancy
- Screen for complications (eye appointment, serum creatinine, urine ACR, blood pressure)
- Start on ASA 81mg od at 12-16weeks gestation to reduce risk of preeclampsia
- Refer to Diabetes Clinic.

Gestational Diabetes:

- If unable to achieve glycemic targets in 1-2 weeks, start on insulin or medication.
- Ideally manage with insulin, but metformin can be used as alternative to insulin (does cross placenta).
- Glyburide can be used in women who decline insulin and don't tolerate metformin/inadequately managed on metformin.
- Refer to Diabetes Clinic.

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HELP YOUR PATIENTS SET SMART GOALS

- Use the SMART goal approach (S=specific, M=measurable, A=achievable, R= realistic, T=timely) to help your patients plan for success. Example of a SMART goal: This week, I will walk for 30 minutes with my husband on Monday and Thursday evenings.
- Assess confidence in achieving the goal by using a scale of 1-10. Scores of 7 or higher indicate that behaviour change is more likely to happen.

Diabetes Flowsheets have been updated to include the new 2018 Canadian Diabetes Guidelines

Talk to your Registered Dietitian for more information

Recipe of the Month

Chicken and Mango in a Warm Coconut Sauce (www.CanolaInfo.org)

Serves 6, Serving Size: 1 cup (250 mL)

Ingredients

- 2 Tbsp (30 mL) all-purpose flour
- 1 Tbsp (15 mL) Spanish paprika
- 1 Tbsp (15 mL) pumpkin pie spice
- 1/8 tsp (0.5 mL) cayenne pepper or crushed red chili flakes
- 4 chicken breasts, boneless, skinless, cubed
- 2 Tbsp (30 mL) canola oil
- 1/2 cup (125 mL) diced red onion
- 1 can (14 ounces/398 mL) light coconut milk
- 1 can (14 ounces/398 mL) diced, unsalted tomatoes
- 1 cup (250 mL) mango chunks, fresh or frozen, thawed



Instructions

1. Preheat oven to 350°F (180°C).
2. In a large zip seal bag, combine flour, paprika, pumpkin pie spice and cayenne pepper or red chili flakes. Shake to mix well. Add chicken, about 1/4 at a time and shake to coat.
3. In a large oven-safe saucepan, heat canola oil over medium-high heat. Add chicken and brown for approximately 5 minutes per side. Remove chicken from pan.
4. Add onions and cook for about 3 minutes or until just softened. Add coconut milk, tomatoes, mango and return chicken to oven safe saucepan.
5. Bake for 25 minutes. Serve on its own or with steamed rice.

Notes

If desired, cubes of pre-roasted squash or pumpkin can be used in place of the mango.

Carbohydrate exchange information:

- 1 Carbohydrate Choice
- 2 Meat & Alternative Choices