Diabetes – Type 1 in Children/Adolescents

Key Highlights

Glycemic targets and therapeutic strategies for adolescents should be the same as for adults. For children 5-12 years old, aim for a glycosolated hemoglobin (A1C) target of $\leq 8.0\%$.

Scope

This guideline is intended for physicians who care for patients with diabetes or who are at risk for developing diabetes. Recommendations include both type 1 and type 2 diabetes unless only one is specified.

Excellent/Good Evidence to Recommend

- Adolescents should have the same glycemic targets and therapeutic strategies as adults. [see below under “Consensus” for children under 13 years old]

Fair Evidence to Recommend

- For medically stable children/adolescents with new-onset diabetes, consider outpatient initial education and management if appropriate personnel and daily telephone consultation is available.

- Regularly screen adolescent females and young women for eating disorders using non-judgemental questions about weight and shape concerns, dieting, binge eating, and insulin omission for weight loss.

- Screening adolescents for microalbuminuria should be done with a first morning urine for albumin to creatinine ratio (ACR); a random urine should be done if a first morning urine cannot be obtained. Abnormal results require confirmation.

Consensus

- All children/adolescents with diabetes should have access to an experienced diabetes health care team and specialists from the time of diagnosis.

- Children 5 –12 years old should aim for a glycosolated hemoglobin (A1C) target of $\leq 8.0\%$. Targets should be graduated according to the patient’s age.
• In children under 5 years old, an A1C target of ≤ 9.0% is acceptable. Use extreme caution to avoid hypoglycemia in this age group.

• If the 2 or 3 daily injection regimen fails to achieve optimal control (or quality of life issues supercede), consider increasing the frequency of injections, changing the type of intermediate- and fast-acting insulin, or changing to insulin pump therapy.

• Counsel adolescents about smoking prevention or cessation.

• Counsel adolescent females on contraception and sexual health to avoid unplanned pregnancy.

• Annual screening for microalbuminuria should begin once children reach both puberty and 5 years from the diagnosis of type 1 diabetes.

• Before initiating treatment for microalbuminuria, demonstrate persistence and/or progression by repeated sampling every 3 – 4 months over one year.

• Dyslipidemia screening should only be done on children/adolescents with type 1 diabetes and
  o another risk factor (such as severe obesity); and/or
  o family history of hyperlipidemia or premature coronary artery disease; or
  o those with poor metabolic control.

The above recommendations were derived from the following GAC endorsed guideline:

Rating (out of 4): 🍊🍊🍊🍊

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