4. Comprehensive Medical Evaluation and Assessment of Comorbidities: *Standards of Medical Care in Diabetes—2021*

The American Diabetes Association (ADA) “Standards of Medical Care in Diabetes” includes the ADA’s current clinical practice recommendations and is intended to provide the components of diabetes care, general treatment goals and guidelines, and tools to evaluate quality of care. Members of the ADA Professional Practice Committee, a multidisciplinary expert committee (https://doi.org/10.2337/dc21-SPPC), are responsible for updating the Standards of Care annually, or more frequently as warranted. For a detailed description of ADA standards, statements, and reports, as well as the evidence grading system for ADA’s clinical practice recommendations, please refer to the Standards of Care Introduction (https://doi.org/10.2337/dc21-SINT). Readers who wish to comment on the Standards of Care are invited to do so at professional.diabetes.org/SOC.

**PATIENT-CENTERED COLLABORATIVE CARE**

**Recommendations**

4.1 A patient-centered communication style that uses person-centered and strength-based language and active listening; elicits patient preferences and beliefs; and assesses literacy, numeracy, and potential barriers to care should be used to optimize patient health outcomes and health-related quality of life. 

4.2 People with diabetes can benefit from a coordinated multidisciplinary team that may draw from diabetes care and education specialists, primary care providers, subspecialty providers, nurses, dietitians, exercise specialists, pharmacists, dentists, podiatrists, and mental health professionals.

A successful medical evaluation depends on beneficial interactions between the patient and the care team. The Chronic Care Model (1–3) (see Section 1 “Improving Care and Promoting Health in Populations,” https://doi.org/10.2337/dc21-S001) is a patient-centered approach to care that requires a close working relationship between the patient and clinicians involved in treatment planning. People with diabetes should receive health care from a coordinated interdisciplinary team that may include diabetes care and education specialists, physicians, nurse practitioners, physician assistants, nurses, dietitians, exercise specialists, pharmacists, dentists, podiatrists, and mental health professionals. Individuals with diabetes must assume an active role in their care. The patient, family or support people, physicians, and health care team should together formulate the management plan, which includes lifestyle
The goals of treatment for diabetes are to prevent or delay complications and optimize quality of life (Fig. 4.1). Treatment goals and plans should be created with patients based on their individual preferences, values, and goals. This individualized management plan should take into account the patient’s age, cognitive abilities, school/work schedule and conditions, health beliefs, support systems, eating patterns, physical activity, social situation, financial concerns, cultural factors, literacy and numeracy (mathematical literacy), diabetes history (duration, complications, current use of medications), comorbidities, health priorities, other medical conditions, preferences for care, and life expectancy. Various strategies and techniques should be used to support patients’ self-management efforts, including providing education on problem-solving skills for all aspects of diabetes management.

Provider communication with patients and families should acknowledge that multiple factors impact glycemic management but also emphasize that collaboratively developed treatment plans and a healthy lifestyle can significantly improve disease outcomes and well-being (4–7). Thus, the goal of provider-patient communication is to establish a collaborative relationship and to assess and address self-management barriers without blaming patients for “noncompliance” or “nonadherence” when the outcomes of self-management are not optimal (8). The familiar terms “noncompliance” and “nonadherence” denote a passive, obedient role for a person with diabetes in “following doctor’s orders” that is at odds with the active role people with diabetes take in directing the day-to-day decision-making, planning, monitoring, evaluation, and problem-solving involved in diabetes self-management. Using a nonjudgmental approach that normalizes periodic lapses in self-management may help minimize patients’ resistance to reporting problems with self-management. Empathizing and using active listening techniques, such as open-ended questions, reflective statements, and summarizing what the patient said, can help facilitate communication. Patients’ perceptions about their own ability, or self-efficacy, to self-manage diabetes are one important psychosocial factor related to improved diabetes self-management and treatment outcomes in diabetes (9–13) and should be a target of ongoing assessment, patient education, and treatment planning.

Language has a strong impact on perceptions and behavior. The use of empowering language in diabetes care and education can help to inform and motivate people, yet language that shames and judges may undermine this effort. The American Diabetes Association (ADA) and the Association of Diabetes Care & Education Specialists (formerly called American Association of Diabetes Educators) joint consensus report, "The Use of Language in Diabetes Care and Education," provides the authors’ expert opinion regarding the use of language by

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**Figure 4.1**—Decision cycle for patient-centered glycemic management in type 2 diabetes. Reprinted from Davies et al. (101).
health care professionals when speaking or writing about diabetes for people with diabetes or for professional audiences (14). Although further research is needed to address the impact of language on diabetes outcomes, the report includes five key consensus recommendations for language use:

- Use language that is neutral, nonjudgmental, and based on facts, actions, or physiology/biology.
- Use language free from stigma.
- Use language that is strength based, respectful, and inclusive and that imparts hope.
- Use language that fosters collaboration between patients and providers.
- Use language that is person centered (e.g., “person with diabetes” is preferred over “diabetic”).

COMPREHENSIVE MEDICAL EVALUATION

Recommendations

4.3 A complete medical evaluation should be performed at the initial visit to:
- Confirm the diagnosis and classify diabetes.
- Evaluate for diabetes complications and potential comorbid conditions.
- Review previous treatment and risk factor control in patients with established diabetes.
- Begin patient engagement in the formulation of a care management plan.
- Develop a plan for continuing care.

4.4 A follow-up visit should include most components of the initial comprehensive medical evaluation (see Table 4.1). A

4.5 Ongoing management should be guided by the assessment of overall health status, diabetes complications, cardiovascular risk (see the Risk Calculator, Section 10 “Cardiovascular Disease and Risk Management,” https://doi.org/10.2337/dc21-S010), hypoglycemia risk, and shared decision-making to set therapeutic goals. B

The comprehensive medical evaluation includes the initial and follow-up evaluations, assessment of complications, psychosocial assessment, management of comorbid conditions, and engagement of the patient throughout the process. While a comprehensive list is provided in Table 4.1, in clinical practice the provider may need to prioritize the components of the medical evaluation given the available resources and time. The goal is to provide the health care team information so it can optimally support a patient. In addition to the medical history, physical examination, and laboratory tests, providers should assess diabetes self-management behaviors, nutrition, social determinants of health, and psychosocial health (see Section 5 “Facilitating Behavior Change and Well-being to Improve Health Outcomes,” https://doi.org/10.2337/dc21-S005) and give guidance on routine immunizations. The assessment of sleep pattern and duration should be considered; a meta-analysis found that poor sleep quality, short sleep, and long sleep were associated with higher A1C in people with type 2 diabetes (15). Interval follow-up visits should occur at least every 3–6 months individualized to the patient, and then at least annually.

Lifestyle management and psychosocial care are the cornerstones of diabetes management. Patients should be referred for diabetes self-management education and support, medical nutrition therapy, and assessment of psychosocial/emotional health concerns if indicated. Patients should receive recommended preventive care services (e.g., immunizations, cancer screening, etc.); smoking cessation counseling; and ophthalmological, dental, and podiatric referrals.

The assessment of risk of acute and chronic diabetes complications and treatment planning are key components of initial and follow-up visits (Table 4.2). The risk of atherosclerotic cardiovascular disease and heart failure (see Section 10 “Cardiovascular Disease and Risk Management,” https://doi.org/10.2337/dc21-S010), chronic kidney disease staging (see Section 11 “Microvascular Complications and Foot Care,” https://doi.org/10.2337/dc21-S011), presence of retinopathy, and risk of treatment-associated hypoglycemia (Table 4.3) should be used to individualize targets for glycemia (see Section 6 “Glycemic Targets,” https://doi.org/10.2337/dc21-S006), blood pressure, and lipids and to select specific glucose-lowering medication (see Section 9 “Pharmacologic Approaches to Glycemic Treatment,” https://doi.org/10.2337/dc21-S009), antihypertension medication, and statin treatment intensity.

Additional referrals should be arranged as necessary (Table 4.4). Clinicians should ensure that individuals with diabetes are appropriately screened for complications and comorbidities. Discussing and implementing an approach to glycemic control with the patient is a part, not the sole goal, of the patient encounter.

IMMUNIZATIONS

Recommendation

4.6 Provide routinely recommended vaccinations for children and adults with diabetes as indicated by age (see Table 4.5 for highly recommended vaccinations for adults with diabetes). A

The importance of routine vaccinations for people living with diabetes has been elevated by the coronavirus disease 2019 (COVID-19) pandemic. Preventing avoidable infections not only directly prevents morbidity but also reduces hospitalizations, which may additionally reduce risk of acquiring infections such as COVID-19. Children and adults with diabetes should receive vaccinations according to age-appropriate recommendations (16,17). The Centers for Disease Control and Prevention (CDC) provides vaccination schedules specifically for children, adolescents, and adults with diabetes (see https://www.cdc.gov/vaccines/). The CDC Advisory Committee on Immunization Practices (ACIP) makes recommendations based on its own review and rating of the evidence, provided in Table 4.5 for selected vaccinations. The ACIP evidence review has evolved over time with the adoption of Grading of Recommendations Assessment, Development, and Evaluation (GRADE) in 2010 and then the Evidence to Decision or Evidence to Recommendation (ETR) frameworks in 2018 (18). Here we discuss the particular importance of specific vaccines.

Influenza

Influenza is a common, preventable infectious disease associated with high mortality and morbidity in vulnerable populations, including youth, older adults, and people with chronic diseases. Influenza vaccination in people with diabetes has been found to significantly reduce
Table 4.1 - Components of the comprehensive diabetes medical evaluation at initial, follow-up, and annual visits

<table>
<thead>
<tr>
<th>Category</th>
<th>Initial Visit</th>
<th>Every Follow-Up Visit</th>
<th>Annual Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Past Medical and Family History</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes history</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Characteristics at onset (e.g., age, symptoms)</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>- Review of previous treatment regimens and response</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>- Assess frequency/cause/severity of past hospitalizations</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Family history</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Family history of diabetes in a first-degree relative</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>- Family history of autoimmune disorder</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Personal history of complications and common comorbidities</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>- Comorbid conditions (e.g., obesity, OSA, NAFLD)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>- High blood pressure or abnormal lipids</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>- Macrovascular and microvascular complications</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>- Hypoglycemia awareness/frequency/causes/timing of episodes</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>- Presence of hemoglobinopathies or anemias</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>- Last dental visit</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>- Last dilated eye exam</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>- Visits to specialists</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Interval history</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>- Changes in medical/family history since last visit</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Behavioral Factors</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Eating patterns and weight history</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>- Assess familiarity with carbohydrate counting (e.g., type 1 diabetes, type 2 diabetes treated with MDI)</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>- Physical activity and sleep behaviors</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>- Tobacco, alcohol, and substance use</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>Medications and Vaccinations</strong></td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>- Current medication regimen</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>- Medication-taking behavior</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>- Medication intolerance or side effects</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>- Complementary and alternative medicine use</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>- Vaccination history and needs</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>Technology Use</strong></td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>- Assess use of health apps, online education, patient portals, etc.</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>- Glucose monitoring (meter/CGM): results and data use</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>- Review insulin pump settings and use</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>Social Life Assessment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social network</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>- Identify existing social supports</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>- Identify surrogate decision maker, advanced care plan</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>- Identify social determinants of health (e.g., food security, housing stability &amp; homelessness, transportation access, financial security, community safety)</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

Continued on p. S44
influenza and diabetes-related hospital admissions (19). Given the benefits of the annual influenza vaccination, it is recommended for all individuals ≥6 months of age who do not have a contraindication. Influenza vaccination is critically important in the next year as the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) and influenza viruses will both be active in the U.S. during the 2020–2021 season (20). The live attenuated influenza vaccine (LAIV), which is delivered by nasal spray, is an option for patients beginning at age 2 years through age 49 years, for those who are not pregnant, but patients with chronic conditions such as diabetes are cautioned against taking the LAIV and are instead recommended to receive the inactive or recombinant influenza vaccination. For individuals ≥65 years of age, there may be additional benefit from the high-dose quadrivalent inactivated influenza vaccine (20).

### Pneumococcal Pneumonia

Like influenza, pneumococcal pneumonia is a common, preventable disease. People with diabetes are at increased risk for the bacteremic form of pneumococcal infection and have been reported to have a high risk of nosocomial bacteremia, with a mortality rate as high as 50% (21). There are two vaccination types, the 23-valent pneumococcal polysaccharide vaccine (PPSV23) and the 13-valent pneumococcal conjugate vaccine (PCV13), with distinct schedules for children and adults. All children are recommended to receive a four-dose series of PCV13 by 15 months of age. For children with diabetes who have incomplete series by ages 2–5 years, the CDC recommends a catch-up schedule to ensure that these children have four doses. Children with diabetes between 6–18 years of age are also advised to receive one dose of PPSV23, preferably after receipt of PCV13.

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### Table 4.1 (cont.)- Components of the comprehensive diabetes medical evaluation at initial, follow-up, and annual visits

<table>
<thead>
<tr>
<th>PHYSICAL EXAMINATION</th>
<th>INITIAL VISIT</th>
<th>EVERY FOLLOW-UP VISIT</th>
<th>ANNUAL VISIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Height, weight, and BMI; growth/pubertal development in children and adolescents</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• Blood pressure determination</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• Orthostatic blood pressure measures (when indicated)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• Fundoscopic examination (refer to eye specialist)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• Thyroid palpation</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• Skin examination (e.g., acanthosis nigricans; insulin injection or insertion sites, lipodystrophy)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• Comprehensive foot examination</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• Visual inspection (e.g., skin integrity, callus formation, foot deformity or ulcer, toenails)**</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• Screen for PAD (pedal pulses—refer for ABI if diminished)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• Determination of temperature, vibration or pinprick sensation, and 10-g monofilament exam</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• Screen for depression, anxiety, and disordered eating</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• Consider assessment for cognitive impairment*</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• Consider assessment for functional performance*</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LABORATORY EVALUATION</th>
<th>INITIAL VISIT</th>
<th>EVERY FOLLOW-UP VISIT</th>
<th>ANNUAL VISIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>• A1C, if the results are not available within the past 3 months</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• If not performed/available within the past year</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• Lipid profile, including total, LDL, and HDL cholesterol and triglycerides*</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• Liver function tests*</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• Spot urinary albumin-to-creatinine ratio</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• Serum creatinine and estimated glomerular filtration rate</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• Thyroid-stimulating hormone in patients with type 1 diabetes*</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• Vitamin B12 if on metformin (when indicated)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• Serum potassium levels in patients on ACE inhibitors, ARBs, or diuretics*</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

ABI, ankle-brachial pressure index; ARBs, angiotensin receptor blockers; CGM, continuous glucose monitors; MDL, multiple daily injections; NAFLD, nonalcoholic fatty liver disease; OSA, obstructive sleep apnea; PAD, peripheral arterial disease

*at 65 years of age or older

*may be needed more frequently in patients with known chronic kidney disease or with changes in medications that affect kidney function and serum potassium (see Table 11.1)

*may also need to be checked after initiation or dose changes of medications that affect these laboratory values (i.e., diabetes medications, blood pressure medications, cholesterol medications, or thyroid medications)

*in people without dyslipidemia and not on cholesterol lowering therapy; testing may be less frequent

*should be performed at every visit in patients with sensory loss, previous foot ulcers, or amputations

---

(19)
Table 4.2—Assessment and treatment plan*

Assessing risk of diabetes complications
- ASCVD and heart failure history
- ASCVD risk factors and 10-year ASCVD risk assessment
- Staging of chronic kidney disease (see Table 11.1)
- Hypoglycemia risk (see Table 4.3)

Goal setting
- Set A1C/blood glucose target
- If hypertension is present, establish blood pressure target
- Diabetes self-management goals

Therapeutic treatment plans
- Lifestyle management
- Pharmacologic therapy: glucose lowering
- Pharmacologic therapy: cardiovascular disease risk factors and renal
- Use of glucose monitoring and insulin delivery devices
- Referral to diabetes education and medical specialists (as needed)

ASCVD, atherosclerotic cardiovascular disease. *Assessment and treatment planning are essential components of initial and all follow-up visits.

For adults with diabetes, one dose of PPSV23 is recommended between the ages of 19–64 years and another dose at ≥65 years of age. The PCV13 is no longer routinely recommended for patients over 65 years of age because of the declining rates of pneumonia due to these strains (22). Older patients should have a shared decision-making discussion with their provider to determine individualized risks and benefits. PCV13 is recommended for patients with immunocompromising conditions such as asplenia, advanced kidney disease, cochlear implants, or cerebrospinal fluid leaks (23). Some older patients residing in assisted living facilities may also consider PCV13. If the PCV13 is to be administered, it should be given prior to the next dose of PPSV23.

Hepatitis B

Compared with the general population, people with type 1 or type 2 diabetes have higher rates of hepatitis B. This may be due to contact with infected blood or through improper equipment use (glucose monitoring devices or infected needles). Because of the higher likelihood of transmission, hepatitis B vaccine is recommended for adults with diabetes aged <60 years. For adults aged ≥60 years, hepatitis B vaccine may be administered at the discretion of the treating clinician based on the patient’s likelihood of acquiring hepatitis B infection.

COVID-19

During the coming year, it is expected that vaccines for COVID-19 will become available and that people with diabetes should be a priority population. The COVID-19 vaccine will likely become a routine part of the annual preventive schedule for people with diabetes.

ASSESSMENT OF COMORBIDITIES

Besides assessing diabetes-related complications, clinicians and their patients need to be aware of common comorbidities that affect people with diabetes and may complicate management (24–28). Diabetes comorbidities are conditions that affect people with diabetes more often than age-matched people without diabetes. This section discusses many of the common comorbidities observed in patients with diabetes but is not necessarily inclusive of all the conditions that have been reported.

Autoimmune Diseases

**Recommendations**

4.7 Patients with type 1 diabetes should be screened for autoimmune thyroid disease soon after diagnosis and periodically thereafter. B

4.8 Adult patients with type 1 diabetes should be screened for celiac disease in the presence of gastrointestinal symptoms, signs, or laboratory manifestations suggestive of celiac disease. B

People with type 1 diabetes are at increased risk for other autoimmune diseases, with thyroid disease, celiac disease, and pernicious anemia (vitamin B12 deficiency) being among the most common (29). Other associated conditions include autoimmune hepatitis, primary adrenal insufficiency (Addison disease), dermatomyositis, and myasthenia gravis (30–33). Type 1 diabetes may also occur with other autoimmune diseases in the context of specific genetic disorders or polyglandular autoimmune syndromes (34). Given the high prevalence, nonspecific symptoms, and insidious onset of primary hypothyroidism, routine screening for thyroid dysfunction is recommended for all patients with type 1 diabetes. Screening for celiac disease should be considered in adult patients with suggestive symptoms (e.g., diarrhea, malabsorption, abdominal pain) or signs (e.g., osteoporosis, vitamin deficiencies, iron deficiency anemia) (35,36). Measurement of vitamin B12 levels should be considered for patients with type 1 diabetes and peripheral neuropathy or unexplained anemia.

Cancer

Diabetes is associated with increased risk of cancers of the liver, pancreas, endometrium, colon/rectum, breast, and bladder (37). The association may result from
shared risk factors between type 2 diabetes and cancer (older age, obesity, and physical inactivity) but may also be due to diabetes-related factors (38), such as underlying disease physiology or diabetes treatments, although evidence for these links is scarce. Patients with diabetes should be encouraged to undergo recommended age- and sex-appropriate cancer screenings and to reduce their modifiable cancer risk factors (obesity, physical inactivity, and smoking). New onset of atypical diabetes (lean body habitus, negative family history) in a middle-aged or older patient may precede the diagnosis of pancreatic adenocarcinoma (39). However, in the absence of other symptoms (e.g., weight loss, abdominal pain), routine screening of all such patients is not currently recommended.

### Cognitive Impairment/Dementia

#### Recommendation

**4.9** In the presence of cognitive impairment, diabetes treatment regimens should be simplified as much as possible and tailored to minimize the risk of hypoglycemia. B

Diabetes is associated with a significantly increased risk and rate of cognitive decline and an increased risk of dementia (40,41). A recent meta-analysis of prospective observational studies in people with diabetes showed 73% increased risk of all types of dementia, 56% increased risk of Alzheimer dementia, and 127% increased risk of vascular dementia compared with individuals without diabetes (42). The reverse is also true: people with Alzheimer dementia are more likely to develop diabetes than people without Alzheimer dementia. In a 15-year prospective study of community-dwelling people >60 years of age, the presence of diabetes at baseline significantly increased the age- and sex-adjusted incidence of all-cause dementia, Alzheimer dementia, and vascular dementia compared with rates in those with normal glucose tolerance (43). See Section 12 “Older Adults” (https://doi.org/10.2337/dc21-S012) for a more detailed discussion regarding screening for cognitive impairment.

#### Hypoglycemia

In type 2 diabetes, severe hypoglycemia is associated with reduced cognitive function, and those with poor cognitive function have more severe hypoglycemia. In a long-term study of older patients with type 2 diabetes, individuals with one or more recorded episodes of severe hypoglycemia had a stepwise increase in risk of dementia (46). Likewise, the ACCORD trial found that as cognitive function decreased, the risk of severe hypoglycemia increased (47). Tailoring glycemic therapy may help to prevent hypoglycemia in individuals with cognitive dysfunction. See Section 12 “Older Adults” (https://doi.org/10.2337/dc21-S012) for more detailed discussion of hypoglycemia in older patients with type 1 and type 2 diabetes.

#### Hypertension

In those with type 2 diabetes, the degree and duration of hyperglycemia are related to dementia. More rapid cognitive decline is associated with both increased A1C and longer duration of diabetes (42). The Action to Control Cardiovascular Risk in Diabetes (ACCORD) study found that each 1% higher A1C level was associated with lower cognitive function in individuals with type 2 diabetes (44). However, the ACCORD study found no difference in cognitive outcomes in participants randomly assigned to intensive and standard glycemic control, supporting the recommendation that intensive glucose control should not be advised for the improvement of cognitive function in individuals with type 2 diabetes (45).

#### Hyperglycemia

In type 2 diabetes, severe hyperglycemia is associated with reduced cognitive function, and those with poor cognitive function have more severe hyperglycemia. In a recent meta-analysis of studies comparing intensive and standard glycemic control, higher hyperglycemia had a stepwise increase in risk of dementia (46). Likewise, the ACCORD trial found that as cognitive function decreased, the risk of severe hyperglycemia increased (47). Tailoring glycemic therapy may help to prevent hyperglycemia in individuals with cognitive dysfunction. See Section 12 “Older Adults” (https://doi.org/10.2337/dc21-S012) for more detailed discussion of hyperglycemia in older patients with type 1 and type 2 diabetes.

#### Statins

A systematic review has reported that data do not support an adverse effect of statins on cognition (50). The U.S. Food and Drug Administration postmarketing surveillance databases have also revealed a low reporting rate for cognitive-related adverse events, including cognitive dysfunction or dementia, with statin therapy, similar to rates seen with other commonly prescribed cardiovascular medications (50). Therefore, fear of cognitive decline should not be a barrier to statin use in individuals with diabetes and a high risk for cardiovascular disease.

#### Nonalcoholic Fatty Liver Disease

**Recommendation**

**4.10** Patients with type 2 diabetes or prediabetes and elevated liver enzymes (ALT) or fatty liver on ultrasound should be evaluated for presence of nonalcoholic steatohepatitis and liver fibrosis. C

Diabetes is associated with the development of nonalcoholic fatty liver disease, including its more severe manifestations of nonalcoholic steatohepatitis, liver fibrosis, cirrhosis, and hepatocellular carcinoma (51). Elevations of hepatic transaminase concentrations are associated with higher BMI, waist circumference, and triglyceride levels and lower HDL cholesterol levels. Noninvasive tests, such as elastography or fibrosis biomarkers, may be used to assess risk of fibrosis, but referral to a liver specialist and liver biopsy may be required for definitive diagnosis (52). Interventions that improve metabolic abnormalities in patients with diabetes (weight loss, glycemic control, and treatment with specific drugs for hyperglycemia or dyslipidemia) are also beneficial for fatty liver disease (53,54). Pioglitazone, vitamin E treatment, and liraglutide treatment of biopsy-proven nonalcoholic steatohepatitis have each been shown to improve liver histology, but effects on longer-term clinical
Table 4.5—Highly recommended immunizations for adult patients with diabetes (Advisory Committee on Immunization Practices, Centers for Disease Control and Prevention)

<table>
<thead>
<tr>
<th>Vaccination</th>
<th>Age-group recommendations</th>
<th>Frequency</th>
<th>GRADE evidence type*</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B</td>
<td>&lt;60 years of age; ≥60 years of age discuss with doctor</td>
<td>Two- or three-dose series</td>
<td>2</td>
<td>Centers for Disease Control and Prevention (CDC). Use of hepatitis B vaccination for adults with diabetes mellitus: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2011;60: 1709–1711</td>
</tr>
<tr>
<td>Human papilloma virus (HPV)</td>
<td>≤26 years of age; 27–45 years of age may also be vaccinated against HPV after a discussion with their health care provider</td>
<td>Three doses over 6 months</td>
<td>2 for females, 3 for males</td>
<td>Meites E, Szilagyi PG, Chesson HW, Unger ER, Romero JR, Markowitz LE. Human papillomavirus vaccination for adults: updated recommendations of the Advisory Committee on Immunization Practices. MMWR 2019;68:698–702</td>
</tr>
<tr>
<td>Pneumonia (PPSV23 [Pneumovax])</td>
<td>19–64 years of age, vaccinate with Pneumovax</td>
<td>One dose</td>
<td>2</td>
<td>CDC. Updated recommendations for prevention of invasive pneumococcal disease among adults using the 23-valent pneumococcal polysaccharide vaccine (PPSV23). MMWR 2010;59:1102–1106</td>
</tr>
<tr>
<td></td>
<td>≥65 years of age, obtain second dose of Pneumovax, at least 5 years from prior Pneumovax vaccine</td>
<td>One dose; if PCV13 has been given, then give PPSV23 ≥1 year after PCV13 and ≥5 years after any PPSV23 at age &lt;65 years</td>
<td>2</td>
<td>Falkenhorst G, Remschmidt C, Harder T, Hummers-Pradier E, Wichmann O, Bogdan C. Effectiveness of the 23-valent pneumococcal polysaccharide vaccine (PPV23) against pneumococcal disease in the elderly: systematic review and meta-analysis. PLoS ONE 2017;12:e0169368</td>
</tr>
</tbody>
</table>

Continued on p. S48
outcomes are not known (55–57). Treatment with other glucagon-like peptide 1 receptor agonists and with sodium–glucose cotransporter 2 inhibitors has shown promise in preliminary studies, although benefits may be mediated, at least in part, by weight loss (57–59).

**Hepatitis C Infection**

Infection with hepatitis C virus (HCV) is associated with a higher prevalence of type 2 diabetes, which is present in up to one-third of individuals with chronic HCV infection. HCV may impair glucose metabolism by several mechanisms, including directly via viral proteins and indirectly by altering proinflammatory cytokine levels (60). The use of newer direct-acting antiviral drugs produces a sustained virological response (cure) in nearly all cases and has been reported to improve glucose metabolism in individuals with diabetes (61). A meta-analysis of mostly observational studies found a mean reduction in A1C levels of 0.45% (95% CI −0.60 to −0.30) and reduced requirement for glucose-lowering medication use following successful eradication of HCV infection (62).

**Pancreatitis**

Diabetes is linked to diseases of the exocrine pancreas such as pancreatitis, which may disrupt the global architecture or physiology of the pancreas, often resulting in both exocrine and endocrine dysfunction. Up to half of patients with diabetes may have some degree of impaired exocrine pancreas function (63). People with diabetes are at an approximately twofold higher risk of developing acute pancreatitis (64).

Conversely, prediabetes and/or diabetes has been found to develop in approximately one-third of patients after an episode of acute pancreatitis (65); thus, the relationship is likely bidirectional. Postpancreatitis diabetes may include either new-onset disease or previously unrecognized diabetes (66). Studies of patients treated with incretin-based therapies for diabetes have also reported that pancreatitis may occur more frequently with these medications, but results have been mixed and causality has not been established (67–69).

Islet autotransplantation should be considered for patients requiring total pancreatectomy for medically refractory chronic pancreatitis to prevent postsurgical diabetes. Approximately one-third of patients undergoing total pancreatectomy with islet autotransplantation are insulin free 1 year postoperatively, and observational studies from different centers have demonstrated islet graft function up to a decade after the surgery in some patients (70–74). Both patient and disease factors should be carefully considered when deciding the indications and timing of this surgery. Surgeries should be performed in skilled facilities that have demonstrated expertise in islet autotransplantation.

**Fractures**

Age-specific hip fracture risk is significantly increased in both people with type 1 diabetes (relative risk 6.3) and those with type 2 diabetes (relative risk 1.7) in both sexes (75). Type 1 diabetes is associated with osteoporosis, but in type 2 diabetes, an increased risk of hip fracture is seen despite higher bone mineral density (BMD) (76). In three large observational studies of older adults, femoral neck BMD T-score and the World Health Organization Fracture Risk Assessment Tool (FRAX) score were associated with hip and nonspine fractures. Fracture risk was higher in participants with diabetes compared with those without diabetes for a given T-score and age or for a given FRAX score (77). Providers should assess fracture history and risk factors in older patients with diabetes and recommend measurement of BMD if appropriate for the patient’s age and sex. Fracture prevention strategies for people with diabetes are the same as for the general population and may include vitamin D supplementation. For patients with type 2 diabetes with fracture risk
factors, thiazolidinediones (78) and sodium-glucose cotransporter 2 inhibitors (79) should be used with caution.

**Sensory Impairment**

Hearing impairment, both in high-frequency and low- to midfrequency ranges, is more common in people with diabetes than in those without, with stronger associations found in studies of younger people (80). Proposed pathophysiologic mechanisms include the combined contributions of hyperglycemia and oxidative stress to cochlear microangiopathy and auditory neuropathy (81). In a National Health and Nutrition Examination Survey (NHANES) analysis, hearing impairment was about twice as prevalent in people with diabetes compared with those without, after adjusting for age and other risk factors for hearing impairment (82). Low HDL cholesterol, coronary heart disease, peripheral neuropathy, and general poor health have been reported as risk factors for hearing impairment for people with diabetes, but an association of hearing loss with blood glucose levels has not been consistently observed (83). In the Diabetes Control and Complications Trial/ Epidemiology of Diabetes Interventions and Complications (DCCT/EDIC) cohort, time-weighted mean A1C was associated with increased risk of hearing impairment when tested after long-term (≥20 years) follow-up (84). Impairment in smell, but not taste, has also been reported in individuals with diabetes (85).

**Low Testosterone in Men**

**Recommendation 4.11**

In men with diabetes who have symptoms or signs of hypogonadism, such as decreased sexual desire (libido) or activity, or erectile dysfunction, consider screening with a morning serum testosterone level. B

Mean levels of testosterone are lower in men with diabetes compared with age-matched men without diabetes, but obesity is a major confounder (86,87). Testosterone replacement in men with symptomatic hypogonadism may have benefits including improved sexual function, well-being, muscle mass and strength, and bone density (88). In men with diabetes who have symptoms or signs of low testosterone (hypogonadism), a morning total testosterone level should be measured using an accurate and reliable assay (89). In men who have total testosterone levels close to the lower limit, it is reasonable to determine free testosterone concentrations either directly from equilibrium dialysis assays or by calculations that use total testosterone, sex hormone binding globulin, and albumin concentrations (89). Please see the Endocrine Society Clinical Practice Guideline for detailed recommendations (89). Further tests (such as luteinizing hormone and follicle-stimulating hormone levels) may be needed to determine if the patient has hypogonadism. Testosterone replacement in older men with hypogonadism has been associated with increased coronary artery plaque volume, with no conclusive evidence that testosterone supplementation is associated with increased cardiovascular risk in hypogonadal men (89).

**Obstructive Sleep Apnea**

Age-adjusted rates of obstructive sleep apnea, a risk factor for cardiovascular disease, are significantly higher (4- to 10-fold) with obesity, especially with central obesity (90). The prevalence of obstructive sleep apnea in the population with type 2 diabetes may be as high as 23%, and the prevalence of any sleep-disordered breathing may be as high as 58% (91,92). In obese participants enrolled in the Action for Health in Diabetes (Look AHEAD) trial, it exceeded 80% (93). Patients with symptoms suggestive of obstructive sleep apnea (e.g., excessive daytime sleepiness, snoring, witnessed apnea) should be considered for screening (94). Sleep apnea treatment (lifestyle modification, continuous positive airway pressure, oral appliances, and surgery) significantly improves quality of life and blood pressure control. The evidence for a treatment effect on glycemic control is mixed (95).

**Periodontal Disease**

Periodontal disease is more severe, and may be more prevalent, in patients with diabetes than in those without and has been associated with higher A1C levels (96–98). Longitudinal studies suggest that people with periodontal disease have higher rates of incident diabetes. Current evidence suggests that periodontal disease adversely affects diabetes outcomes, although evidence for treatment benefits remains controversial (28,99). In a randomized clinical trial, intensive periodontal treatment was associated with better glycemic control (A1C 8.3% vs. 7.8% in control subjects and the intensive-treatment group, respectively) and reduction in inflammatory markers after 12 months of follow-up (100).

**References**

51. El-Serag HB, Tran T, Everhart JE. Diabetes increases the risk of chronic liver disease and hepatocellular carcinoma. Gastroenterology 2004;126:460–468


