Executive Summary: Standards of Medical Care in Diabetes—2010

Modified version focused on CCNC Quality Measures and Feedback Processes

See http://care.diabetesjournals.org/content/33/Supplement_1/S11.full for full edition of ADA 2010 Clinical Practice Recommendations

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Current criteria for the diagnosis of diabetes

- A1C ≥6.5%: The test should be performed in a laboratory using a method that is National Glycohemoglobin Standardization Program (NGSP) certified and standardized to the Diabetes Control and Complications Trial (DCCT) assay.
- FPG ≥126 mg/dl (7.0 mmol/l): Fasting is defined as no caloric intake for at least 8 h.
- 2-h plasma glucose ≥200 mg/dl (11.1 mmol/l) during an oral glucose tolerance test (OGTT): The test should be performed as described by the World Health Organization using a glucose load containing the equivalent of 75 g anhydrous glucose dissolved in water.
- In a patient with classic symptoms of hyperglycemia or hyperglycemic crisis: a random plasma glucose ≥200 mg/dl (11.1 mmol/l).

Testing for diabetes in asymptomatic patients

- Testing to detect type 2 diabetes and assess risk for future diabetes in asymptomatic people should be considered in adults of any age who are overweight or obese (BMI ≥25 kg/m^2) and who have one or more additional risk factors for diabetes (see Table 4 of Standards of Medical Care in Diabetes—2010). In those without these risk factors, testing should begin at age 45 years. (B)
- If tests are normal, repeat testing should be carried out at least at 3-year intervals. (E)
- To test for diabetes or to assess risk of future diabetes, A1C, FPG, or 2-h 75-g OGTT are appropriate. (B)
- In those identified with increased risk for future diabetes, identify and, if appropriate, treat other cardiovascular disease (CVD) risk factors. (B)

A1C

- Perform the A1C test at least two times a year in patients who are meeting treatment goals (and who have stable glycemic control). (E)
- Perform the A1C test quarterly in patients whose therapy has changed or who are not meeting glycemic goals. (E)
- Use of point-of-care testing for A1C allows for timely decisions on therapy changes, when needed. (E)

Glycemic goals in adults

- Lowering A1C to below or around 7% has been shown to reduce microvascular and neuropathic complications of type 1 and type 2 diabetes. Therefore, for microvascular disease prevention, the A1C goal for nonpregnant adults in general is <7%. (A)

- In type 1 and type 2 diabetes, randomized controlled trials of intensive versus standard glycemic control have not shown a significant reduction in CVD outcomes during the randomized portion of the trials. Long-term follow-up of the DCCT and UK Prospective Diabetes Study (UKPDS) cohorts suggests that treatment to A1C targets below or around 7% in the years soon after the diagnosis of diabetes is associated with long-term reduction in risk of macrovascular disease. Until more evidence becomes available, the general goal of <7% appears reasonable for many adults for macrovascular risk reduction. (B)

- Subgroup analyses of clinical trials such as the DCCT and UKPDS and evidence for reduced proteinuria in the ADVANCE trial suggest a small but incremental benefit in microvascular outcomes with A1C values closer to normal. Therefore, for selected individual patients, providers might reasonably suggest even lower A1C goals than the general goal of <7%, if this can be achieved without significant hypoglycemia or other adverse effects of treatment. Such patients might include those with short duration of diabetes, long life expectancy, and no significant CVD. (B)

- Conversely, less stringent A1C goals than the general goal of <7% may be appropriate for patients with a history of severe hypoglycemia, limited life expectancy, advanced microvascular or macrovascular complications, or extensive comorbid conditions and those with longstanding diabetes in whom the general goal is difficult to attain despite diabetes self-management education, appropriate glucose monitoring, and effective doses of multiple glucose-lowering agents including insulin. (C)

Hypertension/blood pressure control

Screening and diagnosis

- Blood pressure should be measured at every routine diabetes visit. Patients found to have systolic blood pressure ≥130 mmHg or diastolic blood pressure ≥80 mmHg should have blood pressure confirmed on a separate day. Repeat systolic blood pressure ≥130 mmHg or diastolic blood pressure ≥80 mmHg confirms a diagnosis of hypertension. (C)

Goals

- Patients with diabetes should be treated to a systolic blood pressure <130 mmHg. (C)

- Patients with diabetes should be treated to a diastolic blood pressure <80 mmHg. (B)

Treatment

- Patients with a systolic blood pressure of 130–139 mmHg or a diastolic blood pressure of 80–89 mmHg may be given lifestyle therapy alone for a maximum of 3

months, and then if targets are not achieved, be treated with addition of pharmacological agents. (E)

- Patients with more severe hypertension (systolic blood pressure ≥140 or diastolic blood pressure ≥90 mmHg) at diagnosis or follow-up should receive pharmacologic therapy in addition to lifestyle therapy. (A)

- Lifestyle therapy for hypertension consists of: weight loss if overweight, DASH-style dietary pattern including reducing sodium and increasing potassium intake, moderation of alcohol intake, and increased physical activity. (B)

- Pharmacologic therapy for patients with diabetes and hypertension should be with a regimen that includes either an ACE inhibitor or an angiotensin receptor blocker (ARB). If one class is not tolerated, the other should be substituted. If needed to achieve blood pressure targets, a thiazide diuretic should be added to those with an estimated glomerular filtration rate (GFR) (see below) ≥30 ml/min per 1.73 m^2 and a loop diuretic for those with an estimated GFR <30 ml/min per 1.73 m^2. (C)

- Multiple drug therapy (two or more agents at maximal doses) is generally required to achieve blood pressure targets. (B)

- If ACE inhibitors, ARBs, or diuretics are used, kidney function and serum potassium levels should be closely monitored. (E)

- In pregnant patients with diabetes and chronic hypertension, blood pressure target goals of 110–129/65–79 mmHg are suggested in the interest of long-term maternal health and minimizing impaired fetal growth. ACE inhibitors and ARBs are contraindicated during pregnancy. (E)

Dyslipidemia/lipid management

Screening

- In most adult patients, measure fasting lipid profile at least annually. In adults with low-risk lipid values (LDL cholesterol <100 mg/dl, HDL cholesterol >50 mg/dl, and triglycerides <150 mg/dl), lipid assessments may be repeated every 2 years. (E)

Treatment recommendations and goals

- Lifestyle modification focusing on the reduction of saturated fat, *trans* fat, and cholesterol intake; increase of n-3 fatty acids, viscous fiber, and plant stanols/sterols; weight loss (if indicated); and increased physical activity should be recommended to improve the lipid profile in patients with diabetes. (A)

- Statin therapy should be added to lifestyle therapy, regardless of baseline lipid levels, for diabetic patients:

  with overt CVD. (A)

without CVD who are over the age of 40 years and have one or more other CVD risk factors. (A)

- For lower risk patients than the above (e.g., without overt CVD and under the age of 40 years), statin therapy should be considered in addition to lifestyle therapy if LDL cholesterol remains above 100 mg/dl or in those with multiple CVD risk factors. (E)

- In individuals without overt CVD, the primary goal is an LDL cholesterol <100 mg/dl (2.6 mmol/l). (A)

- In individuals with overt CVD, a lower LDL cholesterol goal of <70 mg/dl (1.8 mmol/l), using a high dose of a statin, is an option. (B)

- If drug-treated patients do not reach the above targets on maximal tolerated statin therapy, a reduction in LDL cholesterol of ~30-40% from baseline is an alternative therapeutic goal. (A)

- Triglycerides levels <150 mg/dl (1.7 mmol/l) and HDL cholesterol >40 mg/dl (1.0 mmol/l) in men and >50 mg/dl (1.3 mmol/l) in women are desirable. However, LDL cholesterol-targeted statin therapy remains the preferred strategy. (C)

- If targets are not reached on maximally tolerated doses of statins, combination therapy using statins and other lipid-lowering agents may be considered to achieve lipid targets but has not been evaluated in outcome studies for either CVD outcomes or safety. (E)

- Statin therapy is contraindicated in pregnancy. (E)

Antiplatelet agents

- Consider aspirin therapy (75-162 mg/day) as a primary prevention strategy in those with type 1 or type 2 diabetes at increased cardiovascular risk (10-year risk >10%). This includes most men >50 years of age or women >60 years of age who have at least one additional major risk factor (family history of CVD, hypertension, smoking, dyslipidemia, or albuminuria). (C)

- There is not sufficient evidence to recommend aspirin for primary prevention in lower risk individuals, such as men <50 years of age or women <60 years of age without other major risk factors. In patients in these age-groups with multiple other risk factors, clinical judgment is required. (C)

- Use aspirin therapy (75-162 mg/day) as a secondary prevention strategy in those with diabetes with a history of CVD. (A)

- For patients with CVD and documented aspirin allergy, clopidogrel (75 mg/day) should be used. (B)

- Combination therapy with ASA (75–162 mg/day) and clopidogrel (75 mg/day) is reasonable for up to a year after an acute coronary syndrome. (B)

Smoking cessation

- Advise all patients not to smoke. (A)
- Include smoking cessation counseling and other forms of treatment as a routine component of diabetes care. (B)

Coronary heart disease

Screening

- In asymptomatic patients, evaluate risk factors to stratify patients by 10-year risk, and treat risk factors accordingly. (B)

Treatment

- In patients with known CVD, ACE inhibitor (C) and aspirin and statin therapy (A) (if not contraindicated) should be used to reduce the risk of cardiovascular events.
- In patients with a prior myocardial infarction, B-blockers should be continued for at least 2 years after the event. (B)
- Longer term use of B-blockers in the absence of hypertension is reasonable if well tolerated, but data are lacking. (E)
- Avoid TZD treatment in patients with symptomatic heart failure. (C)
- Metformin may be used in patients with stable congestive heart failure (CHF) if renal function is normal. It should be avoided in unstable or hospitalized patients with CHF. (C)

Nephropathy screening and treatment

General recommendations

- To reduce the risk or slow the progression of nephropathy, optimize glucose control. (A)
- To reduce the risk or slow the progression of nephropathy, optimize blood pressure control. (A)

Screening

- Perform an annual test to assess urine albumin excretion in type 1 diabetic patients with diabetes duration of $\geq$5 years and in all type 2 diabetic patients starting at diagnosis. (E)

- Measure serum creatinine at least annually in all adults with diabetes regardless of the degree of urine albumin excretion. The serum creatinine should be used to estimate GFR and stage the level of chronic kidney disease (CKD), if present. (E)

Treatment

- In the treatment of the nonpregnant patient with micro- or macroalbuminuria, either ACE inhibitors or ARBs should be used. (A)

- While there are no adequate head-to-head comparisons of ACE inhibitors and ARBs, there is clinical trial support for each of the following statements:

  In patients with type 1 diabetes with hypertension and any degree of albuminuria, ACE inhibitors have been shown to delay the progression of nephropathy. (A)

  In patients with type 2 diabetes, hypertension, and microalbuminuria, both ACE inhibitors and ARBs have been shown to delay the progression to macroalbuminuria. (A)

  In patients with type 2 diabetes, hypertension, macroalbuminuria, and renal insufficiency (serum creatinine >1.5 mg/dl), ARBs have been shown to delay the progression of nephropathy. (A)

- If one class is not tolerated, the other should be substituted. (E) Reduction of protein intake to 0.8–1.0 g · kg body wt^{-1} · day^{-1} in individuals with diabetes and the earlier stages of CKD and to 0.8 g · kg body wt^{-1} · day^{-1} in the later stages of CKD may improve measures of renal function (urine albumin excretion rate, GFR) and is recommended. (B)

- When ACE inhibitors, ARBs, or diuretics are used, monitor serum creatinine and potassium levels for the development of acute kidney disease and hyperkalemia. (E)

- Continued monitoring of urine albumin excretion to assess both response to therapy and progression of disease is recommended. (E)

- Consider referral to a physician experienced in the care of kidney disease when there is uncertainty about the etiology of kidney disease (active urine sediment, absence of retinopathy, rapid decline in GFR), difficult management issues, or advanced kidney disease. (B)

Retinopathy screening and treatment

General recommendations

- To reduce the risk or slow the progression of retinopathy, optimize glycemic control. (A)

- To reduce the risk or slow the progression of retinopathy, optimize blood pressure control. (A)

Screening

- Adults and children aged 10 years or older with type 1 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist within 5 years after the onset of diabetes. (B)

- Patients with type 2 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist shortly after the diagnosis of diabetes. (B)

- Subsequent examinations for type 1 and type 2 diabetic patients should be repeated annually by an ophthalmologist or optometrist. Less-frequent exams (every 2-3 years) may be considered following one or more normal eye exams. Examinations will be required more frequently if retinopathy is progressing. (B)

- High-quality fundus photographs can detect most clinically significant diabetic retinopathy. Interpretation of the images should be performed by a trained eye care provider. While retinal photography may serve as a screening tool for retinopathy, it is not a substitute for a comprehensive eye exam, which should be performed at least initially and at intervals thereafter as recommended by an eye care professional. (E)

- Women with preexisting diabetes who are planning pregnancy or who have become pregnant should have a comprehensive eye examination and be counseled on the risk of development and/or progression of diabetic retinopathy. Eye examination should occur in the first trimester with close follow-up throughout pregnancy and for 1 year postpartum. (B)

Treatment

- Promptly refer patients with any level of macular edema, severe nonproliferative diabetic retinopathy (NPDR), or any proliferative diabetic retinopathy (PDR) to an ophthalmologist who is knowledgeable and experienced in the management and treatment of diabetic retinopathy. (A)

- Laser photocoagulation therapy is indicated to reduce the risk of vision loss in patients with high-risk PDR, clinically significant macular edema, and in some cases of severe NPDR. (A)

- The presence of retinopathy is not a contraindication to aspirin therapy for cardioprotection, as this therapy does not increase the risk of retinal hemorrhage. (A)

Neuropathy screening and treatment

- All patients should be screened for distal symmetric polyneuropathy (DPN) at diagnosis and at least annually thereafter, using simple clinical tests. (B)

- Electrophysiological testing is rarely needed, except in situations where the clinical features are atypical. (E)

- Screening for signs and symptoms of cardiovascular autonomic neuropathy should be instituted at diagnosis of type 2 diabetes and 5 years after the diagnosis of type 1 diabetes. Special testing is rarely needed and may not affect management or outcomes. (E)

- Medications for the relief of specific symptoms related to DPN and autonomic neuropathy are recommended, as they improve the quality of life of the patient. (E)

Foot care

- For all patients with diabetes, perform an annual comprehensive foot examination to identify risk factors predictive of ulcers and amputations. The foot examination should include inspection, assessment of foot pulses, and testing for loss of protective sensation (10-g monofilament plus testing any one of: vibration using 128-Hz tuning fork, pinprick sensation, ankle reflexes, or vibration perception threshold). (B)

- Provide general foot self-care education to all patients with diabetes. (B)

- A multidisciplinary approach is recommended for individuals with foot ulcers and high-risk feet, especially those with a history of prior ulcer or amputation. (B)

- Refer patients who smoke, have loss of protective sensation and structural abnormalities, or have history of prior lower-extremity complications to foot care specialists for ongoing preventive care and life-long surveillance. (C)

- Initial screening for peripheral artery disease (PAD) should include a history for claudication and an assessment of the pedal pulses. Consider obtaining an ankle-brachial index (ABI), as many patients with PAD are asymptomatic. (C)

- Refer patients with significant claudication or a positive ABI for further vascular assessment and consider exercise, medications, and surgical options. (C)

Immunization

- Annually provide an influenza vaccine to all diabetic patients 6 months of age. (C)

- Administer pneumococcal polysaccharide vaccine to all diabetic patients $\geq$2 years of age. A one-time revaccination is recommended for individuals >64 years of age previously immunized when they were <65 years of age if the vaccine was administered >5 years ago. Other indications for repeat vaccination include nephrotic syndrome, chronic renal disease, and other immunocompromised states, such as after transplantation. (C)

Psychosocial assessment and care

- Assessment of psychological and social situation should be included as an ongoing part of the medical management of diabetes. (E)

- Psychosocial screening and follow-up should include, but is not limited to, attitudes about the illness, expectations for medical management and outcomes, affect/mood, general and diabetes-related quality of life, resources (financial, social, and emotional), and psychiatric history. (E)

- Screen for psychosocial problems such as depression and diabetes-related distress, anxiety, eating disorders, and cognitive impairment when self-management is poor. (C)

Diabetes self-management education

- People with diabetes should receive diabetes self-management education (DSME) according to national standards when their diabetes is diagnosed and as needed thereafter. (B)

- Effective self-management and quality of life are the key outcomes of DSME and should be measured and monitored as part of care. (C)

- DSME should address psychosocial issues, since emotional well-being is associated with positive diabetes outcomes. (C)

- Because DSME can result in cost-savings and improved outcomes (B), DSME should be reimbursed by third-party payors. (E)

Glucose monitoring

- Self-monitoring of blood glucose (SMBG) should be carried out three or more times daily for patients using multiple insulin injections or insulin pump therapy. (A)

- For patients using less frequent insulin injections, noninsulin therapies, or medical nutrition therapy (MNT) alone, SMBG may be useful as a guide to the success of therapy. (E)

- To achieve postprandial glucose targets, postprandial SMBG may be appropriate. (E)

- When prescribing SMBG, ensure that patients receive initial instruction in, and routine follow-up evaluation of, SMBG technique and their ability to use data to adjust therapy. (E)

- Continuous glucose monitoring (CGM) in conjunction with intensive insulin regimens can be a useful tool to lower A1C in selected adults (age >25 years) with type 1 diabetes. (A)

- Although the evidence for A1C-lowering is less strong in children, teens, and younger adults, CGM may be helpful in these groups. Success correlates with adherence to ongoing use of the device. (C)

- CGM may be a supplemental tool to SMBG in those with hypoglycemia unawareness and/or frequent hypoglycemic episodes. (E)

Medical nutrition therapy

General recommendations

- Individuals who have pre-diabetes or diabetes should receive individualized medical nutrition therapy (MNT) as needed to achieve treatment goals, preferably provided by a registered dietitian familiar with the components of diabetes MNT. (A)

- Because MNT can result in cost-savings and improved outcomes (B), MNT should be covered by insurance and other payors. (E)

Energy balance, overweight, and obesity

- In overweight and obese insulin-resistant individuals, modest weight loss has been shown to reduce insulin resistance. Thus, weight loss is recommended for all overweight or obese individuals who have or are at risk for diabetes. (A)

- For weight loss, either low-carbohydrate or low-fat calorie-restricted diets may be effective in the short-term (up to 1 year). (A)

- For patients on low-carbohydrate diets, monitor lipid profiles, renal function, and protein intake (in those with nephropathy) and adjust hypoglycemic therapy as needed. (E)

- Physical activity and behavior modification are important components of weight loss programs and are most helpful in maintenance of weight loss. (B)

Dietary fat intake in diabetes management

- Saturated fat intake should be $<7\%$ of total calories. (A)

- Reducing intake of *trans* fat lowers LDL cholesterol and increases HDL cholesterol (A); therefore, intake of *trans* fat should be minimized. (E)

Carbohydrate intake in diabetes management

- Monitoring carbohydrate, whether by carbohydrate counting, exchanges, or experience-based estimation, remains a key strategy in achieving glycemic control. (A)

- For individuals with diabetes, the use of the glycemic index and glycemic load may provide a modest additional benefit for glycemic control over that observed when total carbohydrate is considered alone. (B)

Other nutrition recommendations

- Sugar alcohols and nonnutritive sweeteners are safe when consumed within the acceptable daily intake levels established by the Food and Drug Administration (FDA). (A)

- If adults with diabetes choose to use alcohol, daily intake should be limited to a moderate amount (one drink per day or less for adult women and two drinks per day or less for adult men). (E)

- Routine supplementation with antioxidants, such as vitamins E and C and carotene, is not advised because of lack of evidence of efficacy and concern related to long-term safety. (A)

- Benefit from chromium supplementation in people with diabetes or obesity has not been conclusively demonstrated and, therefore, cannot be recommended. (C)

- Individualized meal planning should include optimization of food choices to meet recommended dietary allowances (RDAs)/dietary reference intakes (DRIs) for all micronutrients. (E)

Physical activity

- People with diabetes should be advised to perform at least 150 min/week of moderate-intensity aerobic physical activity (50–70% of maximum heart rate). (A)

- In the absence of contraindications, people with type 2 diabetes should be encouraged to perform resistance training three times per week. (A)

Prevention of type 2 diabetes

- Patients with IGT (A), IFG (E), or an A1C of 5.7–6.4% (E) should be referred to an effective ongoing support program for weight loss of 5–10% of body weight and increase in physical activity to at least 150 min/week of moderate activity such as walking.

- Follow-up counseling appears to be important for success. (B)

- Based on potential cost savings of diabetes prevention, such counseling should be covered by third-party payors. (E)

- In addition to lifestyle counseling, metformin may be considered in those who are at very high risk for developing diabetes (combined IFG and IGT plus other risk factors such as A1C >6%, hypertension, low HDL cholesterol, elevated triglycerides, or family history of diabetes in a first-degree relative) and who are obese and under 60 years of age. (E)

- Monitoring for the development of diabetes in those with pre-diabetes should be performed every year. (E)

Primary prevention of diabetes

- Among individuals at high risk for developing type 2 diabetes, structured programs emphasizing lifestyle changes including moderate weight loss (7% body weight) and regular physical activity (150 min/week), with dietary strategies including reduced calories and reduced intake of dietary fat, can reduce the risk for developing diabetes and are therefore recommended. (A)

- Individuals at high risk for type 2 diabetes should be encouraged to achieve the U.S. Department of Agriculture (USDA) recommendation for dietary fiber (14 g fiber/1,000 kcal) and foods containing whole grains (one-half of grain intake). (B)

Children and adolescents

Glycemic control

- Consider age when setting glycemic goals in children and adolescents with type 1 diabetes, with less stringent goals for younger children. (E)

Nephropathy

- Annual screening for microalbuminuria, with a random spot urine sample for microalbumin-to-creatinine ratio, should be initiated once the child is 10 years of age and has had diabetes for 5 years. (E)

- Confirmed, persistently elevated microalbumin levels on two additional urine specimens should be treated with an ACE inhibitor, titrated to normalization of microalbumin excretion if possible. (E)

Hypertension

- Treatment of high-normal blood pressure (systolic or diastolic blood pressure consistently above the 90th percentile for age, sex, and height) should include dietary intervention and exercise, aimed at weight control and increased physical activity, if appropriate. If target blood pressure is not reached with 3–6 months of lifestyle intervention, pharmacologic treatment should be initiated. (E)

- Pharmacologic treatment of hypertension (systolic or diastolic blood pressure consistently above the 95th percentile for age, sex, and height or consistently greater than 130/80 mmHg, if 95% exceeds that value) should be initiated as soon as the diagnosis is confirmed. (E)

- ACE inhibitors should be considered for the initial treatment of hypertension. (E)

- The goal of treatment is a blood pressure consistently <130/80 or below the 90th percentile for age, sex, and height, whichever is lower. (E)

Dyslipidemia

Screening

- If there is a family history of hypercholesterolemia (total cholesterol >240 mg/dl) or a cardiovascular event before age 55 years, or if family history is unknown, then a fasting lipid profile should be performed on children >2 years of age soon after diagnosis (after glucose control has been established). If family history is not of concern, then the first lipid screening should be performed at puberty (≥10 years). All children diagnosed with diabetes at or after puberty should have a fasting lipid profile performed soon after diagnosis (after glucose control has been established). (E)

- For both age-groups, if lipids are abnormal, annual monitoring is recommended. If LDL cholesterol values are within the accepted risk levels (<100 mg/dl [2.6 mmol/l]), a lipid profile should be repeated every 5 years. (E)

Treatment

- Initial therapy should consist of optimization of glucose control and MNT using a Step II American Heart Association diet aimed at a decrease in the amount of saturated fat in the diet. (E)

- After the age of 10 years, the addition of a statin is recommended in patients who, after MNT and lifestyle changes, have LDL cholesterol >160 mg/dl (4.1 mmol/l) or LDL cholesterol >130 mg/dl (3.4 mmol/l) and one or more CVD risk factors. (E)

- The goal of therapy is an LDL cholesterol value <100 mg/dl (2.6 mmol/l). (E)

Retinopathy

- The first ophthalmologic examination should be obtained once the child is 10 years of age and has had diabetes for 3-5 years. (E)

- After the initial examination, annual routine follow-up is generally recommended. Less frequent examinations may be acceptable on the advice of an eye care professional. (E)

Celiac disease

- Children with type 1 diabetes should be screened for celiac disease by measuring tissue transglutaminase or anti-endomysial antibodies, with documentation of normal serum IgA levels, soon after the diagnosis of diabetes. (E)

- Testing should be repeated if growth failure, failure to gain weight, weight loss, or gastroenterologic symptoms occur. (E)

- Consideration should be given to periodic re-screening of asymptomatic individuals. (E)

- Children with positive antibodies should be referred to a gastroenterologist for evaluation. (E)
- Children with confirmed celiac disease should have consultation with a dietitian and placed on a gluten-free diet. (E)