

Managing diabetic dyslipidemia: Testing is step one

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Recently, the Centers for Disease Control and Prevention (CDC) estimated that 18.2 million Americans have diabetes, the sixth leading cause of death in the United States.¹ Of that number, over 70% of all deaths are due to macrovascular complications—CVD, cerebrovascular disease, and peripheral vascular disease.² CVD events are 4 times more likely, occur at a younger age, and have a much greater case fatality rate among adults with diabetes.³ Indeed, the National Cholesterol Education Program (NCEP) considers diabetes to be a CVD risk equivalent, requiring aggressive care to prevent future vascular events.⁴

The CDC estimated in 2000 that 70% to 97% of individuals with diabetes have dyslipidemia.⁵ Improved control of blood lipids can reduce cardiovascular complications by 24% to 55%.⁶ Yet reports from two academic medical centers indicate that only 35.5% of patients attending their diabetes clinics had reached the goal of LDL <100mg/dl.⁷

A study of Medicare claims indi-

cates that one of the key reasons that so many diabetic patients have uncontrolled dyslipidemia is that lipid testing is not performed frequently enough for these patients. From April 2001 to March 2003, MetaStar's analysis of Medicare Part B claims data shows that 15.5% of diabetic patients in Wisconsin—almost 1 out of 6—did not have a lipid panel drawn.⁸ And this was within a 2-year period, which is the recommended frequency of testing only for patients with low-risk lipid values (LDL <100mg/dl, HDL >50 mg/dl, triglycerides <150 mg/dl). For adult patients with diabetes who have not reached these values, the American Diabetes Association recommends lipid assessments at least annually and more often if needed.⁹ The American Association of Clinical Endocrinologists system of intensive diabetes self-management has even stronger recommendations: follow-up assessments at intervals of no longer than 3 months, with each assessment to include a fasting lipid profile.¹⁰

As with many other health indicators, the situation is even worse in the case of minorities. Diabetes is substantially more prevalent in the African-American population than among whites: The 1997 Behavioral Risk Factor Surveillance Survey found that almost 18% of Wisconsin African-American respondents reported being told by a health

professional that they had diabetes, as opposed to 4.2% of whites.¹¹ However, MetaStar's analysis of Medicare Part B claims data indicates that while 15.1% of non-African American diabetic beneficiaries did not have their lipids tested, 25.9% of African-American diabetic beneficiaries did not.

The lesson is clear. Greater efforts must be made to ensure that all diabetic patients receive a regular lipid assessment, so that those who are dyslipidemic can obtain appropriate treatment.

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