Managing diabetic dyslipidemia: Testing is step one

Jay A. Gold, MD, JD, MPH

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 indicates 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.

References

The mission of the Wisconsin Medical Journal is to provide a vehicle for professional communication and continuing education of Wisconsin physicians.

The Wisconsin Medical Journal (ISSN 1098-1861) is the official publication of the Wisconsin Medical Society and is devoted to the interests of the medical profession and health care in Wisconsin. The managing editor is responsible for overseeing the production, business operation and contents of Wisconsin Medical Journal. The editorial board, chaired by the medical editor, solicits and peer reviews all scientific articles; it does not screen public health, socioeconomic or organizational articles. Although letters to the editor are reviewed by the medical editor, all signed expressions of opinion belong to the author(s) for which neither the Wisconsin Medical Journal nor the Society take responsibility. The Wisconsin Medical Journal is indexed in Index Medicus, Hospital Literature Index and Cambridge Scientific Abstracts.

For reprints of this article, contact the Wisconsin Medical Journal at 866.442.3800 or e-mail wmj@wismed.org.

© 2004 Wisconsin Medical Society