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LETTER TO THE EDITOR

Reply to the Letter by M.S. Raghuraman Regarding "Perioperative Management of Diabetes Mellitus: Novel Approaches"

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Dear Editor,

We thank Dr. Raghuraman for his comments on our article [1] and appreciate the opportunity to clarify our statement about the postoperative glycemic goals.

We agree that perioperative glycemic control needs more attention from all medical professionals and we look forward to future studies in this area. We also agree that many of the perioperative glycemic control measures can be implemented by physicians without special training in diabetes.

Regarding the risk of hypoglycemia with glucose targets 100–180 mg/dl on the general floors, we want to clarify that our suggestion is based on several pieces of data, the American Diabetes Association (ADA) guidelines, and our own experience. In fact, the ADA clinical practice guidelines suggest a target glucose range of 80–180 mg/dl in the perioperative period [2]. We agree that treatment targets should be individualized and in some patients, higher glucose levels may be appropriate [3]. However, it is highly unlikely that the risk of hypoglycemia will be increased if the lower end of the target range is 100 instead of 110 or 140 mg/dl. In a study of postoperative glycemic control comparing basal-bolus insulin with sliding scale insulin regimen on the general floors, where fasting and premeal glucose targets were 100–140 mg/dL, severe hypoglycemia occurred in only 4 out of 104 patients in the basal-bolus group and 0 of 107 patients in the sliding scale group [4]. We suggest surveillance of any glycemic control program to ensure that hypoglycemia rate does not go up after implementation of the program. If rate of hypoglycemia increases, the target glucose level may be adjusted to higher levels after ruling out other causes like incorrect implementation of protocols or inadequate blood glucose testing.

References

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