

24 DE OUTUBRO – QUINTA-FEIRA

SESSÃO TELEVOTER DIABETES

**ANTÓNIO PEDRO MACHADO
SIMÕES PEREIRA**

Critérios para o diagnóstico de **Diabetes**

A1C $\geq 6.5\%$

ou

Gl jej ≥ 126 mg/dl

ou

PTGO - Glicémia à 2ª hora ≥ 200 mg/dL

ou

Qualquer gl ≥ 200 mg/dL em doente com sintomas clássicos de hiperglicémia ou crise hiperglicêmica

Na ausência de hiperglicémia inequívoca o resultado deverá ser confirmado

Critérios para o diagnóstico de **Prediabetes**

Gl jj - entre 110 - 125 mg/dl *

ou

PTGO - Glicémia entre 140 - 199 mg/dl à 2ª hora

ou

A1C - entre 5.7 - 6.4%

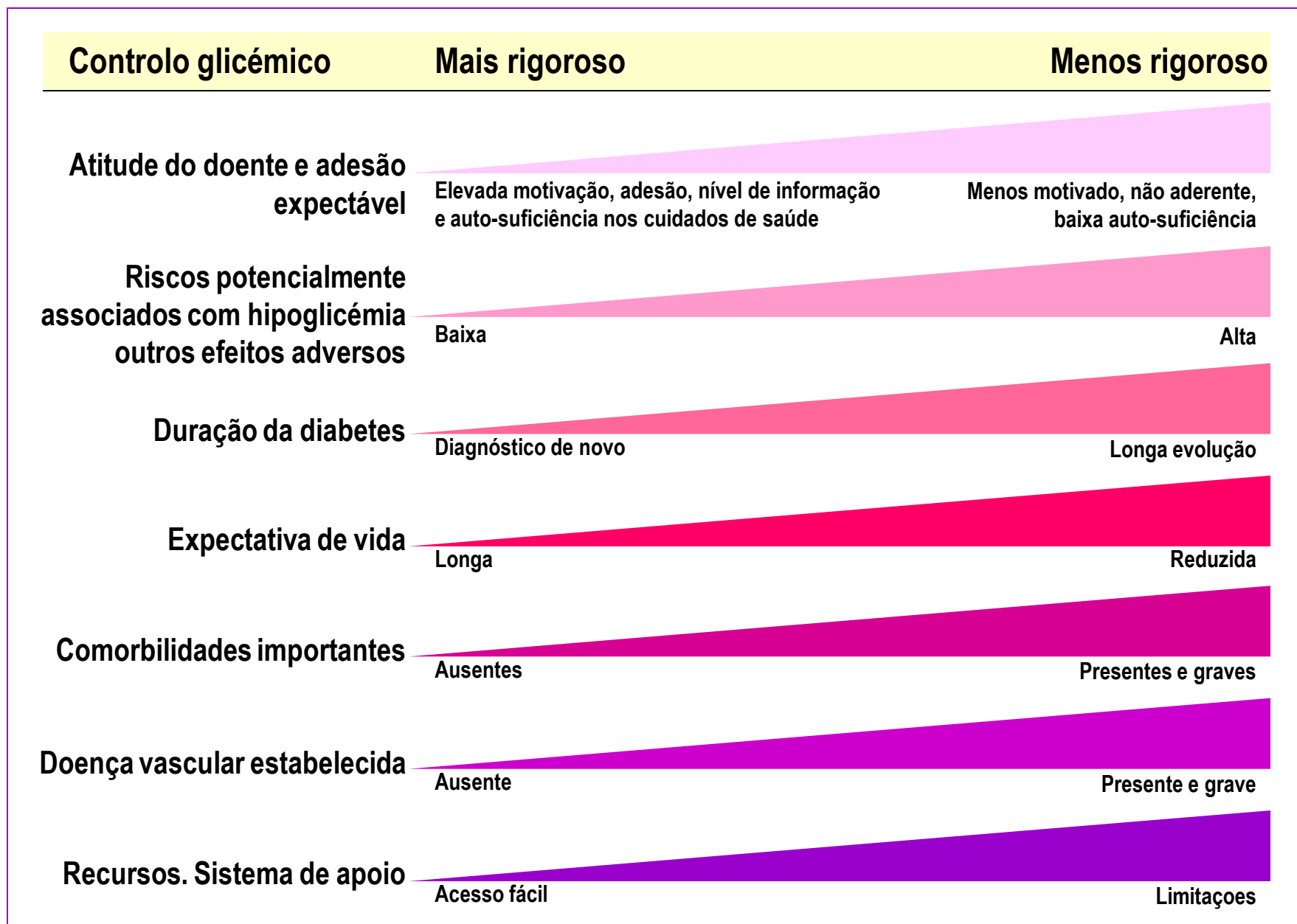
**A1C e risco de desenvolvimento de diabetes num
follow-up médio de 5 anos**

HbA1C	Risco de diabetes
5.5 – 6.0%	9 - 25%
6.0 – 6.5%	25 – 50%

Indicações para tratamento com metformina na pré-diabetes (prevenção da DM2)

- **Aumento da tolerância à glucose
(PTGO gl 2h entre 140-199 mg/dL) (A)**
- **Anomalia da glicemia em jejum
(G ljj entre 110-125 mg/dL) (E)**
- **A1C entre 5.7-6.4% (E)**
- **Especialmente se:**
 - **IMC > 35 Kg/m²**
 - **Idade < 60 anos**
 - **Diabetes gestacional prévia**

Elementos usados para definir os alvos glicêmicos a atingir



Objectivos glicémicos em adultos

HbA1C alvo



± 6%	Factores de decisão	± 8%
Elevada motivação, adesão, nível de informação e auto-suficiência	Atitude do doente e adesão expectável	Baixa motivação, adesão, nível de informação e auto-suficiência
Baixo	Risco associado a hipoglic.	Elevado
Baixo	Risco de hipoglicémia	Elevado
Curta	Duração a diabetes	Longa
Elevada	Expectativa de vida	Baixa
Sem	Doença microvascular	Avançada
Sem	Doença macrovascular	Estabelecida
Sem	Comorbilidades associadas	Múltiplas, graves
Adequado	Recursos. Sistema de apoio	Inadequado

Objectivos glicémicos em adultos

(mulheres não grávidas)

HbA1C	< 7.0%
Gl capilar pré-prandial	70-130 mg/dL
Gl capilar pp (1-2 h)	< 180 mg/dL

Objectivos glicémicos em adultos

(mulheres não grávidas)

A1C < 6.5% (\pm 6%)	A1C < 7%	A1C < 7.5-8%
<ul style="list-style-type: none">• Se o risco associada às hipoglicémias for baixo• Diabetes de curta evolução• Expectativa de vida longa• Sem DCV significativa	Objectivo global	<ul style="list-style-type: none">• Se o risco associada às hipoglicémias for alto• Diabetes de longa evolução• Expectativa de vida diminuída• Com DCV significativa

A SCORE Chart não se aplica aos diabéticos

Risco de DCV fatal aos 10 anos

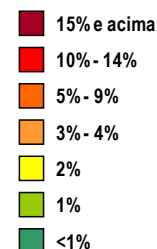
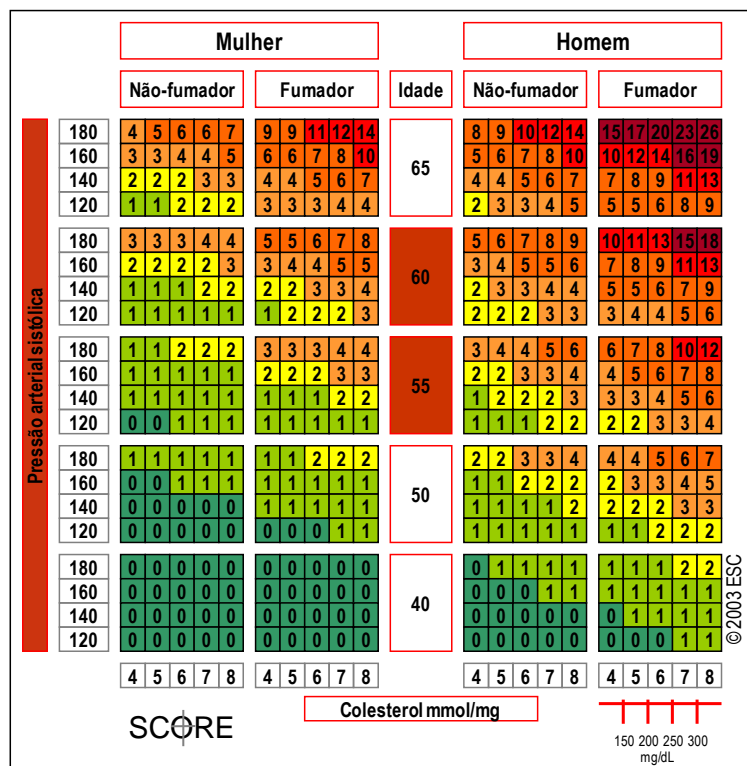
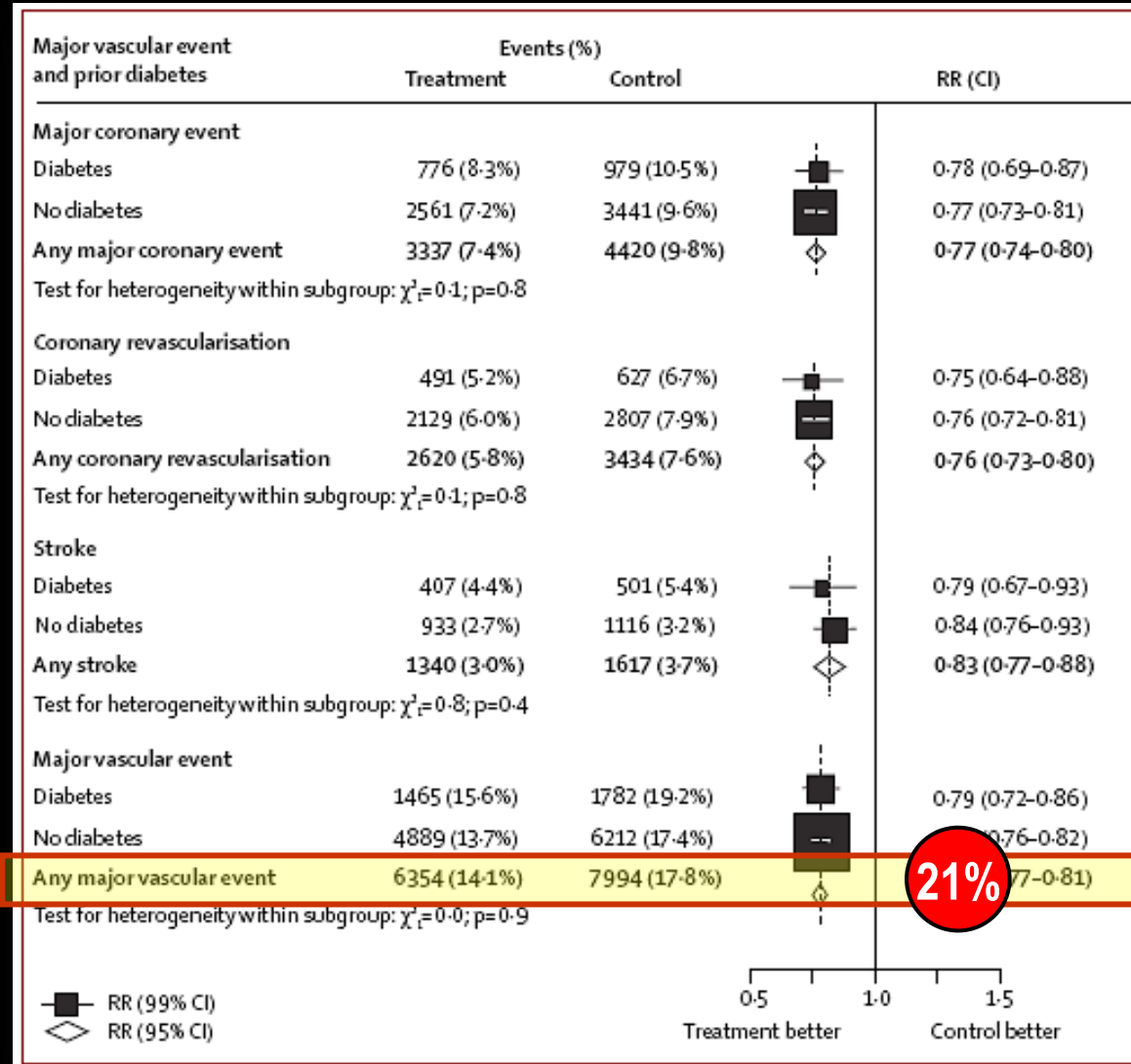


Tabela de baixo-risco
para utilizar em:

Bélgica
França
Grécia
Itália
Luxemburgo
Espanha
Suíça
Portugal

Metanálise CTTC

Eficácia das Estatinas nos diabéticos



Dislipidémia/modificação dos lípidos em diabéticos

Recomendações terapêuticas e objectivos

Deve prescrever-se uma estatina em adição à modificação dos estilos de vida, independentemente dos valores lipídicos basais:

- Com DCV documentada (A)
- Sem DCV em idades > 40 anos com ≥ 1 factor de risco CV adicional (A)

Para doentes de baixo risco (< 40 anos e sem DCV documentada)

- Considerar indicação para estatina em adição à modificação dos estilos de vida se LDL > 100 mg/dL
- Se presentes múltiplos factores de risco CV

Dislipidémia/modificação dos lípidos em diabéticos

Recomendações terapêuticas e objectivos

Em diabéticos sem DCV documentada

- LDL < **100** mg/dL (B)

Em diabéticos com DCV documentada

- LDL < **70** mg/dL, usando dose elevada de uma estatina (B)

Type 2 Diabetes as a "Coronary Heart Disease Equivalent"

An 18-year prospective population-based study in Finnish subjects

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TAPANI RÖNNEMAA, MD²

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MARKKU LAAKSO, MD¹

OBJECTIVE — The purpose of this study was to investigate the hypothesis that coronary heart disease (CHD) mortality in diabetic subjects without prior evidence of CHD is equal to that in nondiabetic subjects with prior myocardial infarction or any prior evidence of CHD.

RESEARCH DESIGN AND METHODS — During an 18-year follow-up total, cardiovascular disease (CVD) and CHD deaths were registered in a Finnish population-based study of 1,373 nondiabetic and 1,059 diabetic subjects.

RESULTS — Adjusted multivariate Cox hazard models indicated that diabetic subjects without prior myocardial infarction, compared with nondiabetic subjects with prior myocardial infarction, had a hazard ratio (HR) of 0.9 (95% CI 0.6–1.5) for the risk of CHD death. The corresponding HR was 0.9 (0.5–1.4) in men and 1.9 (0.6–6.1) in women. Diabetic subjects without any prior evidence of CHD (myocardial infarction or ischemic electrocardiogram [ECG] changes or angina pectoris), compared with nondiabetic subjects with prior evidence of CHD, had an HR of 1.9 (1.4–2.6) for CHD death (men 1.5 [1.0–2.2]; women 3.5 [1.8–6.8]). The results for CVD and total mortality were quite similar to those for CHD mortality.

CONCLUSIONS — Diabetes without prior myocardial infarction and prior myocardial infarction without diabetes indicate similar risk for CHD death in men and women. However, diabetes without any prior evidence of CHD (myocardial infarction or angina pectoris or ischemic ECG changes) indicates a higher risk than prior evidence of CHD in nondiabetic subjects, especially in women.

Diabetes Care 28:2901–2907, 2005

Type 2 diabetes increases the risk of coronary heart disease (CHD) events at least by two- to threefold in type 2 diabetic subjects compared with nondiabetic subjects (1). In type 2 diabetic women the relative risk is even greater (2). The reasons for this increased risk are largely unknown but could be related at least in part to more adverse changes in cardiovascular risk factors among diabetic women compared with diabetic men. Although the incidence of CHD events in nondiabetic subjects has

considerably decreased during the last decades, this is not true for type 2 diabetic patients, particularly for women (3).

We previously reported that type 2 diabetic patients without a history of prior myocardial infarction have the same risk of CHD death as nondiabetic subjects with a history of prior myocardial infarction (4). This observation has led to the conclusion that type 2 diabetes is a CHD equivalent and has had a profound effect, particularly on the recommendations for treatment of dyslipidemia (5).

During recent years other studies have investigated the same question in different populations and study settings. Contradictory results have been obtained, with some studies confirming our original findings (6–10) and some studies reporting opposite results, especially among men (11–18). The conclusion of these studies is that type 2 diabetes might be a CHD equivalent, but only among women.

Our original study population included 1,059 patients with type 2 diabetes and 1,373 nondiabetic subjects, who were followed for up to 7 years (4). The limitation of our original study was that the number of CHD deaths during the follow-up was relatively low. Furthermore, data analysis was not done separately for men and women, and myocardial infarction was the only criterion used for CHD.

Because of contradictory data from other studies, we have prolonged the follow-up of our cohort to up to 18 years using mortality from CHD, cardiovascular disease (CVD), and all causes as end points. Furthermore, we have analyzed the results separately for men and women, and, in addition to a prior history of myocardial infarction, we have applied other criteria for the presence of CHD at baseline.

RESEARCH DESIGN AND METHODS

A detailed description of study participants has been published previously (4). A random sample of 1,373 nondiabetic subjects (638 men and 735 women) and 1,059 type 2 diabetic subjects (581 men and 478 women) participated in the baseline study carried out in 1982–1984. All subjects were aged 45–64 years, and they were born and living in the Turku University Hospital district in West Finland and in the Kuopio University Hospital district in East Finland. The random sample of nondiabetic subjects was taken from the population register, and type 2 diabetic subjects were identified through a national drug reimbursement register. The mean age was 54.6 years in nondiabetic men, 54.8 years in nondiabetic women, 57.3 years in dia-

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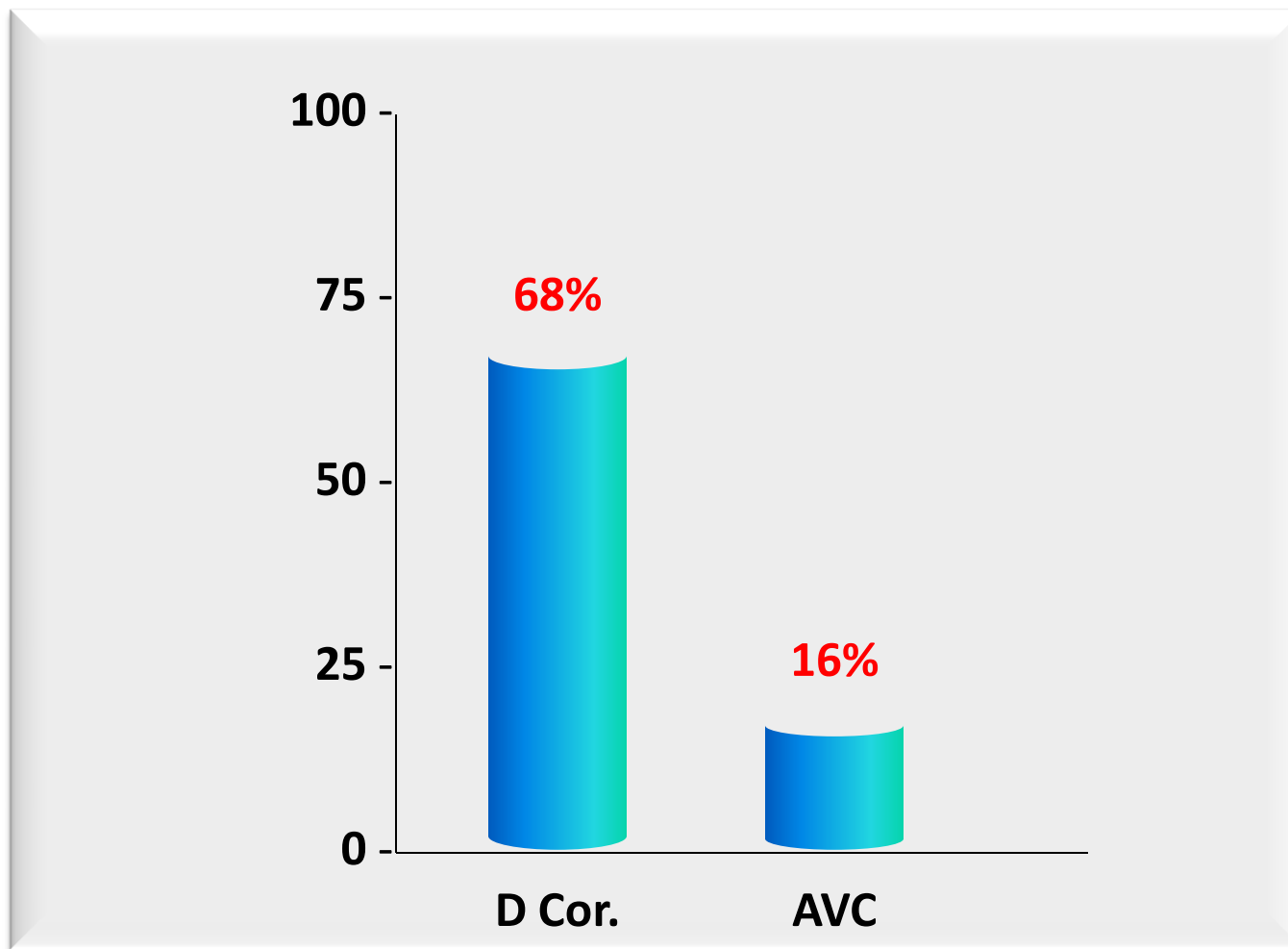
Abbreviations: CHD, coronary heart disease; CVD, cardiovascular disease; ECG, electrocardiogram; WHO, World Health Organization.

A table elsewhere in this issue shows conventional and Système International (SI) units and conversion factors for many substances.

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Principais causas de morte em diabéticos com idade >65 anos



Centers for Disease Control and Prevention. *National Diabetes Fact Sheet: General Information and National Estimates on Diabetes in the United States, 2007*. Atlanta, GA, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2008

N Engl J Med. 1997;337:1360–1369

Prevenção primária com AAS em diabéticos com risco de doença CV >10% num horizonte de 10 anos

AAS (75-162 mg/dia)

- ♥ **Homens >50 anos**
- ♥ **Mulheres >60 anos**
- ♥ **Com um factor de risco major adicional**
 - História familiar de DCV
 - HTA
 - Tabagismo
 - Dislipidemia
 - Albuminúria

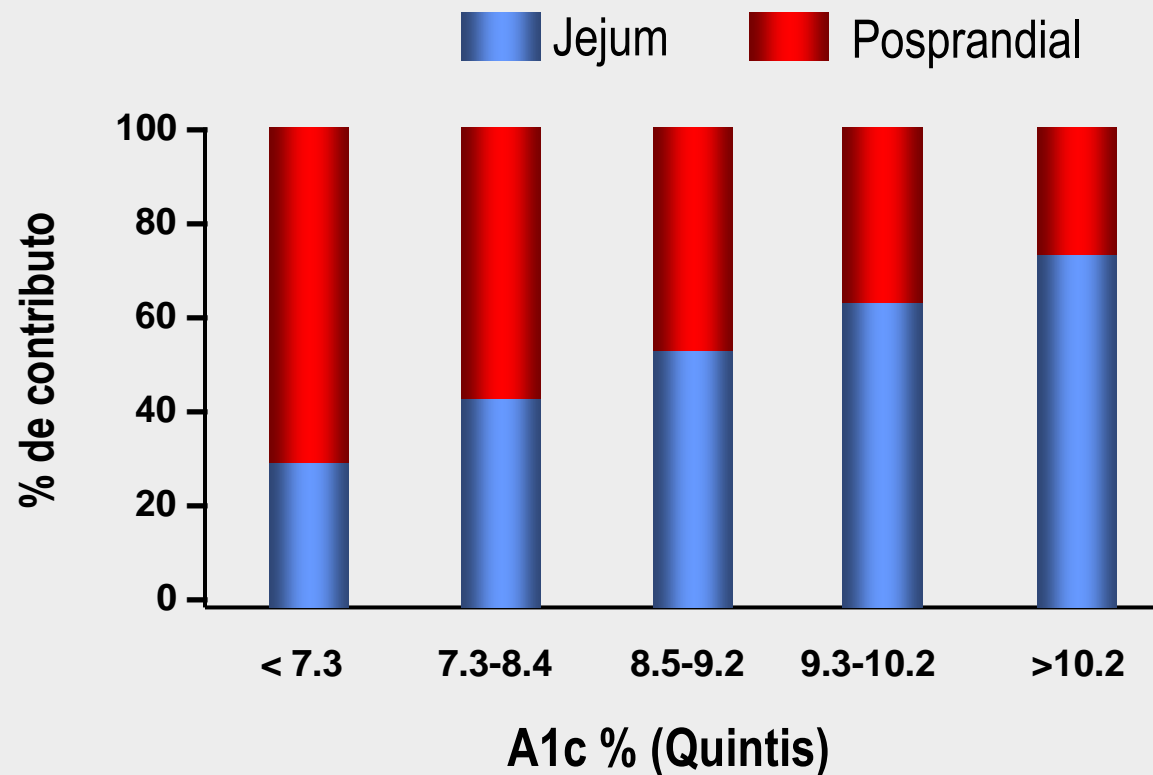
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Contributo da glicémia em jejum e posprandial para a HbA1c em diabéticos tipo 2



Eficácia das várias intervenções na redução da HbA1c

Intervenções para reduzir a glicémia	Decréscimo da HbA1c esperado em monoterapia (%)
Alteração de estilos de vida	1.0 – 2.0
Metformina	1.0 – 2.0
Sulfonilureias	1.0 – 2.0
Insulina	1.5 – 3.5
Glinidas	0.5 – 1.5
Inibidores da α -glicosidade	0.5 - 0.8
Inibidores da DPP-4	0.5 – 0.8

Glinidas. Normas de prescrição

1. Apenas como fármaco de 2ª linha (em adição à metformina)

a) Pessoas com estilo de vida errático, com omissão frequente de refeições

