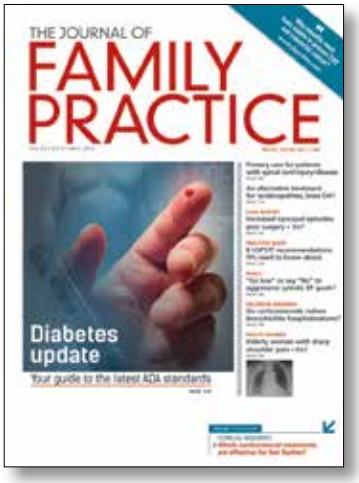
Rethinking A1C targets for patients with mental illness?



The article, "Diabetes update: Your guide to the latest ADA standards," by Shubrook, et al (*J Fam Pract.* 2016;65:310-318) is a precise review of current recommendations for diabetes. We would like to draw attention, however, to comorbid diabetes and mental illness.

Diabetes and serious mental illness often coincide, making the treatment of both conditions difficult and leading to higher rates of complications.[1]

The American Diabetes Association (ADA)'s "Standards of Medical Care in Diabetes" recognizes that hemoglobin A1C targets for patients should be individualized.[2] We consider it important to discuss challenges and limitations with each patient.

For example, a more lenient A1C goal may be appropriate when:

- the assessment of the patient shows that he or she is struggling with active symptoms of mental illness
- new medications with undesirable metabolic effects are prescribed or titrated
- social support is poor
- patients have limited confidence in their ability to accomplish tasks and goals
- patients have cognitive limitations
- patients abuse substances.

We suggest that when factors are favorable (eg, younger patient, well-controlled serious mental illness, adequate support, good cognitive skills, no hazardous use of substances, good level of confidence in the ability to control diabetes), the A1C target can be set lower. When the factors are less favorable (eg, older patient, poorly controlled mental illness, abusing substances, cognitive impairment), the target should be set higher and incrementally reduced as care engagement, circumstances, and symptom control improve.

There is a need for further research to investigate the factors that can impact diabetes self-management in patients with comorbid mental illness.

Corinna Falck-Ytter, MD
Stephanie W. Kanuch, MEd
Richard McCormick, PhD
Michael Purdum, PhD
Neal V. Dawson, MD
Shari D. Bolen, MD, MPH
Martha Sajatovic, MD
Cleveland, Ohio

1. Ducat L, Philipson LH, Anderson BJ. The mental health comorbidities of diabetes. *JAMA*. 2014;312:691-692.
2. American Diabetes Association. Standards of Medical Care in Diabetes—2016. *Diabetes Care*. 2016;39(Suppl 1). Available at: http://care.diabetesjournals.org/content/diacare/suppl/2015/12/21/39.Supplement_1.DC2/2016-Standards-of-Care.pdf. Accessed May 18, 2016.

A tool to help limit patients' sodium intake

The average American consumes about 3400 mg/d of sodium, which is more than double the 1500 mg recommended by the American Heart Association.[1] Excess sodium added to foods during commercial processing and preparation represents the main source of sodium intake in American diets.[2] Nevertheless, adding salt at the table is still very common, and peo-

FIGURE
"Salt Awareness—Limit Today" (SALT) label

IMAGE COURTESY OF ZVI WEIZMAN, MD

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We suggest that when patients have poorly controlled mental illness, the A1C target should be set higher, and then reduced as circumstances improve.

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ple who add salt at the table have 1.5 g higher salt intakes than those who do not add salt.[3] And as we know, high sodium intake has been associated with elevated blood pressure and an increased rate of cardiovascular disease.[4]

I have designed a self-produced "**S**alt **A**wareness—**L**imit **T**oday" (SALT) label (**FIGURE**). This label is attached to the cap of a salt shaker in such a way that less salt flows through the openings of the cap. Moreover, the label serves as a reminder to limit salt intake in general. The feedback I have received from my patients has been extremely positive; they report increased awareness and decreased sodium intake. I mention it here so that others may benefit.

Zvi Weizman, MD
Beer-Sheva, Israel

1. Cobb LK, Anderson CA, Elliott P, et al; American Heart Association Council on Lifestyle and Metabolic Health. Methodological issues in cohort studies that relate sodium intake to cardiovascular disease outcomes: a science advisory from the American Heart Association. *Circulation.* 2014;129:1173-1186.
2. Jackson SL, King SM, Zhao L, et al. Prevalence of excess sodium intake in the United States - NHANES, 2009-2012. *MMWR Morb Mortal Wkly Rep.* 2016;64:1393-1397.
3. Webster J, Su'a SA, Ieremia M, et al. Salt intakes, knowledge, and behavior in Samoa: Monitoring salt-consumption patterns through the World Health Organization's surveillance of noncommunicable disease risk factors (STEPS). *J Clin Hypertens (Greenwich).* 2016.
4. Mozaffarian D, Fahimi S, Singh GM, et al; Global Burden of Diseases Nutrition and Chronic Diseases Expert Group. Global sodium consumption and death from cardiovascular causes. *N Engl J Med.* 2014;371:624-634.

The stethoscope remains an outstanding, inexpensive, and convenient screening tool and its use needs to be emphasized.

Point-of-care ultrasound: It's no replacement for the stethoscope

In his August editorial, Dr. Hickner noted that an article in the issue prompted him to "wonder whether ultrasound might become the stethoscope of the future" (*J Fam Pract.* 2016; 65:516). To that I say that we need to avoid conflating the stethoscope with point-of-care ultrasound (POCUS).

It is well documented that auscultation skills rapidly deteriorate (specifically in the cardiology realm) in clinical practice.[1] This may occur because many physicians already think ultrasound can replace actually listening to their patients' hearts. The motto has become, "I'll just order an echo."

POCUS is an imaging modality. Period. It can be used to auscultate, but Doppler ultrasound is not as precise as the stethoscope when used by a practiced listener for identifying the source and subtle characteristics of murmurs.[2] The stethoscope remains an outstanding, inexpensive, and convenient screening tool and its use needs to be emphasized.

I strongly believe in training all medical students in POCUS—but as a complementary and adjunctive tool—not as something to replace a perfectly functional piece of equipment used around the world to provide good care.

Todd Fredricks, DO
Athens, Ohio

1. Vukanovic-Criley JM, Hovanesyan A, Criley SR, et al. Confidential testing of cardiac examination competency in cardiology and noncardiology faculty and trainees: a multicenter study. *Clin Cardiol.* 2010;33:738-745.
2. Tavel ME. Cardiac auscultation. A glorious past—but does it have a future? *Circulation.* 1996;93:1250-1253.