

ISPAD Clinical Practice Consensus Guidelines 2006–2007

Introduction

With this issue of *Pediatric Diabetes*, the first chapters of the Clinical Practice Consensus Guidelines 2006–2007 of the International Society for Pediatric and Adolescent Diabetes (ISPAD) are published. Sequential chapters will be published in subsequent issues of *Pediatric Diabetes*. Finally, the complete set of these guidelines will be published as a future compendium.

In 2003, the total child population of the world (0–14 yr) was estimated to be 1.8 billion, of whom 0.024% have diabetes. This means that 430 000 children around the world have diabetes, with 65 000 new cases diagnosed each year (1). This very large number of children need help with injections of insulin in order to survive and live a full life without restrictions or disabling complications and without being stigmatized for their diabetes.

In 1993, members of ISPAD formulated the Declaration of Kos, proclaiming their commitment to 'promote optimal health, social welfare, and quality of life for all children with diabetes around the world by the year 2000'. Although all the aims and ideals of the Declaration of Kos were not reached by 2000, we believe that slowly, by small steps, the worldwide care of children with diabetes mellitus is improving.

ISPAD published its first set of guidelines in 1995 (2) and its second in 2000 (3). Since then, the acceptance of intensive therapy for children, even for very young children, has increased worldwide. Insulin pump usage has risen in all age groups in countries where this treatment modality can be afforded. However, intensive therapy requires an investment in better and more comprehensive education for the caregivers in order for it to be successful.

The ISPAD Consensus Guidelines 2000 have been translated into 11 languages, indicating the need for a truly international document. In 2003–2005, national guidelines for childhood diabetes were released: the Australian Clinical Practice Guidelines from the National Health and Medical Research Council (writing committee chair, Martin Silink)(4) and in the United Kingdom, the National Institute for Clinical Excellence Clinical Guidelines (group leader, Stephen Greene) (5). Both these publications are truly evidence-based in that they deal with the body of evidence in a systematic approach, grading each

reference, and building the case for each recommendation. In 2003, the Canadian Diabetes Association published Clinical Practice Guidelines with chapters both on type 1 diabetes mellitus (T1DM) and type 2 diabetes mellitus (T2DM) in children and adolescents (6). In 2005, the American Diabetes Association (ADA) published their statement on the care of children and adolescents with T1DM (7).

This third edition of ISPAD's Consensus Guidelines, now entitled 'Clinical Practice Consensus Guidelines', is much larger and has been enriched by reference to and resources in the above-mentioned national guidelines. In the Introduction to previous ISPAD Guidelines, the acknowledged intention was for the next version of our guidelines to be referenced. We have used the ADA system for grading evidences (Table 1) (8). Whenever possible, the reference for a statement or recommendation has been included, but as readers will note, a vast majority of the recommendations and suggestions will have the grade E (expert consensus or clinical experience).

The 2006–2007 Guidelines are based on a wide consensus of clinical practice. They were drafted by international writing teams, modified by experts in different specialties from many countries, debated at the annual ISPAD meeting in 2005 by the members, and reviewed by members via the internet and the ISPAD website. As far as possible, significant input by individuals has been acknowledged. Many thanks to those numerous individuals who have contributed but whose names could not be included.

As was the same in the 2000 Guidelines, the 2006–2007 edition places education at the center of clinical management. Education is the vehicle for optimal self-management, the key to success. New chapters have been added on T2DM in children and adolescents, monogenic diabetes, and exercise.

We hope, therefore, that the Guidelines will be widely consulted and will be used to

- improve awareness among governments, state health-care providers, and the general public of the serious long-term implications of poorly managed diabetes and of the essential resources needed for optimal care
- assist individual caregivers in managing children and adolescents with diabetes in a prompt, safe, consistent, equitable, and standardized manner in accordance with the current views of experts in the field.

Table 1. The evidence grading system for Clinical Practice Recommendations of the American Diabetes Association (ADA) (8)

Level of evidence	Description
A	<p>Clear evidence from well-conducted, generalizable, randomized, controlled trials that are adequately powered, including:</p> <ul style="list-style-type: none"> ● Evidence from a multicenter trial ● Evidence from a meta-analysis incorporating quality ratings ● Compelling non-experimental evidence (i.e., 'all or none' rule) developed by the Center for Evidence-Based Medicine at Oxford* <p>Supportive evidence from well-conducted, randomized, controlled trials that are adequately powered, including:</p> <ul style="list-style-type: none"> ● Evidence from a well-conducted trial at one or more institutions ● Evidence from a meta-analysis that incorporated quality ratings in the analysis
B	<p>Supportive evidence from well-conducted cohort studies including:</p> <ul style="list-style-type: none"> ● Evidence from a well-conducted prospective cohort study or registry ● Evidence from a well-conducted meta-analysis of cohort studies <p>Supportive evidence from a well-conducted case-control study</p>
C	<p>Supportive evidence from poorly controlled or uncontrolled studies including:</p> <ul style="list-style-type: none"> ● Evidence from randomized clinical trials with ≥ 1 major or ≥ 3 minor methodological flaws that could invalidate the results ● Evidence from observational studies with high potential for bias (such as case series with comparison with historical controls) ● Evidence from case series or case reports <p>Conflicting evidence with the weight of evidence supporting the recommendation</p>
E	Expert consensus or clinical experience

*Either all patients died before therapy, at least some survived with therapy, or some patients died without therapy, and none died with therapy (e.g., the use of insulin in the treatment of diabetic ketoacidosis).

As in 2000, 'these Guidelines are not strict protocols nor are they the final word'. Individual clinical judgment and decision making also require the family's values and expectations to be considered, with the best outcomes being reached by consensus.

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