Section 14:

Children and Adolescents

Children and adolescents with diabetes and their parents/caregivers should receive culturally sensitive and developmentally appropriate individualized diabetes self-management education and support according to national standards at diagnosis and routinely thereafter. Recommendations for managing Type 1 diabetes are comprehensively addressed in the ADA *Standards of Care in Diabetes—2024* document.

School and Child Care

Youth spend significant time in school/day care, necessitating personnel training for optimal diabetes care.

Proper care ensures optimal diabetes management and safe access to all school- or day care–sponsored opportunities.

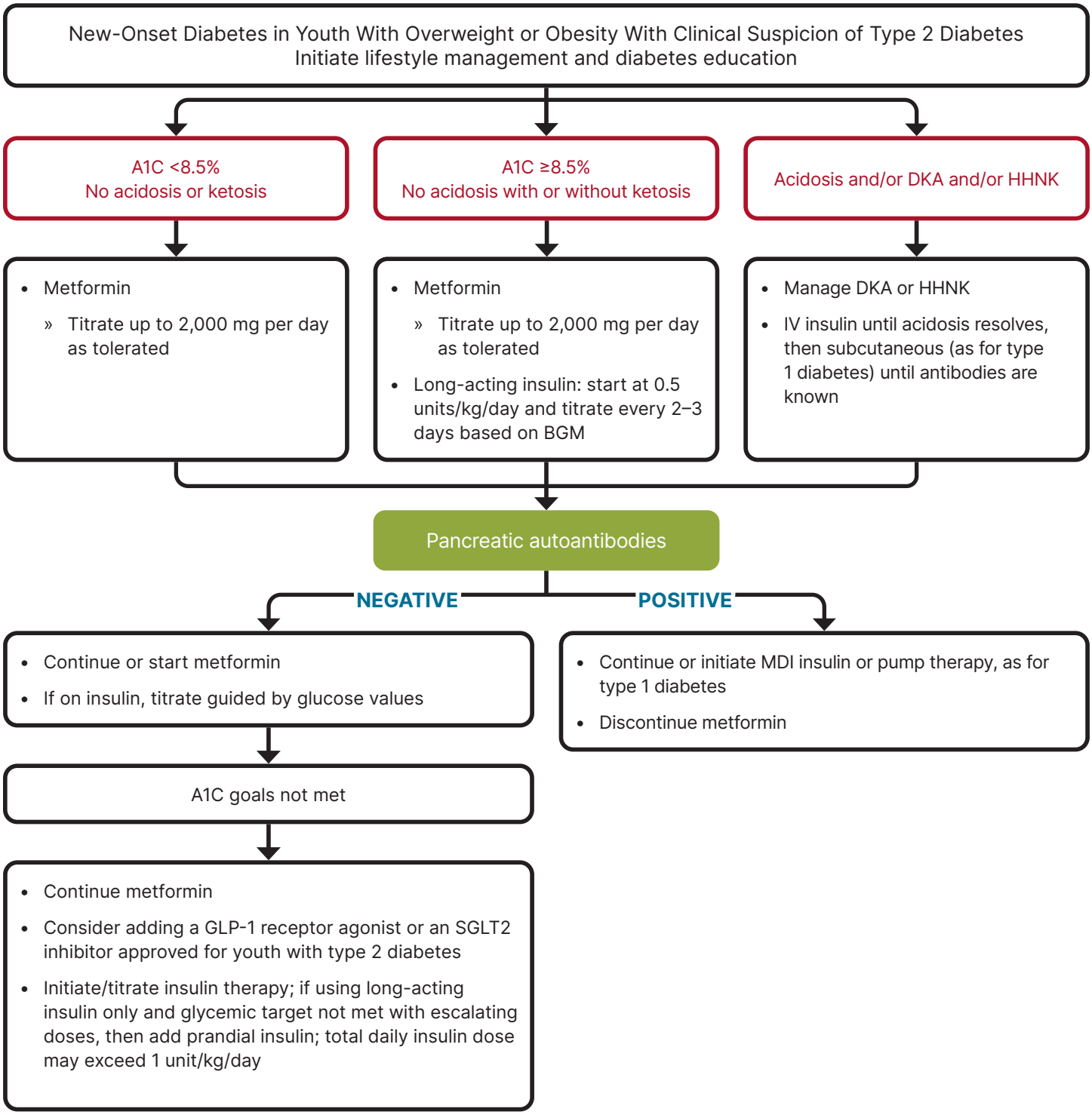
Federal and state laws require schools, day care facilities, and other entities to provide needed diabetes care to enable the children to safely access the school or day care environment.

Type 2 Diabetes in Youth and Adolescents

Screening	• Risk-based screening should be considered after the onset of puberty or ≥10 years of age, whichever occurs earlier, in youth with overweight (BMI ≥85th percentile) or obesity (BMI ≥95th percentile) and who have one or more additional risk factors for diabetes.
Diagnosis	• Fasting plasma glucose, 2-h plasma glucose during a 75-g oral glucose tolerance test, and A1C can be used to diagnose prediabetes or diabetes in children and adolescents. • In those in whom a diagnosis of type 2 diabetes is being considered, a panel of pancreatic autoantibodies should be tested to exclude the possibility of autoimmune type 1 diabetes.
Treatment	• Treatment of type 2 diabetes in youth may include: metformin, insulin, a glucaogon-like peptide 1 (GLP-1) receptor agonist approved for use in youth with type 2 diabetes, and/or the sodium–glucose cotransporter 2 (SGLT2) inhibitor empagliflozin. (See figure on the next page.)
Complications	• Blood pressure should be measured at every clinic visit and treated if found to be elevated on three separate measurements. • Urine albumin-to-creatinine ratio and estimated glomerular filtration rate should be obtained at the time of diagnosis then annually. • Neuropathy screening by foot exam should be done at diagnosis and then annually. • Retinopathy screening by dilated fundoscopy should be done at diagnosis and then annually. • Evaluation for nonalcoholic fatty liver disease (by measuring AST and ALT) should be done at diagnosis and then annually. • Screening for symptoms of obstructive sleep apnea should be done at each visit. • Evaluate for polycystic ovary syndrome in female adolescents when indicated. • Lipid screening should be done after optimizing glycemia and then annually.

Suggested citation: American Diabetes Association Primary Care Advisory Group. 14. Children and adolescents: *Standards of Care in Diabetes—2024* abridged for primary care professionals. Clin Diabetes 2024;42:218–219 (doi: 10.2337/cd24-a014).

Addressing Probable New Cases of Type 2 Diabetes in Youth



Management of new-onset diabetes in you with overweight or obesity with clinical suspicion of type 2 diabetes. A1C 8.5% = 69 mmol/mol. Adapted from Arslanian S, Bacha F, Grey M, Marcus MD, White NH, Zeitler P. Evaluation and management of youth-onset type 2 diabetes: a position statement by the American Diabetes Association. Diabetes Care 2018;41:2648–2668. BGM, blood glucose monitoring; DKA, diabetic ketoacidosis: HHNK, hyperosmolar hyperglycemic nonketotic syndrome; IV, intravenous; MDI, multiple daily injection.