



COMMENT ON UNDERWOOD ET AL.

## Preoperative A1C and Clinical Outcomes in Patients With Diabetes Undergoing Major Noncardiac Surgical Procedures. *Diabetes Care* 2014;37:611–616

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I read with interest the paper by Underwood et al. (1). Their data give credence to the recommendations made by 2011 Joint British Diabetes Societies Inpatient Care Group national guideline on the management of people with diabetes undergoing surgery or procedures (2). The U.K. document suggests a cutoff HbA<sub>1c</sub> of 8.5% (69 mmol/mol) before proceeding to elective surgery to minimize the likelihood of developing postoperative complications as shown by a multitude of previous authors. There are also a large number of recommended audit standards that should be met. Data presented in a plenary session at the Diabetes U.K. Annual Professional Conference in 2013 showed that the vast majority of diabetes teams in the U.K. were aware of this national guidance, and many had either adopted or adapted

them for use in their institutions. I would like to therefore strongly disagree with the authors when they state that there “are no standards of care for optimal A1C level before surgery.”

The authors do not explain why they chose those particular HbA<sub>1c</sub> cutoffs. Were they chosen in advance, or were the data analyzed post hoc to try and fit their hypothesis? As the authors will be aware, an HbA<sub>1c</sub> of 8% (64 mmol/mol) is not an ideal target for many people—in particular, the frail elderly—who are more likely to have to undergo elective procedures and thus may be at higher risk of developing hypoglycemia. Thus, in trying to achieve preoperative optimization, they may increase the risk of immediate harms by the development of severe hypoglycemia.

Finally, as the authors acknowledge, while there are plenty of data to show that poor glycemic control is associated with harm, there are almost no data to show that improving glucose levels is associated with benefit (3).

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### References

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