Table 1.

Screening Care for the Eyes and Feet in Diabetes

Complication	Testing	Where/by whom	Frequency
Retinopathy	Comprehensive dilated eye examination	Ophthalmologist or optometrist who is educated and qualified in diabetic retinopathy	Annually[a, b]
Foot Ulcers[c]	Comprehensive examination by clinician	Clinic visits Refer high-risk patients to foot and/or vascular specialists if indicated	Annually, more often as needed
	Identify loss of protective sensation: Vibratory testing with 128-Hz tuning fork, 10-g monofilament testing, pinprick sensation, ankle reflex testing, vibration perception threshold with use of biothesiometer[d]	Clinic visits	Annually
	Pedal pulses and assessment for claudication[e]	Clinic visits	Annually
	Visual inspection	Clinic visits	Each visit
	Visual inspection	Self-management by patient	Daily

[a]Patients with new diagnosis of type 1 diabetes should have the initial eye exam within 5 years of diabetes diagnosis. Patients with new diagnosis of type 2 diabetes should have the initial eye exam at time of diabetes diagnosis.

[b]Eye exams every 2-3 years can be considered if initial eye exams are normal. Exams more frequent than once yearly may be needed if retinopathy is present.

[c]High risk patients include those with diabetic nephropathy (particularly those on dialysis), prior amputation, prior foot ulcer history, known peripheral neuropathy, foot deformity, peripheral vascular disease, visual impairment, poor glycemic control and tobacco use.

[d]Perform 2 of these tests with regular screening, typically the monofilament and another test.

[e]An ankle-brachial index (ABI) should be done in patients who have symptoms of peripheral vascular disease (PAD). In addition, an ABI should be considered in patients >50 years old and in patients <50 years old who have risk factors for PAD since patients with PAD are often asymptomatic.

Information taken from the American Diabetes Association: Standards of Medical Care in Diabetes - 2012. Diabetes Care January 2012 35:S11-S63.