A Special Diabetes Issue and Ingredients for a Successful Transition of Care

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This issue of Pediatric Annals includes a collection of insightful articles about subgroups of children with diabetes mellitus that can pose a clinical challenge—those with signs of insulin resistance, hypertriglyceridemia, obesity, and cystic fibrosis-related diabetes. The issue is guest edited by Dr. Jon David Oden, the Chief of Endocrinology, Diabetes and Obesity at the University of Arkansas for Medical Sciences/Arkansas Children’s Hospital, who has a special interest in the management of the complexities associated with different forms of diabetes as well as comorbid clinical issues such as severe hypertriglyceridemia, significant signs of insulin resistance, obesity, and cystic fibrosis. In addition, adolescents with chronic disease require a seamless transition to adult care providers, and strategies to achieve a successful transition are also discussed in this issue.

TRANSITION OF CARE

As our pediatric patient population with chronic disease grows “older,” we are challenged to decide when we will no longer provide care for them. We work with our family medicine, internal medicine, and subspecialty colleagues to make sure the transition of care is smooth. In reviewing the literature about transition of care for chronic illness in children and adolescents, the process begins at age 13 to 14 years.1 This transition of care is defined in a position paper by the Society for Adolescent Medicine as “the purposeful, planned process that addresses the medical, psychosocial, educational, and vocational needs of adolescents and young adults with chronic medical and physical conditions as they move from child-centered to adult oriented health care systems.”2 A comprehensive, current summary of the clinical problems, ideally electronic in nature, should be written by the provider and kept by the patient and family, available for review by any new providers, primary care, emergent, or subspecialty.3 This structured transition, which also includes the family, should be facilitated in early visits with the adult provider to meet and discuss the “new system or approach” for ongoing care and should begin during adolescence to smooth the transition process. The hope is that when the pediatrician “officially” ceases being the primary care provider and the adult-focused care begins, the transition will be smooth and successful.1-3 In their review article, Reichek and Danner-Koptik1 summarize the transition process for childhood cancer survivors in this way: “the broad goal of transition is for the AYAs [adolescents and young adults] to achieve successful engagement in the adult system, to receive developmentally and medically appropriate care, and to facilitate their maximum potential and optimal quality of life. The process should be coordinated, family centered, and planned, so the AYA can mature into the knowledge of the transition to adult care and have supports in place to achieve the transition goal. Patients will gradually need to assume more medical autonomy and this increased responsibility for their own health care could start in early adolescence.”1

REFERENCES