NON-TYPE 1 DIABETES MELLITUS (NT1DM)

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REPORTING INFORMATION
(To be completed by the CPSP Senior Coordinator)

Report number:	
Month of reporting:	
Province:	
Today's date:	

Please complete the following sections for the case identified above.
Strict confidentiality of information will be assured.

CASE DEFINITION FOR NON-TYPE 1 DIABETES MELLITUS (NT1DM)

Report any patient 0 to 17.9 years of age with a diagnosis of non-type 1 diabetes, either new or revised, with clinical features that are **not** consistent with classic type 1 diabetes (non-obese child with symptomatic acute hyperglycemia).

Canadian Diabetes Association definition of diabetes

- fasting plasma glucose (FBG) ≥7.0 mmol/L* or
- random plasma glucose ≥11.1 mmol/L* or
- two hour plasma glucose ≥11.1 mmol/L* after a standard (75g) oral glucose tolerance test

* Requires a second, confirmatory test if child is asymptomatic

Clinical features suggestive of non-type 1 diabetes mellitus are listed below. If you are uncertain whether your patient has NT1DM, please report the case for study investigators to review and classify.

- Obesity (body mass index $>95^{th}$ percentile for age and gender)
- Family history of T2DM in a first or second degree relative(s)
- Belonging to a high-risk ethnic group (e.g., Aboriginal, African, Hispanic, South-Asian)
- A history of exposure to diabetes in utero (diagnosed before or during pregnancy)
- Acanthosis nigricans
- Polycystic ovarian syndrome
- Diabetes in a person with a syndrome often associated with type 2 diabetes (Prader-Willi Syndrome)
- Diabetes in a non-obese patient with at least one first-degree relative and/or two second-degree relatives with diabetes
- Minimal or no insulin requirement with a normal or near normal A1c level (4-6%) one year after diagnosis
- A diagnosis of diabetes while on medical therapy with a known diabetogenic medication (e.g., glucocorticoid, L-asparaginase, cyclosporine, tacrolimus, atypical antipsychotic, anticonvulsant)

Exclusions: Do not report any cystic fibrosis-related diabetes or patients in critical care settings requiring short-term insulin therapy for stress hyperglycemia

SECTION 1 – DEMOGRAPHIC INFORMATION

1.1 Date of birth: _____ /_____ /_____ (DD / MM / YYYY) 1.2 Sex: Male ___ Female ___

1.3 Province/Territory of residence: _____

1.4 Ethnicity

Caucasian _____ Hispanic _____ Middle Eastern _____ African/Carribean _____

Aboriginal – *If known:* First Nations _____ Inuit _____ Métis _____

Asian – *If known:* Chinese _____ Japanese _____ Filipino _____ Vietnamese _____

Indian _____ Pakistani _____

SECTION 1 – DEMOGRAPHIC INFORMATION (cont'd)

1.4 Ethnicity (cont'd)

Mixed (specify) _____

Other (specify) _____

Unknown _____

SECTION 2 – FAMILY HISTORY OF TYPE 2 DIABETES

		No	Yes	Unknown
2.1	Mother with gestational diabetes during the pregnancy with this child	___	___	___
2.2	Mother with diabetes (type 1 or type 2) before pregnancy	___	___	___
2.3	Father with diabetes	___	___	___
2.4	Second-degree family member with diabetes	___	___	___

SECTION 3 – PATIENT DIAGNOSIS OF NON-TYPE 1 DIABETES MELLITUS

3.1 Specify diagnosis (if known) and date of diagnosis (if known):

Date of diagnosis (DD/MM/YYYY)

___ Diagnosis unknown or unconfirmed _____ /_____ /_____

___ Type 2 diabetes mellitus (evidence of insulin resistance) _____ /_____ /_____

___ Monogenic diabetes (confirmed/suspected gene mutation) _____ /_____ /_____

___ Diagnosis secondary to medical treatment

Please specify: ___ glucocorticoids ___ tacrolimus

___ L-asparaginase ___ atypical antipsychotic

___ cyclosporine ___ anticonvulsant

___ other: _____

3.2 Is there a co-existing genetic syndrome (e.g., Prader-Willi syndrome)? Yes ___ No ___

Please specify: _____

3.3 Is this a revised diagnosis if type 1 diabetes mellitus? Yes ___ No ___

If yes, please answer below:

3.3.1 Date of diagnosis of type 1 diabetes mellitus: _____ /_____ /_____
DD MM YYYY

3.3.2 Reason that prompted a revised diagnosis:

___ low or lack of insulin requirement

___ excellent control on minimal insulin

___ non-obese child with an affected parent

___ other (specify) _____

SECTION 4 – SIGNS AND SYMPTOMS AT <u>FIRST PRESENTATION</u>

4.1 Height: _____ cm Weight: _____ kg Date measured: _____ /_____ /_____
DD MM YYYY

4.2	Symptom	No	Yes	Unknown	Symptom	No	Yes	Unknown
4.2.1	Asymptomatic	___	___	___	4.2.5 Diabetic ketoacidosis (ph < 7.35)	___	___	___
4.2.2	Polyuria	___	___	___	4.2.6 *Acanthosis nigricans*	___	___	___
4.2.3	Polydypsia	___	___	___	4.2.7 Obesity	___	___	___
4.2.4	Weight loss	___	___	___	4.2.8 Fatigue	___	___	___

4.2.9 Skin/genital infection (e.g., vaginal yeast infection) ___ ___ ___

4.2.10 Other (specify) _____

SECTION 5 – INVESTIGATIONS AT PRESENTATION

The list of investigations below is an inclusive list and all investigations may not apply. Please fill in the results of investigations that are available for your patient.

	Test	Results (with units)	Unknown
5.1	Random blood glucose	_____	____
5.2	Fasting blood glucose	_____	____
5.3	Oral glucose tolerance test (fasting value/2-hour value)	_____/_____	____
5.4	Glucosuria	_____	____
5.5	Ketonuria	_____	____
5.6	ph/bicarbonate	_____/_____	____
5.7	Insulin	_____	____
5.8	C-peptide	_____	____
5.9	A1c (please provide normal range)	_____	____
5.10	If antibody investigations were done, please complete below. If no antibody investigations were done, please check here: ____		
5.10.1	Glutamic acid decarboxylase (GAD)	_____	____
5.10.2	Islet cell antibody (ICA)	_____	____
5.10.3	Insulin antibody	_____	____
5.10.4	Tyrosine phosphatase antibody (IA-2∀)	_____	____

5.11 If genetic testing for monogenic forms of diabetes was done, please indicate the mutation identified:

_____

SECTION 6 – MANAGEMENT WITHIN THE FIRST MONTH OF PRESENTATION (please check all that apply)

	Treatment	Yes	No	Unknown
6.1	Insulin	___	___	___
6.2	Oral hypoglycemic	___	___	___
6.3	Lifestyle counseling (diet and exercise)	___	___	___

If you have investigated your patient for metabolic co-morbidities, please complete Section 7.

SECTION 7 – ASSOCIATED METABOLIC CO-MORBIDITIES AT PRESENTATION

	Co-morbidity	Yes	No	Unknown
7.1	Polycystic ovarian syndrome	___	___	___
7.2	Dyslipidemia	___	___	___
7.3	Hypertension	___	___	___
7.4	Non-alcoholic fatty liver disease (ALT > 90 or "fatty liver" on U/S)	___	___	___
7.5	Renal disease (micro/macroalbuminuria)	___	___	___
7.6	Other (e.g., pancreatitis) – please specify: _____			

SECTION 8 – REPORTING PHYSICIAN

First name_____ Surname_____

Address_____

City_____ Province_____ Postal code_____

Telephone number_____ Fax number_____

E-mail_____ Date completed_____

Thank you for completing this form.