Change of HbA1c reporting to the new SI units

TO THE EDITOR: The position statement by Jones and colleagues regarding the change of HbA1c reporting to the new Système International (SI) units — which has been recommended by the Australasian Association of Clinical Biochemists, the Australian Diabetes Educators Association, the Australian Diabetes Society and the Royal College of Pathologists of Australasia — provides a comprehensive summary of the rationale behind the proposed change and suggests a 2-year period of dual reporting.1

However, Jones et al did not specify targets for children and adolescents, and we believe that it is important to do so. The incidence of type 1 diabetes in Australian children and adolescents is among the highest in the world1 and, in New South Wales, type 2 diabetes represents at least 10% of cases of new-onset diabetes in adolescents.2 National evidence-based clinical care guidelines for type 1 diabetes in children, adolescents and adults4 include age-specific targets for HbA1c, while recognising that such targets are predominantly consensus based.

HbA1c targets for young people with type 1 diabetes are higher, with a level of <7.5% recommended for children and adolescents in the Australian guidelines and in those produced by the International Society for Pediatric and Adolescent Diabetes (ISPAD).5 Jones et al note that “Achievement of HbA1c targets must be balanced against risk of severe hypoglycaemia, especially among older people”;1 this is also the case for young people. For children and adolescents with type 2 diabetes, the ISPAD guidelines recommend an HbA1c target of <7%.5

The move to SI units represents a major change in the established, widely recognised outcome measure of glycaemia; during the transition period, the specific needs of young people with diabetes must not be forgotten.

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**IN REPLY:** We appreciate Craig and colleagues’ comments regarding the importance of reporting general HbA1c targets for children and adolescents with type 1 and type 2 diabetes. In our position statement, the headings of Box 2 and Box 3 indicated that the targets listed were for adults with type 1 diabetes and adults with type 2 diabetes, respectively. While it is not possible to highlight every clinical situation, we agree that providing general HbA1c targets for children and adolescents will add value to our article, and we have updated it accordingly, recognising the differences in these targets for type 1 diabetes (≤ 58 mmol/mol, ≤ 7.5%) and type 2 diabetes (≤ 53 mmol/mol, ≤ 7.0%). In the interests of uniformity and simplicity, the paediatric targets expressed as “<” have been adjusted to “≤”, which represents differences of less than 1.5% of the target values.

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