Solche Umsatzverschiebungen führen nach ökonomischer Theorie zu Gegenreaktionen, die dann wieder negativ ausgelegt werden können. Deshalb haben wir unser Monitoring in über 4000 Arztpraxen mit Praxislabor und speziell bei den stark betroffenen Grundversorgern nun auch auf diesen Aspekt ausgerichtet. Statistisch verhält sich die betroffene Ärzteschaft vorbildlich – sie konzentriert sich eindeutig mehr auf die qualitative Betreuung der Patienten als auf die von BAG und Preisüberwacher permanent unterstellten pekuniären Interessen.

Schlussfolgerungen

Die einzige Lösung für das Praxislabor in der Revision der Analysenliste wäre die betriebswirtschaftlich saubere Abbildung des Praxislabors gewesen. Dies hätte ausschliesslich mit dem «Point-of-Care-Modell» realisiert werden können. Nachdem das BAG es explizit abgelehnt hat, die betriebswirtschaftlich und sachgerechte Berechnung zu monitorisieren, wird die FMH dieses Monitoring selber übernehmen müssen.

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New insights into diagnosis and management of gestational diabetes mellitus

Recommendations of the Swiss Society for Endocrinology and Diabetology (SSED)

Physiology and current knowledge about gestational diabetes led to the adoption of new diagnostic criteria and blood glucose target levels during pregnancy by the SSED. The full recommendations have been published in "Therapeutische Umschau" (2009; 66:695-706).

The 6th International Workshop Conference on Gestational Diabetes mellitus in Pasadena (held in 2008) defined new diagnostic criteria based on the results of the HAPO-Trial. These criteria were presented during the American Diabetes Association (ADA) congress in New Orleans in 2009. According to the new criteria, there is no need for screening, but all pregnant women have to be tested with a 75 g oral glucose tolerance test (OGTT) between the 24th and 28th week of pregnancy. The new diagnostic values are very similar to the ones previously adopted by the ADA, with the exception that only one out of three values has to be elevated in order to make the diagnosis of gestational diabetes. Due to this important difference it is very likely that gestational diabetes will be diagnosed more frequently in the future. The diagnostic criteria are: Fasting plasma glucose ≥ 5.1 mmol/l, 1-hour value ≥ 10.0 mmol/l or 2-hour value ≥ 8.5 mmol/l. Based on current knowledge and randomized trials, it is much more difficult to define glucose target levels during pregnancy. This difficulty has led to many different recommendations being issued by diabetes societies. The SSED follows the arguments of the International Diabetes Federation (IDF) that self-blood glucose monitoring itself lacks precision and that there are very few randomized trials. Therefore, the target levels have to be easy to remember and might be slightly different in mmol/l or mg/dl. The SSED adopts the tentative target values of the IDF with fasting plasma glucose values < 5.3 mM and 1- and 2-hour postprandial (after the end of the meal) values of < 8.0 and 7.0 mmol/l, respectively (table 1).

Table 1 Recommendations of the IDF and SSED 2009 (values referenced on plasma)

Fasting or preprandial	< 5.3 mM (95 mg/dl)
1-hour postprandial	< 8.0 mM (145 mg/dl)
2-hour postprandial	< 7.0 mM (125 mg/dl)

The last part of these recommendations deals with the therapeutic options during pregnancy (nutrition, physical exercise and pharmaceutical treatment). If, despite lifestyle changes, the target values are not met, approximately 25% of the patients have to be treated pharmaceutically.

Insulin therapy is still the preferred treatment option, but metformin (and as an exception glibenclamide) can be used, if there are major hurdles for the initiation of insulin therapy.

SSED management board

Roger Lehmann (president), Emanuel Christ (vice president), Peter Wiesli (finances), Sylvia Baer Cornu, Mirjam Christ-Crain, Petra Elsässer Imboden, Christoph Henzen, Alain Golay, Pierre Maechler, Christian Meier, François Pralong, Andreas Rohrer, Eugen Schönle.

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