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Update on Diabetes Management

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Large clinical diabetes trials have demonstrated beneficial effects of lowering hemoglobin A1C on microvascular complications. Lessons from these trials revealed that sustained intensification of medical therapy is difficult and pointed towards the progressive loss of beta cell mass over time. In the light of these results, nine new classes of drugs have been introduced over the last decade. In spite of this, the newer drugs were less potent in their efficacy to lower hemoglobin A1C than insulin therapy. Furthermore, there are yet no clinical data to demonstrate their ability to preserve beta cell function in humans. Besides that, serious adverse events were noted with the newer agents. Given all that, it is important to lower hemoglobin A1C, then again the way to get there is as important as learning what and when to add on therapies.

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The use of HbA1c in detection of glycemic control in CKD 4, and dialysis patient with type 2 diabetes

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Poor glycemic control is a predictor of mortality in diabetic dialysis patients. HbA1c is regarded as the gold standard for measurement of glycemic control and is invaluable in the treatment of diabetic patients. Both the (DCCT and UKPDS), showed that maintaining blood glucose at normal or near-normal levels can reduce many diabetic complications. However both trials excluded end stage renal disease patients (CKD 4 and 5) from the study population. And most patients as well as doctors consider that diabetic patients with advanced renal disease are less likely to develop hyperglycemia.

Aim of the study is to evaluate diabetic control using HbA1c in type 2 diabetic patients with; CKD 4, and in diabetic dialysis patients.

Patients and methods: 100 type 2 diabetic patients were divided into 2 groups; group I (G I); 50 dialysis diabetic patients, and group II (G II); 50 CKD 4 diabetic patients. For all patients we measured fasting (FBS) and post-prandial blood sugar (PPBS), HbA1c, cholesterol, s. albumin.

Results: using the cut off value of HbA1c of <7, 50 % of G I and 24% of G II had poor diabetic control. Hemodialysis group had significantly lower HbA1c level (7.328 ± 0.972) the predialysis group (8.598 ± 1.31); ($p=0.0001$). HbA1c level was strongly correlated with FBS and PPBS levels and with duration of diabetes illness ($r=0.71, 0.69$ and $0.62, 0.7$ in G I and G II, and with duration ($r=0.42$)). Patients with poor glycemic control had longer diabetes duration than cases with good control.

Conclusion: poor glycemic control is common in dialysis as well as CKD 4 patients and is strongly related to duration of diabetes. This necessitates proper control of diabetes in those patients to prevent complications. HbA1c can be used as a good tool in prediction of glycemic control in dialysis as well as CKD 4 patients.

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