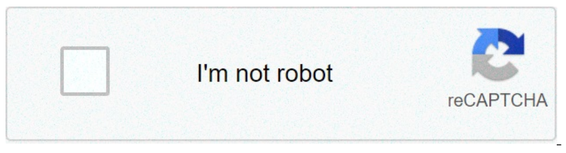

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Review Volume 4 Edition 5 Jazan Business Health, Ministry of Health, Japanese, Saudi Arabia Correspondence: Mohammed H Abtaleb, Jazan Business for Health, Ministry of Health, Jazan, Saudi Arabia Receipt: 3 June 2016 | Published: 16 September 2016 Quote: Abutaleb MH. Diabetes mellitus: an overview. Pharmacol PHARMACOL INT J. 2016; 4 (5): 406-411. DOI: 10.15406 / PPIJ.2016.04.00087 Download PDF Abstract diabetes is one of the main causes of mortality in the world with around 422 million (8.5% of the global population) currently diagnosed. The incidence is expected to continue to expand despite the great efforts on the means of treatments are exercised. This article provides an overview of the diabetes mellitus, its epidemiology, treatment and the role of different health professionals in its management. Diabetes is a multi-factorial, chronic and progressive metabolic disorder characterized by chronic hyperglycemia due to defects in the metabolism of carbohydrates, fats and proteins. Persistent hyperglycemia is associated with long-term damage, dysfunction and failure of various organs, especially eyes, kidneys, nerves, heart and blood vessels.1 Diabetes is ranked in three main types: type 1 , type 2 and gestational diabetes mellitus (GDM). Other specific types derive from specific causes. Type 1 diabetes usually affects children and people below thirty years, but can also influence more elderly adults. Although the pathogenesis is not fully understood, type 1 diabetes is characterized by a loss of insulin secretion due to idiopathic attacks or autoimmune destruction of beta cells Secret insulin of Langerhans islets in the pancreas.2 Therefore; It is mainly treated with insulin replacement therapy. Type 2 diabetes is the most common globally. Mostly affecting adults over thirty years, although many cases have been diagnosed many cases among obese children. The type 2 diabetes has also been known as non-insulin-dependent diabetes mellitus (NIDDM) or delayed diabetes; However, this term is no longer used due to confusion can cause if patients were classified on the basis of the treatment rather than pathogenesis. The gestational diabetes Mellitus (GDM) occurs when glucose intolerance is observed for the first time during pregnancy. The pathogenesis of GDM still remains largely unknown; Nevertheless studies have shown the involvement of unpleasergdom and defects in the insulin reporting path, with a consequent reduction in the Dubata of glucose and transport in skeletal muscles and adipocytes.3 Other specific types are those in which the process below or process The disease can be identified relatively specificly. They include the EXOCRINO pancreatic disease, such as fibrocalcolosopancreatopathy or secondary to use medicines such as corticosteroids. All types of diabetes including type 2 are diagnosed when typing the fasting plasma glucose is more than 7 mmol / l at least twice. Other diagnostic criteria are shown in Table 1. Despite the search volume that was invested in the search for diabetes in recent decades, the pathogenesis of type 1 diabetes is not fully understood but it is thought to derive from more factors involving anomalies Genetics and / or environmental factors, leading to a loss of insulin secretion or a decrease in insulin action. The pathophysiology of type 2 diabetes is simply characterized by insulin resistance, impairment of the production of hepatic glucose production and reduced cell cells of Î², the failure of cells are subsequent to the failure of cells Î².7 is believed that the primary result so a reduction of secondary insulin secretion to genetic anomalies and other risk factors involved in most patients with type 2 diabetes These results in beta cells respond less effectively to hyperglycemia or a decrease in the biological response of insulin to target tissues.8 The decrease in the biological insulin response (resistance to insulin) occurs because insulin is not able to bind to the receptor due to defects in Insulin receptor sites or disturbances in the binding insulin signal transduction. Exceeding the resistance to insulin requires pancreatic cells IÂ² to increase the amount of secreted insulin, a state called hyperinsulinemia. Since accelerated endogenous glucose exit occurs simultaneously hyperinsulinemia, at least in the first and half sickness phases, resistance to insulin in liver cells becomes an important engine of hyperglycemia in type 2 diabetes diabetes.7 The release of pro-inflammatory adipose cytokines derived from the fabric and high level of free fatty acids have also been shown to play a role in the development of insulin-resistance in liver and skeletal muscle and fat cells.8 different risk factors have been associated with the development of type 2. The factors Genetics in some ethnic groups, family history of diabetes, and the increase in the population of age are examples of non-modifiable risk factors. However, the lifestyle associated with the non-healthy diet, physical inactivity and smoke usually leads to overweight, dyslipidemia, hypertension and reduced glucose tolerance (IGT) are the most common risk factors for diabetes escalation Epidemiology.9 Environmental factors such as exposure to arsenic and mercury, physical life conditions, stress levels, work voltages and low socio-economic status are also believed to contribute to diabetes development.9 the fact that people With type 2 diabetes may not be diagnosed with Manyyears or to be unconscious of long-term damage caused by the disease system mandates disease measures. Increase combinations of the aforementioned risk factors have contributed to the global epidemiology both type 1 and type diabetes 2. Diabetes of type 2 is today one of the most common diseases in the world. The number of people with type 2 diabetes is increasing in every nation. The global prevalence of diabetes among adults is currently estimated at around 382 million; With 175million not diagnosed and the largest accident is between 40 and 59 years of age.10 by 2035, this number is intended to increase at over 592 million.10.11 in 2014, it is estimated that diabetes hits 422million (8.5%) of the population in the World.12 These numbers are far superior estimates.13Ã ¢ Previous 16 Diabetes is considered one of the biggest problems and greater challenges for health Systems.17Ã ¢ 19 the incidence of diabetes In the world it is increasing, in particular between children .20.21 in a WHO report, it was estimated that the appearance of global diabetes would increase to about 4.4%, which affects more than 366,212 million in 2030 With a variation of about 114% as 2000.16 it is estimated that 23% of the Saudis are in diabetes or pre-diabetes phase. Clinical demonstration in diabetic patients is similar in both type 1 and 2 diabetes, but the intensity of clinical characteristics differs. The main symptoms include polydipsia (excessive and prolonged thirst), polyphagia (excessive hunger) and polyuria (excessive urination), weight loss, cramps in the muscles of the limbs, blurred vision, constipation and fatigue. The progressive nature of diabetes over time is associated with two types of long-term diabetes complications: macrovascular and microvascular. The latter usually occur previously and can result in retinopathy, nephropathy and peripheral neuropathy. The first can lead to coronary sickness, stroke, peripheral vascular disease and damage or loss of sight, extremities and management Kidney.1 of patients with diabetes consumes more than 10% of the NHS annual budget, more than the middle of which supports patients with serious complications diabetes diabetes.22,23 The expanding population in the UK will have a huge impact on NHS expenditure unless the cost of treatment is significantly reduced, which could have a On the patient Care.24 a significant increase in diabetes rates will also be burden of the workload of those who manage and prevent the disease and its complications, and this will also be Assistance to cost implications.24 The implementation of national guidelines in routine clinical practice was associated with the latest technologies and prescription drugs25 better use of anti-hyperglycemic drugs and improve glycemic control at the recommended level of HBA1C. 26 Appendix 1.0 lists and summarize the pharmacological agents available for glycemia control. The main objective of diabetic care is to improve the quality of life of people with diabetes and to increase their life expectancy. The achievement of this result depends on the supply of complete, complementary and integrated health and social treatments through primary and secondary settings through specialized diabetes professionals. Diabetes is a complex disease and its management requires to address prevention, early detection and complications management as well as optimal hyperglycemia control, hypertension, dyslipidemia, obesity and other CVD risk factors. The management of diabetes and associated complications and their risk factors involves the prescription of different pharmacological and non-pharmacological modes in addition to regular screening to prevent long-term complications.27.28 for the implementation of such measures, the key priority is ¨ The patient's education and empowerment, 29 in addition to the care system provided by the team of multidisciplinary specialists within modern health systems, diabetes care is usually provided in primary assistance through specialized diabetes clinics, but Complex cases are treated in diabetic centers specialized in secondary care in which multidisciplinary diabetes are available following a national guideline or local protocols adapted by a national guide or algorithm based on known evidence. The Diabetes team is usually driven by a medical diabetologist and in most cases includes specialized diabetes nurses, dietissions, podiatrists and other collaborators such as ophthalmologists, nephrologists and pharmacists, in addition to the assistance services provided by family doctors . This has improved clinical efficiency, communication and care of patient centrosity.31 in the last decade, new tests have been introduced on lifestyle monitoring, self-estreation education and monitoring and various new treatments are States introduced for different management aspects. The main aspects of the national guideline for type 2 diabetes in the UK are summarized below. Structured education should be offered to people with type 2 diabetes and their vectors at the time of diagnosis. This structured educational program is an evidence-based approach carried out by a trained and tailor-made educator for individual requirements to improve self-management. Advice on nutritional needs should be provided by nutritional experts and must meet cultural needs and dietary counseling should be based on healthy eating habits. Newly diagnosis patients should have the level of plasma glucose monitored daily as part of self-education, with help in the interpretation of results. Support To set the objectives for HBA1C levels, lipid levels and blood pressure must be provided and the HBA1C levels must be checked at least once every six months. The main pharmacological treatments used to control hyperglycemia in type 2 diabetes are oral insulin and / or antidiabetic agents, as illustrated in appendix 1. Metformin must be offered as a first line of treatment if HBA1C is not reduced to Levels of destination unless the patient has contraindications due to kidney damage or hypotension. Sulphonilura must be used Second treatment line, and these treatments should be evaluated by measuring HBA1C levels. If the level is not checked, the dosage should be increased. People who use sulfoniluree should be educated about the danger of hypoglycemia. Rasting rapids of acting insulin (eg insulin Aspart, Lispro and glulisins) must be administered only to people with uncontrolled hyperglycemia and unstable lifestyles such as those who cannot regularly eat a similar quantity of food at a similar time due For example, work on shifts. People with levels of HBA1C higher than 7.5% are required to take insulin or humane tiazolidine, if insulin is not appropriate. In obese individuals with> 7.5% HBA1C, exenatide, an insulin stimulator secretion and glucagon secretion inhibitor, should be given when HBA1C does not improve at this point and exenatide must be interrupted after twelve months if the body weight is not lost And blood glucose is not reduced. An insulin pen injector must therefore be proposed, starting from human insulin, followed by a mixture of analogues of insulin or insulin glargine. A structured program should be used when the insulin is started to title of blood glucose at the level with a concentration of insulin administered to establish the best dose to avoid hypoglycemia. The arterial pressure must be monitored at least once a year or frequently in patients at risk of high blood pressure. In the event of patients who already take anti-hypertensive at the time of diagnosis, blood pressure control and treatment should be magazines. Councils on healthy lifestyle should be offered to people with blood pressure over 140/80 mmHg or 130/80 mmHg in people with kidney disease; Supervision Cerebrovascular damage or with eyes should be offered. Angiotensin (ACE) or angiotensine or angiotensine 2 blocker receptor (ARB) inhibitors (ARB) must be administered whenever possible and based on individual requirements for the drug. If the pressure is not controlled, socciantagonist channel should be administered as a second or third treatment line if the desired blood pressure is not reached. It is not necessary a formal assessment of cardiovascular risk, such as type 2 patient diabetes are already at risk of premature CVD. The UKPDS risk engine should be used instead for management. Cardiovascular risk must be evaluated each year, the complete lipid profile control. Over 50 years old people should be offered at low dosage (typically 75-100mg / day) of aspirin. Clopidogrel should only be used for aspirin intolerant people. In patients where triglycerides in whey is abnormal, fasting lipid profile should be evaluated. Simvastatin must be administered to people over 40 years or people under 40 years who have little prognosis of developing cardiovascular disease. Increasing hypocolesterolemizing treatment should be considered if the lens cholesterol level is not achieved. The prevention of nephropathy can be evaluated by testing urine microalbuminuria and, if present, renal failure must be evaluated by measuring the clearance of creatinine or glomerular filtration speed evaluation problem (GFR) .28.32 per eye, eye screening must be carried out at Moment of the diagnosis and then every year later. Topic Midriary must be used after the evaluation of visual housing and photography of the pre-digital retina. Development of neuropathic symptoms should be evaluated annually and discovered discussed, including management and prognosis if any neuropathic symptoms are present. You must administer analgesics to relieve pain, and if the treatment does not provide the desired result, tricyclic antidepressants should be considered and the answer obtained should be evaluated. If the result is still as desired, then Duloxetine, pregabalin or Gabapentin should be processed, according to the current drug practice. Erectile dysfunction must be evaluated annually and discussed. If it is erectile dysfunction, a phosphodiesterase of type 5 inhibitor must be administered, and if it does not produce the desired result, other forms of interventions should be discussed, Intracavernosa Injections.33 A diabetes management goal is to get a better glycemic, blood pressure and lipid control. Glycemia is generally measured by the levels of HBA1C. HBA1C is a representative of the percentage of the total glycated hemoglobin usually for a period of 3 months. It is considered a standard measure of blood sugar and glycemic control in the indicated period. HBA1C prefers FBS to test blood sugar levels in diabetic patients as it does not involve that they require the patient to fast for 8 hours minimum before before as done in the latter and can serve as a marker to detect microvascular complications.34 intensive glycemic control resulting in less than 7% HbA1c levels have been shown to be beneficial for type 2 diabetes, however, 35,36, caution is needed in those in which established complications can be detected or exaggerated especially with intensity.37Ã ¢ sharp and progressive 39 physicians should consider these facts when disease management. The HbA1c level was the first objective measure used to assess the severity of hyperglycemia in different ethnic cohorts adjusted for age with diabetes.40 Other clinical outcomes measured in Diabetes Care systolic and diastolic blood pressure for hypertension control, total cholesterol, triglycerides and LDL and HDL lipoprotein â â monitoring for hyperlipidemia, and weight or body mass index (BMI) for obesity.28 the main objectives set by NICE for the management of type 2 diabetes in the UK they are in concert with other guidelines in most countries, including those of the American diabetes Association (ADA) ADA standards.41,42 act as a regulatory body for the treatment of diabetes in the United States just as beautiful act in the UK and according to them the following sets are favorite targets for the management of diabetes in most patients in some patients should have the individualized goals n according to their particular needs: HbA1c

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