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Dka management guidelines british

The Joint British Diabetes Societies Guidelines for the management of diabetic ketoacidosis (this does not include Hypersmolar Hyperglycemic Syndrome) are available in full at: (i) (ii) (iii) . This article summarizes key changes from previous guidelines and discusses the reasons for the new recommendations. The main point is: Monitoring the response to treatment (i) The preferred method for monitoring the response to treatment is bedside measurement of capillary blood ketone using a ketone meter. (ii) If blood ketone measurements are not available, windy pH and bicarbonate should be used in association with bedside blood glucose monitoring to assess treatment responses. (iii) Venous blood should be used from arteries (unless respiratory problems dictate otherwise) in blood gas analysis. (iv) Confirmation of pH interment laboratory, bicarbonate and electrolyte only. Insulin administration (i) Insulin must be infused intravenously at a fixed level based on weight until ketosis has been resolved. (ii) When blood glucose drops below 14 mmol/l, 10% glucose should be added to allow insulin levels to continue. (iii) If already taken, long acting insulin analogues such as insulin glargine (Lantus®), Sanofi Aventis, Guildford, Surrey, UK) or insulin detemir (Levemir®), Novo Nordisk, Crawley, West Sussex, UK.) should be continued in regular doses. Delivery of care (i) A team of diabetes specialists should be involved as soon as possible. (ii) Patients should be treated in areas where staff are experienced in the management of ketoacidosis. The Combined British Diabetes Societies (JBDS) for the Inpatient Care group was created in 2008 to 'provide a set of diabetes inpatient guidelines and proposed standards of care within secondary care organisations', with the overall aim of improving inpatient diabetes care through the development and use of high-quality evidence-based guidelines, and through better inpatient care pathways. The JBDS-IP group is created and supported by diabetes UK, ABCD and the UK Diabetes Inpatient Specialist Nurse (DISN) group, and works closely with NHS England, TREND-UK and with other professional organisations. Rowan Hillson's 2017 inpatient safety award A SurveyMonkey of JBDS-IP guidelines conducted at the end of 2012 revealed: The guidelines have been actively distributed (>21,000 copies, excluding downloads) 85-100% of the respondents team knew the guidelines >90% adoption in 118 UK Trusts for longer guidelines, and about 50% for the 2012 guidelines Rated very highly in terms of patient safety, overall quality and clinical value The group administrator is Christine Jones and if you or You would like to contribute to the guidelines in the future, please contact him he Core members of JBDS-IP (listed below) include diabetes consultants and diabetes specialist nurses from across the UK, with all 4 countries represented. Biennial face-to-face meetings interspersed with teleconferences ensure regular contact between members. The Guidelines included on this page have been commissioned and supported by BSPED and reflect the Community's view of best practices for the majority of patients with the condition. However, each patient should be considered an individual in the context of their condition and other medications and therefore the reader's discretion is necessary in the application of their use. Every effort has been made to ensure the factual accuracy of the content but no acceptable responsibility for litigation, claims, or complaints arising from the use of the guidelines. If you have a query or comment, or would like to raise concerns about the BSPED guidelines, or any guidelines on this page, please contact the BSPED Office who will ensure your message is forwarded to the Clinical Guidelines Officer and the BSPED Clinical Committee. These guidelines are produced by accredited national bodies (e.g. NICE, RCPCH, ACCO, SIGN), of which BSPED is a stakeholder. BSPED may have been involved in the development of these guidelines but is not the original author of these guidelines. Please review the BSPED Clinical Guidelines Authentication document for the process. The author of the guidelines is required to sign the BSPED Declaration of Interest form (conflicting definitions of interest are listed on the form). Skip to Paediatric Diabetes Guidelines Nice British National Formulary (BNF) website is only available to users in the UK, Crown Dependency and UK Overseas Territories. If you are sure to see this page in error, please contact us. Ketan Dhatariya Address for correspondence: Dr Ketan Dhatariya Elsie Bertram Diabetes Centre, Norfolk and Norwich University Hospital NHS Foundation Trust, Colney Lane, Norwich, Norfolk, NR4 7UY, England. Phone: +44 (0)1603 288170 E-mail: ketan.dhatariya@nnuh.nhs.uk Br J Diabetes Vasc Dis 2015;15:31-33 Abstract The Diabetes Society of England (JBDS) looked in detail at evidence-based management for diabetic ketoacidosis (DKA) and produced a series of guidelines to support management Due to the nature of research into DKA there are some areas that lack an evidence base, so expert comments and experience support some recommendations. This article explains the historical basis of the development of this condition management, how we came to the current situation and why the ongoing national DKA audit is so important in purifying what is currently happening across the UK in clinical practice. Keywords: diabetic ketoacidosis, development guidelines, comma diabetes, insulin, evidence-based drugs. Introduction In 2010 JBDS produced guidelines for the management of DKA. Data In 2013 presented at the Diabetes UK Annual Professional Conference showed that more than 85% of all UK hospitals that responded to the online questionnaire said they had adopted or adapted the guidelines. In 2013 these guidelines were then updated to reflect new evidence and to include some suggestions, criticisms, and comments made about the first edition. However, there are still some concerns about the document; the most frequently aired are those that surround the lack of evidence for many recommendations. For this reason a national audit of the current management of DKA is underway – to try to gather information about what is currently being done, and whether the current guidelines help or impede management, or if there are areas that need to be changed to improve results. I hope that by the time you read this your team will contribute to the audit by submitting data on the five patients treated at your hospital with DKA, as well as institutional forms that collect information about the make-up of diabetes teams across the UK. Data is collected from all adult teams as well as for all DKA admissions for those over the age of 14 from the pediatric team. If you are based in a UK hospital and still want to submit data, then please do so by downloading the form from the ABCD website. One of the most frequently asked questions is 'why?'. Why do guidelines recommend weight loss, fixed levels of intravenous insulin infusion when for many years it was a variable rate; why move to bedside ketone measurements; why is the blood gas windy; and so on. To answer this, and many other questions, it may be useful to look at the history of DKA and its management. Pre-insulin era One of the earliest descriptions of 'comma diabetes' is from 1886.3 In it, the author describes how, for poor people who develop type 1 diabetes, life is miserable, and usually very short. It has previously been recognized that fasting (or rather, enforced rationing) had relieved diabetic glycoouria during the German siege of Paris in 1870 and this led to the development of a severe and carbohydrate-free diet. At the turn of the century several leading diabetes specialists such as Fredrick Allen in the US, or Bernard Naumyn in Germany, managed to keep people alive for several months, or even a year or two on this strict and unacceptable regimen.4 The introduction of insulin in 1922–23 was perhaps the greatest medical breakthrough of the 20th century. What drives those who are 'early adopters' of the new wonder drug is how to use it - how often, how much, and so on, and how to balance the effects of decline with too low risk or do not provide enough to prevent ketosis. It is in this background that DKA management evolves. High-dose insulin Initial report on management management DKA for the first 20 years after insulin availability documented that between January 1923 and August 1940 12% of patients died if they were presented with DKA, and they were given, on average, 237 units of insulin in the first 24 hours – with an average of 83 units administered in the first 3 hours.5 The authors went on to report that between August 1940 and May 1944, only 1.6% of patients died, and the average insulin dose given in the first 24 hours was 287 units (range 50 to 1770 units), with an average of 216 units administered in the first 3 hours.5 Thus, high-dose insulin treatment for DKA management became the 'norm'. In 1949, Black and Malins of Birmingham reported a series of 170 consecutive cases of DKA treated with an average of 265 units (range of 140 to 500 units) of intravenous insulin for those who were sleepy but could be drained, an average of 726 units (range 250 to 1400 units) for those who are reliable with difficulties, and an average of 870 units (range 500 to 1400 units) for those who are unconscious at entry.6 What is lacking, of course, in very preliminary reports is aggressive fluid management. Black and Malins reported that they would typically give a 'pint (568 mL) of saline for 15-30 minutes, followed by a second pint given at the same rate, and then perhaps a third, followed by 5% glucose given on pints per hour'.6 They, however, it is also among the first to describe the classification of severity for DKA, something that the American Diabetes Association continues to advocate.7 Low doses of insulin and aggressive fluid replacement While there have been sporadic reports of low-dose insulin being used to successfully treat DKA, it wasn't until Sönksen et al in 1972.8 and then Kidson et al9 and Page et al10 in back-to-back publications in the British Medical Journal, that showed that low ketone levels and glucose were fairly lowered. The dose used is 1.2 to 9.6 units per hour from Kidson et al, and a fixed rate of 6 units per hour from Page et al. In addition, the 6 units per hour provided by Kidson et al produced plasma insulin concentrations of ~100 µU/mL. This is compared to concentrations in healthy individuals ~40-50 µU/mL (<20 fasting, ~40 prandial).9 Weight-based FRIIII has also now been successfully used for decades.7,11 The FRIIII concept is well established in pediatric diabetes.12 and the question often arises 'when does a child become an adult?'. What is still missing from the report by Kidson et al is a liquid replacement regimen. Page et al commented that they gave 3.66L (range 1.5 to 6 L) in the first six hours, and averaged 5.5L (range 2.75 to 9 L) in the first 12 hours. Thus the aggressive fluid regimen administered along with the low-dose intravenous insulin infusion regimen became the standard of care for DKA management the next four decades. UK team of diabetes specialists during </20> </20>. The 30-year-old has developed diabetes into a medical speciality of his own. Many of the people appointed in the 1970s and 1980s as 'general practitioners with an interest in diabetes' have now been overtaken by 'diabetes consultants and general medicine'. This shift, while seemingly small, has implications for the management of patients with diabetes in general, but particularly for those present with DKA. It was shown in the late 1990s that, when patients with DKA were looked after by doctors specialising in diabetes, their results were better than those treated by 'general practitioners'.13 With the advent of Diabetes Inpatient Specialist Nurses,14 there has been a wholesale step towards diabetes care delivered by a team of diabetes specialists. Indeed, with the recent application of Best Practice Rates for DKA, there is now a financial incentive for hospitals to provide such services.15 Ketone and vengeful blood gas measurements In 1972 Hockaday and Alberti suggested that the body's concentration of plasma ketones greater than 3 mmol/L would be the same as 'severe' acidosis.16 However, the technology needed to measure ketones is not routinely available. The development of monitoring of urine ketones is a major advance, and it becomes the recommended standard of care when monitoring the treatment of DKA.17 Since the physiology of ketosis becomes better understood, it becomes clear that, while the ketone sticks of urine detect acetic acid, they are poor in detecting β-hydroxybutyrate, the dominant ketone in the blood. With the advent of handheld bedside ketone monitoring equipment there is a better understanding that the pathological problem in DKA is ketosis/acidosis than hyperglycaemia.18 Avoidance of arterial blood gas should be welcomed. This author clearly recalls the radial artery aneurysm caused by a sample of ruptured arterial blood gas on my last night on the phone as a medical registrant (treated with the wise use of a sphygmomanometer). Evidence has shown that the difference between arterial and venous pH and bicarbonate is not large enough to change management and is much less invasive for patients.19 Where are we now? In the late 1990s and early 2000s there was a consensus that the best way to treat DKA was with aggressive fluid management and low dose intravenous insulin infusions. In addition, it was agreed that regular monitoring of blood gas helps management decisions. It is also recognized that electrolyte deficiency is common and that for some - potassium in particular - replacement is required. What there is no consensus about, however, is how much fluid, which fluid, how much insulin, pork gas or arteries, how much potassium, bicarbonate yes or no, phosphate yes or no, and so on. Thus it is often left to individual hospitals to create their own DKA guidelines (and for incoming applicants to rewrite). In 2006, ask for two to establish a set of guidelines that would form the basis of a standard care regimen.20 It quickly became clear that there was an appetite for such documents to be used by those at the 'front door'. However, it needs more detail and more evidence based on the emergency team to accept its use. It was at this time that the JBDS Inpatient Care Group was also formed: a collaboration between ABCD, Diabetes UK, and the National Diabetes Inpatient Nurse Group consisting of individuals interested in inpatient care. The authors of the initial ABCD DKA guidelines join others and a more comprehensive document was written.1 and revised in 2013.2 Given the 2013 properties and heterogeneity of the condition, it remains difficult for any team to see a sufficient number of cases to be able to assess the impact of the guidelines. Therefore, an audit of DKA management is currently underway – based on JBDS guidelines. It is designed to capture data on five consecutive admissions with DKA in all hospitals across the UK and to see if and where DKA management can be improved. The same audit form is also used to assess the care of all pediatric patients over the age of 14. The future direction of optimal care for DKA has not yet been determined. The numbers that need to be treated to answer the question of 'nuance' will be a very large and randomized controlled trial because it is not possible. Until then, consensus and audit should be sufficient. Like all JBDS documents, DKA guidelines are dynamic. If the current audit shows the need for changes, then they will be made. In the meantime, please contribute to the audit, and if you have any criticisms, comments, or suggestions please feel free to air them. KD's conflict of interest is the lead author on the 2nd edition of the JBDS guidelines on the management of DKA in adults referred to in the text. Travelling to a meeting for a group of authors during the production of guidelines paid for by Diabetes UK Funding KD is a full-time employee of the ETHICAL approval of the UK National Health Service Unnecessary KD Guarantor Contributor KD is the sole author of Reference 1. Savage MW, Dhatariya K, Kilvert A et al. Combined Guidelines of the British Diabetes Society for the management of diabetic ketoacidosis. Diabet Med 2011;28:508-15. 2. Dhatariya K, Savage M, Claydon A et al With British Diabetes Societies Inpatient Care Group. Management of diabetic ketoacidosis in adults. Second edition. 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