Diabetes Balance Optimization In Prison

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INTRODUCTION

Diabetes is an endocrine disease that requires great rigor in its therapeutic management, both for the treatment, for the management of the balance of food, physical activity and stress. The prison environment can be both a brake, but also the where we restart a support from the beginning. It is still necessary that the means put in works are at the height of this care and that of the arrival until the exit of the patient and beyond.The aim is to demonstrate that, apart from prison constraints, detention can be the place where the patient's follow-up can be resumed, which allows him to better balance his pathology and avoid the complications.

METHOD

A search with the terms imesh "diabet" AND "prisons" was performed on Pubmed. The research is quite broad because there are few publications on the different types of custody, particularly in France (the prison organization is specific to each country and therefore difficult to transpose to France). No publication date has been voluntarily chosen in view of the few studies carried out. The inclusion criteria are, first and foremost, the specific management of diabetes, and the exclusion criteria are everything that is not related to the management of diabetes, or studies that are too restrictive (such as specific complications of diabetes), or the management of other chronic diseases in prison.

CONCLUSION

Prison health is not a highly studied subject, both abroad and especially in France. Diabetes is a public health priority both in prison and in the general population. The therapeutic management of the diabetic patient in prison must revolve around the patient, from entry to exit. It includes therapeutic education, therapeutic management during incarceration and coordination of care with the various specialized physicians, during incarceration and upon release from prison. This includes the training of prison staff who are the first to warn of problems in detention. For institutions that do not have a specialist diabetology physician in the health units, could the advanced practice nurse not play an important role in the follow-up, education and management of these very special patients?

References :

ANALYSYS

The management of the diabetic patient always refers to the recommendations made by the high health authorities, they are common to all patients regardless of the place of their care. Below is a table with the biological goals of a diabetic patient.

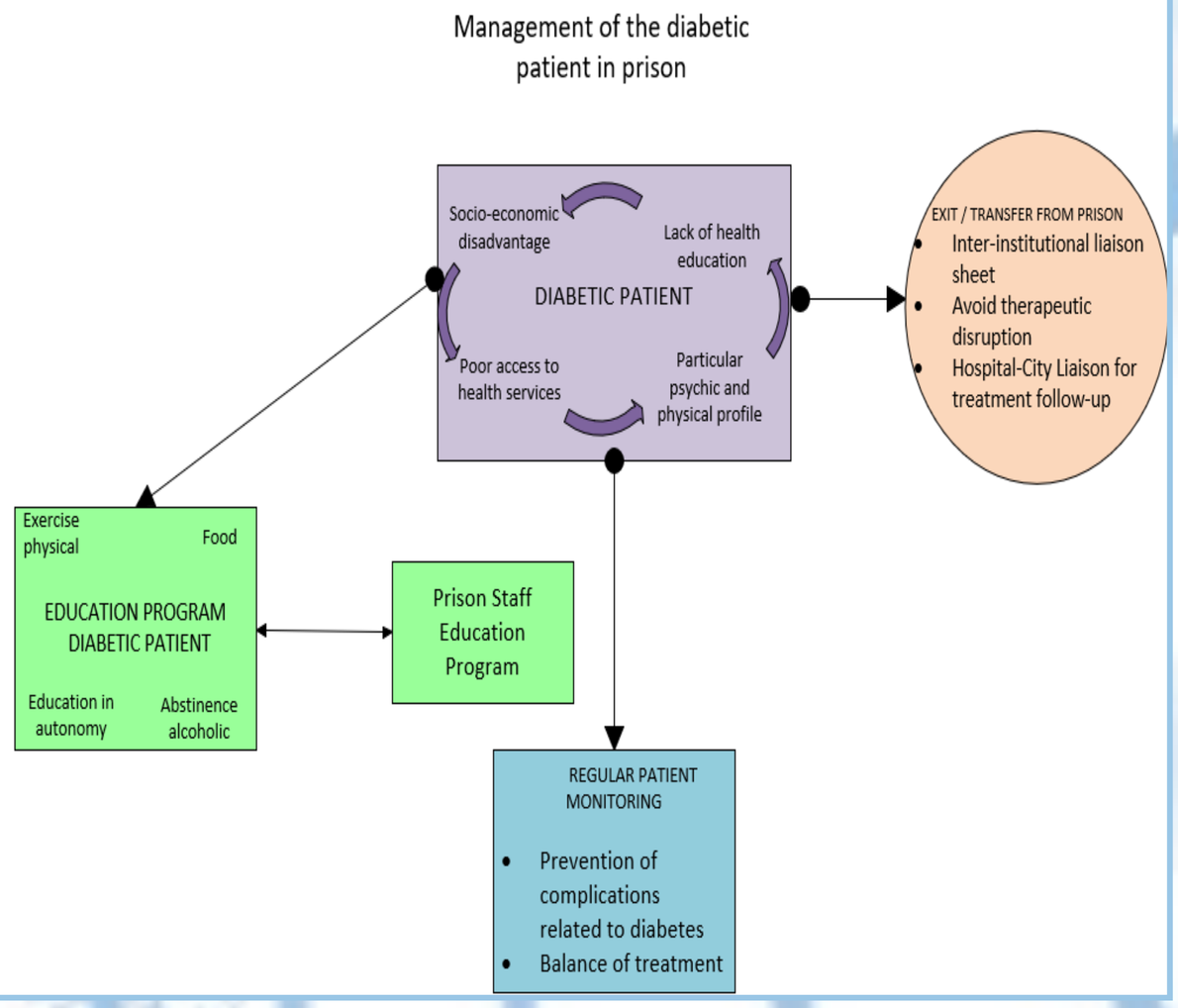
Summary of recommendations for adults with diabetes mellitus	
Glycemic control :	
A1C	< 7%
Preprandial plasma glucose	90-130 mmg/dl (5.0-7.2 mmol/l)
Peak postprandial plasma glucose	<180 mg/dl (<10.0 mmol/l)
Blood pressure	<130/80 mmHg
Lipids :	
LDL	<100(<2.6 mmol/l)
Triglycéridest	<150 mg/dl (<1.7 mmol/l)
HDL	> 40 mg/dl (>1.1 mmol/l)

https://care.diabetesjournals.org/content/26/suppl_1/s33

This table is a summary of the various complications associated with diabetes with their management to limit them. The nurse in advenced practice can play an important role in limiting these complications in the context of an education during consultations with the patient.

Preventing and managing complications	
High blood pressure	• Blood pressure at every routine diabetes visit • Treatment
Lipid management	• Lowering LDL cholesterol • Lower triglycerides to <150 mg/dl (1.7 mmol/l) and raise HDL cholesterol >40 mg/dl (1.15 mmol/l)
Prevent cardiovascular events in diabetic	• Aspirin therapy (75–325 mg/day) for primary prevention
Smoking cessation	• Include smoking cessation and other forms of treatment
CHD screening and treatment	• Exercise stress testing in asymptomatic diabetic patients
Nephropathy screening and treatment	• Optimize glucose control • Optimize blood pressure control • Annual test for the presence of microalbuminuria
Diabetic retinopathy screening and treatment	• within 3 to 5 years of onset of type 1 diabetes: fundus and annual full ophthalmologist's examination
Foot care	• Foot examination and educate all patients, especially those with risk factors or complications • Refer high-risk patients to foot care specialists
Immunization	• Annually influenza vaccine to all diabetic patients • Pneumococcal vaccine for adults with diabetes

Synthesis of all therapeutic treatments in different institutions



Taking care of type 2 diabetes and clinical inertia : litterature review

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INTRODUCTION

In our health system, patients with Type 2 diabetes (T2D) can be treated by a diabetes specialist, a general practitioner or any doctor with a different speciality. According to international recommendations, it is necessary for healthy that the patient T2D is treated with insulin as soon as possible, in case of failure of oral anti-diabetics. These patients should also be educated to manage their own treatments.

METHODS

A search was conducted in PUBMED and GOOGLE SCHOLAR for resources written in English and published between 2016 and 2019.
The key words [Patient Care Management], [Diabetes Mellitus,type 2] and [General Practitioner] were used in all relevant combinations.
The exclusion criteria were [children].
A total of 62 records, from which we excluded 57 as they did not discuss generalist practioners .
As result, 5 studies from Europe and the United States of America.
In this research, we will see if T2D management differs from one doctor to another.

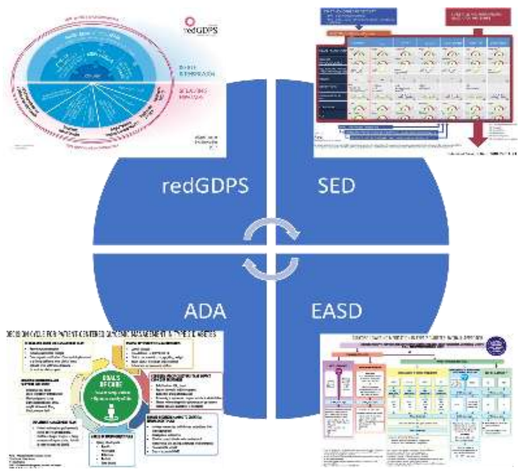
RESULTS

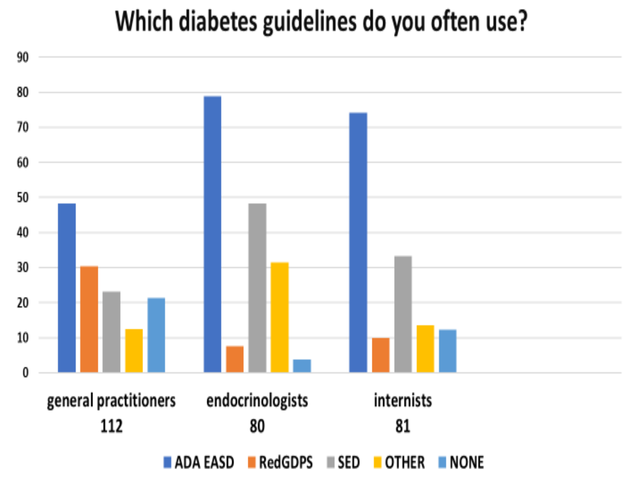
There are many recommendations to help doctors take care of type 2 diabetic patients: treatments, target hba1c, follow-up. The ADA insists that the patient should be at the heart of care and that therapeutic education is important in order to educate the patient. A relationship of trust must therefore exist with the doctor in order to make the patient cooperate.
In patients who are not balanced with oral antidiabetics T2D patients, early initiation of insulin therapy avoids complications and there is evidence that those who are educated have fewer complications than patients with insulin delay.
But there are several barriers to initiating insulin-based treatment among treating physicians. This creates disparities between the care of general practitioners and diabetologists who work with multidisciplinary teams.
In fact, the treating physicians do not have training in therapeutic education and do not work with therapeutic education teams .
Patients who are not educated must be seen very often and the general practitioner does not have time to follow correctly the evolution of these patients.
Some doctors fear that their patients will have a hypo and will try to avoid them by delaying insulin.
First-line doses are lower, glycemic targets are higher and clinical inertia sets in as patients never reach an optimal Hba1c.

CONCLUSION

Being followed up by a diabetologist working in a multidisciplinary team is the current best management of type 2 diabetes because the patient has direct access to therapeutic education.
A partnership with an advanced practice nurse could be a solution to help the general practitioner.

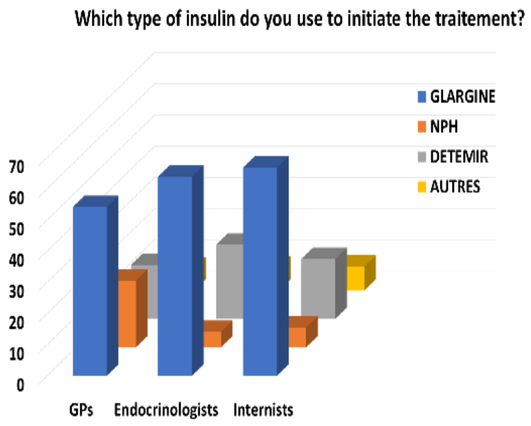
DIFFERENT GUIDELINES DIFFERENT ATTITUDES

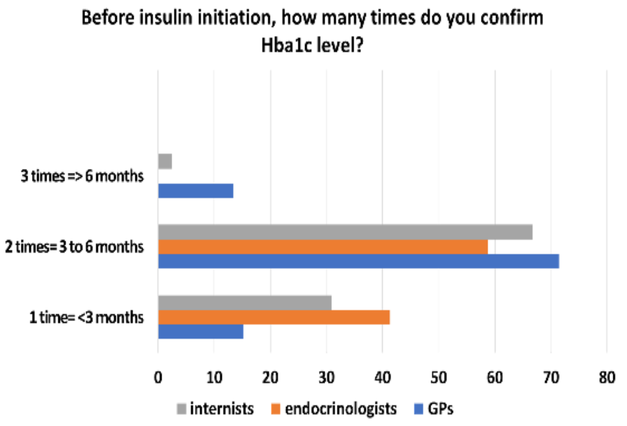


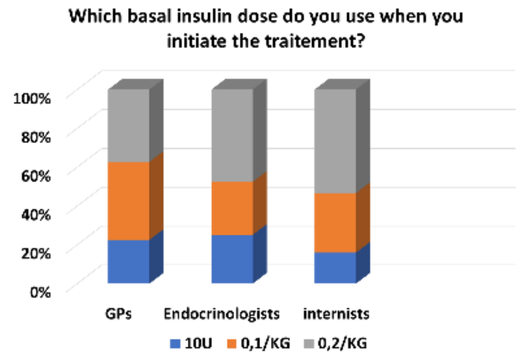


ADA-EASD: American Diabetes Association-European Association for the Study of Diabetes; RedGEDAPS Primary Care Diabetes Spanish Guideline; SED: Spanish Society of Diabetes Guideline.

The American Diabetes Association and the European Association for the Study of Diabetes convened a panel to update the prior position statements . These include additional focus on lifestyle management and diabetes self-management education and support. For those with obesity, efforts targeting weight loss, including lifestyle, medication, and surgical interventions, are recommended.



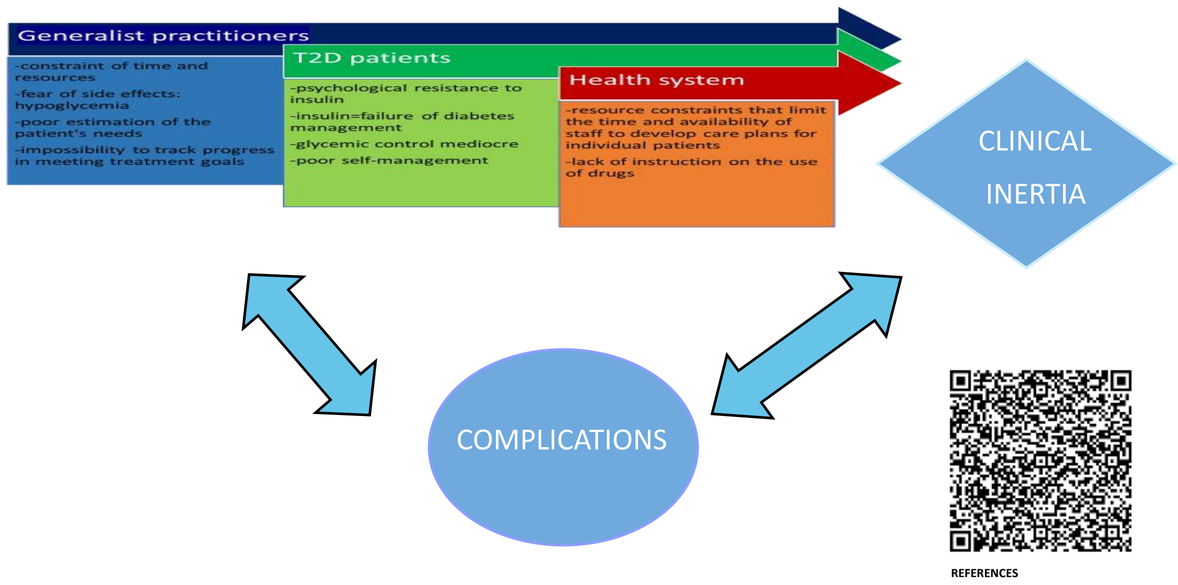




	GPs	Diabetologists	Internists	
Which upper limit of fasting blood glucose do you use as good control target in insulin treated patients?				
100 mg/dL	5.4	16.3	7.4	
120 mg/dL	24.1	37.5	35.8	
130 mg/dL	35.7	32.6	19.8	
140 mg/dL	32.1	13.8	34.6	<0.05
>140 mg/dL	2.7	0.0	2.5	

For patients with type 2 diabetes who are not achieving glycemic goals, drug intensification, including consideration of insulin therapy, should not be delayed .
A1C <7.0% (53 mmol/mol)
Preprandial capillary plasma glucose 80–130 mg/dL (4.4–7.2 mmol/L)

Barriers



REFERENCES

BENEFITS OF WEB-BASED MONITORING FOR CANCER PATIENTS

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INTRODUCTION

Many applications and websites have been created and make everyday tasks easier for us. The field of health is no exception, looking in your store "health" many applications are available about diet, sleep, physical activity …, not to mention the connected objects, websites and forum around different pathologies. But for these systems to be approved in the world of medicine, they must meet many requirements and be validated by evidences of their effectiveness and added value for patients.

The purpose of this research is to find randomized clinical trials assessing the benefits of managing and monitoring cancer symptoms and side effects of treatments supported by e-health systems.

Are there proven benefits of e-surveillance from randomized clinical trials?
What systems are used?
What are these benefits?

METHODS

A search was conducted in PUBMED**,** GOOGLE SCHOOLAR AND ELSEVIER for resources published between 2015 and 2019 in English and French.

The keywords: **eHealth or mHealth or telehealth ; cancer ; symptom management**

These were used in all relevant combinations, and inclusion criteria were the randomized controlled trial and use during or after the treatment phase…

The exclusion criteria were study protocols, feasibility studies, the number of non-representative participants, applications including coaching for physical activity, as physical activity itself was previously recognized as improving the quality of life.

I selected 5 studies that in a randomized trial compared the symptoms experienced by patients during a follow-up using the e-health systems versus a standard follow-up.

RESULTS

ALL studies showed significant **benefits** for patients in monitoring symptoms

2 APP (mobile applications)

Monitoring symptoms by weekly questionnaires

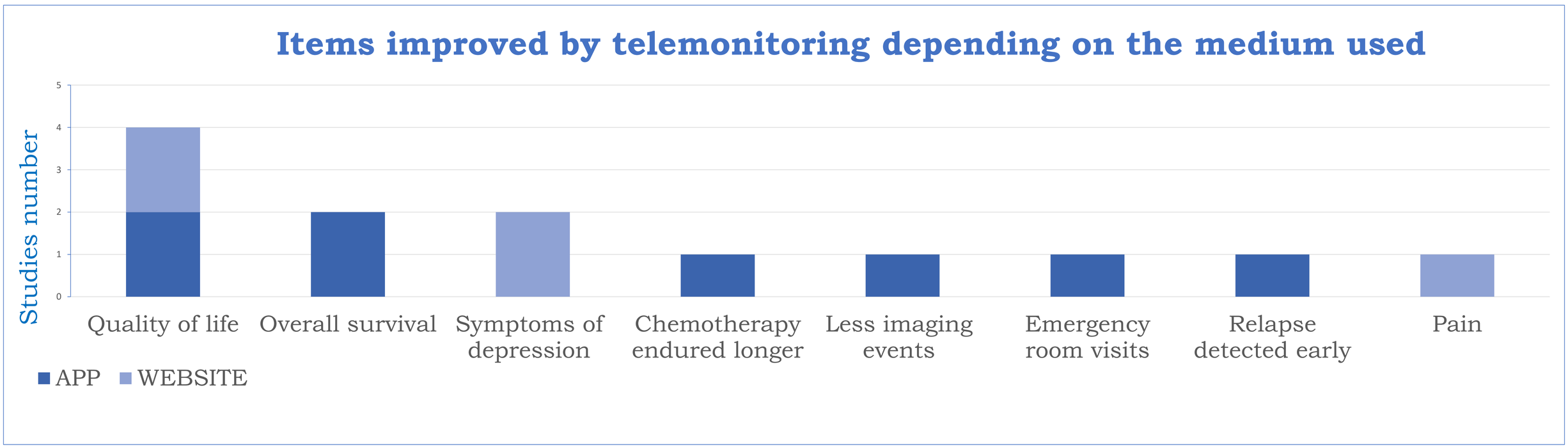
Generates alerts to the expert centers so that they can adjust their supportive care

3 Websites

Gives access of e-strategies of self-management of symptoms

Phone follow-up or e-communication with expert cancer nurses

Items improved by telemonitoring depending on the medium used



CONCLUSION

E-monitoring systems can therefore bring real benefits in the monitoring and management of cancer patients. They help to improve quality of life and various symptoms associated with disease or treatment and thus can increase overall survival. E-Health systems are numerous, but in the end, there are few randomized trials that prove their effectiveness. Many trials are underway but there is a contradiction between the high speed of e-Health software development on the one hand and the long duration of clinical trials on the other. It may be necessary to consider other study concepts in order to distinguish serious APP from applications without proof.

REFERENCES

TO PROMOTE ORGAN DONATION IN FRANCE BY ACTING ON THE MODIFIABLE FACTORS INFLUENCING THE CONSENT OF FAMILIES OF PATIENTS IN ENCEPHALIC DEATH

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INTRODUCTION

According to the World Health Organisation (WHO), 90 000 organ transplants and donations are performed worldwide each year, more than 10 donations per hour (1). Transplantation has become the therapy of choice for patients with organ failure. Patients whom have been declared dead using neurological criteria are the single largest source of transplantable organs (2). Although the number of organ transplants has increased for several decades, the number of patients on transplant waiting lists does not decrease (3). The major factor limiting the number of organ donors is the low-percentage of families who consent to donation (4). Several scientific studies have revealed the existence of factors that could influence families' decision making, thus increasing the rate of organ donation consent rate (5,6,7).

OBJECTIVES

- To identify modifiable factors that influence families' decision in allowing organ donation in four different countries
- To take stock of the situation regarding organ donations in France
- To propose transferable solutions (regarding the modifiable factors) from the comparative analysis of the international models studied

METHODS

A search was conducted in GOOGLE SCHOLAR for resources published between 2000 and 2019 in french and english. The keywords « organ », « tissue », « donation », « families » and « consent » were used in all relevant combinations. Inclusion criteria were to select studies conducted in different countries concerning the case of families donating organs of only brain dead relatives (Iran, USA, UK, France). The exclusion criterion was to eliminate all studies of living organ donation. By using the Centre for Evidence-Based Medicine (CEBM) tool, four articles from scientific literature were selected after a critical read to formulate the research question. Finally, a comparative analysis of the data from these studies was conducted to answer the problematic and fulfill the research objectives.

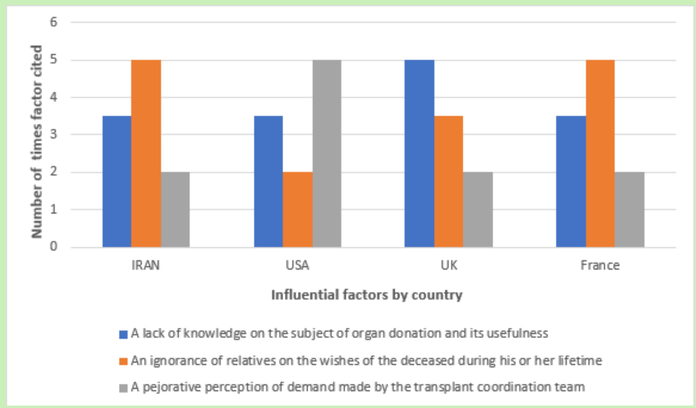
RESULTS

TYPICAL PROFILE OF THE UNIVERSAL ORGAN DONOR

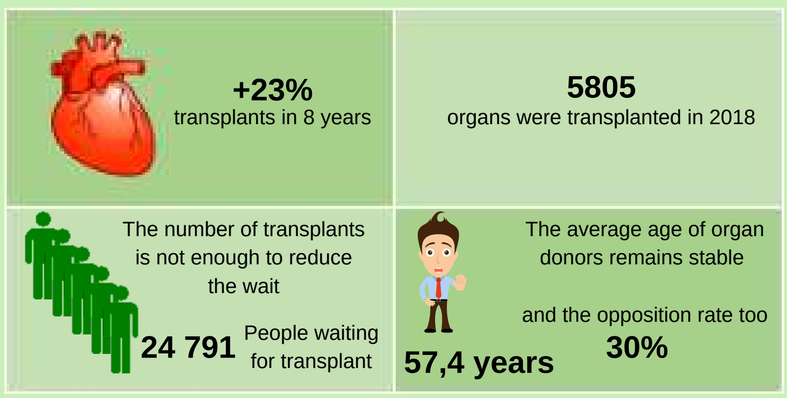
Man
Young
White

Traumatic death

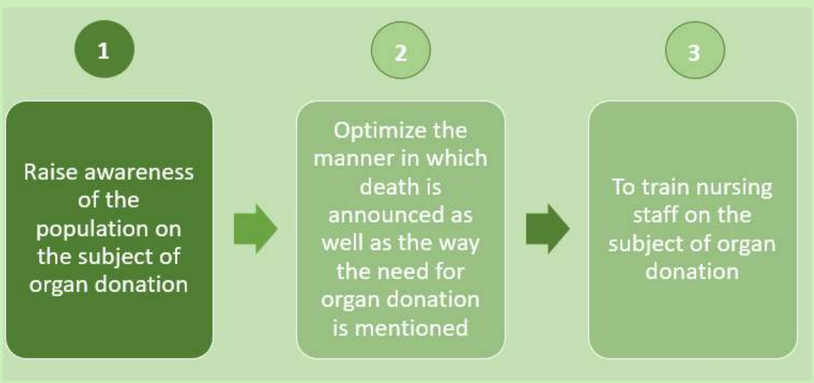
THREE MAIN FACTORS IDENTIFIED FOR ORGAN DONATION REFUSAL BY COUNTRY



CURRENT SITUATION REGARDING ORGAN DONATION IN FRANCE



KEY SOLUTIONS TO IMPROVE FAMILIES' CONSENT RATE FOR ORGAN DONATION IN FRANCE



CONCLUSION

Analysis of the data from the scientific literature has made it possible to identify three main causes for the refusal of families of patient in encephalic death to consent to organ donation : a lack of knowledge on organ donation and its usefulness, relatives' ignorance on the wishes of the deceased during his or her lifetime, and a pejorative perception of demand made by the transplant coordination team. Although data is limited, this systematic review shows that families' consent to organ donation in France could be increased by : population's awareness on the subject of organ donation, an optimization of the manner in which death is announced as well as the way the need for organ donation is mentioned, and the training of health professionals on organ donation.
These solutions deserve to be exploited and implemented in an another study to verify this hypothesis.

REFERENCES