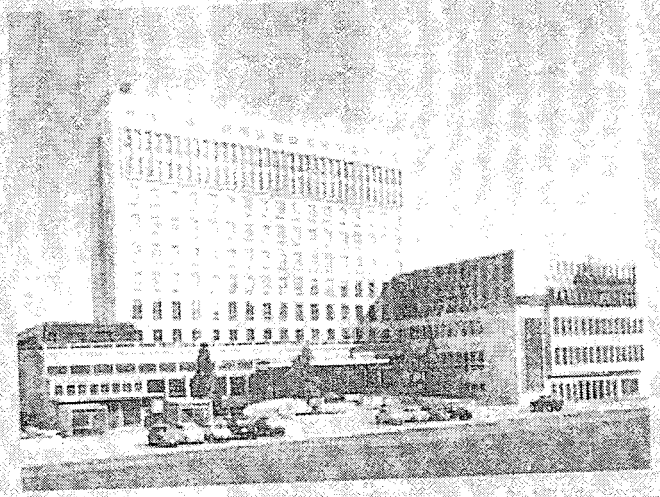
SEEMF

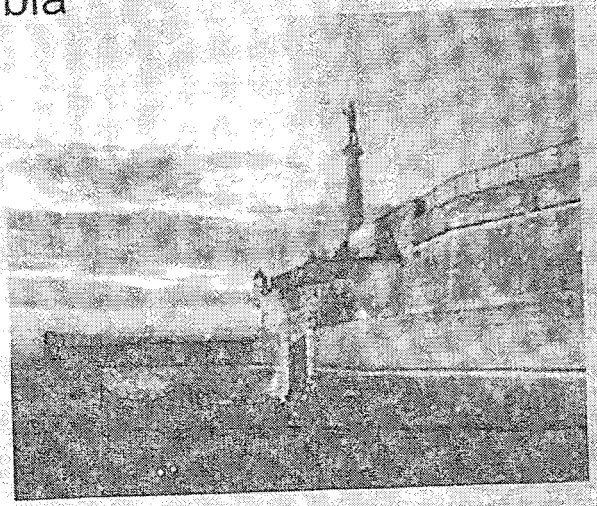
Southeast European Medical Forum

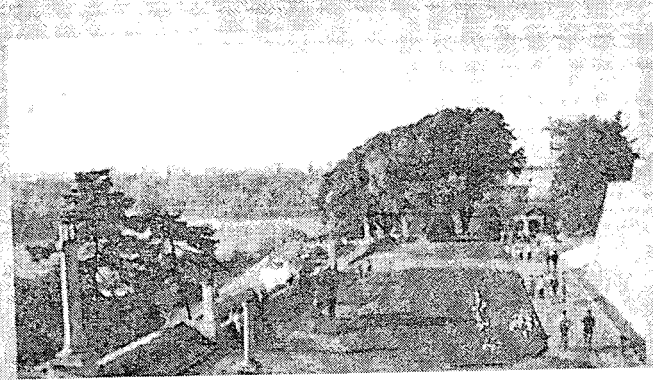
SOUTHEASTEUROPEAN MEDICAL FORUM (SEEMF)

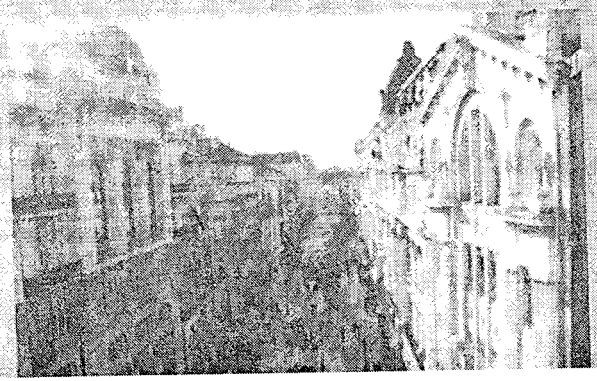
THIRD INTERNATIONAL MEDICAL CONGRESS

12 - 15 September 2012
Belgrade, Serbia









There are modifiable and non-modifiable risk factor of DM; environment causes DM in 70-80 % of cases.Diagnostic tools for diabetes management have been significantly developed and changed; lately PPG has become important for early revealing of the condition, as 70% (vs 30% - FPG) of time a person is in the post-prandial state. In practice we measure PPG only in 30%, and FG – in 70% of cases

. It is known that beta-cell distraction starts several years prior to DM manifestation, that takes place when 50-60% of the cells are destroyed. In 55% of fresh DM micro- and macro-vascular complications are present. In 53% DM is manifested with classic symptoms, while in remaining 47% DM is diagnosed accidentally, during a visit to any doctor. Still many National and In-hospital Guidelines recommend to initiate diabetes management with only dietary therapy. If DM were only a glycemia disorder, it would remain a disease, that could be treated simply with diet and walking! It is proven that the delay in treatment initiation may lead to serious debilitating conditions. Thus, smart therapy, that includes diet, should be initiate at diagnosis. Thus, dietary intervention and increased physical activity are recommended only for high risk population.

While managing DM we should keep in mind both glycemic (glycotoxicity, metabolic memory, hypoglycemia) and non-glycemic (obesity, dyslipidemia, inflammatory markers, hypertension, depression, etc) factors. Initiating DM therapy we should remember new approaches to DM management - smart therapy, treatment individualization. New generation of glucose lowering drugs do not cause severe and frequent hypoglycemic episodes, weight gain, dyslipidemia, hypertension and inflammation progression . In the past century it was accepted that it was enough to maintain optimal glycemia control to stop DM complication. Today we know that together with optimal glycemia control it is important to influence pathologic chains of CV disorders. Paradoxically, that though a large number of recommendations were naïve from the point of view of today's knowledge, Prof. J. Campbell called DM "not a simple disease, but a silent killer".

DM is integrated with various medical disciplines, like cardiology, psychiatry, obstetrics-gynecology, osteo-arthrology, oncology and others. In 2005 there was no information about the relationship between DM and cancer at the EASD Meeting in Athens, while today links between the conditions are revealed. Even the relation of some hypoglycemic agents to cancer development is being studied. It is in the center of attention of the world diabetes community and world healthcare system.

Unfortunately the system still invests in infectious vs NCDs in proportion typical for the end of the 19 century (5X1) – resources invested in NCD control are not adequate to the scope of the problem.

When we speak about the awaited rise in the prevalence of DM and other NCDs, reality always comes ahead of the prognosis. New approaches and

new technologies, safe, accessible and affordable drugs, diagnostic technologies and education of people with diabetes, HCPs and the society will permit to demolish myths and paradoxes of DM and related conditions.

DIABETES IN PREGNANCY AND NEONATAL MACROSOMIA

Zisovska Elizabeta, Professor, PhD
University Clinic for Gynecology and Obstetrics, Skopje, Macedonia
Tel number: +389 76 233242; e-mail address: elizabeta.zisovska@ugd.edu.mk

In general, macrosomia, or large for gestational age newborns (LGA) is defined as a birth weight greater than the 90th percentile for age. However, it has been suggested to restrict the definition to infants with birth weights greater than the 97th percentile (2 standard deviations above the mean) as this more accurately describes infants who are at greatest risk for perinatal morbidity and mortality. Diabetes is one of the most frequent medical condition resulting in LGA newborns, and may be induced by pregnancy or, if pre-exisistent, affects the pregnancy. Unfortunately, pregnancy makes diabetes much harder to control. High blood sugar levels (BSL) in pregnant women could be complicated by vasculopathy, and if it not, fetal hyperinsulinism and macrosomia are mostly present. They may have large organs, particularly the liver, adrenal glands, and heart. These infants may have episodes of low blood sugar (hypoglycemia) shortly after birth because of increased insulin. However, an enlarged heart may take several months to get better. In this study, our objective was to present some indicators in LGA babies, comparing them in relation to diabetes in pregnancy. Methods: prospective study, monitoring few biochemical, clinical and other indicators. The identification of the LGA newborns was performed using WHO growth standards for both sexes (male/female) issued 2009. Results: during the first six months of 2012, 2396 full term newborns were examined, divided in three groups: A-56 LGA babies (20,8%) whose mothers had no history of Diabetes; B-116 LGA babies (43,1%) of mothers with pre-gestational Diabetes; C-97 LGA babies (36,1%) of mothers with Gestational diabetes. Parameters compared between the three groups were: Body mass index (BMI), initial glycaemia, perinatal outcome. BMI was in normal range in group A, border-line in group B and statistically not significant higher in group C(BMI=16,9) Glycaemia was taken

according to the National Guidelines (30 minutes after the second feed) and the results showed significantly lower BSL in group C, mean 1,7±0,2 mmol/L (OR 2.19, 95% CI, 1.25–3.82, P=0.01). Both groups of newborns (A and B) had no significant difference in the mean value of BSL. The ratio male/female was significantly higher in the group A (1,4) compared to other two groups, suggesting that associated factors other than diabetes are responsible for the macrosomia. Regarding the overall perinatal outcome, significantly higher adverse outcomes were found in the group C of newborns (infants of mothers with gestational diabetes), (OR 1.9; 95% CI 1.2-2.9). Such outcomes were: death, hypertrophic cardiomyopathy, congenital heart defects, death, birth trauma and polycythemia. The results showed that LGA babies have much higher risk if their mothers have gestational diabetes compared to pre-existing diabetes, and particularly with those whose mothers had no history or parameters of diabetes. These findings suggest that pre-existing diabetes is known risk factor before the conception, the glucoregulation is established well, and if controlled, the adverse outcomes are rare. On the other hand, the gestational diabetes occurs during the pregnancy, and the impact on the fetus depends strongly on the early identification and good management.

КЪМ СИНДРОМА НА ДИАБЕТНОТО ХОДИЛО

В..Костов ,В .Василев,А.Кехайов ,Е.Лефтеров ,М. Савов ,В .Прнчев,Б.Полянов, проф.А Атанасов,д.м.н.
ДМЦ, "Св.Панталеймон*"София ,МБАЛ Бургас ,МБАЛ "Д-р Бр.Щукеров" Смлоян ,МБАЛ " Св.Ив .Рилски 2003 "Дупница

СЗО / Световна здравна организаця /определи като отделна нозологична единица синдромът на диабетното ходило.

Чрез стандартизирани наши анкетни карти , анализирахме получените данни от 14467 болни от диабет,60.5 % мъже и 39.5 % жени,със средна възраст 59 г. и 6 месеца .По давност на диабета болните са разпределени:

-с давност до 3 години - 0 болни,
-3-5 години- 574 болни = 3.96%
-5-10 години - 2576 болни = 17.8%
-над 10 години - 11317 болни = 78.2 %

Ние се придържаме към класификацията на СЗО на синдрома на диабетното ходило и според нея анкетираните болни са разпределени:

а.с невропатична форма - 1015 болни =10.84%

б.с невроисхемична форма - 5062 болни =54.1%
в.с исхемична форма - 3277 болни = 35.03 %

Данните посочват ,че невропатичната форма е открита при по-млади болни с краткосрочност на диабета.Като услажненя са открити гнойно-некротични

DIABETES MELLITUS AND END STAGE RENAL DISEASE RELATED TO HEMOSTASIS IMBALANCE

Petar Dejanov, MD. PhD
Clinic of Nephrology, Medical Faculty, University Ss. Cyril and Methodius, Skopje, Macedonia
ph: +389(02)3147193, fax: +389(02)311362, e-mail: petardejanov@yahoo.com

Background: Chronic diseases are often related to hemostasis imbalance due to vascular affection which may cause further disease complication. The aim of our study was to examine hemostasis in patients with diabetes mellitus (DM), end stage renal disease (ESRD) and arterial and venous thrombosis.

Material and methods: Patients with chronic diseases were divided as following diseases: DM (n=129); ESRD (n=412); arterial and venous thrombosis (n=165). The number of 125 healthy subjects served as a control group. The performed global hemostasis tests were: protrombine time (sec); caolin-cephaline time (sec); trombine time (sec); fibrin degradation products (FDP) (mg/ml); platelet count and aggregation in adenosine diphosphate (ADP). These parameters were compared between chronic patients and control group. The biological activity of von Willebrand factor (vWf) (%) was examined in each of patient groups and was compared to the control group. For statistical analysis, student t test was used with statistical significance for p less than 0.05.

Results: Examined parameters showed impaired values in chronic disease v.s. control group as following: for protrombine time - 12.6±0.6 sec. v.s. 12.0±0.2 sec. ($p<0.01$); for caolin-cephaline time – 54.1±6.6 sec. v.s. 51.2±1.9 sec. ($p<0.05$); for thrombine time – 19.8±3.4 sec. v.s. 15.4±0.6 sec. ($p<0.001$); for FDP – 16.5±3.6 mg/ml v.s. 2.4±0.8 mg/ml ($p<0.001$); platelet count - 356±112x10^9 v.s. 285±61x10^9 ($p<0.01$); aggregation in ADP - 140±112 v.s. 48±21 ($p<0.001$). For vWf in all chronic patient groups were found increased values: diabetes mellitus - 271±174% ($p<0.01$); ESRD -