Course note (MEMS Annual congress MAC12) on 15th July – 17th July 2022

Important take home messages:

Dyslipidemia

- In all age groups, lifestyle therapy is the primary intervention for metabolic syndrome
- In adults of 40 to 75 years evaluated for primary atherosclerotic cardiovascular disease (ASCVD) prevention, have a clinician – patient risk discussion before starting the therapy;

i. Risk discussion, include a review of major risk factors (e.g., smoking, elevated blood pressure, 10-year risk of ASCVD)

- Statin initiation is advised in adults of 40 to 75 years without DM, intermediate risk of 10-year for ASCVD with risk enhancing factors which are:

i. Family history of premature ASCVD
ii. Persistent elevated LDL-C(≥4.1mmol/L)
iii. CKD
iv. History of preeclampsia or premature menopause (<40 years old)
v. Persistent elevation of triglyceride (TG) ≥ 1.97 mmol/L

Diabetes

- Diabetic ketoacidosis (DKA) criteria:

i. D – Diabetes Mellitus or GM > 11 mmol/L
ii. K – blood Ketone ≥3 mmol/L or ketonuria 2+ or more
iii. A – Bicarb < 15mmol/L and/or venous pH < 7.3

- If patient has autoimmune disease, consider him/her to have type 1 DM until proven otherwise
- Acanthosis Nigricans usually absent in type 1 DM
- Commonly hyperventilation in DKA is misdiagnosed as AEBA, abdominal pain misdiagnosed as acute abdomen, vomiting misdiagnosed as AGE, polyuria misdiagnosed as UTI

- Hypoglycemia:

i. Glucose alert value: ≥ 3 mmol/L < 3.9 mmol/L
ii. Clinically significant hypoglycemia: <3 mmol/L
iii. Severe hypoglycemia: Altered mental and or physical status requiring assistance

- Stepwise approach always starts with lifestyle changes +/- drug therapy then wait.
- Target hbA1c < 7% then wait until glucose level rise and therapy is failing before reinforce lifestyle and adherence.
- Wait again and then only intensify therapy by increasing dose, replacing, or adding other medications.

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