

General treatment of diabetes mellitus

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Description

The model disease for behavior treatment is diabetes. According to estimates, 2.8% of the world's population had diabetes in 2000; by 2030, that number is expected to have doubled. Due to the fact that roughly 50% of diabetics are unaware of their condition, these statistical estimates probably underestimate the true occurrence. Diabetes mellitus actually doubles age-adjusted mortality.

Our understanding is that a type 2 diabetes treatment plan based on research can increase life expectancy and lead to a positive outlook. In reality, the majority of patients do not adhere to the self-management guidelines for exercise, a balanced diet, and medicine.

Patients with diabetes must establish daily routines as part of their treatment, including measuring blood sugar levels, sometimes administering insulin multiple times daily, adhering to a diet, participating in physical activity, and taking medication. The majority of the treatment is under the patients' control. They have decisions to make every day, and these choices affect their physical state, prognosis, and likelihood of experiencing consequences.

Avoiding early decompensation, preventing or delaying the onset of late disease complications, reducing mortality, and maintaining a high quality of life are the basic objectives of treating diabetes. Regarding the disease's chronic complications, it is evident that good glycemic control allows for the reduction of the incidence of microvascular complications (retinopathy, nephropathy, and

neuropathy), but good glycemic control by itself does not appear to be as important in the prevention of macrovascular complications (ischemic heart disease, cerebrovascular disease, peripheral arteriopathy).

In this regard, treating hyperglycemia should be seen as a component of a comprehensive strategy to address the multiple risk factors present in these patients (Arterial Hypertension (AHT), dyslipidemia, smoking). Therefore, it is not very logical to use a medication to achieve excellent glucose control while ignoring other cardiovascular risk factors. Even if no specific goals are met for any of them, addressing cardiovascular risk factors as a whole will undoubtedly be more advantageous to the diabetic patient. The therapeutic goals are detailed in The strongest indicator of diabetes control is glycosylated Haemoglobin (HbA1c), which tells you how well your blood sugar has been managed over the last two to three months and should stay below 7%.

Our confession is Carl Rogers' person-centered therapy. We think that everyone has the potential to grow and succeed, but they also require empathy and unwavering acceptance. It's crucial to establish a cosy environment where patients feel free to be open and honest and express their worries and uncertainties. The trans theoretical model from Prochaska and DiClemente (1992), which aids in understanding and supporting behavioral changes, is our other confession.

This idea holds that behavior changes occur throughout a number of stages, with typical modifications occurring at each one. The

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important tenet of this theory is that there are additional stages (pre-pragmatic, pragmatic, and preparatory) before the plainly visible stage of action, and if we can identify these stages, we may assist the patient in getting through them. We must acknowledge and explain to the patient that difficult times and relapses are inevitable consequences of progress, and that must develop coping mechanisms.

Hyperglycemic decompensation frequently happens in a known diabetic patient, or diabetes may even be diagnosed for the first time, as a result of the metabolic response to stress and the spike in counter-regulatory hormones (such

as cortisol, catecholamines) that takes place right after an AMI. Both people with diabetes and people without diabetes experience an increase in intrahospital mortality as a result of the stress-induced hyperglycemia that comes along with AMI. The therapeutic strategy should work toward glycemia readings between 100 and 150 mg/dL (5.8 to 8.3 mmol/L). Due to the significant cardiovascular risks in the interval right after an AMI, hypoglycemia must be avoided. In the time of elevated myocardial irritability that follows an infarction, the catecholamine discharges brought on by insulin-induced hypoglycemia have an arrhythmogenic potential that can be deadly.