Tamaulipas
Gobierno del Estado

Secretaría de Salud

UAT Universidad Autónoma de TAMAULIPAS

1er Congreso Internacional

"HACIA UN SISTEMA DE SALUD INTEGRAL Y HUMANISTA EN TAMAULIPAS"

DM2

Prevención, control y remisión con Medicina de Estilo de Vida

15 de Mayo del 2025

"La diabetes mellitus tipo 2 es un trastorno metabólico ***heterogéneo*** *con defectos multifactoriales, incluyendo* ***resistencia a la insulina****,* ***disfunción de las células beta pancreáticas*** *y producción hepática inapropiada de glucosa."*

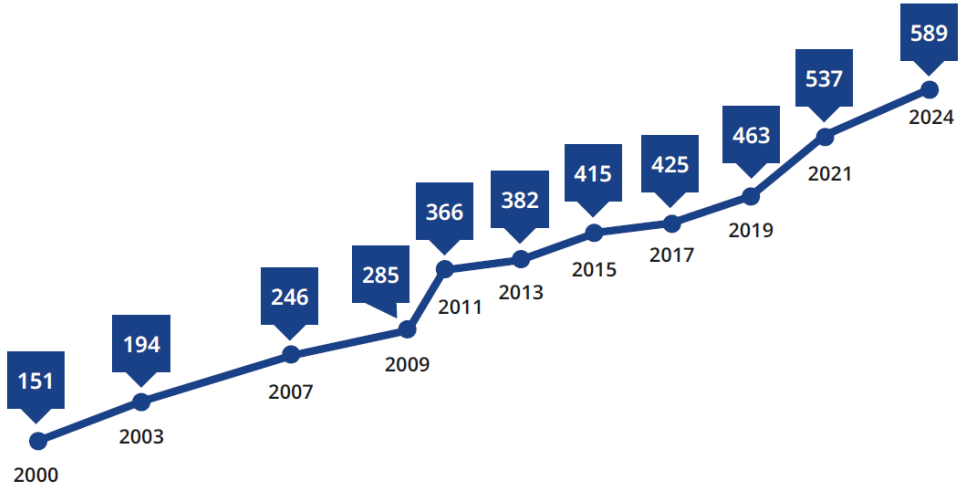
Garber, A. J., et al. (2023). *Consensus Statement by the American Association of Clinical Endocrinologists and American College of Endocrinology on the Comprehensive Type 2 Diabetes Management Algorithm*. Endocrine Practice, 29(2), 1-42.

AACE®
American Association of Clinical Endocrinology

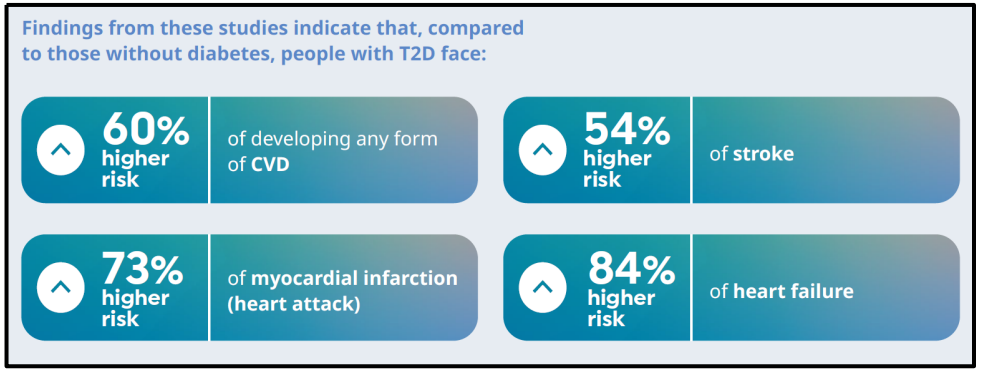
*"La diabetes tipo 2 surge de la interacción entre **predisposición genética** y **factores ambientales**, como la obesidad y el sedentarismo, que conducen a una combinación de **resistencia a la insulina y fallo de las células beta**."*

Davies, M. J., et al. (2023). Management of Hyperglycemia in Type 2 Diabetes, 2023. A Consensus Report by the EASD and ADA. Diabetologia, 66(1), 1-30.

EASD European Association for the Study of Diabetes



IDF Diabetes Atlas 11th Edition - 2025 | diabetesatlas.org



- ★ 56% mayor riesgo de demencia
- ★ 25 - 30% retinopatía diabética
- ★ 10% alto riesgo de pérdida de visión
- ★ Principal causa de ERC
- ★ Principal causa de amputaciones no traumáticas
- ★ 12% del gasto global en salud

¿PARA QUE TRATAMOS LA DIABETES?

Disminuir riesgo de complicaciones:

- Agudas
- Crónicas
  - Microvasculares
  - Macrovasculares

Articles

Intensive blood-glucose control with sulphonylureas or insulin compared with conventional treatment and risk of complications in patients with type 2 diabetes (UKPDS 33)

UK Prospective Diabetes Study (UKPDS) Group*

Interpretation Intensive blood-glucose control by either sulphonylureas or insulin substantially decreases the risk of microvascular complications, but not macrovascular disease, in patients with type 2 diabetes. None of the individual drugs had an adverse effect on cardiovascular outcomes. All intensive treatment increased the risk of

treatment: any diabetes-related endpoint (sudden death, death from hyperglycaemia or hypoglycaemia, fatal or non-fatal myocardial infarction, angina, heart failure, stroke, renal failure, amputation [of at least one digit], vitreous haemorrhage, retinopathy requiring photocoagulation, blindness in one eye, or cataract extraction); diabetes-related death (death from myocardial infarction, stroke, peripheral vascular disease, renal disease, hyperglycaemia or hypoglycaemia, and sudden death); all-cause mortality. Single clinical endpoints and surrogate subclinical endpoints were also assessed. All analyses were by intention to treat and frequency of hypoglycaemia was also analysed by actual therapy.

chlorpropamide (2·6 kg) or glibenclamide (1·7 kg).

Interpretation Intensive blood-glucose control by either sulphonylureas or insulin substantially decreases the risk of microvascular complications, but not macrovascular disease, in patients with type 2 diabetes. None of the individual drugs had an adverse effect on cardiovascular outcomes. All intensive treatment increased the risk of hypoglycaemia.

Lancet 1998; **352:** 837–53
See Commentary page xxx

Introduction

Started in 1977, the UK Prospective Diabetes Study

Complicaciones Vs HbA1c

Microvasculares:

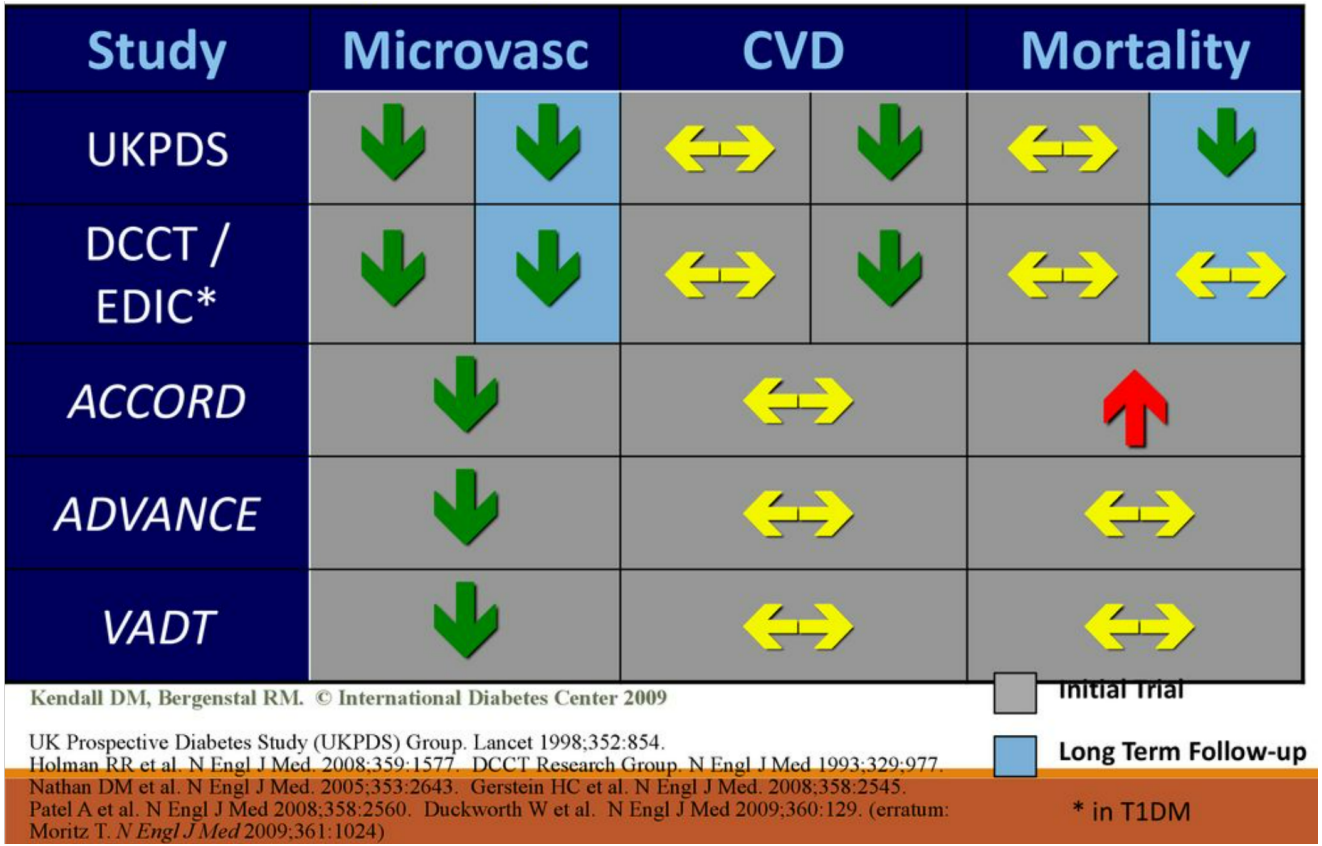
- Riesgo **X 10** con HbA1c de **5.5% a 9.5%**

Macrovasculares:

- Riesgo **X 2** con HbA1c de **5.5% a 9.5%**

UKPDS 33. Lancet 352:837– 853, 1998

Impacto del control glucémico intensivo



Kendall DM, Bergenstal RM. © International Diabetes Center 2009

UK Prospective Diabetes Study (UKPDS) Group. Lancet 1998;352:854.
Holman RR et al. N Engl J Med. 2008;359:1577. DCCT Research Group. N Engl J Med 1993;329:977.
Nathan DM et al. N Engl J Med. 2005;353:2643. Gerstein HC et al. N Engl J Med. 2008;358:2545.
Patel A et al. N Engl J Med 2008;358:2560. Duckworth W et al. N Engl J Med 2009;360:129. (erratum: Moritz T. *N Engl J Med* 2009;361:1024)

PREVENCIÓN

The New England
Journal of Medicine

VOLUME 346 FEBRUARY 7, 2002 NUMBER 6

REDUCTION IN THE INCIDENCE OF TYPE 2 DIABETES WITH LIFESTYLE INTERVENTION OR METFORMIN

DIABETES PREVENTION PROGRAM RESEARCH GROUP*

ABSTRACT

Background Type 2 diabetes affects approximately 8 percent of adults in the United States. Some risk factors — elevated plasma glucose concentrations in the fasting state and after an oral glucose load, overweight, and a sedentary lifestyle — are potentially reversible. We hypothesized that modifying these factors with a lifestyle-intervention program or the administration of metformin would prevent or delay the development of diabetes.

Methods We randomly assigned 3234 nondiabetic persons with elevated fasting and post-load plasma glucose concentrations to placebo, metformin (850 mg twice daily), or a lifestyle-modification program with the goals of at least a 7 percent weight loss and at least 150 minutes of physical activity per week. The mean age of the participants was 51 years, and the mean body-mass index (the weight in kilograms divided by the square of the height in meters) was 34.0; 68 percent were women, and 45 percent were members of minority groups.

TYPE 2 diabetes mellitus, formerly called non-insulin-dependent diabetes mellitus, is a serious, costly disease affecting approximately 8 percent of adults in the United States.[1] Treatment prevents some of its devastating complications[2,3] but does not usually restore normoglycemia or eliminate all the adverse consequences. The diagnosis is often delayed until complications are present.[4] Since current methods of treating diabetes remain inadequate, prevention is preferable. The hypothesis that type 2 diabetes is preventable[5,6] is supported by observational studies and two clinical trials of diet, exercise, or both in persons at high risk for the disease[7,8] but not by studies of drugs used to treat diabetes.[5]

The validity of generalizing the results of previous prevention studies is uncertain.[9] Interventions that work in some societies may not work in others, because social, economic, and cultural forces influence

Methods We randomly assigned 3234 nondiabetic persons with elevated fasting and post-load plasma glucose concentrations to placebo, metformin (850 mg twice daily), or a lifestyle-modification program with the goals of at least a 7 percent weight loss and at least 150 minutes of physical activity per week. The mean age of the participants was 51 years, and the mean body-mass index (the weight in kilograms divided by the square of the height in meters) was 34.0; 68 percent were women, and 45 percent were members of minority groups.

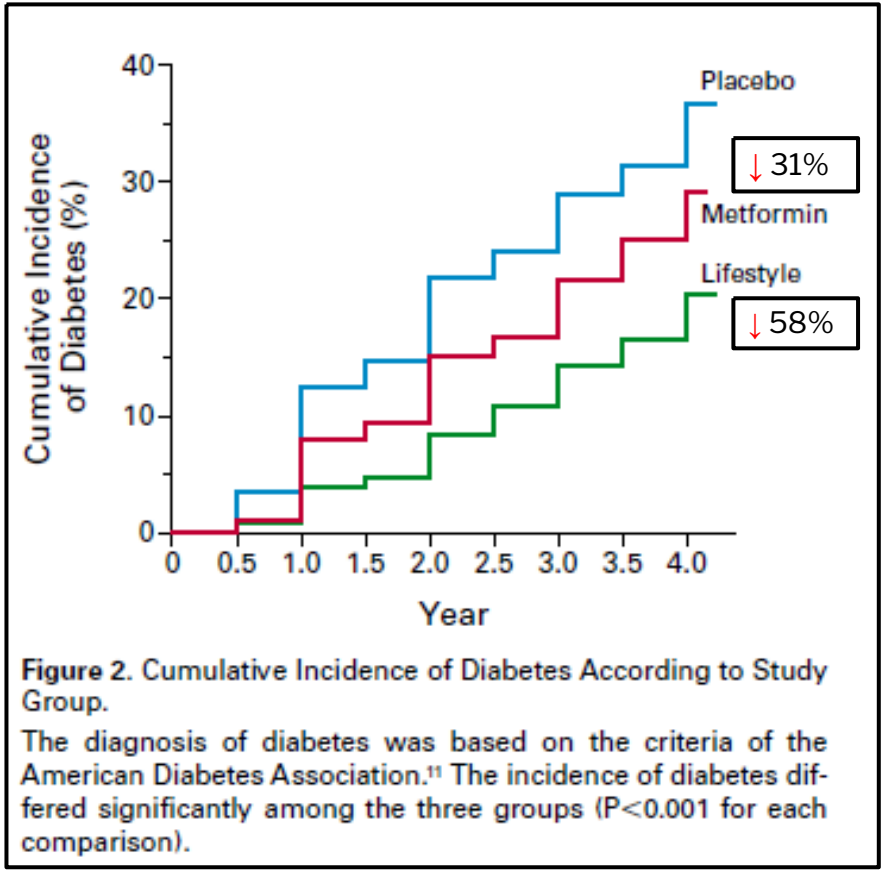


Figure 2. Cumulative Incidence of Diabetes According to Study Group.

The diagnosis of diabetes was based on the criteria of the American Diabetes Association.[11] The incidence of diabetes differed significantly among the three groups ($P<0.001$ for each comparison).

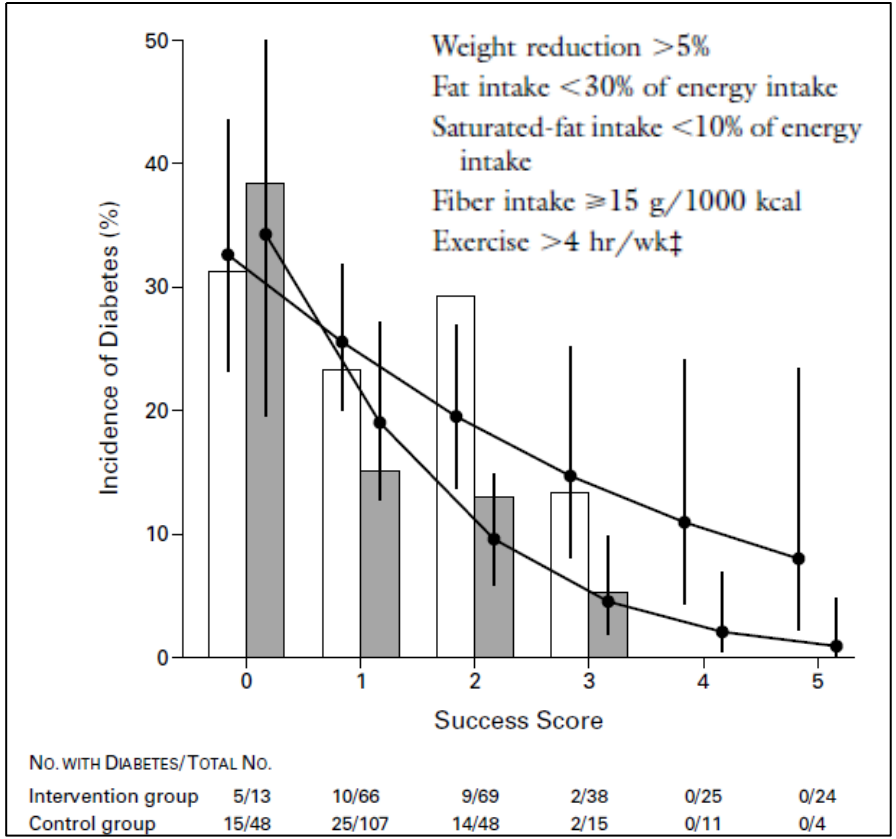
Conclusions Lifestyle changes and treatment with metformin both reduced the incidence of diabetes in persons at high risk. The lifestyle intervention was more effective than metformin. (N Engl J Med 2002; 346:393-403.)

The New England
Journal of Medicine

VOLUME 344 MAY 3, 2001 NUMBER 18

PREVENTION OF TYPE 2 DIABETES MELLITUS BY CHANGES IN LIFESTYLE AMONG SUBJECTS WITH IMPAIRED GLUCOSE TOLERANCE

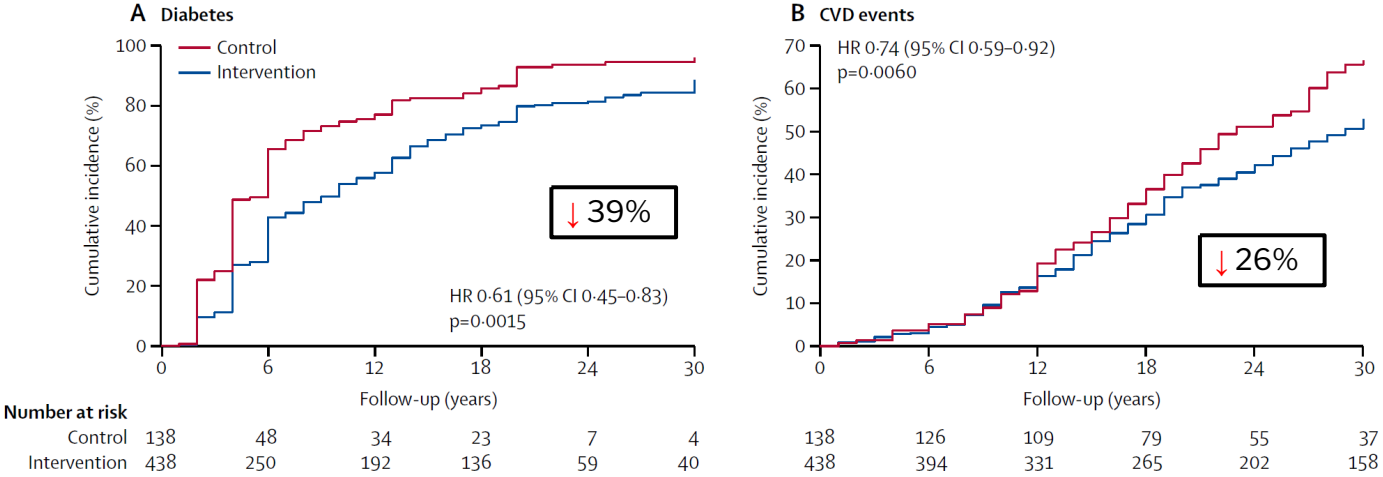
JAAKKO TUOMILEHTO, M.D., PH.D., JAANA LINDSTRÖM, M.S., JOHAN G. ERIKSSON, M.D., PH.D., TIMO T. VALLE, M.D., HELENA HÄMÄLÄINEN, M.D., PH.D., PIRJO ILANNE-PARIKKA, M.D., SIRKKA KEINÄNEN-KIUKAANNIEMI, M.D., PH.D., MAURI LAAKSO, M.D., ANNE LOUHERANTA, M.S., MERJA RASTAS, M.S., VIRPI SALMINEN, M.S., AND MATTI UUSITUPA, M.D., PH.D., FOR THE FINNISH DIABETES PREVENTION STUDY GROUP

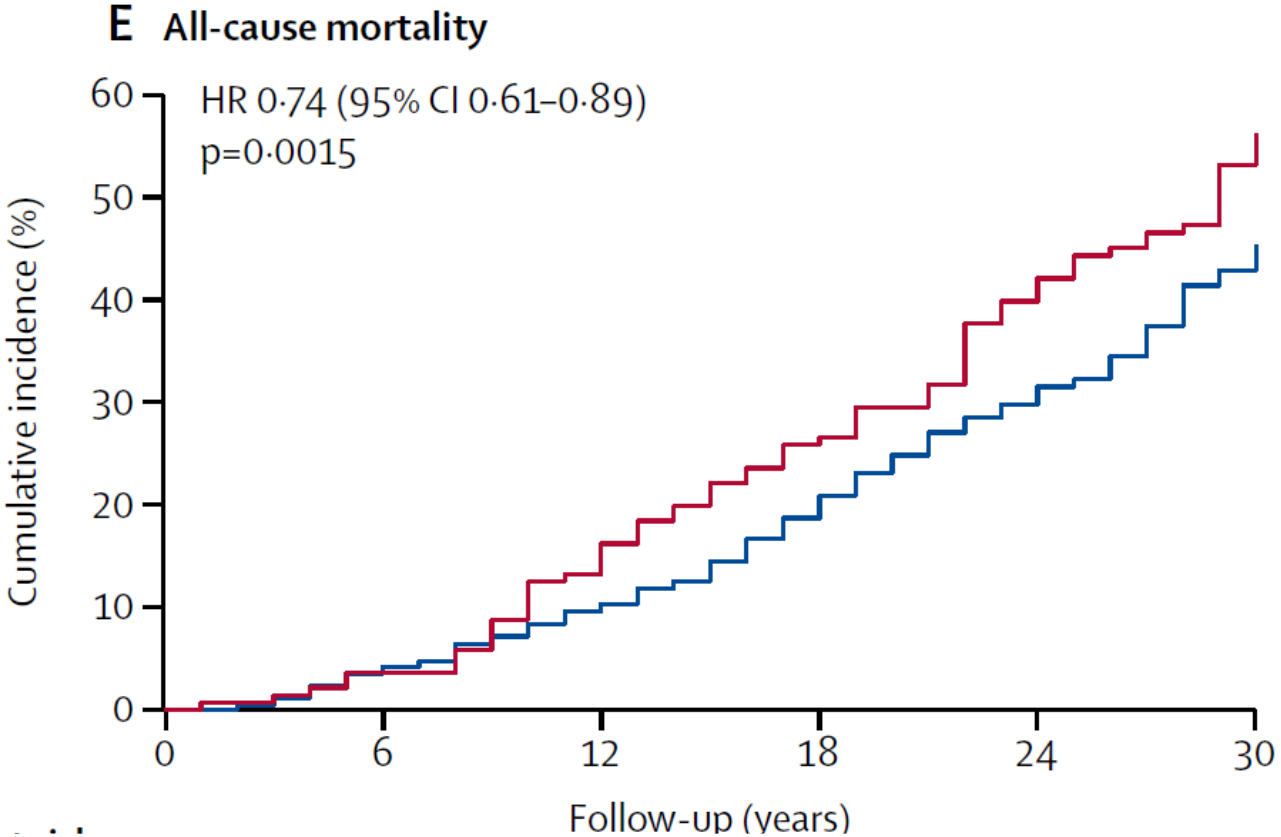


NO. WITH DIABETES/TOTAL NO.						
Intervention group	5/13	10/66	9/69	2/38	0/25	0/24
Control group	15/48	25/107	14/48	2/15	0/11	0/4

Morbidity and mortality after lifestyle intervention for people with impaired glucose tolerance: 30-year results of the Da Qing Diabetes Prevention Outcome Study

Qiuhong Gong, Ping Zhang*, Jinping Wang, Jixiang Ma, Yali An, Yanyan Chen, Bo Zhang, Xinxing Feng, Hui Li, Xiaoping Chen, Yiling J Cheng, Edward W Gregg, Yinghua Hu, Peter H Bennett†, Guangwei Li†, for the Da Qing Diabetes Prevention Study Group‡*





↓ 26%

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 JULY 20, 2006 VOL. 355 NO. 3

TCF7L2 Polymorphisms and Progression to Diabetes in the Diabetes Prevention Program

Jose C. Florez, M.D., Ph.D., Kathleen A. Jablonski, Ph.D., Nick Bayley, B.A., Toni I. Pollin, Ph.D., Paul I.W. de Bakker, Ph.D., Alan R. Shuldiner, M.D., William C. Knowler, M.D., Dr.P.H., David M. Nathan, M.D., and David Altshuler, M.D., Ph.D., for the Diabetes Prevention Program Research Group

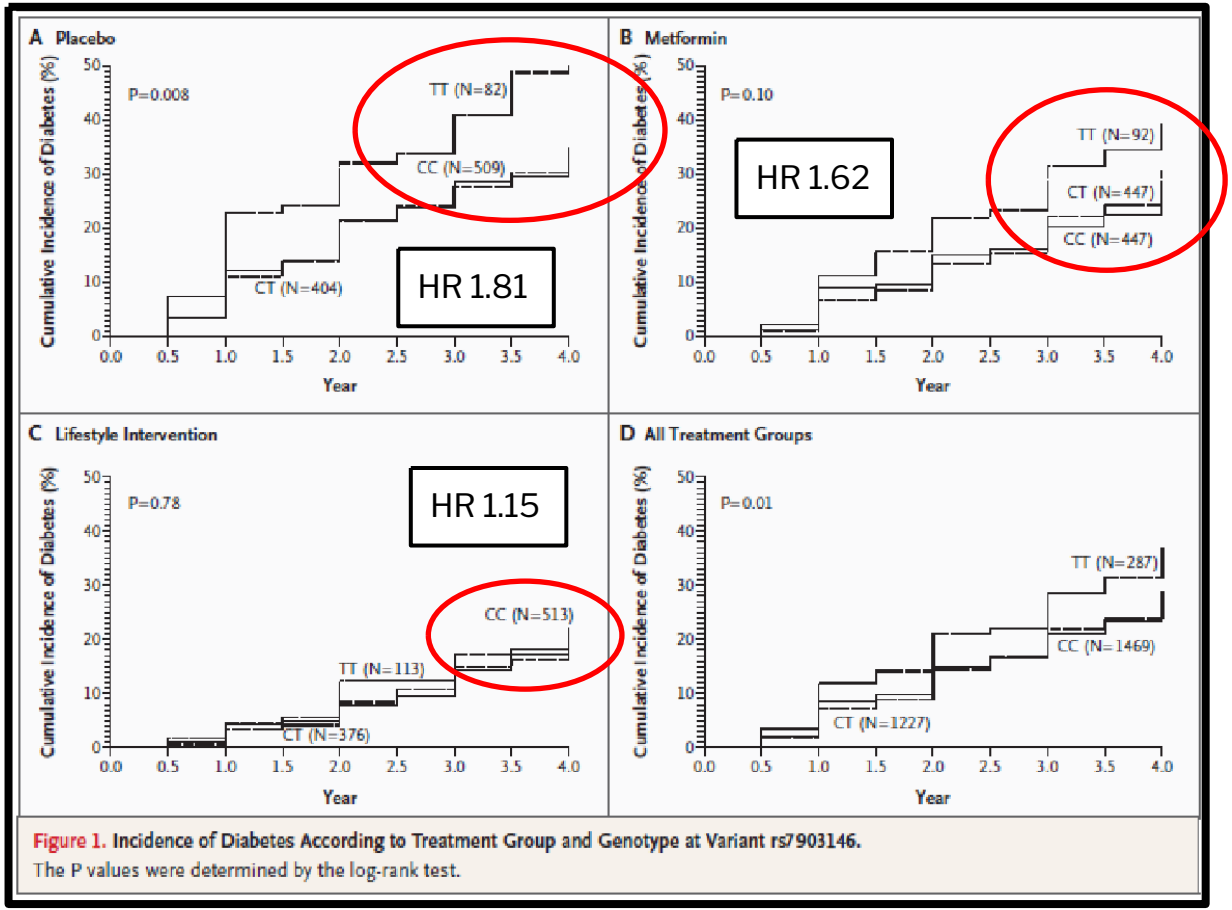
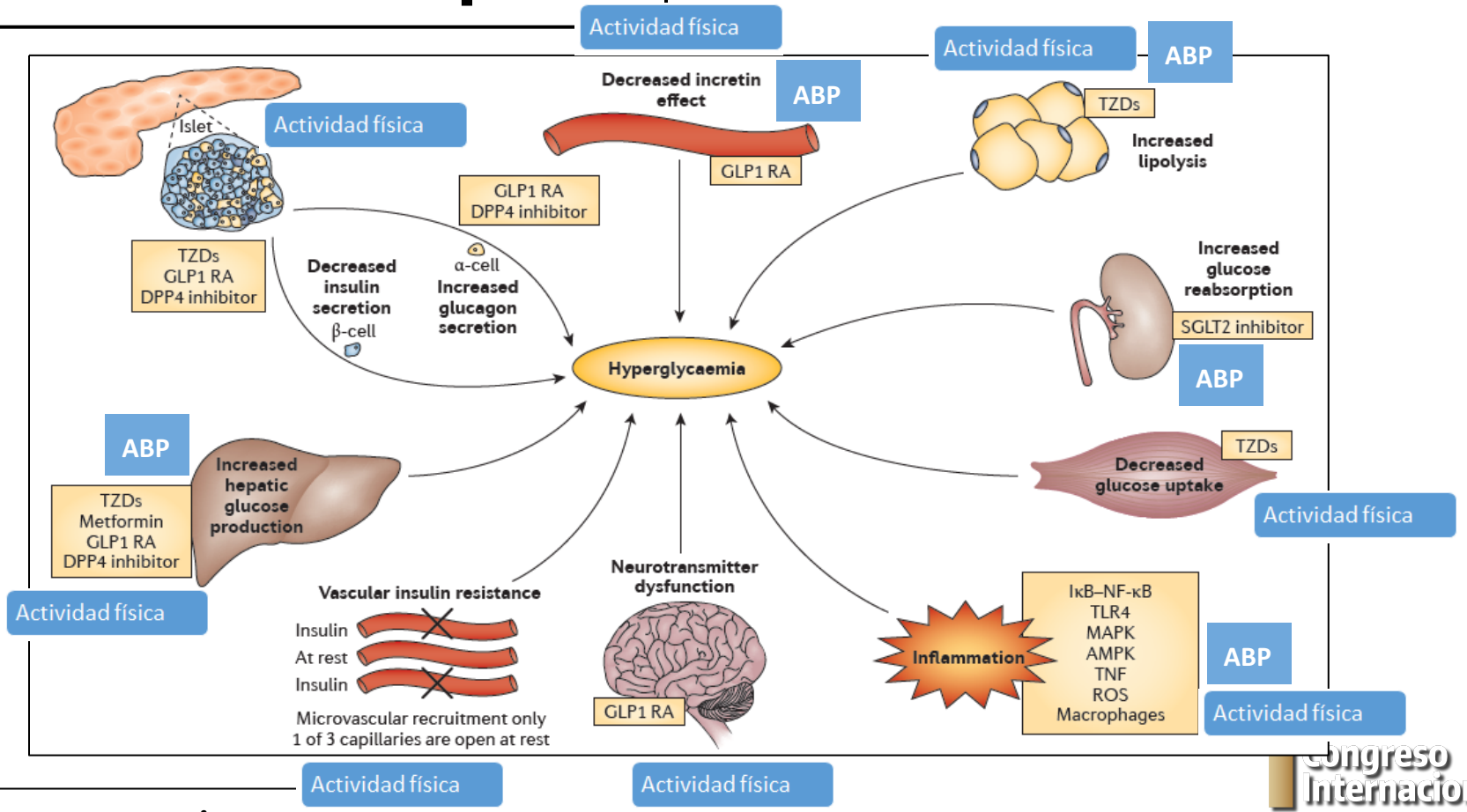


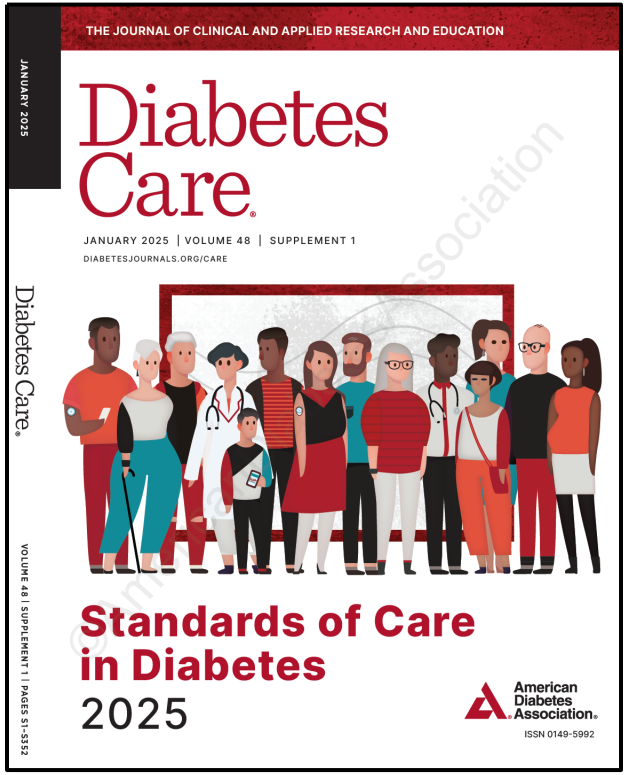
Figure 1. Incidence of Diabetes According to Treatment Group and Genotype at Variant rs7903146.
The P values were determined by the log-rank test.

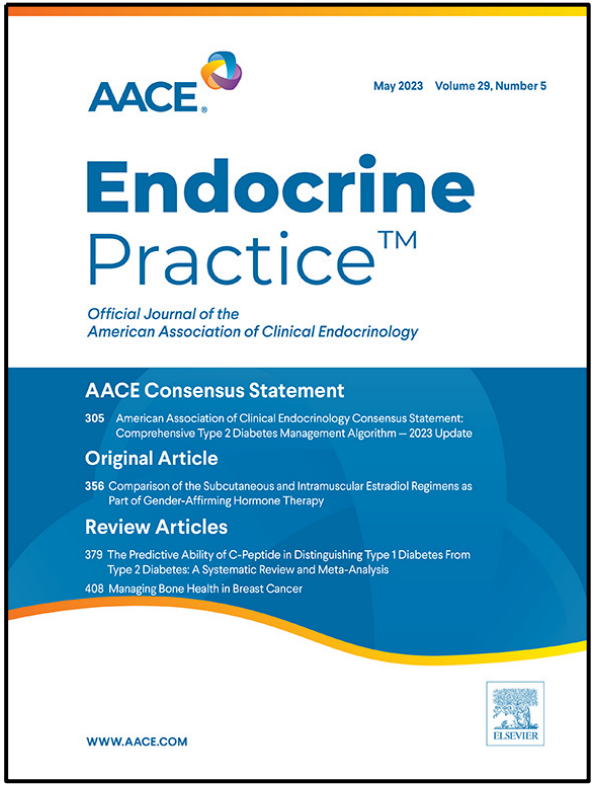
TRATAMIENTO

Decadent Decoplet

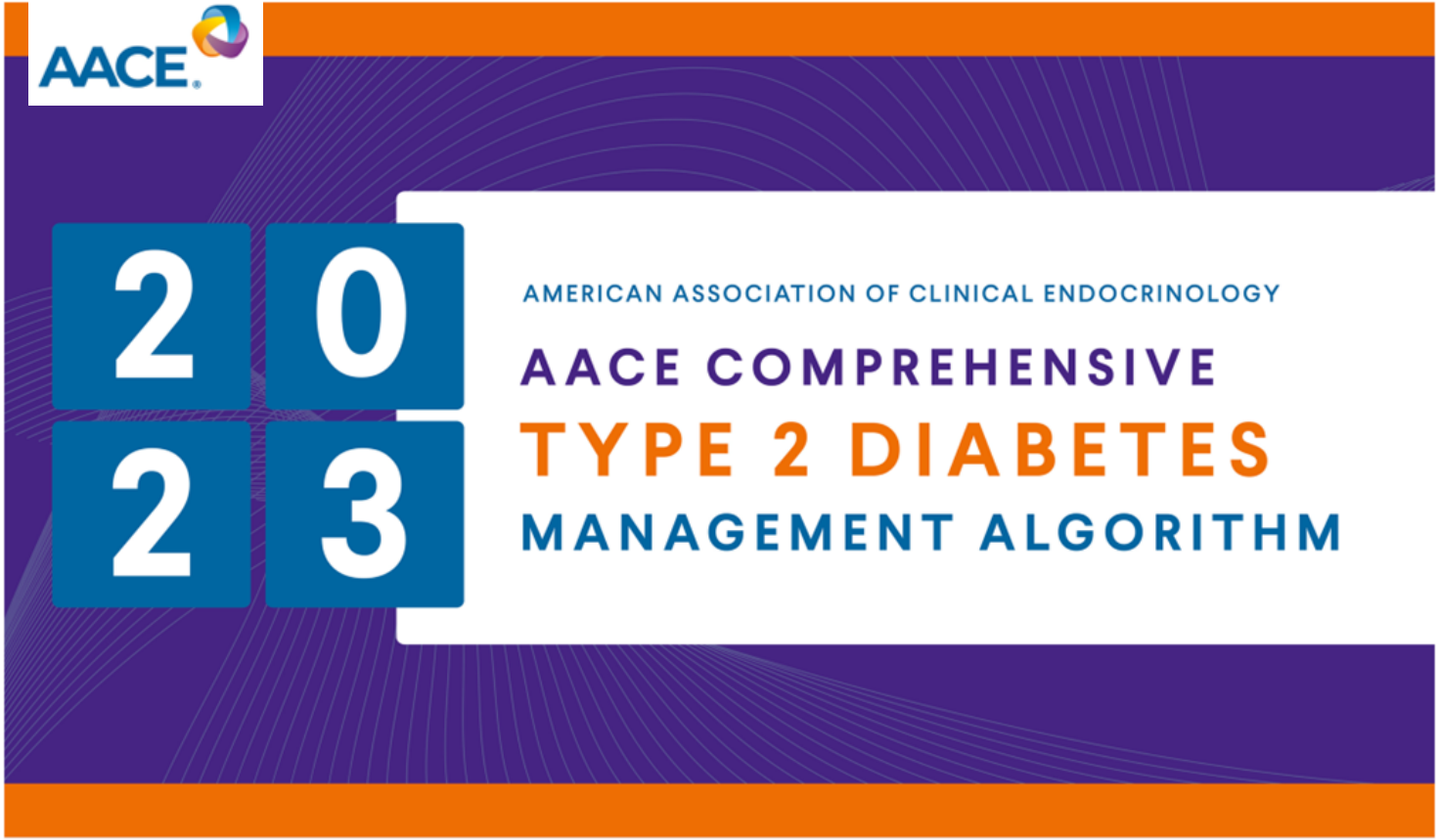


DeFronzo. Nature Reviews 2016





The cornerstone of type 2 diabetes management is promoting a lifestyle that includes a healthy diet, regular physical activity, smoking cessation and maintenance of healthy body weight. If changes to lifestyle are not sufficient to control blood glucose levels, oral medication is usually initiated, with metformin as the first-line medication.



ENDOCRINE PRACTICE Vol 29 (2023) 305e340

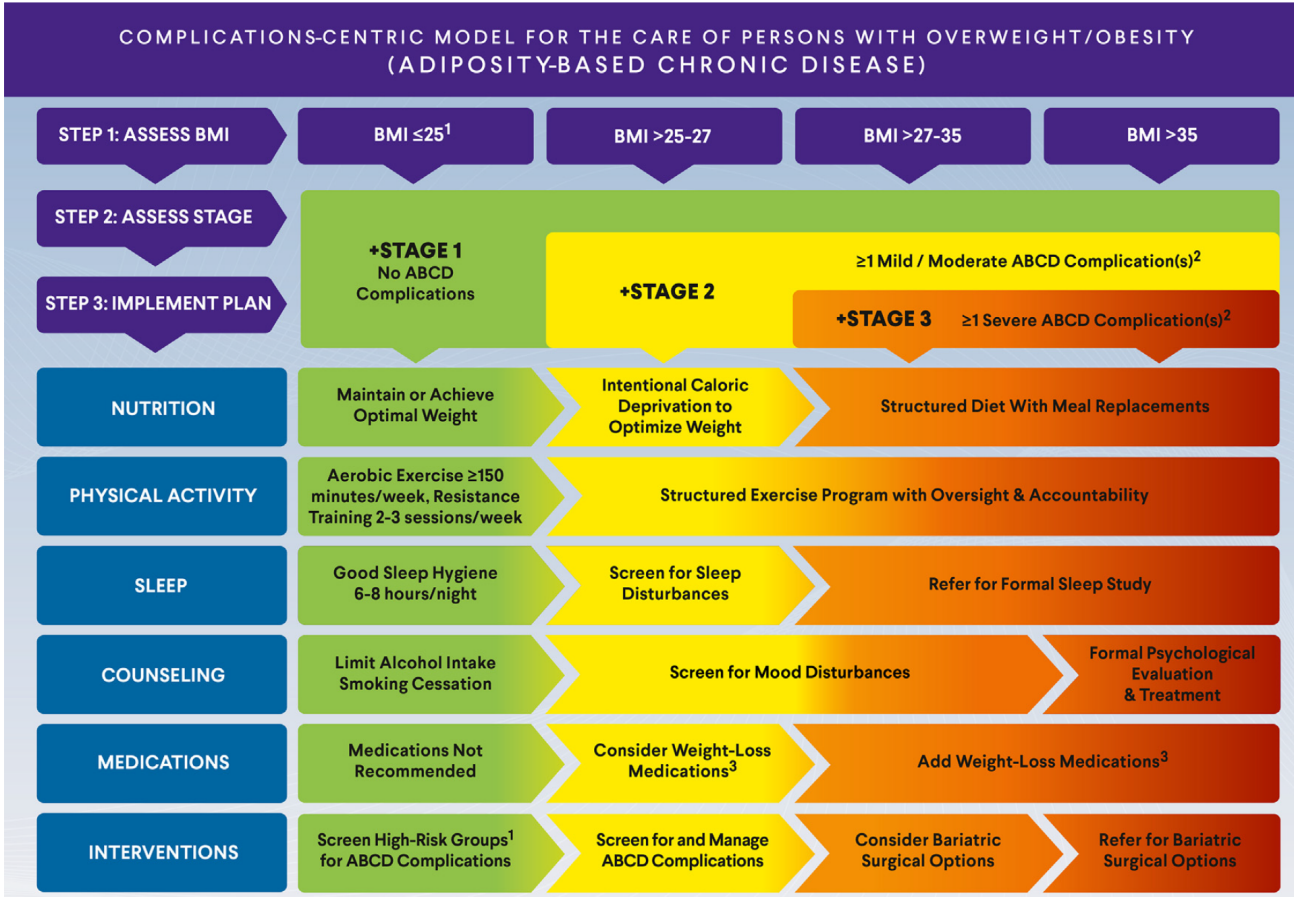
PRINCIPLES OF THE AACE COMPREHENSIVE TYPE 2 DIABETES MANAGEMENT ALGORITHM

1.	Lifestyle modification underlies all therapy.
2.	Maintain or achieve optimal weight.
3.	Choice of antihyperglycemic therapy reflects glycemic targets, ASCVD, CHF, CKD, overweight/obesity, and NAFLD.
4.	Choice of therapy includes ease of use and access.

AACE

Lifestyle modification underlies all therapy. Lifestyle modification includes exercise, healthy dietary changes, smoking cessation, and reduced alcohol intake. Additional aspects of lifestyle modification include assessment and management of sleep disorders and depression. The Complications-Centric Model for the Care of Persons with Overweight/Obesity (Algorithm Fig. 2) emphasizes the

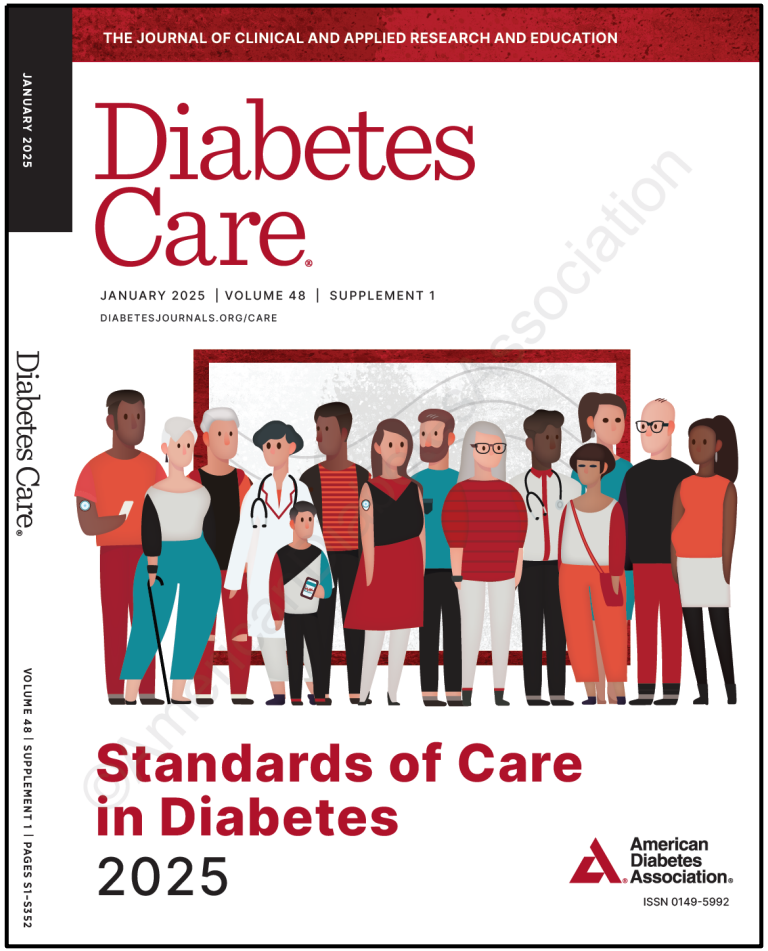
ENDOCRINE PRACTICE Vol 29 (2023) 305e340



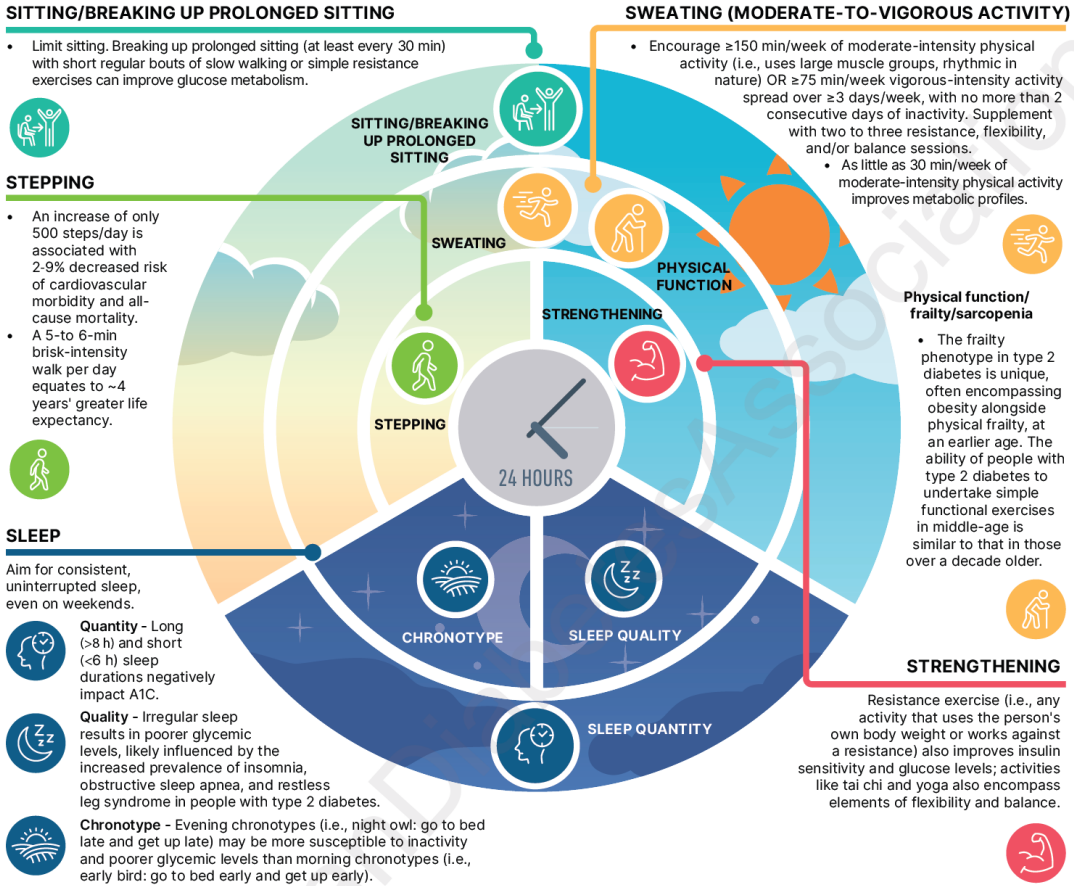
AACE

1er Congreso Internacional

"HACIA UN SISTEMA DE SALUD INTEGRAL Y HUMANISTA EN TAMAULIPAS"



Importance of 24-Hour Physical Behaviors for Type 2 Diabetes



SUEÑO

Sleep Characteristics Associated With Increased Risk of Type 2 Diabetes

Sleep occupies approximately one-third of the day for most people and modulates a variety of metabolic, endocrine, and cardiovascular processes (32). The latest ADA-EASD consensus report on management of hyperglycemia highlights sleep as a central component in the management of prediabetes and type 2 diabetes, placing it, for the first time, on the same level as other lifestyle behaviors (e.g., physical activity and nutrition)

⇧50% riesgo de DM2 con ***duración*** menor a 6 ó mayor a 9 h

⇧40 - 84% riesgo de DM2 con pobre ***calidad*** del sueño

⇧150% en personas con ***cronotipo*** vespertino (búhos)

Diabetes Care Volume 48, Supplement 1, January 2025

	Glucose/ insulin	Blood pressure	A1C	Lipids	Physical function	Depression	Quality of life
SITTING/BREAKING UP PROLONGED SITTING	↓	↓	↓	↓	↑	↓	↑
STEPPING	↓	↓	↓	↓	↑	↓	↑
SWEATING (MODERATE-TO-VIGOROUS ACTIVITY)	↓	↓	↓	↓	↑	↓	↑
STRENGTHENING	↓	↓	↓	↓	↑	↓	↑
ADEQUATE SLEEP DURATION	↓	↓	↓	↓	?	↓	↑
GOOD SLEEP QUALITY	↓	↓	↓	↓	?	↓	↑
CHRONOTYPE/CONSISTENT TIMING	↓	?	↓	?	?	↓	?

IMPACT OF PHYSICAL BEHAVIORS ON CARDIOMETABOLIC HEALTH IN PEOPLE WITH TYPE 2 DIABETES

↑ **Higher levels of improvement** (physical function, quality of life) ↓ **Lower levels of improvement** (glucose/insulin, blood pressure, A1C, lipids, depression)
? No data available
↑ Green arrows = strong evidence ↑ Yellow arrows = medium-strength evidence ↑ Red arrows = limited evidence

Figure 5.2—Importance of 24-h physical behaviors for type 2 diabetes. Adapted from Davies et al. (75).

Nutrition Therapy for Adults With Diabetes or Prediabetes: A Consensus Report

Alison B. Evert,[1] Michelle Dennison,[2] Christopher D. Gardner,[3] W. Timothy Garvey,[4,5] Ka Hei Karen Lau,[6] Janice MacLeod,[7] Joanna Mitri,[8] Raquel F. Pereira,[9] Kelly Rawlings,[10] Shamera Robinson,[11] Laura Saslow,[12] Sacha Uelmen,[11] Patricia B. Urbanski,[13] and William S. Yancy Jr.[14,15]

Diabetes Care 2019;42:731–754 | https://doi.org/10.2337/dci19-0014

This Consensus Report is intended to provide clinical professionals with evidence-based guidance about individualizing nutrition therapy for adults with diabetes or prediabetes. Strong evidence supports the efficacy and cost-effectiveness of nutrition therapy as a component of quality diabetes care, including its integration into the medical management of diabetes; therefore, it is important that all members of the health care team know and champion the benefits of nutrition therapy and key nutrition messages. Nutrition counseling that works toward improving or maintaining glycemic targets, achieving weight management goals, and improving cardiovascular risk factors (e.g., blood pressure, lipids, etc.) within individualized treatment goals is recommended for all adults with diabetes and prediabetes.

Though it might simplify messaging, a "one-size-fits-all" eating plan is not evident for the prevention or management of diabetes, and it is an unrealistic expectation given the broad spectrum of people affected by diabetes and prediabetes, their cultural backgrounds, personal preferences, co-occurring conditions (often referred to as comorbidities), and socioeconomic settings in which they live. Research provides clarity on many food choices and eating patterns that can help people achieve health goals and quality of life. The American Diabetes Association (ADA) emphasizes that medical nutrition therapy (MNT) is fundamental in the overall diabetes management plan, and the need for MNT should be reassessed frequently by health care providers in collaboration with people with diabetes across the life span, with special attention during times of changing health status and life stages (1–3).

This Consensus Report now includes information on prediabetes, and previous ADA nutrition position statements, the last of which was published in 2014 (4), did not. Unless otherwise noted, the research reviewed was limited to those studies conducted in adults diagnosed with prediabetes, type 1 diabetes, and/or type 2 diabetes. Nutrition therapy for children with diabetes or women with gestational diabetes mellitus is not addressed in this review but is covered in other ADA publications, specifically *Standards of Medical Care in Diabetes* (5,6).

[1]*UW Neighborhood Clinics, UW Medicine, University of Washington, Seattle, WA*
[2]*Oklahoma City Indian Clinic, Oklahoma City, OK*
[3]*Stanford Diabetes Research Center and Stanford Prevention Research Center, Department of Medicine, Stanford University, Stanford, CA*
[4]*Diabetes Research Center, Department of Nutrition Sciences, University of Alabama at Birmingham, Birmingham, AL*
[5]*Birmingham Veterans Affairs Medical Center, Birmingham, AL*
[6]*Joslin Diabetes Center, Boston, MA*
[7]*Companion Medical, Inc., Columbia, MD*
[8]*Section on Clinical, Behavioral and Outcomes Research Lipid Clinic, Adult Diabetes Section, Joslin Diabetes Center, Harvard Medical School, Boston, MA*
[9]*Simple Concepts Consulting, Bellevue, WA*
[10]*Vida Health, San Francisco, CA*
[11]*American Diabetes Association, Arlington, VA*
[12]*Department of Health Behavior and Biological Sciences, University of Michigan School of Nursing, Ann Arbor, MI*
[13]*St. Luke's Health Care System, Duluth, MN*
[14]*Duke Diet and Fitness Center, Department of*

Is MNT effective in improving outcomes?

Reported hemoglobin A_{1c} (A1C) reductions from MNT can be similar to or greater than what would be expected with treatment using currently available medication for type 2 diabetes (9). Strong evidence supports the effectiveness of MNT interventions provided by RDNs for improving A1C, with absolute decreases up to 2.0% (in type 2 diabetes) and up to 1.9% (in type 1 diabetes) at 3–6 months. Ongoing MNT support is helpful in maintaining glycemic improvements (9).

Nutrition Therapy for Adults With Diabetes or Prediabetes: A Consensus Report

Diabetes Care 2019;42:731–754 | https://doi.org/10.2337/dci19-0014

Alison B. Evert,[1] Michelle Dennison,[2] Christopher D. Gardner,[3] W. Timothy Garvey,[4,5] Ka Hei Karen Lau,[6] Janice MacLeod,[7] Joanna Mitri,[8] Raquel F. Pereira,[9] Kelly Rawlings,[10] Shamera Robinson,[11] Laura Saslow,[12] Sacha Uelmen,[11] Patricia B. Urbanski,[13] and William S. Yancy Jr.[14,15]

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[12]Department of Health Behavior and Biological Sciences, University of Michigan School of Nursing, Ann Arbor, MI
[13]St. Luke's Health Care System, Duluth, MN
[14]Duke Diet and Fitness Center, Department of

People with diabetes and those at risk for diabetes are encouraged to consume at least the amount of dietary fiber recommended for the general public; increasing fiber intake, preferably through food (vegetables, pulses [beans, peas, and lentils], fruits, and whole intact grains)

REMISIÓN

Hombre de 43 años.

DM2 Dx reciente.

HbA1c = 12.3%

Glucemia en ayunas 322 mg%.

Sin criterios de crisis hiperglucémica

PÁGINA: 4 / 8
GENERADO: 06/01/2021

Vida Sana: Clínica del Estilo de Vida
TELÉFONO: +52 8262137251

MRN:
FUENTES: FreeStyle Libre

Registro diario

4 octubre 2020 - 31 octubre 2020 (28 Días)

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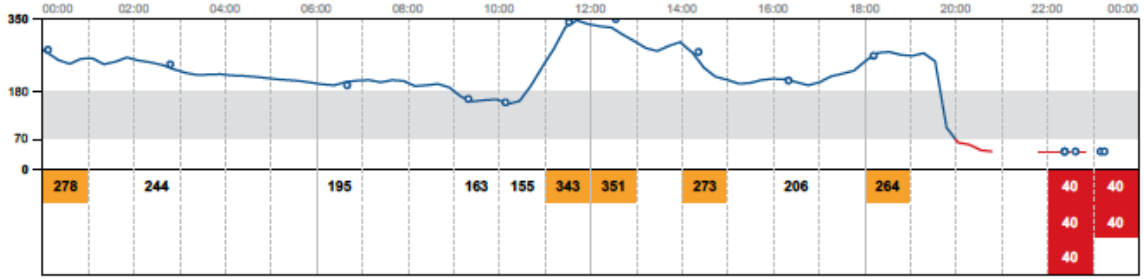
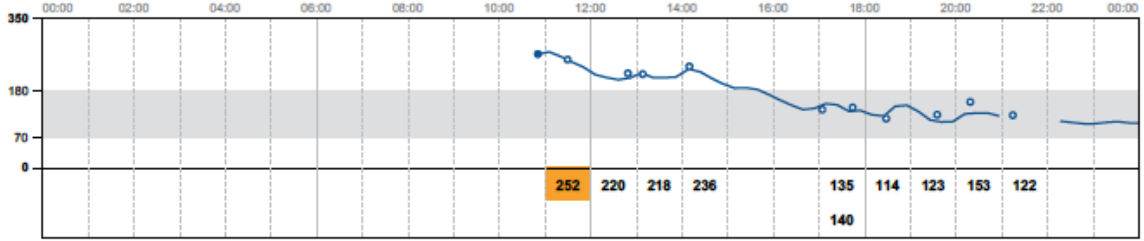
DOM. 18 oct.

Glucosa mg/dL



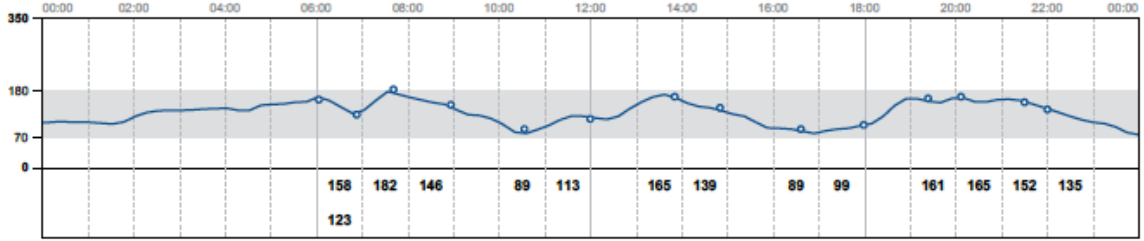
LUN. 19 oct.

Glucosa mg/dL



MAR. 20 oct.

Glucosa mg/dL



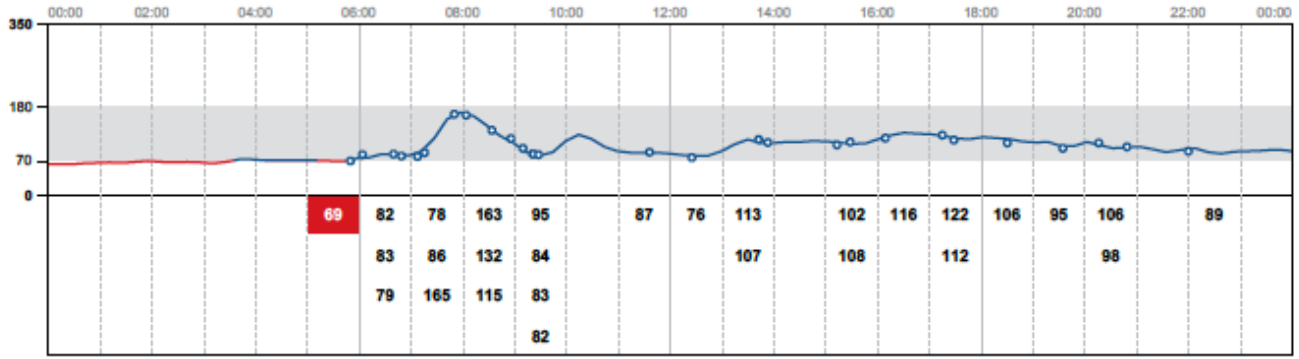
Registro diario

4 octubre 2020 - 31 octubre 2020 (28 Días)

LibreView

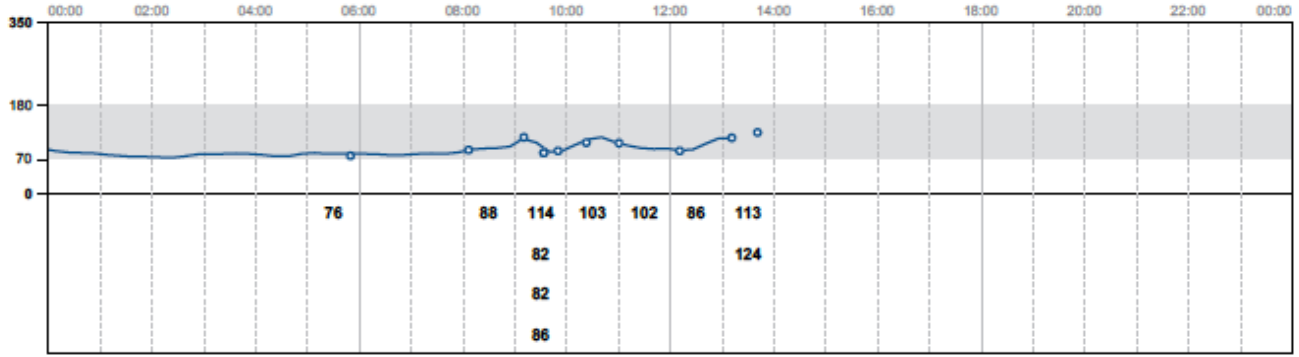
VIE. 30 oct.

Glucosa mg/dL



SÁB. 31 oct.

Glucosa mg/dL



1er Congreso Internacional

"HACIA UN SISTEMA DE SALUD INTEGRAL Y HUMANISTA EN TAMAULIPAS"

	Admission	Day 12 (Discharge)	Difference
Weight	105 kg	100.3 kg	- 4.7 kg
Fat Mass	27.2 kg	25.6 kg	-1.6 kg
Muscular Mass	44.2 kg	42.5 kg	-1.7 kg
BP	144/81 mmHg	130/79 mmhg	-14 / -2 mmhg
HR	71 lpm	64 lpm	-7 bpm
Total Cholesterol	322 mg/dl	160 mg/dl	-162 mg/dl
LDL	109 mg/dl	107 mg/dl	-2 mg/dl
HDL	31 mg/dl	35 mg/dl	+4 mg/dl
Triglycerides	494 mg/dl	96 mg/dl	**-398 mg/dl**
TG/HDL	15.93	2.74	-13.26
FBG	322 mg/dl	93 mg/dl	**-229 mg/dl**
C Peptide Post OGTT	2.4	3.55	**+ 47.9 %**
HOMA IR	3.82	1.26	**- 32.9 %**
HOMA2B	17.4%	46.7%	**+ 29.3%**
Visceral Fat	10	9.2	**-0.8**

Informe del AGP

25 octubre 2020 - 31 octubre 2020 (7 Días)

LibreView

ESTADÍSTICAS Y OBJETIVOS DE GLUCOSA

25 octubre 2020 - 31 octubre 2020	**7 Días**
El % que el sensor de tiempo está Activo	**96%**

Rangos y objetivos para	Diabetes tipo 1 o tipo 2
Rangos de glucosa	**Objetivos % de lecturas (hora/día)**
Rango deseado 70-180 mg/dL	Más de 70% (16h 48min)
Por debajo de 70 mg/dL	Menos de 4% (58min)
Por debajo de 54 mg/dL	Menos de 1% (14min)
Por encima de 180 mg/dL	Menos de 25% (6h)
Por encima de 250 mg/dL	Menos de 5% (1h 12min)

Cada aumento de tiempo del 5 % en el rango (70-180 mg/dL) tiene beneficios clínicos.

Glucosa promedio	**92** mg/dL
Indicador de control de glucosa (GMI)	**5.5% o 37 mmol/mol**
Variabilidad de glucosa	**18.0%**

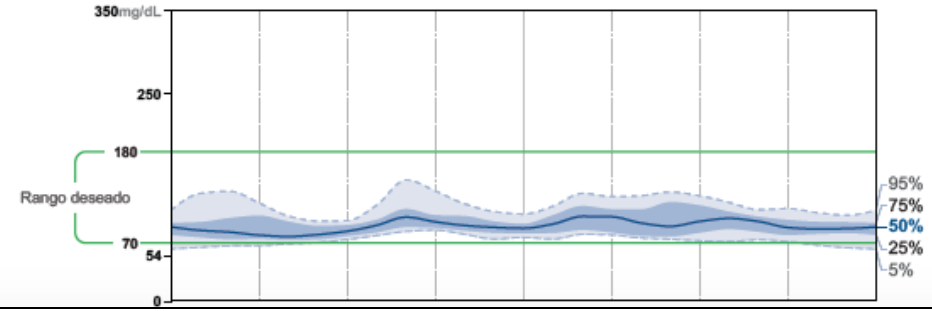
Se define como el porcentaje del coeficiente de variación (%CV); objetivo ≤36%

TIEMPO EN LOS RANGOS

Muy elevado	>250 mg/dL	**0%** (0min)
Alto	181 - 250 mg/dL	**0%** (0min)
Rango deseado	70 - 180 mg/dL	**95%** (22h 48min)
Bajo	54 - 69 mg/dL	**5%** (1h 12min)
Muy bajo	<54 mg/dL	**0%** (0min)

PERFIL AMBULATORIO DE GLUCOSA (AGP)

El AGP es un resumen de los valores de glucosa del período de informe, en el que la mediana (50 %) y otros percentiles se muestran como si hubieran sucedido en un único día.



1er Congreso Internacional

"HACIA UN SISTEMA DE SALUD INTEGRAL Y HUMANISTA EN TAMAULIPAS"

Hombre de 56 años. Albañil. Casado, vive con esposa y dos hijas.

Derivado por Urología por DM2 no controlada. Balanopostitis a repetición.
Además cansancio, pérdida involuntaria de peso y síntomas de hiperglucemia.

DM2 Dx en 4/2020.

Signos Vitales de Estilo de Vida:
* Ex TBQ: suspendió hace 8 años.
* Sueño: 22:00 - 07:00. Reparador
* Movimiento: sedentario
* Estrés: No considera que sea un problema, se siente tranquilo. 3/10.
* Alimentación:
  - Desayuno: 5 tamales + café + 30 nueces aprox
  - Comida: Pollo en salsa + 7 tortillas de maíz + 4 mandarinas + agua
  - Cena: papas con huevo + 5 tortillas

DATO	28 Marzo 2022	08 Junio 2022
HbA1c	10.8% (promedio 262 mg/dl)	5.9% (promedio 121 mg/dl)
Glucemia basal	228 mg	80 mg/dl
Insulina basal	14.8 uUI/mL	9.82 uUl/mL
Péptido C basal	3.44 mg/dl	3.33 ng/mL
HOMA IR	8.3	1.9
HOMA 2	B: 37.6%	B: 221%
Peso	86.6 kg	79.6 kg
IMC	29.27	27.54

1er Congreso Internacional

"HACIA UN SISTEMA DE SALUD INTEGRAL Y HUMANISTA EN TAMAULIPAS"

Diabetologia (2011) 54:2506–2514
DOI 10.1007/s00125-011-2204-7

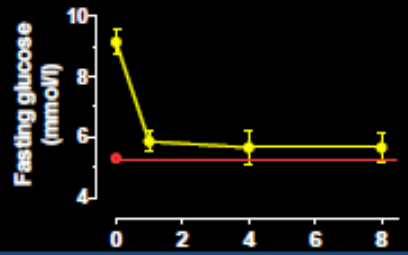
ARTICLE

Reversal of type 2 diabetes: normalisation of beta cell function in association with decreased pancreas and liver triacylglycerol

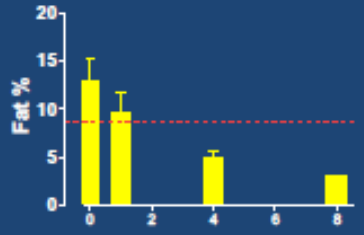
E. L. Lim · K. G. Hollingsworth · B. S. Aribisala · M. J. Chen · J. C. Mathers · R. Taylor

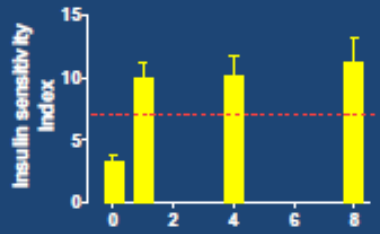
- 11 pacientes en grupo de intervención / 8 pacientes en grupo control
- 50 años en promedio
- <4 años de duración
- IMC 33 Kg/m2
- Hipocalórica severa
- 1, 4 y 8 semanas

The Counterpoint study – Type 2 diabetes, 800kcal diet

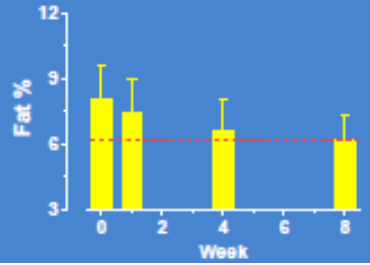


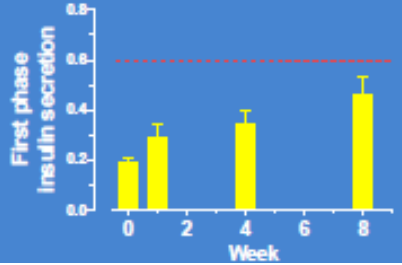
Liver

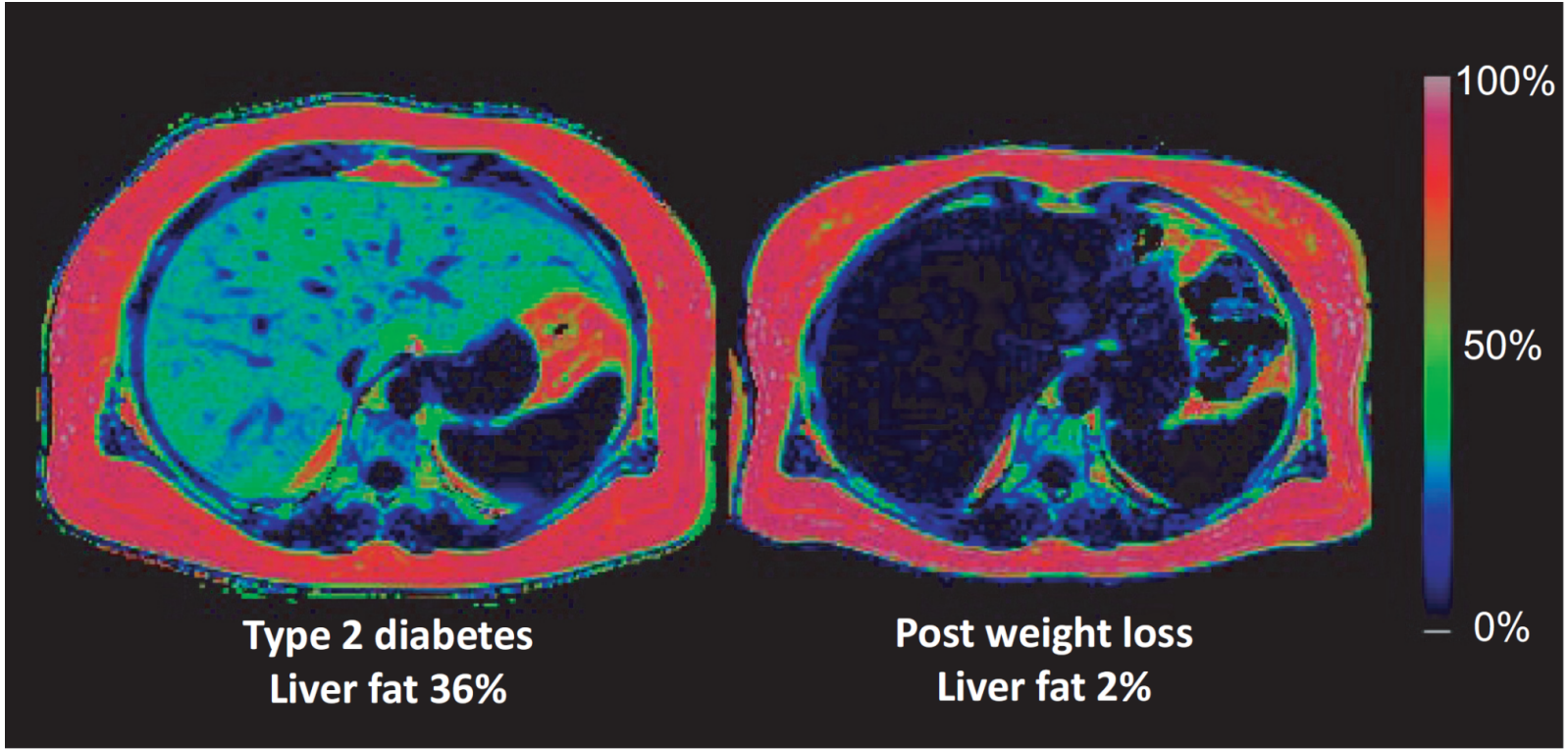




Pancreas

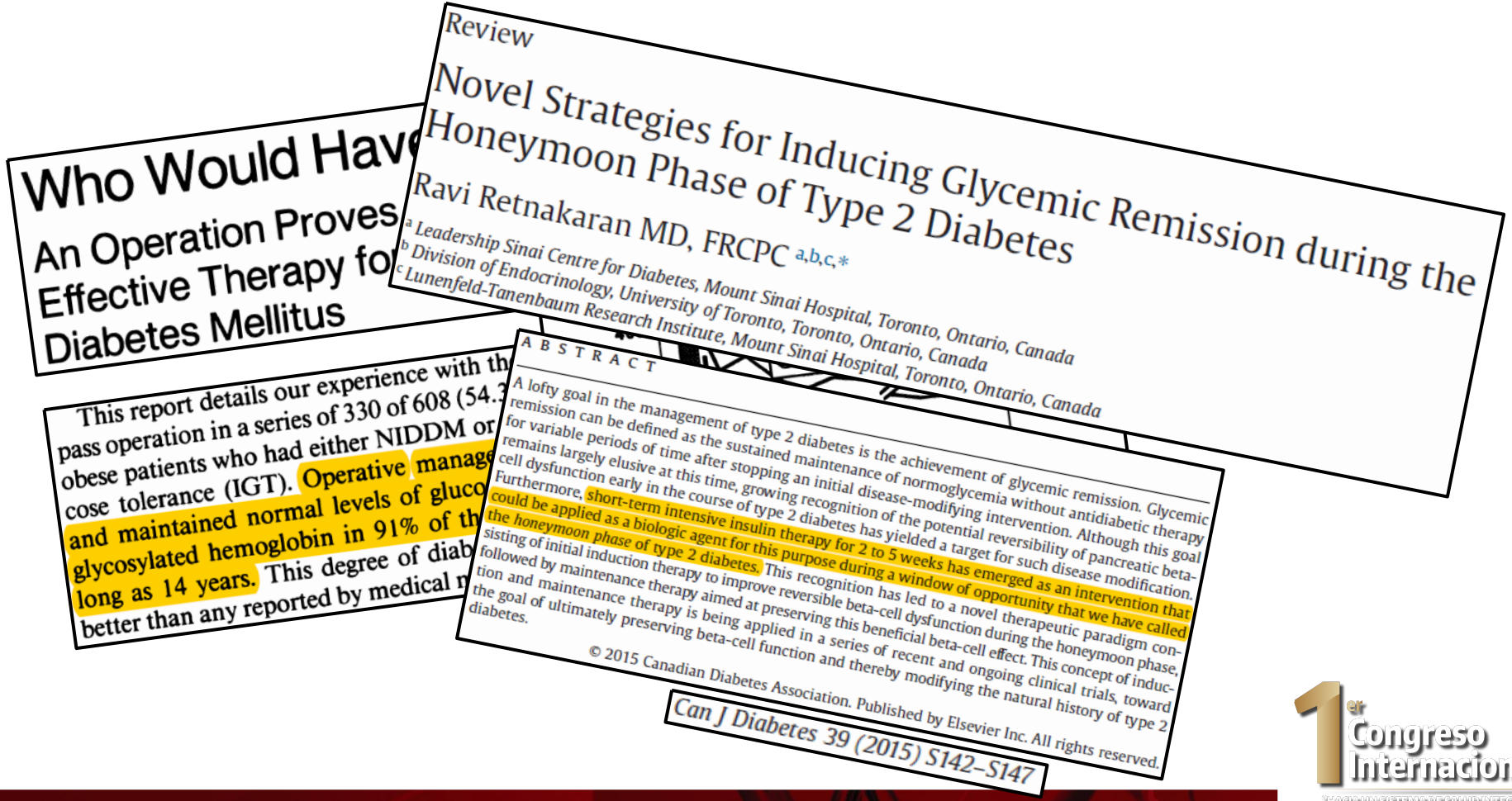






Journal of Internal Medicine, 2021, 289; 754–770


OPTIFAST



Who Would Have
An Operation Proves
Effective Therapy fo
Diabetes Mellitus

This report details our experience with th
pass operation in a series of 330 of 608 (54.
obese patients who had either NIDDM or
cose tolerance (IGT). Operative manage
and maintained normal levels of gluco
glycosylated hemoglobin in 91% of th
long as 14 years. This degree of diab
better than any reported by medical

Review

Novel Strategies for Inducing Glycemic Remission during the Honeymoon Phase of Type 2 Diabetes

Ravi Retnakaran MD, FRCPC [a,b,c,*]

[a] Leadership Sinai Centre for Diabetes, Mount Sinai Hospital, Toronto, Ontario, Canada
[b] Division of Endocrinology, University of Toronto, Toronto, Ontario, Canada
[c] Lunenfeld-Tanenbaum Research Institute, Mount Sinai Hospital, Toronto, Ontario, Canada

ABSTRACT

A lofty goal in the management of type 2 diabetes is the achievement of glycemic remission. Glycemic remission can be defined as the sustained maintenance of normoglycemia without antidiabetic therapy for variable periods of time after stopping an initial disease-modifying intervention. Although this goal remains largely elusive at this time, growing recognition of the potential reversibility of pancreatic beta-cell dysfunction early in the course of type 2 diabetes has yielded a target for such disease modification. Furthermore, short-term intensive insulin therapy for 2 to 5 weeks has emerged as an intervention that could be applied as a biologic agent for this purpose during a window of opportunity that we have called the *honeymoon phase* of type 2 diabetes. This recognition has led to a novel therapeutic paradigm consisting of initial induction therapy to improve reversible beta-cell dysfunction during the honeymoon phase, followed by maintenance therapy aimed at preserving this beneficial beta-cell effect. This concept of induction and maintenance therapy is being applied in a series of recent and ongoing clinical trials, toward the goal of ultimately preserving beta-cell function and thereby modifying the natural history of type 2 diabetes.

Can J Diabetes 39 (2015) S142–S147

¿Para que la remisión?

- Menor riesgo de complicaciones micro y macrovasculares
- Menor riesgo de complicaciones agudas
- Menor requerimiento de medicamentos
- Menores costos de atención
- Satisfacción y autoeficacia

Diabetologia (2024) 67:459–469
https://doi.org/10.1007/s00125-023-06048-6

ARTICLE

Impact of remission from type 2 diabetes on long-term health outcomes: findings from the Look AHEAD study

Edward W. Gregg[1,2] · Haiying Chen[3] · Michael P. Bancks[3] · Raoul Manalac[4] · Nisa Maruthur[5] · Medha Munshi[6] · Rena Wing[7] · for the Look AHEAD Research Group

Received: 11 February 2023 / Accepted: 28 September 2023 / Published online: 18 January 2024

Abstract

Aims/hypothesis We examined the association of attainment of diabetes remission in the context of a 12 year intensive lifestyle intervention with subsequent incidence of chronic kidney disease (CKD) and CVD.

Methods The Look AHEAD study was a multi-centre RCT comparing the effect of a 12 year intensive lifestyle intervention with that of diabetes support and education on CVD and other long-term health conditions. We compared the incidence of CVD and CKD among 4402 and 4132 participants, respectively, based on achievement and duration of diabetes remission. Participants were 58% female, and had a mean age of 59 years, a duration of diabetes of 6 year and BMI of 35.8 kg/m^2. We applied an epidemiological definition of remission: taking no diabetes medications and having HbA_{1c} <48 mmol/mol (6.5%) at a single point in time. We defined high-risk or very high-risk CKD based on the Kidney Disease Improving Global Outcomes (KDIGO) criteria, and CVD incidence as any occurrence of non-fatal acute myocardial infarction, stroke, admission for angina or CVD death.

Results Participants with evidence of any remission during follow-up had a 33% lower rate of CKD (HR 0.67; 95% CI 0.52, 0.87) and a 40% lower rate of the composite CVD measure (HR 0.60; 95% CI 0.47, 0.79) in multivariate analyses adjusting for HbA_{1c}, BP, lipid levels, CVD history, diabetes duration and intervention arm, compared with participants without remission. The magnitude of risk reduction was greatest for participants with evidence of longer-term remission.

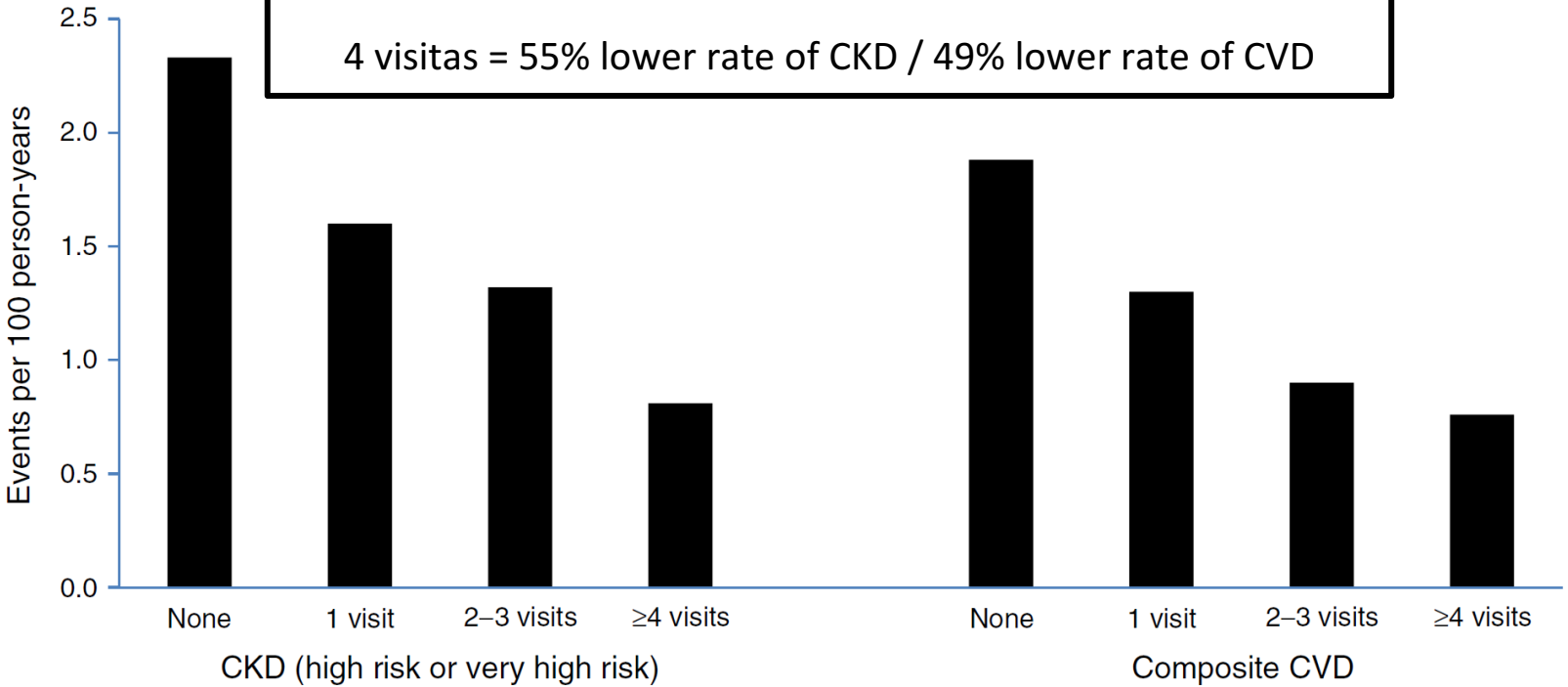
Conclusions/interpretation Participants with type 2 diabetes with evidence of remission had a substantially lower incidence of CKD and CVD, respectively, compared with participants who did not achieve remission. This association may be affected by post-baseline improvements in weight, fitness, HbA_{1c} and LDL-cholesterol.

Trial registration ClinicalTrials.gov NCT00017953

Data availability https://repository.niddk.nih.gov/studies/look-ahead/

Any remission = 33% lower rate of CKD / 40% lower rate of CVD

4 visitas = 55% lower rate of CKD / 49% lower rate of CVD



REVIEW ARTICLE

β-Cell dysfunction in diabetes: a crisis of identity?

M. F. Brereton PhD† | M. Rohm PhD† | F. M. Ashcroft ScD, PhD

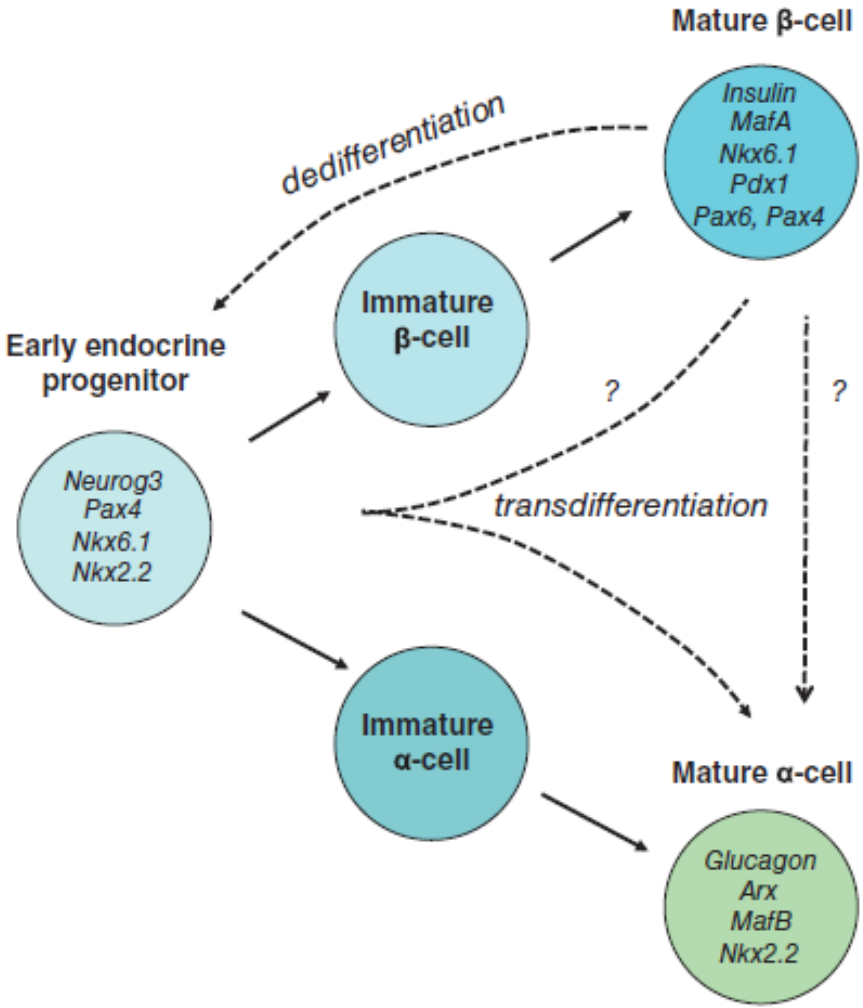
Department of Physiology, Anatomy and Genetics and OXION, University of Oxford, Oxford, UK

†These authors contributed equally.

Conflict of interests: The authors declare no conflict of interest.

Corresponding Author: Prof Frances M. Ashcroft, Henry Wellcome Centre for Gene Function, University Laboratory of Physiology, Parks Road, Oxford OX1 3PT UK (frances.ashcroft@dpag.ox.ac.uk).

Type 2 diabetes is characterized by insulin resistance and a progressive loss of β-cell function induced by a combination of both β-cell loss and impaired insulin secretion from remaining β-cells. Here, we review the fate of the β-cell under chronic hyperglycaemic conditions with regard to β-cell mass, gene expression, hormone content, secretory capacity and the ability to de- or transdifferentiate into other cell types. We compare data from various in vivo and in vitro models of diabetes with a novel mouse model of inducible, reversible hyperglycaemia (βV59M mice). We suggest that insulin staining using standard histological methods may not always provide an accurate estimation of β-cell mass or number. We consider how β-cell identity is best defined, and whether expression of transcription factors normally found in islet progenitor cells, or in α-cells, implies that mature β-cells have undergone dedifferentiation or



Dirección de Medicina de Estilo de Vida Saludable

Diplomado de Medicina de Estilo de Vida Saludable

Perfil de personal capacitado

- Residentes de Especialidades Médicas
- Internos de pregrado
- Pasantes de medicina
- Pasantes de enfermería
- Jefes de enseñanza
- Profesionales de la salud
- Profesionales de la salud extra institucionales
- Personal técnico y administrativo

5293

Capacitados

Fuente: Registros del Programa de Capacitación de Medicina de Estilo de Vida Saludable

thebmj

BMJ 2017;359:j5469 doi: 10.1136/bmj.j5469 (Published 13 December 2017)

Hope may be one of most powerful therapeutic aspects of the doctor-patient relationship.[2-13] Framing the concept as part of the art of medicine risks making it intangible and potentially unattainable. Understanding that hope is a measurable psychological construct, associated with a plausible neurobiological mechanism and clinical benefits, should help clinicians prioritise the required skills and use hope to its full potential in all clinical encounters.

of medicine, "relying on personal experience and instinct." However, hope is in fact a practical therapeutic tool that can be optimised just like any other management approach.

Despite the considerable attention given to the doctor-patient relationship during medical training, hope has traditionally been neglected. Many doctors still don't have a clear idea about how to use hope as therapy while at the same time being realistic and truthful about uncertainty and the potential for poor outcomes. Communication skills training tells us to avoid saying

months to explore the associations between patients' hope and optimism—measured with validated scales—and treatment adherence. The authors found that change in hope (but not change in optimism) was a significant predictor of improvement in both glycaemic control and self monitoring of blood glucose levels.

Biological explanation

lujohn.florez@tamaulipas.gob.mx