



The Application of a New Protocol in the Mangement of Diabetic Acidosis in the Children Hospital

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Received Date: May 02, 2023

Published Date: June 01, 2023

Introduction

The two types of diabetes in children: Type 1 diabetes, which is the most common endocrine metabolic disease, and Type 2 diabetes, which is the most common endocrine metabolic disease. Type 1 diabetes is caused by hyperglycaemia associated with diabetic ketoacidosis and lack of insulin, while Type 2 diabetes is caused by prolonged hyperglycaemia and lack of insulin. Diabetes is classified into four stages: Stage 1: ruined immunity, Stage 2: beginning morbid diabetes, and Stage 3: spontaneous recovery. Stage 1 is due to hyperglycaemia associated with diabetic ketoacidosis and lack of insulin, while Stage 2 is due to hyperglycaemia associated with diabetic ketoacidosis and lack of insulin. Type 2 diabetes is caused by prolonged hyperglycaemia and lack of insulin, while Stage 3 is caused by prolonged hyperglycaemia and lack of insulin.

The onset of type 1 diabetes is usually in infancy and at a middle age 7 and up. It is associated with other autoimmune diseases such as thyroiditis, and in some children and adults with disease drunken pattern 1 Zalki-ato harden many-disease Addison empty carrot Langerhans do not have autoimmunity. Type 1 diabetes is associated with other autoimmune diseases such as thyroiditis, and in some children and adults with disease drunken pattern 1 Zalki-ato harden many-disease Addison empty carrot Langerhans do not have autoimmunity. Reasons known to crash-free include drugs, chemicals, viruses, mitochondrial dysfunction, and eradication. related to type 2 diabetes, which is a type of diabetes that is usually caused by peripheral resistance.

This resistance is caused by the pancreas and irradiation, and is known as Non-insulin (Adult-onset diabetes mellitus) or (dependent diabetes mellitus NiDDM) or (Maturity-onset diabetes of the Young MoDY). Type 2 diabetes is usually caused by obesity and not dependent on insulin, but some adults develop acidosis during Sepsis, severe or stress, and need insulin to fix the symptoms and hyperglycemia. This is known as Non-insulin (Adult-onset diabetes mellitus) or (dependent diabetes mellitus NiDDM) or (Maturity-onset diabetes of the Young MoDY). related to type 2 diabetes, which is a type of diabetes that is usually caused by peripheral resistance.

That most patients with Type 2 diabetes have a pattern of rising insulin in the blood when diagnosed, but this is less than the level appropriate for age, sex, and weight comparison with not injured with disease diabetes. Additionally, some patients may develop to DM(T1), and those with a story family positive for pattern the second show that they have an intolerance to glucose as an autosomal dominant inheritance in the same family. Additionally, some patients may develop to DM(T1), and those with a story family positive for pattern the second show that they have an intolerance to glucose as an autosomal dominant inheritance in the same family. Finally, it is important to note that there is a

genetic component to the pathogenesis of Type 2 diabetes, which includes flaws in the received insulin wall and patterns specific from HLA or immunity.

That most patients with Type 2 diabetes have a pattern of rising insulin in the blood when diagnosed, but this height with insulin in serum is less than the appropriate level for age, sex and weight comparison. Additionally, some patients may develop to DM (T1), and when some patients with a family positive for pattern the second show that they have an intolerance to glucose as an autosomal dominant inheritance in the same family. This increases the occurrence of Type 2 diabetes in children by 10% due to environmental and obesity factors. Additionally, there are three species other from disease diabetes, such as rodenticide cystic or mother land glands, other like Cushing or Eat some medications and toxins like syndromes genetic specific and includes flaw in received insulin wall. Finally, there are three species other from disease diabetes, such as rodenticide cystic or mother land glands, other like Cushing or Eat some medications and toxins like syndromes genetic specific and includes flaw in received insulin wall.

Related to the diagnosis of diabetes mellitus. Diabetes mellitus is a condition that affects the body's ability to regulate blood sugar levels. It is caused by resistance for insulin with high insulin compensation to maintain blood sugar within the level of stability with obesity, especially in the abdomen and viscera, hypertriglyceridemia and hypertension arterial. related to the diagnosis of diabetes mellitus, which is a condition that affects the body's ability to regulate blood sugar levels. It is caused by resistance for insulin with high insulin compensation to maintain blood sugar within the level of stability with obesity, especially in the abdomen and viscera, hypertriglyceridemia and hypertension arterial.

Related to the diagnosis of diabetes mellitus, which is a condition that affects the body's ability to regulate blood sugar levels. the clinical findings of diabetic acidosis and hypovolemia. Polyphagia usually occurs during the early stages of the disease and some patients experience anorexia, appetite, nausea and vomiting, and pain in the abdomen. Hyperventilation and deep breathing (Kussmaul) represent respiratory compensation for acidosis metabolism and results haste. Children with diabetic acidosis and hypovolemia are less likely to show classic signs of hypovolemia such as dryness of the oral mucosa and skin folds than patients with a similar degree of weight loss from vomiting and diarrhea due to inflammatory bowel disease. This important distinction is a reflection of excess water loss from sodium with osmotic diuresis caused by diabetes and water loss from hyperventilation so that water circulates freely.

The rise in plasma osmolarity is caused by extracellular and intracellular fluid loss and water loss. Neurological starting results such as drowsiness, lethargy, and altered sensation to coma are associated with the severity of hyperosmolarity. Diabetic acidosis in children is the leading cause of death and should be dealt with immediately. Standard diagnosis is non-to-bear sugar and disease diabetes.

NONSUGAR TOLERANCE(IGT)	DISEASEDIABETES(DM)
SUGARFASTING BLOOD125-110 MG/DL OF SUGARPLASMA LESS THAN TWO HOURS AFTER A MEAL 200 MG/DL	AA LANDDIABETES MELLITUS WITH RANDOM BLOOD SUGAR MORE THAN 200 MG/DL 11.1 (MOL/L) OR SUGARFASTING BLOOD IS MORE OR EQUAL126 MG/DL. OR SUGARPLASMA MORE THAN TWO HOURS AFTER A MEAL200MG/DL

Acidosis Khaloni diabetes is the end result of metabolic disorders resulting from severe insulin deficiency, whether in quantity or actually. It is a result of exposure to sick disease diabetes, which can lead to pain and deaths in children. Data from the Association European medicine children glands deaf (I got along 2006 in a year and association diabetes American ADA (2004 in a year) and the International Diabetes Children and Adolescents Diseases Association (ISPAD) indicate that acidosis depletion volume and hyperosmolarity of serum are mild to moderate diabetes degrees, hyperosmolarity, hypovolemia, and severe acidosis. Associated clinical manifestations of acidosis depletion include mild to moderate diabetes degrees, hyperosmolarity, hypovolemia, and severe acidosis, and classified diabetic acidosis to mild-mediate-tighten hand according schedule the next:(8) and hypernatremia more than 150 as an acid intense.

Intense	Middle	Light	Natural	
Less from 10	15-10	20-16	28-20	Co2 intravenous
7,15	7,25-7,15	7,35-7,25	7,45-7,35	Ph intravenous
Kussmaul or dampen breathing - and age - low consciousness may reach To hibernate	Breathing kussmaul-headed with tendency to sleep -met To wake up	Headed alert but he's tired	Thei exchanged	Clinically

The clinical manifestations of diabetic acidosis, the degree of hyperosmolarity, hypovolemia, and severity of acidosis, and the signs and diagnoses of diabetic acidosis. Hyperglycemia is to rise sugar in the blood 15 sponsored |l-ketone more than CO₂, dl|mg600 more than Ambulance, and he currently to rise Sugar Walpole light to absent and serum osmolality more than 320 miles Osmol|. It is more common in adults who suffer from control bad on diabetes, and it is associated with condition dehydrated severe and difficulty in management drop the pressure. Epidemiology: Diabetic acidosis is the initial presentation for children with new-onset type diabetes, and other studies from Europe and North America show frequency happening Diabetic acidosis as a primary symptom of type 1 diabetes (15-67%). the findings of a large prospective study that included 8 attacks each diabetes 5 years.

The study found that children from a low socioeconomic background were at increased risk of DKA, with 25% of children from the original population being diagnosed with acidosis and 25% of children from the Irish being diagnosed with acidosis and 40% of children from the Mexicans being injured by pattern 2. The study also found that children from a low socioeconomic background were at increased risk of DKA, with 32% of the children aged less than 5 being diagnosed with acidosis and 32% of the children aged less than 5 being diagnosed with DKA. The study also found that children from a low socioeconomic background were at increased risk of DKA, with 32% of the children aged less than 5 being diagnosed with acidosis and 32% of the children aged less than 5 being diagnosed with DKA. Finally, the study found that children from a low socioeconomic background were at increased risk of DKA, with 32% of the children aged less than 5 being diagnosed with acidosis and 32% of the children aged less than 5 being diagnosed with Diabetes.

Related to the risk of acidosis recurrence and a comprehensive treatment program for diabetes mellitus in previously healthy children. Type 2 diabetes is less common in children with ASD than those with type 1 diabetes, and there is a difference in degree of PH between Type 2 and Type 1 diabetics. Seizures are a major factor in recurrent acidosis, and stress increases the levels of catecholamines and ketones. Diagnosis of diabetes mellitus in previously healthy children requires a trial evaluation, and the signs and symptoms of acidosis are related to the degree of hyperosmolarity, hypovolemia, and acidosis. Other outcomes include weight loss, plenty of urinating during the night, smooth diurnal urine, candidiasis, and in infants and young children, the diagnosis is more difficult because they cannot express thirst and are not toilet trained.

Additionally, unexplained severity of acidosis candidiasis, nappy rash, metabolic or hypovolemia increases the suspicion The severity of metabolic acidosis depends on three factors: an average

production of ketogenic, duration of survival, and an average F rice acid in the urine. Nitroprusside can reduce the severity of ketoacidosis and convert beta-hydroxybutyrate to acetone and acetoacetate, but not with beta-hydroxybutyrate. Additionally, direct measurement of -Hydroxybutyrate should be used whenever possible, as it may reduce the severity of ketoacidosis and convert beta-hydroxybutyrate to acetone and acetoacetate. Finally, the presence of acids ketogenic with blood can decrease the stalagmite gap without affecting the plasma bicarbonate concentration or, consequently, the degree of acidosis.

The clinical and laboratory findings used to estimate the severity of diabetic acidosis. These include the ketone gap, which is useful in breathing an average- $\text{HCO}_3^- + \text{Cl}^-$ (Hco3+ cl) - in serum (Na) = AG, the effect on perfusion renal command that limits Munaf rice ketogenic-s, desperate Plasma beta-hydroxybutyrate, which is the direct method for monitoring the presence of acids Alk Lithuanian with blood-acase nervousness-h Machine Decreased fluid volume-Duration, the best Land-level Awareness, processing and abnormalities seen in diabetic acidosis, the need to level from care, the need to amend on results examinations physical and laboratory for the child, the use of insulin and corrected set Arbat Liquids and electrolytes and metabolic acidosis and lack the size and potassium and depletion phosphates Possibly during initial treatment and should be monitored the patient Carefully Search" on any scientist denote on Existence edema cerebral. Dr. Arsat conducted a detailed study on a year-old female 10 years old with DKA wastage of water and electrolytes. Data from available studies are consistent with the following average losses in water: 30-100 (70ml| kg kg|mk 13-5Na K 7-6 Mk | kg). Management Liquids initial for children with acidosis Moderate :ESPE|LWPES - recommended meeting -10%7 and this with Fluid loss by Present Oshdid. Urinary losses from diabetic osmotic urine, digestive losses from vomiting or diarrhea, and hypovolemic shock are rare in acidosis. It is difficult to assess the degree of dehydration in children with DKA until on experienced doctor. Many of the clinical outcomes used to assess volume status are not as reliable as a patient's condition. Edema of the skin also the because of Hyper Ventilation and breathing from the mouth he have pharynx dry always almost. Accreditation on her in a lot from sometimes Alan Loss questioner she from all from outside cell and inside cell that fluid replacement is recommended to reduce the risk of cerebral edema in children, and that fluid replacement may reduce the risk of cerebral edema in children with high fluid volume replacement during the first 4 hours of treatment. Additionally, fluid replacement may reduce the risk of cerebral edema in children with high fluid volume replacement during the first 4 hours of treatment. Additionally, fluid replacement may reduce the risk of cerebral edema in children with high fluid volume replacement during the first 4 hours of

treatment. Finally, the use of isotonic fluids may be prudent in patients who have deficiency marked by size.

The clinical and laboratory findings that can be used to estimate the severity of diabetic acidosis. These findings include the ketone gap, which is useful in breathing an average- $\text{HCO}_3^- + \text{Cl}^-$ ($\text{HCO}_3^- + \text{Cl}^-$) - in serum (Na^+) = AG, the effect on perfusion renal command that limits Munaf rice ketogenic-s, desperate Plasma beta-hydroxybutyrate, which is the direct method for monitoring the presence of acids Alk Lithuanian with blood-a case nervousness-h, Machine Decreased fluid volume-Duration, the best Land-level Awareness, processing and abnormalities seen in diabetic acidosis, the need to level from care, the need to amend on results examinations physical and laboratory for the child, the use of insulin and corrected set Arbat Liquids and electrolytes and metabolic acidosis and lack the size and potassium and depletion phosphates Possibly during initial treatment and should be monitored the patient Carefully Search" on any scientist denote on Existence edema cerebral. the average losses in fluids and electrolytes in children with acidosis. These losses include urinary losses from diabetic osmotic urine, digestive losses from vomiting or diarrhea, and hypovolemic shock. It is difficult to assess the degree of dehydration in children with DKA until an experienced doctor is present. Fluid replacement goals include compensation, recovery, and restoration of effective circulating volume through sodium replacement and water loss. Laboratory studies are useful to confirm a decrease in volume in the blood. Most experts recommend fluid replacement. Alan's article discusses the use of isotonic fluids to reduce the risk of cerebral edema. He explains that initial size offset: hgm rate compensation depends on the size itinerant effective and usually begins fullness Liquids in acidosis goldilocks to severe with Pump 10ml/kg through hour one if excites suspicion by size itinerant effective. An extra pump of 10 ml/kg over the next hour and generally do not give more than 20 ml/kg of total boluses should be given. The patient's cardiovascular status is assessed and the patient's cardiovascular status should be assessed with Ringeractat with addition. Subsequent fluid replacement: 2-1,5 times the size the next more slowly and should not exceed an average tracking the patient an average. Maintenance should not include urinary loss. the volume of isotonic saline that should be initially used to correct total deficiency of potassium in the body. After 4-6 hours, the volume should be reduced to half isotonic and isotonic saline depending on the patient's condition and stability. Insulin should be administered at a rate of 0.1 l/kg/hour and can be reduced to 0.05 l/kg/hour in children with obvious sensitivity to insulin. The volume of isotonic and isotonic saline depends on the patient's condition and stability.

That the patient should pay consideration to increase the concentration of sodium in liquids and cut an average leaked and m neck the patient, and that the sodium concentration in the blood should be gradually increased attributed to a decrease in the level of glucose. This decrease can be calculated

according to the equation an average revision $Na = \text{measure Na with serum (TC42+ and height expected from the Na next: TC he the increase above the average natural to focus Sugar in the blood (mg|dl) and must be divided TC on 2,3 MK| for every drop by how much 2,4 if measured funded| And therefore should that Rises Sodium in the blood by about 100 mg|dl in plasma glucose level. potassium : (13-2-28) The urinary and digestive systems contribute significantly to many diseases, such as hypokalemia and hyperosmolarity. Insulin, which impedes the entry of potassium into the cells, and hyperosmolarity, which withdraws water and potassium from the cells, lead to an increase in blood potassium. In children with diabetic acidosis who do not have renal failure, it is important to compensate potassium with blood carefully during therapy.$

Patients who suffer from a deficiency or excess of potassium should add potassium with start therapy with insulin (on but) if the patientK (to solution brine) and insulin will decrease from 40 mk|l of K way example addition the K in serum. If the patientK (minus) should immediately start replacing potassium 40 mL with M neck his focus with blood all hour and modify using concentration potassium initial the need according to him analyzes. Delay a leak insulin and/or give it in a form Diluted until Back potassium in the blood. The average natural potassium should be added when the patient's focus is high, and verified from urine with M neck chloride and potassium phosphate and potassium chelate.

The potential risks of using sodium bicarbonate in the treatment of acidosis. These risks include the potential to increase plasma ketones through a leak, slow down an average recovery from acidosis, and the potential for edema, ischemic, and correction rapid acidosis with therapy with bicarbonate. Additionally, the potential for edema, ischemic, and correction rapid acidosis with therapy with bicarbonate may be lead to loss potassium the blood to all. Additionally, the potential for edema, ischemic, and correction rapid acidosis with therapy with bicarbonate may be lead to loss potassium the blood to all. Additionally, the potential for edema, ischemic, and correction rapid acidosis with therapy with bicarbonate may be lead to loss potassium the blood to all.

The indications for treatment with phosphates in diabetes. Low plasma phosphate levels can lead to arrhythmias, phosphoglycerate art, and its effect on metabolism with the body. Surveillance monitoring is important for treating acidosis diabetes, as it requires close monitoring of the patient's vitality, status, and blood glucose levels. Blood glucose measurements should be adjusted by adjusting the concentration of dextrose with liquids and insulin. Patients with severe acidosis or an abnormal serum potassium concentration should be monitored outgoing and incoming accurately. A urinary catheter must be placed to measure the amount of urine.

Related to the treatment of acidosis and diabetes. It is important to stop the insulin infusion when the stalagmite gap is reduced to normal, blood sugar is 200-300 mg, and the patient is taking insulin under the skin. Borderline diabetic acidosis can be managed in the ambulance, but inpatient hospitalization is appropriate for young children. The dose should be adjusted accordingly and monitored for sugar and electrolytes in the blood and balance liquids. Complications and deaths are common in acidosis and diabetes, with edema, ischemic, and lung inhalation being the most common causes of death.

Related to the treatment of acidosis and diabetes, and the patient is taking insulin under the skin. the symptoms of diabetic acidosis, such as death, edema, ischemic, inhale, Sepsis, failure renal, pulmonary, ARDS, loss of sugar, embolicerebral and arterial, loss of potassium and other electrolyte disturbances, shock, acidosis metabolism, late hyperchloride, gap stalagmites, normal and this is Type from acidosis not for him furnish Art bad and correct gradual. The main cause of mortality in diabetic acidosis is edema, ischemic, inhale, Sepsis, failure renal, pulmonary, ARDS, loss of sugar, embolicerebral and arterial, loss Potassium and other electrolyte disturbances, shock, acidosis metabolism, late hyperchloride, gap stalagmites, normal and this is Type from acidosis not for him furnish Art bad and correct gradual. The main cause of mortality in diabetic acidosis is edema, ischemic, inhale, Sepsis.

That those who suffer from acidosis diabetes may be in danger, and that they may have drop in levels of awareness, protection, and intubation to protect the airway. Additionally, they may have any loss or hyper with potassium, and may notice height goldilocks in serum for miles and lipase in around to rise pancreatic enzymes. Additionally, they may have any loss or hyper with potassium, and may look to her with any loss or hyper with potassium. Additionally, they may have any loss or hyper with potassium, and may look to her with any loss or hyper with potassium. Finally, they may have any loss or hyper with potassium, and may have any loss or hyper with potassium.

The findings of a study conducted on 41 children with diabetic acidosis. The study found that 56% of the children had compression for the ventricle through a period of therapy and were more susceptible to change Art the condition 12 out of 22 children with from 15 in mental from Those from Without compression ventricle (and estimated Glasgow lesscompression ventricular Opposite 4 out of 19 out without compression). The group control indicated that complaining cerebral occurs usually in children with acidosis and with that it the j remove from not the obvious what if He was swell the brain under clinically. Among children with other causes of acidosis, it is difficult to determine whether they as a result of cerebral edema or to change Art In the mental state observed in this study.

The potential causes of edema in diabetic acidosis (DKA). It is possible that the cerebral edema in DKA may be related to a combination of two or more factors, such as loss perfusion, vascular, and osmolarity. Additionally, there are other metabolic and inflammatory factors such as hyperglycemia-induced increase in the permeability of the brain barrier and the new generation of solutes within the brain. Additionally, there are risk factors for the development of cerebral edema in children with DKA, such as acidosis drunken and factors danger. Finally, it is important to note that the best land before diagnosis with DKA Severe and from it:- young children.

That sodium failed to rise as expected with the initiation of insulin and fluid therapy, indicating a greater fall in plasma osmolality. Additionally, increased blood urea may represent a greater degree of hypovolemia, and the severity of the acidosis was no longer significant in this model. Bicarbonate therapy was used to correct acidosis, and adjustments were made for the severity of acidosis and the initial partial pressure was less than CO_2 arterial. It was suggested that careful use of liquids for not Existence insulin as a worker could reduce any risks potential. Finally, the following criteria are useful in identifying children whose life may be threatened: The most important details are that DKA can lead to dehydration, malfunctioning metabolism, and deprivation of sleep, so it is important for children to be monitored by a doctor with high suspicion of edema and immediate intervention.

The diagnostic criteria for edema; ischemic, and the treatment recommendations for edema; ischemic. The diagnostic criteria for edema; ischemic include a movement and response verbal for pain not normal, a situation with side respiratory nervousness, an improvement in the volume within the blood vessels during sleep, vomiting, headache, idleness, and a diastolic blood pressure of 90 mm - age > 5 years. The treatment recommendations for edema; ischemic include a fluid intake rate of 72-48 hours, mannitol 1-0.25g/kg on road vein on Bezel 20 minute, and can tack Arr dose in two hours if did not be there. The results of the study suggest that mannitol is not effective for treating edema; ischemic, as the majority of patients presented with symptoms suggestive of severe cerebral edema. the factors that can lead to the death of children from cerebral edema.

These include excessive stress, tracheal intubation and hyperventilation, continuous intracranial pressure monitoring, avoidance of rapid drop of serum osmolality, sodium bicarbonate unless necessary, and raising the head 30 degrees with elimination of obstructions to the venous return. Additionally, Dr Arsat recommends that a concerted effort be made to identify and treat children with edema cerebral, as this can help to reduce the average deaths and pain associated with edema. The protocol used for the management of diabetic acidosis in the Children's University Hospital in Damascus is outlined in this text. It outlines how to deal with diabetes during the disease and distress,

such as using insulin to shorten the influence of glucose in the blood and khlon urine, and guiding the patient to eat the appropriate food at cheap prices. Additionally, it outlines the symptoms of diabetic hospitalization, such as loss of weight, number of mart breathing, rising severe blood sugar, change in a state of consciousness, fly up My heat Uncontrollable, and nausea or Vomiting that did not respond to the measure.

Sodium<155		Sodiumbetween155-130		Sodium> 130		the hour
300>sugar	300<sugar	300>sugar	300< sugar	sugar > 300	300< sugar	
500 millie M Squarefrom salin%0,9						the hour1
500 millie MA box of half saline with dextrose%5	500 square miles than half Saleen %0,45	500 miles mA box of half saline with dextrose%5	500 miles mSquare from salin0.9% and a half Saleen %0,45		500 square miles Saleen %0,9	the hour2
We should addition Potassium after the patient urinates according to potassium values in the serum in the form of potassium chloride 6<: mk l the Potassium is added6-2 MK Focus added20-40 mLof replacement fluids is less than2 MK Focus added40-60 mL replacement fluids						
The Bicarbonate is given intravenously, except when the blood pressure drops> PH 7 and at Shock						
Give insulin regulars intravenously dosedprimitive0,1 lonliness kgThen, it begins to be intravenously infused0,1 lonliness kg per hour in veinseparate						
200ml mA box of half saline with%0,45 dextrose %5	200ml mSquare from half of saline %0,45	200ml mA box of saline0,9% with dextrose%5	200ml mbox of salin %0,9		200 ML mma quarter of salin %0,9	hours-3
Continue a leak insulin 0,1 lonliness kg per hour in a form bicarbonate<)15with M neck sugar the blood and modify infusion According to it is preferred drop Sugarquickly equal to100 mg dl per hour						
When The patient is relieved of acidosis. Insulin can be inverted into the skin, while the infusion continues for another hour, lest the return of high blood sugar, and the dose of insulin under the skin every6-4 hours Just Valuable Sugar						
100ml mHourly box of saline%0,9 with dextrose %5						
Liquid potassium chloride according to its serum titer. Insulin is administered subcutaneously every6-4 hours Just Valuable Sugar						In the24 hours next

- Diabetic acidosis management protocol(:protocol Nelson -19 protocolapplied in our study:(4))

comment	therapy	the time
<input type="checkbox"/> We may need to repeat fast dictation <input type="checkbox"/> M. Incoming and outgoing control, including That vomiting <input type="checkbox"/> Use parchment paper <input type="checkbox"/> Mannitol is required for use Alright edema; <input type="checkbox"/> In case of hypoglycaemia < 100 mg dl h decrease leak Liquids %20	<input type="checkbox"/> 20-10ml/kg Venous diaphragm from Saline 9 per thousand with a leak insulin 0,1-0,05 Ionliness/kg/hour <input type="checkbox"/> extended 0,5 Ml any 50 Ionliness insulin regular in 49,5 Ml Serum Physiological. So we get on 1 ml = 1 unit <input type="checkbox"/> The insulin bag must be changed every 8 hours Because we smooth it out	first hour
<input type="checkbox"/> infusion rate: <input type="checkbox"/> 85ml/kg + Maintenance - shower with to divide output on 23 hours <input type="checkbox"/> case of potassium 3>MK give 1-0.5mC/kg Oral or intravenous potassium supplementation 80 MK <input type="checkbox"/> If the blood sugar is less than 180 mg/dl despite Dextrose use %10 done decrease insulin %20	<input type="checkbox"/> Half saline solution while continuing with insulin <input type="checkbox"/> 40mL Potassium chloride <input type="checkbox"/> dextrose %5 in case sugar the blood less from 250 mg/dl	the hour second until the acidosis is gone
the vomiting CO ₂ —more or equal to 16 electrolytes normal	Ward Oral with subcutaneous insulin	a variable

The calculations of fluids allowed for the first 24 hours, the amount of fluids allowed for the rest of the day, the amount of fluids allowed for the first hour, the amount of fluids allowed for the second hour, the amount of fluids allowed for the third hour, the amount of fluids allowed for the fourth hour, the amount of fluids allowed for the fifth hour, the amount of fluids allowed for the sixth hour, the amount of fluids allowed for the seventh hour, the amount of fluids allowed for the eighth hour, the amount of fluids allowed for the ninth hour, the amount of fluids allowed for the tenth hour, the amount of fluids allowed for the eleventh hour, the amount of fluids allowed for the fifteenth hour, the amount of fluids allowed for the sixteenth hour, the amount of fluids allowed for the seventeenth hour, the amount of fluids allowed for the sixteenth hour, the amount of fluids allowed for the seventeenth hour, the amount of fluids allowed for the twentieth hour, the amount of fluids allowed for the twentieth hour, the amount of fluids allowed for the twentieth hour, that potassium is used to compensate for the

Citation: Mahmoud Mahmoud "The Application of a New Protocol in the Mangement of Diabetic Acidosis in the Children Hospital" MAR Pediatrics, Volume 4 Issue 2

loss of potassium in acidosis patients, and that liquids are best calculated based on the weight, not the surface of the body. The protocol includes tables with columns containing electrolytes-PH-mink, irlm-balance fluids, and must be drawnhid Artblood all (2-1) hour in severe acidosis and all (4-3) hours in Light and medium. The paper also includes tables with columns containing electrolytes-PH-mink, irlm-balance fluids, and must be drawnhid Artblood all (2-1) hour in severe acidosis and all (4-3) hours in Light and medium. Additionally, the paper includes tables with columns containing electrolytes-PH-mink, irlm-balance fluids, and must be drawnhid Artblood all (2-1) hour in severe acidosis and all (4-3) hours in Light and medium. Finally, the paper includes tables with columns containing electrolytes-PH-mink, irlm-bal

The goals of the study, which are to apply an internationally approved protocol for fluids and solutions in the children's hospital, and to compare the results resulting from the application of the new protocol with the results resulting from the application of the old protocol. The goal is to find a protocol that is suitable for different cases and with the least possible amount of stress Mixturescaused by the application. The study is conducted in two phases, with the first phase consisting of analyzing the symptoms of diabetic acidosis and the second phase consisting of comparing the results resulting from the application of the new protocol with the results resulting from the application of the old protocol. The goal is to find a protocol for managing diabetic acidosis that is suitable for different cases and with the least possible amount of stress Mixturescaused by the application. that the study included all patients with acidosis diabetes who returned to the children's hospital during the period of one year 2015-2013 and who were treated with protocols suggested in the study.

The study returned data from the discharge files of former patients by filling out a special form that was designed to conduct the study, and the data was collected by filling out the same form after placing an advertisement in the hospital. The analyzes required to complete the study and apply the new protocol included sugar and salt, insulin, sugar ketate, electrolyte and gas analysis, or acidosis control insomnia. The data was collected by filling out the same form after placing an advertisement in the hospital.

Results

the statistical methods used to measure and disseminate results. These include average arithmetic, standard deviation, range and percentages for the study of descriptive statistics for variables, Pearson correlation to study the relationship between variables, test student to study the difference between two groups, and test analysis Unilateral variance to study the difference between more than two groups.

Additionally, the comparison results application protocol Therapeutic the old with the new from where the number of hours Exit from acidosis diabetes according to intensity acidosis was conducted. The statistical methods used in the study include average arithmetic, standard deviation, range and percentages for the study of descriptive statistics for variables, Pearson correlation to study the relationship between variables, test student to study the difference between two groups, and test analysis Unilateral variance to study the difference between more than two groups. the statistics between protocols Therapeutic the old and the new in terms of hours Exit from acidosis diabetes, and that in both severe and moderate acidosis in the children of the study, there was a difference in moral p-value between protocols Therapeutic the old and the new in terms of middle number hours Exit from acidosis diabetes and that in acidosis the weak, there was a difference in moral p-value between protocols Therapeutic the old and the new in terms of middle number hours Exit from acidosis diabetes and that in both severe and moderate acidosis in the children of the study, there was a difference in moral p-value between protocols Therapeutic the old and the new.

number hours Exit of diabetic acidosis according to the severity of the acidosis			
protocol the new	protocol the old	Count verses	intensity acidosis
22	13	number children	severe acidosis
28,409	31,769	average	
12,534	5,703	Alhhhhhhh hhhhhhh Arv normative	
9	17	limit the lowest	
56	43	limit the highest	
47	26	Term	
0.29		p-value	
the There is spreads Same indication Statistic		The result	
17	20	number children	mild acidosis
20,117	24.15	average	
10,682	6,499	Alhhhhhhh hhhhhhh Arv normative	

6	13	limit the lowest	
42	34	limit the highest	
36	21	Term	
0.18		p-value	
the There is spreads Same indication Statistic		The result	
8	14	number children	Acidosis Weak
10	13,285	average	
2.67	5.63	Alhhhhhhh hhhhhhh Arv normative	
7	7	limit the lowest	
16	25	limit the highest	
9	18	Term	
0.08		p-value	
There is spreads Same indication Favor prot And Cole the new Statistic		The result	

The comparison of the results of applying the old treatment protocol with the new one in terms of the number of return hours PH. This is done by comparing the results of applying the old treatment protocol with the new one in terms of the number of return hours PH for the normal, severe acidosis, moderate acidosis, and weak acidosis in children study. The study found that the protocol Therapeutic the old And the new were equal in middle number hours 0.05 benchmark adult (back PH) for the normal, and that the protocol Therapeutic the old And the new were equal in middle number hours 0.05 benchmark adult (back PH) for the normal, and that according intensity acidosis diabetes I have children dr family : schedule number (2) Schedule comparison Statistics Descriptive between the old and new treatment protocol for the number of return hours PH and that according intensity Diabetic acidosis.

number hours back For normal, according to the severity of acidity			
PH			
protocol new	the protocol the old	Countverses	intensity acidosis
22	13	number children	severe acidosis
15.27	16.92	average	
5.37	2.69	Alhhhhhhhhhhhhhhhh Arv normative	
4	10	limit the lowest	
23	20	limit the highest	
19	10	Term	
0.23		p-value	
the There is spreads Same indication		Statistic	
17	20	number children	mild acidosis
11	11.45	average	
5.37	3,153	Alhhhhhhhhhhhhhhhh Arv normative	
3	5	limit the lowest	
25	19	limit the highest	
22	14	Term	
0.75		p-value	
the There is spreads Same indication		Statistic	The result
8	14	number children	acidosis weak
4.25	5,428	average	
2.43	3,130	Alhhhhhhhhhhhhhhhh Arv normative	
2	2	limit the lowest	
10	12	limit the highest	
8	10	Term	
0.37		p-value	
the There is spreads Same indication		Statistic	The result

The results of a study conducted by Al Mutabaqan on children with diabetes and acidosis. The study found that the number of hours of release from diabetic acidosis and the number of hours back PH to level were equivalent between protocol Therapeutic the old and protocol Therapeutic the new, and that the strength of the correlation between number hours Exit from acidosis diabetes and number hours back PH was even higher when applying the protocol Therapeutic the new comparison with it when application Protocol Therapeutic the old. Additionally, the compatibility between number hours Exit from acidosis diabetes and number hours back PH for the straight was better when application Protocol TherapeuticNew in the case of moderate acidosis or mild acidosis.

The result	protocol the new	The result	protocol the old	Statistics	intensity acidosis
There is Engagement	0.91	There is Engagement	0.91	withhope Engagement	severe acidosis
moral	0	moral	0	p-value	
There is Engagement	0.94	There is Engagement	0.69	withhope Engagement	mild acidosis
moral	0	moral	0.001	p-value	
There is Engagement	0.96	There is Engagement	0.80	withhope Engagement	acidosis weak
moral	0	moral	0.001	p-value	

Dr family set Arbat electrolytesSodium according to severity of diabetic acidosis, and for every protocol Therapeutic the old and new Al Mutabaqan on children: schedule number (4) set Arbat electrolytes Sodium.

protocol the new			protocol the old			Statistics	severity of acidosis
rate deficiency Sodium	Hyper Sodium rate	normal rate for sodium	rate deficiency Sodium	Hyper Sodium rate	normal rate for sodium		
3	2	17	3	---	10	the number	severe acidosis
13.7%	9%	77.3%	23%	---	77%	The ratio Centennial	

6	1	10	5	3	12	the number	mild acidosis
35.4%	6%	58.8%	25%	15%	60%	The ratio Centennial	
1	---	7	2	---	12	the number	acidosis weak
12.5%	---	87.5%	14.3%	---	85.8%	The ratio Centennial	

Dr family set Arbat electrolytes (Potassium) according to the severity of diabetic acidosis according to the protocol Therapeutic and AI Mutabaqan on children.

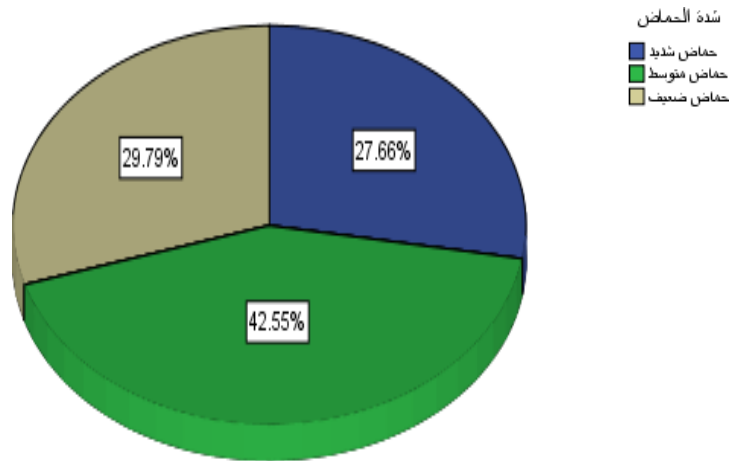
protocol the new			protocol the old			Statistics	intensity acidosis
rate deficiency potassium	Hyper an average potassium	normal rate for potassium	rate deficiency potassium	Hyper an average potassium	normal rate for potassium		
2	---	20	1	---	12	the number	severe acidosis
9%	---	91%	7.7%	---	92.3%	The ratio Centennial	
1	---	16	2	---	18	the number	mild acidosis
6%	---	94%	10%	---	90%	The ratio Centennial	
---	---	8	2	---	12	the number	acidosis weak
---	---	100%	14.3%	---	85.7%	The ratio Centennial	

The new AI Mutabaqan protocol for treating children with acidosis and diabetes is based on the severity of the acidosis. Mixtures are tailored to the severity of the acidosis.

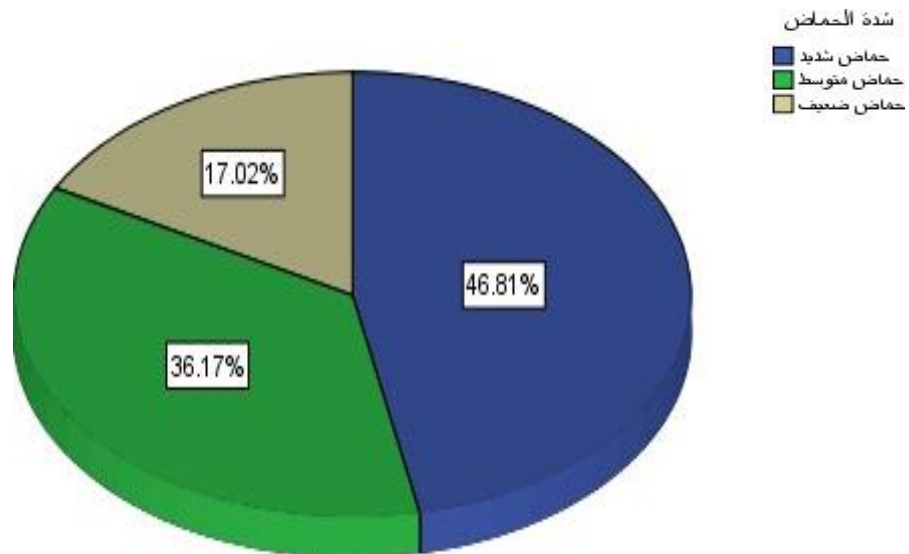
cases Death		Cases of cerebral edema				shortages Sugar		Statistics	severity of acidosis
New Protocol	Old Protocol	protocol the new		protocol the old		New Protocol	Old Protocol		
		without application mannitol	with application mannitol	without application mannitol	with application mannitol				
1	1	---	6	2	1	---	2	the number	

4.5%	7.7%	---	27.3%	15.4%	7.7%	---	15.4%	The ratio Centennial	severe acidosis
---	---	3	---	2	5	---	1	the number	mild acidosis
---	---	17.6%	---	10%	25%	---	5%	The ratio Centennial	
---	---	1	---	---	4	---	---	the number	acidosis weak
---	---	15.4%	---	---	28.6%	---	---	The ratio Centennial	

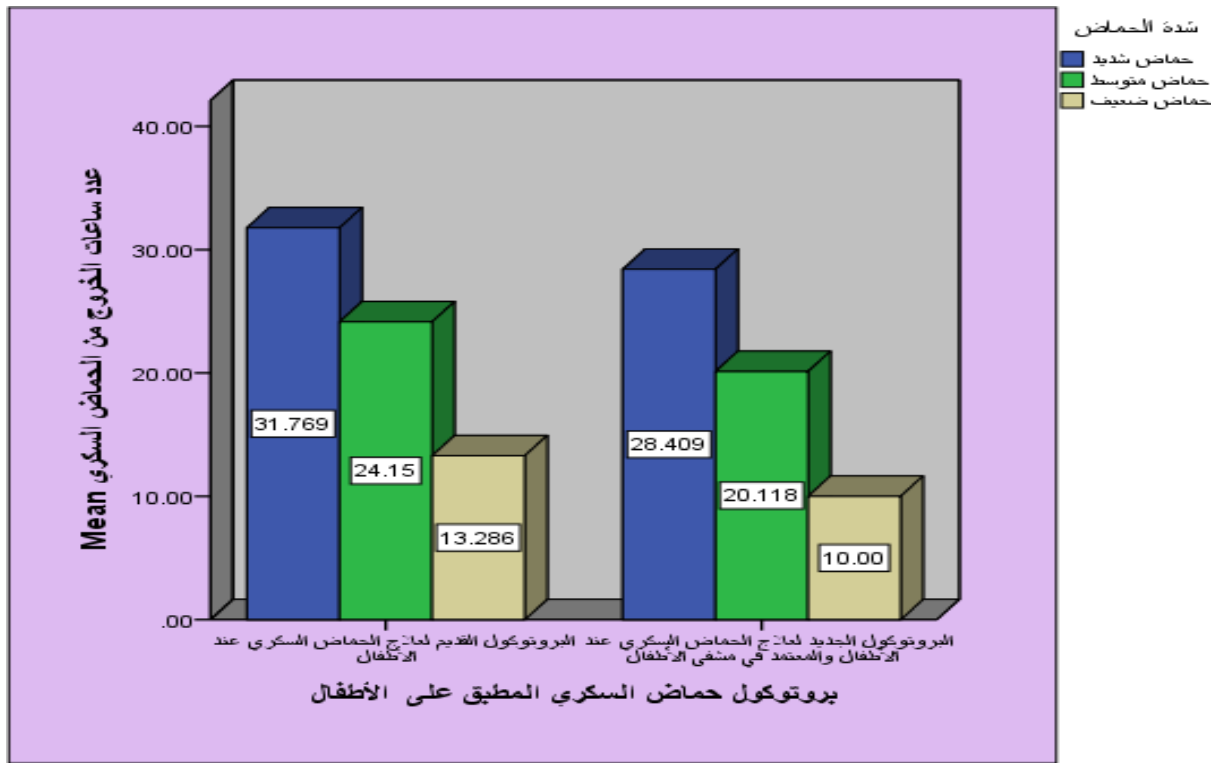
The most important idea is to classify cases of acidosis diabetes based on their severity.



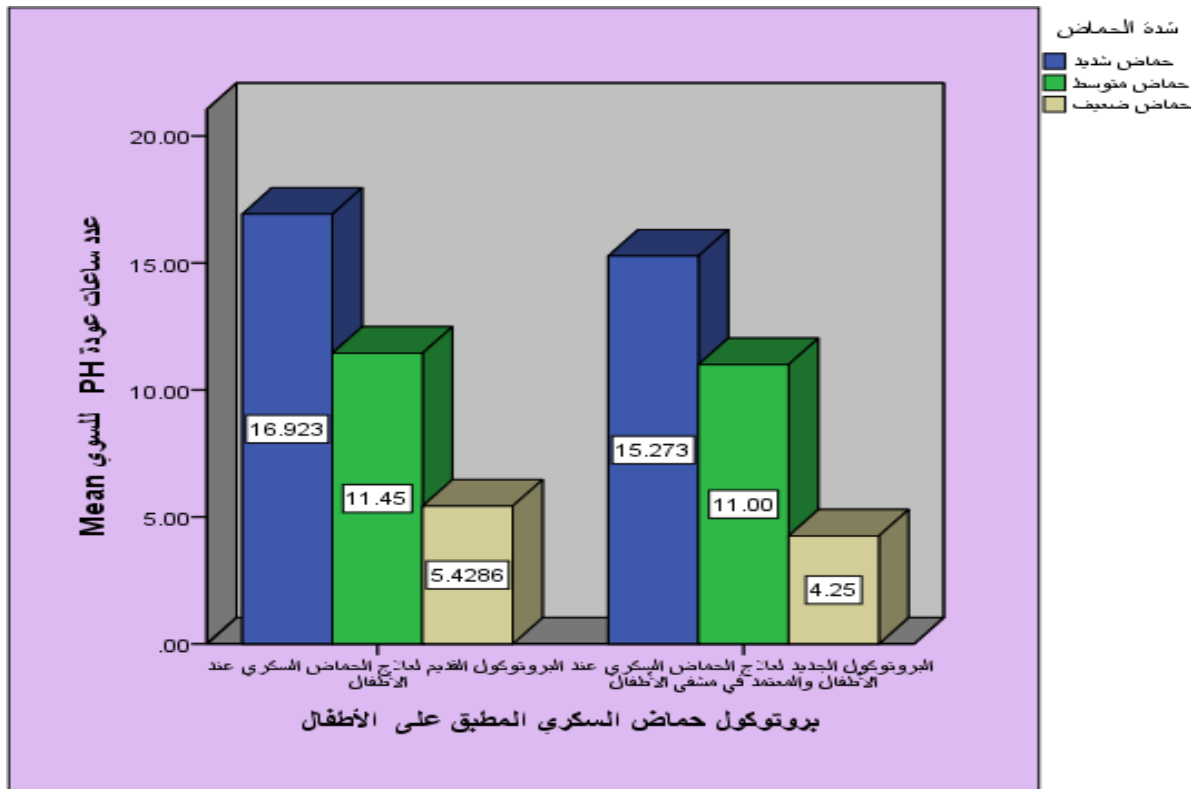
The most important idea is to classify cases of acidosis diabetes based on their severity.



The new protocol classifies cases of acidosis diabetes according to the intensity of the acidosis.



The two protocols differ in the number of hours taken to exit from acidosis.



The difference between the two protocols is the number of return hours PH.

Citation: Mahmoud Mahmoud "The Application of a New Protocol in the Mangement of Diabetic Acidosis in the Children Hospital" MAR Pediatrics, Volume 4 Issue 2

Results & Discussion

the results of a study conducted on a child with acidosis. The results showed that the new protocol had a significant difference in application in both severe and moderate acidosis, with a significant difference in favor of the new protocol in the case of mild acidosis. However, there was no clear difference in the perturbation of the sodium ion/ sodium debugger between the old protocols and the new protocols. This suggests that the two protocols are equal in the average number of return hoursph for normal in acidity, severe and average, and the light. The study found that there was no clear difference in the perturbation of the potassium ion between the two protocols applied to the children of the study.

The cases of cerebral edema were more when applying the new protocol in the case of severe acidosis only, and the rate of deaths was one in both cases. Recommendations included confirmation on pain neck urging, awareness, admission of any acidic child for the first time in intensive care, admission of the child to intensive care when symptoms suggestive of cerebral edema appear, conducting educational lectures about the risks of diabetes, the necessity of adherence to treatment, insulin in a form, periodic, with the need for free insulin for all patients, a J See Ocular examination with renal function frequently, tracking glandular clinic periodically, education children and the parents on method the correct way to administer insulin, and raising awareness and close monitoring to avoid its complications.

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