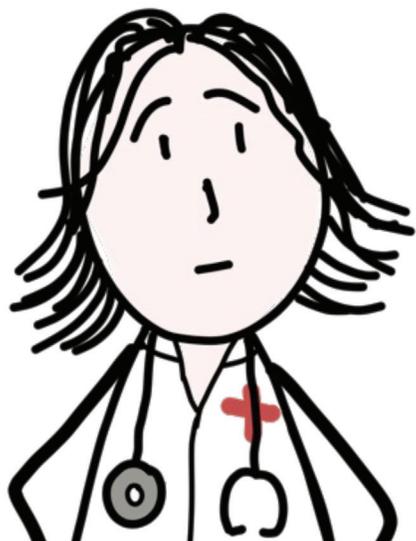


Sesión 2: Para organizar las ideas

Iñaki Lorente Armendáriz
Psicólogo col N-0284.

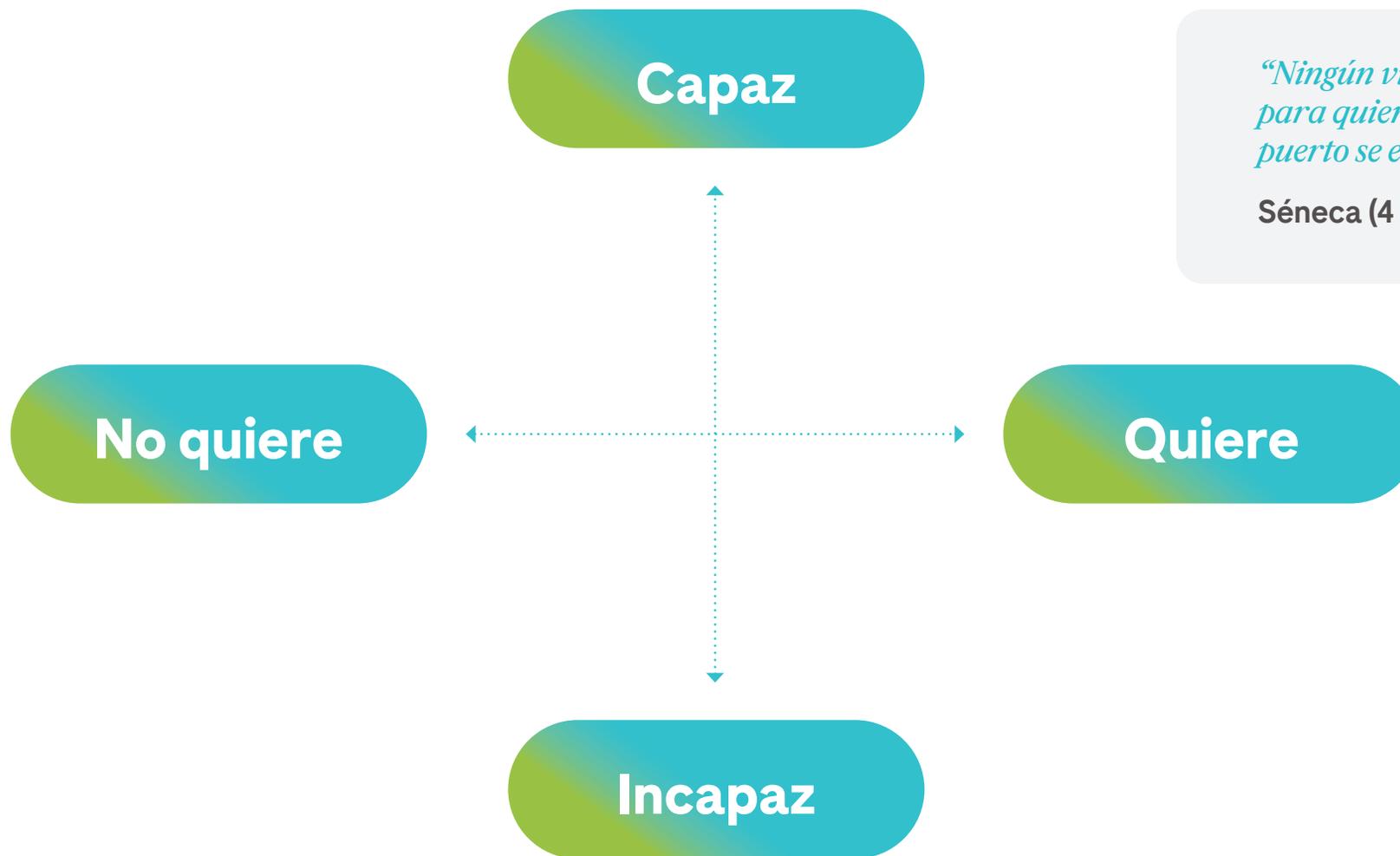


¿?



¿Por dónde empiezo?

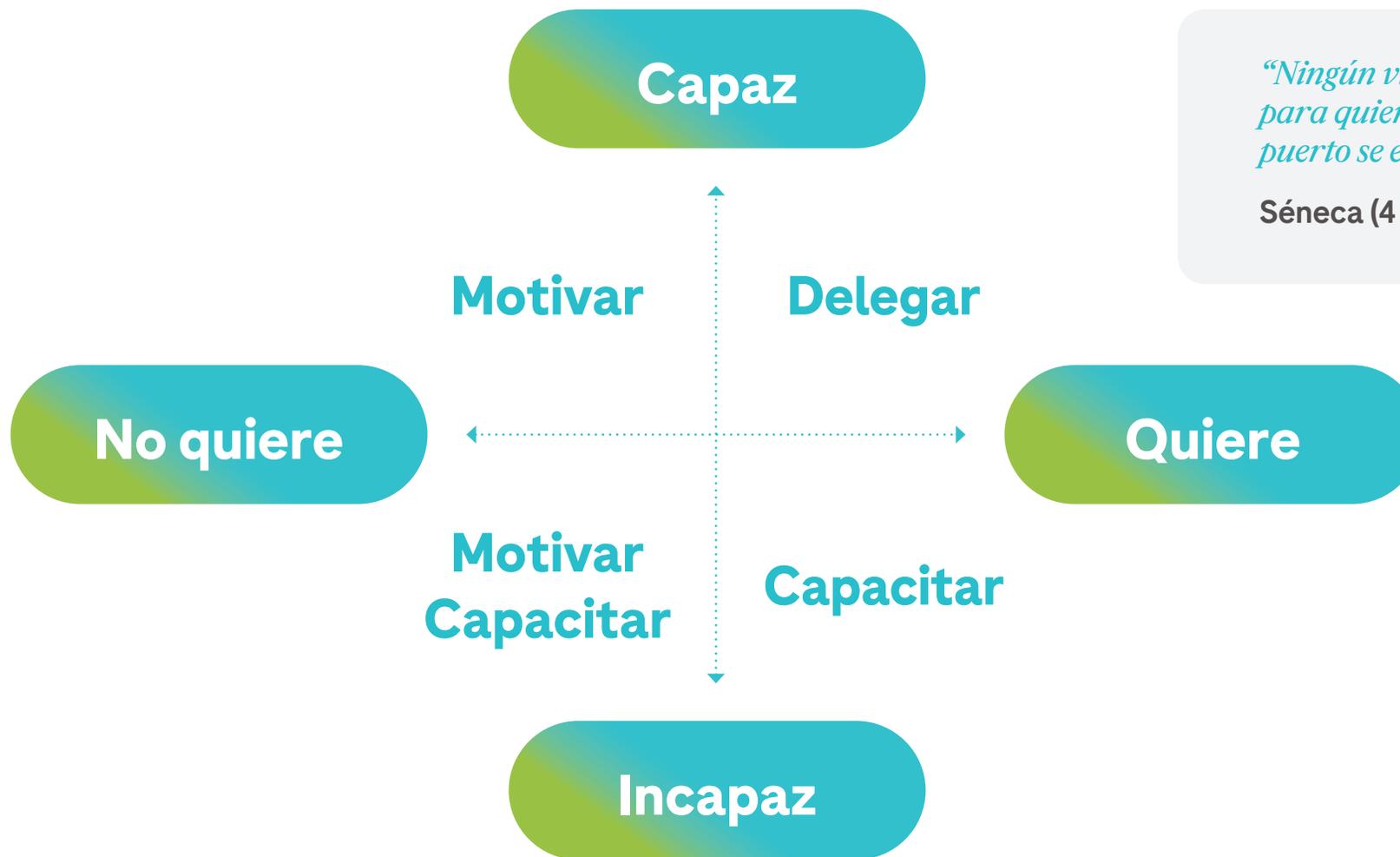
Orientar la intervención



“Ningún viento será bueno para quien no sabe a qué puerto se encamina.”

Séneca (4 a. C. - 65 d. C.)

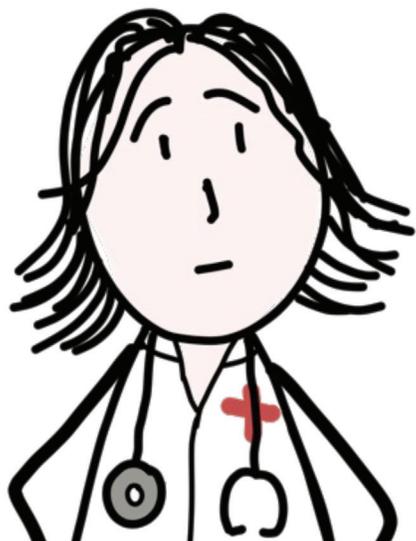
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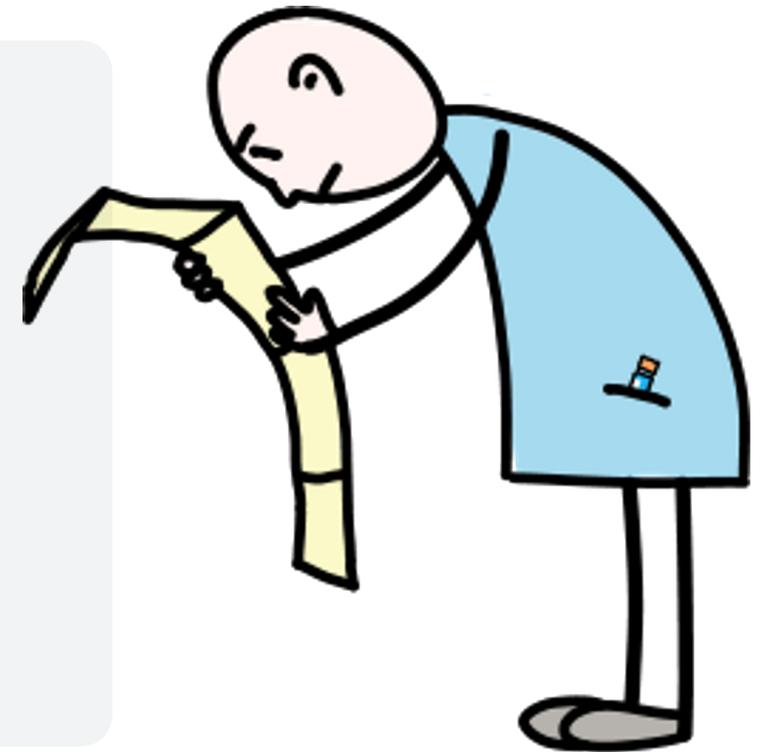
¿?



¿Qué sugiere
la palabra motivación?

Motivación. Introducción

- Puede que sepa dónde se encuentra.
- Puede que sepa a dónde quiere llegar.
- Puede que, incluso, tenga un buen transporte.
- ... Pero sin una fuente de energía, no se moverá.



Motivación. Definición

“Es el conjunto de factores que impulsan a una persona a realizar determinadas acciones y persistir en ellas hasta su culminación”.⁽¹⁾

Angela Lee Duckworth.

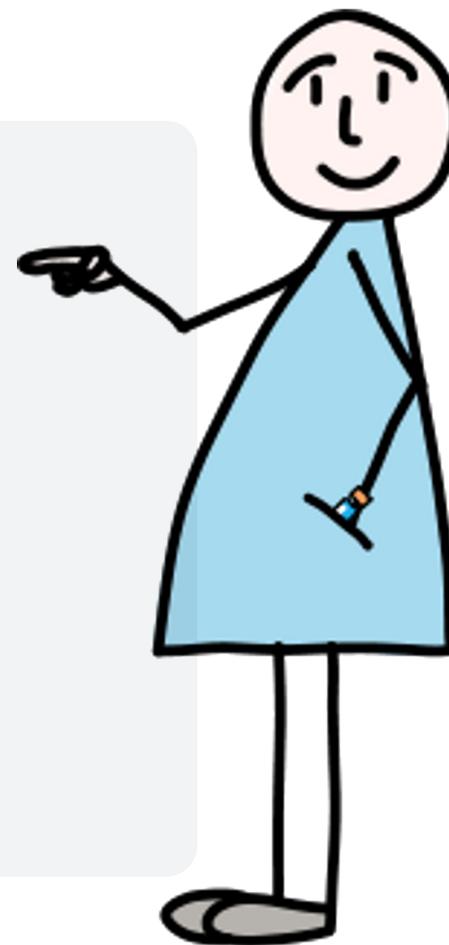
Es la energía que impulsa hacia una meta.



1. Duckworth, A. L., Peterson, C., Matthews, M. D., & Kelly, D. R. (2007). Grit: perseverance and passion for long-term goals. *Journal of personality and social psychology*, 92(6), 1087-1101.

Motivación. Algunas características

- Es personal.
- Es un fenómeno interno.
- Variable.
- Imposible de inyectar.
- Se retroalimenta.



Imprescindibles

- Tiene una necesidad a cubrir.
- El resultado depende de ella.
- Capaz de conseguirlo.

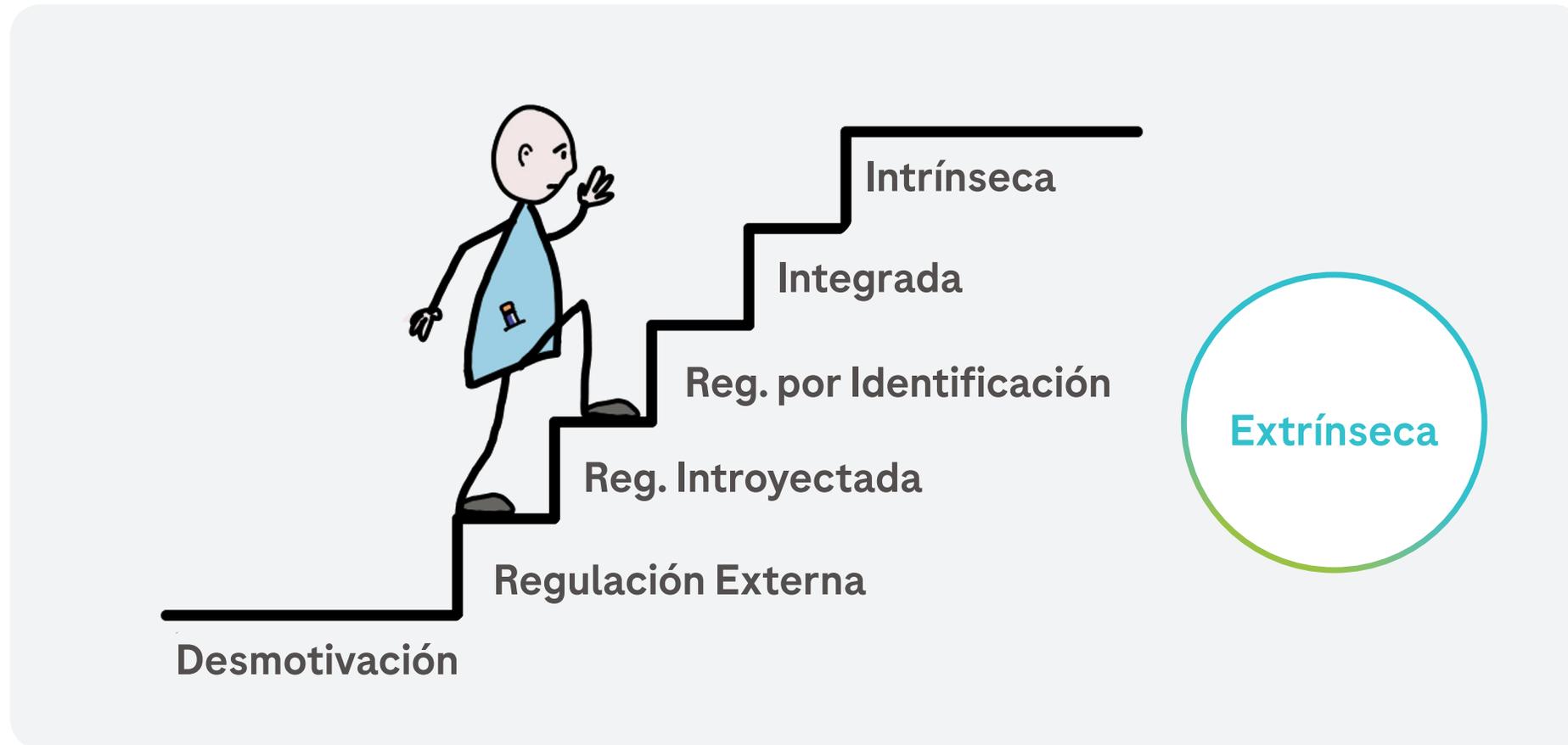


Imprescindibles

- Tiene una necesidad a cubrir.
- El resultado depende de ella.
- Capaz de conseguirlo.



La teoría de la Autodeterminación. (E. Deci y R. Ryan.1985⁽¹⁾)

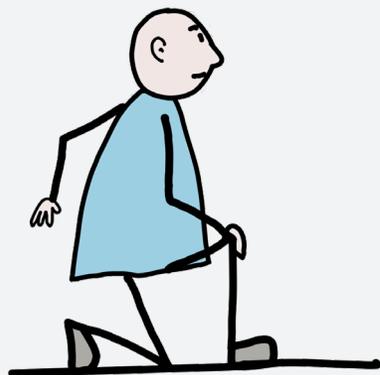


1. Deci, E., & Ryan, R. (1985). The general causality orientations scale: Self-determination in personality. *Journal of Research in Personality*, 19, 109 - 134.

Motivación. Tipos

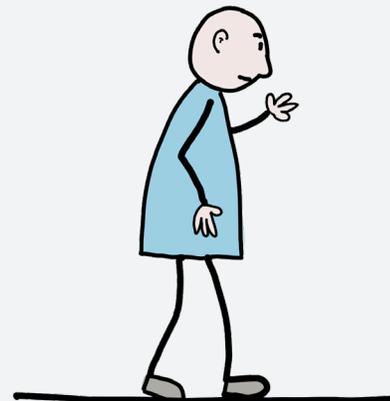
Motivación de **INICIO**

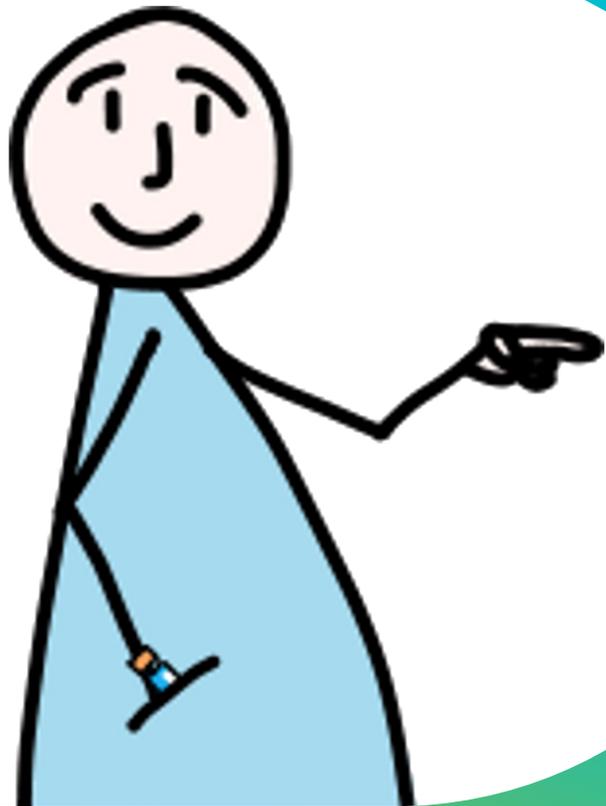
Necesaria para empezar a andar.



Motivación de **MANTENIMIENTO**

Necesaria para convertir una conducta en hábito.



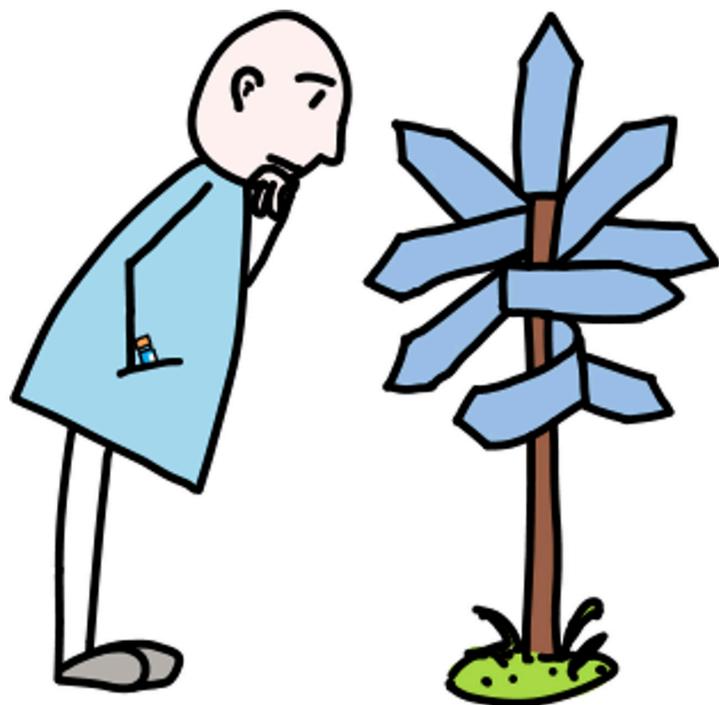


“Deseo”
¿Por qué quieres hacerlo?

Fuerza de motivación: Deseos + Facilitadores + Incentivos

- Esta relacionado con una necesidad a cubrir o un premio a obtener.
- Son subjetivos
- Aumentará la **FUERZA** si la asociamos a deseos que sean importantes para el paciente.





“Facilitadores”
¿Qué te podría ayudar?

Fuerza de motivación: Deseos + Facilitadores + Incentivos

Son aquellos elementos que favorecen o simplifican la realización de una acción.

- Avisos (postit, alarmas en el móvil...).
- Citas programadas.
- Hojas de registro.
- Elegir MUY bien el objetivo.



Programación de citas como facilitador

Programar el acompañamiento

Febrero	Marzo	Abril	Mayo
   	  	  	 
Junio	Julio	Agosto	Septiembre
 	 		 
Octubre	Noviembre	Diciembre	Enero
			



Entrevista inicial



Revisión



Contacto telefónico



Sesión Individual (media hora)

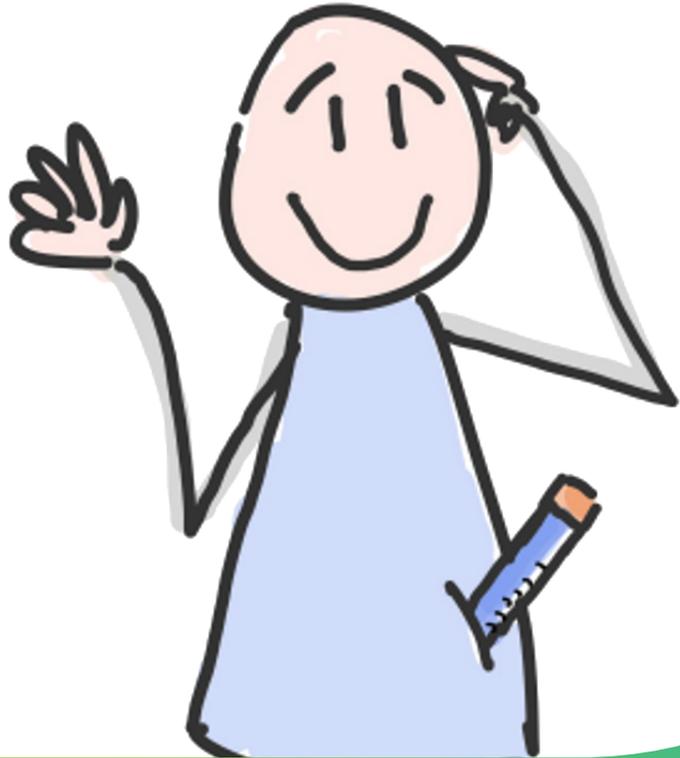


Sesión de pareja (una hora)

Reflexionar con la mano

Seguir igual		Cambiar	
¿Qué gano?	¿Qué pierdo?	¿Qué gano?	¿Qué pierdo?
.....
.....
.....
.....
.....
.....

- Ayuda a sistematizar la reflexión
- Puede hacerlo fuera de la consulta



“Incentivo”
¿Con qué te
puedes premiar?

Fuerza de motivación: Deseos + Facilitadores + Incentivos

¿Qué me puede incentivar?:

- “Celebrar el logro yéndome a un concierto”,
- “Comprarme otras zapatillas”,
- “Darme un homenaje,
- ...

Uno de los mayores reforzadores es **el reconocimiento** de las personas significativas, en este caso, tú.





Diseñar objetivos

Establecer Objetivos

S.M.A.R.T



George Doran. 1981

Específico

¿Qué quieres lograr exactamente?

Medible

¿Cómo sabrás que has alcanzado el objetivo?

¿Qué habrá cambiado que te permita saber que lo has conseguido?

Alcanzable

¿Es posible que con tus capacidades lo consigas?

Relevante

¿Cuál es tu nivel de compromiso con este objetivo?

Time-bound

¿Cuándo esperas alcanzarlo?

¿Cada cuánto tiempo vas a medir mis progresos?

¿Cuáles son los tres primeros pasos que te acercan a tu objetivo?

Establecer Objetivos



Establecer Objetivos



Establecer Objetivos



Establecer Objetivos



Establecer Objetivos



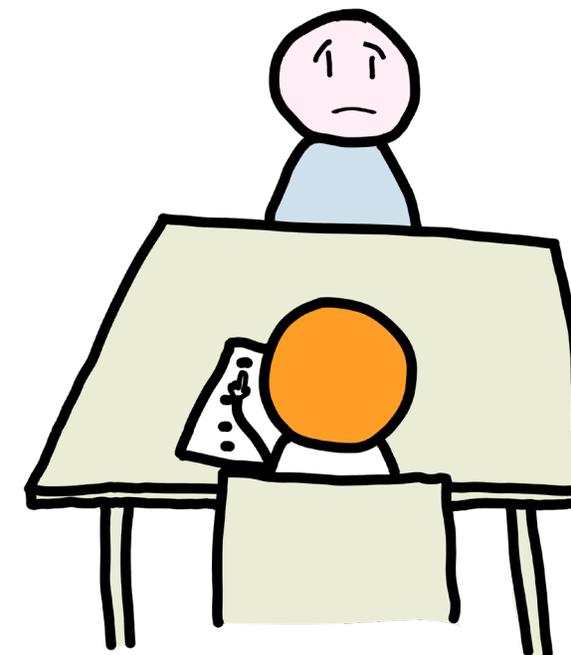
Negociar Objetivos

Ir con una propuesta y 100 argumentos que la avalen NO es negociar, es comunicar una decisión.

Clasificar los objetivos según importancia

- Innegociables
- Importantísimos
- Importantes
- Triviales

¿Para mí?
¿Para él?
¿Para los dos?





**Para dar mensajes
de forma eficaz**

Alimentación en diabetes tipo 2

Serafín Murillo

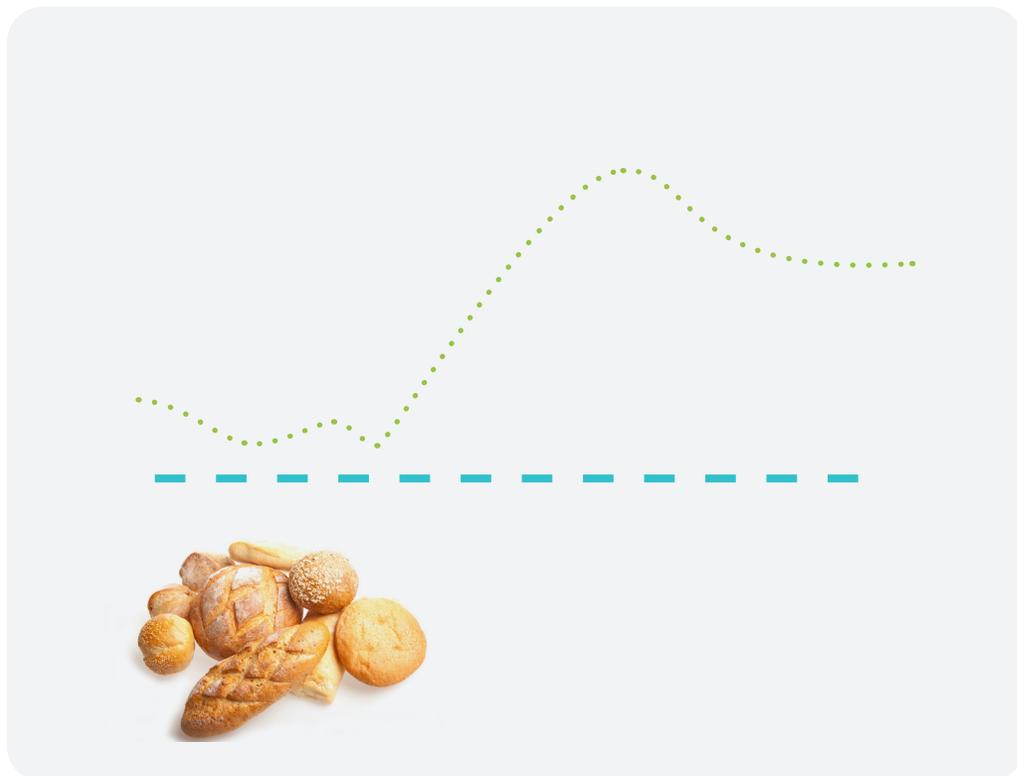
Dietista-Nutricionista

Universitat de Barcelona

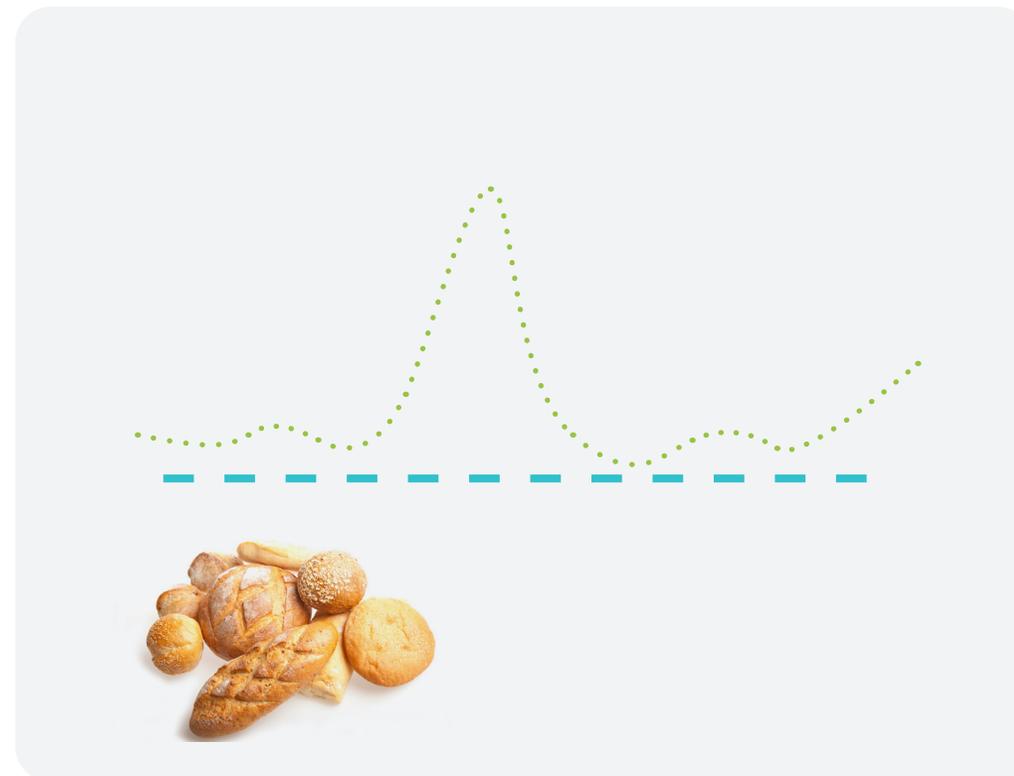
Hospital Sant Joan de Déu



Los perfiles de glucemia



Cantidad de hidratos de carbono



Tipo de hidratos de carbono



Control de los Hidratos de carbono

Control de los hidratos de carbono

Riesgo de hipoglucemia

Bajo

- Tiazolidinedionas
- Metformina
- Inhibidores alfa-glucosidasas
- Agonistas rGLP-1
- Inhibidores DPP-4
- Inhibidores SGLT2

Moderado

- Sulfonilureas
- Insulina (basal)
- Meglitinidas

Alto

- Insulina (basal bolus)



Control de los hidratos de carbono

Riesgo de hipoglucemia

Bajo

- Tiazolidinedionas
- Metformina
- Inhibidores alfa-glucosidasas
- Agonistas rGLP-1
- Inhibidores DPP-4
- Inhibidores SGLT2

Moderado

- Sulfonilureas
- Insulina (basal)
- Meglitinidas

Alto

- Insulina (basal bolus)



Libertad en cantidad y distribución de los hidratos de carbono

Control de la cantidad y distribución de los hidratos de carbono

Control de los hidratos de carbono

01 Lácteos				
Alimento	1 ración de HC (en gramos)	¿Cuántas raciones de HC contiene el alimento en su medida habitual?		LIG
		Medida Habitual	Raciones de HC	
Cuajado	175	Unidad (125ml)	0,6	35
Flan	45	Unidad (110g)	2,5	60
Helado de crema	50	Bola mediana (100g)	2	60
Helado de hielo	50	Tartina individual (150ml)	3	60
Helado "sin azúcares añadidos"	100	Unidad (100ml)	2	65
Leche desnatada	200	Unidad (200ml)	1	35
Leche semidesnatada	200	Vaso o taza (200ml)	1	30
Leche entera	200	Vaso o taza (200ml)	1	27
Leche condensada	20	Cuchara sopera (20g)	1	61
Leche en polvo	25	Cuchara sopera colmada (25g)	1	30
Kéfir	200	Unidad (125ml)	0,5	35
Nata líquida	300	Botellín o brick (200ml)	0,7	35
Natillas	50	Unidad (125ml)	2,5	60
Petit suisse	75	Unidad (50g)	0,6	40
Queso fresco	250	Tartina individual (70g)	0,5	35
Quesos de pasta, semis o curados	No valorable			
Yogur natural, entero o desnatado	200	Unidad (125ml)	0,5	35
Yogur desnatado, de sabores o fruta	150	Unidad (125ml)	0,8	35
Yogur entero, de sabores o fruta	70	Unidad (125ml)	1,5	35
Yogur tipo Activia	100	Unidad (100ml)	1	35
Yogur tipo Activia 0%	200	Unidad (100ml)	0,5	35
Yogur líquido	70	Unidad (200ml)	3	40

02 Cereales y derivados, harinas, legumbres y tubérculos				
Alimento	1 ración de HC (en gramos)	¿Cuántas raciones de HC contiene el alimento en su medida habitual?		LIG
		Medida Habitual	Raciones de HC	
Atrémuz	50	Tapa (30g)	0,6	35
Arroz blanco, crudo	13			
Arroz blanco, hervido	38	Plato grande (240g)	6	70
Arroz integral, crudo	13	Plato mediano (160g)	4	70
Arroz integral, cocido	40	Guarnición (80g)	2	85
Arroz trinchado para el desayuno	12			
Arroz salvaje, crudo	13			
Arroz salvaje, cocido	34	Plato grande (240g)	6	50
Avena, crudo	15	Plato mediano (160g)	4	50
Avena, hervido	34	Guarnición (80g)	2	50
Boniato	50	Tamaño pequeño (80g)	1,6	50
		Tamaño mediano (160g)	3,2	50
		Tamaño grande (320g)	6,4	50
Cebada, crudo	14			
Cebada, hervido	42			45
Certano, crudo	15			45
Certano, cocido	38			
Cereales desayuno (trigo)	15			77
Cereales desayuno, ricos en fibra (20g)	20			50
Cereales tipo muesli	15			65
Cuscús, crudo	15			

Tus manos como herramientas

Por LN Beatriz Portilla Camacho

La manera más común y la mejor para medir las porciones de los alimentos es utilizando tazas, cucharas, balanza o pesas, sin embargo, es imposible que a cualquier lugar al que vayas utilices estas medidas para controlar tus porciones, por esta razón aquí te explicamos una manera sencilla para medir las porciones de lo que comes usando tus manos como herramienta.

Por grupos de alimentos

Verduras y hortalizas

- Lechugas 1 taza =
- Espinacas lo que quepa en tus
- Brócoli dos manos juntas,
- Zanahoria ahuecadas.
- Jicama
- Pepino



Frutas

- Manzana ½ taza =
- Pera una mano,
- Mango ahuecada
- Papaya
- Fresas



Alimentos de origen animal

- Carnes cocidas 85 gramos = palma
- Hamburguesa de la mano
- Pechuga de pollo
- Filete de pescado
- Lomo de cerdo
- Pescado enlatado (atún, salmón)



Cereales

- Pasta 1 taza = el tamaño
- Cereal de caja de un puño cerrado
- Amaranto
- Granola



Aceites y grasas

- Mantequilla 1 cucharada =
- Margarina dos pulgares juntos
- Queso crema
- Mayonesa
- Crema ácida
- Aderezo para ensaladas
- Aceite de oliva



(Los tamaños de las porciones de cada grupo de alimentos, usan como guía la mano de una mujer adulta)





Aplanando la curva

Estrategias para reducir Índice y carga glucémica

Aplanando la curva

Definición

“Velocidad y magnitud con que los Hidratos de Carbono (HC) presentes en los alimentos aumentan la glucemia”.

No solo es la velocidad, sino el efecto que producen los HC en las 2 horas posteriores a ingerirlos.



¿Cómo se calcula?

Paso 1.

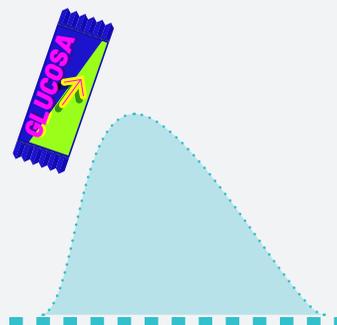
Se selecciona un grupo de personas sanas (mínimo 10 personas).

Esto se realiza en un laboratorio.



Paso 2.

Un día toman 50g de glucosa y se miden los valores de glucemia durante 2 horas (minuto 0, 15, 30, 45, 60, 90 y 120)



Día 1

Paso 3.

Otro día toman 50g hidratos de carbono en forma del alimento que se quiere estudiar. En el caso de la pera, unos 500g de pera aportan esos 50g de HC.

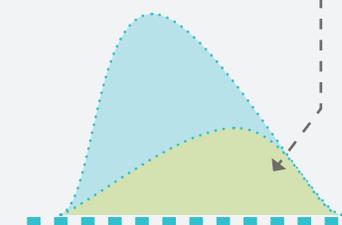


Día 2

Paso 4.

Se divide el Área Bajo la Curva obtenida con cada uno de los dos alimentos.

Esto de aquí es el área bajo la curva



● Día 1 ● Día 2

Aplanando la curva

REVIEW article

Front. Nutr., 10 November 2022

Sec. Nutrition and Metabolism

Volume 9 - 2022 |

<https://doi.org/10.3389/fnut.2022.1025993>

This article is part of the Research Topic

Food Digestibility and the Regulation of Glucose and Lipid Metabolism

[View all 6 Articles >](#)

Culinary strategies to manage glycemic response in people with type 2 diabetes: A narrative review



Serafin Murillo^{1,2,3},



Ariadna Mallol¹,



Alba Adot¹,



Fabiola Juárez¹,



Alba Coll¹,

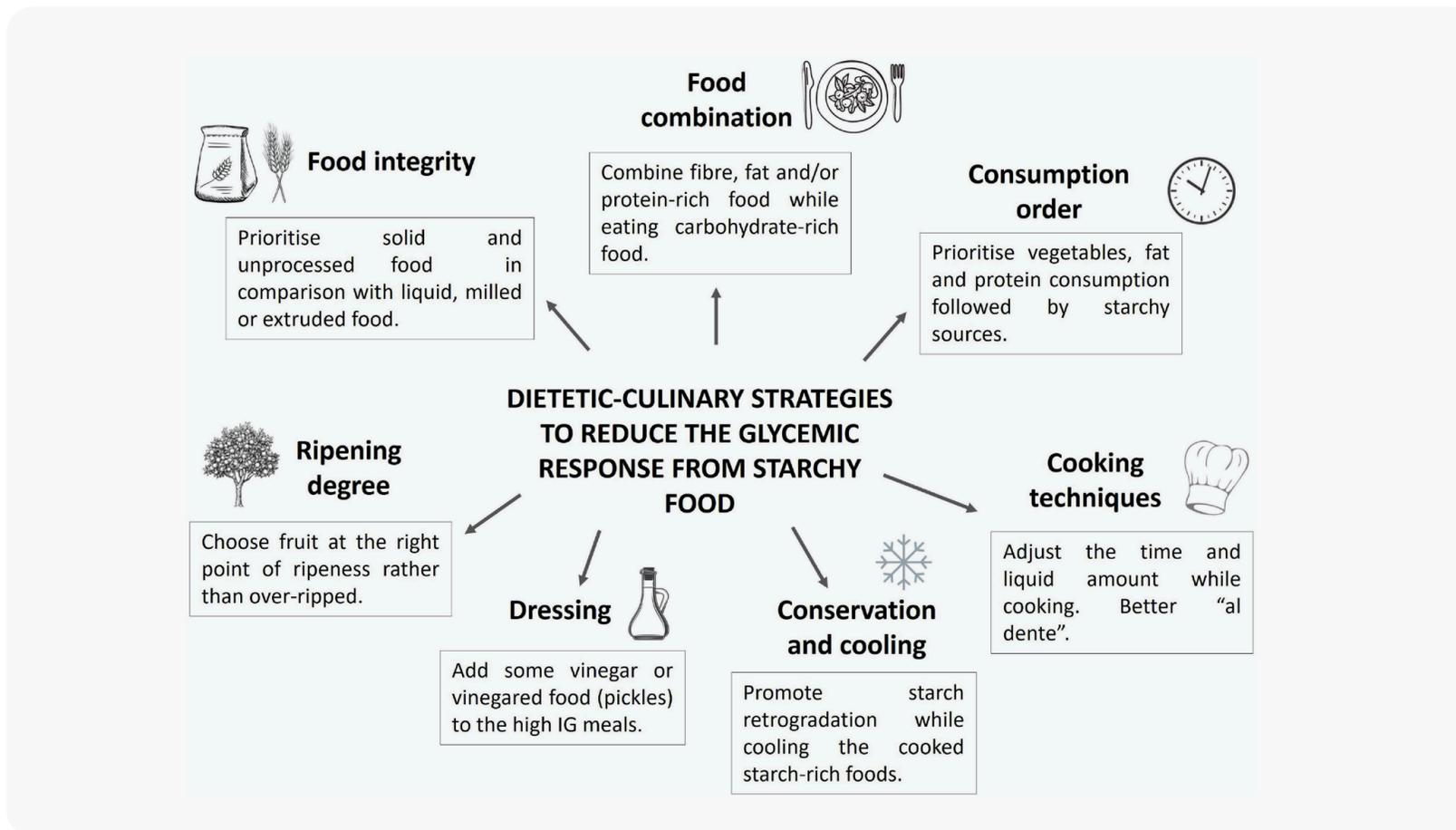


Isabella Gastaldo² and

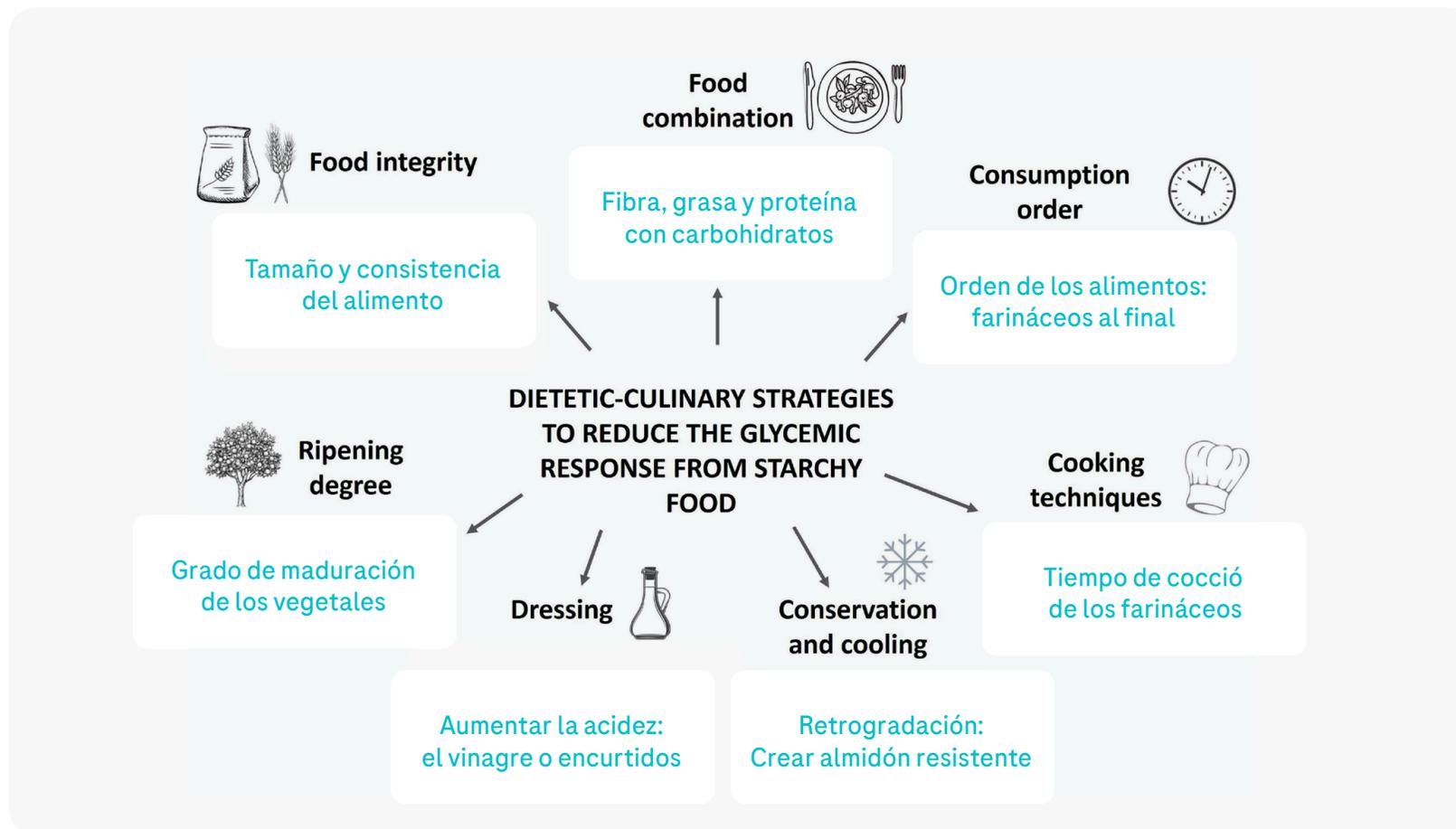


Elena Roura^{1*}

Aplanando la curva

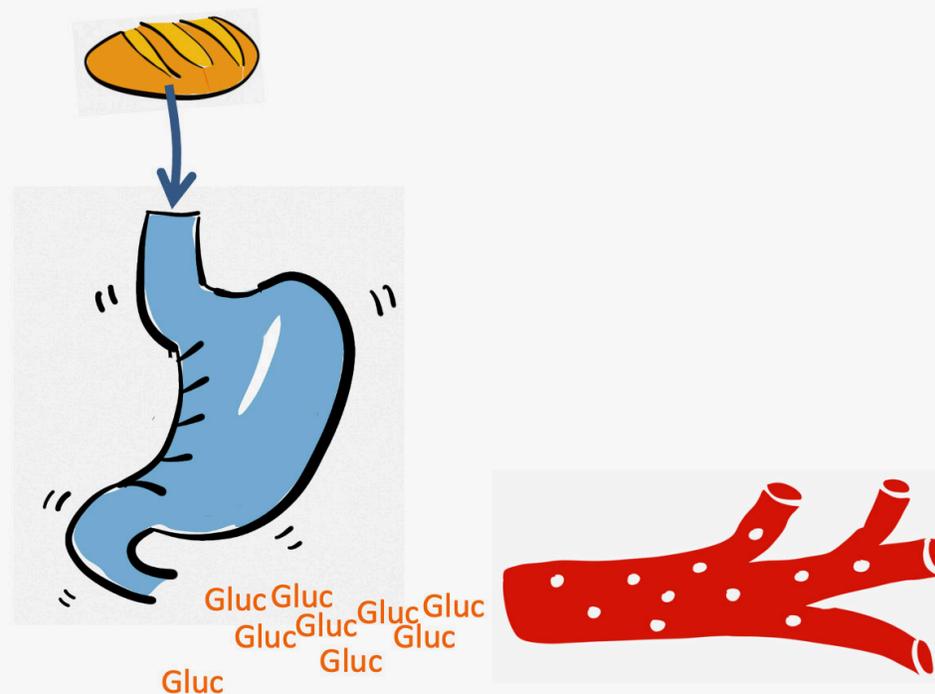


Aplanando la curva



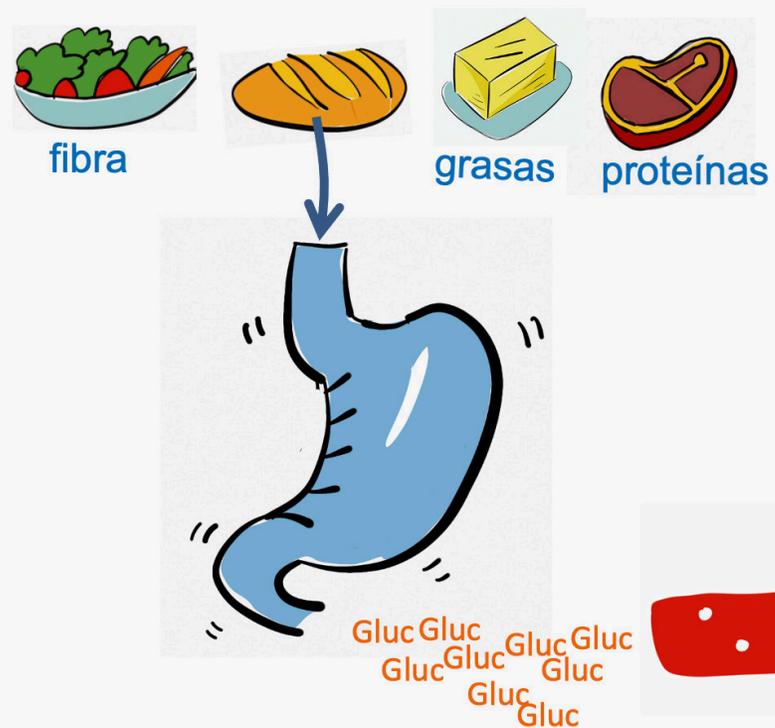
Aplanando la curva

Enlentece
la digestión
de los hidratos
de carbono



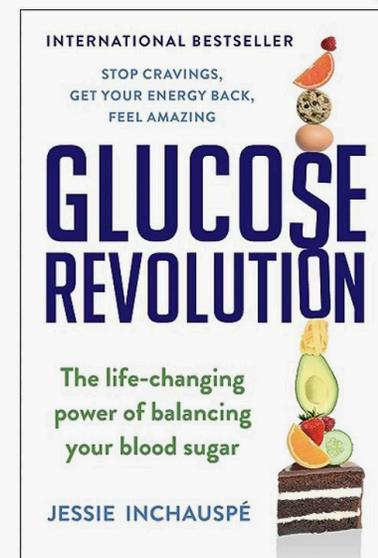
Aplanando la curva

**Enlentecer
la digestión
de los hidratos
de carbono**



Aplanando la curva

El **orden** de los
alimentos **importa**



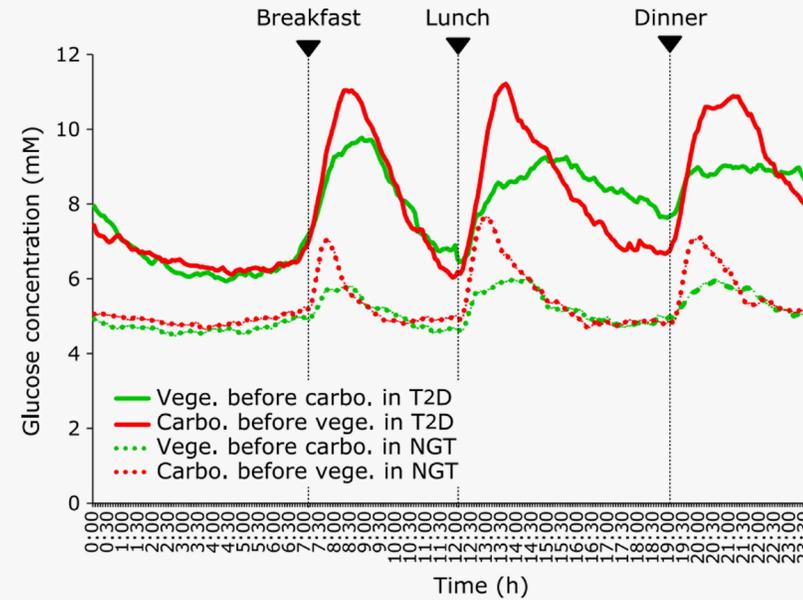
Aplanando la curva

Effect of eating vegetables before carbohydrates on glucose excursions in patients with type 2 diabetes

Saeko Imai,^{1,*} Michiaki Fukui² and Shizuo Kajiyama^{2,3}

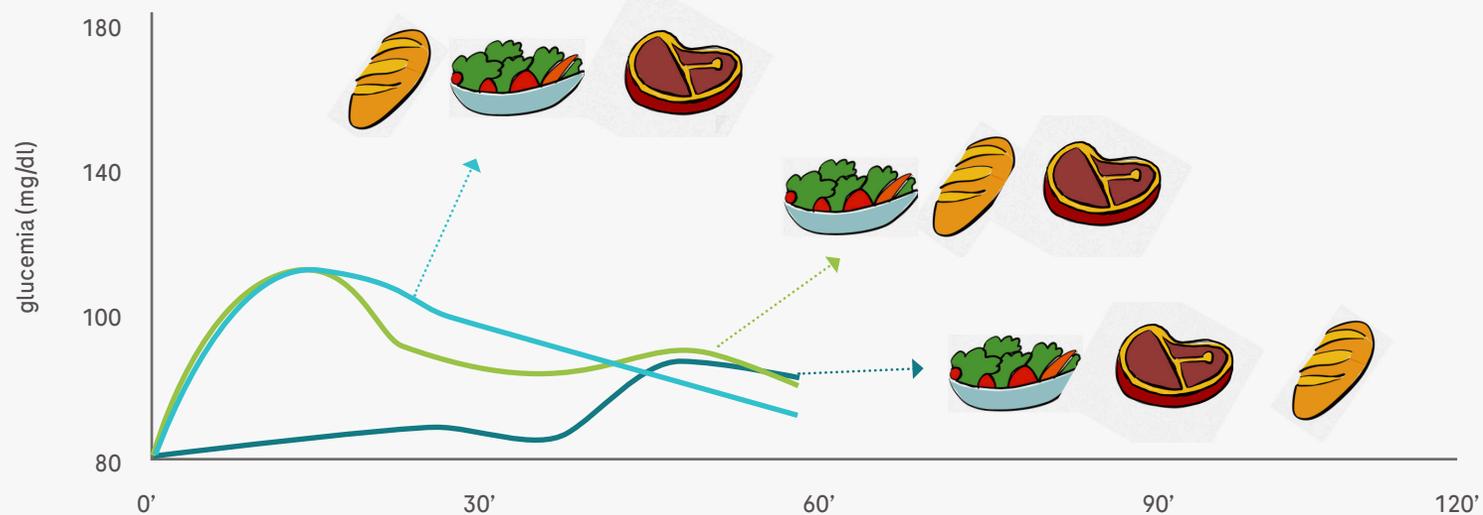
¹School of Comprehensive Rehabilitation, Osaka Prefecture University, 3-7-30 Habikino, Habikino-shi, Osaka 583-8555, Japan
²Department of Endocrinology and Metabolism, Kyoto Prefectural University of Medicine, Graduate School of Medical Science, 465 Kajii-cho, Kawaramachi-Hirokoji, Kamigyo-ku, Kyoto 602-8566, Japan
³Kajiyama Clinic, 25-1-136 Oiwake-cho, Saiin, Ukyo-ku, Kyoto 615-0035, Japan

(Received 5 August, 2013; Accepted 28 October, 2013; Published online 27 December, 2013)



Aplanando la curva

Farináceos al final de las comidas



Aplanando la curva

Farináceos al final de las comidas

Table 2. Summary of findings from GRADE assessments.

Outcome	Effect	Number of participants (trials)	Certainty of evidence
PPG	10 of 10 trials found that, in conditions where carbohydrate-rich foods were eaten last or in the last portion of the meal, PPG was lower as a function of AUC, peak glucose, and/or glucose at some timepoints (particularly within 90 minutes of feeding)	194 (10)	⊕⊕⊕⊕†
PPI	7 of 7 trials observed at least one PPI outcome that was lower after eating carbohydrate-rich foods at the end of a meal.	103 (7)	⊕⊕⊕⊕†
GLP-1	GLP-1, as measured by AUC postprandially, tended to be higher with carbohydrate-last eating conditions in 3 of 3 trials.	54 (3)	⊕⊕⊕⊕†

Table 2. Summary of findings from GRADE assessments.

Outcome	Effect	Number of participants (trials)	Certainty of evidence
GIP	Inconsistent effects were observed for time-course changes.	38 (2)	⊕⊕⊕⊕†‡
Ghrelin	1 trial showed no effect of food order, while 1 showed that eating carbohydrate-rich foods last led to a greater suppression after 3 h.	32 (2)	⊕⊕⊕⊕†‡
Eating-related perceptions (hunger, fullness/satiety, etc.)	No effects of food order were observed.	32 (2)	⊕⊕⊕⊕†‡

⊕⊕⊕⊕ = high certainty; ⊕⊕⊕⊕ = moderate certainty; ⊕⊕⊕⊕ = low certainty; ⊕⊕⊕⊕ = very low certainty. †Downgraded one level due to imprecision. ‡Downgraded one level due to methodological limitations. §Downgraded one level due to inconsistency. AUC: area under the curve; GIP: gastric inhibitory peptide; GLP-1: glucagon-like peptide-1; PPG: postprandial glucose; PPI: postprandial insulin.

Aplanando la curva

Crear almidón resistente



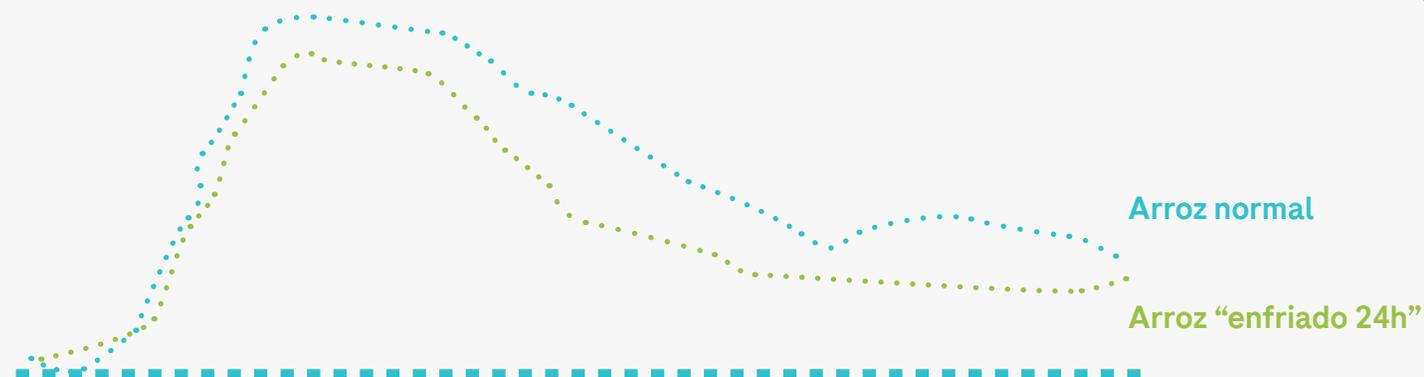
TABLE 1 Classification of types of resistant starch (RS) and food sources [adapted from Raigond, et al. (46)].

Type of resistant starch	Description	Food sources
RS1	Physically inaccessible, non-digestible matrix	Whole or partly milled grains and seeds
RS2	Ungelatinized resistant starch granules	Raw potato starch, green bananas, high-amylose corn starch
RS3	Retrograded starch (cooled gelatinized starch)	Cooked and cooled potato, bread, pasta, rice, food products with repeated moist heat treatment
RS4	Chemically modified starch	Etherized, esterified or cross-bonded starches (used in processed foods: breads, cakes)

Each of the different modifications that foods can undergo and their impact on GR are detailed below.

Aplanando la curva

Retrogradación almidón resistente



Arroz
Pasta
Patata

01.

Hervir

02.

Enfriar 24h (nevera)

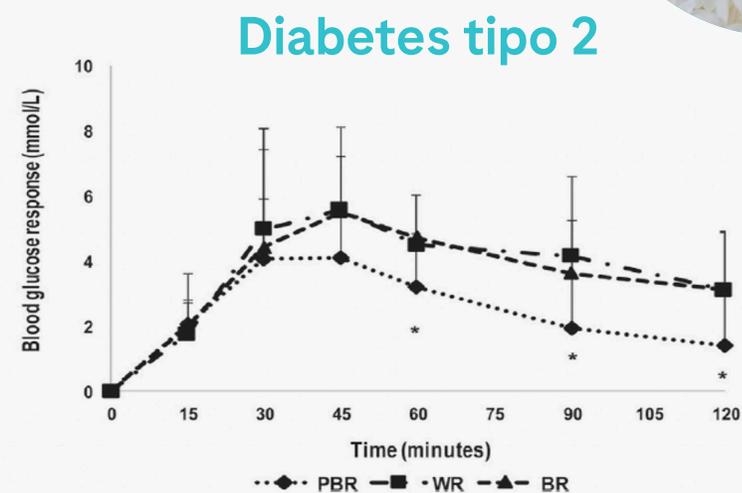
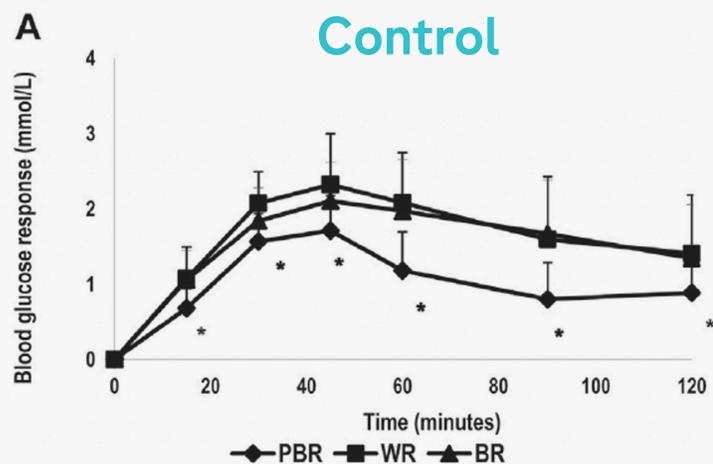
03.

Comer (se puede calentar)

Aplanando la curva



Retrogradación almidón resistente



Aplanando la curva

Vinagre y respuesta postprandial



DIABETES RESEARCH AND CLINICAL PRACTICE I 27 (2017) 1–9



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Diabetes Research
and Clinical Practice

journal homepage: www.elsevier.com/locate/diabres



International
Diabetes
Federation



Review

Vinegar consumption can attenuate postprandial glucose and insulin responses; a systematic review and meta-analysis of clinical trials



Aplanando la curva

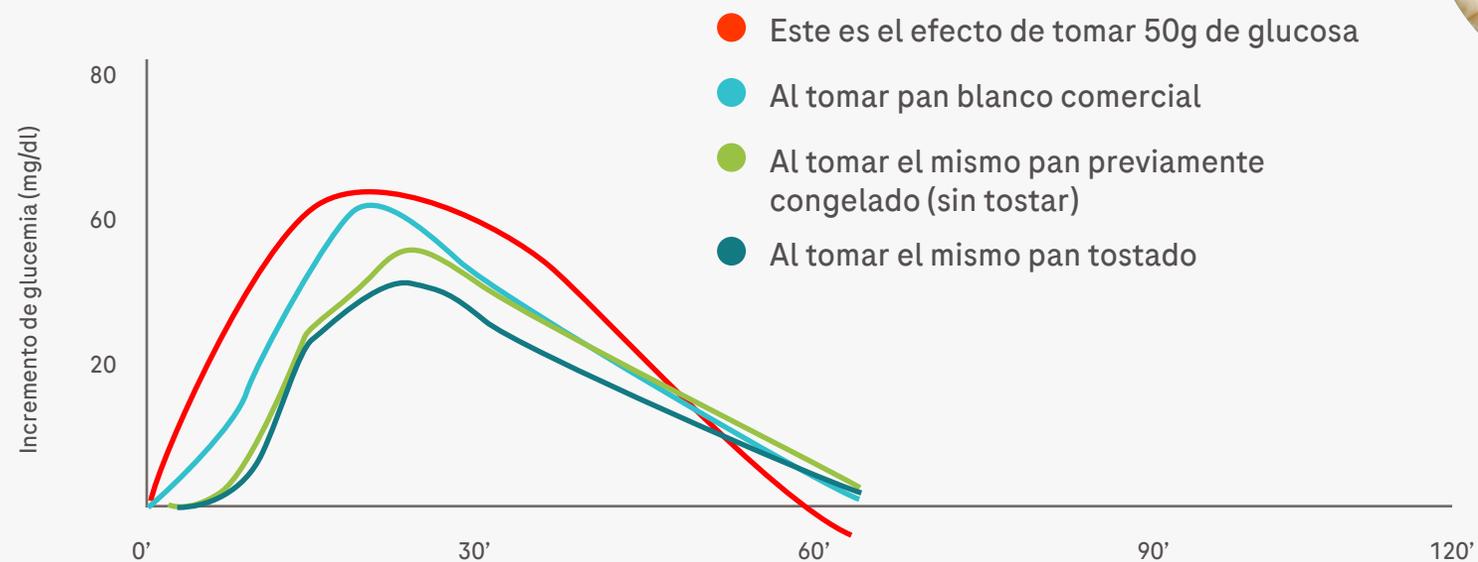
Table 2 – Subgroup analyses of the effect of vinegar consumption on glucose AUC.

	No. of comparisons	Quantitative data analysis			Heterogeneity analysis	
		SMD (95% CI)	Z value	P value	I ² , %	P value
Overall effect	20	-0.60(-1.08, -0.11)	2.42	<0.001	80.2	<0.001
Vinegar type						
Apple cider vinegar	5	-0.90(-1.32, -0.48)	4.27	<0.001	0.0	0.80
White vinegar	12	-0.64 (-0.92, -0.37)	4.64	<0.001	67.6	<0.001
Participants' glucose homeostasis disorders						
Without ^a	10	-0.46 (-0.75, -0.17)	3.16	0.002	14	0.31
With ^b	10	-0.74 (-1.06, -0.41)	4.50	<0.001	89.2	<0.001

SMD, standard mean difference.
^a Without glycemc disorders.
^b Diabetes, impaired glucose tolerance or insulin resistant.

Aplanando la curva

Técnicas de cocción



Aplanando la curva

Técnicas de cocción

¡Este estudio lo explicó en 1986!

Glycemic Response to Pasta: Effect of Surface Area, Degree of Cooking, and Protein Enrichment

T. M. S. WOLEVER, BM, MSc, D. J. A. JENKINS, DM, J. KALMUSKY, RPhD, C. GIORDANO, RPhD, S. GIUDICI, RPhD, A. L. JENKINS, RPhD, L. U. THOMPSON, PhD, G. S. WONG, MD, AND R. G. JOSSE, MD

To see whether food form, the degree of cooking, or protein enrichment affected the glycemic response to pasta, we gave test-meal breakfasts to 13 diabetic patients. Macaroni had a significantly greater glycemic index (GI) (68 ± 9) than spaghetti (45 ± 6 , $P < .01$); the GI of star pasta was intermediate (54 ± 6). The GI of spaghetti was not significantly affected by cooking for 5 or 15 min (45 ± 6 and 46 ± 5 , respectively), or by protein enrichment (38 ± 4). The GI of spaghetti was similar in 11 non-

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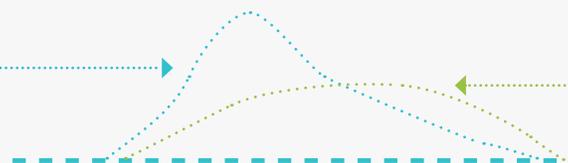
Más tiempo de cocción, más rápido aumentan la glucemia



Arroz
Pasta

Tiempo cocción 15'

Tiempo de espera de unos 15-20'



Tiempo cocción entre 5-10'

No necesita tiempo de espera entre insulina y empezar a comer

Aplanando la curva

Otros factores

Factor	Effect
 <p>Eating during Daylight vs Nighttime</p>	<p>Eating earlier in the day (lunch time): Improves body weight control Improves glycemic control, ↓ postprandial glucose peak ↑ Postprandial insulin (secretion/sensitivity), ↑ GLP-1 ↓ Diabetes risk Improves hunger regulation (via aligning with normal daily oscillations of ghrelin)</p>
 <p>Carbohydrates</p>	<p>Less CHO in the meals/day and less readily available CHO: ↓ Postprandial glucose excursions ↑ Insulin responses ↓ Insulin resistance Early consumption of CHO: ↓ postprandial glucose, insulin, GLP-1</p>
 <p>Protein/Fat Preload</p>	<p>Prolong gastric emptying ↓ Absorption of CHO ↓ Postprandial glucose ↑ Insulin release Improves β-cell function ↑ GLP-1 ↑ Satiety</p>
 <p>Fibers</p>	<p>↓ Absorption of CHO ↓ Gastric emptying ↓ Postprandial glucose ↑ Satiety ↓ Risk for diabetes</p>

Aplanando la curva

Otros factores

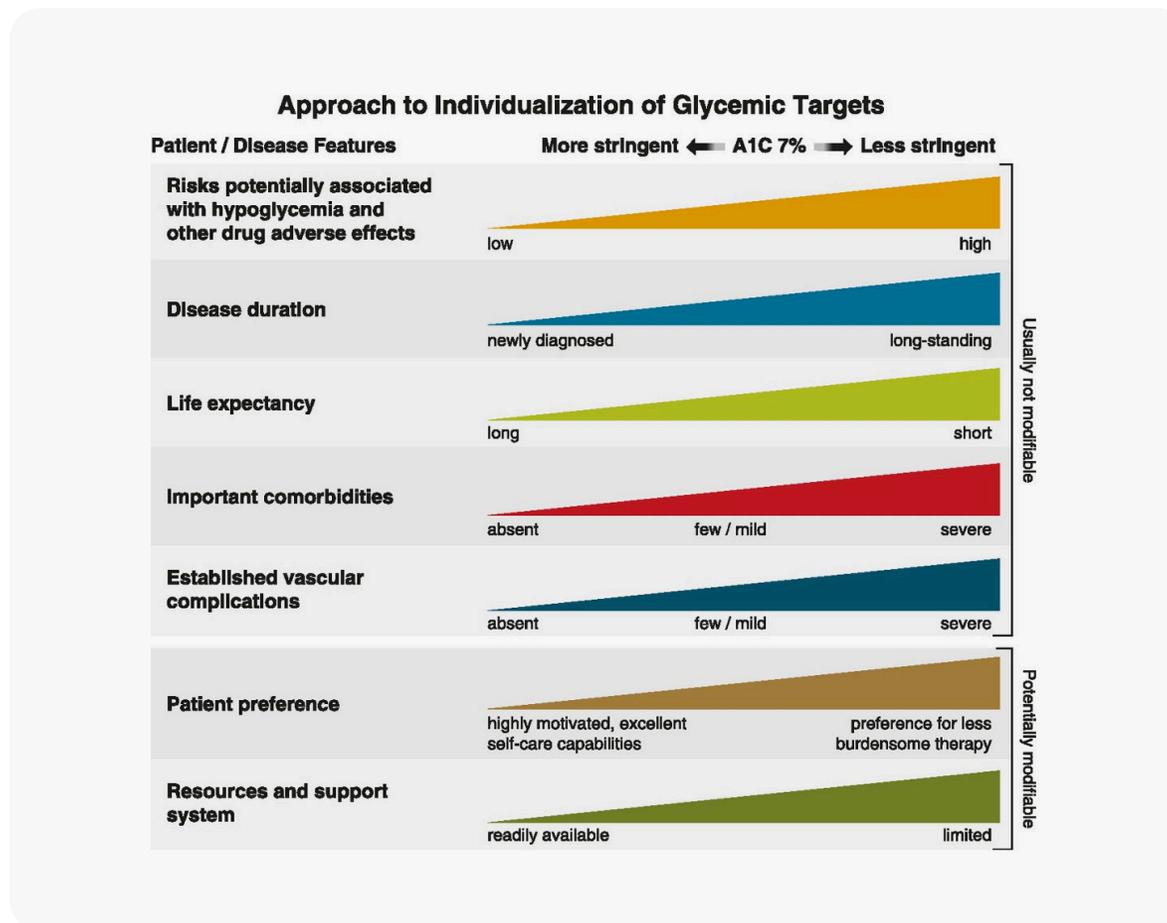
Factor	Effect
 <p>Slow vs Fast Eating</p>	<p>Fast eaters: Weight gain, ↑ Postprandial glucose peaks, ↑ Daily glycemc excursions</p> <p>Slow eaters: Enhanced diet-induced thermogenesis, ↑ Serum adiponectin, ↓ NEFA, ↓ IL-1β/IL-6 and positive influence on Ghrelin and PYY</p>
 <p>Exercise / Physical Activity</p>	<p>↓ Postprandial glucose, ↓ Body weight, ↓ Fasting/Postprandial insulin, ↓ HOMA ↓ HbA1c, ↓ Diabetes risk, ↓ Triglycerides, ↓ CVD risk ↑ IRS1 and GLUT1/GLUT4 activity, ↑ HDL</p>
 <p>cinnamon, yogurt, vinegar, whey protein, tree nuts, polyphenols</p>	<p>↓ Diabetes risk Trend towards improved glycemia (↑ Insulin, ↓ HbA1c, ↓ postprandial hyperglycemia) Improves lipidemia (↓ chol, ↓ TG, ↓ LDL, ↑ HDL) ↓ CHO intestinal absorption due to fat content Delay gastric emptying (vinegar) Delay digestion of CHO (vinegar) Improves muscle glucose uptake (vinegar)</p>



Valoración del caso

No todo es la diabetes tipo 2

Valoración del caso



Valoración del caso

Table 12.1—Framework for considering treatment goals for glycemia, blood pressure, and dyslipidemia in older adults with diabetes

Patient characteristics/ health status	Rationale	Reasonable A1C goal‡	Fasting or preprandial glucose	Bedtime glucose	Blood pressure	Lipids
Healthy (few coexisting chronic illnesses, intact cognitive and functional status)	Longer remaining life expectancy	<7.0–7.5% (53–58 mmol/mol)	80–130 mg/dL (4.4–7.2 mmol/L)	80–180 mg/dL (4.4–10.0 mmol/L)	<140/90 mmHg	Statin unless contraindicated or not tolerated
Complex/ intermediate (multiple coexisting chronic illnesses* or 2+ instrumental ADL impairments or mild-to-moderate cognitive impairment)	Intermediate remaining life expectancy, high treatment burden, hypoglycemia vulnerability, fall risk	<8.0% (64 mmol/mol)	90–150 mg/dL (5.0–8.3 mmol/L)	100–180 mg/dL (5.6–10.0 mmol/L)	<140/90 mmHg	Statin unless contraindicated or not tolerated
Very complex/poor health (LTC or end- stage chronic illnesses** or moderate-to- severe cognitive impairment or 2+ ADL impairments)	Limited remaining life expectancy makes benefit uncertain	Avoid reliance on A1C; glucose control decisions should be based on avoiding hypoglycemia and symptomatic hyperglycemia	100–180 mg/dL (5.6–10.0 mmol/L)	110–200 mg/dL (6.1–11.1 mmol/L)	<150/90 mmHg	Consider likelihood of benefit with statin

This table represents a consensus framework for considering treatment goals for glycemia, blood pressure, and dyslipidemia in older adults with diabetes. The patient characteristic categories are general concepts. Not every patient will clearly fall into a particular category. Consideration of patient and caregiver preferences is an important aspect of treatment individualization. Additionally, a patient's health status and preferences may change over time. ADL, activities of daily living; LTC, long-term care. ‡A lower A1C goal may be set for an individual if achievable without recurrent or severe hypoglycemia or undue treatment burden. *Coexisting chronic illnesses are conditions serious enough to require medications or lifestyle management and may include arthritis, cancer, congestive heart failure, depression, emphysema, falls, hypertension, incontinence, stage 3 or worse chronic kidney disease, myocardial infarction, and stroke. "Multiple" means at least three, but many patients may have five or more (50). **The presence of a single end-stage chronic illness, such as stage 3–4 congestive heart failure or oxygen-dependent lung disease, chronic kidney disease requiring dialysis, or uncontrolled metastatic cancer, may cause significant symptoms or impairment of functional status and significantly reduce life expectancy. Adapted from Kirkman et al. (3).

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(multiple coexisting chronic illnesses* or 2+ instrumental ADL impairments or mild-to-moderate cognitive impairment)	expectancy, high treatment burden, hypoglycemia vulnerability, fall risk		mmol/L	mmol/L		or not tolerated
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Healthy (few complex/ intermediate (multiple coexisting chronic illnesses* or 2+ instrumental ADL impairments or mild-to-moderate cognitive impairment)	Longer remaining remaining life expectancy, high treatment burden, hypoglycemia vulnerability, fall risk	<7.0–7.5% <8.0% (64 mmol/mol)				

moderate-to-severe cognitive impairment or 2+ ADL impairments) hypoglycemia and symptomatic hyperglycemia

This table represents a consensus framework for considering treatment goals for glycemia, blood pressure, and dyslipidemia in older adults with diabetes. The patient characteristic categories are general concepts. Not every patient will clearly fall into a particular category. Consideration of patient and caregiver preferences is an important aspect of treatment individualization. Additionally, a patient's health status and preferences may change over time. ADL, activities of daily living; LTC, long-term care. ‡A lower A1C goal may be set for an individual if achievable without recurrent or severe hypoglycemia or undue treatment burden. *Coexisting chronic illnesses are conditions serious enough to require medications or lifestyle management and may include arthritis, cancer, congestive heart failure, depression, emphysema, falls, hypertension, incontinence, stage 3 or worse chronic kidney disease, myocardial infarction, and stroke. **Multiple means at least three, but many patients may have five or more (50). **The presence of a single end-stage chronic illness, such as stage 3–4 congestive heart failure or oxygen-dependent lung disease, chronic kidney disease requiring dialysis, or uncontrolled metastatic cancer, may cause significant symptoms or impairment of functional status and significantly reduce life expectancy. Adapted from Kirkman et al. (3).

Valoración del caso

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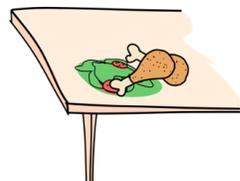
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Complex/ intermediate (multiple coexisting chronic illnesses* or 2+ instrumental ADL impairments or hypoalbuminemia)	Intermediate remaining life expectancy, high treatment burden, hypoglycemia	<8.0% (64 mmol/mol)	90–150 mg/dL (5.0–8.3 mmol/L)	100–180 mg/dL (5.6–10.0 mmol/L)	<140/90 mmHg	Statin unless contraindicated or not tolerated

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†A1C goal should be individualized based on patient characteristics, comorbidities, and treatment burden. *Coexisting chronic illnesses are conditions serious enough to require medications or lifestyle management and may include arthritis, cancer, congestive heart failure, depression, emphysema, falls, hypertension, incontinence, stage 3 or worse chronic kidney disease, myocardial infarction, and stroke. **The presence of a single end-stage chronic illness, such as stage 3–4 congestive heart failure or oxygen-dependent lung disease, chronic kidney disease requiring dialysis, or uncontrolled metastatic cancer, may cause significant symptoms or impairment of functional status and significantly reduce life expectancy. Adapted from Kirkman et al. (3).

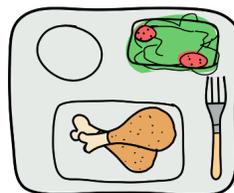
Para dar mensajes de forma eficaz

Desparramado sobre
la mesa



Debes dejar de cenar
tantos carbohidratos.

En bandeja de metal



Por tu salud, debes
dejar de cenar tantos
carbohidratos.

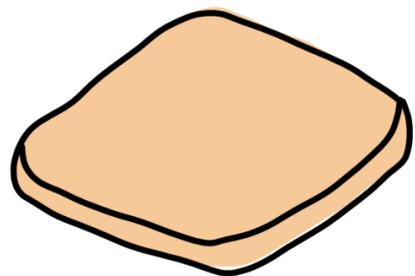
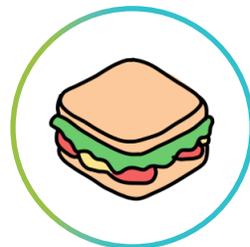
En plato



Estoy seguro de que
puedes, **pero** debes
dejar de cenar tantos
carbohidratos.

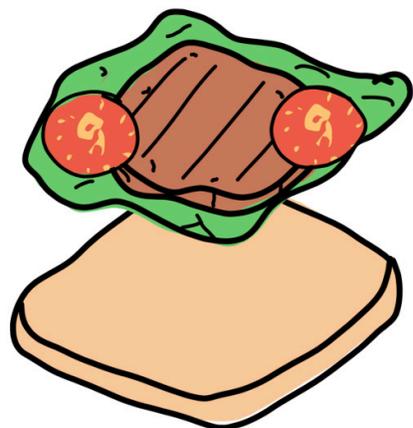
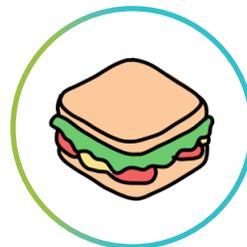
Debes dejar de cenar
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Para dar mensajes de forma eficaz



Capa de apertura: Empezar reconociendo las fortalezas y cualidades positivas.

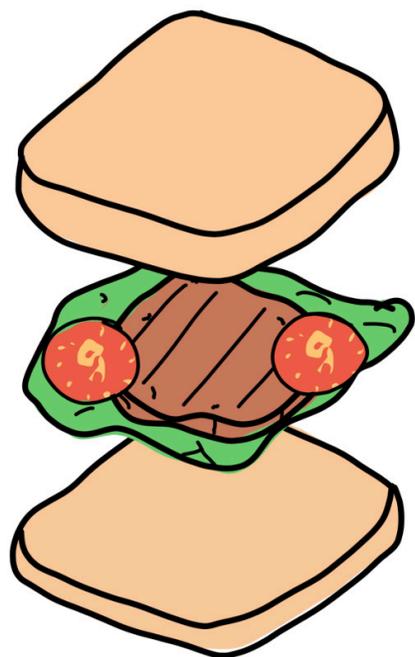
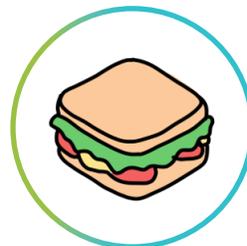
Para dar mensajes de forma eficaz



Capa central: Se aborda el cambio de conducta de forma clara, específica y objetiva.

Capa de apertura: Empezar reconociendo las fortalezas y cualidades positivas.

Para dar mensajes de forma eficaz

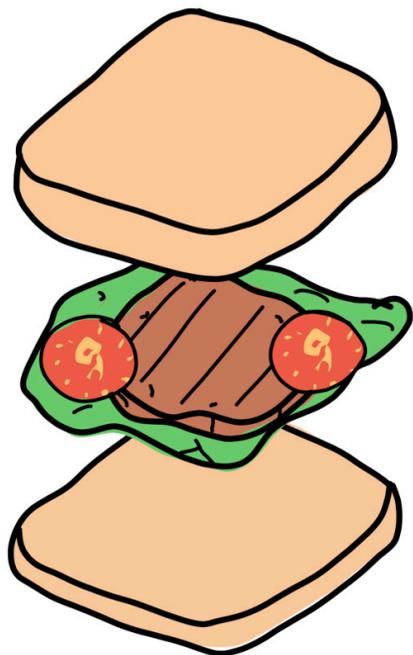
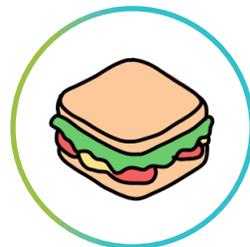


Capa de cierre: Reiterar nuestro apoyo y mostrar confianza en su capacidad de cambio.

Capa central: Se aborda el cambio de conducta de forma clara, específica y objetiva.

Capa de apertura: Empezar reconociendo las fortalezas y cualidades positivas.

Para dar mensajes de forma eficaz



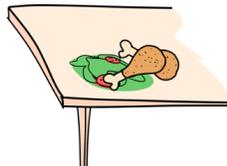
Estoy convencido de que con la ayuda de tu hija y con la mía puedes lograrlo.

Por eso te propongo reducir el consumo de carbohidratos de la cena.

Creo que eres una persona muy comprometida con su salud.

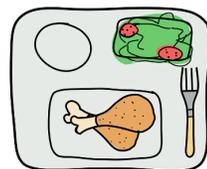
Para dar mensajes de forma eficaz

Desparramado sobre la mesa



Debes dejar de cenar tantos carbohidratos.

En bandeja de metal



Por tu salud, debes dejar de cenar tantos carbohidratos.

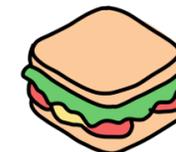
En plato



Estoy seguro de que puedes, **pero** debes dejar de cenar tantos carbohidratos.

Debes dejar de cenar tantos carbohidratos **pero** estoy seguro de que puedes.

En sándwich



Creo que eres una persona muy comprometida con tu salud.

Por eso te propongo reducir el consumo de carbohidratos de la cena.

Estoy convencido de que con la ayuda de tu hija y con la mía podrás lograrlo.

ACCU-CHEK®

Connecting what counts.