Q178: list the criteria of hyperosmolar non ketonic coma.

1. Blood glucose concentration may exceed so mmol/L
2. Cerebral cellular dehydration which contributes to coma
3. Hyperventilation
4. Hypernatremia due to predominant water loss

Q179: outline (Tabulate) the clinical and biochemical features of diabetic patient presenting in coma due to

a. Hypoglycemia
b. Ketoacidosis
c. Hyperosmolar coma
d. Lactic acidosis
e. Uremia
f. Cerebrovascular accidents

Q180: metros the types of coma other than hyperosmolar ketotic and non ketotic in diabetics?

Q181: why is it necessary to give prompt glucose replacement? What is the recommended dose of glucose that must be prescribed in such case?

Q182: when there is no intravenous access of intravenous glucose solution (50 ml – 20% glucose) in the case of hypoglycemia?

Q183: explain briefly the repletion of fluid electrolytes in diabetic ketoacidosis?

Q184: why is it important to monitor central venous pressure in diabetic ketoacidosis?

Q185: at what plasma glucose level soluble insulin must be administered?

Q186: at what PH level, bicarbonate must be infused in diabetic ketoacidosis? At what extent of PH must the infusion stopped?

Q187: why is it very important for the good control of bicarbonate infusion in ketoacidosis?

Q188: why is it necessary to measure plasma potassium before insulin is given to patients with ketoacidosis?

Q189: what is the importance of intravenous heparin 5000 D 8 hourly in diabetic ketoacidosis conditions?

Q190: list the steps for the initial investigation of a diabetic patient presenting in coma.

Q191: according to WHO criteria, how is diabetes mellitus confirmed?

Q192: At what plasma glucose level is diabetes mellitus unlikely?

Q193: what are the indications for performing OGTT to diagnose diabetes mellitus?

Q194: at what case dose OGTT become important other than D.M. diagnosis?

Q195: briefly state the procedure for oral glucose tolerate test.

Q196: explain how is OGTT interpreted in the following cases:

1. Diabetes mellitus unlikely.
2. Impaired glucose tolerance.
3. Impaired fasting glucose.
4. Diabetes mellitus.

Q197: what are the causes of result differences in the radius of blood sugar when using venous plasma, venous whole blood and capillary whole blood?

Q198: list down the factors which affect OGTT results?

Q199: "There is controversy in the interpretation of OGTT results during pregnancy", explain why?

Q200: define hypoglycemia? How is it diagnosed in the laboratory?

Q201: what is meant by "Pseudo hypoglycemia"?

Q202: when does hypoglycemia symptoms appear at plasma sugar concentration of higher than 2.5 mmol/L?

Q203: what is the cause of the clinical symptoms associated with hypoglycemia? Mention those symptoms.

Q204: define "Neuroglycopenia"

Q205: what is the "whipple's traid" of hypoglycemia?

Q206: how is hypoglycemia classified?

Q207: explain how is hypoinsulinemia hypoglycemia diagnosed in the laboratory?

Q208: list the endocrine causes of hypoglycemia.

Q209: "Impaired liver function may lead to hypoglycemia", explain why?

Q210: why do renal failure lead sometimes to hypoglycemia?

Q211: outline the causes of hypoglycemia in diabetic patients?

Q212: "Measurement of plasma C-peptide may help to differentiate exogenous insulin administration", explain why?

Q213: what is the response of insulin antibodies?

Q214: what is the cause of reactive hypoglycemia?

Q215: what is the cause of "late dumping syndrome"?

Q216: what is the cause of alcohol – induced hypoglycemia?

Q217: what is the causes of neonatal of children hypoglycemia?