

ANSWERS TO PSAP 2013 BOOK 1 (CARDIOLOGY/ENDOCRINOLOGY)



ENDOCRINOLOGY I

NEW PHARMACOTHERAPIES FOR TYPE 2 DIABETES

Questions 1 and 2 pertain to the following case.

R.S., a 34-year-old man (weight 86 kg) with type 2 diabetes mellitus (T2DM) and an A1C of 10.2%, is being converted from oral diabetes drug therapy to basal/bolus insulin with insulin glargine and insulin aspart. His endocrinologist wants to start R.S.'s total daily insulin at 0.5 unit/kg/day.

1. Which one of the following is the most appropriate initial dose estimate of rapid-acting insulin aspart before breakfast for R.S.?
- A. 2.
 - B. 4.
 - C. 7.
 - D. 14.

1. Answer: C

This patient's total daily insulin (TDI) requirements equal 43 units (86 kg \times 0.5 unit/kg/day). Half of this is usually used for basal insulin requirements and half for bolus insulin requirements before meals. The 21 units for bolus requirements should initially be divided equally between three meals (i.e., 7 units, Answer C, is correct). The other three options would provide either too much or too little estimated insulin at each meal. Answers A and B would likely not provide enough insulin at meal time and lead to hyperglycemia, whereas Answer D has the potential to cause hypoglycemia because it could provide too much insulin.

1. Peters K. Intensifying treatment of type 2 diabetes mellitus: adding insulin. *Pharmacotherapy* 2011;31(12 suppl):545-645. [PubMed Link](#)
2. Garber A. Insulin intensification strategies in type 2 diabetes when one injection is no longer sufficient. *Diabetes Care* 2009;32(5 suppl):1-6. [PubMed Link](#)

2. After initiating and assessing the basal and bolus insulin regimen as accurate in this patient, which one of the following is the best estimate for how much 1 unit of insulin aspart would decrease R.S.'s serum glucose concentration in the case of hyperglycemic excursions?
- A. 10.
 - B. 20.
 - C. 40.
 - D. 80.

2. Answer: C

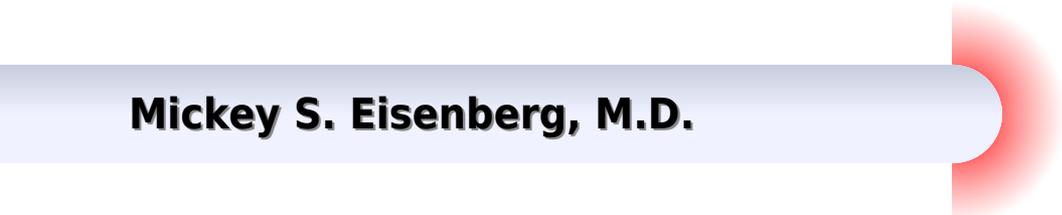
Again, this patient's TDI equals 43 units. The rule of 1800 (i.e., the quotient 1800/TDI) is commonly used to estimate correctional insulin requirements and gives the approximate milligram-per-deciliters decrease in plasma glucose 1 unit of rapid-acting insulin may attain. In this case 1800/43 = 42 (Answer C is correct). Hence, 1 unit of insulin aspart would be expected to lower his glucose concentration 42 mg/dL. Answer A and Answer B underestimate the decrease in glucose concentration, whereas Answer D overestimates it.

1. Peters K. Intensifying treatment of type 2 diabetes mellitus: adding insulin. *Pharmacotherapy* 2011;31(12 suppl):545-645. [PubMed Link](#)
2. Correction factor: The 1800 rule for determining your correction factor. [Internet Link](#)

3. A patient with T2DM is currently receiving an insulin-only regimen of premixed insulin 70/30. The morning dose is 20 units before breakfast, and the evening dose is 10 units before dinner. The patient has frequent bouts of low blood glucose concentrations between 1 a.m. and 3 a.m. The average morning fasting glucose concentration is 75 mg/dL, and the average after-dinner glucose concentration is 250 mg/dL. Which one of the following would be the best option for this patient to optimize glycemic control?
- A. Convert to insulin glargine and glulisine.

Psap 2013 1 Cardiology Answers

Mickey S. Eisenberg, M.D.



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Emergency Medical Services, 2 Volumes Jane H. Brice, Theodore R. Delbridge, J. Brent Myers, 2021-11-17 The two volume Emergency Medical Services Clinical Practice and Systems Oversight delivers a thorough foundation upon which to succeed as an EMS medical director and prepare for the NAEMSP National EMS Medical Directors Course and Practicum Focusing on EMS in the real world the book offers specific management tools that will be useful in the reader's own local EMS system and provides contextual understanding of how EMS functions within the broader emergency care system at a state local and national level The two volumes offer the core knowledge trainees will need to successfully complete their training and begin their career as EMS physicians regardless of the EMS systems in use in their areas A companion website rounds out the book's offerings with audio and video clips of EMS best practice in action Readers will also benefit from the inclusion of A thorough introduction to the history of EMS An exploration of EMS airway management including procedures and challenges as well as how to manage ventilation oxygenation and breathing in patients including cases of respiratory distress Practical discussions of medical problems including the challenges posed by the undifferentiated patient altered mental status cardiac arrest and dysrhythmias seizures stroke and allergic reactions An examination of EMS systems structure and leadership

Emergency Medical Services Jane H. Brice, Theodore R. Delbridge, J. Brent Myers, 2021-08-12 The two volume Emergency Medical Services Clinical Practice and Systems Oversight delivers a thorough foundation upon which to succeed as an EMS medical director and prepare for the NAEMSP National EMS Medical Directors Course and Practicum Focusing on EMS in the real world the book offers specific management tools that will be useful in the reader's own local EMS system and provides contextual understanding of how EMS functions within the broader emergency care system at a state local and national level The two volumes offer the core knowledge trainees will need to successfully complete their training and begin their career as EMS physicians regardless of the EMS systems in use in their areas A companion website rounds out the book's offerings with audio and video clips of EMS best practice in action Readers will also benefit from the inclusion of A thorough introduction to the history of EMS An exploration of EMS airway management including procedures and challenges as well as how to manage ventilation oxygenation and breathing in patients including cases of respiratory distress Practical discussions of medical problems including the challenges posed by the undifferentiated patient altered mental status cardiac arrest and dysrhythmias seizures stroke and allergic reactions An examination of EMS systems structure and leadership

Resuscitate! Mickey S. Eisenberg, M.D., 2013-05-15 Sudden cardiac arrest is the leading cause of death among adults yet it need not be fatal Though survival in most communities is very poor a few communities achieve rates as high as 50% Why are some communities so successful in snatching life from the jaws of death Resuscitate describes the steps any EMS system can take to improve cardiac arrest survival It is written for the medical directors administrative directors fire chiefs dispatch directors and program supervisor who direct and run EMS systems all

across the country and for the EMTs paramedics and dispatchers who provide frontline care This second edition of Resuscitate provides fifteen concrete steps to improve survival Four steps will lead to rapid improvements at the local level and are relatively easy to implement Six additional steps are more difficult to implement but also likely to improve survival The remaining steps recommend changes at the national level Resuscitate is the official textbook for the Resuscitation Academy held twice a year in Seattle Cosponsored by Seattle Medic One King County EMS and the Medic One Foundation the Academy draws attendees from throughout the world for two intensive days of classes demonstrations and workshops to acquire the knowledge and tools to improve survival in their own communities This new edition includes lessons learned from attendees of the Academy as well as from the faculty s evolving thoughts on how to measure performance and improve survival one community at a time It also includes an addendum on the Resuscitation Academy resuscitationacademy.org For more than thirty years Mickey S Eisenberg M D Ph D has played a leading role in developing King County Washington s emergency response to cases of sudden cardiac arrest a system recognized as among the very best in the nation He is a professor of medicine at the University of Washington and serves as the medical director of King County Emergency Medical Services

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