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How Should The World Manage The Challenge of Childhood Diabetes!!

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The frequency of ketoacidosis at onset of childhood in the world particularly in developing countries is significant. Prevention of diabetic ketoacidosis and control of its rising frequency should be a healthcare target [1]. The epidemic of childhood diabetes is a worldwide challenge that could be directly related to the whole world challenging epidemic of childhood obesity or it is simply part of the dramatic spread of adulthood diabetes worldwide [2-4].

Similar to the spread of adult DM, *Helicobacter pylori* could arise as a major environmental reason that could be directly related to the flaring challenge of childhood diabetes. A possible link between *H. pylori* and diabetes mellitus in children has been mentioned in some studies while this relation has been denied by other reports [5, 6].

H. pylori could migrate or get forced to migrate to the colon under the influence of antibiotics where it will continue to produce ammonia for a reason or no reason leading to accumulation of profuse amounts of ammonia un-opposed or buffered by any acidity. Accumulation of profuse amounts of ammonia in the colon is toxic and could constitute a biological stress to the body causing toxic pancreatitis that could lead to potential stress diabetes in predisposed children. The spread of *H. pylori*-induced childhood diabetes could constitute more than 90% of the world's burden of childhood diabetes during the latest three decades specifically since the implementation of the triple anti-*H. pylori* antibiotic eradication strategy in 1986 [7-10].

The concept of the biological toxic stress leading to an onset of *H. pylori*-induced childhood diabetes is not just hypothetical or scientific fantasy as upon the basis of this concept the newly-discovered childhood diabetic condition has been readily and adequately corrected in many children; around 89% of cases in some recent studies [10].

Colon clear with the senna leaves extract purge and vinegar-mixed food therapy have been recently demonstrated to effectively deal with the challenge of *H. pylori* including eradication of colonic and abnormal-behavior gastric *H. pylori* strains in addition to prevention of recurrence [8, 9].

Therefore; countries should follow a characteristic strategy towards *H. pylori* dyspepsia and *H. pylori*-related dysglycemia:

- Any newly discovered childhood diabetes should be first considered a potential condition not an established illness and should be treated as stress diabetes. Children should be immediately

investigated for existence of colonic *H. pylori* strains and immediate employment of colon clear with the senna leaves purge once followed by vinegar mixed salad or yogurt with principal meals once or twice daily for one week. Patients with inadequate response to colon care and colon clear by vinegar and the senna could do revision of the senna purge twice with one-month space between them. Patients who remain hyperglycemic in spite of these measures should be given one-week physical rest together with physiological rest of the pancreas by administration of fractionated regular insulin doses for one week. Children who do not recover after that could be considered established diabetics and could receive the anti-diabetic medication appropriate to their condition.

- Children who recover a potential diabetic condition should practice extreme carefulness towards out-side home meals and should return to colon care and colon clear either on regular basis or at least whenever they develop colonic troubles. They should care from gastric recurrence by regular dental hygiene and cleaning of dental plaques as being possible reservoirs for *H. pylori* or children can just employ mouth wash with diluted dietary vinegar as tolerated once or twice weekly together with washing hands with vinegar and water after washing with soap in order to avoid fecal-oral recurrence as soap alone does kill *H. pylori* [8].
- The antibiotic aggression towards *H. pylori* should be re-discussed in details and gastric sedatives including anti-urease activity should be subjected to severe revision and accurate re-determination.
- The world should stop searching/re-searching after *H. pylori*; save these funds and direct them towards raising the life and water supply standards in poor and developing countries as the matter of *H. pylori* is essentially a sanitary conflict before it is a medical challenge and rich people tour in poor countries while poor people travel to work as food handlers in rich countries; that is how abnormal *H. pylori* strains travel from stomach to stomach via meals and navigate all over the world [8].
- Patients and families should be educated as concerns misbehavior in food habits and antibiotic use.
- Orientation of primary health care units as concerns natural measures towards *H. pylori* dyspepsia.
- Dyspeptic mothers should investigate for existence of colonic *H. pylori* strains and deal with them via employing natural measures (colon care and colon clear) but not antibiotics in order to avoid transmitting *H. pylori* to their kids. Mothers preparing food for their kids particularly if dyspeptic should usually wash hands with vinegar then water after washing with soap.
- Pregnant mothers should not feel lazy to cook and should not love the fast food for themselves and their kids during pregnancy.
- Food handlers should strictly and frequently disinfect hands with vinegar and travelers should make vinegar a friend to their meals while touring.

References

1. Habib HS. "Frequency and clinical presentation of ketoacidosisat onset of childhood type 1 diabetes mellitus in Northwest Saudi Arabia". Saudi Med J 26.12 (2005): 1936-9.
2. Sabin MA and Shield JP. "Childhood obesity". Front Home Res 36 (2008): 85-96.
3. De Ferranti SD and Osganian SK. "Epidemiology of pediatric metabolic syndrome and type 2 diabetes mellitus". Diab Vasc Dis Res 4.4 (2007): 285-96.
4. Al-Nozha MM., et al. "Diabetes mellitus in Saudi Arabia". Saudi Med J 25.11 (2004): 1603-10.
5. Salardi S., et al. "Helicobacter pylori and type 1 diabetes mellitus in children". J Pediatr Gastroenterol Nutr 28.3 (1999): 307-9.
6. Dore MP., et al. "Diabetes mellitus and Helicobacter pylori infection". Nutrition 16.6 (2000): 407-10.
7. Farinha P and Gascoyne RD. "Helicobacter pylori and MALT Lymphoma". Gastroenterology 128.6 (2005): 1579-605
8. Nasrat AM., et al. "Misconception and misbehavior towards Helicobacter pylori is leading to major spread of illness". General Med S1 (2015): 002.
9. Nasrat SAM., et al. "The dramatic spread of diabetes mellitus worldwide and influence of Helicobacter pylori". General Med 3.1 (2015): 159-62.
10. Nasrat AM., et al. "The challenge of childhood diabetes". General Med 3.4 (2015): 193.