In evidence-based practice, insulin has been shown to decrease the prevalence of hyperglycemia, decrease the complications associated with microvascular complications, reduce the risk of acute complications, and improve glycemic control. However, insulin therapy can be challenging due to potential hypoglycemia and hyperglycemia, and it requires careful monitoring and adjustment.

**INTRODUCTION**

Insulin therapy is widely used to treat type 1 and type 2 diabetes, as well as other conditions such as gestational diabetes and prediabetes. While subcutaneous insulin therapy is the most common method, oral and intravenous insulin therapy are also used in certain situations.

**METHODS: A DIFFERENT STRATEGY**

Bolus insulin is often prescribed for basal, prandial, and纠正性 bolus therapy. In basal, prandial, and纠正性 bolus therapy, insulin is administered based on the total daily dose. It is necessary to have a correct weight on each patient to administer to help calculate the correct insulin dose and in effort to prevent under-dosing or over-dosing.

- Using the current kilogram (kg) weight of the patient, the total daily dose (TDD) is determined by taking the kg weight of the patient multiplied by a coefficient of 0.5 U/kg (TDD = kg x 0.5 U/kg). To promote more sensitive to insulin such as in multifunctional, renal, cardiac or elderly, the coefficient is reduced to a more conservative 0.3 U/kg.

- TDD is then distributed as approximately 50% basal and 50% bolus insulin. The basal insulin dose becomes one half of the TDD. The Basal-Prandial SubQ basal insulin is one half of the TDD split equally between breakfast, lunch, and dinner meals.

- Basal-Prandial SubQ basal insulin is added to the Basal-Prandial schedules doses from specific glucose level regimes. The correction dose regimes are: Low, Medium, High, or Other Dose. These are not to be confused with "sliding scale insulin." Based on the TDD of insulin of the patient, each regimen contains a glucose range with a specific amount of insulin in units to administer: Low and Medium normally start with one unit. High-dose starts with two units. And, other dose is written in by the physician or endocrinologist.

**EVIDENCE BASED RESULTS**

- Insulin therapy has been shown to decrease the prevalence of hyperglycemia, decrease the complications associated with microvascular complications, reduce the risk of acute complications, and improve glycemic control.

- Basal-Pranidal SubQ insulin therapy has been studied in several trials, the largest being the RABBIT 2 trial conducted in 2007 by Umpierrez et al. Basal on the results of this trial, it was shown that Basal-Pranidal significantly improved glycemic control compared to an increased risk of hyperglycemia in an adult internal medicine population.

- A prospective, multicenter, randomized study trial conducted by Umpierrez, et al. on the optimal management of hyperglycemia in non-intensive care unit patients with type 2 diabetes using Basal-Pranidal therapy vs. sliding scale insulin (SSI). Basal glucose was used daily and Basal glucose to before meals and at bedtime, starting at 0.6-0.8 U/kg (BMI 40-200 mg/dL) or 0.5 U/kg-BMI (BMI >200 mg/dL) versus the standard sliding scale four times a day (4pD). Glycemic control was defined as BG <140 mg/dL. Results indicated the following:

  - Achieved the goal (BG<140 mg/dL) in 10% in the SSI group.
  - Insulin improvement was larger in the SSI group.
  - Significant difference in basal-Pranidal vs. SSI in achieving goal.

- Different in hyperglycemia and hypoglycemia.

- Sliding Scale Insulin (SSI) has been found to be insufficient in treating hyperglycemia. SSI is NOT recommended by the experts, currently ADA and ACS. Joa Comallow and diabetes minus the effect of the basal-Pranidal SubQ insulin therapy. A standard of prandial for a hospitalized patient with diabetes is to be slow, basal or prandial, and correct basal-Prandial SubQ insulin therapy, more commonly referred to as the Basal.

**METHODS**

In insulin therapy, it is important to identify the correct dose of insulin to administer and to monitor for potential hypoglycemia and hyperglycemia. Basal-Prandial SubQ insulin therapy is a practice adopted to treat hospitalized patients, as it can provide better glucose control with minimal or no hypoglycemia. Basal-Pranidal SubQ insulin therapy is a practice adopted to treat hospitalized patients, as it can provide better glucose control with minimal or no hypoglycemia.

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**REFERENCE**