

## Traveling With Diabetes Supplies

The Federal Aviation Administration implemented stepped-up security measures in response to the tragic events on September 11, 2001.

Here is a list of information the American Diabetes Association (ADA) received regarding people with diabetes who need to fly with their supplies and equipment within the 50 United States.

This information was received verbally from a representative of the FAA's Aviation, Security Policy & Planning Division (Washington, D.C. headquarters).

- ♦ Passengers may board with syringes or insulin delivery systems only if they can produce a vial of insulin with a professional, pharmaceutical pre-printed label which clearly identifies the medication. No exceptions will be made.

- ♦ Passengers who must test their blood glucose levels but who do not require insulin, boarding with their lancets is acceptable as long as the lancets are capped, and as long as the lancets are brought on with the glucose meter that has the manufacturer's name embossed on the meter.

- ♦ Keep your glucagon kit intact in its original pre-printed pharmaceutically labeled container.

- ♦ Due to forgery concerns, prescriptions and letters of medical necessity will not be accepted.

- ♦ Passengers should consult their individual air carrier for both domestic (US) and international travel regulations. Be advised that the FAA's policy and the policy of each airline is subject to change.

Please contact the ADA at 703-549-1500 x-2108 so they may be kept informed of airline protocols and security measures. For more information from the FAA, please call 1-866-289-9673.

For full text article visit ADA's website at [www.diabetes.org](http://www.diabetes.org) click on Community and Resources article located in Information & News.

## Diabetes in the Elderly

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One benefit of improving health is a longer life. With longer living however comes an increase in the incidence of diabetes. Diabetes mellitus today is commonly under-diagnosed and under-treated in those over 70. Classical symptoms may be absent and infection or a cardiovascular event may precipitate diagnosis. When symptoms are present they may be attributed to physiological changes of aging which they resemble. Increased awareness on our part can help differentiate between changes of normal aging, diseases of older adults, and the effects of diabetes. Adult diagnostic criteria are used for the elderly with initial priority given to eliminating glycemic symptoms. The next priority should take into account the individual's projected longevity and the risks for acute or long-term effects of poor glucose control.

### Treatment Considerations

Adequate nutrition is the primary goal of the meal planning aspect of treatment. Older adults have lower energy needs, different body composition, altered nutrient absorption, and increased carbohydrate intolerance. Contributing causes of irregular eating or drinking include changes in taste, lack of transportation, physical disabilities, medications, alcohol use or social isolation. Weight can be maintained if meal planning includes favorite foods adapted for new needs. Dehydration can result from decreased thirst perception and limited access to fluids especially in people with existing renal changes or taking diuretics. The effect of dental diseases on eating and nutrition can be significant and has even been linked to coronary heart disease. Over 40% of all people over 65 are edentulous. Regular assessment of barriers to healthy eating is essential. Stocking emergency food supplies such as frozen meals or no cook options can be helpful.

### Exercise

The Diabetes Prevention Program has recently reported impressive weight loss and exercise results for obese individuals over 70. Exercise plans should be based on personal preferences and functional capacity. An aerobic program can target 50-60% maximum heart rate for those beginning an exercise routine and increase gradually. Physical limitations can be accommodated through stationary bicycling, swimming, water aerobics, "mall walking", or chair exercises. Exercising with others provides additional safety as well as opportunities for socialization. Education precautions are still pertinent regarding hypoglycemia avoidance and timing of exercise. Removing obstacles to attendance such as acceptable timing, cost, or accessibility may avoid the high drop out rates seen in some exercise programs for older adults.

### Medications

Older patients may be taking multiple medications for a variety of diseases or symptoms. Routine review by the diabetes team can detect redundant therapies and incompatibilities. Simplification of dosing, avoiding side effects, and considering drug cost may encourage patients to take their drugs as scheduled. New oral agents may offer improved safety profiles. As with all people with diabetes, when oral treatment of hyperglycemia is too cumbersome or ineffective, insulin should not be delayed. Positive attitudes of health professionals coupled with supervised practice and regular observation can facilitate insulin therapy while avoiding errors.

### Self-Management Education

Studies show that many patients receive little if any diabetes education. Older adults require at minimum some basic, meaningful, practical knowledge about diabetes, to correct existing misconceptions. A comfortable, accepting environment for care can overcome cultural or social communication barriers that exist. Jargon and unnecessary detail should be avoided. Since hyperglycemia impairs learning, clinicians may need to postpone education until control is accomplished. At these times, written reinforcement and access to the educator for clarification can be especially useful. Formal assessment of mental status using the Mini Mental State, Short Portable Mental Status, or Neurobehavioral Cognitive Status Examination can clarify how to accommodate those with limitations. Group





## Mark Your Calendar!

Upcoming Meetings

### American Diabetes Association

49th Annual Advanced  
Postgraduate Course

- ◆ February 1-3, 2002  
San Francisco, CA

### American Diabetes Association

Regional Postgraduate Course

- ◆ Postponed until March 2002  
Irving, TX

### Abstract Deadlines

All AADE members are encouraged to submit topics for presentations at the 2002 Annual Meeting, August 7-11, in Philadelphia, PA

#### Deadlines:

Oral presentations:

January 11, 2002

Research oral presentations:

January 11, 2002

Educational sharing poster presentations:

May 3, 2002

For on-line abstract details visit [www.aadenet.org](http://www.aadenet.org). For questions contact Melissa Kadian at [mkabadian@aadnet.org](mailto:mkabadian@aadnet.org) or 800-338-3633 ext. 841

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education that includes coping skills has been demonstrated to improve glycemic control as well as enhance learning over time in older patients. Groups usually incorporate interaction, group driven objectives, and structured question and answer times.

## TEACHING TIPS

- ◆ Focus on one or two points
- ◆ Use printed materials that are easy to read
- ◆ Use familiar, concrete examples
- ◆ Provide magnifiers
- ◆ Check audiovisual tools for clarity
- ◆ Augment spoken information with visual aids
- ◆ Adapt for color blindness
- ◆ Make the learning sessions brief
- ◆ Repeat key learning points
- ◆ Use fonts that are simple, bold, and large size
- ◆ Avoid shouting, prevent distracting noises
- ◆ Use frequent practice opportunities, phone follow-up, home care for those with limited mobility

## Mental Health

Stressful tasks of aging include retirement, marital changes, widowhood, grandparenting, dying and death. Older adults are concerned about functional abilities, health, quality of life, adjustments and losses. Limited income, isolation or limited mobility can lead to inadequate self-care or loss of hope. Having diabetes can increase stress. Many adults are able to place events in perspective and resolve life-long issues. Social support can improve individual coping.

Changes in memory, information-processing speed, and attention span normally decline with age. Some occur more frequently with chronic hyperglycemia. Glucose control can improve energy level, memory, and certain cognitive disorders. Unrecognized depression is common among older adults and people with diabetes. Hearing loss or sensory or functional impairments can exacerbate depression. Depression may be accompanied by alcohol and drug abuse. If other mental changes are significant, diagnosis may be difficult. Educators should regularly assess and refer patients to mental health professionals for diagnosis when depression is suspected. Treatment can have major effects on quality of life.

## Long-Term Complications of Diabetes

Older adults have a higher incidence and accelerated development of long-term complications, sometimes at the time they are diagnosed. This results in increased rates of amputation, MI, stroke, vision loss, and kidney failure. Screening is neglected in the elderly and specific actions can protect older adults with diabetes.

1. Frequent foot and footwear inspection, incorporating assistance from others may be needed. Footwear should accommodate shape and specific sensation problems. A podiatrist or orthotic specialist referral may be necessary.
2. Cardio-preventive strategies are weighed against needed treatments for comorbidities and expected benefits. Stroke prevention efforts focus on glucose control, treating atrial fibrillation, and control of hypertension. If EKGs show evidence of previous cardiac damage, patients should learn the signs/symptoms of congestive heart failure.
3. Annual screening, glucose control, and treatment of retinopathy and maculopathy for can save vision. Limited vision can seriously impact diabetes self-care. Clinicians should assess the effects of vision on self-monitoring, medication administration, and foot care.
4. Diabetic nephropathy coupled with the renal changes associated with aging can precipitate kidney failure. Routine lab screening for kidney disease is needed for early detection and treatment. Patients can learn the signs/symptoms of urinary tract infections.

## Key Points in Caring for Older Adults

1. Assess as an individual while anticipating special age related needs.
2. Match instruction to patients specific diabetes-related goals.
3. Present key information in easy-to-read or heard messages.
4. Use groups and active learning methods when possible.
5. Teach at a slower pace, use memory aides, incorporate family and caregivers in instruction.
6. When hyperglycemia or sensory/cognitive deficits are present, evaluate communication often.
7. Consider cost, accessibility, safety, support systems, and the effect on quality of life for each care recommendation or treatment.

For additional details and references please visit: [www.paddocklabs.com/publications/diab/diabindex.html](http://www.paddocklabs.com/publications/diab/diabindex.html)

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