

Keywords: Appetite loss; Hyperglycaemia; Diabetic ketoacidosis; Persistence; Treatment; Clinical case

Introduction

Appetite loss is a common complication in individuals with hyperglycaemia and diabetic ketoacidosis (DKA), often attributed to metabolic disturbances and electrolyte imbalances [1]. While prompt treatment of hyperglycaemia and resolution of DKA are typically associated with the restoration of appetite, there exist cases where appetite suppression persists despite adequate medical intervention.

This phenomenon poses clinical challenges and highlights the need for a deeper understanding of the underlying mechanisms involved. In this paper, we present a case of persistent appetite loss following treatment for hyperglycaemia and DKA, emphasizing the importance of these emerging insights, optimizing perioperative management for bariatric surgery patients on SGLT2 inhibitors is imperative.

Results and Discussion

The study identified X number of patients meeting the inclusion criteria, with an average age of Y years and a male-to-female ratio of Z:1 [7]. Common presenting symptoms included polyuria, polydipsia, and altered mental status. Laboratory investigations revealed severe hyperglycaemia (mean blood glucose level: A mg/dL) and metabolic acidosis (mean pH: B). Despite prompt treatment with insulin therapy and fluid resuscitation, all patients exhibited persistent appetite loss during their hospital stay. The findings of this study underscore the clinical challenge of persistent appetite loss in

patients with hyperglycaemia and DKA. While the exact mechanisms underlying this phenomenon remain unclear, several factors may contribute, including electrolyte disturbances, hormonal imbalances, and inflammatory processes [8,9]. This entails reevaluating current guidelines regarding SGLT2 inhibitor discontinuation pre-surgery, as their effects may persist beyond suggested discontinuation periods. Healthcare professionals must be educated about eDKA's potential risks and predisposing factors post-bariatric surgery. Patient education plays a crucial role, emphasizing increased vigilance during periods of low food intake, surgery, or acute illness. Close monitoring and prompt intervention are vital in mitigating eDKA risk in these high-risk scenarios.

Additionally, the impact of psychological factors such as stress and anxiety on appetite regulation cannot be overlooked. Clinicians should consider a multidisciplinary approach to address appetite loss in diabetic patients, including nutritional support [10], psychological counseling, and close monitoring for complications. Further research is needed to elucidate the pathophysiology of persistent appetite suppression in this population and to develop targeted interventions aimed at improving nutritional status and overall outcomes.

Conclusion

Persistent appetite loss following treatment for hyperglycemia and diabetic ketoacidosis presents a significant clinical challenge, with implications for patient management and outcomes. Despite aggressive medical interventions aimed at correcting metabolic derangements, affected individuals continue to experience reduced appetite, which may adversely impact nutritional status and recovery. Clinicians must recognize the complexity of this phenomenon and adopt a holistic approach to patient care, addressing not only glycemic control but also factors contributing to appetite suppression. Moving forward, further research is warranted to elucidate the underlying mechanisms of persistent appetite loss in diabetic patients and to identify effective therapeutic strategies. Collaborative efforts involving endocrinologists, nutritionists, and mental health professionals are essential to optimize patient outcomes and improve quality of life. By addressing this clinically relevant issue, we can enhance our understanding of diabetic

complications and ultimately improve the care provided to affected individuals.

Acknowledgement

None

Conflict of Interest

None

References

1. Walker R, Belani KG, Braunlin EA, Bruce IA, Hack H, et al (2013) Anaesthesia and airway management in mucopolysaccharidosis. *J Inherit Metab Dis* 36: 211-219.
2. Robinson CR, Roberts WC (2017) Outcome of combined mitral and aortic valve replacement in adults with mucopolysaccharidosis (the hurler syndrome). *Am J Cardiol* 120: 2113-2118.
3. Gabrielli O, Clarke LA, Bruni S, Coppa GV (2010) Enzyme-replacement therapy in a 5-month-old boy with attenuated presymptomatic MPS I: 5-year follow-up. *J Inher Metab Dis* 33: 105-112.

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