

How Should the World Manage the Challenge of Diabetes Mellitus

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Abstract

Methicillin-resistant *Staphylococcus aureus* (MRSA) is one of the most important pathogens that cause nosocomial infections. However, microbiological culture techniques take a few days to yield results; therefore, a simple, cost-effective, and rapid detection system is required for screening for MRSA and related bacteria: Methicillin-resistant *Staphylococcus epidermidis* (MRSE) carriers during the hospital admissions process. In this study, we described the simplified method using by one-time use and screen-printed carbon electrodes, relied upon current quantification of Hoechst dyes which bound with DNA amplified via polymerase chain reaction (PCR) targeted for MRSA *mecA* gene. Amount of DNA-bound Hoechst molecules were measured by the hand-held potentiostat within two minutes. We found that the peak of a Hoechst-mediated current depended upon the number of MRSA cells, and successfully distinguished between carriers and a non-carrier based on nasal swabs from the patients. This method required only 10 μ L for application, and the results could be obtained within total 60 min from sample collection when a minimum of 1×10^3 MRSA cells was present. These results suggested that this minimized technique has the potential to become a useful system of active surveillance for MRSA/MRSE carriers.

Keywords: *H. pylori*; Diabetes mellitus; Anti-biotics

Introduction

The last three decades have shown prevalence of abnormal-behavior *Helicobacter pylori* strains and rising figures of many medical challenges related to these strains of the bacterium. It means that the last three decades demonstrated rediscovery of *H. pylori*, the antibiotic aggression towards it, the prevalence of its abnormal-behavior strains instead of getting rid of them, and the flare up of a lot of medical challenges related to these *H. pylori* strains [1,2]. A medical study which does not correlate between these obvious findings is definitely not employing a clinical sense.

H. pylori colonized the stomach since an immemorial time; [1] as if both the stomach wall and the bacterium used to live together in peace harmless to each other. *H. pylori* in the stomach leads a physiological behavior identical with that of natural bacteria; namely its existence since an immemorial time, having mostly-harmless long history inside the stomach before being attacked by antibiotics, its huge biological talents for survival inside the stomach and its gastric recurrence is being unavoidable. In addition to that, *H. pylori* is protective against the development of low acidity-related carcinoma of the cardia of stomach [1,2].

Although eradications regimens seem to efficiently eradicate *H. pylori* from the stomach; the emergence of antibiotic-resistant *H. pylori* strains and the severe side effects are major drawbacks of these treatments [1]. *H. pylori* is not eradicated from the stomach but forced to migrate elsewhere as evidenced by its re-appearance in unusual existence exceeding limits of the stomach together with the development of new unusual symptoms[1,2] More efficient, economic and friendly drugs should be developed.

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 is toxic and constitutes a biological stress to the body that could lead to stress diabetes in predisposed individuals. Administration of oral hypoglycemic pills to a stressed pancreas means an insistence to flog a tired horse turning a potential condition into an established chronic illness with consequent flare up of the diabetic phenomena all over the world [1-3].

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 via interference with re-setting up of further colonization via oral intake [2,3].

H. pylori, being a natural bacterium, [1,2] travels from stomach to stomach via meals. As rich people tour in poor countries and poor people travel to work in rich countries; therefore, bad *H. pylori* strains travel from stomach to stomach and navigate from country to country.

Accumulation of acidic metabolites and inflammatory mediators in the tissues and circulation is a fact that has been documented and reported. Glucose-insulin disproportion is a major reason for accumulation of these toxic elements in the body. These substances can induce vascular spasm and other effects on vascular endothelium [4,5]. Therefore; a dysglycemic patient might no way face a cardiac event, leg ischemia or diabetic foot complication in his life. Elimination of these toxic elements is a challenge that would definitely help to correct an underlying micro-circulatory error. Therefore; countries should follow a strategy towards *H. pylori* dyspepsia and *H. pylori* - related dysglycemia:

- Newly discovered diabetes should be first considered a potential condition not an established illness and should be treated as stress diabetes. Patients should be immediately investigated for existence of colonic *H. pylori* strains with immediate employment of colon clear for positive cases using the senna leaves purge once, then followed by vinegar therapy mixed with food once or

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twice daily for one week. The senna purge could be employed empirically for patients who were found negative for colonic *H. pylori* strains. Patients with inadequate improvement of blood sugar level after colon care and colon clear by the vinegar and senna could repeat the senna purge monthly for two times. 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; they must not receive oral pills for hyperglycemia. Patients who do not recover after these measures can be considered established diabetic patients and can receive the anti-diabetic medication as appropriate to their condition.

- Patients who recover a potential diabetic condition should practice extreme carefulness towards out-side home meals and should return to colon care and colon clear whenever they develop colonic troubles. They should care from gastric recurrence by regular dental hygiene and dental plaques cleaning or mouth wash with diluted dietary vinegar twice weekly and washing hands with vinegar and water after washing with soap in order to avoid fecal-oral recurrence as soap alone does kill *H. pylori*.
- The antibiotic aggression against *H. pylori* should be stopped and gastric sedatives including anti-urease activity should be subjected to severe revision and accurate redetermination.
- Stop searching/researching after *H. pylori*; save these funds and direct them towards raising the life and water supply standards in poor and developing countries.
- Patients and family education as concerns misbehavior in food habits and antibiotic use.

- Orientation of primary health care units as concerns natural manures towards *H. pylori* dyspepsia.
- Food handlers should strictly and frequently disinfect hands with vinegar and travelers should make vinegar a friend with their meals while touring.
- Developing the awareness about the need of a diabetic patient to undergo blood-let out cupping therapy once a year or once during the course of his diabetes in order to guard against coronary and peripheral ischemic issues as withdrawal of the ischemic mediators from the body and circulation is not feasible through the available clinical measures but only via cupping therapy [6,7].

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