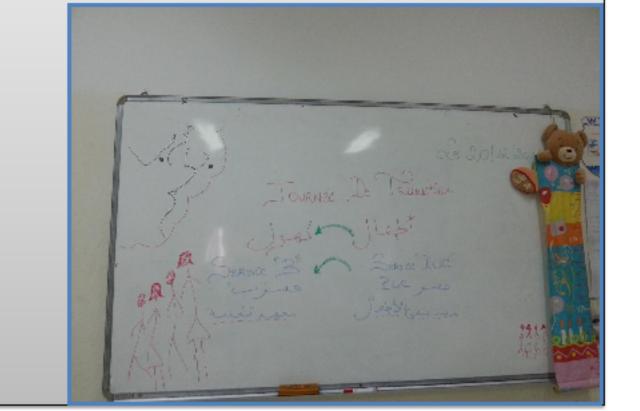
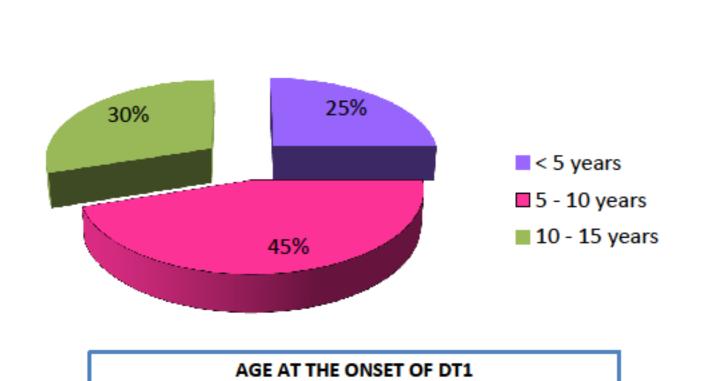
IMPLEMENTATION OF EFFECTIVE TRANSITION FROM PAEDIATRIC TO ADULT DIABETES CARE:

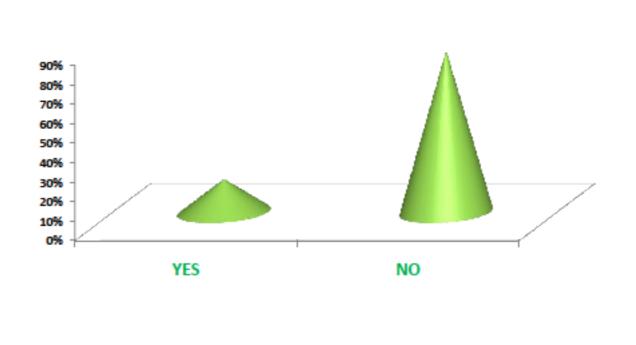
Epidemiological and Clinical characteristics. A PIONEERING EXPERIENCE IN NORTH AFRICA

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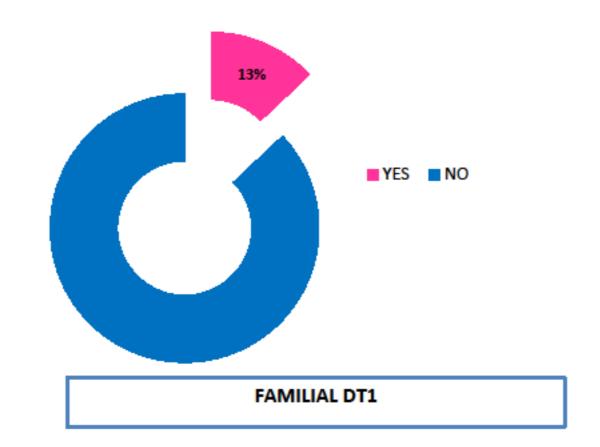


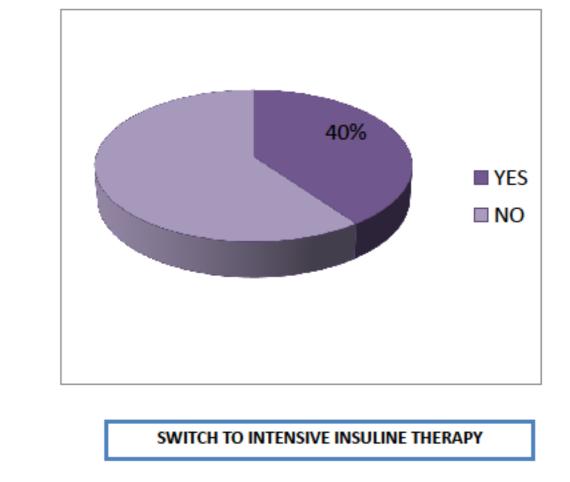
- Background: Diabetes mellitus (DM) is a chronic metabolic disorder requiring daily care to prevent both acute and chronic complications.
 Healthcare providers are challenged to manage the transition of adolescents from pediatric to adult diabetes services. Until recent date, this change of the medical team was lived by teenagers as a tearing and a discontinuity of the medical care.
- Objective and hypotheses: While centers providing structured integrated pediatric and adult care seem optimal, diabetic teenagers suffered from an unsuitable care. These patients are in need of transition programs to prevent discontinuities in specialized care.
- Method: In collaboration with an adult endocrinology department, we developed a transition program for adolescents with DM. A meeting of transition is organized with the whole pediatric team and the adult one in which patients meet their new medical staff, ask their questions and express their fears. DM related issues are recorded in a specially developed 'diabetes health passport' used by the patient. This 'passport' accompanies the patient through the transition process, providing anticipatory guidance, ongoing assessment of psychosocial issues and promotes self-care in collaboration with both pediatric and adult healthcare providers. After this meeting, patients benefit from an outpatient transition in the endocrinology adult department.
 - Results:
- * Number of meetings: 5 (from 2012 to 2014)
- * 44 DM teenagers have been succesfully transitioned from pediatric to adult care
- * Sex ratio = 0,91 (23 females/ 21 males)
- * Mean age at the onset of the DM: 7,5 years
- * Chronic complications: retinopathy = 0
 - nephropathy = 2 cases
 - cardiac disease = 0
 - distal neuropathy = 2 cases
- * Associated autoimmune diseases: Celiac disease = 3 cases
 - Hypothyroidism = 1 case
- * Spontaneous puberty in all patients
- * 5 patients have left their schooling



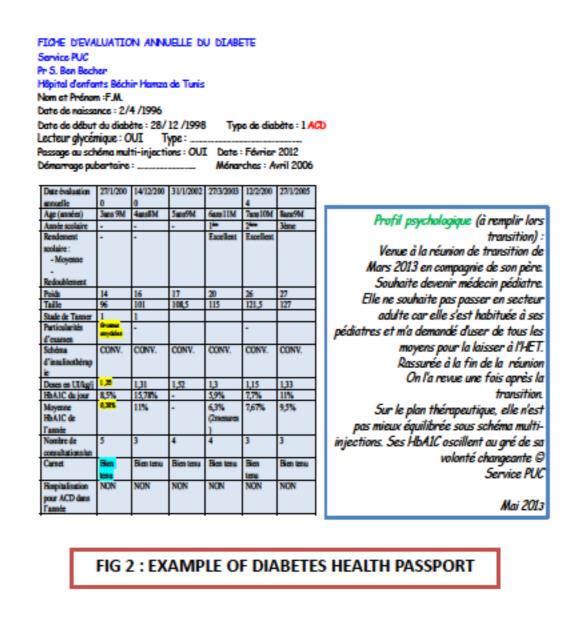


KDA AT THE ONSET











- Results:
- * 52% of the patients went to the transition meeting accompanied by their mothers
- * Average pediatric follow up time : 9 years (2 15 years)
- * Mean age during transition: 14,9 years (14 23 years)
- * Pediatric and adult teams (fig 1 and 3) include *practionners, nurses, nutritionists* and *secretaries* so as to make patients feel totally at ease once their transition done
 - * All the patients have received a « diabetes health passport » (fig 2) after the meeting
 - * Meetings were decisive for 56,5% of the teenagers who attend them; their fears eased and they accepted to leave their pediatric team
 - * All of them benefit from an outpatient transition in the adult department

Conclusion: We report on the successful implementation of a structured program for adolescents with DT1 transitionning from pediatric to adult care. Our systematic approach is pioneering in North Africa and appears to provide a structure for ensuring continuity of care and effective transition.







