

**PROSPECTIVE OBSERVATIONAL STUDY ON GERIATRIC  
DIABETIC PATIENTS****Gopal Teli<sup>\*</sup>, Sarika Gupta, Niraj Shrestha and Jeet BM**

Kailash Institute of Pharmacy and Management, GIDA, Gorakhpur (U.P.), India.

Article Received on  
15 Feb 2015,Revised on 10 March 2015,  
Accepted on 02 April 2015**\*Correspondence for****Author****Gopal Teli**Kailash Institute of  
Pharmacy and  
Management, GIDA,  
Gorakhpur (U.P.), India.**ABSTRACT**

**STUDY OBJECTIVE:** This Prospective observational study on Geriatric Diabetic patients was conducted to establish the current status of diabetic patients in Gorakhpur. **PARTICIPANTS:** Patients with Diabetic Mellitus. **STUDY DESIGN:** Prospective observational study. **STUDY SITE:** 1). Star Hospital, Gorakhpur, U.P. **PATIENTS AND METHODS:** Forty patients were studied using a prescription auditing Performa. Data was recorded from the patient's attending the outpatient department using a chance random sample method. Patients who co-operated were interviewed and information was filled in the Performa. **RESULT:** The result suggested that the current status of geriatric

patients suffering from diabetes in star hospitals of Gorakhpur. Demographic analysis of data revealed that the study population comprised of more male (56%) than female (44%). Majority of the patients were in the age group of 50-60 years (32%) and 50-60 kg weight (40%). About three per cent of females and eight per cent of the males had a family history of diabetes. **CONCLUSION:** This study concluded that the present status of diabetes is more common in male than female in Gorakhpur. Based on these base line data and analysis, in the present time, an intervention was suggested to improve the current status of diabetes for future control. This study may be more meaningful to improve, further, the prescribing through successful implementation of interventional program in the health care centers and give more attention on male and over age and weight patient than female lesser weight patient in Gorakhpur.

**KEYWORDS:** Diabetic patient, prospective study, outpatient department, Star Hospital.**OBJECTIVES:** This study will investigate the hypothesis that detail the current status of geriatric diabetic patient and use of a care platform and its educational content by Diabetic

patients will positively influence perceived quality of life, wellbeing and degree of self-reliance. Furthermore, it will inform the majority of geriatric diabetic patient whether they are male or female and the influence of platform use on clinical parameters, like glycemic control, will be investigated. It also inform the age and weight of patient which comprises more patients. It will assess the effects of clinical parameters and quality of life on micro- and macro-vascular complications and mortality.

**Other objectives are**

To reduce the symptoms of diabetic patients.

To concentrate on non-pharmacotherapy.

To make sure rationale use of medicine.

**PATIENTS AND METHODS**

The study was conducted at star hospitals after obtaining consent to collect information from patients attending the physician in outpatient department. Forty prescriptions from one physician were collected from star hospitals at Gorakhpur for a period of one month (march to april 2014). Individual patients were interviewed using the prepared questionnaire for this study after their visit to the doctor.

The patients who co-operated were interviewed and information was filled in Performa. The tool used was a set of prepared questionnaire for each patient whose diagnosis was based on clinical evidence provided by the doctor and the technique adopted was personal interview with the patient. All the patients were asked for information as specified in the questionnaire. Their habits, socio-economic status, past medication and disease and occupation were also asked as mentioned in the patients' information. Verbal consent was taken from every patient before enrolling in this study. This was an observational study aimed at identifying the current status of geriatric diabetic patient in Gorakhpur.

Questions were asked about the smoking status and educational level and family history of any diabetes in the past. All the patient history per prescription was observed.

**STUDY VARIABLES OF DATA**

The study variable in the study are - age, sex, weight, smoking, occupation, family history, clinical diagnosis, anti- diabetic prescribed, single/multiple drug therapy, brand name, generic name, dosage forms of anti- diabetic drug.

Physicians take a medical history to establish the diagnosis of diabetes. The physicians use **impaired glucose tolerance (IGT) and impaired fasting glucose (IFG)** for the confirm diagnosis of diabetes.

### INCLUSION AND EXCLUSION CRITERIA

Only outpatients suffering from diabetes alone were included in the study. Diabetic patients who suffered from other disease such as hypertension and other heart problem were also included in the study. Patients of encephalitis, chronic bronchitis, depression, chronic ulcer, cancer and pneumonia were excluded.

### COLLECTION OF DATA

All the data was collected directly from the hospital pharmacy and from patient. In the collection of data mainly three people were involved, collector, doctor and patient. All the information were taken from the patient regarding diabetes symptoms, drugs used, frequency of taking drugs, route of administration, past medication disease history and their economic conditions.

### ANALYSIS OF DATA

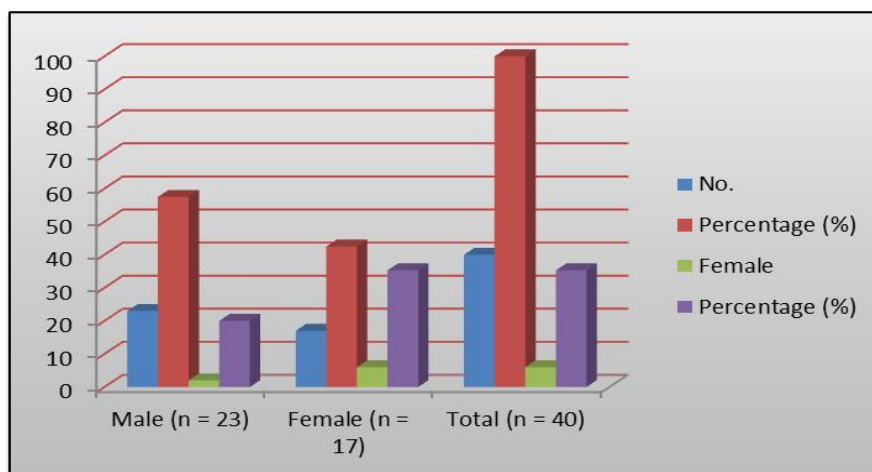
1. Compilation of data was done.
2. Data were classified in different independent variable.
3. The data was tabulated using excel in the computer.
4. Percentage was calculated.

### RESULTS

The results suggested that the current status of male and female patients suffering from diabetes in Gorakhpur star hospital is presented in [Table 1]. Demographic analysis of data revealed that the study population comprised of more male than female. Majority of the patients were in the age group of 50-60 years [Table 2] and 50-60 kg weight [Table 3]. About three per cent of females and eight per cent of the males had a family history of diabetes.

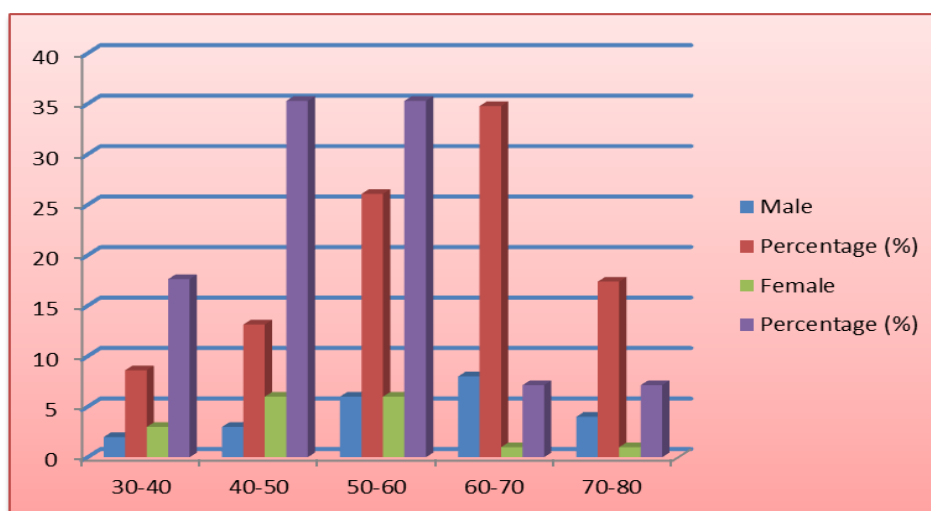
**Table 1: Demographic distribution of diabetic patients according to sex.**

Sex	Male (n = 23)	Female (n = 17)	Total (n = 40)
No.	23	17	40
Percentage (%)	57.5	42.5	100



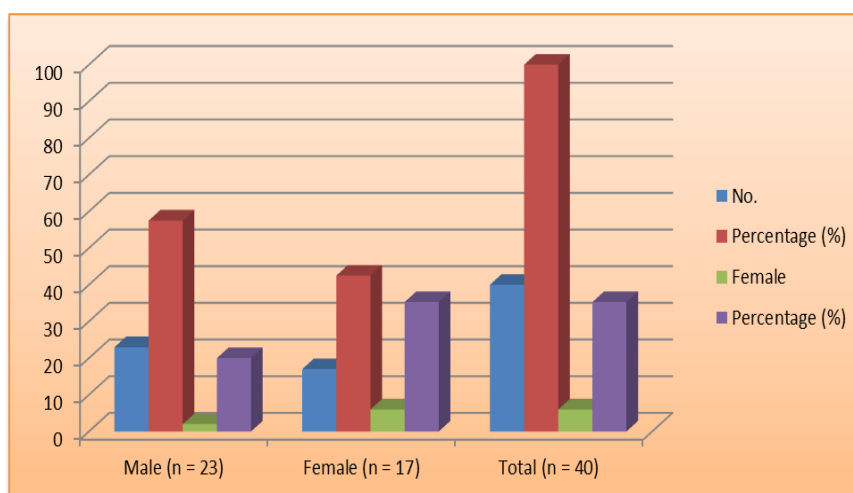
**Table 2: Demographic distribution of diabetic patients according to age.**

Sr. no.	Age groups (yrs.)	Male (n = 23)	Percentage (%)	Female (n = 17)	Percentage (%)	Total (40)
1	30-40	2	08.61	3	17.64	5(12.5%)
2	40-50	3	13.14	6	35.29	9(22.5%)
3	50-60	6	26.08	6	35.29	12(30%)
4	60-70	8	34.78	1	07.14	9(22.5%)
5	70-80	4	17.39	1	70.14	5(12.5%)
Total		23	100	17	100	40(100%)



**Table 3: Demographic distribution of diabetic patients according to weight.**

Sr. no.	Weight groups (kg.)	Male (n = 23)	Percentage (%)	Female (n = 17)	Percentage (%)	Total (40)
1	40-50	5	21.74	2	20.00	7(16%)
2	50-60	7	30.43	6	35.29	13(40%)
3	60-70	6	26.09	6	35.29	12(28%)
4	70-80	5	21.74	3	17.64	8(16%)
Total		23	100	17	100	40(100%)



## DISCUSSION

A prescription-based observational survey is considered one of the scientific methods to assess and evaluate the rationality of the prescription current status of disease. Recommendations of various international bodies on diabetes which help to improve diabetic condition of the patient and ultimately reduce the diabetic condition. Analysis of forty cases of diabetic patient, in this study, revealed that diabetes was more prevalent in males than females. Demographic characteristics also showed that males (57.5%) were suffering more from diabetes than females (42.5%). The physicians diagnose the diabetes by history and examination. The diabetic patients do not require more than one drug to control the symptoms hence combination therapy does not require to treat diabetes. In this study (30%) patients were come under 50-60 yrs. Age and only (12.5%) patients were come under 30-40, 60-70 yrs. age and (40%) patients were come under 50-60 kg. weight and only (16%) patients were come under 40-50, 70-80 kg weight. This indicated the diabetic patients mainly suffering in 50-60 yrs. age 50-60 kg weight.

## CONCLUSION

This study concluded that the present status of diabetes is more common in male than female in Gorakhpur. Based on these base line data and analysis, in the present time, an intervention was suggested to improve the current status of diabetes for future control. We recommend that the practitioners can be used as facilitators in future training programs for general practitioners, family physicians and primary care physicians to reduce morbidity, mortality and economic costs of diabetes. In conclusion, national diabetes education program will be beneficial as an initial step, in improving diabetes knowledge and increasing awareness in the medical community to improve the quality of life and productivity of the individual with

diabetes. This study may be more meaningful to improve, the prescribing through successful implementation of interventional program in the health care centers and give more attention on male and over age and weight patient than female lesser weight patient in Gorakhpur.

## REFERENCES

1. Commissioning Diabetes Foot Care Services. London: NHS Diabetes, 2011. Available from [www.diabetes.nhs.uk/document.php?o=23](http://www.diabetes.nhs.uk/document.php?o=23), last accessed, 27 Feb 2012.
2. Kumar S, Ashe HA, Parnell LN et al. The prevalence of foot ulceration and its correlates in type 2 diabetic patients: a population-based study. *Diabetes Med*, 1994; 11: 480–4.
3. Walters DP, Gatling W, Mullee MA, Hill RD. The distribution and severity of diabetic foot disease: a community study with comparison to a non-diabetic group. *Diabetes Med* 1992; 9: 354–8.
4. National Diabetes Inpatient Audit 2010 NHS Diabetes [http://www.diabetes.nhs.uk/information\\_and\\_data/diabetes\\_audits/national\\_diabetes\\_inpatient\\_audit/](http://www.diabetes.nhs.uk/information_and_data/diabetes_audits/national_diabetes_inpatient_audit/) last accessed, 27 Feb 2012.
5. Jeffcoate WJ, van Houtum WH. Amputation as a marker of the quality of foot care in diabetes. *Diabetologia* 2004; 47: 2051–8.
6. Dorresteijn JA, Kriegsman DM, Assendelft WJ, Valk GD. Patient education for preventing diabetic foot ulceration. *Cochrane Database Syst Rev*, 2010: CD001488.
7. Bowen G. et al. The impact of a diabetic foot protection team (DFPT) on outcomes for patients with diabetic vascular disease *British Journal of Surgery*, 2008; 95(S1): 4-5.
8. Personal communication, Graham Bowen, Clinical Lead for Diabetes, Southampton City PCT, 2004-07.
9. Mazzi CP, Kidd M. A framework for the evaluation of Internet-based diabetes management. *J Med Internet Res.*, 2002; 10; 4(1): e1.
10. Ralston JD, Revere D, Robins LS, Goldberg HI. Patients' experience with a diabetes support programme based on an interactive electronic medical record: qualitative study. *BMJ.*, 2004; 328(7449): 1159.
11. Nunn E, King B, Smart C, Anderson D. A randomized controlled trial of telephone calls to young patients with poorly controlled type 1 diabetes. *Pediatr Diabetes*, 2006; 7(5): 254-9.
12. Malasanos TH, Patel BD, Klein J, Burlingame JB. School nurse, family and provider connectivity in the FITE diabetes project. *J Telemed Telecare*. 2005; 11 Suppl 1:76-8.

13. Lee TI, Yeh YT, Liu CT, Chen PL. Development and evaluation of a patient-oriented education system for diabetes management. *Int J Med Inform.*, 2007; 76(9): 655-63.
14. Gambling T, Long AF. Exploring patient perceptions of movement through the stages of change model within a diabetes tele-care intervention. *J Health Psychol.*, 2006; 11(1): 117-28.
15. Boaz M, Hellman K, Wainstein J. An automated telemedicine system improves patient-reported well-being. *Diabetes Technol Ther.*, 2009; 11(3): 181-6.
16. Sokol MC, Mc Guigan KA, Verbrugge RR, Epstein RS. Impact of medication adherence on hospitalization risk and healthcare cost. *Med Care*, 2005; 43: 521–30.
17. Wagner EH, Sandhu N, Newton KM, et al. Effect of improved glycemic control on health care costs and utilization. *JAMA*, 2001; 285: 182–9.
18. Shetty S, Secnik K, Oglesby AK. Relationship of glycemic control to total diabetes-related costs for managed care health plan members with type 2 diabetes. *J Manag Care Pharm*, 2005; 11: 559–64.
19. Peterson A.M, Nau DP, Cramer JA, et al. A checklist for medication compliance and persistence studies using retrospective databases. *Value Health*, 2007; 10: 3–12.
20. Hughes D, Cowell W, Koncz T, Cramer J, International Society for Pharmacoeconomics & Outcomes Research Economics of Medication Compliance Working Group. Methods for integrating medication compliance and persistence in pharmacoeconomic evaluations. *Value Health*, 2007; 10: 498–509.
21. Johnson JA, Pohar SL, Majumdar SR. Health care use and costs in the decade after identification of type 1 and type 2 diabetes: a population-based study. *Diabetes Care*, 2006; 29: 2403–8.
22. Liu L, Hader J, Brossart B, et al. Impact of rural hospital closures in Saskatchewan, Canada. *Soc Sci Med*, 2001; 52: 1793–804.
23. Phillips PJ. Gestational diabetes. *Aust Fam Physician*, 2006; 35: 701–3.
24. Newton KM, Wagner EH, Ramsey SD, et al. The use of automated data to identify complications and comorbidities of diabetes: a validation study. *J Clin Epidemiol*, 1999; 52: 199–207.
25. Wilchesky M, Tamblyn RM, Huang A. Validation of diagnostic codes within medical services claims. *J Clin Epidemiol*, 2004; 57: 131–41.
26. Grymonpre R, Cheang M, Fraser M, et al. Validity of a prescription claims database to estimate medication adherence in older persons. *Med Care* 2006; 44: 471–7.



27. Salas M, Ward A, Caro J. Health and economic effects of adding nateglinide to metformin to achieve dual control of glycosylated hemoglobin and postprandial glucose levels in a model of type 2 diabetes mellitus. *Clin Ther*, 2002; 24: 1690–705.
28. Balu S. Incremental treatment expenditure of diabetes in the United States. *Manag Care Interface*, 2007; 20: 20–7.
29. Valentine WJ, Erny-Albrecht KM, Ray JA, et al. Therapy conversion to insulin among patients with type 2 diabetes treated with oral agents: a modeling study of cost-effectiveness in the United States. *Adv Ther* 2007; 24: 273–90.
30. Pawaskar MD, Camacho FT, Anderson RT, et al. Health care costs and medication adherence associated with initiation of insulin pen therapy in Medicaid-enrolled patients with type 2 - diabetes: a retrospective database analysis. *Clin Ther*, 2007; 29: 1294–305.
31. Lee WC, Balu S, Cobden D, et al. Medication adherence and the associated health-economic impact among patients with type 2 diabetes mellitus converting to insulin pen therapy: an analysis of third-party managed care claims data. *Clin Ther*, 2006; 28: 1712– 25.
32. Kalsekar I, Iyer S, Mody R, et al. Utilization and costs for compliant patients initiating therapy with pioglitazone or rosiglitazone versus insulin in a Medicaid fee-for-service population. *J Manag Care Pharm*, 2006; 12: 121–9.
33. Rowan JA, Hague WM, Gao W, Battin MR, Moore MP; MiG Trial Investigators (2008) Metformin versus insulin for the treatment of gestational diabetes. *N Engl J Med* 358: 2003-2015.
34. Nicholson W, Bolen S, Witkop CT, Neale D, Wilson L, et al. Benefits and risks of oral diabetes agents compared with insulin in women with gestational diabetes: a systematic review. *Obstet Gynecol*, 2009; 113: 193-205.
35. Dhulkotia JS, Ola B, Fraser R, Farrell T. Oral hypoglycemic agent's vs insulin in management of gestational diabetes: a systematic review and metaanalysis. *A.M J Obstet Gynecol*, 2010; 203: 457.
36. Silva JC, Pacheco C, Bizato J, de Souza BV, Ribeiro TE, et al. (2010) Metformin compared with glyburide for the management of gestational diabetes. *Int J Gynaecol Obstet*, 2010; 111: 37-40.
37. Moore LE, Clokey D, Rappaport VJ, Curet LB (2010) Metformin compared with glyburide in gestational diabetes: a randomized controlled trial. *Obstet Gynecol*, 2010; 115: 55-59.



38. Ijäs H, Vääräsmäki M, Morin-Papunen L, Keravuo R, Ebeling T, et al. (2011) Metformin should be considered in the treatment of gestational diabetes: a prospective randomised study. *BJOG*, 2011; 118: 880-885.
39. Nicholson W, Baptiste-Roberts K. Oral hypoglycaemic agents during pregnancy: The evidence for effectiveness and safety. *Best Pract Res Clin Obstet Gynaecol*, 2011; 25: 51-63.
40. Glueck CJ, Goldenberg N, Pranikoff J, Loftspring M, Sieve L, et al. (2004) Height, weight, and motor-social development during the first 18 months of life in 126 infants born to 109 mothers with polycystic ovary syndrome who conceived on and continued metformin through pregnancy. *Hum Reprod*, 2004; 19: 1323-1330.
41. Institute of Medicine. (2009) Weight gain during pregnancy: Reexamining the guidelines. Gibson KS, Waters TP, Catalano PM maternal weight gain in women who develop gestational diabetes mellitus. *Obstet Gynecol*, 2012; 119: 560-565.
42. . Hedderon MM, Weiss NS, Sacks DA, Pettitt DJ, Selby JV, et al. Pregnancy weight gain and risk of neonatal complications: macrosomia, hypoglycemia, and hyperbilirubinemia. *Obstet Gynecol*, 2006; 108: 1153-1161.
43. Klonoff DC. Personalized medicine for diabetes. *J Diabetes Sci Technol*, 2008; 2(3): 335-41.
44. Timmerberg BD, Wurst J, Patterson J, Spaulding RJ, Belz NE. Feasibility of using videoconferencing to provide diabetes education: a pilot study. *J Telemed Telecare.*, 2009; 15(2): 95-7.