

# **CONTROL OF TYPE II DIABETES, ITS RELATIONSHIP WITH OBESITY AND BASAL METABOLIC RATE**

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## **ABSTRACT**

### **BACKGROUND**

The prevalence of T2DM is around 7-10%. Control of diabetes and factors influencing it in third world countries need to be clearly defined as most of the people are poorly controlled.

### **MATERIALS AND METHODS**

This was a Prospective cross sectional study. Non-probability consecutive sampling was used to collect data for 5 months. A total of 766, type 2 diabetic patients were enrolled who visited SiDER (Sakina Institute of Diabetes and Endocrine Research Center) at Shalamar Hospital, Lahore, Pakistan. The data was analyzed by SPSS 22 version.

### **RESULTS**

Results showed that, out of 766 diabetics, 40.3% were male and 59.7% were females. The mean age was  $48.72 \pm 10.43$  years, 53.39% were obese, 32.64% were overweight and only 13.97% were normal body mass index. HbA1c levels in the sample population showed that only 13.05% had very healthy control i.e. 7 or less. There was a positive co-relation between basal metabolic rate and body mass index and no statistically significant relation between basal metabolic rate and glycemic control.

### **CONCLUSION**

There is a significantly high percentage of young age group suffering from diabetes. People with high body mass index have poor glycemic control. More powerful studies are needed to establish a relation between glycated hemoglobin and basal metabolic rate.

**Key words:** Diabetes Mellitus, Glycemic Control, Obesity and Basal Metabolic Rate

## INTRODUCTION

Diabetes is a very common health problem with a prevalence of around 7-10% worldwide <sup>(1)</sup>. There is equal number of pre-diabetics and almost 50% are undiagnosed <sup>(2)</sup>. The most common and prevalent form of diabetes is type II <sup>(3)</sup>. The association of T2DM is with obesity which is a very an established constituent of metabolic syndrome as well, and the relationship of obesity, T2DM and metabolic syndrome has been well established <sup>(4)</sup>.

It is a known fact that 3 major underlying mechanisms could lead to T2DM namely insulin resistance, incretin and insulin deficiencies <sup>(5)</sup>. Android obesity is common in this part of the world which leads to insulin resistance <sup>(6)</sup>. As visceral fat is the most active adipose tissue of the body, these adipose tissues are active in releasing free fatty acids in the circulation which in turns leads to insulin resistance <sup>(7, 8)</sup>.

One of the factors which seem to be important in determining higher body mass index is basal metabolic rate <sup>(9)</sup>. There is a positive co-relation between basal metabolic rate and body mass index hence it is desirable to have an understanding of basal metabolic rate and its relation to the other factors associated with control of diabetes.

This study correlates obesity and basal metabolic rate with the glycemic control of the patients. Obesity is found to be more common in female diabetics. In other studies it is suggested that obesity is more common in non-whites than whites <sup>(10)</sup>. Race is considered as an important

variable and may have impact on Resting Energy Expenditure of the individual. There is a documented difference in Resting Energy Expenditure when compared among different races <sup>(11)</sup>.

It is also observed that majority of the diabetics do not achieve target HbA1c (7%) goals, especially in developing countries <sup>(12)</sup>. It has been shown in Diabetes control and complications trial (DCCT), United Kingdom Prospective Diabetes Study (UKPDS) that long term complications can be modified by reducing the risk with tight glycemetic control reflective by HbA1c and self-monitored blood glucose <sup>(13)</sup>.

## **MATERIALS AND METHODS**

Prospective cross sectional study was planned to assess the glycemetic control and its relationship relation with basal metabolic rate and body mass index. Non-probability consecutive sampling was used. Type 2 diabetic subjects were recruited in the same manner and a total of 766 patients were enrolled from May 2016 to October 2017, who visited SiDER (Sakina Institute of Diabetes and Endocrine Research Center) at Shalamar Hospital, Lahore, which is a tertiary care teaching hospital. Written consent was taken from every subject before collecting data and study was approved by the Institutional Review Board (IRB) of Shalamar Medical and Dental College Lahore. Only pre-diagnosed diabetic subjects with a random blood sugar of more than 200mg/dl at two occasions and blood sugar fasting more than 126mg/dl were included in the study. People with Gestational Diabetes, type 1 diabetes, hyperthyroid and hypothyroid were excluded. The cut point value for HbA1c was assigned as, very healthy levels: 7% or less than 7 %, fairly healthy level: 7.1%- 8.0%, too high, needs therapeutic action 8.1-10.0% and much too high, needs therapeutic action >10.0%, labeled as category 1, 2, 3, & 4 respectively <sup>(14)</sup>. Body mass index more than 30 kg/m<sup>2</sup> considered as obese, BMI of greater than 25kg/m<sup>2</sup> but less than

30 kg/m<sup>2</sup> were overweight and BMI of less than 25kg/m<sup>2</sup> but more than 18 kg/m<sup>2</sup> were labeled normal <sup>(15)</sup>. Harris Benedict equation was used to calculate the basal metabolic rate of the patients <sup>(16, 17)</sup>. The data was analyzed by SPSS (Statistical Package for Social Sciences) 22 version. Qualitative variables were presented by mean ± S.D while quantitative variables presented by frequencies and percentages. For statistical significance independent t-test, Chi- Square and ANOVA was used as appropriate.

## RESULTS

**Table:1 Descriptive Statistics of Type 2 Diabetics**

Variables		Frequency (%)
Gender	Male	309(40.3%)
	Female	457(59.7%)
Age (mean±S.D)		48.72±10.43
Age groups (years)	≤25	5(0.7%)
	26-40	173(22.6%)
	41-55	411(53.7%)
	56-70	163(21.3%)
	≥70	14(1.8%)
BMI	Normal	107(13.97%)
	Over weight	250(32.64%)
	Obese	409(53.39%)
Glycemic Control Categories	Very healthy level	100(13.05%)
	Fairly healthy levels, needs improvement	74(9.66%)
	Too high, need therapeutic action	184(24.02%)
	Much too high, needs therapeutic action	408(53.26%)
BSR		264.12±99.368
BMR		1487±218.284

Table 1 shows that out of 766 diabetics, 40.3% were male and 59.7% were females. The mean age was 48.72±10.43 years. Body mass index distribution shows, 53.39% were obese, 32.64%were overweight and only 13.97%were normal. There was no underweight patient. Glycated hemoglobin data shows that 13.05% of the patients falls in healthy category, 9.66% in

category 2 had fairly healthy levels and needs improvement, 24.02% in category 3, had too high A1c levels and 53.26% in category 4, had much too high and needs therapeutic action.

**Table: 2 Mean Description of glycemic control and other variables with gender**

Variables		Group		P-value*
		Male	Female	
Age(mean±s.d)		49.79±10.984	48.00±10.984	0.020
Age n(%)	≤25	1(0.3%)	4(0.9%)	0.045
	26-40	63(20.4%)	110(24.1%)	
	41-55	158(51.1%)	253(55.4%)	
	56-70	78(25.2%)	85(18.6%)	
	≥70	9(2.9%)	5(1.1%)	
BMI (mean±s.d)		27.081±4.6873	30.733±5.7631	0.001
BMI	Normal	66(21.4%)	41(9.0%)	0.001
	Over weight	135(43.7%)	115(25.2%)	
	Obese	108(35.0%)	301(65.9%)	
BMR (mean±s.d)		1609.77±235.16	1405±160.23	0.001
BSR(mean±s.d)		255±96.424	269.81±101.081	0.054
HbA1c (mean±s.d)		10.5364±3.3597	11.0284±3.5197	0.054
		2	8	
Glycemic Control Categorie s	Very health levels (category 1)	43(13.9%)	57(12.5%)	0.499
	Fairly healthy levels, needs improvement (category 2)	34(11.0%)	40(8.8%)	
	Too high, need therapeutic action (category 3)	77(24.9)	107(23.4)	
	Much too high, needs therapeutic action (category 4)	155(50.2%)	253(55.4%)	

\*95% confidence interval was used as significant

Table 2 shows 65.9% females were obese as compared to 35.0% males. 21% of the males and only 9.0% of the females had normal body mass index. Mean metabolic rate of males and females were 1609.77±235.16 and 1405±160.23 respectively. The average blood glucose levels of males and females were 255±96.424 and 269.81±101.081 respectively. This shows that females had high body mass index, high blood sugar levels and too much high HbA1c as compared to males.

**Table: 3 (a) Relation of glycemic control with basal metabolic rate**

Glycemic Control Categories (HbA1c)	BMR (mean±s.d)	P-value*
Very health levels (category 1)	1481.17±197.98	0.096
Fairly healthy levels, needs improvement (category 2)	1513.49±237.68	
Too high, need therapeutic action (category 3)	1516.03±23	
Much too high, needs therapeutic action (category 4)	1471.9480±212.44	

\*95% confidence interval was used as significant

**Table: 3 (b) Distribution of HbA1c with Body Mass Index**

		Body Mass Index			Total
		Normal	Over weight	Obese	
Glycemic Control Categories	Very health levels (category 1)	13(12.1%)	35(14.0%)	52(12.7%)	100(13.1%)
	Fairly healthy levels, needs improvement (category 2)	9(8.4%)	23(9.2%)	42(10.3%)	74(9.7%)
	Too high, need therapeutic action (category 3)	22(20.6%)	60(24.0%)	102(24.9%)	184(24.0%)
	Much too high, needs therapeutic action (category 4)	63(58.9%)	132(52.8%)	213(52.1%)	408(53.3%)
	Total	107(100.0%)	250(100.0%)	409(100.0%)	766(100.0%)

Table 3 (a, b) shows that as the glycemic control of the patient worsen from category 1 to category 3, their metabolic rate increases from 1481.17±197.98 to 1516.03±23 but as the glycemic control falls in category 4, the basal metabolic rate drops to 1471.9480± 212.44. This difference might be due to the fact that other factors like body mass index is also lower in this

category of glycemic control, as 58.9% were normal body mass index, 52.8% were overweight and 52.1% were obese in category 4.

## **DISCUSSION**

For the management of diabetic patients, dietary advised is one of the main pillars along with education, investigations and medications. The energy expenditure is essential to assess the nutritional status of the patients. As shown in table 1 almost 86 % were above the normal weight and 53% were obese which is quite reflective of relationship between weight and diabetes <sup>(18)</sup>.

The maximum number of diabetics which was 53.7% belonged to the age group (41-55 years). A significant number of diabetics belonged to a younger age group (26-40 years); which was 22.3% of all the sample diabetic population. This holds true for the other Asian population and is in contrast with Caucasian <sup>(19)</sup>. It is observed that almost 76.3% of this diabetic population belonged to age group from 26-55years, which is the prime working age for any country and forms the backbone for development.

It is much needed that this particular age group with a maximum number i.e. 76.3% should be very well controlled and should be able to perform at their maximum ability level. Paradoxically when we look at the glycemic control categories in the sample population it was seen that 50.2% males and 55.4% females were in category 4. Only 13.9% in male and 12.5% in female were in category 1 of glycemic control.

In this study we also compared the relationship of glycated hemoglobin levels, in obese diabetics and non-obese diabetics and subsequently the basal metabolic rate of obese diabetics and non-obese diabetics. The basal metabolic rate increases as the glycemic control worsens

from category one to category three of glycemic control, however there is a decrease in basal metabolic rate in category 4. This could be due to more percentages of less body mass indexes in this category. Theoretically this reduction in body mass index in this particular category could be due to increased catabolism which is not healthy <sup>(20)</sup>.

The female diabetics are more than 1.5 years younger and had high body mass index as compared to their male counterparts, which are statistically significant <sup>(18)</sup>. This holds true in all age groups which were studied. Only 9% of the females can be regarded as having normal body mass index and a very significant percentage which is 65.9% was obese as compared to 35% male obese. Quite a few reasons can be debated about this very crucial finding of significantly high percentage of female obese as compared to male obese. A few causes of this obesity could be multiparty and high intake of calories during pregnancy, as a part of Asian culture. Lack of awareness about general health fitness, lack of self-care, as it is a cultural norm that the role of female in the society is subservient and only to look after their husbands, children, husband's families specially husband's parents <sup>(21)</sup>. All these factors may lead to difficulty in finding time for their own social life and hence is translated into poor health outcome which in this case is obesity. It is also worth mentioning that this gender is also deprived of outdoor, leisure exercise facilities especially in our culture <sup>(22)</sup>.

Studies in the past have shown that basal metabolic rate is higher in diabetics as compared with non-diabetics. It is also shown that this holds true when the people are converted from pre diabetics to diabetics <sup>(23)</sup>. It is also suggested that high basal metabolic rate in diabetic patients may be a cause of weight loss in uncontrolled early stages of diabetes <sup>(9)</sup>. It is interesting to look at the basal metabolic rate and comparing both the genders. In spite of the fact that there

is significantly more obesity in the female gender group as compared to the males; however their actual basal metabolic rate is low which is statistically significant.

In spite of a higher body mass index in the higher socioeconomic group, the overall glycemic control is better in the high socioeconomic group i.e.17.4% had very healthy levels of A1c as compared to 11.6% in the low/ middle socioeconomic group which is statistically significant. There could be number of reasons to explain this difference, the few of them might be the better awareness, affordability and tendency to come out of unacceptable cultural norms<sup>(24)</sup>.

Most of the patients in the study have high body mass index and poorly controlled diabetes. The younger age group is more vulnerable to develop diabetes and the overall glycemic control is quite poor in the studied population. Further to this, it is a relatively smaller sample size for an epidemiological cross sectional study. More powerful studies are needed in this regard, especially to establish a relation between glycosylated hemoglobin and basal metabolic rate. It is also recommended that a customized local guide lines should be formed for the better control. The other limitation in this study is that most of the people visiting the facility were from urban areas and it does not depict the cultural preferences of other part of the population.

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