

# M.S.Rukshana<sup>1</sup>, A.Doss<sup>1</sup> and C.Kasturi<sup>2</sup>

<sup>1</sup>Department of Microbiology, Kamaraj College, Tuticorin, Tamil Nadu, India. <sup>2</sup>Department of Botany, National College, Trichy, Tamil Nadu, India.

#### **Article Info**

Received 01/06/2016 Revised 15/06/2016 Accepted 30/06/2016

Key words:- Diabetes, post prandial hyperglycemia, synthetic drugs, natural drugs.

# ABSTRACT

Diabetes is a major metabolic, multi-causal and heterogeneous disorder which causes significant morbidity and mortality with considerable burden to healthcare resources. Diabetes is due to either the pancreas not producing enough insulin or the cells of the body not responding properly to the insulin produced. There are three main types of diabetes. Among those types post prandial hyperglycemia cause high mortality rate. In this study it highlights the insufficiency of the currently available drugs for controlling the disease and its complications and more needs to be done. A survey was carried out among an adult rural population to assess the prevalence of hyperglycemia. Synthetic drugs were using to treat diabetes but it can also lead to many severe problems. So alternative medicines using natural plants and herbs should be found to get rid of this critical situation. The death arising not only due to diabetes but also the synthetic medication taking against diabetes.

# INTRODUCTION

Diabetes Mellitus can be called simply as diabetes. Diabetes is a group of metabolic disorders characterized by abnormal metabolism, which results most notably in hyperglycemia, due to defects in insulin secretion, insulin action, or both. Diabetes is a serious chronic disease without a cure, and it is associated with significant morbidity and mortality. Either because the pancreas does not produce enough insulin (insulin deficiency), or cells do not respond to the insulin that is produced (insulin resistance). Insulin is a hormone produced by the pancreas. It has a function to control the amount of blood sugar. It works by attaching to the insulin receptor in cell to influence the Glut-4 to transport glucose. Diabetes is a serious disease associated with acute (due to hyperglycemia) and chronic (due to vascular damage) complications. There are three types of diabetes such as Diabetes Mellitus Type 1, Diabetes Mellitus Type 2 and Gestational Diabetes.

Corresponding Author

#### M.S.Rukshana

Email: - rukshanasana94@gmail.com

Nowadays treatment for diabetes was carried out by synthetic medications. Metformin and Glibenclamide was widely used to treat diabetes. Various other medications were also used. But these synthetic medicines would cause many side effects to the patients. The death rate of diabetes was increasing not only because of diabetes but also by the synthetic medication that was used against diabetes. Alternative treatments are there for diabetes in a natural way but no one is following the natural medication. Further research is needed for the improvement of natural medicines for diabetes. The significance of my study was to show number of people get affected by diabetes in a particular population, sex, and the ages in which they are getting affected.

#### MATERIALS AND METHODS

A survey was conducted among individuals of both sex in various ages over a period of one week. The survey was carried out in Lakshmi Hospital, Tirunelvelli to assess the prevalence of diabetes. The population in this hospital was minimum 20-30 patients a day. Age difference in men and women was also observed. Many parameters have been used to detect the presence of



diabetes and also various problems related to diabetes such as concentrations of urea, creatinine, liver function enzymes, cholesterol etc. This survey was based on these parameters.

#### **RESULT AND DISCUSSION**

The survey was carried out within 50-60 patients. Among the patients majority of them were women. And the shocking result was many pregnant women were affected by diabetes mainly post prandial hyperglycemia. Among the population 81% of them were women and 75% of them were men. Blood and urine sample was collected from the patients in a very sterile technique. These samples were used for the parameters to test the presence of glucose, various enzymes, fats etc. Blood sample was mostly used for testing procedures. Urine sample is used for the testing of albumin, sugar and deposits of cells. In blood sample testing parameters the values were noted for the normal and abnormal behaviours. The test carried out in urine will give the result in positive or negative form and the concentration as +, ++, +++. In the parameters glucose was tested for the detection of glucose in both urine and blood.

The liver enzymes were also tested by the parameters such as SGOT (Serum Glutamic Oxalo acetic Transaminase) and SGPT (Serum Glutamic Pyruvic Transaminase). It was measured to check the function of liver which was mostly get affected for diabetes patients. Cholesterol was also checked by the parameters such as LDL (Low Density Lipoprotein), HDL (High Density Lipoprotein), VLDL (Very Low Density Lipoprotein) and

TGL (Triglycerides) which shows the presence of fats in the body. Fat concentration will also depend upon the diabetic patients. Protein tests also carried out with parameters such as Urea, Creatinine and Albumin. Albumin was tested in both blood and urine sample. Other protein tests were carried out only in blood sample. The results of the survey were tabulated below. Glucose values for men and women were given. (Table 1 and Table 2). The glucose concentration was shows the presence of diabetes. The liver enzymes were also tabulated for men and women. (Table 3 and Table 4). In this the result shows that not only the abnormal value leads to abnormal results. It may vary depend upon the patients. Cholesterol was detected by many parameters stated above which was tabulated for men and women. (Table 5 and Table 6). It detects the fat content of the diabetes patient. Protein test was carried out in diabetic patient to check the abnormal functions by the urea, creatinine and albumin content. These results were given separately for men and women. (Table 7 and Table 8).

From the result it shows a rising prevalence of diabetes. And mainly women are affected a lot by diabetes. In this study the result was depend upon the age and sex. By other parameters for other enzymes was also detected so that other problems can also be revealed. Because diabetic patient will have many other problems related to fat, liver and cholesterol. It was mainly due to the synthetic medication. From this survey it was clear that many peoples are affected by diabetics. So awareness should be given to everyone about the risk factor of diabetics.

Table 1. Glucose concentration for men in both urine and blood sample

| S.No | Age        | Sample | Glucose | Normal/Abnormal |
|------|------------|--------|---------|-----------------|
| 1    | 40         | Blood  | 402     | Abnormal        |
| 1    | 42         | Urine  | +       | Abiofilia       |
| 2    | 71         | Blood  | 281.5   | Abrowsal        |
| 2    | /1         | Urine  | ++      | Abhormai        |
| 2    | 25         | Blood  | 100     | Normal          |
| 5    | 33         | Urine  | Nil     | Normai          |
| 4    | 72         | Blood  | 150     | Normal          |
| 4    | 15         | Urine  | Nil     | Normai          |
| 5    | 60         | Blood  | 295     | Abrowsal        |
| 5    | 00         | Urine  | ++      | Abhormar        |
| 6    | 21         | Blood  | 116     | Normal          |
| 0    | 51         | Urine  | Nil     | Normai          |
| 7    | <u>0</u> 2 | Blood  | 113.1   | Normal          |
| /    | 02         | Urine  | Nil     | Normai          |
| 0    | 43 -       | Blood  | 312     | Abnormal        |
| 0    |            | Urine  | +++     | Abhormar        |
| 0    | 42         | Blood  | 213     | Abnormal        |
| 9    | 42         | Urine  | +       | Autornia        |
| 10   | 01         | Blood  | 125.4   | Normal          |
| 10   | 01         | Urine  | Nil     | nomiai          |



| S.No | Age | Sample | Glucose | Normal/Abnormal |
|------|-----|--------|---------|-----------------|
| 1    | 50  | Blood  | 240     | A har a mus a l |
| 1    | 59  | Urine  | ++      | Abnormal        |
| 2    | 50  | Blood  | 300.7   | A har same al   |
| 2    | 30  | Urine  | +++     | Abhormai        |
| 2    | 26  | Blood  | 280     | Abnormal        |
| 5    | 50  | Urine  | +       | Abhormai        |
| 4    | 67  | Blood  | 192     | Ahnormal        |
| 4    | 07  | Urine  | +       | Abnormal        |
| 5    | 69  | Blood  | 234     | Abnormal        |
| 5    |     | Urine  | ++      | Abhormai        |
| 6    | 10  | Blood  | 90      | Normal          |
| 0    | 48  | Urine  | Nil     | INOTINAI        |
| 7    | 54  | Blood  | 112     | Normal          |
| /    | 34  | Urine  | Nil     | INOTINAI        |
| o    | 60  | Blood  | 250     | Abnormal        |
| 0    | 69  | Urine  | +       | Abhormai        |
| 0    | 22  | Blood  | 262     | Abnormal        |
| 9    | 32  | Urine  | ++      | Abhormal        |
| 10   | 50  | Blood  | 125.1   | Normal          |
| 10   | 50  | Urine  | Nil     | normal          |

 Table 2. Glucose concentration for women in both urine and blood sample

# Table 3. Liver enzyme concentration for men in blood sample

| S.No | Age | SGOT | SGPT |
|------|-----|------|------|
| 1    | 42  | 22   | 17   |
| 2    | 71  | 46   | 53   |
| 3    | 35  | 17   | 14   |
| 4    | 73  | 26   | 19   |
| 5    | 60  | 15   | 20   |
| 6    | 31  | 40   | 45   |
| 7    | 82  | 19   | 25   |
| 8    | 43  | 25   | 32   |
| 9    | 42  | 21   | 17   |
| 10   | 81  | 12   | 14   |

# Table 4. Liver enzyme concentration for women in blood sample

| S.No | Age | SGOT | SGPT |
|------|-----|------|------|
| 1    | 59  | 49   | 38   |
| 2    | 56  | 13   | 26   |
| 3    | 36  | 42   | 35   |
| 4    | 67  | 17   | 20   |
| 5    | 69  | 15   | 12   |
| 6    | 48  | 39   | 45   |
| 7    | 54  | 18   | 12   |
| 8    | 69  | 24   | 29   |
| 9    | 32  | 46   | 39   |
| 10   | 50  | 19   | 15   |

# Table 5. Cholesterol concentration for men in blood sample

| S.No | Age | LDL | HDL | VLDL | TGL   |
|------|-----|-----|-----|------|-------|
| 1    | 42  | 45  | 175 | 32   | 78    |
| 2    | 71  | 120 | 22  | 10   | 66.6  |
| 3    | 35  | 178 | 58  | 25   | 116.9 |



#### Rukshana MS et al. / European Journal of Molecular Biology and Biochemistry. 2016;3(2):107-112.

| 4  | 73 | 39.2 | 38 | 144 | 196  |
|----|----|------|----|-----|------|
| 5  | 60 | 123  | 36 | 28  | 140  |
| 6  | 31 | 182  | 45 | 37  | 159  |
| 7  | 82 | 143  | 31 | 15  | 125  |
| 8  | 43 | 189  | 43 | 34  | 145  |
| 9  | 42 | 134  | 70 | 43  | 55.8 |
| 10 | 81 | 180  | 50 | 26  | 78.2 |

#### Table 6. Cholesterol concentration for women in blood sample

| S.No | Age | LDL | HDL | VLDL | TGL   |
|------|-----|-----|-----|------|-------|
| 1    | 59  | 156 | 48  | 45   | 256   |
| 2    | 56  | 178 | 21  | 15   | 103.9 |
| 3    | 36  | 98  | 56  | 24   | 149   |
| 4    | 67  | 180 | 78  | 50   | 130   |
| 5    | 69  | 113 | 37  | 9    | 295   |
| 6    | 48  | 100 | 40  | 42   | 134.2 |
| 7    | 54  | 189 | 54  | 32   | 110   |
| 8    | 69  | 143 | 89  | 45   | 128   |
| 9    | 32  | 98  | 30  | 14   | 256   |
| 10   | 50  | 178 | 34  | 38   | 167   |

#### Table 7. Protein concentrations for men in blood sample

| S.No | Age | Urea | Creatinine |
|------|-----|------|------------|
| 1    | 42  | 32   | 1.20       |
| 2    | 71  | 47.7 | 1.1        |
| 3    | 35  | 42   | 1.4        |
| 4    | 73  | 42   | 1.1        |
| 5    | 60  | 47.7 | 1.7        |
| 6    | 31  | 26.1 | 1.0        |
| 7    | 82  | 31.7 | 1.0        |
| 8    | 43  | 38   | 1.8        |
| 9    | 42  | 42   | 1.3        |
| 10   | 81  | 35.2 | 1.0        |

#### Table 8. Protein concentrations for women in blood sample

| S.No | Age | Urea | Creatinine |
|------|-----|------|------------|
| 1    | 59  | 38   | 0.8        |
| 2    | 56  | 28.1 | 1.0        |
| 3    | 36  | 30   | 0.9        |
| 4    | 67  | 42   | 1.1        |
| 5    | 69  | 36   | 1.6        |
| 6    | 48  | 29.2 | 0.8        |
| 7    | 54  | 29   | 0.9        |
| 8    | 69  | 38.9 | 1.0        |
| 9    | 32  | 35   | 0.9        |
| 10   | 50  | 37.5 | 0.9        |

# SUMMARY AND CONCLUSION

A high prevalence of diabetes was noted in this rural population. It is also true that changes have been noted in the lifestyle of the population, which could have contributed to the above survey and also their medication of synthetic medicines. Therefore, future research in this survey should be made and want to identify natural remedies for diabetics using medicinal plants.

# ACKNOWLEDGEMENT: None

# **CONFLICT OF INTEREST:**

The authors declare that they have no conflict of interest.



# REFERENCES

- 1. Ali M and Knight A. (2009). Comparative healthcare, Diabetes Mellitus. Australasian Medical Journal, 1(5), 1–9.
- 2. Anjana RM, Ali MK, Pradeepa R, Deepa M, Datta M, Unnikrishnan R, Rema M and Mohan V. (2011). The need for obtaining accurate nationwide estimates of diabetes prevalence in India rationale for a national study on diabetes. *Indian Journal of Medical Research*, 133, 369–80.
- 3. Arora V, Malik JS, Khanna P, Goyal N, Kumar N and Singh M. (2010). Prevalence of diabetes in urban Haryana. *Australasian Medical Journal*, 3(8), 488–94.
- 4. Authoritative Institute of Health and Welfare (AIHW) (2013, December 13). National health priority areas.
- Bramley, D, Hebert, P, Jackson, R. and Chassin, M. (2004). Indigenous disparities in disease-specific mortality, a crosscountry comparison, New Zealand, Australia, Canada, and The United States. *New Zealand Medical Journal*, 117(1207), U1215.
- 6. Iyer SN, Drake AJ, West RL and Tanenberg RJ. (2011). Diabetic muscle infarction, a rare complication of long-standing and poorly controlled diabetes mellitus. *Case Reports in Medicine*, 2011, 407921.
- 7. Joshi, S.R. and Parikh, R.M. (2007). India diabetes capital of the world, now heading towards hypertension. *Journal of the Association of Physicians of India*, 55, 323.
- 8. Khalil H and George J. (2012). Diabetes management in Australian rural aged care facilities, A cross-sectional audit. *Australasian Medical Journal*, 5(11), 575–80.
- 9. Kumar A. (2010). Insulin guidelines, taking it forward. Medicine Update (API India), 20, 127-30.
- 10. Kumar A, Goel MK, Jain RB, Khanna P and Chaudhary V. (2013). India towards diabetes control, Key issues. *Australasian Medical Journal*, 6(10), 524.
- 11. Mathew E, Ahmed M, Hamid S, Abdulla F and Batool K. (2010). Hypertension and dyslipidaemia in Type 2 diabetes mellitus in United Arab Emirates. *Australasian Medical Journal*, 3(11), 699–706.
- 12. Minnie A and Rattigan S. (2012). Barriers to the management of Diabetes Mellitus is there a future role for Laser Doppler Flowmetry? *Australasian Medical Journal*, 5(12), 627–32.
- 13. Misra A and Khurana L. (2011). Obesity-related non-communicable diseases, South Asians vs White Caucasians. *International Journal of Obesity (London)*, 35(2), 167–87.
- 14. Mohan V, Deepa R, Shanthi Rani S and Premalatha G. (2001). Prevalence of coronary artery disease and its relationship to lipids in a selected population in south India. *Journal of American College of Cardiology*, 38, 682–687.
- 15. Mohan V and Deepa R. (2006). Obesity and abdominal obesity in Asian Indians. *Indian Journal of Medical Research*, 123(5), 593–96.
- 16. Mohan V, Shah S and Saboo B. (2013). Current glycemic status and diabetes related complications among type 2 diabetes patients in India, data from the A1chieve study. *Journal of the Association of Physicians of India (Supplement)*, 61, 12–15.
- 17. Mohan V, Seshiah V, Sahay BK, Shah SN, Rao PV and Banerjee S. (2012) Current status of management of diabetes and glycaemic control in India, Preliminary results from the Diabetic Care India 2012 Study, 61, a645–a677.
- 18. National Diabetes Education Program. (2013, December 13). Centers for Disease Control and Prevention.
- 19. National service frameworks and strategies. (2013 December 13).
- 20. National Health Services. (2011 July).
- 21. Pradeepa R, Rema M, Vignesh J, Deepa M, Deepa R and Mohan V. (2008). Prevalence and risk factors for diabetic neuropathy in an urban south Indian population, The Chennai urban rural Epidemiology Study (CurES-55). *Diabetic Medicine*, 25, 407–412.
- 22. Premalatha G, Shanthi Rani CS, Deepa R, Markovitz J and Mohan V. (2000). Prevalence and risk factors of peripheral vascular disease in a selected south Indian population The Chennai urban Population Study (CuPS) Diabetes Care, 23, 295–1300.
- 23. Ramachandran A, Snehalatha C, Kapur A, Vijay V, Mohan V, Das AK, Rao PV, Yajnik CS, Prasanna Kumar KM and Nair JD. (2001). Diabetes Epidemiology Study Group in India (DESI). High prevalence of diabetes and impaired glucose tolerance in India, National Urban Diabetes Survey. Diabetologia, 44(9), 1094–101.
- 24. Rastogi A, Bhadada SK, Saikia UN and Bhansali A. (2011). Recurrent diabetic myonecrosis, a rare complication of a common disease. *Indian Journal of Medical Science*, 65(7), 311–4.
- 25. Rao CR, Kamath VG, Shetty A and Kamath A. (2011). A cross-sectional analysis of obesity among a rural population in coastal southern Karnataka, India. *Australasian Medical Journal*, 4(1), 53–57.
- Rema M, Premkumar S, Anitha B, Deepa R, Pradeepa R and Mohan V. (2005). Prevalence of diabetic retinopathy in urban India, The Chennai urban rural Epidemiology Study (CurES) Eye Study. I. Investigative Ophthalmology & Visual Science, 46, 2328–2333.
- 27. State-based diabetes prevention and control program. (2013 December 13). Centers for Disease Control and Prevention. U.S Department of Health & Human Services.



- 28. Sui Z, Turnbull D and Dodd J. (2013). Enablers of and barriers to making healthy change during pregnancy in overweight and obese women. *Australasian Medical Journal*, 6(11), 565–77.
- 29. Sukala WR, Page RA, Rowlands DS, Lys I, Krebs JD, Leikis MJ and Cheema BS. (2012). Exercise intervention in New Zealand Polynesian peoples with type 2 diabetes, Cultural considerations and clinical trial recommendations. *Australasian Medical Journal*, 5(8), 429–35.
- Unnikrishnan RI, Anjana RM and Mohan V. (2011). Importance of Controlling Diabetes Early-The Concept of Metabolic Memory, Legacy Effect and the Case for Early Insulinisation. *Journal of the Association of Physicians of India* (Supplement), 50, 8–12.
- 31. Unnikrishnan RI, Rema M, Pradeep R, Deepa M, Shanthirani CS, Deepa R and Mohan V. (2007). Prevalence and risk factor of diabetic nephropathy in an urban south Indian population; The Chennai urban rural Epidemiology study (CurES-45) Diabetes Care, 30, 2019–2024.
- 32. Verma R, Khanna P and Mehta B. (2012). National programme on prevention and control of diabetes in India, Need to focus. *Australasian Medical Journal*, 5(6), 310–5.
- 33. Wild S, Roglic G, Green A, Sicree R and King H. (2004). Global prevalence of diabetes-estimates for the year 2000 and projections for 2030. Diabetes Care, 27(3), 1047–53.
- 34. Whiting Dr, Guariguata L, Weil C and Shawj. (2011). IDF Diabetes atlas, Global estimates of the prevalence of diabetes for 2011 and 2030. *Diabetes Research and Clinical Practice*, 94, 311–21.
- 35. Zargar AH, Khan AK, Masoodi SR, Laway BA, Wani AI, Bashir MI and Dar FA. (2000). Prevalence of type 2 diabetes mellitus and impaired glucose tolerance in the Kashmir Valley of the Indian subcontinent. *Diabetes Research and Clinical Practice*, 47(2), 135–46.

