A CASE STUDY ON

DIABETES MELLITUS

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"Diabetes is not the END, it's the BEGINNING of a new way of LIVING

Objectives of Case study Presentation

To discuss one of the macrovascular complications of Diabetes mellitus in the patient selected

DIABETES MELLITUS

Diabetes mellitus is a metabolic disease characterized by high blood sugar levels due to the pancreas not producing enough insulin or the body not effectively using the insulin it produces

Incidence and prevalence of DM

Global Increase:

The number of people with diabetes rose significantly from 200 million in 1990 to 830 million in 2022, with the fastest rise in low- and middle-income countries.

India's Burden:

In India approximately 101 million adults have diabetes and nearly 25 million are prediabetic.Over 50% of the people with diabetes are unaware of their condition, leading to delayed diagnosis and treatment. National incidence of diabetes increased from 162.74 per 100000 in 1990 to 264.53 per 100000 in 2021, with an APC of 0.63% (report on 11 th May 2025). According to WHO there are 77 million cases of diabetes in 2025.

Patient Information

Name: Mr.X

Age: 55 years

Gender: Male

Date of admission: 12/10/25

Date of discharge: 14/10/2025

Chief complaints: Left sided weakness, i.e., weakness of both upper and lower limbs since afternoon of 12.10.25.

Present health history:

Patient was a native of Guntur. He came to Chintalapudi village on some work. At this place he suddenly had weakness of left upper and lower limbs and was taken to Community Health centre, Chintalapudi. At that time patient was conscious, coherent. His blood pressure was 210/100 mm of Hg, Pulse 68 /mt, SPO2 was 96% on right hand, GRBS was 160 mg/dl. He was given Inj Lasix 40 mg stat, Inj Vitamin B 12 IM stat and Inj Rantac 50 mg IV. He was referred to Government General Hospital Eluru for further management.

Past medical history:

No significant past health history

Past surgical history:

There was no past surgical history

Family history:

No family history of diabetes mellitus and hypetension.

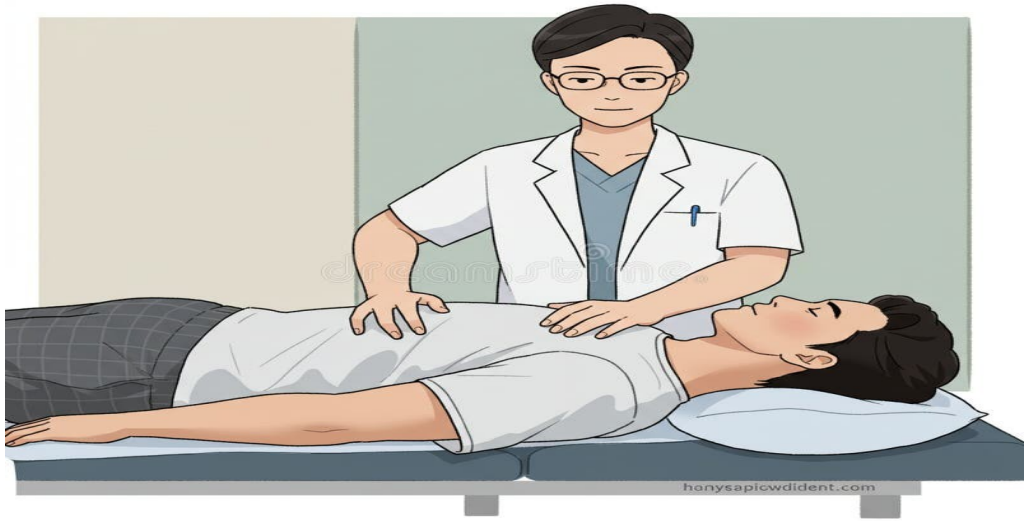
Personal history:

- Smoking :- No history
- Alcohol : - No history
- Food habit :- patient is having mixed meal pattern
- Bowel and bladder :- Regular bowel and bladder habit
- Sleeping Pattern :- having regular 8-10 hours of sleep during both day time and night time.
- Occupation : farmer

P HYSICAL EXAMINATION

General Inspection:

- Gait : Unable to walk due ro weakness of both left sided limbs.
- Body Build : Normal
- Consciousness : Conscious and coherent



Vital signs

- Temperature : 98.6*f
- Pulse : 88 b/minute
- Respiration : 20 /minute, regular
- Blood Pressure : 150/90 mm Hg in unaffected arm

General examination

- Pupils were bilaterally equal and reacting to light
- Muscle strength of left upper and lower limbs was decreased

Physical examination

1.**Head**

Hair color grey and texture normal

2.**Eyes**

Vision was normal

3. **Ears**

No discharge and difficulty in hearing

4. **Nose**

No discharge , bleeding and smelling problem.

5.**Mouth**

No missing teeth and dental carries, no deviation of angle of mouth

6. **Neck**

No enlarged lymph node and thyroid gland,normal neck mobility is present

7. **Extremities**

Normal on right side not no sensation on left side both upper and lower limbs.

SYSTEMIC EXAMINATION

Respiratory examination

- Inspection- normal
- Palpation- Non tender
- Percussion- Resonant in all side of the chest.
- Auscultation- Bilaterally normal vesicular breath sounds

Cardiovascular system

- Inspection: Normal S1 and S2 No other abnormalities were detected.

Abdominal examination:

Inspection- no distension ,moving symmetrically with respiration, no dilated superficial veins, no scar marks

Palpation- No tenderness present

liver- no engarlgement

Percussion- No dullness present

Auscultation-Bowel sounds present (normal)

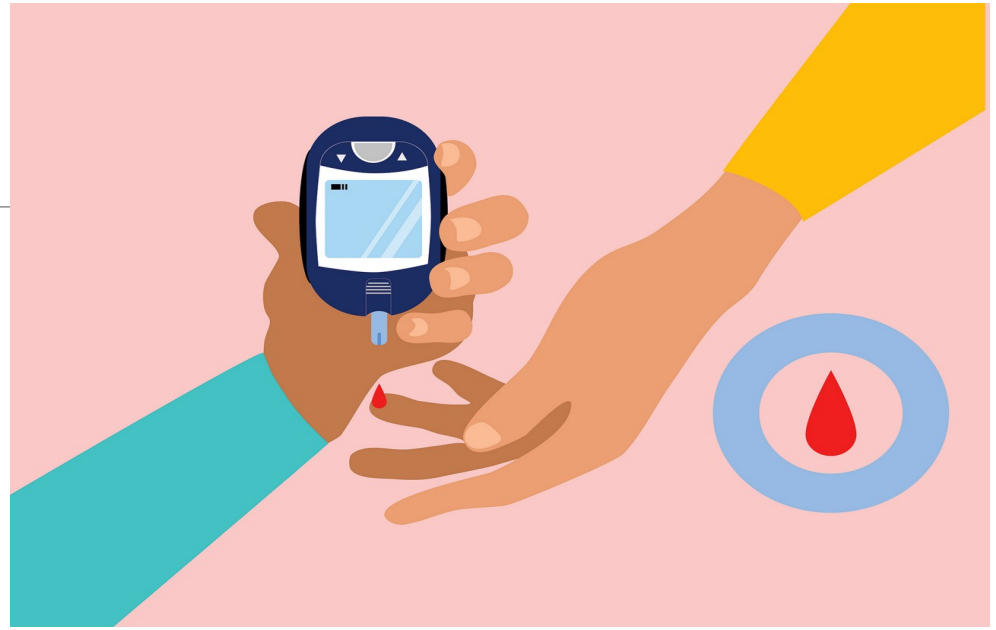
CNS examination

- Mental function is adequate

- Motor examination eg position of limbs normal ,no atrophy, uncoordinated gait due to weakness of left sided limbs.
- Sensory examination- loss of sensation on left side to temperature, loss of ability to distinguish hot and cold, pain sensation.

Investigations (12/10/2025)

Hematological



- RBS-290 mg/dl
- Sodium -145 m mol /L
- Potassium- 4.2 mmol / L
- Createnine-0.7mg/dl
- Blood urea-27 mg/dl

Sr albumin- 4.0 gm/dl

Total Proteins- 7.4 gm / dl

S. Bilirubin - 0.5 mg / dl

conti....

CBP Findings

Hb-13.1 gm /dl

Platelet count- 2.1L/ cumm

PCV- 43 %

Viral markers- negative

Blood Sugar levels:

GRBS- 290 gm/dl

CT Scan of brain shows lacunar infarcts involving bilateral MCA territories

Early small vessel ischemic changes

Age related mild diffuse cerebral atrophic changes.

Diagnosis- CVA with DM

Treatment

Inj Citicholine 100 ml IV BD

T. atorvastatin 20 mg HS

T. Metformin 500 mg BD

T. Glimipride 1 mg OD

T Asprin 75 mg OD

T. Clopidogrel 75 mg OD

Inj Mannitol 100 ml BD

Head end elevation

Physiotherapy

Recommendations (Informal Health Teaching)

1. Diabetic Diet plan with strict salt restriction to control Hypertension.
2. Foot care and skin care on the left side as it is paralysed
3. Exercises- Active and passive exercises to improve circulation
4. Adequate fluid intake (3-4lt daily) to prevent dehydration
5. Regular check up to prevent further complications

"It all starts in the mind. Just keep reminding yourself that you can beat this"