

Evolution of the follow-up of the diabetic patient during the pandemic in community Autonomous (Aragon), health sector and Primary Care center

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Introduction

Diabetes mellitus (DM) type II is a global public health problem and causes an increase in morbidity and mortality in the affected population as a result of the development of micro and macrovascular complications. That is why monitoring and control is required narrow, as well as complications and associated risk factors.

Primary Care is the gateway for the rest of the health offer, guarantees the globality and continuity of care throughout the patient's life.¹ It has a central position in the care of people with DM type II. It is the second reason for consultation for chronic pathology in primary care, after arterial hypertension.²

The current pandemic situation caused by SARS-CoV-2 has caused since its an increase in care pressure and a progressive saturation of health systems began worldwide, limiting the attention, material and personal resources of various chronic diseases that require periodic reviews, such as DM, generating with this a worsening of the evolution in the levels of parameters and indicators of assessment and follow-up of the diabetic patient.

Objectives

- I. To know the prevalence of diabetics in outpatient and hospital sector.
- II. Observe which parameters have suffered the greatest worsening in their values.
- III. Compare the evolution of the same between the health center, the hospital sector and
- IV. Autonomous community (Aragon).

Methods

The data of this descriptive study were collected in relation to the months of January, April, July, October and December 2020 (rest of the months were excluded because glycated haemoglobin varies every 3 months) of the User Database (BDU) of the OMI-AP program. Likewise, the total number of diabetics in Sector II of Zaragoza has been compared (25782 diabetics) and Aragon (84300 diabetics).

Inclusion criteria: type II diabetic population without age or sex limits and chose the following control indicators: glycated hemoglobin, glomerular filtration rate, microalbuminuria, hypoglycemia and retinopathy.

Results

Prevalence of diabetic hospital sector 25782 (6.44%), outpatient 1190 (6.14%).

Glycated haemoglobin: both in ambulatory and in sector and autonomous community (Aragon) at the end of the year the control decreased by 9%, 6% and 8% respectively. Microalbuminuria: since

January until April the good control was maintained in the 3 areas until the figures fell without improvement. Glomerular filtration rate: globally 80% of patients with DM type II had a control suitable in January 2020. Hypoglycaemia: only 13% were controlled in the 3 areas studied at the end of the year compared to 30% initially. Retinography: 48% of our patients had adequate controls in the outpatient clinic observing the most decrease marked in October up to 35%. In the sector and autonomous community we observe better control in the last 2 months.

Conclusion

Worsening during 2020 of the health indicators of Diabetes Mellitus type II at the 3 levels. Glomerular filtration is the most recorded best controlled parameter. Accessibility to Primary Care has been reduced in the pandemic period in vulnerable patients.

Discussion

The COVID-19 pandemic has caused a stop in the care of chronic patients. The fear of transmission has caused the suspension of both therapies and delay in the diagnosis of serious diseases such as stroke or heart attacks and monitoring of chronic diseases of our patients of a whole professional life. Several studies have seen that it has had a great emotional impact.¹

A recent study from China during the pandemic has shown that elderly patients with type II diabetes mellitus experienced worsening glycemic control manifested as an increase in fasting blood glucose.³ The impact of social distancing, quarantine and lockdown on lifestyles would likely have led to worse glucose control. First, confinement and social distancing would have limited the physical activities of people with DM. Second, the restriction in food supply during lockdown would have forced people with DM to modify their eating habits previously associated with good glycemic control. Third, obtaining antidiabetic drugs and glucose strips would have been more complicated amid the ongoing restrictions. Finally, people with diabetes mellitus would not have been able to visit their doctors for routine clinical check-ups; therefore, an appropriate adjustment of treatment in these patients would not have been possible. This would have resulted in sustained periods of hyperglycemia (and

probably frequent episodes of hypoglycemia) that would not have been addressed given the absence of face-to-face consultations at the health center.⁴

The COVID-19 pandemic has multiplied its devastating effects on the chronic diseases of our patients.

Several of the risk factors and non-communicable diseases such as obesity, diabetes and cardiovascular disease are associated with an increased risk of vulnerability and neglect from COVID-19. But diseases not only interact with biological factors, but also with social factors. Urgent action needed to address chronic disease syndemic, social inequalities and COVID-19.²

International studies conducted in mid-April ruled that neglecting the control of risk factors (high blood pressure, high cholesterol, diabetes, overweight, smoking, diet and sedentary lifestyle) during the pandemic, either due to quarantine or lack of control of medical parameters, could increase between 3,500 and 10,500 new diagnoses of cardiovascular disease that would have previously been preventable between April and October. As for the number of preventable deaths, it could increase between 6,000 and 9,000 cases before the end of the year.⁵

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None.

Conflicts of interest

Author declare that there is no conflicts of interest.

References

1. Social Welfare and Family, Government of Aragon. *Primary Care Aragon*. 2011.
2. Guerra A, Cañizo R, Loscos R. Prevalence, degree of control and treatment of cardiovascular risk factors in type 2 diabetic patients in a health center. *Av Diabetol*. 2007;23(2):131-136.
3. Xue T, Li Q, Zhang Q, et al. Blood glucose levels in elderly subjects with type 2 diabetes during COVID-19 outbreak: a retrospective study in a single center. *Endocrinology*. 2020.
4. Banerjee M, Chakraborty S, Pal R. Diabetes self-management amid COVID-19 pandemic. *Diabetes Metab Syndr*. 2020;14(4):351-354.
5. Parra Molina E, Martínez Ferrer JG. Interpretación de los análisis en la diabetes mellitus. *semFYC*. 2019;15(2):91-96.