INTRODUCTION
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Diabetes mellitus is the most common endocrine disease. The true frequency is difficult to ascertain because of differing standards of diagnosis but probably it is between 1 and 2 percent. The disease is characterized by metabolic abnormalities; by long-term complications involving the eyes, kidneys, nerves and blood vessels; and by a lesion of the basement membranes demonstrable by electron microscopy.

The first clinical description and the name of diabetes was given almost two thousand years ago by Aretaeus of Cappadocia.

There has been a greater increase in the number of diabetics in the past few decades than can be explained by the general increase in average age of the population. In the United States, diabetes statistically holds seventh place as a cause of death and third place as a cause of blindness.

Insulin dependent (Type I) diabetes is due to damage to the Beta cells of Pancreatic islet of Langerhans. It is not directly inherited, although individuals may inherit a predisposition associated with certain HLA types. The peak incidence is 10 - 20 years, although elderly patients can also be Insulin dependent. Non-insulin dependent
(Type II) diabetes has no known cause, although in many causes there is a strong genetic component, unrelated to the HLA system. It is most prevalent after middle age and occurs most frequently between the ages of 50 and 70 years, although there is a certain amount of overlap between the two types of diabetes.

The prognosis of the diabetic patient has basically changed with the discovery of insulin. Diabetic coma was the main cause of death in diabetics before 1921, and the average time of survival was about 5 years. Today, a diabetic lives almost as long as the average normal person. His fate is extensively determined by the late complications of the blood vessels. Involvement of small as well as large blood vessels presently represents almost 80% of the direct cause of death in the diabetic patient. They should, therefore, be the main object of the medical and scientific effort.

Diabetic microangiopathy is virtually specific for diabetes mellitus according to Jaeger (1856). Diabetic retinopathy represents a direct result of this angiopathy. Arteriosclerosis and hypertension may predispose for the development of diabetic retinopathy. Diabetes on the other hand, may cause earlier development of arteriosclerosis and hypertension.
Vision is significantly affected due to functional or structural damage of different structures of the eye. These changes are related to duration of disease, age of onset and control of diabetes.

The diabetes in eyes creates problems in two different ways, one by affecting the body functions as a risk factor, secondly by changing the osmolarity of blood and tissue hydration which leads to rapid and repeated changes in number of glasses, blurring of vision, muscle weakness, recurrent infection of lid, changes in lens and retina along with raised intraocular pressure. Among these diabetic retinopathy is a serious complication which leads to blindness.