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The present study consisted a total of 63 patients, 25 diabetic and 38 non-diabetic dyspeptics, who were subjected to upper gastrointestinal endoscopy and rapid urease test. Out of the 25 diabetic dyspeptics, 18 (72%) patients were RUT+ve where as among the 38 non-diabetic dyspeptics, 20 (52.6%) patients were RUT+ve (table 1). Biopsy specimens from RUT-ve patients which were sent for histologic detection of *H. pylori* turned out to be positive in 2 diabetic dyspeptic patients and 1 control dyspeptic patient (table 2).

Thus this study showed a total prevalence of *Helicobacter pylori* in diabetic dyspeptic to be 80% where as in control dyspeptics to be 55.26% (table 3; P<0.05 but > 0.01).

This result appears quite similar to many other previous studies on comparable series (106-108,112,115,117,119-122) which have shown a significant correlation between *H. Pylori* and diabetes stating the possible role of autonomic neuropathy(95,122), microvascular complications and increased susceptibility of infection in diabetics (97,101,121).

In the present study prevalence of *H. Pylori* infection increased with increasing age in both diabetic & control dyspeptics with 70% in diabetic and 50% in control dyspeptics in 30-39 yrs age group. The
prevalence reached 100% in diabetic and 80% in control dyspepts in age group 50-59 years (table 4), which is in accordance with the usual trend of H.Pylori prevalence with age. The difference however was not statistically significant in our study (P>0.1).

The prevalence of H. Pylori in male and female was similar (P>0.5). It was 76.9% and 54.5% in male diabetic and control dyspepts respectively while 83.3% and 56.6% in female diabetic and control dyspepts respectively (table 5).

All our patients were from a low and middle socioeconomic status. None were from high socioeconomic group, which could be due to the reason that Bundelkhand is an economically backward area. In our study there was no significant difference in the prevalence of H pylori in low and middle socioeconomic group (P>0.1). Prevalence in low socioeconomic group was 87.5% and 61.54% in diabetic & control dyspepts respectively, while in middle socioeconomic group it was 66.7% & 41.67% in diabetic and control dyspepts respectively (table 6).

Among diabetic dyspepts, 85.7% H. Pylori +ve patients were hailing from rural areas, 85.7% were H. Pylori +ve patients and from the urban areas 72.7% were H. Pylori +ve. Among control dyspeptic hailing from rural areas, 59.1% were H. Pylori +ve while from the
urban areas 50% were H. Pylori +ve ((table 7). The difference in the two
groups was not statistically significant(P>0.1).

The complaints were similar in H. pylori +ve and H. pylori -ve
groups in both diabetic & control dyspeptics. Belching with bloating was
the most common complaint in diabetic dyspeptics (in 84% of diabetic
dyspeptics) where as pain in abdomen/epigastric discomfort was the
most common complaint in control dyspeptics (in 73.68% of control
dyspeptics). Increased prevalence of belching and bloating in diabetics
dyspeptics can be attributed to higher incidence of gastroparesis in
diabetics.

In our study there was no significant correlation between duration
of symptoms and prevalence of H.pylori ( P > 0.5 ). The prevalence of
H. Pylori in diabetics and control dyspeptics having complaints for < 1
year was 77.7% and 55.5% respectively, which was similar to the
prevalence of H. Pylori in diabetics and control dyspeptics having
complaints for > 1 year ( 81.25% and 55% respectively) (table 9) This
shows that duration of complaints have no affect on H Pylori
prevalence.

With increase in duration of diabetes complications in diabetics
also increase . Increase in incidence of microvascular complications
and autonomic neuropathy may cause altered G I motility and promote
H. Pylori colonization . In our study the prevalence of H Pylori was
significantly more in patients having diabetics for more than 5 years.
(100%) as compared with patients with diabetes of duration less than 5 years (58.3%). (table 10; P<0.05)

In our study upper G.I endoscopy findings in H. pylori +ve diabetic dyspeptics showed gastritis in 65%, reflux esophagitis in 30%, duodenitis in 30%, gastric ulcer in 10%, duodenal ulcer in 10% and normal finding in 35% patients. The results were quite similar to endoscopy findings in H. pylori +ve control dyspeptics which were gastritis in 52.4%, reflux esophagitis in 28.6%, duodenitis in 23.8%, gastric ulcer in 9.5%, duodenal ulcer in 9.5% and normal finding in 33.3% patients (table 11). No patient had evidence of malignancy on upper G.I endoscopy in either group.

Among H. pylori -ve diabetic dyspeptics maximum no. of patients had normal findings on upper G.I endoscopy followed by reflux esophagitis in 40% and gastritis in 20% patients. Among control dyspeptics upper G.I endoscopy findings showed normal finding in 70.5%, reflux esophagitis in 23.5%, gastritis in 11.7% and gastric ulcer in 5.6% patients. The findings in our study were similar to the usual trend in practice.

Autonomic neuropathy in diabetics by causing delayed gastric emptying (Gastroparesis diabeticorum) has been implicated in the increased prevalence of H. Pylori infection in diabetics. But in our study there was no significant difference in autonomic neuropathy between
both *H. Pylori* positive and *H. Pylori* negative diabetic diabetic patients.

The prevalence of autonomic neuropathy was found to be 25% in *H. pylori* +ve patients and 20% in *H. Pylori* -ve patients. Thus other factors like increased susceptibility to infections and microvascular complications in diabetics may be responsible for the increased *H. Pylori* prevalence in them.