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Case Report: Type 2 Diabetes Mellitus for The Elderly with Less Family Support

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CASE REPORT

Mrs. R, 65 years old came to Puskesmas B with complaints of fatigue during activities accompanied by weakness since 1 week ago. The patient has been diagnosed with Diabetes Mellitus since 2 years ago, but the patient admitted that she sometimes went to the health center once every 2 or 3 months depending on the patient's complaints. According to the patient's acknowledgment, initially complaints of fatigue were felt rarely but gradually became more frequent and appeared during light activities and felt continuously. Complaints are not accompanied by blurred vision or numbness.

The patient admitted that if the medicine from the puskesmas ran out, complaints in the form of frequent thirst, frequent urination, hunger, and fatigue were felt again which indicated that the patient's blood sugar was rising, the patient admitted that the highest blood sugar reached 600 mg/dL. During Mrs. R's treatment, Mrs. R not only went to the health center for treatment but also frequently went to midwives and paramedics near the house.

Mrs. R took the drugs metformin and glimepiride if she had just gone to a health professional when she had a complaint, Mrs. R admitted that because of the complaint of feeling weak, Mrs. R often consumed date juice 3 times 1 spoon every day. Mrs. R is often given explanations by health workers to maintain her diet, but according to her she still can't regulate her diet properly. Mrs. R still can be active and currently the patient is active as a housewife, every Saturday, Mrs. R follows the program from the village, namely elderly gymnastics, on other days Mrs. R does not do sports, and only does home activities. Mrs. R denied smoking

history, denied drinking alcohol, and denied drugs. Mrs. R currently lives with her husband and one grandson.

On physical examination found, general condition: looks moderately ill; consciousness: *compos mentis*; blood pressure 120/80 mmHg; pulse: 80 x/minute; breathing: 20 x/minute; body temperature: 36.4 °C; weight: 58 kg; height: 155 cm; Patient BMI: 24.8 overweight nutritional status. Current blood sugar 300 mg/dl. Mrs. R once checked blood at the biolab partner clinical laboratory on August 25, 2020 with an HbA1c result of 8.7%. Lipid profile Cholesterol 203 mg/dL, Triglycerides 137mg/dL, HDL 73 mg/dL, LDL 132 mg/dL. Kidney function urea 29 mg/dL, Creatinine 0.64 mg/dL.

Biological Diagnosis and Psychosocial Diagnosis

A holistic diagnosis was formulated as the patient having a complaint of fatigue during activities accompanied by weakness since 1 week ago, she is worried that her condition would worsen and wishes that her pain can be relieved and her condition controlled in order to carry out her normal daily activities. The patient is considered as an elderly overweight lady, with uncontrolled diet with little physical activity.

Diagnosis was made based on patients' history, physical and lab examination, which was conducted both at the puskesmas and during home visits. Though she denied any classical symptoms of diabetes, a current blood sugar of 300 mg/dl and risk factors of being overweight, with uncontrolled diet and physical activity leads to the diagnosis of diabetes type 2.

On psychosocial diagnosis, the patient is deeply concerned that the disease will get worse. She has no prior awareness or knowledge of diabetes, referring to only her awareness that illnesses will take longer to heal. The patient assumes this disease is a disease that

does not need routine treatment. She lives with her husband and one grandson. Currently the patient has seven children, the first to fifth children are married, the sixth and seventh children are not married but live in different cities with the patient.

Assessment

Table 1. Results of Depression Screening with Geriatric Depression Scale (GDS)

1	Apakah anda sebenarnya puas dengan kehidupan anda?	YA	TIDAK
2	Apakah anda telah meninggalkan banyak kegiatan dan minat atau kesenangan anda?	YA	TIDAK
3	Apakah anda merasa kehidupan anda kosong?	YA	TIDAK
4	Apakah anda sering merasa bosan?	YA	TIDAK
5	Apakah anda mempunyai semangat yang baik setiap saat?	YA	TIDAK
6	Apakah anda takut bahwa sesuatu yang buruk akan terjadi pada anda?	YA	TIDAK
7	Apakah anda merasa bahagia untuk sebagian besar hidup anda?	YA	TIDAK
8	Apakah anda sering merasa tidak berdaya?	YA	TIDAK
9	Apakah anda lebih senang tinggal di rumah daripada pergi ke luar dan mengerjakan sesuatu hal yang baru?	YA	TIDAK
10	Apakah anda merasa mempunyai banyak masalah dengan daya ingat anda dibandingkan kebanyakan orang?	YA	TIDAK
11	Apakah anda pikir bahwa hidup anak sekarang ini menyenangkan?	YA	TIDAK
12	Apakah anda merasa tidak berharga seperti perasaan anda saat ini?	YA	TIDAK
13	Apakah anda merasa penuh semangat?	YA	TIDAK
14	Apakah anda merasa bahwa keadaan anda tidak ada harapan?	YA	TIDAK
15	Apakah anda pikir bahwa orang lain lebih baik keadaannya dari anda?	YA	TIDAK

SKOR :
Geriatric Depression Scale score: 3 (point number 2, 4, 9)

Table 2. Mini Mental State Examination (MMSE) Instrument Screening Results

Maximum Score	Senior Score	Information
10	10	Orientation
3	3	Registration
5	5	Attention and Calculation
3	3	Remember
9	9	Language
Awareness: compos mentis		
Interview Place: patient's house		

Family Assessment Tools

Figure 1. Genogram

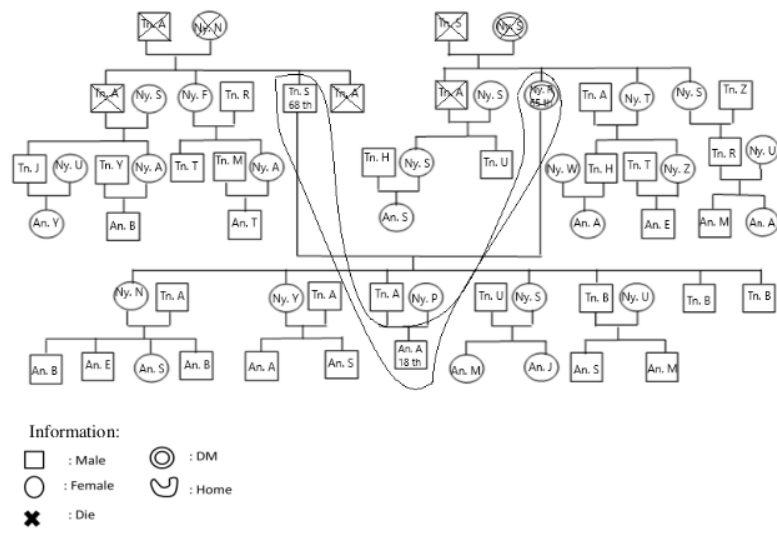
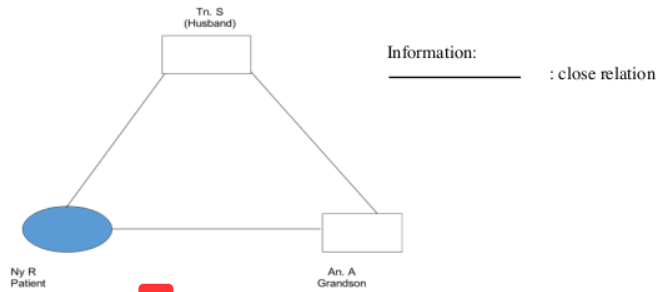


Figure 2. Family Map



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Table 3. Family APGAR Score

Adaptation	: 2
Partnership	: 2
Growth	: 2
Affection	: 2
Resolve	: 1

Total Family APGAR Score: 9 (good family function).

Table 4. Family SCREAM Analysis

SOURCE	PATHOLOGY	KET
<i>Social</i>	Good interaction between family members, patient participation in active community activities. Currently the patient spends time at home with family members.	-
<i>Culture</i>	Satisfaction or pride in good culture, this can be seen from daily interactions both in the family and in the environment, many cultural traditions are still followed. Using Javanese language, manners and politeness.	-
<i>Religious</i>	The application of the teachings is also good, this can be seen from the sufferers and their families who routinely pray five times a day, the patients also wear headscarves and the patient's husband often prays to the mosque.	-
<i>Economic</i>	This family is classified as middle class, primary needs can be met, secondary needs and economic plans are adequate, a priority scale is needed to meet the needs of life	+
<i>Educational</i>	Low education of family members, patient and husband are elementary school graduates	+
<i>Medical</i>	In seeking health services, families use puskesmas services and use the Jamkesmas card (BPJS) for treatment. Patients claim that they will only seek treatment if there are complaints, patients rarely do health checks regarding their illness.	+

FORMULATION OF THE PROBLEM

The issue in this case is multifaceted, encompassing not only the clinical aspects of diabetes type 2 and overweight, but also the psychosocial aspects of the patient's ability to self-manage her disease. Type 2 diabetes is a debilitating condition that causes cognitive and functional deficits as well as dependency, putting a considerable strain on healthcare systems as well as social services. Long-term care is required for type 2 diabetes, which places a strain on personal, family, and public resources. Type 2 diabetes, on the other hand, is a self-managing illness in which patients can meet 99 percent of their own needs⁽¹⁾.

Diabetes management in older individuals is difficult since there is such a wide range of clinical presentation, psychosocial milieu, and resource availability in this population. Both glycemic goals and diabetes management can be influenced by a person's living situation and the level of accessible social support. Diabetes management varies depending on where older

persons live (i.e., whether they are community dwelling or live in an assisted-living facility or a nursing home)⁽²⁾.

Because the senior population is physiologically diverse, a full assessment, which incorporates functional factors in the decision-making process, is required⁽³⁾. The elderly have the highest risk of hypoglycemia as a consequence of diabetes treatment among adults of all ages. The loss in body mass associated with aging and frailty syndrome might result in a significant reduction in the demand for anti-diabetic medications, both oral and insulin. Similarly, as kidney function declines with age, the doses of medicines that stimulate insulin production or insulin levels that have been successfully regulating the course of the illness may become excessively high⁽⁴⁾.

DISCUSSION

Comorbidities (geriatric syndromes) such as cognitive impairment, depression, functional disability, falls and fractures, polypharmacy, chronic pain, and urine incontinence are all increased by aging and diabetes. If doctors are unaware of these coexisting disorders, they may recommend treatment that is too complicated for a patient with cognitive impairment, or they may overlook an opportunity to treat depression, which can lead to medication nonadherence and social isolation⁽²⁾.

Overweightness, obesity, inheritance, and a lifestyle that includes smoking and drunk²⁰ss were the leading causes of diabetes⁸ the key causes of type 2 diabetes were a person's lifestyle and eating⁸ habits, which led to overweightness and obesity. Type 2 diabetes has a hereditary component from a close family member and is linked to gene alterations that are passed down via the family's genetic line⁽⁵⁾. Geriatric patients are different from other young adult patients, both in terms of health concepts and in terms of causes, travel, and symptoms and signs of the disease so that, the procedure for diagnosis in geriatric patients is different from other populations.

Diabetes Management in Elderly

Early implementation of multimodal and multidisciplinary¹⁶ therapies focused on nutritional education and physical activity in older individuals with type 2 diabetes has been proven to be helpful in maintaining functional autonomy. For all diabetic patients, even older adults, lifestyle adjustment is critical as a first step. Although very restricted diets are not indicated for older persons, counseling to avoid big carbohydrate loading at any one meal can help to lower glucose excursions without putting them on a restrictive diet. Exercise is beneficial to people of all ages. When creating an exercise regimen, it's crucial to consider the patients' physical abilities⁽²⁾.

From the results of nutritional assessment by nutrition officers the following results were obtained: weight: 58 kg; height: 155 cm; BMI: 24.8 kg/m² (overweight).

Calculate energy requirements in JMP patients:

Using the Brocca formula can be determined Ideal Weight (BBI) = (Height - 100) x 1 kg = 55 kg.

Basal Energy = BBI x 25 kcal/kg BB = 55 x 25 = 1,375 calories

Correction of 65 years old reduces 10% = -137.5 calories

Correction of mild activity added 20% = +275 calories

Correction of fat nutritional status = -20% = -275 calories

So the need for energy = 1.375-137.5 + 275-275 = 1,237.5 calories.

Dietary behavior was linked to a higher mean fasting blood sugar level, which was statistically significant⁵. The high consumption of sweets is a crucial issue that can be targeted to enhance diabetes control in Malay patients⁽¹⁾.

In the elderly, nutrition education programs have shown to enhance metabolic regulation. Because these diets often provide minimal proteins, they should be avoided in senior individuals due to an increased risk of hypoglycemia and malnutrition⁽³⁾.

One of the pillars of type 2 diabetes management is physical activity. Physical activity, particularly multicomponent activity (aerobic, resistance, flexibility, and balancing), has been proven to improve not only glucose control but also functional independence, self-esteem, and quality of life in the elderly with diabetes. Resistance exercise to improve muscle mass is a key component in preventing and treating DM 2 in the elderly, and it is the preferred regimen for frail old patients. Contrary to popular belief, moderate to high-intensity activities are more beneficial for glycemic management and are generally safe for the elderly⁽³⁾.

As a general rule, treatment for older individuals should begin with low-dose antidiabetic drugs with low hypoglycemia risk (particularly metformin and dipeptidyl peptidase-4 inhibitors (DPP-4I)), with a gradual increase in dose and monitoring of response after each increase. Drugs linked to a high risk of hypoglycemia (sulfonylureas and insulin, especially postprandial and combinations) should be avoided as much as possible. Several studies have proved its safety in the treatment of elders. Its benefits include its effectiveness in lowering HbA_{1c} levels, positive effects on body mass and lipid profiles, and the fact that metformin is a medicine that improves prognosis^{(3), (4), (6)}.

Education

Diabetes self-care was found to be significantly linked to the patients' diabetes knowledge in older individuals. When compared to patients with low diabetes awareness, individuals with good and adequate diabetes knowledge had better diabetic self-care. Education is a critical component that must be prioritized. This investment will ensure that the high expenses associated with diabetic complications are reduced over time. Patient education increased patient understanding and had a good effect on metabolic management, according to two meta-analyses⁽¹⁾.

Evidence revealed that a patient's self-efficacy and motivation, together with proper knowledge, can

accurately predict behavioural improvements. Motivation and self-efficacy (confidence) were critical in forming a change intention. An individual might attain his or her specific goals with the idea that they will retain the improvements if they act with intention and receive suitable knowledge⁽⁷⁾. Meanwhile, a 2017 study looked into type 2 diabetes patients' preferences for DSME (Diabetes Self-Management Education). Patients prefer to be trained in fewer sessions and for shorter periods of time, according to research. This suggests that the substance of educational sessions, as well as how they are tailored to patients' needs, are more essential than the quantity and duration of the educational sessions⁽⁸⁾.

Family Support

Families are one of the key providers of social support for adults with DM, according to systematic reviews, and families actively participate in the health treatment of adults and elders. When patients have blood relatives, care is most typically delivered by a family member, not just because of their existing link, but also since this is a cultural responsibility. Social support can be thought of as a personal dimension of family ties, i.e., something that happens as a result of them, regardless of the family structure⁽⁹⁾.

Friends, family members, nurses, and physicians can all help patients. The results of this study were consistent with those of other research conducted around the world, suggesting a beneficial relationship between family support and diabetes self-care. When compared to individuals who had no caregiver throughout their sickness or were cared for by others, such as friends or nursing home employees, elderly patients who were cared for by their family had better levels of diabetic self-care⁽¹⁾. When compared to those who did not have family support, adherence to diet and exercise was found to be higher⁽⁷⁾.

Many studies included family members' information and roles in program activities such as providing emotional support for problem-solving and assisting patients in resolving emotional distress, or providing information and roles to facilitate, accommodate, remind, motivate, and partner with behavior change and task completion. In some of the trials included in this evaluation, family members were included in an intervention program. Family members may be able to assist patients in strengthening self-management therapies and extending the duration of the intervention's effectiveness⁽¹⁰⁾.

Religion and spirituality of the members of a family can influence both positively and negatively the approach of the family facing a problem; in other words, it can interfere with their ability to deal with a particular pathology. The spirituality and religion can still

influence family habits, values and health care to the patient⁽¹¹⁾.

Understanding family profiles is one way to gain a full understanding of patients as members of their families. In addition to risk assessment, family history data can be utilized to tailor health messaging, which may be more effective than standardized health messages in promoting healthy behaviors⁽¹²⁾.

Risk of Depression

Diabetes has been linked to an increased incidence of depression. Poor blood sugar control, a rigorous diet, and physical activity requirements, as well as medication, may raise the risk of depression in diabetic patients. Chronic stress was discovered to cause hyper-activation of the hypothalamic-pituitary-adrenal axis and an increase in cortex, which has been identified as a key mechanism for interpreting the clinical links between diabetes and depression⁽¹³⁾.

According to Goldney et al, diabetics have a higher prevalence of depression than non-diabetics, with about 24 percent of diabetics having depression compared to 17.1 percent of non-diabetics. In a systematic study of depression in diabetics, Gavard et al found that the prevalence of depression in diabetics ranged from 8.5 percent to 27.3 percent. Depression, on the other hand, is linked to a 60% increased risk of type 2 diabetes⁽¹⁴⁾.

The high incidence of comorbid depression in diabetes patients may be due to the disease's psychosocial burden, a lack of social support, awareness of having a chronic disease and its associated problems and limitations, and the resulting psychological burden. Furthermore, co-morbid depression linked to poor diabetes control measures such as glycemic control, retinopathy, nephropathy, neuropathy, microvascular problems, and sexual dysfunction in people with diabetes⁽⁶⁾.

The psychological and pharmacological treatment of depression in subjects with diabetes is associated with significant clinical improvements. Such improvements occur not only in mood but also in adherence to diet and treatment regimens for type 2 diabetes, thereby impacting glycemic control, reducing chronic complications and improving quality of life⁽¹⁵⁾.

Those who were overweight, had poor physical capabilities and exercise, and had several additional ailments had a higher risk of depression, according to multivariate analysis, whereas those who took metformin had a lower risk of depressive symptoms⁽⁶⁾.

Activating and empowering evaluates whether physicians convene family meetings to address a patient's health problem or problems that arise as a result of the health problem, provide family counseling to address the patient's health issues, improve the

family's ability to manage the patient's health issues, strengthen the family's ability to manage the patient's health problems, raise the family's knowledge of how to manage the patient's health problems, evaluate family coping, and determine the impact of the patient's sickness on the family⁽¹²⁾. The family approach in the

management of diabetes mellitus helps identify factors that influence clinically, personally, and family psychosocially. With this approach, management will be more comprehensive and is expected to improve the patient's quality of life.

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