Type 2 Diabetes Correlates with Comorbidity and Nutritional Status but Not with Functional Health in Geriatric Ward Patients: A Cross-Sectional Study in Poland

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Purpose: The study aimed to assess the comorbidity profile, functional, and nutritional health in geriatric ward patients depending on their type 2 diabetes (DM) status.

Patients and Methods: We performed a cross-sectional study of 416 patients – median age 82 years (IQR 77–86), 77.4% female, 96.9% community-dwelling – consecutively admitted to the geriatric ward at the turn of 2014 and 2015. Comprehensive geriatric assessment results were analyzed (including self-care and instrumental activities of daily living, cognitive abilities, emotional health, risk of falls, frailty status, dynapenia, nutritional health, morbidity, biochemical parameters, and pharmacotherapy).

Results: DM was observed in 126 (30.3%) patients hospitalized in the study period; 4% of DM cases were newly diagnosed. In comparison to patients without DM, older adults with type 2 DM were significantly more frequently burdened with multimorbidity (61.1% versus 39.7%, P<0.001), polypharmacy (88.9% versus 74.7%, P=0.001), obesity (59.8% versus 34.5%, P<0.001), abdominal obesity (94.4% versus 75.5%, P<0.001), chronic kidney disease (61.1% versus 48.6%, P=0.02) and cardiovascular diseases: ischemic heart disease (66.7% versus 47.9%, P<0.001), congestive heart failure (50.0% versus 34.1%, P=0.002), atrial fibrillation (30.2% versus 20.7%, P=0.04) and peripheral arterial disease (24.6% versus 11.4%, P<0.001). There were no significant differences in all functional parameters evaluated.

Conclusion: Type 2 DM patients were significantly more often burdened with multimorbidity, polypharmacy, obesity, and had an unfavorable profile of cardiovascular diseases than patients without DM, but – contrary to our expectations – they did not differ in any functional characteristic assessed. However, this may be due to the geriatric ward patients’ specificity of health problems in the advanced, more complex disablement process phases.

Keywords: diabetes, older adults, geriatric department, comprehensive geriatric assessment, obesity, disability, chronic diseases, multimorbidity

Summary

- Due to the aging of the population and the growing obesity epidemic, diabetes mellitus (DM) prevalence will increase in developed countries. It is associated with significant morbidity and mortality, but findings on its consequences for the geriatric population’s functional status are inconsistent.
- We aimed to assess the health and functional correlations of type 2 DM in older patients admitted to the geriatric ward.
• Type 2 DM patients were significantly more often burdened with multimorbidity, polypharmacy, obesity. They also had an unfavorable profile of cardiovascular diseases than patients without DM. Contrary to our expectations, they did not differ in any functional status characteristics that we assessed.
• The specificity of the health problems of patients hospitalized in the geriatric ward, being in the advanced or final phase of the disablement process, could influence the results, but it needs further research.

Introduction

Diabetes mellitus (DM) is one of the most common health problems in old age, associated with significant morbidity and mortality. The disease burden of DM in developed countries is still growing. In 2019 its global prevalence was estimated to be 9.3% (463 million people) and projected to reach 10.9% (700 million) by 2045. This is partly due to the aging population and the growing population obesity epidemic. Body mass index (BMI) was the most vital factor associated with an increase in the prevalence of diabetes.

Both obesity and diabetes and at least partly sarcopenia are known risk factors for developing physical disability among older adults. Moreover, cardiovascular disease and other long-term DM complications can place these individuals at higher risk for functional impairment and worsen their prognosis. However, some studies’ results did not clearly show a relationship between diabetes and impaired performance in the elderly population. Also, although 1/3 - 1/3 of geriatric wards patients have type 2 diabetes, comparatively little is known to what extent DM correlates with a disability and chronic diseases profile in this specific population, generally seriously affected by multimorbidity and disability. Therefore, the study aimed to explore health and functional correlates of type 2 DM in older patients admitted to the geriatric ward (“DM+” group), in comparison to those not burdened with the disease (“DM-” group).

Materials and Methods

We performed a secondary analysis of data collected during the cross-sectional study on frailty and multimorbidity in patients of the Department of Geriatrics (Hospital of the Ministry of Interior and Administration in Bialystok, Poland). All consecutive patients, admitted mainly electively to the department at the turn of 2014 and 2015, took part in the study. One of the main goals of patients’ stay in the ward being a sub-acute care facility is to conduct a comprehensive geriatric assessment and to create a long-term care plan. It is often impossible to indicate a single reason for hospitalization, as the overwhelming majority of patients have a multimorbidity and disability problem. The mean length of stay is seven days.

Patient Characteristics

We collected data on sociodemographic characteristics, the prevalence of 14 chronic diseases (peripheral arterial disease, ischemic heart disease, chronic cardiac failure, myocardial infarction, hypertension, atrial fibrillation, history of transient ischemic attack (TIA) or stroke, chronic obstructive pulmonary disease, neoplasm, dementia, Parkinsonism, chronic osteoarthritis, osteoporosis, and chronic renal disease), medicines taken before hospitalization, history of hospitalizations and falls in the last 12 months. We verified information obtained from the patient by reviewing all of the patient’s medical records, clinical examination results, and an interview with their guardians.

Measurements

We assessed patients’ functional abilities with the results of tests carried out as a part of the comprehensive geriatric assessment, routinely performed for each patient hospitalized in the ward. The ability to perform self-care activities of daily living was assessed with the Barthel Index and instrumental activities of daily living (IADL) with six Duke Older American Resources and Services (OARS) items I-ADL. Cognitive abilities were assessed with the Abbreviated Mental Test Score (AMTS). The possibility of depression was evaluated with the 15-item Geriatric Depression Scale (GDS). Dementia and depression diagnosis was based on a more in-depth neuropsychological examination. Walking speed was measured during the 4.6m walk from standing position in usual gait speed (the fastest time of 2 trials was used). According to the Southampton protocol, handgrip strength was measured in the dominant hand using a hand-held hydraulic dynamometer DHD-1 (SAEHAN, Changwon, South Korea). Frailty was assessed with the 7-item Canadian study of health and aging Clinical Frailty Scale (CFS). The risk of malnutrition was evaluated with the Mini Nutritional Assessment-Short Form (MNA-SF). Body mass index (BMI), waist, and hips circumferences were measured according to the standard procedures. The waist-hip ratio was counted as the circumference of the waist divided by
that of the hips. The risk of recurrent falls was assessed with
the Performance Oriented Mobility Assessment (POMA),\textsuperscript{21}
and with the Timed Up and Go Test (TUG).\textsuperscript{22} For the self-
reported physical activity level, the 4-level Saltin-Grimby
physical activity level scale (SGPALS) was used.\textsuperscript{23} Data on
serum creatinine, albumin, fasting glucose, and the oral
glucose tolerance test results were extracted from patients’
medical records. Renal function was assessed with a glo-
merular filtration rate- GFR, counted using the
Chronic Kidney Disease Epidemiology Collaboration
(CKD-EPI) formula.\textsuperscript{24} HbA\textsubscript{1C} measurements were made
with the immunoinhibition method using an Olympus
AU400 analyzer (Beckman-Coulter, Brea, CA, USA).

Study Parameters
The DM+ group included patients diagnosed before the
hospitalization and persons without a previous diagnosis
fulfilling any of the following WHO criteria: fasting
plasma glucose (FPG) \(\geq 7.0\) mmol/L (126 mg/dl) or 75 g
oral glucose tolerance test (OGTT) with FPG \(\geq 7.0\) mmol/
L (126 mg/dl) or 2-hour plasma glucose \(\geq 11.1\) mmol/L
(200 mg/dl) or random plasma glucose \(\geq 11.1\) mmol/L
(200 mg/dl) in the presence of typical diabetes
symptoms.\textsuperscript{25} Multimorbidity was defined as having 5 or
more diseases of 14 listed above and taking 5 or more
drugs was treated as polypharmacy. A score of 6 or 7 of
CFS was classified as severe frailty.\textsuperscript{26} Chronic kidney
disease- ie stage 3, 4, and 5 CKD according to Kidney
Disease Outcome Quality Initiative (KDOQI)- was di-
gnosed if GFR was \(<60\) mL/min/1.73m\textsuperscript{2}. Patients with
BMI \(\geq 30\) kg/m\textsuperscript{2} were classified as obese, according to the
standard BMI ranges.\textsuperscript{27} Those with BMI \(<24\) kg/m\textsuperscript{2} were
treated as at risk for malnutrition, as recommended in the
geriatric literature.\textsuperscript{28} Malnutrition was also suspected if
serum albumin was below 35g/L and if the MNA-SF
score was below 8. Abdominal obesity was defined as
waist circumference >80 cm in women and >94 cm in
men. It was classified as severe- if the waist circumference
value was above 88 cm in women and above 102 cm in
men, and as mild- if the waist circumference was below
these cut-offs.\textsuperscript{29} Dynapenia (suggestive for probable sár-
copenia) was derived from the handgrip strength, and it
was diagnosed in men if grip strength was lower than
27 kg and in women if it was lower than 16 kg.\textsuperscript{30} Gait
speed equal or lower than 0.8 m/s, and/or TUG equal or
higher than 20 s was treated as an impaired performance.
If the patient with dynapenia had a poor result in one of
these tests, dynapenia was treated as severe. Patients were
classified with SGPALS as physically inactive if they were
mainly reading, watching television, using computers or
doing other sedentary activities during leisure-time.

Statistical Analysis
The IBM SPSS Version 18 Software suit (SPSS, Chicago, IL,
USA) and STATISTICA 13.3 software package (TIBCO
Software, Palo Alto, CA, USA) was used to analyze the
data collected. The Shapiro–Wilk test was used to assess
the distribution of variables. Data were presented as means
(M) and standard deviation (SD) for normally distributed
continuous variables, as medians (Me) and interquartile
range (IQR) for not normally distributed ones and the num-
ber of cases and percentages for categorical variables.
Proportions were compared using \(\chi^2\) tests or Fisher’s exact
test, as appropriate, while the independent samples Student’s
t-test and the Mann–Whitney \(U\)-test were used to compare
the distribution of continuous variables. Missing values were
omitted, and statistics in such cases were calculated for the
adequately reduced groups. A P value of less than 0.05 was
regarded as significant.

Ethics Approval and Informed Consent
It was a secondary analysis of data collected in the pre-
vious study. The Ethics Committee approved the source
study at the Medical University of Białystok (no R-I-002/
305/2013). All procedures performed were following the
ethical standards of the Medical University of Białystok
Ethics Committee and with the Helsinki declaration, and
its later amendments. It is a study of usual practice. All
study participants, or their guardians, gave their informed
consent to participate in it.

Results
A total of 416 patients hospitalized during the study period
took part in the analysis. Figure 1 presents the patients’
/enrollment into the study. The median age of patients was
82 years (IQR 77–86), and the majority of them were
above 75 years of age (84.1%), female (77.4%), and
community-dwelling (96.9%). There were 126 (30.3%)
patients with diabetes (DM+ cases). In 5 (4%) patients, it
was a newly diagnosed diabetes. Out of 121 patients
diagnosed before hospitalization, 16 (13.2%) were only
on a diabetic diet, and 105 (86.8%) received antidiabetic
medications. A total of 48 (45.7%) patients on glucose-
lowering agents received sulfonylureas, 65 (61.9%)-
metformin, and 31 (29.5%) were on insulin. The HbA\textsubscript{1C} was
available in 98 DM cases, and its median value was 6.5
DM+ and DM- groups did not differ in any of the functional status parameters assessed in our study (Table 2) - they had similar scores of Barthel Index, IADL, AMTS, GDS, POMA, CFS, and Norton scale. There were no differences observed in handgrip strength, the prevalence of dynapenia, in gait speed, TUG results, the prevalence of severe frailty, or the percentage of patients classified as physically inactive with SGPALS.

Mean value of BMI was significantly higher in DM+ group (32.3± 6.1 kg/m² versus 28.0±5.5 kg/m² in DM- group, P<0.001) and so were mean value of waist circumference (1.05 ± 0.14 m versus 0.94± 0.12 m in DM- group, P<0.001) and median value of WHR (0.93, 0.88–0.96 versus 0.90, 0.86–0.95, P=0.002). The majority of patients with DM were obese according to BMI (59.8% versus 34.5% in non-DM, P<0.001) and had abdominal obesity (94.4%, compared to 75.5% of the non-DM group, P<0.001). In the latter case, a significant difference resulted mainly from the significantly more frequent occurrence of severe abdominal obesity in people with diabetes (82.2% versus 56.4% in the non-DM group, P<0.001). We did not observe any difference in the MNA-SF score and the prevalence of protein-energy malnutrition risk evaluated with this scale. There were no significant differences in serum albumin value and the percentage of patients with albumin <35g/L.

Due to the relatively large number of missing data, in the case of some functional state and nutritional status characteristics, an attempt was made to perform a comparative analysis of their number between people with and without DM. For all analyzed variables, the differences in the number of missing data between these groups were statistically insignificant (Table 3).

**Discussion**

The study confirmed that diabetes mellitus is a common health problem in older patients hospitalized in the geriatric ward. Its prevalence in our study was 30.3%. A total of 4% of all DM cases were diagnosed for the first time during this hospitalization, which confirms that diabetes can be asymptomatic for a long time and not diagnosed until old age. In our previous study, newly diagnosed DM was observed even more often - in 9% of cases.10

Patients admitted to a geriatric ward constitute a population seriously affected by multimorbidity and disability.12 Nevertheless, the DM+ group’s health was worse compared to non-DM participants in our study. The DM+ patients had a greater burden of chronic diseases and multimorbidity and significantly more often.

(6.0, 7.8) %. In 61.2% of DM cases, the disease was tightly controlled, with HbA1C ≤7% [53 mmol/mol], and only in 19.4% of DM cases, HbA1C was above 8%.

DM+ patients and patients without DM did not differ in age, sex, place of residence, percentages of people living in long term care, and living alone. The groups differed significantly in the median number of chronic diseases (5.0, IQR 4.0–6.0 versus 4.0, IQR 3.0–5.0 in DM- group, P<0.001), and in the median number of medications taken (9.0, IQR 6.0–12.0 versus 6.0, IQR 4.0–9.0 in DM- group, P<0.001). DM+ patients were burdened significantly more often with multimorbidity (61.1% versus 39.7% in DM- group, P<0.001) and polypharmacy (88.9% versus 74.7% in DM- group, P<0.001).

The percentage of some diseases was significantly higher in the DM+ group: ischemic heart disease (66.7% versus 47.9% in DM- group, P<0.001), chronic cardiac failure (50.0% versus 34.1% in DM- group, P=0.002), peripheral arterial disease (24.6% versus 11.4% in DM- group, P<0.001), atrial fibrillation (30.2% versus 20.7% in DM- group, P=0.04), and chronic kidney disease (61.1% versus 48.6% in DM- group, P=0.02). The percentage of hypertension, history of myocardial infarction, TIA/stroke, osteoporosis, depression, and dementia, was not significantly different in both groups. Similar percentages of DM+ and DM- patients reported hospitalization in the last year (information on the average number of hospitalizations was not available)- Table 1.
experienced polypharmacy. In this respect, our study confirmed other authors’ findings that older adults with DM rarely have only one chronic disease. Multimorbidity should be addressed not only in the literature (that is still mainly single disease-focused) but first of all in DM+ patients’ care. A consequence of this is also polypharmacy with a high risk of drug interactions. As a result, there is an increasing risk of hypoglycemia when antidiabetic medicines are taken simultaneously. The median HbA1C in the group of DM patients was 6.5% in our study, so in half of them, the risk of recurrent hypoglycemia was undoubtedly high.

Our study confirmed that DM in patients admitted to the geriatric ward is connected primarily with the unfavorable profile of cardiovascular risk factors and predisposes to several cardiovascular diseases’ co-occurrence. DM+ and DM- patients did not differ in the prevalence of arterial hypertension only, the frequency of which exceeded 80% in the whole study group. In DM+ patients, significantly more often, obesity, abdominal obesity, ischemic heart disease, congestive heart failure, atrial fibrillation, and peripheral arterial disease were observed. We also observed a significant association between DM and renal impairment.

Contrary to our expectations and other authors’ findings, we did not notice any significant differences between DM+ and DM- groups in the functional parameters evaluated in our study. Our results are relatively
Table 2 Characteristics of Study Participants- Nutritional and Functional Correlates of DM

| Parameter | Total     | DM+ Group | DM- Group | P valuea | Missing Data |
|-----------|-----------|-----------|-----------|----------|--------------|
| No. (%) of Patients | 416 (100.0) | 126 (30.3) | 290 (69.7) |          |              |

**Functional characteristics**

| Parameter                          | Total (IQR) | DM+ Group (IQR) | DM- Group (IQR) | P value | Missing Data |
|------------------------------------|-------------|-----------------|-----------------|---------|--------------|
| Barthel Index, Me (IQR)            | 90.0 (70.0–100.0) | 90.0 (70.0–100.0) | 90.0 (70.0–100.0) | 0.94    | 6            |
| IADL, Me (IQR)                     | 7.0 (3.0–11.0) | 7.0 (2.0–10.0)  | 7.5 (3.0–11.0)  | 0.26    | 10           |
| AMTS, Me (IQR)                     | 8.0 (6.0–9.0) | 8.0 (6.0–9.0)   | 8.0 (6.0–9.0)   | 0.59    | 35           |
| GDS, Me (IQR)                      | 7.0 (3.0–10.0) | 6.0 (3.0–10.0)  | 7.0 (4.0–9.0)   | 0.67    | 52           |
| Handgrip strength, kg, M (SD)      | 18.9 (7.4) | 18.9 (7.3)      | 18.9 (7.4)      | 0.99    | 66           |
| In men (N=76)                      | 26.3 (8.3) | 26.7 (7.6)      | 26.2 (8.6)      | 0.79    | 18           |
| In women (N=274)                   | 16.8 (5.6) | 16.6 (5.4)      | 16.9 (5.7)      | 0.66    | 48           |
| Dyspnea, n (%)                     | 164 (46.9) | 49 (48.5)       | 115 (46.2)      | 0.72    | 66           |
| Gait speed, m/s, Me (IQR)          | 0.65 (0.40–0.96) | 0.66 (0.38–0.97) | 0.64 (0.40–0.94) | 0.93    | 102          |
| Gait speed, 0.8m/s, n (%)          | 205 (65.3) | 61 (69.3)       | 144 (63.7)      | 0.43    | 102          |
| POMA, Me (IQR)                     | 23.0 (17.0–28.0) | 22.0 (17.0–28.0) | 24.0 (18.0–28.0) | 0.47    | 94           |
| POMA<19, n (%)                     | 95 (29.5) | 31 (34.1)       | 64 (27.7)       | 0.26    | 94           |
| TUG, s, Me (IQR)                   | 17.4 (11.8–28.0) | 19.23 (13.14–29.12) | 16.9 (11.7–27.1) | 0.32    | 115          |
| TUG=20s, n (%)                     | 128 (42.5) | 40 (44.9)       | 88 (41.5)       | 0.61    | 115          |
| Falls in the last 12 months, n (%) | 157 (43.9) | 50 (48.1)       | 107 (42.1)      | 0.35    | 58           |
| CFS, Me (IQR)                      | 5.0 (4.0–5.0) | 5.0 (4.0–5.0)   | 5.0 (4.0–5.0)   | 0.56    | -            |
| Severe frailty, n (%)              | 102 (24.5) | 33 (26.2)       | 69 (23.8)       | 0.60    | -            |
| Norton scale score, Me (IQR)       | 17 (15–19) | 17 (15–19)      | 17 (15–19)      | 0.89    | 6            |
| SGPALS, sedentary, n (%)           | 168 (41.0) | 55 (45.1)       | 113 (39.2)      | 0.28    | 6            |

**Nutritional characteristics**

| Parameter                          | Total (IQR) | DM+ Group (IQR) | DM- Group (IQR) | P value | Missing Data |
|------------------------------------|-------------|-----------------|-----------------|---------|--------------|
| BMI, kg/m2, M (SD)                 | 29.3 (6.0)  | 32.3 (6.1)      | 28.0 (5.5)      | <0.001  | 62           |
| BMI<25 kg/m2, n (%)                | 66 (18.6)   | 8 (8.8)         | 58 (23.0)       | <0.001  | 62           |
| BMI>30 kg/m2, n (%)                | 148 (41.8)  | 61 (59.8)       | 87 (34.5)       | <0.001  | 62           |
| WHR, Me (IQR)                      | 0.90 (0.87–0.95) | 0.93 (0.88–0.96) | 0.90 (0.86–0.95) | 0.002   | 63           |
| Waist circumference, m, M (SD)     | 0.97 (0.13) | 1.05 (0.14)     | 0.94 (0.12)     | <0.001  | 52           |
| In women (n=282)                   | 0.96 (0.13) | 1.04 (0.14)     | 0.93 (0.12)     | <0.001  | 40           |
| In men (n=82)                      | 1.02 (0.13) | 1.09 (0.13)     | 0.98 (0.12)     | <0.001  | 12           |
| Abdominal obesity, n (%)           | 295 (81.0)  | 101 (94.4)      | 194 (75.5)      | <0.001  | 52           |
| Mild abdominal obesity, n (%)      | 62 (17.0)   | 13 (12.1)       | 49 (19.1)       | 0.13    | 52           |
| Severe abdominal obesity, n (%)    | 233 (64.0)  | 88 (82.2)       | 145 (56.4)      | <0.001  | 52           |
| MNA-SF, Me (IQR)                   | 12.0 (9.0–13.0) | 12.0 (9.0–13.0) | 11.0 (9.0–13.0) | 0.53    | 12           |
| MNA-SF<8, n (%)                    | 72 (17.8)   | 24 (19.7)       | 48 (17.0)       | 0.52    | 12           |
| Albumin, g/L, M (SD)               | 38.9 (3.8)  | 38.9 (3.7)      | 38.9 (3.8)      | 0.95    | 27           |
| Albumin <35g/L, n (%)              | 58 (14.9)   | 17 (14.0)       | 41 (15.3)       | 0.88    | 27           |

Notes: x2 test or Fisher exact test, as appropriate, for categorical variables; t-test for independent samples or Mann–Whitney test for continuous or interval variables. In all analyses a two-tailed P value of less than 0.05 was regarded as significant.

Abbreviations: AMTS, Abbreviated Mental Test Score; BMI, body mass index; CFS, 7 point Clinical Frailty Scale; DM, diabetes mellitus; DM+, patients with diabetes; DM-, non-diabetic patients; GDS, Geriatric Depression Scale; IADL, instrumental activities of daily living; IQR, interquartile range; M, mean value; Me, median value; MNA-SF, Mini Nutritional Assessment- Short Form; n, number of cases; POMA, Performance Oriented Mobility Assessment; SD, standard deviation; SGPALS, Saltin-Grimby physical activity level scale; TUG, Timed Up and Go Test; WHR, waist hip ratio.

parallel to the study results conducted by da Cruz Anjos et al., which did not confirm any negative impact of type 2 DM on the older women’s functional status, apart from slowing down the gait. Our study groups did not differ in the abilities to perform activities of daily living, in the frailty status, in the prevalence of dynapenia, or physical performance (such as gait speed, TUG, and POMA test results). However, this may be due to the specificity of health problems and generally large and complex disability of hospitalized patients in the geriatric ward. They are rather phenotypically similar to the residents of long-term care facilities representing a real challenge for the
physician. The influence of other than DM risk factors for disability in the advanced and final phase of the disabl-
ment continuum may also be crucial and limit the possi-
bility of noticing the impact of this disease on geriatric
patients’ functional efficiency,\(^35\) but this would require
more in-depth analysis. Nevertheless, patients with similar
characteristics possess a great challenge for healthcare.
Illness complexity should lead to modification of treat-
ment goals and methods of achieving them.\(^36\) The older
population with DM is heterogeneous. The disease management
should adjust to patients’ health and nutritional and func-
tional status.\(^36\)\(^-\)\(^38\) It can potentially address the most-
relevant outcomes in the older population with DM. This
disease is relatively often over-treated,\(^39\) despite the
changing guidelines for diabetes care in older adults.\(^36\)

Our study’s strength is that we conducted it in a big

group of geriatric patients with specific disease profiles
who underwent the comprehensive geriatric assessment.
Our data were collected during the ward’s daily clinical
work, which influences study’s value. However, our study
has got some limitations. First of all, we researched a
convenient sample of people admitted to the geriatric
ward and not a random sample from the general popula-
tion. Therefore the results can be generalized for patients
of similar settings only. On the other hand, we wanted to
check whether the relationship of diabetes with morbidity
and disability will be noticeable in geriatric ward patients
who constitute an exceptionally burdened population in
terms of health. Additionally, as our study was based on
the secondary analysis of data previously collected, some
pieces of information were limited, as indicated in tables.
Although the frequency of missing data did not differ
significantly between the DM+ and the DM- groups, we
cannot rule out that it might have influenced the analysis’s
final results for at least some assessed functional and
nutritional parameters.

**Conclusion**

As we expected, type 2 DM patients were significantly
more often burdened with multimorbidity, polypharmacy,
obesity and had an unfavorable profile of cardiovascular
diseases than patients without DM. Contrary to our expec-
tations- they did not differ in functional status character-
istics. It may result from the specificity of patients
hospitalized in the geriatric ward health problems, being
in the advanced or final phase of the disablement process.

**Abbreviations**

AMTS, Abbreviated Mental Test Score; BMI, body mass
index; CFS, Clinical Frailty Scale; CKD-EPI, Chronic
Kidney Disease Epidemiology Collaboration; DM, diabetes mellitus; DM+, patients with diabetes; DM-, patients without diabetes; FPG, fasting plasma glucose; GDS, Geriatric Depression Scale; GFR, glomerular filtration rate; HbA1c, glycosylated HbA1c hemoglobin; IADL, instrumental activities of daily living; IQR, interquartile range; KDOQI, Kidney Disease Outcome Quality Initiative; M, mean; Me, median; MNA-SF, Mini Nutritional Assessment-Short Form; NYHA, New York Heart Association; OARS, Older Americans Resources and Services; OGTT, oral glucose tolerance test; POMA, Performance Oriented Mobility Assessment; SD, standard deviation; SGPALS, Saltin-Grimby physical activity level scale; TIA, transient ischemic attack; TUG, Timed Up and Go Test; WHO, World Health Organization.

Data Sharing Statement
The data supporting the results in the current study are available from the corresponding author on reasonable request.

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Disclosure
The authors report no conflicts of interest in this work.

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