Visual evoked potential changes in pre-diabetics, type 2 diabetics and normal subjects

Zaahid Naseer1, Arun Kumar M2*, Roopakala M S3, Pramila Kalra4

1Intern, 2Assistant Professor, 3,4Professor, 1,2,4Dept. of Physiology, 3Dept. of Endocrinology, Ramaiah Medical College, Bangalore, Karnataka, India

*Corresponding Author:
Email: drarunkm@gmail.com

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Abstract

Introduction: Diabetes mellitus type 2 is the most common metabolic disorder and diabetic retinopathy is the leading cause of blindness. Persistent hyperglycemia leads to damage of microvasculature supplying the retina and optic pathway. Visual evoked potential is the most commonly used test to evaluate the integrity of visual pathway. The purpose of the study is to compare the visual evoked potential latency and amplitude between the pre-diabetes, diabetes and normal controls.

Materials and Methods: There were three groups in the study with 23 patients in each group: pre-diabetic group, diabetic group and controls. Group was made based on fasting blood sugar levels. Pattern visual evoked potential was measured in all the groups by connecting scalp electrodes according to 10-20 International electrode placement system. Latency and amplitude of N75, P100 and N145 were measured and used for statistical analysis.

Results: All the parameters individually were compared between three groups using ANOVA test. There was no statistical difference between latencies and amplitude all the three parameters N75, P100, N145 in all the three channels O1-NE, O2-NE, Oz-NE in all the three groups.

Conclusion: There is no differences in the visual evoked potential latency and amplitude in the between pre-diabetics, diabetes and controls.

Keywords: Visual evoked Potential, Diabetic retinopathy, Pre-diabetes, P100, N75, N145.
is impaired VEP latency. VEP studies have been done in several condition related to diabetes and its complications. There are no studies which have considered done comparing VEP latency changes between diabetic and pre-diabetic condition. There could be a possibility of optic nerve/pathway damage that could occur as a result of hyperglycemia in pre-diabetes. The aim of the study was to detect the latency and amplitude changes in pre-diabetics and diabetic patients and compare them with normal subjects.

**Materials and Methods**

The study was conducted at M S Ramaiah Medical College and Memorial Hospitals. It was a case control study with 23 subjects in each of three groups: prediabetic, diabetic and control group. The sample size was calculated based on the study conducted on the Visual evoked potential in non-insulin dependent diabetes retinopathy it was found that mean P100 latency of both eyes in diabetes patient was 110.14±5.30 ms(mean ± SD). In controls 100.17 ±0.75 ms, so with a power of 95% and confidence level of 95% it was proposed to include 23 patients of diabetes, 23 subjects of pre-diabetes and 23 controls in present study with an effect size of 1.32. The study was approved by institutional ethical committee.

The groups were made based on the fasting blood sugar (FBS) levels according to WHO Criteria. Fasting blood sugar level less than 100 gm/dl, more than 125 mg/dl are considered to be normal and diabetic group respectively. FBS levels between 100-125 mg/dl in considered in pre-diabetes group. Patients were in the age group of group was 30-60 years were included in the study. Alcoholics, smokers and patients with local eye disorders and abnormal fundoscopy were excluded from study. The FBS was determined by hexokinase method using the early morning samples collected from the after overnight fasting.

The study participants were explained about procedure of the visual evoked potential (VEP) and consent was obtained. If the patient had applied oil to head, they were asked to come on another day after taking head bath. If the participants were using spectacles they were asked to wear them during test procedure. The pattern VEP was measured and analyzed in all the groups by using Galileo NT instrument and software. The skin is prepared by abrading and degreasing. Five surface EEG electrodes were used and placed according to 10-20 international system. The recording electrodes were placed at Oz, O1 and O2 using conducting jelly. Oz is a point 5 cm above the inion in the occipital region, 5 cm to the left of it O1 and 5 cm right to that is O2. The reference electrode (NE) is placed at Fpz or 12cm above the nasion. The ground electrode is placed at the vertex, i.e. at Cz. Resistance of less than 5 ohms was considered acceptable. Stimuli used is a standard checkerboard pattern which alternates at the frequency of 10/sec and is projected on the computer screen. Subjects were asked to focus at the center regions of screen with one eye at the time, the other eye was covered. Average of 200 responses was taken for interpreting the latencies and amplitudes. Latencies marked were N75, P100 and N145 by stimulus giving to both the eyes separately. Latency and amplitudes of first negative wave (N75), first positive wave (P100) and second negative wave (N145) was determined for all three leads i.e., O1-NE, O2-NE and OZ-NE.

Data was tabulated and analyzed using MS-Excel and SPSS software version 17. The statistical test used was descriptive analysis with mean and SD for baseline parameters. The latency and amplitude were compared using ANOVA analysis.

**Results**

The study consists of 23 subjects in each of 3 groups i.e., pre-diabetes group, diabetes group and control group. The mean and SD values of VEP latencies of N75, P100 and N145 in the three leads i.e., O1-NE, O2-NE and OZ-NE measured from right eye stimulus and left eye stimulus are depicted in table 1 and 2 respectively. Mean values of latencies of N75, P100 and N145 is more in diabetes group when compared to the pre-diabetic group which is more when compared to the control group. On application of one way analysis of variance (ANOVA) there was no significant difference in all the parameters.

**Table 1: Comparison VEP latencies in the groups with right eye stimulus**

| Channel | Latency | Prediabetic group | Diabetic group | Control group | P value |
|---------|---------|-------------------|----------------|---------------|---------|
| O1-NE   | N75     | 76.47 ± 4.513     | 75.93 ± 6.772  | 71.99 ± 9.831 | 0.107   |
|         | P100    | 103.59 ± 4.703    | 105.25 ± 12.714| 100.16 ± 11.791| 0.270   |
|         | N145    | 140.32 ± 19.671   | 154.98 ± 37.361| 143.84 ± 34.488| 0.314   |
| O2-NE   | N75     | 74.15 ± 4.293     | 76.74 ± 9.921  | 73.82 ± 7.367 | 0.401   |
|         | P100    | 103.86 ± 6.198    | 106.28 ± 11.94 | 100.04 ± 20.699| 0.375   |
|         | N145    | 143.92 ± 13.335   | 157.02 ± 38.337| 141.48 ± 21.656| 0.133   |
| Oz-NE   | N75     | 76.83 ± 7.591     | 74.06 ± 6.512  | 73.1 ± 7.171  | 0.220   |
|         | P100    | 104.38 ± 7.942    | 101.77 ± 4.338 | 101.44 ± 5.089| 0.229   |
|         | N145    | 144.41 ± 15.716   | 143.65 ± 10.51 | 142.96 ± 20.419| 0.959   |

p value < 0.05 was considered statistical difference.
Comparison of amplitudes of P100 in all the channels, O1-NE, O2-NE and Oz-NE was done with stimulus on right and left eye. The Mean values of amplitudes of P100 are almost same in the diabetes group when compared to the pre-diabetic group and control group. On application of one way analysis of variance (ANOVA) there was no significant difference in between the parameters in all the 3 groups. The values are mentioned in table 3.

### Table 2: Comparison VEP latencies in the groups with left eye stimulus

| Channel | Latency | Prediabetic group | Diabetic group | Control group | P value |
|---------|---------|-------------------|----------------|--------------|---------|
| O1-NE   | N75     | 74.77 ± 5.989     | 75.47 ± 6.78   | 72.88 ± 7.194 | 0.423   |
|         | P100    | 104.86 ± 10.91    | 103.17 ± 8.819 | 102.85 ± 6.222 | 0.729   |
|         | N145    | 144.86 ± 9.133    | 147.2 ± 17.062 | 138.24 ± 14.803 | 0.103   |
| O2-NE   | N75     | 75.04 ± 9.056     | 75.65 ± 6.394  | 74.02 ± 8.646  | 0.401   |
|         | P100    | 105 ± 6.263       | 109.84 ± 13.436| 103.24 ± 6.39  | 0.375   |
|         | N145    | 149.07 ± 38.996   | 150.24 ± 18.798| 142.06 ± 15.84 | 0.133   |
| Oz-NE   | N75     | 77.9 ± 9.728      | 76.01 ± 8.764  | 74.12 ± 7.208  | 0.358   |
|         | P100    | 104.4 ± 7.951     | 102.67 ± 7.228 | 100.52 ± 6.403 | 0.214   |
|         | N145    | 145.59 ± 7.38     | 146.84 ± 19.278| 140.22 ± 8.153 | 0.192   |

p value < 0.05 was considered statistical difference.

### Table 3: Comparison VEP amplitudes in all the groups with both eye stimulus

| Channel | Stimulus Side and Wave | Control Group (Mean ± SD) | Prediabetic Group (Mean ± SD) | Diabetic Group (Mean ± SD) | P value |
|---------|------------------------|---------------------------|-------------------------------|---------------------------|---------|
| O1-NE   | Right P100             | 3.69 ± 2.32               | 4.12 ± 2.09                  | 4.51 ± 2.61               | 0.78    |
|         | Left P100              | 3.38 ± 1.89               | 4.53 ± 2.02                  | 5.12 ± 3.1               | 0.378   |
| O2-NE   | Right P100             | 4.1 ± 2.4                 | 4.57 ± 2.97                  | 4.48 ± 2.28              | 0.93    |
|         | Left P100              | 3.89 ± 2.42               | 4.27 ± 2.68                  | 4.79 ± 2.36              | 0.755   |
| Oz-NE   | Right P100             | 2.23 ± 3.4                | 4.94 ± 5.55                  | 6.55 ± 2.78              | 0.115   |
|         | Left P100              | 1.97 ± 2.49               | 4.8 ± 5.45                   | 6.84 ± 2.97              | 0.055   |

p< 0.05 is considered significant

### Discussion

Diabetes is the most common disease and its complication is life threatening. As the duration of diabetes increases and the occurrence of complications also increases. Most often patient reaches the hospital during the stage wherein the disease and its complication had made the patient morbid. Management of such conditions is difficult and challenging. It becomes important to detect such complications in the early stage given an indication to the patient about its impending danger. In this study an attempt was made to identify if it is possible to detect if there was any early damage to the optic nerve and its pathway in patients with Prediabetic condition.

Visual evoked potential is the one of the commonly used test in the assessment of the integrity of optic nerve pathway. When the stimulus is given the light gets processed from the retina enters the optic nerve, optic chiasma, and then enters in the visual area in the occipital area. Electrodes on the scalp is placed on the O1 and O2, these areas corresponds to the scalp region above left and right occipital cortex respectively whereas as Oz corresponds to the center of these to waves.11,12

In all the channels, i.e., O1-NE, O2-NE and Oz-NE, the N75, P100 and N145 did not show any significant change between the three groups. There is no significant delay in the latencies of these waves in the diabetic or prediabetic group. This is in contrary to the studies like Brian et al 2010 who has reported that there is increase in the latency in the subjects with diabetes.13 In another study conducted by Karlica14 et al it is had been reported that latencies of P100 is significantly delayed in diabetes mellitus type I subjects. There are other studies which have studied the effect the blood glucose on VEP recordings in the normal individuals and patient with diabetic retinopathy.15,16

Diabetes mellitus and its complication are better studied by understanding the pathophysiological process involved in development of such complications. Anticipation of complication in the pre-diabetic stage seems to be too early to get the overt effects of retina or optic nerve damage. However few studies are suggestive of increased macular choroidal thickness as the earliest determiner to detect the onset of diabetic retinopathy in pre-diabetes.17 In a cohort study, it was found that the prevalence of pre-diabetes was 22.4%, and of diabetic retinopathy was 8.1% with majority of participants having mild Diabetic retinopathy (7.2%).18 Diabetic retinopathy is classified into two stages: non-proliferative and proliferative. The pathophysiological mechanisms invoked in non-proliferative retinopathy.
include loss of retinal pericytes, increased retinal vascular permeability, alterations in retinal blood flow, and abnormal retinal microvasculature, all of which lead to retinal ischemia. The appearance of neovascularization in response to retinal hypoxemia is hallmark of proliferative diabetic retinopathy. These newly formed vessels appear near the optic nerve and/or macula and rupture easily, leading to vitreous hemorrhage, fibrosis, and ultimately retinal detachment.\textsuperscript{19,20} On prediabetic condition there are several clinical observations recognizing that diabetes-specific microangiopathic complications such as diabetic retinopathy and others might be observed due to persistent hyperglycemia.\textsuperscript{21,22}

Duration of diabetes, in an individual, is important factor which affects the latencies of VEP. As the person spends more time with uncontrolled status or increased blood sugar it has an adverse effect on the microvasculature of various systems.\textsuperscript{23} Circumference of the head is one of the major factors which could affect the latencies in visual evoked potential. It said that the length of optic nerve increases as the head circumference increases and correspondingly there is increase in the latency of these waves. These factors have been ignored in the study and add to the limitation of the study.\textsuperscript{24}

It can be concluded that the there is significant changes in the latencies and amplitude of VEP measurements between diabetes, prediabetes and the study group. The future studies with larger sample size have to be considered to evaluate the possibility of using pattern VEP in the early detection of complications in diabetes.

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