

Relations between Inflammation, access to care and Diabetes in a representative population of Mexico.

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List of group members ordered by alphabet.

Abstract

Background. Background goes here. *Methods.* Methods go here. *Results.* Results here.
Conclusions. Conclusions here.

Keywords: Diabetes, access to care, inflammation, health, Mexico, China

Word count: X (this cannot easily be done automatically, we can also just leave it out)

Relations between Inflammation, access to care and Diabetes in a representative population of Mexico.

Procedures and Sample

Variables

The original WHO dataset contains more than 1,600 variables, not all of which are relevant to our research questions. Therefore, we have limited our analysis to 10 variables, listed below in Table 1. In our analysis, we exclude participants who reported that they already have a formal diabetes diagnosis from a doctor, since we are interested in HBA1C values for people who do not have a diabetes diagnosis. We also exclude participants age 50 or older, since this group typically has high HbA1c levels regardless of the presence of diabetes, as well as participants with CRP levels above 5, since because such values indicate infection which would confound our analysis.

Here I point the reader to figure 1.

Here, I want to point the reader to Figure 2.

Here, I want to point the reader to Figure 3.

Here, I want to point the reader to Figure 4.

Demo of inline code usage. We found that this regression model using 357 participants was not significant $F(2, 354) = 1.06$, $p = 0.35$ with $R^2 = 0.01$. The beta estimate for age was $\beta_{age} = -0.01$ ($SE = 0.01$, $p = 0.36$), and for use of medication $\beta_{medication} = 0.20$ ($SE = 0.18$, $p = 0.28$).

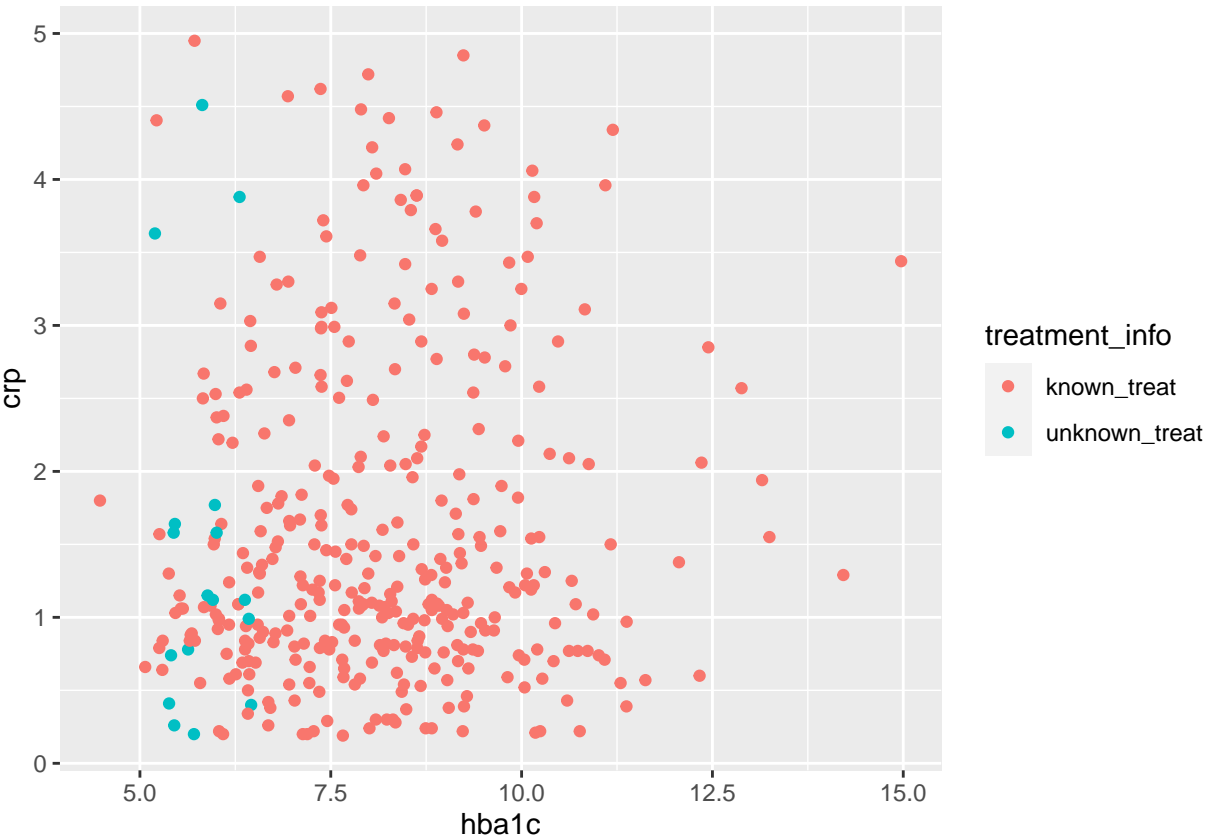


Figure 1. Figure 1 caption goes here.

Table 1

Effect of Medication on CRP, controlling for Age.

predictor	<i>b</i>	95% CI	<i>t</i> (354)	<i>p</i>
Intercept	2.00	[1.06, 2.94]	4.18	< .001
Age	-0.01	[−0.02, 0.01]	-0.91	.362
Medication	0.20	[−0.17, 0.56]	1.07	.284

Note. Model fit: $F(2, 354) = 1.06$, $p = 0.35$, $R^2 = 0.01$.

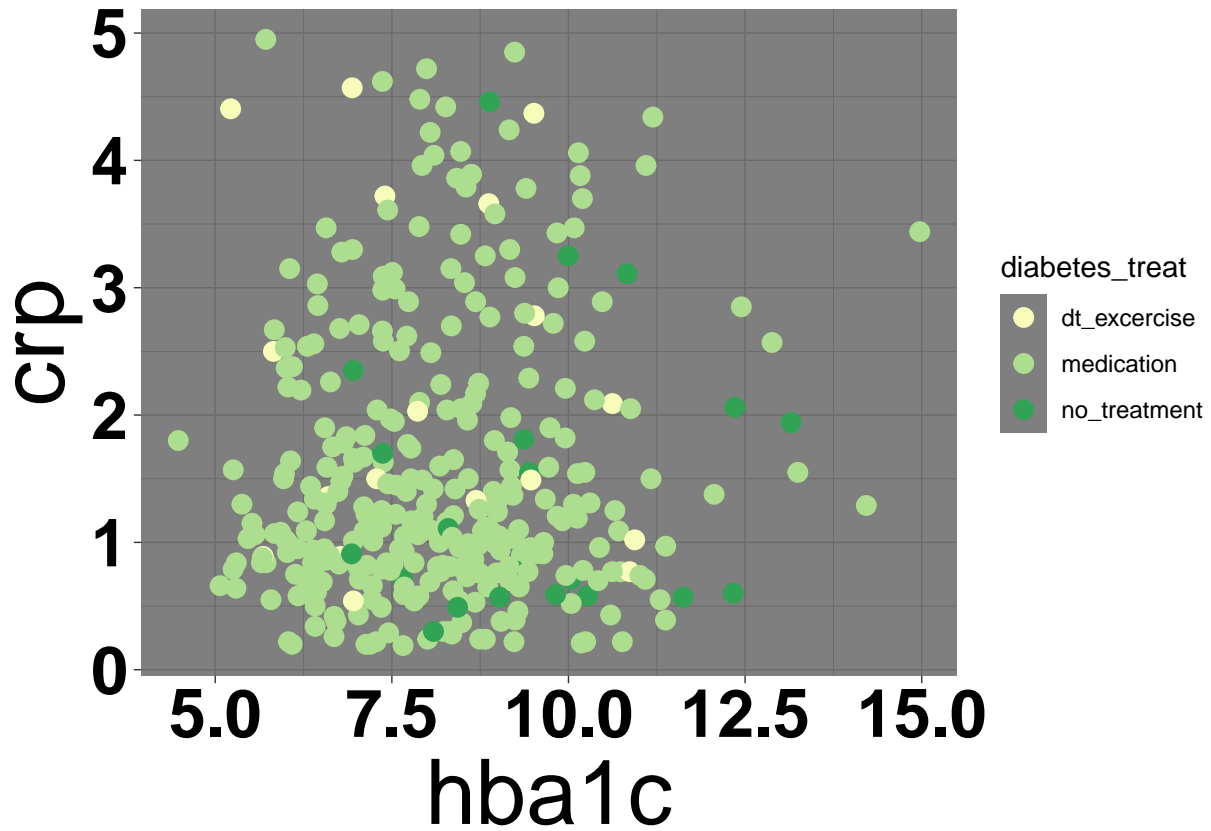


Figure 2. This is the caption of figure 2.

Demo of inline code usage. We found that this regression model using 354 participants was not significant $F(2, 354) = 2.70$, $p = 0.07$ with $R^2 = 0.01$. The beta estimate for age was $\beta_{age} = -0.01$ ($SE = 0.01$, $p = 0.41$), and for diet and exercise $\beta_{Diet} = -0.24$ ($SE = 0.12$, $p < 0.05$).

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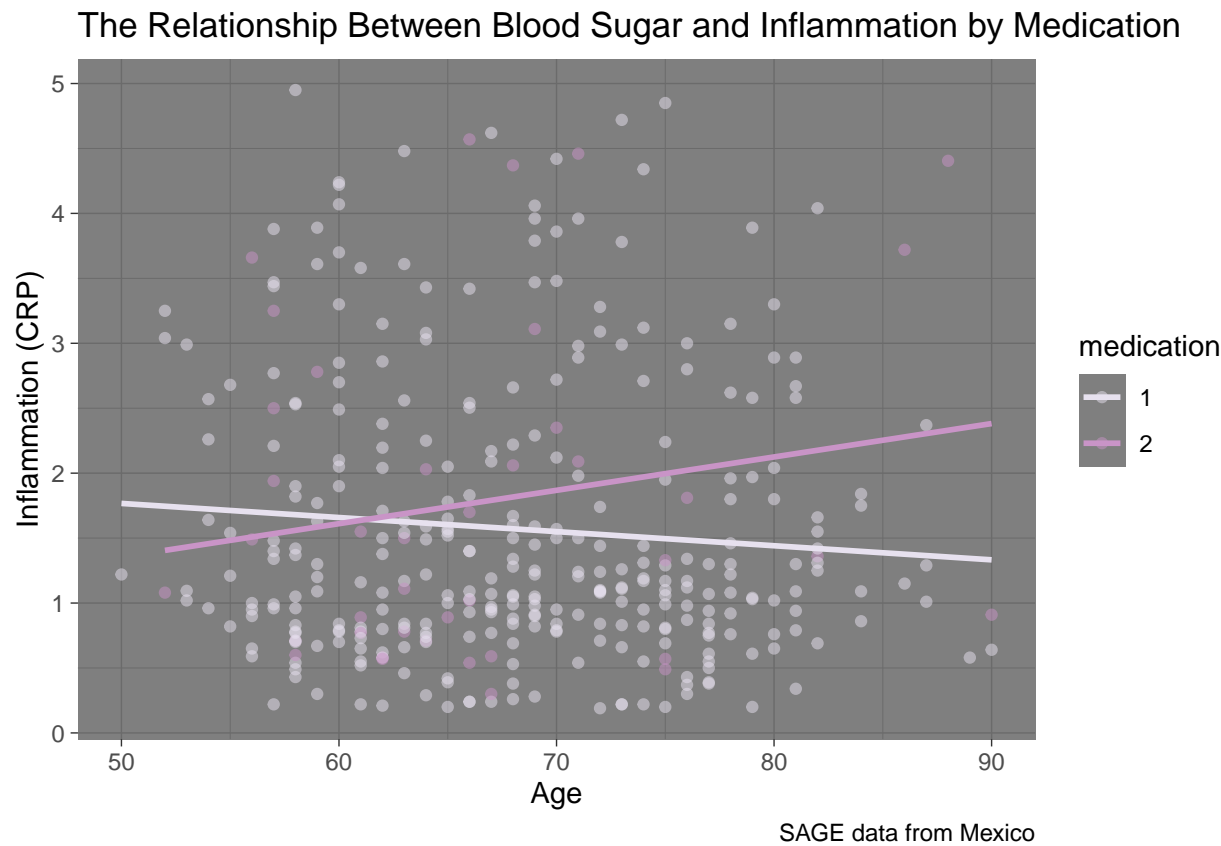


Figure 3. This is the caption of figure 2.

Table 2

Effect of Diet and Exercise on CRP, controlling for Age.

predictor	<i>b</i>	95% CI	<i>t</i> (354)	<i>p</i>
Intercept	2.10	[1.17, 3.04]	4.43	< .001
Age	-0.01	[-0.02, 0.01]	-0.83	.408
Diet and Exercise	-0.25	[-0.47, -0.02]	-2.11	.036

Note. Model fit: $F(2, 354) = 2.71, p = 0.07, R^2 = 0.02$.

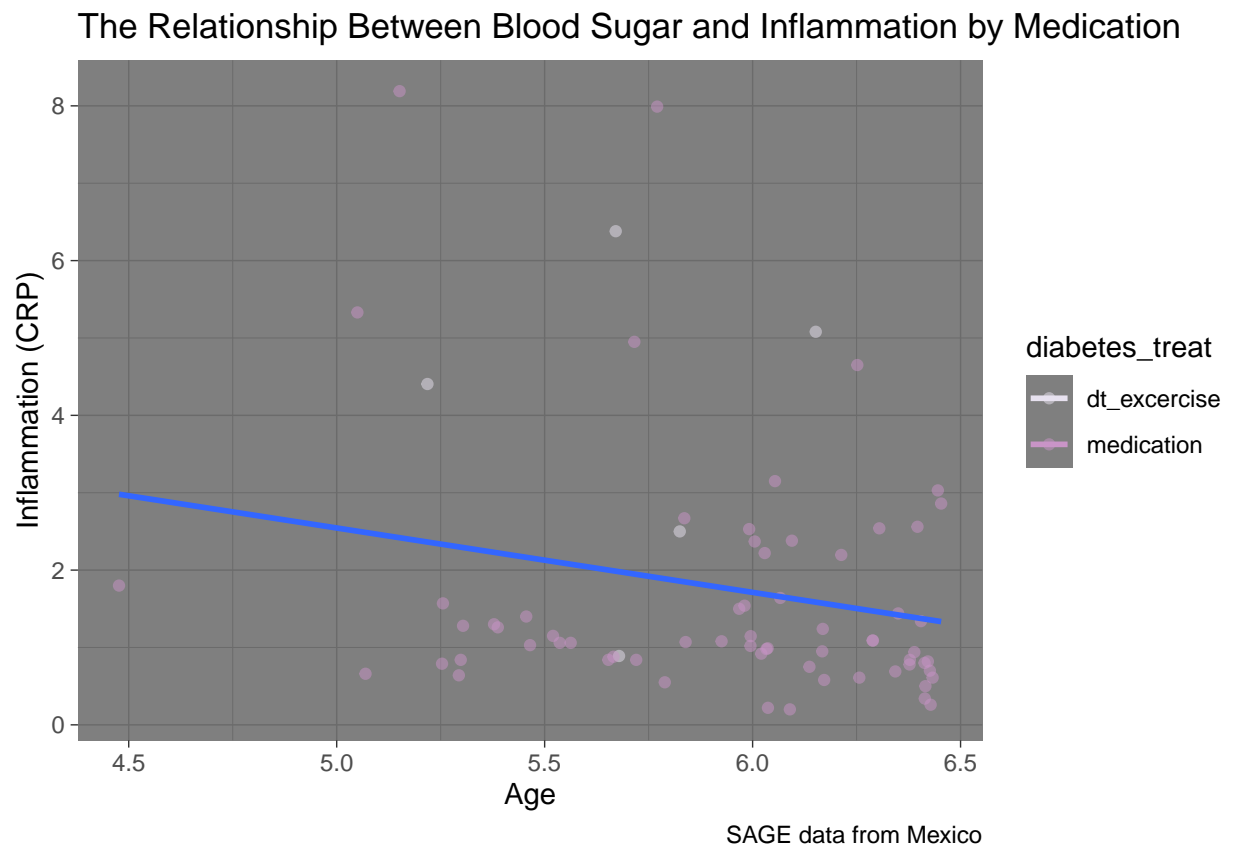


Figure 4. This is the caption of figure 4.

The descriptive statistics for our sample look as follows:

Table 3

Descriptive statistics.

	Mexico
N_{total}	357
Sex	
male	115 (32.20 %)
female	241 (67.50 %)
unknown	1 (0.30 %)
Age	68 ($SD = 8.40$)
Diabetes	

	Mexico
diagnosed	357 (100 %)
undiagnosed	0 (0 %)

Introduction

Diabetes and its insidious complications continue to expand as a global health burden at an alarming rate. As of 2021, there were approximately 537 million adults living with diabetes in the world and this number is expected to jump to 783 million by 2045. A disproportionate percentage of these people live in low to middle income countries (LMICs). In light of the Covid pandemic, it is also of great import that we better understand the relationships between diabetes and infectious diseases as diabetes both increased the severity of Covid (in people with elevated a1c levels) and has increased in incidence during the Covid 19 pandemic (Yang et al., 2020) (Rohm, Meier, Olefsky, & Donath, 2022).

Additionally, diabetes is associated with a steep increase in cardiovascular disease risk and is a leading cause of death in many low to middle income countries (LMICs) including Mexico. Although the precise classification of diabetes remains controversial because of the complex nature of its pathogenesis, there are three universally acknowledged subtypes: type 1 diabetes, type 2 diabetes, and gestational diabetes. Diabetes is a progressive disease in that the longer one has it, the more complications ensue. Therefore, it is helpful to conceptualize diabetes as a process that can be stopped, but not reversed. Research that contributes to slowing down or stopping the process can be extremely valuable to global health regardless of its contribution to cure and prevention because of the astronomical rates of diabetes in our world today.

Inflammation is a strong indicator of diabetes development and progression. Inflammation predicts the development of diabetes (Dilys J. Freeman et al., 2002) (Dilys J.

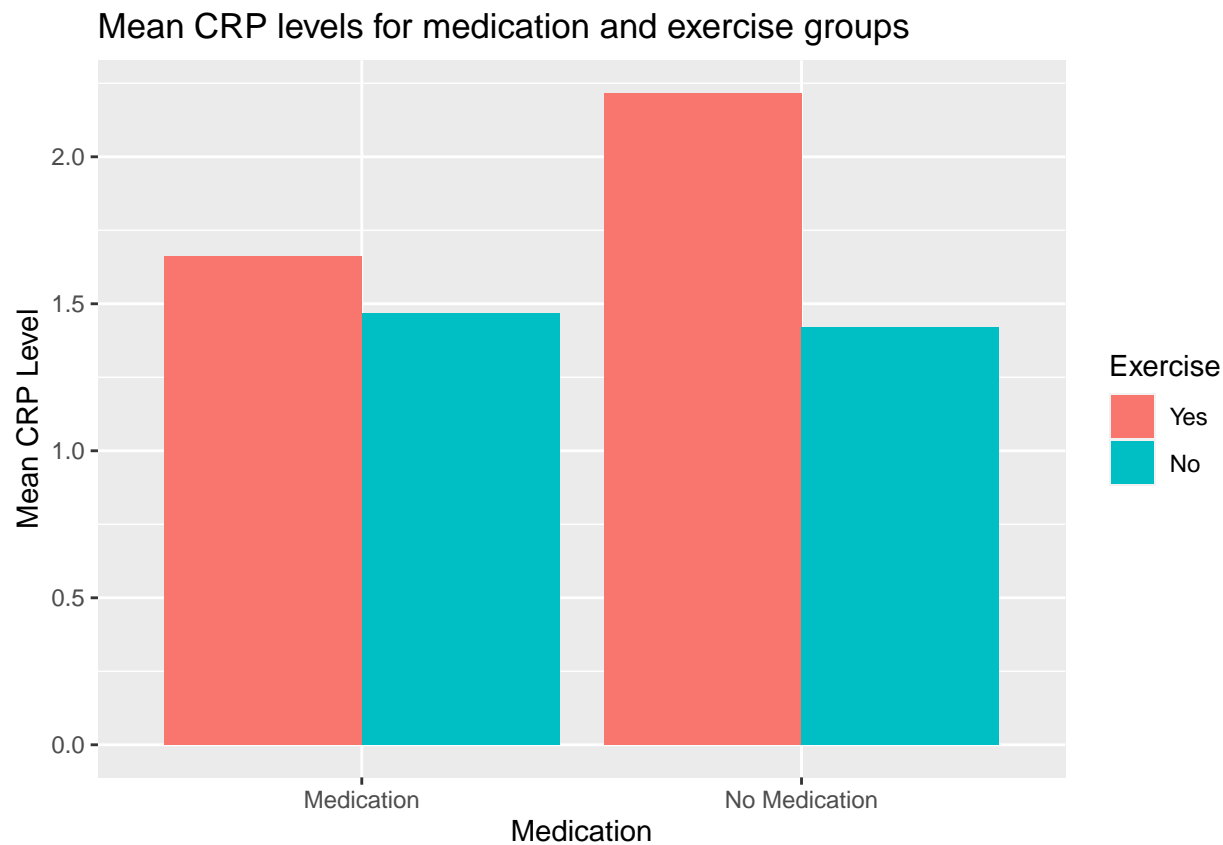


Figure 5. Caption for Figure 5 goes here.

Freeman et al., 2001) (Schmidt et al., 1999). Specifically, trials for drugs directed at inflammation among people with type 2 diabetes have indicated that drugs targeted at inflammation may be a therapeutic option for preventing diabetes (Agrawal & Kant, 2014).Retinopathy and focal neuropathy (Said, 2007) have also been linked to inflammatory processes. Additionally, the direct damage caused by high blood glucose leads to more inflammation and creates a nasty feedback loop wherein inflammation causes more insulin resistance which leads to high blood glucose.

Diabetes treatment and inflammation

The ability of cells to absorb insulin can be increased through diet, exercise, and oral pills.Increasing exercise and dieting can cause major decreases in inflammation. Some of the

drugs for type 2 diabetes aimed at increasing insulin sensitivity also decrease inflammation (e.g., drugs that cause weight loss). In the opposite direction, insulin can cause severe low blood glucose levels that initiate a stress response causing more inflammation.

Methods

C-reactive protein and hba1c measured through dried bloodspots (minimally invasive biomarkers) (McDade, Williams, & Snodgrass, 2007)).

Self-report surveys conducted by trained interviewers.

Data are from the World Health Organization’s Study on Adult Health and Ageing (SAGE). Our data is from 1 of 5 countries where the data were collected.

Cite R packages here

Discussion

Limitations

We were not able to look at pills and insulin separately and some their effects have the potential to cancel each other out. The sex variable was established through interviewer discernment.

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- Agrawal, N. K., & Kant, S. (2014). Targeting inflammation in diabetes: Newer therapeutic options. *World Journal of Diabetes*, 5(5), 697. <https://doi.org/10.4239/wjd.v5.i5.697>
- Freeman, Dilys J., Norrie, J., Caslake, M. J., Gaw, A., Ford, I., Lowe, G. D. O., . . . Study, W. of S. C. P. (2002). C-reactive protein is an independent predictor of risk for the development of diabetes in the west of scotland coronary prevention study. *Diabetes*, 51(5), 1596–1600. <https://doi.org/10.2337/diabetes.51.5.1596>
- Freeman, Dilys J., Norrie, J., Sattar, N., Neely, R. D. G., Cobbe, S. M., Ford, I., . . . Gaw, A. (2001). Pravastatin and the development of diabetes mellitus. *Circulation*, 103(3), 357–362. <https://doi.org/10.1161/01.cir.103.3.357>
- McDade, T. W., Williams, S., & Snodgrass, J. J. (2007). What a drop can do: Dried blood spots as a minimally invasive method for integrating biomarkers into population-based research. *Demography*, 44(4), 899–925. <https://doi.org/10.1353/dem.2007.0038>
- Rohm, T. V., Meier, D. T., Olefsky, J. M., & Donath, M. Y. (2022). Inflammation in obesity, diabetes, and related disorders. *Immunity*, 55(1), 31–55. <https://doi.org/10.1016/j.immuni.2021.12.013>
- Said, G. (2007). Diabetic neuropathy—a review. *Nature Clinical Practice Neurology*, 3(6, 6), 331–340. <https://doi.org/10.1038/ncpneuro0504>
- Schmidt, M. I., Duncan, B. B., Sharrett, A. R., Lindberg, G., Savage, P. J., Offenbacher, S.,

... Heiss, G. (1999). Markers of inflammation and prediction of diabetes mellitus in adults (Atherosclerosis Risk in Communities study): A cohort study. *The Lancet*, 353(9165), 1649–1652. [https://doi.org/10.1016/S0140-6736\(99\)01046-6](https://doi.org/10.1016/S0140-6736(99)01046-6)

Yang, J., Zheng, Y., Gou, X., Pu, K., Chen, Z., Guo, Q., ... Zhou, Y. (2020). Prevalence of comorbidities and its effects in patients infected with SARS-CoV-2: A systematic review and meta-analysis. *International Journal of Infectious Diseases*, 94, 91–95. <https://doi.org/10.1016/j.ijid.2020.03.017>

Figure captions

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- Figure 2.* This is the caption of figure 2.
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- Figure 4.* This is the caption of figure 4.
- Figure 5.* Caption for Figure 5 goes here.

Table captions

- Table 1.* Effect of Medication on CRP, controlling for Age.
- Table 2.* Effect of Diet and Exercise on CRP, controlling for Age.
- Table 3.* Descriptive statistics.
- Table 4.* Descriptive statistics.