

Congestive Heart Failure in Type 2 Diabetic Patients

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DESCRIPTION

People with diabetes are more likely to suffer from Cardiovascular Diseases (CVDs), and numerous variables, including hypertension, are responsible for this increased CVD prevalence. Patients with diabetes have hypertension almost twice as frequently as those without the illness. On the other hand, current data shows that hypertensive people are more likely to acquire diabetes than people with normal blood pressure. Additionally, as hypertension may be responsible for up to 75% of CVD in diabetics, more aggressive therapy (lowering blood pressure to less than 130/85 mm Hg) is advised for those who have both diabetes and hypertension. These individuals also have a number of other significant risk factors for CVD, including diabetes, obesity, atherosclerosis, dyslipidemia, microalbuminuria, endothelial dysfunction, platelet hyperaggregability, and coagulation abnormalities.

Especially in diabetic patients with coexisting hypertension, the cardiomyopathy associated with diabetes is a distinct myopathic condition that appears to be independent of macrovascular/microvascular disease and significantly contributes to CVD morbidity and death. With a focus on the cardiometabolic syndrome, hypertension, microalbuminuria, and diabetic cardiomyopathy, analyses the most recent information on these risk factors and how to manage them. The renin-angiotensin system function in diabetic individuals elevated CVD risk as well as the effects of disrupting this system on the emergence of both clinical diabetes and CVD. Up to 80% of fatalities in people with type 2 diabetes are caused by CVD. In fact, those with type 2 diabetes have a 3-fold greater age-adjusted relative risk of death from cardiovascular events than the overall population. According to a recent population-based study, people with type 2

diabetes who have never had a myocardial infarction die from CVD at a rate that is 7.5 times higher than that of people without the condition. Furthermore, compared to non-diabetics, the incidence of CVD death was three times greater among diabetics who had experienced a myocardial infarction. Women are more likely than males to get CVD as a result of diabetes.

In addition, diabetes eliminates the typical gender differences in CVD prevalence, and after adjusting for other risk factors, the risk of increased mortality is 2.4 times higher in diabetic males and 3.5 times higher in diabetic women. In addition to prediabetic individuals, other risk factors for the cardiometabolic syndrome include obesity, hyperlipidemia, hyperuricemia, and albuminuria. When not attributed to gout, diuretic medication, or other conditions known to cause hyperuricemia, the hyperuricemia that develops in essential hypertension is linked to decreased renal blood flow and elevated renal vascular resistance.

CONCLUSION

The development of left ventricular hypertrophy (observed on echocardiography) and the aforementioned renal hemodynamic involvement occur concurrently with this elevation in serum uric acid in patients with the early stages of essential hypertension, even prior to the onset of proteinuria or impaired renal excretory function. On the other hand, it has been shown that in patients with diabetes and either hypertension or coronary heart disease, microalbuminuria can appear before any clinical signs of either intrarenal vascular disease or diabetes. While CHD, related with occlusive epicardial coronary artery disease, as shown by myocardial infarction, is an arterial disease, it affects the intrarenal arterioles. Nephrosclerosis is also connected with hypertension and renal diabetic vascular disease. The latter condition is made resulting in severe diabetes and hypertension.

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