testosterone, for the female they are used to produce progesterone and estrogen. Cholesterol can be delivered to the adrenaling gland which produce aldosterone, cortisol. Cholesterol also acts as a lipid bilayer in many organs. On the another hand, LDL becomes atherosclerotic when its in a high concentration in the blood, and tends to stick to the lining of blood vessels. High density lipids (HDL) acts as a scavenger in the body by taken up this excess cholesterol through a means called «reverse cholesterol transport reuptake», and are taken back to the liver for excretion [3–4]. 40 % who didn’t consume red meat and pork all had minor incidences and the cause of their disease were basically stress and of smoking cigarette.

60 % fry their foods, all on a regular bases with semi hydrogenated vegetable oils, which are known to contain transfatty acids.

75 % patients eat fruits but not regularly.

Physical activity: 87.5 % patients don’t do regular exercise. Regular physical exercise as apart of a multifunctional intervention corrects endothelial dysfuction, improves symptoms in patients with CAD, augument myocardial perfusion and reduces mortality in patients [4]. Endothelial dysfuction has been identified as a major predictor of future cardiovascular event and preceeds the development of coronary artery dieases (CAD). Based on research in Japan people volunteered for an experiment did 20 mins of exercise every day, the result showed an increase in the HDL level by 2.5mg/dl (6.4 %) and an extra 10 mins work out also lead to an increased output of 1.4mg/dl (10 %) [5–7].

Bad habits: 100% patients smoked from the ages of 20–40 years.

Obesity: 60 % patients are obesed, 20 % – over weight and the rest were normal. The average calories consumed by a person decreases as he or she gets older, from the ages of 16–40 years is 2.4 kcal, 40 years above for a sedentary life style need only an average of 2.1 kcal per day [8]. This excess additional energy are stored as fats in the adipocytes which leads to obesity, increased level of cholesterol and triglycerides.

**Conclusion**

According to the researches reviewed and also interviews, it has shown the benefits of exercise and also those foods stuffs to avoid in order to prevent and decrease any chances of having coronary heart disease. Other consumable goods are cigarette, beer, vodka, transfats, fried foods in hydrogenated oil should be replaced by vegetables, fresh fruits, fish and clean water, poultry, seeds, legumes, whole grains to prevent coronary heart disease.

**REFERENCE**


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**DIABETIC FOOT CARE AMONG PATIENTS**

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**Introduction**

Diabetic Mellitus (DM) is a metabolic disorder that is characterized by chronic hyperglycemia; it’s a common and disabling chronic disease [1, 2]. In this, there is awareness among the population. Young and elderly people are at risk of DM and accounts for about half of the
diabetic foot complication afterwards [3]. DM foot complications are a leading cause of mortality in developing countries and prevalence of diabetes is expected to increase in the next decades in countries [1]. Their elevated risk of diabetic foot has been attributed to their lack of good hygiene regarding their foot, little knowledge on sugar control; calling for targeted educational interventions in improving their diabetic foot knowledge and decreasing their risky behaviors [4]. This rise in prevalence of DM is likely to bring a concomitant increase in its complications among diabetic patients. One important complication of DM are foot problems; these complications are a leading cause of admission, amputation and mortality in diabetic patients [5]. Increasing foot care and control of blood sugar knowledge has been suggested as an effective Diabetic Foot preventive behavioral interventions across different context. Elevating diabetic foot knowledge creates motivation for risk reduction and has been associated with increased foot care, blood testing with normal blood glucose level and treatment uptake [6].

**Aim**
To evaluate and analyze the knowledge and practice of foot care among diabetes patients.

**Material and methods**
This study was carried out in Gomel Regional Hospital N3 in the surgical department and 20 patients were examined, 14 male (70 %), 6 females (30 %). The age ranging from 20–90 years of age; median age of the respondents was 55 years of age. The surveyed instrument used was a structured questionnaire. The questionnaire consisted of 14 questions, concerning: 1) knowledge of foot care; 2) current self-care practice; 3) self-reported barrier; 4) diagnosis Diabetic Foot; 5) treatment Diabetic Foot. Each correct question was assigned one mark.

The outcome variables of the study were knowledge and practice regarding foot care in diabetic patients. Data obtained were analyzed using Chi square. The response to questions on knowledge, practice and barriers to foot care were analyzed, the knowledge and the current practice score of each correspondent was determined. Their knowledge and practice score was classified as good, satisfactory and poor depending upon the score. If score greater than or equal to 70 % (8–11), it was regarded as good, if score was 50–69 % (6–9) it was regarded as satisfactory and if score was less than 50 % (less than 6) it was regarded as poor. Chi square test was used to access the significance of the responses and P value of < 0.05 was considered statistically significant.

**Results**
We enrolled a total of 20 diabetic patients to study, 14 (70 %) were males and 6 (30 %) were females. 3 (15 %) were below the age of 50 years.

Knowledge of foot care. The range of the current score obtained in this study was 0–11 out of maximum possible score of 11. Reports about this disease among patients surveyed, a large majority (71 %) answered that no one has told them about diabetic foot and how to prevent it. 16 (80 %) patients of the diabetes mellitus were unaware that smoking causes poor circulation of the feet, 14 (70 %) were unaware of the first thing to do when they found redness/bleeding between their toes. Majority of the respondent 10 (50 %) had a poor knowledge of diabetic foot care (score < 50).

Current practice of foot care. Less than half of the correspondents (40.9 %) regularly inspect their feet, 39 % regularly wash their feet with warm water and 20.1 % inspect the inside of their footwear. Poor education attainment and low socioeconomic status were significantly associated with lower knowledge and practice score in this study.

Self-reported barriers to foot care. In this study, lack of knowledge of foot care was reported by 7 (35 %) as the barrier to good foot care practice, 9 (45 %) stated low finance and 4 (20 %) stated poor communication between patients and their physician.

Therefore, a greater proportion of diabetic patients had a poor knowledge of diabetic foot care. These deficiencies arises from lack of awareness about the effect of smoking in the cause of poor foot circulation; need for specialist consultation when warning signs like redness/bleeding occurs between toes; importance of regular inspection of foot wear for objects
or torn lining and regular inspection of the feet. We also found out that patients having poor education significantly had lower knowledge of foot care while gender and age difference were not significantly associated with the knowledge of the foot care.

Diagnosis. 17 (85 %) of patients were diagnosed a long time ago with diabetes mellitus before diabetic foot while 3 (15 %) were recently diagnosed with diabetes. 13 (65 %) were aware that controlling their blood sugar will decrease their chances of diabetic foot, 7 (35 %) were not aware. Most patients especially the men checked their blood sugar 15 (75 %) before diagnosed with diabetes, while women 5 (25 %) checked but weren’t constant. There was no significance difference using Fisher exact test (P = 0.2857) after diagnosis with DM, 9 (45 %) check their blood sugar regularly; 11 (55 %) — not regularly. Regarding pedicure 5 (25 %) female do this, 3 (15 %) male also do this while 12 (60 %) of the total correspondent don’t do pedicure.

Treatment. 90 % was on insulin therapy for their diabetic mellitus; while 10% didn’t have any treatment due to finance; (P = 0.515) it’s non-significant. But for the diabetic foot they were admitted to the hospital. In a year, more men were being hospitalized 10 (71.4 %) out of the total % of men while 2 (33.5 %) of total % of women were hospitalized (P = 0.111), there is non-significant difference. All correspondents told that the doctor prescribed treatment for them and they didn’t have any knowledge of how to help themselves.

The result of this study are a wakeup call on the clinicians and nurses to establish a patient and physician friendly educational programs that will enhance and sustain the good knowledge and practice of foot care.

Conclusion
The knowledge and practice of foot care among DM patients in this study were poor; these were associated with illiteracy and low socioeconomic condition. Clinical examination and paraclinical assessments, regular foot examination, patient education, simple hygienic practice and provision of appropriate footwear combined with prompt treatment of minor injuries can decrease ulcer occurrence by 50 %. The result of this study has highlighted the gaps in their knowledge, practice and underscores the urgent need for a patient friendly educational intervention coupled with regular physician reinforcement to reduce the risk of diabetic foot ulcers and amputations.

REFERENCE