Malay ethnicity (n = 125, 86.8%), followed by Indian (n = 14, 9.7%), Chinese (n = 4, 2.8%), and Thai (n = 1, 0.7%). Most participants (n = 90, 62.5%) were from low-income backgrounds. Educational attainment was limited, with 16% having no formal education or only primary-level education. Cognitive function assessment revealed that only 49 participants (34%) had normal cognitive function, while 72 participants (50%) exhibited mild cognitive impairment. Moderate cognitive impairment was observed in 21 participants (14.6%), and severe cognitive impairment was identified in 2 participants (1.4%).

CONCLUSION

This study reveals a strikingly high prevalence of cognitive impairment among individuals with T2DM, underscoring an urgent need for early detection and proactive intervention. As cognitive decline directly influences disease self-management, medication adherence, and overall quality of life, its integration into routine diabetes care is imperative.

EP_A177

TREATMENT OF DYSLIPIDEMIA IN TYPE 2 DIABETES MELLITUS PATIENTS AT THE DIABETES CLINIC, HOSPITAL SULTAN HAJI AHMAD SHAH: A CLINICAL AUDIT

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INTRODUCTION

Dyslipidemia is a major risk factor for cardiovascular disease in patients with Type 2 Diabetes (T2D) and requires aggressive management. The aim of this clinical audit is to assess the appropriateness of dyslipidemia treatment in T2D patients attending the diabetes clinic at Hospital Sultan Haji Ahmad Shah, Temerloh, Pahang.

METHODOLOGY

All T2D patients attending the diabetes clinic from June to July 2024 were included in this clinical audit. Electronic medical records were reviewed for demographic data, comorbidities, lipid profiles, cardiovascular disease risk assessments, and statin prescription patterns.

RESULT

A total of 102 patients were included, with a mean age of 53.2 years, 55.9% being female, and 59.8% having a diabetes duration of more than 10 years. The majority of patients had high to very high cardiovascular risk. Among the patients, 37.3% had chronic kidney disease and 32.4% had ischemic heart disease. The LDL-C control at the latest follow-up was suboptimal, with a mean LDL-C of 2.71 mmol/L. Additionally, 33.3% of patients were not initiated on the appropriate statin intensity, and 12% did not receive any lipid-lowering therapy. 20% of patients were on high doses of atorvastatin (60-80 mg), with limited use of combination therapy. Despite recognizing the patients' cardiovascular risk, there was clinical inertia in intensifying treatment.

CONCLUSION

This clinical audit highlights weaknesses in adherence to clinical guidelines and clinical inertia in dyslipidemia treatment. There is a greater need for continuous education and a stronger emphasis on achieving treatment goals in the management of T2D patients. Additionally, a reassessment of the budget for the availability of combination therapy options is necessary.

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OBESITY TREATMENT: IMPACT OF BLOOD GLUCOSE, LIPID AND NON-ANTIOBESITY DRUGS ON MUSCLE MASS

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INTRODUCTION

While obesity is often linked to excess muscle mass, emerging data reveal a paradoxical relationship between metabolic parameters and sarcopenia. This study examines the interplay between blood glucose regulation, lipid metabolism, and muscle mass retention in metabolic obesity.

METHODOLOGY

A cross-sectional study was conducted at Hospital Sultan Abdul Aziz Shah (HSAAS), Serdang, Selangor, to identify factors influencing muscle mass changes in metabolic obesity. Adults (≥18 years) with BMI ≥27 kg/m² and at least two comorbidities were included, while those with bariatric surgery or conditions causing intentional weight loss were excluded. Clinical data, including BMI, metabolic parameters, and medication use, were collected. Sample size was determined using a correlation formula.

RESULT

Among 35 individuals (BMI ≥26.5 kg/m²), hyperglycemia (HbA1c >6.5%) and hypertriglyceridemia (≥1.7 mmol/L) correlated with muscle loss, whereas normoglycemia