Diabetes is one of the most prevalent causes of neuropathy, and it has a high rate of morbidity and mortality, resulting in more hospitalizations for diabetics than any other illness [1]. A variety of neuropathy patterns can be recognised. ese are divided into three categories: symmetric, asymmetric, and focal. A distal symmetric sensorimotor neuropathy a ects at least half of people with long-term diabetes. Even in the pre-diabetic state, PN can occur early in the course of diabetes. Up to 56 percent of individuals with idiopathic PN have impaired glucose tolerance, which is three times the incidence of matched controls with normal glucose tolerance. and duration of hyperglycaemia are important risk factors for the development of PN. Hypertension, high triglycerides, cigarette use, obesity, micro vascular illness, and cardiovascular disease are all risk e onset is usually gradual, beginning in the toes and forefeet and advancing proximally over time. e majority of patients have both large and small nerve bre involvement, while large bre involvement frequently predominates [2]. Both motor and sensory nerves are a ected by large bre involvement. Pain is limited, but when it does occur, it is described as a dull, cramping discomfort. Before symptoms appear, a physical examination may identify abnormalities. Loss of vibratory sensation and position sensation, as well as reduced Achilles re exes, is some of the rst symptoms. Even when mono lament testing is normal, using a tuning fork to detect vibratory loss can reveal neuropathy [3]. Electro diagnostic investigations provide ndings that are consistent with axon loss and demyelination. Sensory abnormalities are the rst to appear, with sensory investigations revealing the earliest changes on the skin. Because of their more distal placement, medial plantar nerve conduction investigations are more sensitive in patients younger than 60. Motor nerve conduction problems develop later in the disease's progression. A symmetrical pattern of neuropathic abnormalities will be visible on an EMG needle test, with a distal to proximal gradient. Although quanti able strength testing o en reveals decreasing strength, this o en occurs before there is any clinical impairment. Small unmyelinated C bre involvement causes considerable discomfort and hyperalgesia, and it can happen early in diabetes. ere is a loss of temperature awareness as well as autonomic abnormalities such as loss of sweating, dry feet, and vasomotor alterations as the disease advances [4]. Foot ulcers and infections are more likely a result of this.

e discomfort may decrease as the neuropathy advances, but this is an indication of disease progression rather than regression. ere is no di erence between small bre illness and large bre disease when small bre disease develops without large bre involvement. When small bre illness develops without large bre involvement, physical examination

## **Types**

Types of diabetic neuropathy include the following

**Supplemental neuropathy:** Supplemental neuropathy is whimwhams damage that generally a ects the bases and legs and occasionally a ects the hands and arms.

## Autonomic neuropathy: