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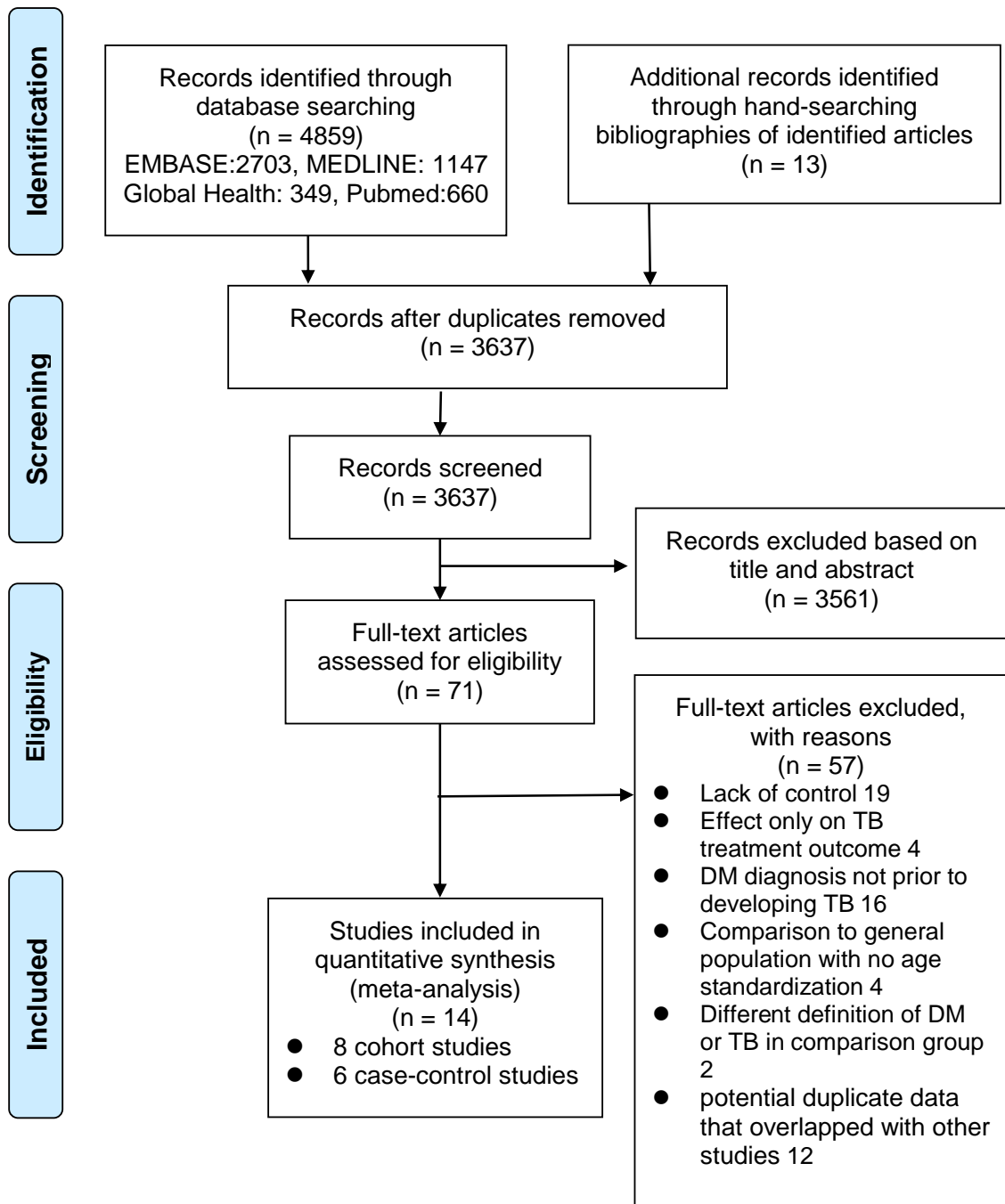


Figure 1 Study selection process

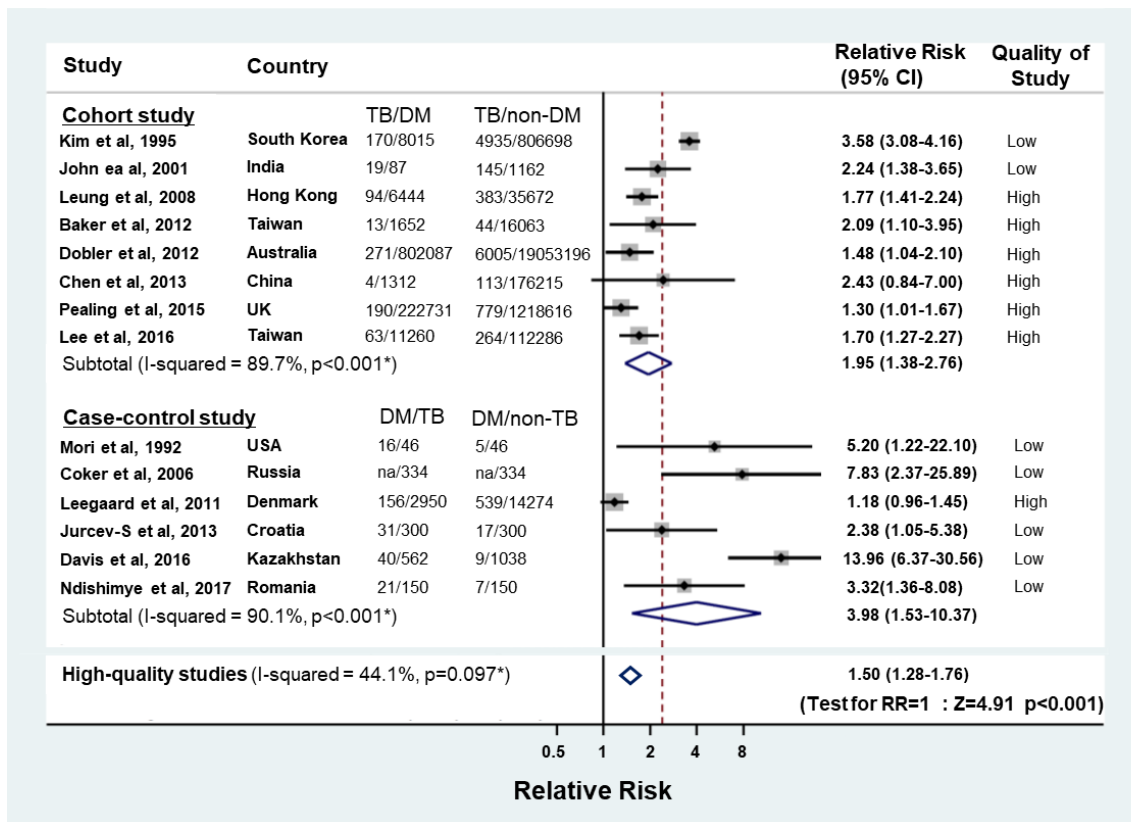


Figure 2 Estimates of effect of DM on active TB in each study and pooled relative risk in cohort studies, case-control studies, and high-quality studies

Relative Risk: Rate ratio in cohort studies and odds ratio in case-control studies, 95% CI: 95% confidence interval, P value*: Test of heterogeneity, na: data not available

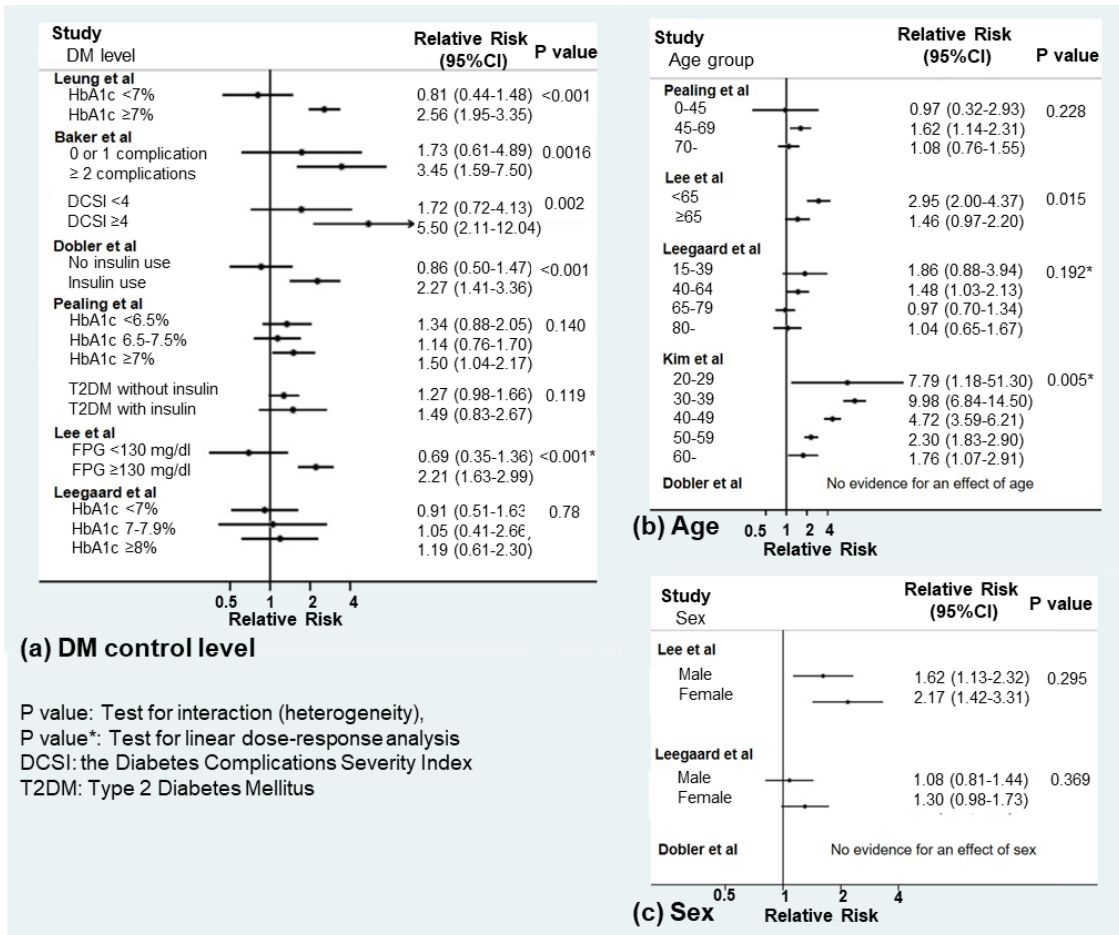
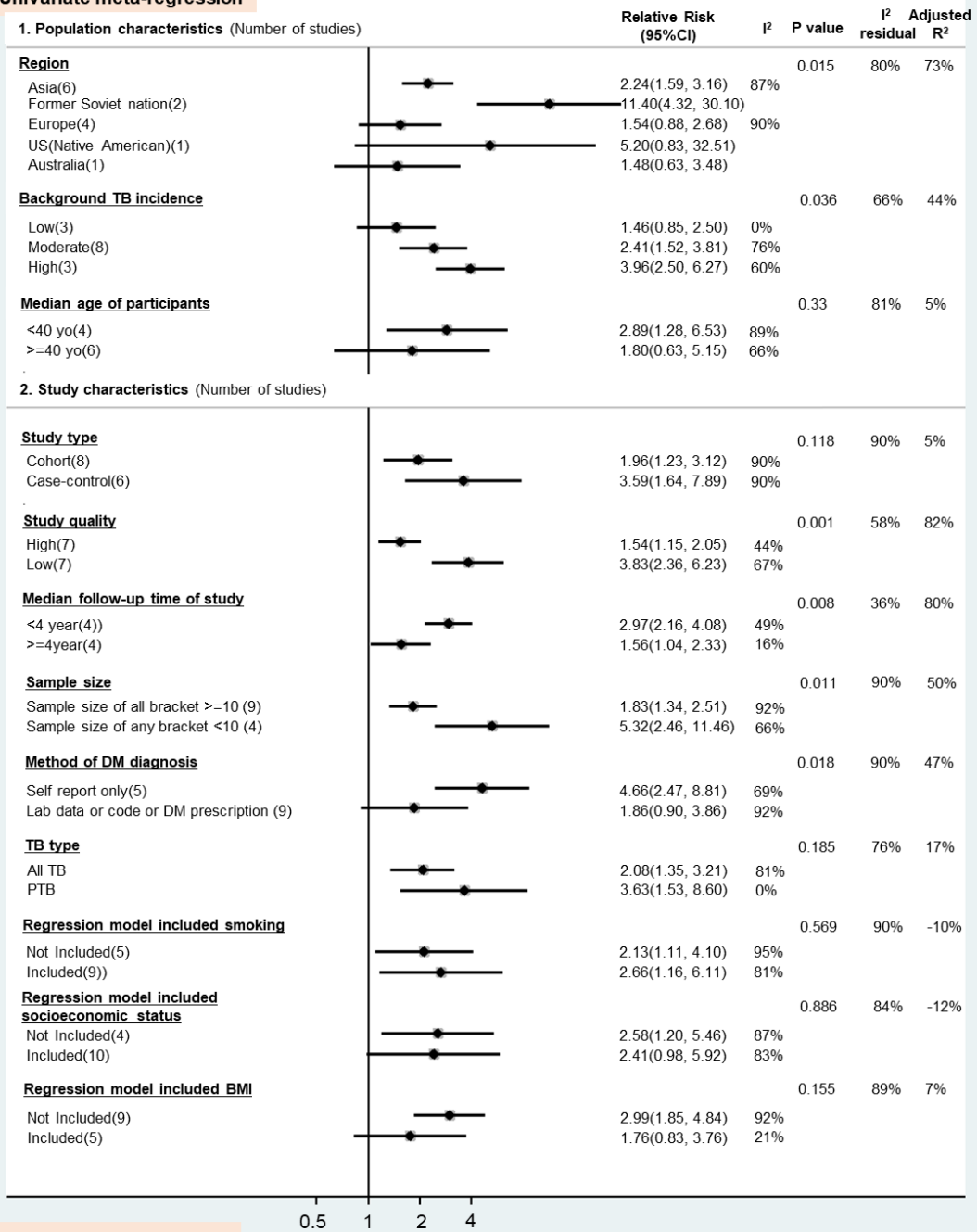


Figure 3 Stratum-specific association between DM and TB: level of control of DM (a), Age (b), and Sex (c)

Univariate meta-regression



Bivariate meta-regression

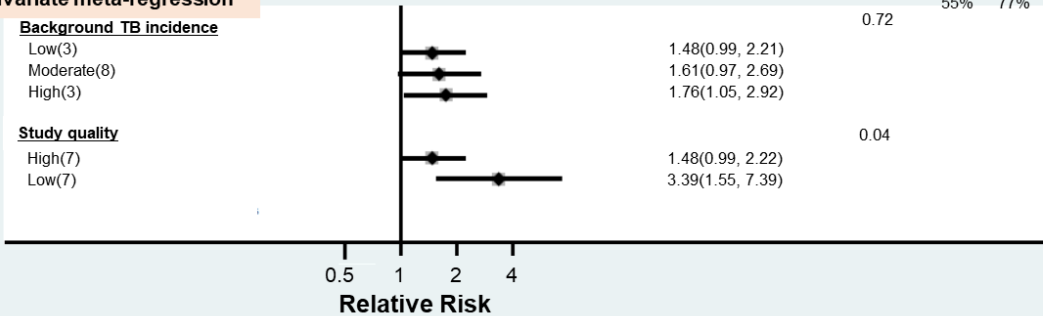
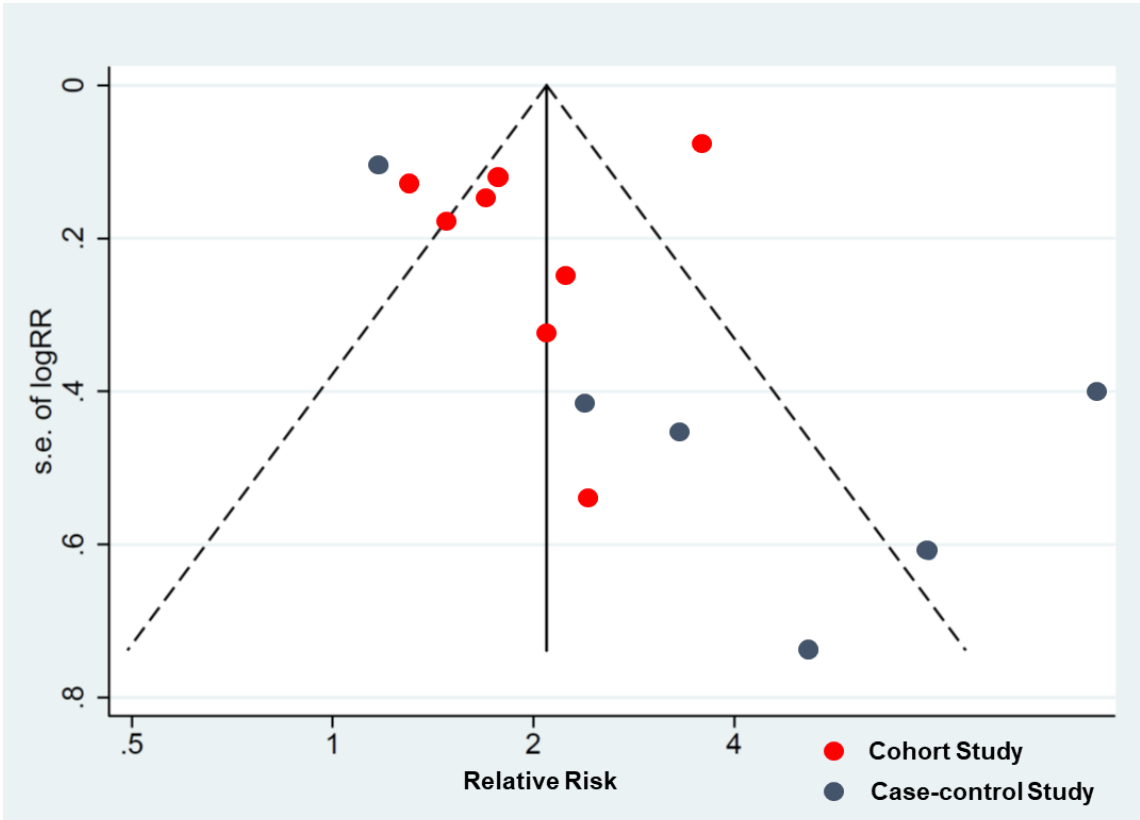


Figure 4 Estimated effect of DM on TB stratified by population characteristics and study characteristics

Background TB incidence (per 100,000 person-years): low <15, moderate 15-100, high >100, Study quality: high 8-9, low -7 (the numbers of stars in Newcastle-Ottawa Scale), I^2 : % variation due to between-study heterogeneity in group computed from Der Simonian-Laird random effect model, P value: test of linear trend (meta-regression), I^2 residual: % residual variation due to heterogeneity, Adjusted R^2 : Proportion of between-study variance, Bivariate meta-regression included only the background TB incidence and study quality in the model.



s.e. of logRR: standard error of log(Relative Risk)

Figure 5 Funnel plot with pseudo 95% confidence limits of the studies included in meta-analysis

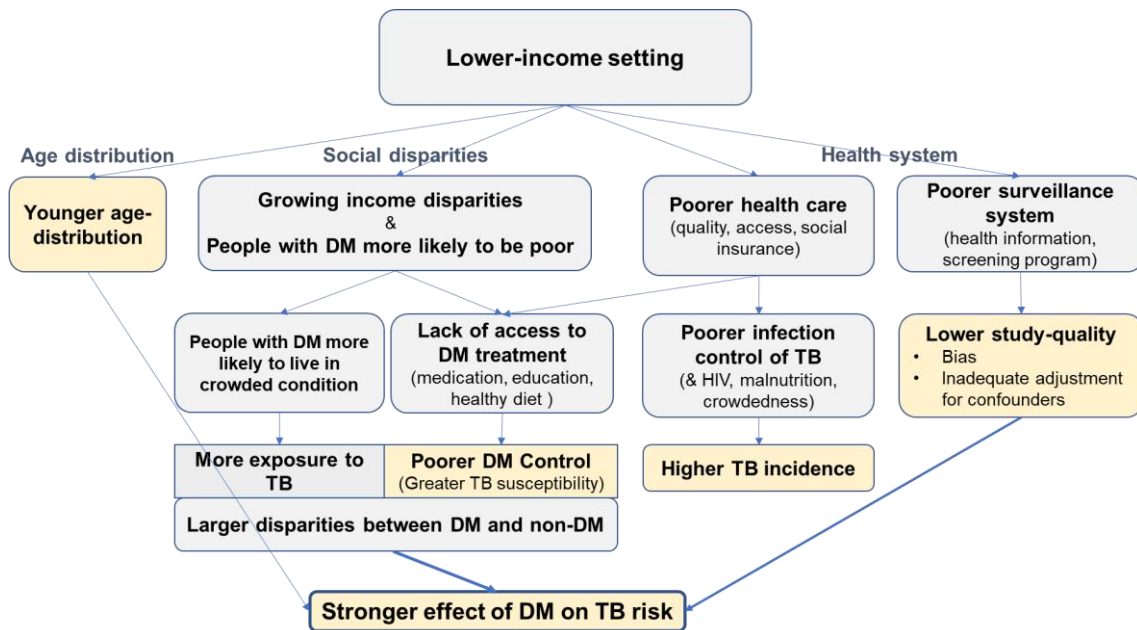
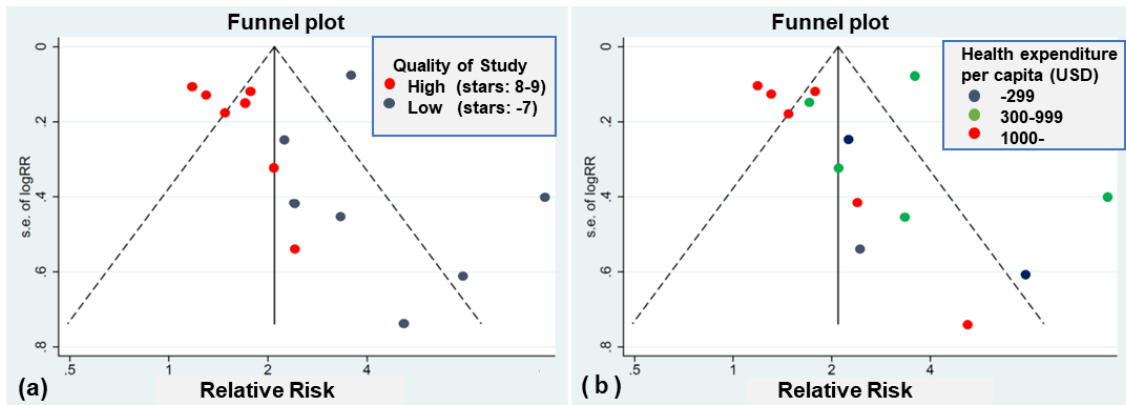


Figure 6 Relationships between factors and the strength of the effect of DM on TB



s.e of logRR: standard error of log (Relative Risk)

Figure 7 Funnel plots with pseudo 95% confidence limits of the studies, grouped by quality of study (a), and health expenditure per capita (b)

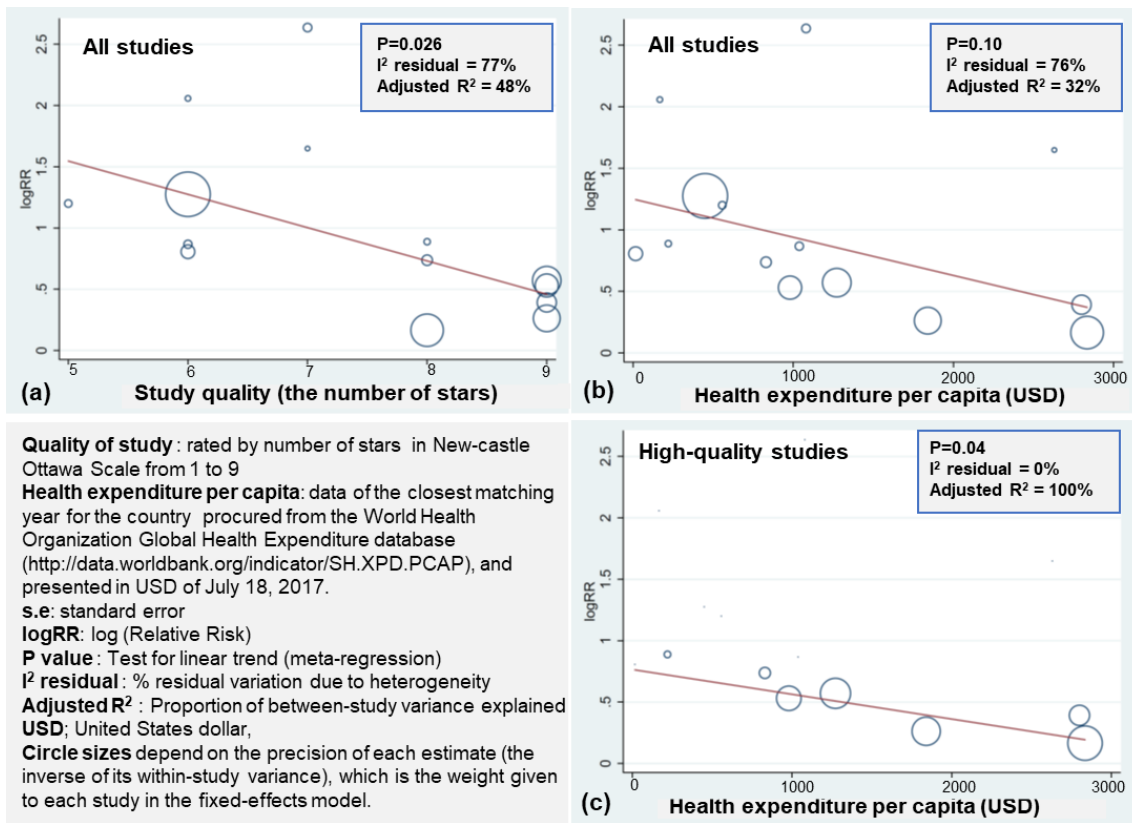


Figure 8 Association between study quality and estimated effect of DM on TB (a), and association between health expenditure per capita and estimated effect of DM on TB in all studies (b) and in high-quality studies (c)