indicating a prevalence comparable to that found in Thessaly \((p=0.699)\). After adjustment for age, the prevalence of DM in Thessaly was found to be 11.77\%, whereas after extrapolating these data to the whole country, the age-standardized prevalence of DM was calculated at 11.97\% (Table 4).

The subsequent analyses included 769 subjects after exclusion of those who declined to undergo the OGTT. The prevalence of DM was found to increase significantly with age \((p=0.001)\) in both sexes, reaching its highest level in the group of 70-80 year-olds without any significant difference between men and women (Figure 1, Table 5). Rural residents had a significantly higher prevalence of DM than urban residents; when it was examined separately, women living in rural regions had significantly higher rates of DM, whereas statistical significance was marginally lost among men. However, this difference was no longer significant after controlling for age. The prevalence of DM was significantly higher in married than in single individuals, but it lost statistical significance when tested separately in men and women (Table 5). Education inversely influenced the frequency of DM: participants with a lower educational level (primary education) had a significantly higher prevalence of DM (Table 5) compared to those with a higher educational level (secondary and tertiary).

Comparative data regarding cardiovascular risk factors are presented in Table 6. As expected, men and women with higher BMI or abdominal obesity had a significantly higher prevalence of DM. On the other hand, subjects with DM or IGT had significantly higher BMI and WC compared to individuals with normoglycemia \((31.51±6.64\text{ vs. } 27.72±5.24 \text{ kg/m}^2, p=0.001; 106.57±13.15 \text{ vs } 93.37±14.79 \text{ cm}, p=0.001\) and \(30.91±5.75 \text{ vs } 27.72±5.24 \text{ kg/m}^2, p=0.006; 101.03±12.57 \text{ vs } 93.37±14.79 \text{ cm}, p=0.003, \text{ respectively})\). An association was also found between DM and hypertension. Men and women with hypertension had a significantly higher prevalence of DM compared to individuals without hypertension (Table 5). Smoking was also negatively associated with DM rates. Smokers had lower rates of DM compared to non-smokers. Hypercholesterolemia was not associated with DM prevalence, nor were hypertriglyceridemia and low HDL (data not shown).

In multiple logistic regression analysis, age, HOMA-IR, alcohol consumption and educational status were independently associated with the presence of T2DM/pre-diabetes (IFG and IGT) when compared...