**Associations between type 2 DM and the study parameters**

Of the 8740 participants, 360 [4.11%, 95% CI 3.70-4.52] had type 2 DM (Table 3). Univariate analysis revealed that prevalence of type 2 DM increased significantly with older age \( (P<0.001) \), increasing BMI \( (P<0.001) \), living in rural regions \( (P=0.01) \), low education level \( (P<0.001) \), manual occupation \( (P=0.01) \), low socioeconomic status \( (P<0.001) \), smoking in the past \( (P<0.001) \), and fewer subjects living together \( (P<0.001) \) (Table 4). Prevalence of known type 2 DM did not differ significantly between males and females. Similarly, there was no difference in the prevalence of type 2 DM among the northern, central, and southern areas of the country or between the selected and non-selected populations.

Multivariate logistic regression analysis in the studied population, after adjustment for region of living (rural, suburban, urban), educational level, occupation, and number of persons living together, demonstrated that the odds of type 2 DM increased significantly with age above 40 years \( (P<0.001) \), BMI \( \geq 30.0 \text{ kg/m}^2 \) \( (P<0.001) \), low socioeconomic status \( (P=0.009) \), and smoking in the past \( (P=0.001) \), while smoking currently was associated with lower odds of type 2 DM \( (P=0.01) \) (Table 5).

**DISCUSSION**

Diabetes is a formidable public health issue incurring a significant social and economic burden which necessitates a multitude of clinical interventions and public health policy decisions. Population-based studies and identification of risk factors are of particular interest for the development of preventive strategies. However, screening of selected groups of the general population and the non-random, non-population-based nature of most relevant studies have given rise to wide variations of the reported DM prevalence in Greece in previous studies.\(^{16-21}\)

The strengths of the present study are: i) a large number of subjects was evaluated in a door-to-door manner by experienced physicians who visited, interviewed, and collected data at their homes; ii) the participants were representative of the total adult target population of the studied areas and, most importantly, of the Greek adult population; iii) a high participation rate was achieved. On the other hand, this study is not without limitations. As in most population-based studies, the determination of DM was based on self-reported, physician-diagnosed DM and was not confirmed diagnostically, although previous data indicated that the reliability of self-reported DM was high.\(^{22}\) Additionally, the actual prevalence of the disease, including the non-diagnosed cases, is clearly underreported. Furthermore, data on some established risk factors of type 2 DM, such as family history of type 2 DM, physical activity, and nutritional factors, are not available.

In our study we found a strong association between