

Not only after myocardial infarction

To the editor: We read with interest the study by Norhammar *et al*¹ describing the treatment and myocardial infarction survival rates according to the presence of diabetes. In their study, 1-year mortality rates decreased between 1995 and 2002 from 16.6% to 12.1% in patients without diabetes and from 29.7% to 19.7%, respectively, in those with diabetes. Despite improved pre-admission and in-hospital treatment, diabetic patients were less often offered acute reperfusion therapy, acute revascularisation or revascularisation within 14 days, aspirin and lipid-lowering treatment at discharge.

Although acute management of patients with myocardial infarction is important, treatment of this population to prevent secondary disease, is also crucial especially of those at higher risk such as diabetics. In a study recently performed in a Spanish clinical practice, in 2024 hypertensive patients with chronic ischaemic heart disease, the influence of diabetes on the diagnosis and therapeutic approach was analysed.^{2 3}

According to the paper of Norhammar *et al*, the presence of other risk factors and cardiovascular comorbidities was also more common in diabetics. Overall, diabetic patients were taking more medication (96.9% of diabetics vs 85.4% of non-diabetics were treated with ≥ 4 drugs, $p < 0.001$). Antihypertensive agents, calcium channel blockers (49.1 vs 42.2%), diuretics (45.1 vs 30.4%) and renin-angiotensin system inhibitors (83.6 vs 72.9%) were more commonly prescribed in diabetics (all $p < 0.01$), while β -blockers were used more frequently in non-diabetics (63.8 vs 68.7%, $p = 0.01$). Blood pressure control ($< 130/80$ mm Hg) was more common in non-diabetics (19.7% vs 26.4% $p = 0.001$). Lipid-lowering drugs were more frequently prescribed in diabetics (77.8 vs 73.9%, $p = 0.036$), but, nevertheless, no differences in low-density lipoprotein-cholesterol control rates were seen between the groups. Notably, patients with diabetes were surprisingly taking fewer antiplatelet agents than non-diabetics (85.2 vs 89.7%, $p = 0.003$). Finally, no differences in diagnostic procedures were found in the performance of stress test (84.5 vs 86.9%) or coronary angiography (60.9 vs 58.1%).

In agreement with Norhammar *et al*, in recent years the management of diabetics with coronary heart disease has been improving, but our data also confirm that application of evidence-based treatment is still lacking.

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The authors' reply: It was with great interest that we read your letter to the editor of *Heart* about a suboptimal use of evidence-based treatment in patients with diabetes and chronic ischaemic heart disease. We agree with your findings that there is insufficient control of risk factors in these patients. The importance of secondary prevention of disease in a diabetic patient after myocardial infarction is indeed highlighted in our report¹ and, for example, clearly visible in fig 2 as successively increasing mortality differences among non-diabetic and diabetic patients over time. This indicates a need for improved secondary preventive measures. Furthermore, a recent analysis from the Euro Heart Survey on diabetes and the heart showed poor adherence to secondary guideline goals, particularly among patients with diabetes. The target level for blood pressure control ($< 140/90$ mm Hg) was only reached by 30% of the patients and low-density lipoprotein-cholesterol levels were unsatisfactory (> 3 mmol/l) among 57%.² Considering the considerably lower targets for blood pressure and lipids advocated in the new European guidelines for patients with pre-diabetes and diabetes and coronary artery disease³ the present

situation must really be considered far from satisfactory.

In conclusion, we agree with Drs Barrios and Escobar that it is not only the acute management of myocardial infarction but also secondary preventive efforts that must be paid much more attention in order to improve the poor prognosis for patients with diabetes mellitus.

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CORRECTIONS

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Justin Zaman and Eric Brunner. Social inequalities and cardiovascular disease in South Asians. *Heart* 2007;**94**:406–7. The first author of this paper should be M Justin Zaman.

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F Antonini-Canterin, *et al*. Left atrial remodelling early after mitral valve repair for degenerative mitral regurgitation. *Heart* 2007;**94**:759–64. In the print journal, the order of the authors is incorrect. The correct order is: F Antonini-Canterin, CC Beladan, BA Popescu, C Ginhina, AC Popescu, R Piazza, E Leiballi, B Zingone, GL Nicolosi.

The corrected paper is available online at: <http://heart.bmj.com/cgi/content/full/94/6/759>.

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