The presence of diabetes mellitus worsens prognosis in acute coronary syndromes. The aim of our study was to analyze retrospectively the influence of diabetes mellitus on the management and prognosis of patients with non-ST-segment elevation acute coronary syndrome. We compared the baseline clinical characteristics of 273 patients (93 diabetic and 180 non-diabetic) admitted consecutively to our department with the diagnosis of non-ST-segment elevation acute coronary syndrome. In both groups, we assessed the medical treatment given during hospitalization and the use of coronary angiography, percutaneous coronary intervention, and coronary artery bypass grafting. Finally, we determined the incidence of heart failure during hospitalization and mortality at 28 days and 6 months in both groups. Multifactorial analysis revealed that diabetes was an independent risk factor for mortality during the study period. Data from our registry indicate that these findings were not associated with more extensive use of interventions in diabetic patients.

Key words: Unstable angina. Diabetes mellitus. Prognosis.
Spain readily explains the growing interest of the cardiologic community in the association between DM and cardiovascular disease. The purpose of our study was to analyze the influence of DM on the prognosis and the clinical and therapeutic approach toward patients with NSTEACS.

METHODS

Study Population and Design

A historical cohort study was conducted with 273 patients (204 men and 69 women) admitted to our hospital from January 2001 to December 2002 with a diagnosis of NSTEACS according to published criteria. Among the total study population, 93 patients (34.1%) had DM versus 180 who were not diabetics. The patients were classified as diabetics if they had been diagnosed with DM, were receiving hypoglycemic therapy, or presented repeatedly high baseline blood sugar levels (>126 mg/dL in at least 2 fasting measurements) during admission. Among the group of diabetics, 43.4% were on insulin therapy, 37.1% were receiving oral antidiabetic therapy, and 19.5% were managed by diet.

Data Analyzed

The following variables were collected in both groups: age, sex, history of cardiovascular risk factors (hypertension, dyslipidemia, and smoking), history of ischemic heart disease, drug therapy received, coronary angiography, and revascularization therapy (percutaneous or surgical) during the hospitalization. Lastly, we analyzed the onset of major cardiovascular events, defined as heart failure during admission and cardiovascular mortality at 28 days and at 6 months. This information was obtained by a review of the medical histories, personal interviews, and a phone survey of the patients.

Statistical Analysis

SPSS (Statistical Package for Social Sciences, version 10.0 for Windows) was used for the data analysis. The quantitative variables are expressed as mean±SD and the qualitative variables as percentages. The χ² test was used to compare the qualitative variables. Quantitative variables were compared using the Student’s t test. Cox proportional-hazards regression models were used to estimate the hazard ratio of clinical variables significantly different in the single-factor analysis (hypertension, dyslipidemia, smoker, history of myocardial infarction, and use of angiotensin-converting enzyme inhibitors [ACE inhibitors]).

RESULTS

The baseline characteristics of the patient population are shown in Table 1. There were no differences in age or sex between the 2 groups. In contrast, diabetic patients presented a higher prevalence of hypertension, dyslipidemia, previous myocardial infarction, and, paradoxically, smoking. Coronary angiography, percutaneous transluminal coronary angioplasty, and coronary bypass surgery was similar in the 2 groups, as is shown in Table 1.

Both groups had similar characteristics with regards to beta-blocker, acetylsalicylic acid, clopidogrel, heparin, and statin therapy during the hospitalization and follow-up phases. However, ACE inhibitors were more commonly used among diabetics (60% vs 37%; P<.05).

With regard to the onset of major cardiovascular events, a higher incidence of heart failure during admission and a higher cumulative incidence of cardiovascular mortality at 28 days and at 6 months was found among the patients with DM (Table 2). The multivariate analysis showed that DM was an independent predictor of mortality (hazard

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TABLE 1. Baseline Clinical Characteristics and Angiography and Revascularization Therapy (Percutaneous or Surgical) During Hospitalization Among the Diabetic and Nondiabetic Groups

<table>
<thead>
<tr>
<th></th>
<th>Group With DM (n=93)</th>
<th>Group Without DM (n=180)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, mean±SD, y</td>
<td>67±12</td>
<td>65±10</td>
<td>.24</td>
</tr>
<tr>
<td>Men</td>
<td>56 (60%)</td>
<td>121 (67%)</td>
<td>.35</td>
</tr>
<tr>
<td>HT</td>
<td>46 (50%)</td>
<td>56 (31%)</td>
<td>.001</td>
</tr>
<tr>
<td>Dyslipidemia</td>
<td>45 (48%)</td>
<td>60 (30%)</td>
<td>.001</td>
</tr>
<tr>
<td>Smoker</td>
<td>44 (47%)</td>
<td>59 (33%)</td>
<td>.002</td>
</tr>
<tr>
<td>History of infarction</td>
<td>21 (23%)</td>
<td>27 (15%)</td>
<td>.01</td>
</tr>
<tr>
<td>Coronary angiography</td>
<td>28 (30%)</td>
<td>58 (32%)</td>
<td>.34</td>
</tr>
<tr>
<td>PTCA</td>
<td>26 (28%)</td>
<td>56 (31%)</td>
<td>.34</td>
</tr>
<tr>
<td>Coronary bypass surgery</td>
<td>6 (6%)</td>
<td>7 (4%)</td>
<td>.30</td>
</tr>
</tbody>
</table>

*DM indicates diabetes mellitus; HT, hypertension; PTCA, percutaneous transluminal coronary angioplasty; SD, standard deviation.

TABLE 2. Development of Heart Failure During Admission and Cumulative Incidence of Cardiovascular Mortality at 28 Days and at 6 Months in Both Groups

<table>
<thead>
<tr>
<th></th>
<th>Group With DM (n=93)</th>
<th>Group Without DM (n=180)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart failure during admission</td>
<td>16 (17%)</td>
<td>13 (7%)</td>
<td>.01</td>
</tr>
<tr>
<td>28-day mortality</td>
<td>3 (3.2%)</td>
<td>3 (1.4%)</td>
<td>.001</td>
</tr>
<tr>
<td>6-month mortality</td>
<td>8 (8.3%)</td>
<td>8 (4.4%)</td>
<td>.01</td>
</tr>
</tbody>
</table>

*DM indicates diabetes mellitus.
In any case, DM
Despite the published
is independently
Therefore, diabetic
and those of the Sociedad
propose that DM per se determines an
we found that there
Likewise, the higher
In contrast, of
we observed that clopidogrel is
different risk stratification after NSTEACS than that of
mortality.
analysis maintained DM as an independent predictor of
European Society of Cardiology guidelines, the mere
more frequent among the diabetics. Diabetes mellitus and
heart failure during admission was more
frequent among the diabetics. Diabetes mellitus and
heart failure have been related to extensive coronary
artery disease, autonomic dysfunction, and a high
prevalence of hypertension. Likewise, the higher
mortality observed among our diabetic patients could be
due to a higher prevalence of hypertension and previous
coronary artery disease. However, multivariate
analysis maintained DM as an independent predictor of
mortality. Consequently, we feel that DM should prompt a
different risk stratification after NSTEACS than that of
a nondiabetic patient. Considering NSTEACS a high-
risk event is a determining factor in deciding on an
invasive therapeutic approach, clearly superior in
general terms to a conservative approach (with results
that can be extrapolated to the diabetic population,
although noticeably lower). According to the
European Society of Cardiology guidelines, the mere
presence of DM is a high risk in NSTEACS, regardless of
the presence of other high-risk criteria (clinical,
electrocardiographic, or biochemical). In contrast, of
the U.S. guidelines and those of the Sociedad Española de Cardiología (Spanish Society of Cardiology) propose that DM per se determines an intermediate risk.

Limitations of the Study
This is a single-center, retrospective study with all the
limitations inherent to this kind of design. In addition,
the new therapeutic recommendations for ACS were
published around the time of the study period and may
explain the sub-optimal use of some of the therapeutic
strategies, now clearly defined for ACS.

CONCLUSIONS
Our study demonstrates that DM confers a special risk status among patients with NSTEACS and we believe that it is possible to optimize treatment for this large subgroup of patients. The decisive findings of epidemiological studies and projections on DM and its cardiovascular impact might indicate the need to adopt more interventional strategies for the treatment of ACS among the diabetic population, thus contributing in part to improve their prognosis following NSTEACS.

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REFERENCES