

Diabetes Meds at MI Discharge Improve Survival

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WASHINGTON — Diabetic patients who had myocardial infarctions and had not resumed their antihyperglycemia medications by discharge were 24% more likely to die within 1 year as were similar patients who had resumed their medications at discharge.

The increased risk of death was especially telling in the first 30 days after dis-

charge. "I was struck by the findings," said Dr. Silvio Inzucchi, principal investigator and professor of medicine at Yale University, New Haven, Conn., during a poster presentation at the annual scientific sessions of the American Diabetes Association.

Dr. Inzucchi and his associates reviewed charts of Medicare patients aged 65 years and older in the National Heart Care Project.

All patients had a confirmed acute MI

and previously documented diabetes treated with antihyperglycemic agents. The study did not include patients who died before discharge, were transferred to another facility, or needed long-term hemodialysis.

Of the 8,751 patient charts, 1,170 (13%) indicated patients had not resumed their diabetes medications by discharge. Within 1 year of discharge, 38% of these patients had died. The 1-year mortality was 28% in the 7,581 patients who were taking

their diabetes medications at discharge.

Notably, 36% of the deaths occurred within the first 30 days after hospital discharge among patients who had not resumed diabetes medications at discharge, compared with 23% of the deaths in those discharged on diabetes medications.

The difference was statistically significant after multivariate Cox analysis for 78 clinical variables—including admission glucose, complications, ventricular function, and concurrent medications—was used to evaluate the association between discharge on diabetes therapy and outcome.

Investigators also found that patients who had not resumed their antihyperglycemic agents at discharge also were more likely to be discharged without receiving statins, β -blockers, ACE inhibitors, and aspirin.

The study is limited by the lack of data regarding changes in patients' prescriptions after discharge. It is unclear if patients immediately visited their primary care doctors and resumed their antihyperglycemic medications.

Dr. Inzucchi said that cardiologists need to address diabetes during discharge planning, even if it's simply to have patients follow up with their primary doctors.

"It's your gold check-off box," he stressed. "What are we going to do about the diabetes?" ■

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INCREASED ACTIVITY OF THE ENDOCANNABINOID SYSTEM (ECS) IS ASSOCIATED WITH INCREASED WAIST CIRCUMFERENCE^{1,2}

INCREASED WAIST CIRCUMFERENCE, A MARKER FOR IAA, IS AN ESTABLISHED CARDIOMETABOLIC RISK FACTOR³

- Significantly increases the risk of myocardial infarction, death from cardiovascular disease, and all-cause mortality⁴
- Has been found to be an independent predictor of type 2 diabetes⁵

ADIPOSE TISSUE IS A HIGHLY ACTIVE ENDOCRINE ORGAN⁶

- Fat cells (adipocytes) produce adiponectin⁶
 - In type 2 diabetes and obesity, adiponectin levels are reduced⁶

TARGETING THE ECS MAY PLAY A POTENTIAL ROLE IN THE CONTROL OF MAJOR CARDIOMETABOLIC RISK FACTORS SUCH AS IAA*

IF YOU ARE INTERESTED IN LEARNING MORE ABOUT THE ECS,
PLEASE CALL 1-800-815-0298 TO RECEIVE A MONOGRAPH.

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Obesity Paradox In Cardiogenic Shock Is Untrue

CHICAGO — The obesity paradox in cardiovascular medicine may not extend to patients with cardiogenic shock, Dr. Paari Dominic Swaminathan said at the annual meeting of the Society for Cardiovascular Angiography and Interventions.

Of 61 consecutive patients who presented to a Chicago hospital with cardiogenic shock secondary to acute MI, 24 were obese. Their in-hospital mortality rate was 33%, compared with just 3% in the 37 patients with a body mass index below 30 kg/m², according to Dr. Swaminathan of Chicago Medical School.

The two groups were similar in terms of demographics and other baseline variables with one exception: The obese patients were significantly younger, with a mean age of 54 years, compared with 63 years in the nonobese.

There were no significant differences between obese and nonobese patients in terms of the two secondary study end points, length of stay and rehospitalization rate.

The obesity paradox is so-named because—despite compelling evidence that obesity is a strong independent risk factor for cardiovascular disease—numerous studies have documented better outcomes for obese patients as compared with nonobese ones with MI, heart failure, and following percutaneous coronary intervention.

—Bruce Jancin