Édition
Masson, 21, rue Camille Desmoulins, 92789 Issy-les-Moulineaux Cedex 9.
Pascal Léger
Tél. : +33 (0)1 73 28 16 74
Fax : +33 (0)1 73 28 16 89
pascal.leger@medimedia.fr

Régie publicitaire
Marie-Pierre Cancel
Tél. : +33 (0)1 73 28 16 63
Fax : +33 (0)1 73 28 16 64
marie-pierre.cancel@medimedia.fr

Abonnements
Tél. : +33 (0)1 73 28 16 34
Fax : +33 (0)1 73 28 16 49
info@masson.fr

2004 : 6 numéros
Abonnements individuels (tous pays) : 199 €
Particuliers : 199 €
Étudiants : 54 €
Abonnements institutionnels :
France (+ Monaco et Andorre) : 214 €
Union Européenne (+ Suisse) : 268 €
Reste du monde : 298 €

Prix de vente au n° : 49 €
Les membres de l’Association de Langue Française pour l’Étude du Diabète et des Maladies Métaboliques et de la Société Française d’Endocrinologie bénéficient de tarifs préférentiels d’abonnement ; se renseigner auprès de l’ALFEDIAM et de la SFE.
Les abonnements sont mis en service dans un délai maximum de quatre semaines après réception de la commande et du règlement. Ils démarrent du premier numéro de l’année. Les réclamations pour les numéros non reçus doivent parvenir chez Masson dans un délai maximum de six mois. Les numéros et volumes des années antérieures (jusqu’à épuisement du stock) peuvent être commandés à la même adresse.


The official organ of / Organe officiel de l’ASSOCIATION DE LANGUE FRANÇAISE POUR L’ÉTUDE DU DIABÈTE ET DES MALADIES MÉTABOLIQUES (ALFEDIAM)

FOUNDERS / FONDATEURS
Jean Canivet et Pierre Lefèbvre (1975)

HONORARY EDITORS IN CHIEF / RÉDACTEURS EN CHEF HONORAIRES
Gabriel Rosselin, Philippe Vague, Gérard Reach, Pierre Saï

EDITORIAL BOARD / COMITÉ DE RÉDACTION
EDITOR IN CHIEF / RÉDACTEUR EN CHEF
Serge Halimi (Grenoble)

EXECUTIVE EDITOR / RÉDACTEUR EXÉCUTIF
Pierre-Jean Guillausseau (Paris)

ASSOCIATE EDITORS / RÉDACTEURS DÉLÉGUÉS
Jacqueline Capeau (Paris)
André Grimaldi (Paris), Dominique Simon et José Timsit (Paris)

CONSULTANTS FOR STATISTICS / CONSULTANTS EN STATISTIQUES
Évelyne Eschwège (Paris) et Laure Papoz (Montpellier)

EDITORS / RÉDACTEURS
Michel Beylot (Lyon), Pierre Châtelain (Lyon), Jean-Louis Chiasson (Montréal), Paul Czernichow (Paris), Jean-Pierre Felber (Lausanne), Giuseppe Paolisso (Napoli) and the Secretary General of the ALFEDIAM ex officio member et le secrétaire général de l’ALFEDIAM, ès-qualité

ADDRESS OF THE EDITOR IN CHIEF / ADRESSE DU RÉDACTEUR EN CHEF
Prof. S. Halimi - Service d’Endocrinologie-Diabétologie-Nutrition
CHU de Grenoble - 38043 Grenoble Cedex - France

E-mail : shalimi@ujf-grenoble.fr

EDITORIAL SECRETARY / ASSISTANTE DE RÉDACTION
Angèle Marion, see address above
Tél. : +33 (0)4 76 76 89 23 - Fax : +33 (0)4 76 76 88 65
Identification of myocardial ischemia in the diabetic patient
Joint ALFEDIAM and SFC recommendations

J. Puel¹, P. Valensi², G. Vanzetto¹, V. Lassmann-Vague², J.-L. Monin¹, Ph. Moulin², Ch. Ziccarelli³, H. Mayaudon³, M. Ovize¹, S. Bernard², E. Van Belle¹, S. Halimi²

¹ SFC (Société Française de Cardiologie), French Society of Cardiology.
³ CNCF (Collège National des Cardiologues Français), National College of French Cardiologists.
Epidemiological perspectives, showing a clear trend towards a considerable increase in the number of people with diabetes mellitus, and recent advances in the exploration and treatment of coronary artery disease incited the French-speaking Association for the Study of Diabetes and Metabolic Diseases, ALFEDIAM (Association de Langue Française pour l’Etude du Diabète et des Maladies Métaboliques), and the French Society of Cardiology, SFC (Société Française de Cardiologie) to hold their first joint conference devoted to updating recommendations for the identification of myocardial ischemia in diabetics.

It has long been recognized that diabetes, a major cardiovascular risk factor, can be considered as an authentic cardiovascular disease due to the frequency and the clinical severity of arterial, cardiac, cerebral or peripheral complications, which still too often lead to late diagnosis of impaired glucose control. In France, the increasing number of diabetic people whose life expectancy is determined by coronary complications makes diabetes mellitus an important public health priority. Due to the specific features of diabetic coronary artery disease, dominated by insidious onset and course, diagnosis of silent myocardial ischemia (SMI) and potential atheromatous lesions of the epicardial coronary vessels is crucial for appropriate therapeutic management of these patients.

Progress in drug and instrumental treatment modalities for coronary insufficiency naturally lead to a reconsideration of the most appropriate therapeutic approach, and by consequence of early screening for SMI, to reduce cardiac morbidity and mortality in diabetic patients. Interest in the prognostic and therapeutic potential of early identification of myocardial ischemia in the symptom-free diabetic has nevertheless been insufficient to incite large-scale multicentric prospective studies searching for clear management guidelines recognized by diabetes specialists, cardiologists, and general practitioners [1-5]. It was thus in a context of ongoing debate concerning the appropriate diagnostic and therapeutic approach that the working group, fully aware of the lack of powerful evidence, attempted to provide consensual responses to four questions raised by the problem of searching for possible myocardial ischemia in the asymptomatic diabetic.

- What is the potentially beneficial therapeutic effect of early diagnosis of SMI?
- Which symptom-free diabetics should be screened for SMI?
- What are the most appropriate screening tests?
- What should be done after screening for SMI?

Starting with studies specifically reporting cohorts of diabetic patients, generally with type 2 diabetes, or with large-scale studies devoted to coronary artery disease where diabetics are an occasional subgroup, the working group attempted to draw up the following recommendations. These recommendations cannot be formal guideline statements for good clinical practice and will have to be re-evaluatated prospectively by the two specialties. They basically concern type 2 diabetes mellitus. Type 1 disease is integrated into the general screening strategies.

**Context**

**Diabetes mellitus**

Diabetes mellitus is an entity defined by its biological phenotype marked by blood sugar above or equal to 1.26 g/l (7 mmol/l) recorded at two separate tests performed in an apparently healthy subject who has fasted for at least eight hours. The current etiopathogenic classification distinguishes [6]:

- Type 1 diabetes which generally results from autoimmune destruction of the pancreatic beta cells, leading to an absolute insulin deficiency. Type 1 is more commonly observed in subjects aged less than 40 years and requires early initiation of insulin therapy.
- Type 2 diabetes, which is more frequent and generally observed in older subjects. Type 2 is characterized by a variable combination of insulin resistance and deficient insulin secretion.
- Other exceptional causes of diabetes: genetic disorders leading to defective beta cell function or defective insulin action, pancreatic or endocrine diseases, toxic or infectious causes. Moderate hyperglycemia, close to glucose intolerance, defined by fasting glucose in the 1.10-1.26 g/l range, which also increases the vascular risk and can progress to diabetes in approximately 50% of the subjects [7].
- The metabolic syndrome which generally accompanies type 2 diabetes and which, according to the National Cholesterol Education Program [8], European Group for the Study of Insulin Resistance [9], is defined by the association of at least three of the following criteria: abdominal obesity (waist circumference > 102 cm for men and 88 cm for women), triglycerides ≥ 1.5 g/l, HDL-cholesterol < 0.4 g/l for men and 0.5 g/l for women, and blood pressure ≥ 135 mmHg (systolic) or ≥ 85 mmHg (diastolic).

The incidence of diabetes is rising constantly. According to the WHO projections, the population of diabetics will double by 2025, especially because of the progression of diabetes in developing countries [10]. In France, the current population of diabetics is estimated at 2.5 million persons, predominantly (90%) subjects with type 2 diabetes. An estimated 300,000-500,000 persons, i.e. 10-15% of the diabetic population, are unaware of their diabetes. Moreover, excessive abdominal adipose tissue, a condition favoring the development of type 2 diabetes, occurs in an estimated 10 million persons.

Cardiovascular complications, which are 2- to 3-fold more frequent than in non-diabetic subjects [11], determine the prognosis of diabetes and contribute to the shorter life expectancy of diabetic subjects, 8 years less for subjects aged 55-64 years and 4 years less for older subjects [12]. The cause of death in diabetics involves a cardiovascular condition in approximately 65-80% of the cases. Cardiovascular events, the lead-
silent myocardial ischemia is ischemia largely explains the often silent nature of myocardial infarction presenting diabetes. The proportion of coronary patients undergoing coronary angiography who have diabetes reaches 20-30% [19]. Diabetes is thus recognized as an important independent risk factor for cardiovascular disease [20, 21]. Traditionally, coronary mortality in a non-coronary diabetic patient is identical to that of a non-diabetic coronary patient [22]. Recent observations, although disputing this statement with a less pessimistic view, clearly confirm that the cardiovascular risk (CVR) in a diabetic patient is greater than that of a non-diabetic person [23, 24].

The gravity of coronary artery disease in diabetics is due to specific anatomic, functional, and biological features of the disease. Although the lesions present a similar morphology, parietal infiltration is more diffuse, more distal, and more calcified in the diabetic subject as demonstrated by coronary angiographic findings [25], and as confirmed by necropsy studies [26]. Endothelial dysfunction, which participates in all the phases of atherosclerosis, is aggravated in the diabetic due to the hyperglycemia and insulin resistance [27]. Together with coagulation disorders related to increased platelet adhesion and aggregation [28] and an imbalance between fibrin formation and lysis [29] which are characteristic features of diabetes, endothelial dysfunction accounts for the accelerated progression of athromatous lesions in the diabetic. Coagulation disorders and endothelial dysfunction also contribute to microcirculation anomalies, which can lead to SMI even if the epicardial vessels are not involved [30]. Cardiac autonomic neuropathy is frequent in diabetics and largely explains the often silent nature of myocardial ischemia [31].

Silent myocardial ischemia

Transient changes in myocardial perfusion, together with temporary alterations of cardiac muscle action and function, which occur without chest pain or angina-equivalent manifestations, is a theoretical pathophysiological definition of SMI. Clinical confirmation is naturally less formal. Depending on the clinical circumstances, three types of SMI are generally distinguished: type 1 in symptom-free patients with no clinical history of coronary artery disease, type 2 in symptom-free patients with a history of myocardial infarction, and type 3 in patients with angina related to coronary artery disease who also experience episodes of SMI [32]. Clinically, type 1 SMI is defined as an electrocardiographic (and/or scintigraphic and/or echocardiographic) anomaly which is silent and transient, and observed during a period of stress in subjects whose electrocardiogram is strictly normal at rest.

Type 1 SMI is two to six times more common in the diabetic subject than in the non-diabetic subject, depending on the series [33]. In the diabetic, the prevalence of SMI varies widely from 10 to 30%, depending on patient selection and the acuity of the screening tests [34, 35]. It is more frequent in diabetics with two other cardiovascular risk factors and can be observed in one-third of the patients [36, 37]. This wide variability is one of the reasons underlying the weak yield of systematic screenings for SMI in known diabetics and highlights the need for rigorous patient selection based on an evaluation of global cardiovascular risk in each diabetic.

SMI, which is premonitory for secondary cardiovascular events, is a factor of poor prognosis [38]. Studies monitoring diabetics demonstrate that SMI is regularly associated with the risk of a major coronary event [39-42]. Several studies have shown that after the age of 60 years the relative risk of a secondary major cardiovascular event is 5.2-fold higher in diabetics with than without SMI [40-42].

The correspondence between SMI and angiographically significant narrowing of the coronary arteries is neither certain nor constant. In the small series reported to date, coronary angiography in patients with SMI demonstrates the presence of one or more zone of ≥70% angiographic stenosis in 30-60% of the cases [36, 42]. Alteration of coronary reserve secondary to intramyocardial microangiopathy, vasomotor disorders due to endothelial dysfunction, and coagulation disorders can be associated and account for the discordance between cardiac function and angiographic findings in the diabetic. Nevertheless, it

<table>
<thead>
<tr>
<th>Table I</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Silent myocardial ischemia, which occurs more frequently in diabetics than non-diabetics, is a poor prognosis factor, premonitory for major cardiac events.</td>
</tr>
<tr>
<td>3. The prevalence of silent myocardial ischemia is high when other vascular risk factors are associated with diabetes.</td>
</tr>
<tr>
<td>4. Silent myocardial ischemia can develop without involvement of the large epicardial coronary vessels.</td>
</tr>
<tr>
<td>5. Nevertheless, the prognosis of silent myocardial ischemia depends on the presence of angiographically significant coronary narrowing.</td>
</tr>
<tr>
<td>6. Search for silent myocardial ischemia in diabetics should not be systematic but rather based on an evaluation of the overall cardiovascular risk of each individual diabetic patient.</td>
</tr>
<tr>
<td>7. Coronary angiography, employing all the safety measures required for this type of exploration in diabetics, is warranted to search for coronary narrowing in diabetic patients presenting silent myocardial ischemia.</td>
</tr>
</tbody>
</table>
appears that the prognosis of SMI is closely dependent on the presence or not of angiographically significant coronary stenosis. Two French studies have recently demonstrated that the presence of significant stenosis is a strong predictive factor for major cardiac events at 2 and 3.5 years in patients with SMI, while in patients with an abnormal scintigraphy but no coronary narrowing, the prognosis is similar to that observed in patients without SMI [16, 42]. Today, coronary angiography, employing all the safety measures required for this type of exploration in diabetics, is warranted to search for coronary narrowing in patients with SMI.

Due to its high prevalence and the potentially serious prognosis, the diagnostic and therapeutic approach to the asymptomatic diabetic patient should focus on SMI. A natural junction between diabetology and cardiology, SMI leads to a discussion concerning the potential therapeutic benefit which could be expected from early screening, and then on adequate selection of diabetic patients with high cardiovascular risk who could benefit from screening tests, as well as on the choice of the best tests, and finally on diagnostic and follow-up strategies based on the screening test results.

**Stenosis and atheromatous lesions. Current data**

The relationship between angiographically significant coronary artery stenosis of ≥ 70% and myocardial ischemia together with long-term prognosis is well established. Prognostic scores, defined from data collected in large cohorts of coronary patients with stable or asymptomatic disease, distinguish between patients with low and high myocardial risk depending on the severity of the coronary lesions. The risk of coronary mortality at five years is an estimated 7.5% in patients with single-vessel disease not involving the anterior interventricular, and rises to 40% for those with triple-vessel disease (of course with involvement of the anterior interventricular) [43, 44]. These angiographic and prognostic data have been used to develop surgical and interventional revascularization treatments [43, 45].

In vivo, progress in morphological, functional, and biological explorations of atheromatosis has led to a better understanding of the atherosclerotic process which occurs as a discontinuous phenomenon where alternating phases of stability and instability modify the vulnerability of the atheromatous lesions. The atheromatous plaque exhibits constant histological and biochemical activity which either favors its stability or its instability. The plaque is rich in lipidoacellular material maintained loosely in a thin fibrous sheath. Vulnerable unstable lesions may fissure or erode leading to the formation of a more or less obstructive endoluminal thrombus [46, 47]. Instability of the atheromatous plaque is a multifactorial phenomenon controlled by numerous independent mechanisms involving mechanical events (loading of the lipidoacellular heart), biochemical activity (metalloproteases), vasomotricity (endothelial dysfunction), and hemodynamic (shear forces) and inflammatory events [48, 49]. All these factors of plaque instability are exacerbated by diabetes. There is no correlation between the qualitative vulnerability of the plaque and the quantitative angiographic assessment of arterial stenosis. Certain angiographic findings suggest that the unstable plaque, the causal agent of acute coronary events, does not produce significant stenosis. Angiograms occasionally performed just before a myocardial infarction show that the coronary artery implicated in the eminent necrosis exhibits less than 50% angiographic stenosis in more than 60% of the patients [50, 51]. The small volume of the unstable lesion and the remodeling of the arterial wall would explain, in this situation, the minimal narrowing demonstrated at angiography [52]. Moreover, endocoronary ultrasound explorations performed at the moment of acute coronary events reveal multiple unstable plaques in 75% of the cases [53]. It thus appears that lesion instability is a multifactorial diffuse phenomenon; while a single plaque can lead to an acute coronary event, numerous lesions can also remain asymptomatic yet expose the patient to the risk of acute or subacute obstruction leading to a paroxysmal episode or remain insidious with the development of scar formation and angiographically significant stenosis.

The complexity of the atheromatous process is reflected in the difficulty encountered in clinical evaluation of coronary atherosclerosis and explains the limitations of functional and morphological explorations. In the asymptomatic diabetic subject, minimally significant atherosclerotic lesions of the arterial wall may go unrecognized at angiography and fail to disclose SMI during exercise, yet can be potentially vulnerable due to the endothelial dysfunction and coagulation disorders characteristic of diabetes. Thus the diagnostic value of functional and morphological explorations, which demonstrate more readily fixed tight coronary stenosis, is not unconditional. Screening for non-stenosing lesions with a high risk of instability using magnetic resonance imaging, endocoronary ultrasound, thermography, palpography and optical coherence tomography (OCT) remains within the realm of clinical research. In everyday practice, the goal focuses less on identifying atheromatous lesions with a risk of instability than on identifying subjects with a high cardiovascular risk. Furthermore, cardiological evaluation only explores a given instant within the course of an unpredictable disease which may progress to a paroxysmal event or remain quiescent or insidiously stenosing. The predictive value of negative exploration results is thus not formal so repeated cardiological evaluations must be performed during the surveillance of the diabetic subject at risk in order to search for progression of silent stenosis.

From a therapeutic point of view, advancing knowledge of the mechanisms leading to the onset and development of atherosclerosis emphasizes the importance of pharmacological and dietetic preventive measures which, via numerous pathways, contribute to preventive and curative stabilization of the vulnerable plaque.
A large body of evidence has been accumulated favoring the efficacy of statins in the diabetic subject. Large-scale studies devoted to secondary prevention have proven the efficacy of therapeutic lowering serum cholesterol, with a 55% reduction of the relative risk of major coronary events at five years in the hypercholesterolemic diabetic treated with simvastatin in the 4S study [57] and a 25% reduction in the normocholesterolemic diabetic given pravastin [CARE study, 58]. In a population of 5,963 diabetics, the Heart Prevention Study (HPS) has confirmed these results showing a significant 22% reduction of the relative risk, a reduction equivalent to that observed in a cohort of non-diabetic subjects [59]. With a 33% reduction of the relative risk, this beneficial effect was also observed in the group of 2,912 asymptomatic diabetics. This gain in prognosis is recorded irrespective of the type of diabetes, its duration, or the quality of glucose control, irrespective of the patient’s age or gender, and finally irrespective of the initial blood pressure, total cholesterol or LDL-cholesterol (LDL-C) levels. Although fewer trials have been conducted with fibrates, these agents have also proven their efficacy for secondary prevention in the diabetic subject [60]. Clinical and biological results reported in these trials have led to the elaboration of guidelines defining therapeutic intervention thresholds depending on the vascular risk and the LDL-C level. For the diabetic patient with two other risk factors, as in the coronary patient, the AFFSAPS (the french drug agency) set the intervention threshold at 1.3 g/l LDL-C, with a target value of 1 g/l in the most recent European guidelines [61].

Strict control of blood pressure is also important in improving vascular prognosis in diabetics. In the UKPDS trial, lowering systolic and diastolic pressures 10 and 5 mmHg respectively led to a 5% reduction in the absolute risk of stroke or vascular death at 5 years [62]. Other studies devoted to prognosis and treatment of hypertensive patients have reported similar results in the subgroup of diabetics [63]. In the latest recommendations the objective is to achieve blood pressure below 130/80 mmHg in the hypertensive diabetic subject [61, 64]. In line with the ADA guidelines, converting enzyme inhibitors should be favored in diabetics with proteinuria or altered left ventricle function [65]. This drug class has proven efficacy in diabetics. In the early phase after myocardial infarction, the 6-week mortality was significantly lower in diabetics treated with lisinopril (8.7% versus 12.4% in the placebo group) in the GISSI3 trial [66]. In diabetics presenting a cardiovascular event or having another cardiovascular risk factor, ramipril produced a significant 25% reduction of relative risk of a cardiovascular event at 4 years in the diabetic subgroup of the HOPE study [67]. The EUROPA trial also recently demonstrated the efficacy of perindopril in combination with a beta-blocker in reducing the vascular risk in the stable coronary patient with, in the diabetic population, a favorable trend which did not reach the level of significance [68].
A meta-analysis of numerous comparative trials shows that aspirin also has proven efficacy for reducing vascular risk both in the diabetic and non-diabetic subject [69]. In diabetics with retinopathy and no sign of coronary artery disease, prescription of aspirin is associated with a 15% reduction of the relative risk of myocardial infarction at 7 years [70]. Thienopyridins have not been evaluated for primary prevention in the diabetic subject. In patients with clinical expression of peripheral, coronary or cerebral artery disease, clopidogrel was found more effective than aspirin in the subgroup of diabetic patients in the CAPRIE study with a 2.1% reduction in the absolute annual risk of a major arterial event [71].

Careful strict control of blood glucose also contributes to improved vascular prognosis in the diabetic. The DIGAMI study demonstrated that the use of insulin following myocardial infarction, from the hospital phase through the third month at least, yielded a 29% reduction in mortality at one year [72]. Finally, in the UKPDS study which recruited asymptomatic patients with type 2 diabetes, a 1% rise in glycated hemoglobin (HbA1c) above the 6.2% threshold is associated with a 11% increase in coronary risk at 10 years [73].

Affirmation of SMI can thus lead to more rigorous and sustained management of the overall cardiovascular risk via more individually adapted drug prescription. In men with a high vascular risk whose SMI has been identified with a positive exercise test, attentive preventive measures contribute to significant reduction of cardiovascular mortality which reaches 61% at 7 years [74]. In subjects with type 2 diabetes presenting microalbuminuria, aggressive therapeutic management (strict blood glucose control, blood pressure controlled at 135/80 mmHg, and prescription of statin and aspirin) decreases the vascular risk by 50% at 7 years in comparison with conventional and occasional treatment of associated risk factors [75].

Myocardial revascularization

A revascularization intervention can be envisaged after discovery of SMI and angiographic demonstration of tight stenosis in arteries supplying a large myocardial territory. Due to the lack of studies specifically devoted to revascularization in the diabetic, and particularly in the asymptomatic diabetic, and in light of continuing progress in surgical and interventional methods, the principle of revascularization and its modalities remains a controversial topic. Large trials have nevertheless pointed out a certain number of notions particularly important for therapeutic decision-making in diabetics with myocardial ischemia.

In patients with stable coronary disease, the efficacy of surgical revascularization has been proven in a group of patients with high myocardial risk presenting stenosis of the left common coronary, a multiple-vessel lesion involving the anterior interventricular and an alteration of left ventricle function [76]. In patients with single-vessel disease and a low cardiovascular risk, revascularization by angioplasty does not have a notable effect on the risk of a major cardiac event but significantly improves functional outcome in patients with a proximal lesion of the anterior interventricular [77]. In coronary patients with SMI, published trials tend to demonstrate the superiority of myocardial revascularization in comparison with anti-ischemic medication alone. Although it lacked power, the ACIP study [78] demonstrated that bypass patients exhibit fewer infraclinical ischemic events and have a significantly lower mortality at one year (0% versus 1.6% in the group given anti-ischemic medications).

In diabetic candidates for revascularization of their multivessel disease, results of large comparative trials favor the surgical option [79]. At 7 years, the BARI trial [80] showed lower mortality in the surgery group (24.5% versus 44% in the balloon angioplasty group) with a clearer benefit for revascularization with using internal mammary. Stent insertion was unable to breach the difference between angioplasty and surgery. In the ARTS trial devoted to diabetics with multivessel disease, one-year mortality was 6.3% in the stent group versus 3.1% in the surgery group [81]. Conversely, data from registries which recruit a less selected population of diabetics do not show any significant difference in the long-term outcome after angioplasty or surgery [82]. Thus no one option predominates for the diabetic with multivessel disease and decisions must be made on an individual basis taking into consideration the etiological context, including age and associated disease, and the analysis of the coronaryogram.

When the indication for angioplasty is retained and when the angiographic conditions are favorable, stent insertion should be preferred. The risk of restenosis, which is particularly high in the diabetic [83], is significantly reduced by stent insertion [84] and reaches, in the best situations, a level equivalent to that observed in non-diabetics [85]. Administration of antiGPIIb-IIIa, and more specifically Abciximab, when inserting a stent contributes to the significant reduction of the restenosis rate [86] and mortality risk at one year [87]. Finally, the results obtained with active stents appear promising and if confirmed should lead to wider indications for angioplasty in the diabetic subject and possibly to more indications for revascularization in these patients [88]. In the population of 379 diabetics included in the SIRIUS trial (26% of the study population), the rate of new revascularization of the stented coronary was 22.3% in the group with an inactive stent and 6.6% in the group with a sirolimus-eluting stent [89].

Coronary risk stratification and patient selection (Table III)

The diabetic population is exposed to a higher cardiovascular risk, but all asymptomatic diabetic subjects do not have SMI or even less so high-risk coronary artery disease which could be improved with revascularization. Large-scale systematic screening for SMI in the asymptomatic diabetic population would have a very low yield and would be almost impossible to implement as well as very costly. Screening must be limited to subjects with a high cardiovascular risk.
whose likelihood of having SMI is high. Ideally, the selection process should allow identifying subjects whose cardiovascular risk could be improved by therapeutic intervention with a result at least equivalent to that obtained by implementation of appropriate curative and preventive measures. This risk/benefit ratio remains to be established. Selection is thus an empirical process searching to identify subjects whose potential risk is high and whose likelihood of having stenosing coronary disease is theoretically high. An evaluation of prior recommendations can be helpful in selecting at-risk subjects. In 1995, the ALFEDIAM recommended screening for SMI in asymptomatic diabetics presenting one of the following features: an associated vascular co-factor, age over 60 years, nephropathy, arteriopathy of the lower limbs [1]. Later application of these recommendations in several French studies enabled discovery of SMI in only 18 to 30% of the screened populations and discovery of coronary artery disease in only 10% [39, 42]. The insufficient selectivity of these earlier recommendations thus led the expert group to add further selection criteria for asymptomatic diabetics who should be included in screening programs. The goal is to retain diabetics with a strong probability of having SMI, basing selection first on age and duration of diabetes, and then on other risk factors, and finally on the presence of peripheral vascular disease or nephropathy.

Overall cardiovascular risk

The two major factors determining cardiovascular risk are age and duration of diabetes. The expert group set the threshold at ≥ 60 years. This corresponds to the mean age of patients included in the most recent primary or primo-secondary prevention trials of subjects with high cardiovascular risk [59, 90]. Beyond 60 years, the prevalence of SMI is high and can be found in 25% of the subjects [91]. Moreover, the predictive value of SMI for major cardiac events is much higher above the age of 60 years (33.3% versus 13.2% before 60 years) [40]. Gender is not a selection criterion because diabetes exposes women to the same cardiovascular risk as observed in men [92, 93]. Duration of diabetes, a factor which is obviously underestimated because diagnosis and therapeutic management of type 2 diabetes occur late after onset of the glycemic disorder, is also an important prognostic determinant. In both men and women whose diabetes has been known for more than 10 years, the relative risk of death from a coronary event is at least three times greater than in non-diabetic subjects of comparable age [93-95]. Age and duration of diabetes often being superimposed factors, the group defined the first selection criterion for inclusion in a screening program for SMI as age > 60 years or duration of diabetes > 10 years.

Further evaluation of the overall cardiovascular risk refines the selection process for identifying high-risk diabetics. Cumulating risk factors increases the cardiovascular risk and it is recognized that smoking, hypertension, and dyslipidemia contribute as much as the glycemic disorder to accelerated development of atherosclerosis. The MRFIT study demonstrated that the annual number of cardiovascular deaths per 10,000 subjects progressed from 20 deaths for diabetics with no associated risk factor to 80 for diabetics with at least two other risk factors [21]. Furthermore, these cofactors are often associated with diabetes. Prevalence of hypertension and/or dyslipidemia is much higher in diabetics than in non-diabetics of the same age [21, 96]. Although not listed as identified risk factors in the early large-scale epidemiology studies, occurrence of a major cardiovascular event before the age of 60 years in a first-degree relative should also be considered as an associated risk factor [3, 97].

Considering that the likelihood of a positive screening test should be high, the expert group proposed screening for SMI among asymptomatic diabetics aged over 60 years or presenting diabetes for more than 10 years who have at least two associated risk factors. This option falls within the category of class IIb recommendations (divergent opinion) described by the ACC/HA [4]. For information, these selection criteria lead to retaining asymptomatic diabetic subjects whose risk of a coronary event at 10 years is ≥ 30% in men and ≥ 24% in women [98]. For this selected population, the relative risk of a coronary event at 10 years is 2.3-fold higher than in diabetics with no other risk factor. It is clear that this measurement of risk, which issues from the Framingham...
Peripheral vascular disease and diabetic nephropathy

Clinical or infraclinical peripheral vascular disease is a factor of poor prognosis in the asymptomatic diabetic subject. Heart disease is the cause of death in the majority of subjects in this category [100]. The prevalence of scintigraphic SMI, which has exceeded 50% in certain series, is higher than in the diabetic subject without peripheral vascular disease [101, 102]. In the Cardiovascular Health Study of a population of 1,343 asymptomatic diabetic patients, the relative risks of death at six years, of a major coronary event, and of myocardial infarction in diabetics with peripheral vascular disease were respectively 1.5-, 1.99- and 1.93-fold that found in diabetics of the same age free of peripheral vascular disease [103]. In a French study, the risks of death and coronary events were 23% and 57.5% in patients with arteriopathy of the lower limbs and SMI with or without diabetes [104].

Microalbuminuria, observed in approximately 25% of all diabetics, is also a factor of poor prognosis which doubles the risk of early death [105]. The prognostic significance is the same as a 30% risk of death at 10 years measured from the Framingham Study. Association of SMI and microalbuminuria is particularly threatening in this situation since the risk of a major cardiovascular event at 5 years is 60% [106]. Since microralbuminuria can be variable and sometimes corresponds to proteinuria, the severity of diabetic nephropathy and its prognostic significance are also highly variable. The level of albuminuria should be considered when screening for SMI.

Thus, whatever the patient’s age or the duration of diabetes, it is recommended to search for SMI in patients with asymptomatic type 2 diabetes who exhibit vascular lesions involving the large extracardiac vessels with loss of at least two pulses on the lower limbs or a vascular murmur corresponding to ultrasound-evaluated stenosis of at least 30%, or isolated proteinuria or microalbuminuria (30-300 mg/24 hr or 20-200 mg/l observed in two urine samples) associated with two other classical risk factors.

Since there is no strong evidence of a relationship between SMI and retinopathy, alterations of the retina alone cannot be retained as a determinant element in the screening strategy.

Other factors and markers of cardiovascular risk

Other factors or markers of cardiovascular risk have also been described. Sufficient evidence has not however been accumulated to enable large-scale risk stratification. Markers of inflammation (fibrinogen and ultrasensitive CRP), blood glucose control by HbA1c assay, and serum homocysteine are biological markers of risk but remain too variable for integration into a strategy of annual evaluation of risk in the asymptomatic diabetic subject. Functional or morphological anomalies such as acceleration of the pulse wave, exaggerated intima-media thickness, left ventricle hypertrophy, cardiac autonomic neuropathy, and coronary calcifications have real predictive value and are strong markers of diffuse atherosclerosis. They are associated with recognized risk factors and are generally found in patients who already have clinically patent arterial disease [36, 39, 41, 107-111]. Most of the complementary explorations allowing confirmation of these anomalies are not readily available for large-scale screening and are generally employed for sophisticated scientific research projects rather than clinical stratification of cardiovascular risk.

Screening tests

These tests are designed to search for SMI in the asymptomatic diabetics selected for screening and to make the diagnosis of coronary lesions. These examinations are also used to establish the prognosis and evaluate the risk of a vascular event.

Resting electrocardiogram

The predictive value of the resting electrocardiogram is very limited. Certain asymptomatic diabetic patients display a normal resting ECG despite the presence of multivessel coronary artery disease [112]; the incidence remains to be determined because coronary angiography is not indicated solely on the basis of this electrocardiographic situation. An annual ECG, as recommended earlier [5] cannot screen for SMI.

In the event of an abnormal resting ECG, the prognostic value is however well defined [113, 114] and should trigger further investigations.

– An abnormal tracing which is only minimally suggestive of SMI, for example intraventricular conduction disorders or anomalous repolarization evoking left ventricle hypertrophy, incite to search for myocardial ischemia using myocardial scintigraphy or stress electrocardiography; an exercise test is not useful here because the electrocardiographic result cannot be properly interpreted.

– An abnormal tracing strongly suggestive of myocardial ischemia, for example a Q wave signaling necrosis or a T
wave signaling subepicardial ischemia, noted on at least three contiguous leads and in the absence of electrical left ventricle hypertrophy, should lead to more invasive exploration. For the expert group, first-intention coronary angiography is warranted especially when the abnormal tracing occurs during the follow-up of a diabetic whose prior ECGs were normal.

The 24-h electrocardiogram is only minimally sensitive and non-specific and has not been included in the latest recommendations [1-3]. Screening for SMI depends on function tests.

**Exercise tests**

Although the sensitivity and specificity of the exercise test could be better, this examination has been validated for coronary stenosis screening of asymptomatic patients with a high myocardial risk (multivessel disease and stenosis of the left common coronary) who are able to perform the test and do not present repolarization anomalies on the resting ECG. In the diabetic, the small series which have been reported demonstrate sensitivity in the 50-67% range with a satisfactory specificity to the order of 75% with significant positive and especially negative predictive values (46% and 87% respectively) [115-117]. Although the exercise test can lack reliability in recognizing single-vessel disease with minimal myocardial risk, it is conversely a high-performance test for recognizing diabetic subjects free of major myocardial risk which would compromise their long-term prognosis.

In correctly selected populations, the exercise test is a low-cost exploration that can be used as an effective first-intention screening test. The results can be divided into the following categories.

- **Negative maximal exercise test** (heart rate reaching 200 bpm minus age). The negative predictive value is close to 90% and, consequently, the probability of severe coronary artery disease is very low [118]. This result is a marker of good long-term prognosis [117]. There is no need to perform a myocardial scintigraphy, which would only add minimal prognostic information [119].

- A **strongly positive exercise test** with ST depression > 2 mm for a threshold of < 75 W or presenting criteria of serious rhythmic or hemodynamic disorders. In this situation, the risk of coronary disease is high and coronary angiography is indicated.

- **Minimally positive or doubtful exercise test**. The positive predictive value of a positive exercise test conducted beyond 75 W with no criteria of gravity is weak, approximately 45% [115, 116]. In this situation, coronary angiography, which could only reveal a low myocardial risk in less than half of the patients is not recommended as a first-intention exploration. A second functional test (scintigraphy or echocardiogram) is however indicated to provide certain complementary prognostic information.

- **Submaximal exercise test**. The duration of the exercise test is a powerful predictive factor. The inability to exercise for more than 440 seconds is associated with a high risk of coronary events [116 Rubler]. In diabetics with two other vascular risk factors who cannot perform an exercise test, the annual rate of major cardiac events is 6- to 7-fold higher than in the same subjects who are able to complete a negative test [116, 41]. Second-intention functional tests with drug-induced stress are strongly recommended in this situation.

**Myocardial perfusion scintigraphy**

Widely available in France, Technetium Myocardial Perfusion Scintigraphy (TMPS) provides optimal evaluation of coronary artery disease. Combined with an exercise and/or drug provocation test, TMPS can confirm the presence of myocardial ischemia, map the territory involved, and determine its severity; it can also be used to assess residual myocardial viability after myocardial infarction and, when performed with synchronized ECG, to evaluate global, segmentary, and left ventricular function.

In the diabetic subject, the diagnostic performance of TMPS is less satisfactory than in the non-diabetic subject. In the different series reported which used variable selection and evaluation criteria, the sensitivity of the test varies from 80-90% with a specificity of 75-90% and positive and negative predictive values of 50-87% and 85-95% respectively [36, 115, 120, 121]. The imperfect diagnostic results are related to the possible presence of left ventricle hypertrophy, endothelial dysfunction, or altered microcirculation which can induce perfusion disorders even in the absence of coronary stenosis.

The usefulness of TMPS results for its strong negative predictive value. In the general population of subjects exposed to vascular risk or presenting clinically patent coronary artery disease, the annual rate of death and/or myocardial infarction is less than 1% when the TMPS is normal [122-124]. The prognostic value of TMPS is also proven in the diabetic population (with or without symptoms). At two years, the rate of major cardiac events was correlated with the TMPS results in a large North American series recruiting 1,271 diabetics: the annual risk was 1-2% when the test was normal and 3-4% when the test was weakly positive but 7% when the test was strongly positive [125]. TMPS also provides strong discrimination in the asymptomatic diabetic population. At five years, the rate of cardiac events was significantly higher when the TMPS was abnormal (19.2% versus 1.9%) in a recent series of 735 diabetic patients free of clinical signs of coronary artery disease [126]. At three years, the risk of major cardiac events in another series of 180 asymptomatic diabetics was 3, 10, and 31% for a normal, weakly positive, or strongly positive TMPS respectively [127].

TMPS provides quantitative and qualitative information. Abnormal perfusion involving more than 20% of the left ventricle mass is highly predictive of a major cardiovascular event [41, 123]. Thus the TMPS is considered abnormal when the perfusion disorder involves at least 10% of the left ventricle mass. Finally, the presence of a reversible defect is preferentially associated with significantly increased risk of a cardiovascular event and the presence of an irreversible defect is predictive of a high risk of cardiac death [128].
Screening and follow-up strategy (Table IV)

An annual check-up for the asymptomatic diabetic subject includes an attentive physical examination and a resting ECG. Laboratory tests search for lipid disorders and evaluate renal function. Together, these results allow defining the overall cardiovascular risk for each diabetic subject and orient the screening strategy. These clinical findings also enable recognizing subjects with patent peripheral arterial disease and identifying rare cases where the electrocardiographic results indicate probable coronary artery disease.

History taking must be conducted with care in order to confirm the absence of symptoms. Exercise-induced angina as well as claudication and angina-equivalent manifestations (thoracoabdominal pain and dyspnea) must be clearly ruled out. Their presence, particularly if recent and exercise-related, can not be the decisive factor but should be taken into consideration in the context of large-scale screening.

Screening cost

The following cost schedule is applied by the French Health Insurance Fund (schedule codes in parenthesis) for the different examinations:
- exercise test (K40): €76.86
- exercise TMPS plus redistribution (Zn255 + radioactive product 225 + K40): €520.05
- diprydamole TMPS plus redistribution (Zn225 + radioactive product 225 + K8.5): €459.57
- transthoracic echocardiography (K50): €94.5
- coronary angiography plus ventriculography (K150 + Z300): €687
- the relationship between exploration costs and therapeutic benefit has not been established because a detailed medico-economic analysis of SMI screening has not been performed to date. Nevertheless, the cost/effectiveness ratio of strategies based on scintigraphy appears to be better than that of strategies centered on coronary angiography indicated because of doubtful exercise test results [137]. The cost of screening can not be the decisive factor but should be taken into consideration in the context of large-scale screening.

Table IV

<table>
<thead>
<tr>
<th>Screening examination</th>
<th>Cost in €</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discovery of a formally described type of ischemia on the resting ECG</td>
<td>warrants further exploration with first-intention coronary angiography.</td>
</tr>
<tr>
<td>An exercise test constitutes a first-intention screening examination.</td>
<td></td>
</tr>
<tr>
<td>TMPS and stress echocardiography are to be performed in the following circumstances:</td>
<td></td>
</tr>
<tr>
<td>Weakly positive exercise test conducted beyond 75 W.</td>
<td></td>
</tr>
<tr>
<td>Doubtful exercise test</td>
<td></td>
</tr>
<tr>
<td>Negative very submaximal exercise test lasting less than 440 seconds.</td>
<td></td>
</tr>
<tr>
<td>Incapacity for exercise.</td>
<td></td>
</tr>
<tr>
<td>Invalidating arteriopathy of the lower limbs.</td>
<td></td>
</tr>
<tr>
<td>Non-ischemic anomalies on the resting ECG (complete LBBB, WPW, electrostimulation, ST depression &gt; 1 mm at rest [4, 99]).</td>
<td></td>
</tr>
</tbody>
</table>
should, depending on the clinical presentation, lead to further extracardiac explorations and/or search for myocardial ischemia. A minute physical examination of the clinically assessable arteries is necessary. Since the absence of pedal pulses can be a normal finding, the diagnosis of lower limb arteriography is based on absence of at least two distal pulses including at least one posterior tibial pulse. Determination of the systolic pressure index, by measuring the blood pressure from the arm and the ankle, lacks specificity in diabetic patients because of the possibility of a media-calcinosis. Discovery of a vascular murmur, particularly at the cervical level, requires ultrasound confirmation to determine its atheromatous nature. Blood pressure should be measured in optimal conditions with, if needed, a second measurement 24 hours later. After this annual clinical, biological, and electrocardiographic check-up, three situations can be described based on the level of cardiovascular risk and the ECG data (Fig. 1).

**Low cardiovascular risk**

Further search for SMI is not indicated, but the cardiovascular risk may change and should be re-evaluated annually. Patients with a low cardiovascular risk should undergo an annual check-up in order to re-evaluate prognosis and search for new risk factors as well as to identify insidious recent developments related to peripheral arterial disease and/or an ECG anomaly.

**High cardiovascular risk (Table III, Fig. 2)**

It is recommended to search for SMI. If the resting ECG is normal, an exercise test should be conducted to guide further management [138]. A negative maximal exercise test is in favor of good prognosis; an annual check-up is indicated and possibly a new functional evaluation three years later. A strongly positive exercise test with a threshold under 75 W warrants prescription of a coronary angiography due to the high probability of underlying coronary artery disease. In the event of a doubtful exercise test, which is submaximal or weakly positive (see chapter on explorations), or the presence of nonspecific repolarization disorders on the resting ECG, the functional exploration should be completed with TMPS or stress echocardiography. The choice between these two explorations is essentially guided by the technical facilities available and operator experience [139]. Coronary angiography is indicated if one of these explorations is positive.

**Ischemia on the resting ECG**

Irrespective of the risk level or the results of the physical examination, the presence of an ischemic disorder on the resting ECG, a Q wave signaling necrosis and/or negative T wave indicating subepicardial ischemia on at least three contiguous leads, is indicative of the need to discuss the usefulness of coronary angiography if electrical left ventricle hypertrophy is absent. Although there remains some controversy concerning the indication for coronary angiography after symptomatic non-complicated myocardial infarction (class II indication in the SFC guidelines) [140], the expert group recommends this exploration for asymptomatic diabetics who present an ischemic disorder on the resting ECG. In this functional situation, the advent of silent electrocardiographic anomalies formally identified as signs of ischemia cannot affirm the stabil-

---

**Figure 1**

- **Yearly control**
  - Careful questioning
  - Complete clinical and particularly CV examination
  - Biological screening: lipids, creatininemia and glycated hemoglobin
  - Search for proteinuria or microalbuminuria
  - Resting ECG

- **Low risk**
  - Search for an SMI
  - ET possible
  - Negative
  - Low positivity
  - Strong positivity

- **High risk**
  - ET impossible or incomplete

- **Ischemic ECG**
  - TSMP or SE
  - Negative
  - or AP* < 10 %
  - Positive
  - or AP* > 10 %

- **Coronarography**

* AP = Abnormality in LV perfusion.
EE: Effort ECG
TSMP: Technetium Myocardial Perfusion Scintigraphy
SE: Stress Echography
SMI: Silent Myocardial Ischaemia
LV: Left Ventricular
ET: Exercise Test
ity of the underlying coronaropathy and constitute an argument in favor of its progression. The probability the large epicardial vessels are involved is high. Angiography can thus enable recognizing lesions causing a high cardiovascular risk and guide revascularization interventions. The risk of coronary angiography conducted under conditions of proper hydration and minimal use of contrast agents is low.

Irrespective of the orientation provided by the initial stratification, patients should undergo an annual check-up for physical examination, laboratory tests, and electrocardiogram. There are no elements available to the expert group enabling a definition of an age limit above which screening for SMI is no longer indicated for high-risk asymptomatic diabetic subjects. If such a limit does exist, it will be defined on an individual basis taking into consideration the physiological age.

Conclusions

Ideally, the screening strategy for SMI should enable identifying subjects whose cardiovascular risk could be compensated for by an at least equivalent therapeutic benefit. The relationship between the measured risk and the expected benefit has not been established. In more practical terms, screening is essentially designed to identify asymptomatic diabetic subjects who might present angiographically significant coronary lesions, specifically multivessel or left common coronary stenosis, for which revascularization interventions have proven efficacy.

More restrictive than the preceding, these guidelines are based on uncertainties. They attempt to resolve the need for efficacy and sobriety by screening the subjects most at risk and by using the most appropriate examinations, thus avoiding useless research. Although they may be ignored and although new, equally uncertain, protocols may have to be drawn-up, these recommendations must be assessed in depth within the framework of a large prospective registry regrouping Diabetologists and Cardiologists. The observations in such a registry, enriched by the supply of new investigational methods such as non-invasive angiography and the development of new, validated, medicinal or interventional means of treatment, will permit the updating of these guidelines on far more solid bases.

References


3S16 Diabetes Metab, 2004,30,3S3-3S18 • www.e2med.com/dm


