IN-HOSPITAL EARLY COMPLICATIONS IN DIABETICS VS NON DIABETICS WITH ACUTE ST ELEVATION MYOCARDIAL INFARCTION AGE GROUP 30-70 YEARS


Armed Forces Institute of Cardiology/National Institute of Heart Disease (AFIC/NIHD)/National University of Medical Sciences (NUMS) Rawalpindi Pakistan, *Pak Emirates Military Hospital/National University of Medical Sciences (NUMS) Rawalpindi Pakistan, **Nishter Hospital Multan Pakistan

ABSTRACT

Objective: To determine in hospital early complications in diabetics’ vs non diabetics with acute ST elevation myocardial infarction.

Study Design: Comparative cross-sectional study.

Place and Duration of Study: The study was conducted in emergency departments and adult cardiology wards of Armed Forces Institute of Cardiology/National Institute of Heart Diseases, from Aug to Nov 2019.

Methodology: A comparative cross sectional study was conducted on 380 patients (190 patients with diabetes and 190 patients without diabetes) who presented with acute ST-Elevation MI in age group 30 to 70 years to emergency department of Armed Forces Institute of Cardiology/National Institute of Heart Disease during specified period. Patients with rescue PCI and new onset of LBBB were also included. Patients with age group lesser than 30 years or greater than 70 years with STEMI were excluded. Sampled with consecutive non probability technique in patients was assessed with ECG, cardiac enzymes, transthoracic echocardiography, renal Doppler and RFTs. All patients were admitted in wards and were followed up during hospital stay. Patients were evaluated and their record of Primary PCI and thrombolysis was also noted. Data was entered and analyzed with SPSS-23.

Results: A total of 380 patients with STEMI were included in this study consisting of 292 (76.8%) male and 88 (23.1%) female from 30 to 70 years. The patients were divided in two groups i.e. diabetic and non-diabetic, 190 patients were included in each group. It was found that frequency of ST-Elevation MI was higher in diabetic group as compared to non-diabetic group. All the patients were analyzed for complications occurred after ST-Elevation MI. LV failure, Brady arrhythmias, atrial fibrillation, post MI angina and cardiogenic shock were the main complications noted. It was found that all these complications are more in diabetic group post MI angina which occurred most frequently in non-diabetic group.

Conclusion: In our study we observed that left ventricular failure and arrhythmias were the major complications. Mortality was higher in diabetic patients than non-diabetic patients. In both groups PPCI and SK reduced mortality. Post MI angina were found more frequent in non-diabetic group.

Keywords: Complications, Diabetic, In hospital, Mortality, Non-diabetic, Streptokinase.

INTRODUCTION

Acute Myocardial Infarction (AMI) can be considered as a potential epidemic for mankind1. The incidence of coronary artery disease is rising in Pakistan1. The acute coronary syndrome includes unstable angina, non-ST segment elevation MI (NSTEMI) and ST segment elevation MI (STEMI)2. Diabetes mellitus is one of the six primary risk factors identified for MI3, others being dyslipidemia, smoking, male gender, hypertension and family history of atherosclerotic arterial disease1,4. Diabetes mellitus is a metabolic disorder which increases the rate of atherosclerosis progression of vascular occlusion4. Even after prompt PPCI and thrombolysis the after-math of diabetic patients is still worse than the non-diabetics, indicating post PCI and post thrombolysis impaired left ventricular function and prognosis5. The aim of PCI and thrombolysis in acute MI is early and complete myocardial reperfusion. Incomplete or failed reperfusion is associated with increased risk of complications6. Analysis of ST-segment resolution on ECG, after fibrinolytic
Early Complications in Diabetics Vs Non Diabetics

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therapy, in cases of ST elevation myocardial Infarction offers an attractive and cost effective solution to assess coronary reperfusion. Whereas coronary angiogram is a marker for epicardial reperfusion, ST segment resolution offers a better reflection of micro vascular reperfusion. Although successful PCI and thrombolysis of the epicardial vessel is necessary for good prognosis, but the micro-vascular flow more strongly correlates with the outcome. ST segment is therefore a better indicator of prognosis, and provides information, which cannot be assessed on basis of coronary angiogram alone. In fact Schroeder et al reported that absence of ST segment resolution was the most powerful independent predictor of early mortality \( p=0.0001 \). ST resolution can also be used as a tool to identify candidates for early invasive procedures such as PTCA, who are at risk of developing complications because of non-resolution of ST segment after initial thrombolytic therapy. Since ECG is widely available even in developing nations, it is important to establish its effectiveness as a tool for assessing reperfusion as it will offer the cheapest alternative for assessing recovery and myocardial salvage.

The aim of our study was to correlate the incidence of complications with diabetes by using ST segment resolution as a tool, thereby reinforcing the role of incomplete ST-resolution as a marker of worse clinical outcome in cases of diabetes with ST-elevated myocardial Infarction in our population. The purpose of this study was to document the complications especially the MACE (major Adverse Cardiovascular Events) and other complications in diabetic and non-diabetic patients after acute ST elevation myocardial infarction in age group from 30 year to 70 years in our institution.

METHODOLOGY

A comparative cross sectional study was conducted on 380 patients (190 patients with diabetes and 190 patients without diabetics) who presented with Acute ST-Elevation MI in age group 30 to 70 years to emergency department of Armed Forces Institute of Cardiology/National Institute of Heart Disease during specified period. Mean age was 53.34 ± 8.38 years as shown in table-I. Patients with rescue PCI and new onset of LBBB were also included. Patients with STEMI age lesser than 30 years or greater than 70 years and patients who has ST elevation due to other reasons like early repolarization, LV hypertrophy, Brugada syndrome and hyperkalemia were excluded. Patients presented with non ST elevation MI and unstable angina were also excluded. Acute ST elevation MI was considered on ECG by ST elevation of 1 mm or more in two or more than two contiguous leads, often with reciprocal ST depression in the contra lateral leads. In lead V2 to V3 ST segment elevation of at least 2mm in men older than 40 years and 2.5 mm in men younger than 40 years, and 1.5 mm in women was taken as significant for acute STEMI.

Sample with consecutive non probability technique were taken and patients were assessed with ECG, cardiac enzymes, transthoracic echocardiography, renal Doppler and RFTs. All patients were admitted in wards and were followed up during hospital stay. Patients were evaluated and history of Primary PCI and thrombolysis was also noted. Data was entered and analyzed with SPSS-23.

Continuous variables were expressed as mean, standard deviation (SD) and qualitative data were presented as percentage and frequencies. Chi-square test was used to determine any significant difference between two groups. A \( p \)-value of less than 0.05 was considered significant. The statistical analysis was performed with SPSS software.

RESULTS

A total of 380 patients with STEMI were included in this study consisting of 292 (76.8%) male and 88 (23.2%) females from 30 to 70 years. The patients were divided in two groups i.e. diabetic and non-diabetic, 190 patients were included in each group as shown in table-I. All the patients were analyzed for in hospital early complications between the two groups on the basis of ECG finding, cardiac enzymes, Trans-
thoracic echocardiography, renal doppler and RFTs. It was found that patients treated with primary PCI or Streptokinase the mortality was lesser than those not treated with PPCI or streptokinase (non-diabetic group mortality was 1.74% while in Diabetic group mortality was 2.97%), as shown in table-IV. It was also found that frequency of ST-Elevation MI is higher in diabetic group as compared to non-diabetic group. All the

Table-I: Demographic data at the time of presentation.

<table>
<thead>
<tr>
<th>Demographic characteristics</th>
<th>Sample size 190 Non Diabetic</th>
<th>Sample size 190 Diabetic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency and Percentage</td>
<td>Frequency Percentage</td>
<td>Frequency Percentage</td>
</tr>
<tr>
<td>Mean ± Age</td>
<td>53.34 ± 8.38</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>160 84.14%</td>
<td>146 76.6%</td>
</tr>
<tr>
<td>Female</td>
<td>30 15.9%</td>
<td>44 23.4%</td>
</tr>
<tr>
<td>Family History</td>
<td>36 18.2%</td>
<td>28 14.9%</td>
</tr>
<tr>
<td>Smoker or ex-smoker</td>
<td>95 50%</td>
<td>85 44.7%</td>
</tr>
</tbody>
</table>

Table-II: Age wise distribution of STEMI from 30 to 70 year.

<table>
<thead>
<tr>
<th>Age wise Distribution</th>
<th>Non Diabetic</th>
<th>Diabetic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>Percentage</td>
<td>Frequency</td>
</tr>
<tr>
<td>30 to 40 years</td>
<td>06 3.1%</td>
<td>07 3.7%</td>
</tr>
<tr>
<td>41 to 50 years</td>
<td>22 11.6%</td>
<td>30 15.7%</td>
</tr>
<tr>
<td>51 to 60 years</td>
<td>68 35.8%</td>
<td>81 42.6%</td>
</tr>
<tr>
<td>61 to 70 years</td>
<td>94 49.5%</td>
<td>72 37.9%</td>
</tr>
</tbody>
</table>

Table-III: Comparison of complications in diabetic vs non diabetic patient after STEMI.

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Non diabetic</th>
<th>Diabetic</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Mechanical</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>VSR</td>
<td>1 0.5%</td>
<td>3 1.57%</td>
</tr>
<tr>
<td>Acute MR</td>
<td>2 1.05%</td>
<td>4 2.1%</td>
</tr>
<tr>
<td>Ventricular anurysem</td>
<td>-</td>
<td>1 0.5%</td>
</tr>
<tr>
<td>LV failure</td>
<td>24 12.98%</td>
<td>40 21.05%</td>
</tr>
<tr>
<td>RV failure</td>
<td>8 4.2%</td>
<td>12 6.3%</td>
</tr>
</tbody>
</table>

2. Arrhythmias
   a. Bradyarhythmis
      1st degree AV block | 23 12.1% | 31 16.3% |
      2nd degree AV block (mobits 1) | 13 6.8% | 21 11.05% |
      2nd degree AV block (mobits 2) | 2 1.05% | 4 2.1% |
      3rd degree AV block | 8 4.2% | 14 7.36% |
      SND                  | 19 10%    | 27 14.2% |
      LBBB                 | 2 1.05%  | 3 1.57%  |
   b. Tachyarhythmis      |
      SVT                  | 4 2.1% | 5 2.63% |
      a.Flutter             | 2 1.05% | 2 1.05% |
      a.Fibrillation        | 18 9.47% | 23 12.10% |

3. Others complications
   Early pericarditis      | 9 4.76% | 11 5.8% |
   Cardiogenic shock       | 17 8.9% | 22 11.5% |
   Post mi angina          | 41 21.6% | 36 18.9% |
   Death                  | 6 3.1% | 9 4.7% |

p-value = 0.05
patients were analyzed for complications occurred after ST-Elevation MI. LV failure, Brady arrhythmias, atrial fibrillation, post MI angina and cardiogenic shock were the main complications noted. It was found that all these complications are more in diabetic group except ventricular tachycardia and post MI angina which occurred most frequently in non-diabetic group. LV failure in another study abroad (27%)\textsuperscript{13}. This difference in percentage compared with a local study from Karachi can be related with the status of diabetes and its management in different areas of the country\textsuperscript{14-16}. In age group 30-40 in greater percentage of diabetic patients were presented with STEMI as compared to non-diabetic group which shows that MI is not only common in advance age among diabetic patients but also in age group lesser than 40 years\textsuperscript{17}. The most significant complications observed during our study were left ventricular failure, arrhythmias, cardiogenic shock and death. All these complications were more common in diabetic group. These results were almost similar to earlier study conducted in Pakistan\textsuperscript{18-20}. Another study conducted in Greece, abroad showed almost similar results\textsuperscript{16}. During our study post MI angina was more common in non-diabetic patients which is against other studies conducted\textsuperscript{21}. Those study showed similar occurrence of these complications in both groups \textsuperscript{22-23}, therefore it needs further study to clarify about the existence of these complications in these two groups. In most studies the history showed that younger patient had first sign of heart disease one to two days back and they often ignored it and not consider themselves to be victim of heart disease at this age which leads to increase in hospital mortality in this age\textsuperscript{24}.

**DISCUSSION**

A total of 380 patients with STEMI were investigated in this study out of which 160 (42.1%) were male and 30 (7.9%) were female. Mean age was 53.34 ± 8.38 years. The demographic characteristic of the study population were showing no significant difference. Out of 190 nondiabetic patients, 160 (84.14%) were males and 30 (15.9%) were females. This number is about 10% lower than patients admitted with AMI in Karachi (43%)\textsuperscript{12}. However, number of diabetics in STEMI observed in our study were almost similar to another study abroad (27%)\textsuperscript{13}. This difference in percentage compared with a local study from Karachi can be related with the status of diabetes and its management in different areas of the country\textsuperscript{14-16}. In age group 30-40 in greater percentage of diabetic patients were presented with STEMI as compared to non-diabetic group which shows that MI is not only common in advance age among diabetic patients but also in age group lesser than 40 years\textsuperscript{17}. The most significant complications observed during our study were left ventricular failure, arrhythmias, cardiogenic shock and death. All these complications were more common in diabetic group. These results were almost similar to earlier study conducted in Pakistan\textsuperscript{18-20}. Another study conducted in Greece, abroad showed almost similar results\textsuperscript{16}. During our study post MI angina was more common in non-diabetic patients which is against other studies conducted\textsuperscript{21}. Those study showed similar occurrence of these complications in both groups \textsuperscript{22-23}, therefore it needs further study to clarify about the existence of these complications in these two groups. In most studies the history showed that younger patient had first sign of heart disease one to two days back and they often ignored it and not consider themselves to be victim of heart disease at this age which leads to increase in hospital mortality in this age\textsuperscript{24}.

**CONCLUSION**

In our study we observed that left ventricular failure and arrhythmias were the major complications. Mortality was higher in diabetic patients than non-diabetic patients. In both groups, PPCI and SK reduced mortality. Post MI angina was found more frequent in non-diabetic group. However further research in this regards
Early Complications in Diabetics Vs Non Diabetics

maybe required. Moreover, it can be seen that Diabetes mellitus can cause more post-MI complications in our population as compared to those in non-diabetic patients; therefore it is also important to decrease its incidence, as it is a modifiable risk factor.

CONFLICT OF INTEREST

This study has no conflict of interest to be declared by any author.

REFERENCES
