Impact of Diastolic Dysfunction on the Development of Heart Failure in Diabetic Patients after Acute Myocardial infarction

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Abstract

**Background:** Diabetes is often associated with an abnormal diastolic function. However, there is no data regarding the contribution of diastolic dysfunction to the development of heart failure (HF) in diabetic patients after acute myocardial infarction (AMI).

**Methods and Results:** 1513 patients with AMI (417 diabetic) underwent echocardiographic examination during the index hospitalization. Severe diastolic dysfunction was defined as a restrictive filling pattern (RFP) based on E/A ratio >1.5 or deceleration time <130 msec. The primary endpoints of the study were readmission for HF and all-cause mortality.

The frequency of RFP was higher in patients with diabetes (20 vs. 14%; \( P = 0.005 \)). During a median follow up of 17 months (range, 8 to 39 months), 52 (12.5%) and 62 (5.7%) HF events occurred in patients with and without diabetes, respectively (\( P < 0.001 \)). There was a significant interaction between diabetes and RFP (\( P = 0.04 \)), such that HF events among diabetic patients occurred mainly in those with RFP. The adjusted hazard ratio for HF was 2.77 \([95\% \text{ CI 1.41–5.46}]\) in diabetic patients with RFP and 1.21 \([95\% \text{ CI 0.75–1.55}]\) in diabetic patients without RFP. A borderline interaction (\( P = 0.059 \)) was present with regard to mortality (adjusted hazard ratio 3.39 \([95\% \text{ CI 1.57–7.34}]\) vs. 1.61 \([95\% \text{ CI 1.04–2.51}]\) in diabetic patients with and without RFP, respectively).

**Conclusion:** Severe diastolic dysfunction is more common among diabetic patients after AMI and portends adverse outcome. HF and mortality in diabetic patients occur predominantly in those with concomitant RFP.

**Key words:** Diabetes mellitus, Diastole, Echocardiography, Heart failure, Myocardial infarction
Introduction

Epidemiological and clinical studies have shown that diabetes mellitus is a major risk factor for the development of heart failure (HF).\textsuperscript{1} Diabetes contributes to the HF epidemic both as a risk factor for coronary artery disease, and via other less well understood mechanisms that directly alter myocardial function.\textsuperscript{2-3} Among patients with chronic HF, patients with diabetes have worse long-term outcomes than their nondiabetic counterparts regardless of the underlying etiology. Diabetes increases the risk for HF hospitalizations and death in patients with reduced or preserved systolic function,\textsuperscript{4} and in patients who are hospitalized for decompensated HF.\textsuperscript{5}

HF is a common and ominous complication in patient with diabetes who sustained an acute myocardial infarction (AMI). HF and cardiogenic shock are more common and more severe in diabetic individuals than would be predicted from the size of the infarct.\textsuperscript{6-9} In the Diabetes Insulin Glucose in Acute Myocardial Infarction (DIGAMI) study of myocardial infarction in patients with diabetes, HF was the most common cause of mortality, accounting for 66% of deaths in the year following the first infarction.\textsuperscript{10} The mechanisms underlying the increased incidence of HF in patients with diabetes and AMI remain poorly understood.\textsuperscript{6}

The increase in the clinical manifestations of HF may occur in the face of a modest decrease in left ventricular systolic function. Therefore, it has been suggested that preexisting subclinical impairment of left ventricular diastolic function contributes to the development of HF in diabetic patients after AMI.\textsuperscript{6-7} However, there is no information with regard to the prevalence and clinical consequences of diastolic dysfunction in diabetic patients with AMI.

Therefore in the present study we sought to determine the contribution of diastolic dysfunction to the development of HF in diabetic patients after AMI. To this aim, we used a prospective database\textsuperscript{11} that provided an opportunity to study the associations between diabetes and HF in the setting of recent AMI, accounting for left ventricular systolic and diastolic
function. We present herein data that supports the hypothesis that in patients with diabetes and AMI, diastolic dysfunction is a major determinant of HF and mortality.

**Methods**

**Patients:** The study cohort consisted of patients enrolled in a prospective observational study designed to determine predictors of postinfarction heart failure. All patients presenting to the intensive coronary care unit with AMI were eligible for entry into the study if they had a diagnosis of AMI according to the American College of Cardiology criteria. The investigational review committee on human research approved the study protocol.

**Echocardiographic examination:** Echocardiography was performed during hospital stay after a median of 2 days from admission [interquartile range 1 to 3 days]. Analysis of diastolic function, left ventricular function and presence and degree of MR was carried out by one of seven experienced noninvasive cardiologists (YA, SR, DM, JL, DA, SC, and SD) without knowledge of the patient outcome. Patients with technically limited Doppler echocardiograms and patients with atrial fibrillation, sinus tachycardia or first-degree AV block resulting in partial fusion of the E and A velocities, ventricular pacing and other arrhythmias (e.g., atrial flutter) were excluded. In addition, to avoid the effects of mitral regurgitation on E wave velocity and other Doppler parameters of filling pressures, we excluded patients with moderate or severe mitral regurgitation, mitral stenosis or prosthetic mitral valves.

Early (E) and late (A) trans-mitral velocities of the mitral inflow, their ratio and the E wave deceleration time (DT) were measured from the apical window using pulsed-wave Doppler with the sample volume placed at the tips of the mitral leaflets during diastole. Previous studies in patients after AMI used several definitions for RFP. In the absence of universal criteria for RFP we chose to use criteria that are consistent with most previous studies. Therefore, restrictive filling pattern (RFP) was defined as the presence of E/A wave ratio of >1.5 or an E-wave deceleration time of <130 ms.
The severity of MR was determined as previously described. Left ventricular ejection fraction (LVEF) was visually estimated and classified as normal (≥ 55%), mildly reduced (45-54%), moderately reduced (30-44%) or severely reduced (<30%). Preserved left ventricular systolic function was defined as LVEF >45% as suggested by the European Study Group on Diastolic Heart Failure and in large clinical trials.

**Definition of diabetes:** Patients were considered as having diabetes if they had been previously informed of the diagnosis by a physician or were taking oral antihyperglycemic agents, or insulin or receiving dietary therapy. Patients without previously diagnosed diabetes who required initiation of antihyperglycemic therapy during hospital stay were also considered to have diabetes.

**Study end points:** The primary end points of the study were: 1) development of HF analyzed by time to first event, and 2) all-cause mortality. HF was defined as readmission to hospital for the management of HF (defined by the presence of new symptoms of paroxysmal nocturnal dyspnea, orthopnea or edema with one or more concurrent signs, including ventricular gallop rhythm, jugular venous distention, bilateral post-tussive rales in at least the lower third of the lung fields, elevated venous pressure, or pulmonary venous congestion on X-ray with interstitial or alveolar edema).

Following hospital discharge, clinical endpoint information was acquired by reviewing the national death registry and by reviewing the hospital records for major clinical events if the patient had been re-hospitalized. To confirm the diagnosis of HF, all hospital records were abstracted. Data were collected on the course and care of the patient during the hospital stay, including admission notes, consultation notes, discharge summaries, and pertinent laboratory data. Three physicians (DA, AM and DM), independently reviewed all records and adjudicated the occurrence of events. The majority rule was applied in case of disagreement.
**Statistical analysis:** Data are expressed as mean ± SD. The baseline characteristics and echocardiographic parameters of the study groups were compared using unpaired *t* test for continuous variables and by the χ² statistic for categorical variables.

Survival curves were constructed using the Kaplan–Meier method, and comparisons were made using the log–rank test. Multivariable Cox proportional hazards modeling was used to determine the relationship between diabetes, RFP and admission for the treatment of HF. Known predictors of the development of HF in survivors of MI were forced into the model: age, LVEF (stratified as normal, mildly reduced, moderately reduced or severely reduced) baseline heart rate, Killip class at admission, hypertension, diabetes, previous infarction mild mitral regurgitation, and RFP). In addition, other potential predictors were considered (gender, serum creatinine, anterior infarction, ST-elevation infarction, coronary revascularization) if they demonstrated an association with HF on univariate analysis (*P* < 0.1). Because recurrent MI greatly increases the risk for HF, all survival analyses were performed censoring the data to the time of recurrent infarction.

Cox proportional hazard modeling was also performed to determine the relationship between diabetes, RFP and mortality. Clinical and echocardiographic variables thought to have clinical importance (age, gender, baseline creatinine, previous infarction, history of hypertension, diabetes, smoking status, anterior infarction, ST-elevation infarction, Killip class, reperfusion therapy, coronary revascularization, mild mitral regurgitation and LVEF) were included in a stepwise multivariable model.

We assessed whether the effect of diabetes on HF and death varied according to RFP status using traditional interaction testing and stratified analyses. The existence of an interaction was formally evaluated with the use of a Cox regression model incorporating terms for the main effect of diabetes, the main effect of RFP, and the interaction between diabetes and RFP. The impact of concomitant RFP on the risk of HF and death was analysed in subgroups of patients...
with preserved (LVEF>45%) and reduced LVEF (LVEF<45%). Two-sided, 95% likelihood ratio confidence intervals (CI) were constructed, and an α-level of 0.05 was used to declare statistical significance of the interaction term. Statistical analyses were performed using the SPSS statistical software Version 15.0 (Chicago, IL).

**Handling of Missing Data:** Of the 2398 patients initially enrolled in the study, 562 (23.7%) had missing data on diastolic function for various reasons including conditions for which interpretation of diastolic function is unreliable; these patients were not included in the analyses. To estimate the influence of missing diastolic function information, the primary analyses were replicated using the maximum likelihood expectation maximization method (which estimates conditional means for missing values, given the observed values of the other covariates) to impute the missing E/A ratio and DT data. These analyses showed no substantive differences, which suggests that any bias due to incomplete diastolic function data was minimal. Therefore, only the analyses from non-imputed data are presented.

**Results**

Between January 2000 and June 2008, 2398 patients were recruited into the study. Patients were excluded due to mitral valve disease (n = 227; moderate or severe mitral regurgitation, mitral stenosis or mitral prosthesis) and atrial fibrillation (n = 96). Inadequate quality of the echocardiogram, missing diastolic function data and other conditions for which interpretation of diastolic function is unreliable resulted in the exclusion of 562 additional patients. The study population consisted of the 1513 remaining patients of whom 417 were diabetic.

Compared with participants for whom diastolic function was available, patients with missing diastolic function data were older (62 ± 13 vs. 60 ± 13; P = 0.002), had higher creatinine levels (1.2 ± 0.7 vs. 1.0 ± 0.5 mg/dl; P < 0.001), were more likely to have tachycardia at admission (12% vs. 6%; P < 0.001), to present with Killip class > I (31% vs. 17%, P < 0.001) and to have reduced LVEF (48% vs. 35%; P < 0.001); they were less likely to undergo percutaneous revascularization (41% vs. 49%; P < 0.001) and were similarly
likely to have diabetes (29% vs. 28%, \( P = 0.65 \)). Among the patients with missing diastolic function, readmission for HF was similar to that of patients with complete data (\( P = 0.59 \)) but mortality was higher (\( P = 0.001 \)).

The clinical characteristics of patients with available diastolic function data according to diabetes status are shown in Table 1. Patients with diabetes were more likely to be older and females; had higher baseline creatinine, and were more likely to have had a previous myocardial infarction and a history of hypertension and smoking; they presented with higher heart rates and higher Killip class.

The overall prevalence of RFP was 15.5% with higher rates of RFP among diabetic patients (Table 1). Patients with diabetes had lower LVEF and higher rates of mild mitral valve regurgitation. They were less likely to receive percutaneous revascularization and more likely to undergo coronary bypass surgery. There was less use of anti-platelet agents and greater use of angiotensin-converting-enzyme inhibitors in patients with diabetes.

**Diabetes, RFP and Heart Failure:** The median duration of follow up after hospital discharge was 17 months (range, 8 to 39 months). During the follow up period 135 patients (8.9%) were readmitted for the treatment of HF. Of these, 114 patients were admitted for HF without a preceding recurrent infarction, with 52 (12.5%) and 62 (5.7%) events occurring in patients with and without diabetes, respectively (\( P < 0.001 \)).

The results of univariable and multivariable Cox model examining the relationship between clinical and echocardiographic variables and risk of HF is shown in **Table 2**. After multivariable adjustments, both diabetes and RFP were independent predictors of subsequent HF, together with age, Killip class above I, moderately and severely reduced LVEF and mild mitral regurgitation **Table 2**.
Kaplan-Meier plots according to RFP and diabetes status showed a markedly increased risk for HF in diabetic patients with RFP (Figure 1). Likelihood ratio tests demonstrated a significant interaction between diabetes and RFP with respect to readmission for HF in the adjusted Cox model ($P = 0.04$), such that the increased risk for HF among diabetic patients occurred predominantly in patients with concomitant RFP (Figure 2). Stratified analyses based on the presence of RFP showed that in patients with RFP ($n = 234$), the adjusted HR for HF was 2.77 in diabetic patients as compared with nondiabetic patients. In contrast, for patients without RFP ($n = 1279$), diabetes was not significantly associated with an increased risk for HF (Figure 2).

**Diabetes, RFP and Mortality:** During the follow up period 117 patients (7.7%) died, with 58 (13.9%) and 59 (5.4%) deaths occurring in patients with and without diabetes, respectively ($P < 0.0001$). In a multivariable Cox proportional hazards model, diabetes and RFP were independently associated with an increased adjusted risk for mortality (Table 3). There was a borderline-significant interaction between diabetes and RFP with regard to the mortality endpoint (Figure 2 and Figure 3; $P = 0.059$). Stratified analyses revealed that in patients with RFP, the adjusted HR for mortality associated with diabetes was 3.39. In contrast, for patients without RFP, the adjusted HR for mortality in patients with diabetes was only 1.61.

**Diabetes, RFP and LVEF:** To study the effect of diastolic dysfunction and diabetes in relation to the presence of left ventricular systolic dysfunction, additional analyses were performed after dividing the study population into 8 groups based on diabetes status, RFP and presence of preserved ($\geq 45\%$) or reduced LVEF. The adjusted HRs for the combined endpoint of HF and death in these 8 groups are shown in Figure 4.

The impact of concomitant RFP on the risk of HF and death was evident in diabetic patients with preserved (LVEF $>45\%$) and reduced LVEF (LVEF $<45\%$) (Figure 4). The
adjusted hazard ratio for HF and death in diabetic patients with RFP and preserved LVEF was higher than that of diabetic patient without RFP and preserved LVEF and similar to that of diabetic patients without RFP but with systolic dysfunction. Diabetic patients with combined diastolic and systolic dysfunction were at highest risk with a striking increase in the risk for HF and death.

**Discussion**

In the present study, we sought to determine the prevalence and clinical consequences of RFP in diabetic patients after AMI. The prevalence of severe diastolic dysfunction was higher among diabetic patients after AMI. Diabetes remained a strong and independent predictor of HF and mortality after adjustment for established clinical predictors of adverse outcome among patients with AMI. However, the association between diabetes and clinical outcomes depended on the presence of RFP. The increase in mortality and HF events among diabetic patients occurred predominantly in those with concomitant RFP. The impact of RFP on the clinical outcome of diabetic patients was robust irrespective of whether LVEF was preserved or reduced.

**Diastolic dysfunction in diabetes:** Diabetes is associated with a variety of cardiac alterations that affect both systolic and diastolic function and result from complex and multifactorial mechanisms. Several ultrastructural changes have been described in the myocardium of diabetic patients, including myocardial triglyceride accumulation, increased deposition of collagen type III and myocardial fibrosis and collagen glycation and cross-linking, leading to greater left ventricular mass and impaired contractility.

Many studies have shown that patients with diabetes manifest diminished left ventricular compliance in the presence of preserved left ventricular systolic function. Diastolic abnormalities as defined by comprehensive Doppler techniques have been documented in both type 1 and type 2 diabetes, and occur in 27–75% of diabetic patients. However, the alterations in diastolic function among diabetic patients have been documented in
asymptomatic individuals, and their long-term consequences or potential to progress to symptomatic HF remains unknown.

**Diastolic dysfunction and post-infarction HF:** While diabetes is associated with increased risk for developing acute coronary events, in the post infarction period, patients with diabetes also have a higher subsequent risk of developing HF. The markedly increased adjusted risk of HF and death associated with diabetes beyond the acute phase of coronary events is poorly understood. Several studies have shown that measures of infarct size and left ventricular function, or alterations in post-infarction left ventricular remodeling do not explain the increased propensity of diabetic patients to develop HF.

The results of the present study indicate that diabetes-related changes in diastolic function markedly increase the risk of HF and death of diabetic patients who survive an AMI, regardless of their residual systolic function. In accordance with previous reports, the present study demonstrates that HF develops more frequently in diabetic patients than in nondiabetic patients after AMI. The significant interaction between diabetes and RFP strongly suggests an independent link between diabetes, diastolic function and clinical outcome. After adjustments for known risk factors for post-infarction HF, the most marked increase in the risk of HF conferred by diabetes was observed in diabetic patients with concomitant severe diastolic dysfunction. Thus, abnormal diastolic function is an important determinant of the progression to clinical HF among diabetic patients with AMI.

The borderline-significant interaction between diabetes and RFP with respect to mortality indicates that diastolic dysfunction also contributes to the increased mortality of diabetic patients after AMI, akin to the association between diastolic dysfunction and all-cause mortality in the general population. These findings suggest that assessment of diastolic function should become an important component of the echocardiographic examination in diabetic patients.
In-hospital and long-term mortality after AMI has declined over the years. However, despite the existence of treatments which may benefit diabetic patients disproportionately, the relative hazard of mortality in diabetic patients has improved little compared with non-diabetic patients. The results of the present study may explain these epidemiological observations, given that strong evidence for a beneficial effect of various therapies in patients with diastolic heart failure is still lacking.

Although the predominant diastolic abnormality during transient ischemia is an impairment in relaxation, the diastolic filling pattern may change during AMI, resulting in a restrictive filling pattern as a result of an increase in resistance to left ventricular filling or increased chamber stiffness. Depending on the patient population and echocardiographic criteria, the prevalence of RFP in previous studies ranged from 13 to 33%. The overall prevalence of RFP in the present study was 15.5%. However, regardless of the definition used, the presence of RFP is a consistent powerful predictor of HF and death in the setting of AMI.

Changes in the composition of the myocardium in terms of increased collagen content during and after repair of the infarct zone and formation of a fibrous tissue scar can alter the mechanical properties of the myocardium after AMI and confer on the heart increased myocardial and chamber stiffness. These changes in left ventricular material properties, when superimposed on preexisting reduced compliance in the diabetic heart, may increase chamber stiffness and explain the higher prevalence of RFP among diabetic patients.

**Study limitations:** This study used simple Doppler assessment of diastolic filling. Although a clear relationship between RFP and clinical outcomes was observed, the addition of more sophisticated diastolic parameters such as tissue Doppler and mitral flow propagation velocity may offer additional benefit, especially for identifying other diastolic filling patterns. However, RFP is the most validated predictor of HF and death after AMI.
Even though all of the patients included in this study underwent echocardiography during their hospital admission, a substantial number of eligible patients had missing diastolic function data due to either inadequate quality of the echocardiogram or associated conditions in which interpretation of diastolic function is unreliable. Therefore, the results of the present study may not be applicable to all post-infarction patients. However, the relatively large study population allows for the present results to be extended to a wide range of patients with AMI. Furthermore, analysis of missing data suggested that any selection biases in the results with regard to the interaction between diabetes and RFP are likely to be minimal.

**Conclusion:** This study demonstrates that RFP, a marker of severe diastolic dysfunction, is more common among diabetic patients after AMI. Diastolic dysfunction is an important determinant of clinical outcomes in diabetic patients after AMI, as the increase in HF and mortality in these patients occurs predominantly in those with concomitant RFP. Our findings suggest that assessment of diastolic function should become an important component of the echocardiographic examination in diabetic patients after AMI.

**Disclosures**
None
References


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**Figure legends**

Figure 1: Kaplan-Meier plot showing the crude cumulative incidence of admission for the treatment of heart failure according to the presence of diabetes and restrictive filling pattern. $P$ values are for the overall comparison among the groups using the log rank test.

Figure 2: Interaction between diabetes and restrictive filling pattern with regard to heart failure (circles) and mortality (squares). Adjusted hazard ratios (with 95% CIs) for diabetic compared with nondiabetic patients are shown for the whole study population and for patients with and without restrictive filling pattern. The interaction plot demonstrates that the increased risk for HF and death among diabetic patients occurred predominantly in patients with concomitant restrictive filling pattern.

Figure 3: Kaplan-Meier plot showing the crude cumulative incidence of mortality according to the presence of diabetes and restrictive filling pattern. $P$ values are for the overall comparison among the groups using the log rank test.

Figure 4: Adjusted hazard ratios and 95% confidence intervals for the combined endpoint of heart failure and death according to diabetes, restrictive filling pattern and left ventricular systolic function. The reference group includes patients without diabetes or restrictive filling pattern and with preserved left ventricular ejection fraction. The number of patients in each group is shown above each bar.
Table 1: Baseline Patient Characteristics

<table>
<thead>
<tr>
<th>Variable</th>
<th>No diabetes (n = 1096)</th>
<th>Diabetes (n = 417)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>59 ± 12</td>
<td>63 ± 11</td>
<td>0.008</td>
</tr>
<tr>
<td>Female gender, n (%)</td>
<td>198 (17)</td>
<td>107 (26)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Serum creatinine (mg/dL)</td>
<td>1.0 ± 0.4</td>
<td>1.1 ± 0.8</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Prior myocardial infarction</td>
<td>195 (18)</td>
<td>105 (26)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Current smoker</td>
<td>151 (14)</td>
<td>76 (18)</td>
<td>0.03</td>
</tr>
<tr>
<td>Hypertension</td>
<td>46 (43)</td>
<td>269 (65)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Anterior infarction</td>
<td>476 (43)</td>
<td>181 (43)</td>
<td>0.95</td>
</tr>
<tr>
<td>ST-elevation infarction</td>
<td>914 (83)</td>
<td>336 (81)</td>
<td>0.17</td>
</tr>
<tr>
<td>Heart rate at admission (beats/min)</td>
<td>77 ± 16</td>
<td>80 ± 16</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Killip Class on admission &gt; I</td>
<td>156 (14)</td>
<td>106 (25)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Restrictive filling pattern</td>
<td>152 (14)</td>
<td>82 (20)</td>
<td>0.005</td>
</tr>
<tr>
<td>Left ventricular ejection fraction</td>
<td></td>
<td></td>
<td>0.001</td>
</tr>
<tr>
<td>Normal</td>
<td>424 (39)</td>
<td>128 (31)</td>
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</tr>
<tr>
<td>Mildly reduced</td>
<td>327 (30)</td>
<td>112 (27)</td>
<td></td>
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<tr>
<td>Moderately reduced</td>
<td>257 (23)</td>
<td>124 (30)</td>
<td></td>
</tr>
<tr>
<td>Severely reduced</td>
<td>88 (8)</td>
<td>53 (13)</td>
<td></td>
</tr>
<tr>
<td>Mild mitral regurgitation</td>
<td>453 (41)</td>
<td>197 (47)</td>
<td>0.04</td>
</tr>
<tr>
<td>Percutaneous revascularization†</td>
<td>537 (49)</td>
<td>159 (38)</td>
<td>0.0002</td>
</tr>
<tr>
<td></td>
<td>Number</td>
<td>Mean (SD)</td>
<td>P</td>
</tr>
<tr>
<td>---------------------</td>
<td>--------</td>
<td>-----------</td>
<td>---------</td>
</tr>
<tr>
<td>Bypass surgery</td>
<td>41 (4)</td>
<td>27 (7)</td>
<td>0.02</td>
</tr>
<tr>
<td>Medications at discharge</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Anti-platelet agents</td>
<td>1076 (98)</td>
<td>402 (96)</td>
<td>0.04</td>
</tr>
<tr>
<td>β-blockers</td>
<td>991 (90)</td>
<td>382 (92)</td>
<td>0.48</td>
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<tr>
<td>ACE inhibitors/ARBs</td>
<td>941 (86)</td>
<td>380 (91)</td>
<td>0.006</td>
</tr>
<tr>
<td>Statins</td>
<td>870 (79)</td>
<td>335 (80)</td>
<td>0.68</td>
</tr>
</tbody>
</table>

Data are expressed as means ± standard deviation (SD) or number (%) for categorical variables.

* To convert from mg/dL to µmol/L multiply by 88.4.

† During hospital course

ACE = Angiotensin converting enzyme; ARB = Angiotensin II receptor blockers
Table 2: Unadjusted and Adjusted Cox’s Proportional Hazards Model for Admission for Heart Failure

<table>
<thead>
<tr>
<th>Variable</th>
<th>Unadjusted</th>
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<th></th>
<th>Adjusted</th>
<th>(95% CI)</th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HR</td>
<td>95% CI</td>
<td>P value</td>
<td>HR</td>
<td>95% CI</td>
<td>P value</td>
<td></td>
</tr>
<tr>
<td>Age (per 10 years)</td>
<td>1.83</td>
<td>1.56–2.14</td>
<td>&lt;0.0001</td>
<td>1.43</td>
<td>1.21–1.70</td>
<td>&lt;0.0001</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>2.39</td>
<td>1.65–3.45</td>
<td>&lt;0.0001</td>
<td>1.65</td>
<td>1.13–2.41</td>
<td>0.001</td>
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<tr>
<td>Killip class &gt; I</td>
<td>6.57</td>
<td>4.54–9.40</td>
<td>&lt;0.0001</td>
<td>2.88</td>
<td>1.90–4.39</td>
<td>&lt;0.0001</td>
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</tr>
<tr>
<td>Mild mitral regurgitation</td>
<td>4.49</td>
<td>2.91–6.91</td>
<td>&lt;0.0001</td>
<td>2.49</td>
<td>1.58–3.92</td>
<td>&lt;0.0001</td>
<td></td>
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<tr>
<td>LVEF</td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Normal</td>
<td>1.0 (Referent)</td>
<td></td>
<td></td>
<td>1.0</td>
<td></td>
<td>–</td>
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<tr>
<td>Mildly reduced</td>
<td>1.66</td>
<td>0.9–3.08</td>
<td>0.11</td>
<td>1.24</td>
<td>0.67–2.32</td>
<td>0.49</td>
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<td>Moderately reduced</td>
<td>4.18</td>
<td>2.41–7.25</td>
<td>&lt;0.0001</td>
<td>2.29</td>
<td>1.30–4.04</td>
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<td>Severely reduced</td>
<td>8.52</td>
<td>4.71–15.40</td>
<td>&lt;0.0001</td>
<td>2.17</td>
<td>1.12–4.20</td>
<td>0.02</td>
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<td>RFP</td>
<td>3.13</td>
<td>2.12–4.0</td>
<td>&lt;0.0001</td>
<td>2.05</td>
<td>1.35–3.11</td>
<td>0.001</td>
<td></td>
</tr>
</tbody>
</table>

The final model adjusted for age, gender, previous infarction, history of hypertension, diabetes, anterior infarction, ST-elevation infarction, coronary revascularization, Killip class on admission, mild mitral regurgitation, left ventricular ejection fraction and restrictive filling pattern.
Table 3: Unadjusted and Adjusted Cox’s Proportional Hazards Model for All-Cause Mortality

<table>
<thead>
<tr>
<th>Variable</th>
<th>Unadjusted</th>
<th>Adjusted</th>
<th>P value</th>
<th>Unadjusted</th>
<th>Adjusted</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HR</td>
<td>95% CI</td>
<td></td>
<td>HR</td>
<td>(95% CI)</td>
<td></td>
</tr>
<tr>
<td>Age (per 10 years)</td>
<td>1.83</td>
<td>1.56–2.14</td>
<td>&lt;0.0001</td>
<td>1.80</td>
<td>1.50–2.16</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Diabetes</td>
<td>2.39</td>
<td>1.65–3.45</td>
<td>&lt;0.0001</td>
<td>1.99</td>
<td>1.23–2.93</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Creatinine (per 1 mg/dL)</td>
<td>1.54</td>
<td>1.38–1.73</td>
<td>&lt;0.0001</td>
<td>1.42</td>
<td>1.22–1.64</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Heart rate &gt; 100 beats/min</td>
<td>2.25</td>
<td>1.38–1.73</td>
<td>&lt;0.0001</td>
<td>2.49</td>
<td>1.58–3.92</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>LVEF</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal</td>
<td>1.0 (Referent)</td>
<td></td>
<td></td>
<td>1.0</td>
<td></td>
<td>–</td>
</tr>
<tr>
<td>Mildly reduced</td>
<td>0.94</td>
<td>0.53–1.69</td>
<td>0.94</td>
<td>0.88</td>
<td>0.49–1.47</td>
<td>0.49</td>
</tr>
<tr>
<td>Moderately reduced</td>
<td>2.52</td>
<td>1.54–4.11</td>
<td>0.002</td>
<td>1.89</td>
<td>1.13–3.15</td>
<td>0.02</td>
</tr>
<tr>
<td>Severely reduced</td>
<td>4.95</td>
<td>2.91–8.41</td>
<td>&lt;0.0001</td>
<td>2.17</td>
<td>1.18–3.80</td>
<td>0.01</td>
</tr>
<tr>
<td>RFP</td>
<td>2.10</td>
<td>1.40–3.16</td>
<td>0.0003</td>
<td>1.90</td>
<td>1.23–2.93</td>
<td>0.004</td>
</tr>
</tbody>
</table>

The final model adjusted for age, gender, previous infarction, history of hypertension, smoking, diabetes, anterior infarction, ST-elevation infarction, coronary revascularization, Killip class on admission, mild mitral regurgitation, left ventricular ejection fraction and restrictive filling pattern.
Figure 2

- Heart Failure ($P_{Interaction} = 0.040$)
- Mortality ($P_{Interaction} = 0.059$)
Figure 3

Cumulative Probability of Mortality

P < 0.0001

Number at risk:

<table>
<thead>
<tr>
<th>Group</th>
<th>0</th>
<th>200</th>
<th>400</th>
<th>600</th>
<th>800</th>
<th>1000</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Diabetes/No RFP</td>
<td>944</td>
<td>910</td>
<td>628</td>
<td>389</td>
<td>248</td>
<td>144</td>
</tr>
<tr>
<td>Diabetes/RFP</td>
<td>335</td>
<td>314</td>
<td>216</td>
<td>131</td>
<td>85</td>
<td>56</td>
</tr>
<tr>
<td>No Diabetes/No RFP</td>
<td>152</td>
<td>144</td>
<td>132</td>
<td>105</td>
<td>66</td>
<td>44</td>
</tr>
<tr>
<td>Diabetes/RFP</td>
<td>82</td>
<td>67</td>
<td>46</td>
<td>32</td>
<td>20</td>
<td>13</td>
</tr>
</tbody>
</table>

Time (Days)
Impact of Diastolic Dysfunction on the Development of Heart Failure in Diabetic Patients after Acute Myocardial Infarction
Doron Aronson, Anees Musallam, Jonathan Lessick, Saleem Dabbah, Shemy Carasso, Haim Hammerman, Shimon Reisner, Yoram Agmon and Diab Mutlak

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