



ESC Guidelines on diabetes, pre-diabetes, and cardiovascular diseases developed in collaboration with the EASD

The Task Force on diabetes, pre-diabetes, and cardiovascular diseases of the European Society of Cardiology (ESC) and developed in collaboration with the European Association for the Study of Diabetes (EASD).

Authors/Task Force Members: Lars Rydén* (ESC Chairperson) (Sweden), Peter J. Grant* (EASD Chairperson) (UK), Stefan D. Anker (Germany), Christian Berne (Sweden), Francesco Cosentino (Italy), Nicolas Danchin (France), Christi Deaton (UK), Javier Escaned (Spain), Hans-Peter Hammes (Germany), Heikki Huikuri (Finland), Michel Marre (France), Nikolaus Marx (Germany), Linda Mellbin (Sweden), Jan Ostergren (Sweden), Carlo Patrono (Italy), Petar Seferovic (Serbia), Miguel Sousa Uva (Portugal), Marja-Riita Taskinen (Finland), Michal Tendera (Poland), Jaakko Tuomilehto (Finland), Paul Valensi (France), Jose Luis Zamorano (Spain)

ESC Committee for Practice Guidelines (CPG): Jose Luis Zamorano (Chairperson) (Spain), Stephan Achenbach (Germany), Helmut Baumgartner (Germany), Jeroen J. Bax (Netherlands), Héctor Bueno (Spain), Veronica Dean (France), Christi Deaton (UK), Çetin Erol (Turkey), Robert Fagard (Belgium), Roberto Ferrari (Italy), David Hasdai (Israel), Arno W. Hoes (Netherlands), Paulus Kirchhof (Germany UK), Juhani Knuuti (Finland), Philippe Kolh (Belgium), Patrizio Lancellotti (Belgium), Ales Linhart (Czech Republic), Petros Nihoyannopoulos (UK), Massimo F. Piepoli (Italy), Piotr Ponikowski (Poland), Per Anton Sirnes (Norway), Juan Luis Tamargo (Spain), Michal Tendera (Poland), Adam Torbicki (Poland), William Wijns (Belgium), Stephan Windecker (Switzerland).

Document Reviewers: Guy De Backer (Review Coordinator) (Belgium), Per Anton Sirnes (CPG Review Coordinator) (Norway), Eduardo Alegria Ezquerro (Spain), Angelo Avogaro (Italy), Lina Badimon (Spain), Elena Baranova (Russia), Helmut Baumgartner (Germany), John Betteridge (UK), Antonio Ceriello (Spain), Robert Fagard (Belgium), Christian Funck-Brentano (France), Dietrich C. Gulba (Germany), David Hasdai (Israel), Arno W. Hoes (Netherlands), John K. Kjeksus (Norway), Juhani Knuuti (Finland), Philippe Kolh (Belgium), Eli Lev (Israel), Christian Mueller (Switzerland), Ludwig Neyses (Luxembourg), Peter M. Nilsson (Sweden), Joep Perk (Sweden), Piotr Ponikowski (Poland), Željko Reiner (Croatia), Naveed Sattar (UK), Volker Schächinger (Germany), André Scheen (Belgium),

*Corresponding authors: The two chairmen equally contributed to the document. Chairperson ESC: Professor Lars Rydén, Cardiology Unit, Department of Medicine Solna, Karolinska Institute, Solna SE-171, 76 Stockholm, Sweden, Tel: +46 8 5177 2171, Fax: +46 8 34 49 64, Email: lars.ryden@ki.se; Chairperson EASD: Professor Peter J. Grant, Division Of Cardiovascular & Diabetes Research, University Of Leeds, Clarendon Way, Leeds LS2 9JT, United Kingdom. Tel: +44 113 343 7721, Fax: +44 113 343 7738, Email: p.j.grant@leeds.ac.uk

Other ESC entities having participated in the development of this document:

Associations: Acute Cardiovascular Care Association (ACCA), European Association of Cardiovascular Imaging (EACVI), European Association for Cardiovascular Prevention & Rehabilitation (EACPR), European Association of Percutaneous Cardiovascular Interventions (EAPCI), European Heart Rhythm Association (EHRA), Heart Failure Association (HFA)

Working Groups: Coronary Pathophysiology and Microcirculation, Thrombosis, Cardiovascular Surgery

Councils: Cardiovascular Nursing and Allied Professions, Council for Cardiology Practice, Council on Cardiovascular Primary Care, Cardiovascular Imaging

The content of these European Society of Cardiology (ESC) Guidelines has been published for personal and educational use only. No commercial use is authorized. No part of the ESC Guidelines may be translated or reproduced in any form without written permission from the ESC. Permission can be obtained upon submission of a written request to Oxford University Press, the publisher of the European Heart Journal and the party authorized to handle such permissions on behalf of the ESC.

Disclaimer. The ESC Guidelines represent the views of the ESC and EASD and were arrived at after careful consideration of the available evidence at the time they were written. Health professionals are encouraged to take them fully into account when exercising their clinical judgement. The guidelines do not, however, override the individual responsibility of health professionals to make appropriate decisions in the circumstances of the individual patients, in consultation with that patient and, where appropriate and necessary, the patient's guardian or carer. It is also the health professional's responsibility to verify the rules and regulations applicable to drugs and devices at the time of prescription.

© The European Society of Cardiology 2013. All rights reserved. For permissions please email: journals.permissions@oup.com

Henrik Schirmer (Norway), Anna Strömberg (Sweden), Svetlana Sudzhaeva (Belarus), Juan Luis Tamargo (Spain), Margus Viigimaa (Estonia), Charalambos Vlachopoulos (Greece), Robert G. Xuereb (Malta).

The disclosure forms of the authors and reviewers are available on the ESC website www.escardio.org/guidelines

Online publish-ahead-of-print 30 August 2013

Keywords

Guidelines • Diabetes mellitus • Cardiovascular disease • Impaired glucose tolerance • Patient management • Prevention • Epidemiology • Prognosis • Diagnostics • Risk factors • Pharmacological treatment • Coronary Interventions

Table of Contents

1. Preamble	3039	6.2 Glucose control	3053
2. Introduction	3040	6.2.1. Microvascular disease (retinopathy, nephropathy, neuropathy)	3053
3. Abnormalities of glucose metabolism and cardiovascular disease	3041	6.2.2. Macrovascular disease (cerebral, coronary and peripheral artery disease)	3053
3.1 Definition, classification and diagnosis	3041	6.2.3. Medium-term effects of glycaemic control	3053
3.2 Epidemiology	3043	6.2.4. Long-term effects of glycaemic control	3053
3.3 Screening for disorders of glucose metabolism	3043	6.2.5. Glycaemic targets	3054
3.4 Disorders of glucose metabolism and cardiovascular disease	3044	6.2.6. Glucose-lowering agents	3054
3.5 Delaying conversion to type 2 diabetes mellitus	3046	6.2.7. Special considerations	3055
3.6 Recommendations for diagnosis of disorders of glucose metabolism	3046	6.2.8. Gaps in knowledge	3056
4. Molecular basis of cardiovascular disease in diabetes mellitus	3046	6.2.9. Recommendations for glycaemic control in diabetes	3056
4.1 The cardiovascular continuum in diabetes mellitus	3046	6.3 Blood pressure	3056
4.2 Pathophysiology of insulin resistance in type 2 diabetes mellitus	3047	6.3.1. Treatment targets	3056
4.3 Endothelial dysfunction, oxidative stress and vascular inflammation	3047	6.3.2. Managing blood pressure-lowering	3057
4.4 Macrophage dysfunction	3047	6.3.3. Conclusion	3057
4.5 Atherogenic dyslipidaemia	3048	6.3.4. Gaps in knowledge	3057
4.6 Coagulation and platelet function	3048	6.3.5. Recommendations for blood pressure control in diabetes	3058
4.7 Diabetic cardiomyopathy	3049	6.4 Dyslipidaemia	3058
4.8 The metabolic syndrome	3049	6.4.1. Pathophysiology	3058
4.9 Endothelial progenitor cells and vascular repair	3049	6.4.2. Epidemiology	3058
4.10 Conclusions	3049	6.4.3. Management of dyslipidaemia	3059
5. Cardiovascular risk assessment in patients with dysglycaemia	3049	6.4.4. Gaps in current knowledge	3060
5.1 Risk scores developed for people without diabetes	3049	6.4.5. Recommendations on management of dyslipidaemia in diabetes	3061
5.2 Evaluation of cardiovascular risk in people with pre-diabetes	3050	6.5 Platelet function	3061
5.3 Risk engines developed for people with diabetes	3050	6.5.1. Aspirin	3061
5.4 Risk assessment based on biomarkers and imaging	3050	6.5.2. P2Y12 receptor blockers	3062
5.5 Gaps in knowledge	3050	6.5.3. Gaps in knowledge	3062
5.6 Recommendations for cardiovascular risk assessment in diabetes	3051	6.5.4. Recommendations for antiplatelet therapy in patients with diabetes	3062
6. Prevention of cardiovascular disease in patients with diabetes	3051	6.6 Multifactorial approaches	3062
6.1 Lifestyle	3051	6.6.1. Principles of multifactorial management	3062
6.1.1. Diet	3051	6.6.2. Gaps in knowledge	3064
6.1.2. Physical activity	3052	6.6.3. Recommendations for multifactorial risk management in diabetes	3064
6.1.3. Smoking	3052	7. Management of stable and unstable coronary artery disease in patients with diabetes	3064
6.1.4. Gaps in knowledge	3052	7.1 Optimal medical treatment for patients with chronic coronary artery disease and diabetes	3064
6.1.5. Recommendations on life style modifications in diabetes	3052		

7.1.1. Beta-adrenergic blockers	3064
7.1.2. Blockers of the renin-angiotensin-aldosterone system	3064
7.1.3. Lipid-lowering drugs	3065
7.1.4. Nitrates and calcium channel blockers	3065
7.1.5. Ivabradine	3065
7.1.6. Antiplatelet and antithrombotic drugs (see also Sections 6.5 and 7.2)	3065
7.1.7. Glucose control in acute coronary syndromes	3065
7.1.8. Gaps in knowledge	3066
7.1.9. Recommendations for the management of patients with stable and unstable coronary artery disease and diabetes	3066
7.2. Revascularization	3066
7.2.1. Myocardial revascularization in stable and unstable coronary artery disease	3067
7.2.2. Type of intervention: coronary bypass graft vs. percutaneous intervention	3067
7.2.3. Specific aspects of percutaneous and surgical revascularization in diabetes mellitus	3069
7.2.4. Myocardial revascularization and glucose-lowering treatments	3069
7.2.5. Gaps in knowledge	3069
7.2.6. Recommendations for coronary revascularization of patients with diabetes	3070
8. Heart failure and diabetes	3070
8.1. Prevalence and incidence of heart failure in type 2 diabetes mellitus, and type 2 diabetes mellitus in heart failure	3070
8.2. Diabetes mellitus and heart failure: morbidity and mortality	3071
8.3. Pharmacological management of heart failure in type 2 diabetes mellitus	3071
8.4. Non-pharmacological therapies for heart failure in diabetes mellitus	3072
8.5. Glucose-lowering treatment in patients with heart failure	3072
8.6. Gaps in knowledge	3073
8.7. Recommendations for management of heart failure in diabetes	3073
9. Arrhythmias: atrial fibrillation and sudden cardiac death	3073
9.1. Diabetes mellitus and atrial fibrillation	3073
9.2. Sudden cardiac death	3074
9.3. Gaps in knowledge	3075
9.4. Recommendations for the management of arrhythmias in patients with diabetes mellitus	3076
10. Peripheral- and cerebrovascular disease	3076
10.1. Peripheral artery disease	3076
10.2. Lower extremity artery disease	3076
10.3. Carotid artery disease	3079
10.4. Gaps in knowledge	3080
10.5. Recommendations for management of peripheral artery disease in diabetes	3080
11. Microvascular disease in the eyes and kidneys	3080
11.1. Pathophysiology of microvascular disease	3080
11.2. Treatment and treatment targets	3080
11.3. Gaps in knowledge	3081
11.4. Recommendations for management of microvascular disease in diabetes	3081
12. Patient-centred care	3082
12.1. General aspects	3082

12.2. Gaps in Knowledge	3082
12.3. Recommendations for patient-centred care in diabetes	3082
13. References	3083

Abbreviations and acronyms

2hPG	2-hour post-load plasma glucose
ABI	ankle–brachial index
ACCOMPLISH	Avoiding Cardiovascular Events through Combination Therapy in Patients Living with Systolic Hypertension
ACCORD	Action to Control Cardiovascular Risk in Diabetes
ACE-I	angiotensin converting enzyme inhibitor
ACS	acute coronary syndrome
ACTIVE	Atrial fibrillation Clopidogrel Trial with Irbesartan for prevention of Vascular Events
ACTIVE A	Atrial fibrillation Clopidogrel Trial with Irbesartan for prevention of Vascular Events Aspirin
ACTIVE W	Atrial fibrillation Clopidogrel Trial with Irbesartan for prevention of Vascular Events Warfarin
ADA	American Diabetes Association
ADDITION	Anglo-Danish-Dutch Study of Intensive Treatment in People with Screen Detected Diabetes in Primary Care
ADP	adenosine diphosphate
ADVANCE	Action in Diabetes and Vascular Disease: Preterax and Diamicon Modified Release Controlled Evaluation
AF	atrial fibrillation
AGEs	advanced glycation end-products
AIM-HIGH	Atherothrombosis Intervention in Metabolic Syndrome with Low HDL/High Triglycerides: Impact on Global Health Outcomes
ALTITUDE	Aliskiren Trial in Type 2 Diabetes Using Cardio-Renal Endpoints
Apo	apolipoprotein
ARB	angiotensin receptor blocker
ARIC	Atherosclerosis Risk In Communities
ARISTOTLE	Apixaban for Reduction in Stroke and Other Thromboembolic Events in Atrial Fibrillation
ASCOT	Anglo-Scandinavian Cardiac Outcomes Trial
ATLAS	Assessment of Treatment with Lisinopril And Survival
AVERROES	Apixaban VERSus acetylsalicylic acid to pRevent strOkES
AWESOME	Angina With Extremely Serious Operative Mortality Evaluation
BARI 2D	Bypass Angioplasty Revascularization Investigation 2 Diabetes
BEST	BEta blocker STroke trial
BMS	bare-metal stent
BP	blood pressure
CABG	coronary artery bypass graft surgery
CAC	coronary artery calcium

CAD	coronary artery disease	FREEDOM	Future REvascularization Evaluation in patients with Diabetes mellitus: Optimal management of Multivessel disease
CAN	cardiac autonomic neuropathy	GFR	glomerular filtration rate
CAPRIE	Clopidogrel vs. Aspirin in Patients at Risk of Ischaemic Events	GIK	glucose-insulin-potassium
CARDia	Coronary Artery Revascularization in Diabetes	GLP-1	glucagon-like peptide-1
CARDS	Collaborative Atorvastatin Diabetes Study	GLUT-4	glucose transporter 4
CETP	cholesterylester transfer protein	HAS-BLED	Hypertension, Abnormal renal/liver function (1 point each), Stroke, Bleeding history or predisposition, Labile INR, Elderly (>65), Drugs/ alcohol concomitantly (1 point each)
CHA ₂ DS ₂ -VASc	cardiac failure, hypertension, age ≥ 75 (doubled), diabetes, stroke (doubled)-vascular disease, age 65–74 and sex category (female)	HbA _{1c}	glycated haemoglobin A _{1c}
CHADS ₂	cardiac failure, hypertension, age, diabetes, stroke (doubled)	HDL	high-density lipoprotein
CHARISMA	Clopidogrel for High Atherothrombotic Risk and Ischaemic Stabilization, Management and Avoidance	HDL-C	high-density lipoprotein cholesterol
CHARM	Candesartan in Heart Failure Assessment of Reduction in Mortality and Morbidity	HI-5	Hyperglycaemia: Intensive Insulin Infusion in Infarction
CI	confidence interval	HOMA-IR	Homeostasis Model Assessment of Insulin Resistance
CIBIS	Cardiac Insufficiency Bisoprolol Study	HOPE	Heart Outcomes Prevention Evaluation
CLI	critical limb ischaemia	HOT	Hypertension Optimal Treatment
COMET	Carvedilol Or Metoprolol European Trial	HPS	Heart Protection Study
COPERNICUS	Carvedilol Prospective Randomized Cumulative Survival	HPS-2-THRIVE	Heart Protection Study 2 Treatment of HDL to Reduce the Incidence of Vascular Events
COX-1 and 2	cyclo-oxygenase 1 and 2	HR	hazard ratio
CTT	Cholesterol Treatment Trialists	HSP	hexosamine pathway
CVD	cardiovascular disease	IFG	impaired fasting glucose
DCCT	Diabetes Control and Complications Trial	IGT	impaired glucose tolerance
DECODE	Diabetes Epidemiology: COllaborative analysis of Diagnostic criteria in Europe	IMMEDIATE	Immediate Myocardial Metabolic Enhancement During Initial Assessment and Treatment in Emergency Care
DES	drug-eluting stent	IMPROVE-IT	IMProved Reduction of Outcomes: Vytorin Efficacy International Trial
DETECT-2	The Evaluation of Screening and Early Detection Strategies for T2DM and IGT	INR	international normalized ratio
DIABHYCAR	Hypertension, Microalbuminuria or Proteinuria, Cardiovascular Events and Ramipril	IR	insulin resistance
DIAMOND	Danish Investigations and Arrhythmia ON Dofetilide	IRS-1	insulin receptor substrate-1
DIG	Digitalis Investigation Group	ISAR-REACT	Intracoronary Stenting and Antithrombotic Regimen: Rapid Early Action for Coronary Treatment
DIGAMI	Diabetes and Insulin–Glucose Infusion in Acute Myocardial Infarction	ITA	internal thoracic artery
DIRECT	Diabetic Retinopathy Candesartan Trials	LDL	low-density lipoprotein
DM	diabetes mellitus	LDL-C	low-density lipoprotein cholesterol
DPP-4	dipeptidylpeptidase-4	LEAD	lower extremity artery disease
ECG	electrocardiogram	Lp a	lipoprotein a
EDIC	Epidemiology of Diabetes Interventions and Complications	LV	left ventricular
eNOS	endothelial nitric oxide synthase	LVEF	left ventricular ejection fraction
EPC	endothelial progenitor cells	MACCE	major adverse cardiac and cerebrovascular events
ERFC	Emerging Risk Factor Collaboration	MAIN	Revascularization for unprotected left main coronary artery stenosis: comparison of percutaneous
EUROASPIRE	European Action on Secondary Prevention through Intervention to Reduce Events	COMPARE	Metoprolol CR/XL Randomized Intervention Trial in Congestive Heart Failure
EUROPA	EUropean trial on Reduction Of cardiac events with Perindopril in stable coronary Artery disease	MERIT-HF	
FDA	Food and Drug Administration	MetS	metabolic syndrome
FFA	free fatty acid	MI	myocardial infarction
FIELD	Fenofibrate Intervention and Event Lowering in Diabetes	MRA	mineralocorticoid receptor antagonists
FINDRISC	FINnish Diabetes Risk Score	N-ER	niacin
FPG	fasting plasma glucose	NAPDH	nicotinamide adenine dinucleotide phosphate hydrogen
		NDR	National Diabetes Register
		NHANES	National Health and Nutrition Examination Survey

NICE	National Institute for Health and Clinical Excellence (UK)	SOLVD	Studies Of Left Ventricular Dysfunction
NNT	number needed to treat	STEMI	ST-elevation myocardial infarction
NO	nitric oxide	SYNTAX	SYNergy between percutaneous coronary intervention with TAXus and cardiac surgery
NOAC	new oral anticoagulants	T1DM	type 1 diabetes mellitus
NYHA	New York Heart Association	T2DM	type 2 diabetes mellitus
OAT	Occluded Artery Trial	TACTICS-TIMI 18	Treat angina with Aggrastat and determine Cost of Therapy with an Invasive or Conservative Strategy-Thrombolysis In Myocardial Infarction
OGTT	oral glucose tolerance test	TG	triglyceride
OMT	optimal medical treatment	TIA	transient ischaemic attack
ONTARGET	ONgoing Telmisartan Alone and in combination with Ramipril Global Endpoint Trial	tPA	tissue plasminogen activator
OR	odds ratio	TRL	triglyceride-rich lipoprotein
ORIGIN	Outcome Reduction with an Initial Glargine Intervention trial	UKPDS	United Kingdom Prospective Diabetes Study
PAD	peripheral artery disease	VADT	Veterans Administration Diabetes Trial
PAI-1	plasminogen activator inhibitor-1	VEGF	vascular endothelial growth factor
PCI	percutaneous coronary intervention	VKA	vitamin K antagonist
PG	plasma glucose	VLDL	very low-density lipoprotein
PI3K	phosphatidylinositol 3-kinases	WHO	World Health Organization
PKC	protein kinase C		
PLATO	PLATelet inhibition and patient Outcomes trial		
PPAR α	peroxisome proliferator-activated receptor alpha		
PPAR γ	peroxisome proliferator-activated receptor gamma		
PREDIMED	Primary Prevention of Cardiovascular Disease with a Mediterranean Diet		
PROActive	PROspective pioglitAzone Clinical Trial In macroVascular Events		
PROCAM	Prospective Cardiovascular Münster		
RAAS	renin-angiotensin-aldosterone system		
RAGE	receptor for advanced glycation end products		
RCT	randomized controlled trial		
RE-LY	Randomized Evaluation of the Long-term anti-coagulant therapy with dabigatran etexilate		
REGICOR	Myocardial Infarction Population Registry of Girona		
RESOLVE	Safety and Efficacy of Ranibizumab in Diabetic Macular Edema Study		
RESTORE	Ranibizumab monotherapy or combined with laser versus laser monotherapy for diabetic macular edema		
RIDE	Ranibizumab Injection in Subjects With Clinically Significant Macular Edema (ME) With Center Involvement Secondary to Diabetes Mellitus		
RISE	Ranibizumab Injection in Subjects With Clinically Significant Macular Edema (ME) With Center Involvement Secondary to Diabetes Mellitus		
ROCKET	Rivaroxaban Once Daily Oral Direct Factor Xa Inhibition, compared with Vitamin K Antagonism for Prevention of Stroke and Embolism Trial in Atrial Fibrillation		
ROS	reactive oxygen species		
RRR	relative risk reduction		
SCORE [®]	The European Systematic Coronary Risk Evaluation		
SGLT2	sodium–glucose co-transporter-2		
SHARP	Study of Heart and Renal Protection		
SMI	silent myocardial ischaemia		
SR-B	scavenger receptor B		

1. Preamble

This is the second iteration of the European Society of Cardiology (ESC) and European Association for the Study of Diabetes (EASD) joining forces to write guidelines on the management of diabetes mellitus (DM), pre-diabetes, and cardiovascular disease (CVD), designed to assist clinicians and other healthcare workers to make evidence-based management decisions. The growing awareness of the strong biological relationship between DM and CVD rightly prompted these two large organizations to collaborate to generate guidelines relevant to their joint interests, the first of which were published in 2007. Some assert that too many guidelines are being produced but, in this burgeoning field, five years in the development of both basic and clinical science is a long time and major trials have reported in this period, making it necessary to update the previous Guidelines.

The processes involved in generating these Guidelines have been previously described and can be found at <http://www.escardio.org/guidelines-surveys/esc-guidelines/about/Pages/rules-writing.aspx>. In brief, the EASD and the ESC appointed Chairs to represent each organization and to direct the activities of the Task Force. Its members were chosen for their particular areas of expertise relevant to different aspects of the guidelines, for their standing in the field, and to represent the diversity that characterizes modern Europe. Each member agreed to produce—and regularly update—conflicts of interest, the details of which are held at the European Heart House and available at the following web address: <http://www.escardio.org/guidelines>. Members of the Task Force generally prepared their contributions in pairs and the ESC recommendations for the development of guidelines were followed, using the standard classes of recommendation, shown below, to provide consistency to the committee's recommendations (Tables 1 and 2).

Initial editing and review of the manuscripts took place at the Task Force meetings, with systematic review and comments provided by the ESC Committee for Practice Guidelines and the EASD Panel for Overseeing Guidelines and Statements.

These Guidelines are the product of countless hours of hard work, time given freely and without complaint by the Task Force members,

Table I Classes of recommendations

Classes of recommendations	Definition	Suggested wording to use
Class I	Evidence and/or general agreement that a given treatment or procedure is beneficial, useful, effective.	Is recommended/is indicated
Class II	Conflicting evidence and/or a divergence of opinion about the usefulness/efficacy of the given treatment or procedure.	
Class IIa	Weight of evidence/opinion is in favour of usefulness/efficacy.	Should be considered
Class IIb	Usefulness/efficacy is less well established by evidence/opinion.	May be considered
Class III	Evidence or general agreement that the given treatment or procedure is not useful/effective, and in some cases may be harmful.	Is not recommended

Table 2 Levels of evidence

Level of evidence A	Data derived from multiple randomized clinical trials or meta-analyses.
Level of evidence B	Data derived from a single randomized clinical trial or large non-randomized studies.
Level of evidence C	Consensus of opinion of the experts and/or small studies, retrospective studies, registries.

administrative staff and by the referees and supervisory committees of the two organizations. It is our hope that this huge effort has generated guidelines that will provide a greater understanding of the relationship between these two complex conditions and an accessible and useful adjunct to the clinical decision-making process that will help to provide further clarity and improvements in management.

The task of developing Guidelines covers not only the integration of the most recent research, but also the creation of educational tools and implementation programmes for the recommendations.

To implement the Guidelines, condensed pocket guidelines, summary slides, booklets with essential messages and an electronic version for digital applications (smartphones, etc.) are produced. These versions are abridged; thus, if needed, one should always refer to the full text version, which is freely available on the ESC website.

2. Introduction

The increasing prevalence of DM worldwide has led to a situation where approximately 360 million people had DM in 2011, of whom more than 95% would have had type 2 DM (T2DM). This number is estimated to increase to 552 million by 2030 and it is thought that about half of those will be unaware of their diagnosis. In addition, it is

estimated that another 300 million individuals had features indicating future risk of developing T2DM, including fasting hyperglycaemia, impaired glucose tolerance (IGT), gestational DM and euglycaemic insulin resistance (IR).¹ The majority of new cases of T2DM occur in the context of westernized lifestyles, high-fat diets and decreased exercise, leading to increasing levels of obesity, IR, compensatory hyperinsulinaemia and, ultimately, beta-cell failure and T2DM. The clustering of vascular risk seen in association with IR, often referred to as the metabolic syndrome, has led to the view that cardiovascular risk appears early, prior to the development of T2DM, whilst the strong relationship between hyperglycaemia and microvascular disease (retinopathy, nephropathy, neuropathy) indicates that this risk is not apparent until frank hyperglycaemia appears. These concepts highlight the progressive nature of both T2DM and associated cardiovascular risk, which pose specific challenges at different stages of the life of an individual with DM. The effects of advancing age, co-morbidities and problems associated with specific groups all indicate the need to manage risk in an individualized manner, empowering the patient to take a major role in the management of his or her condition.

As the world in general—and Europe in particular—changes in response to demographic and cultural shifts in societies, so the patterns of disease and their implications vary. The Middle East, the Asia-Pacific rim and parts of both North and South America have experienced massive increases in the prevalence of DM over the past 20 years, changes mirrored in European populations over the same period. Awareness of specific issues associated with gender and race and, particularly, the effects of DM in women—including epigenetics and *in utero* influences on non-communicable diseases—are becoming of major importance. In 2011 approximately 60 million adult Europeans were thought to have DM, half of them diagnosed, and the effects of this condition on the cardiovascular health of the individual and their offspring provide further public health challenges that agencies are attempting to address worldwide.

DM and CVD develop in concert with metabolic abnormalities mirroring and causing changes in the vasculature. More than half the mortality and a vast amount of morbidity in people with DM is

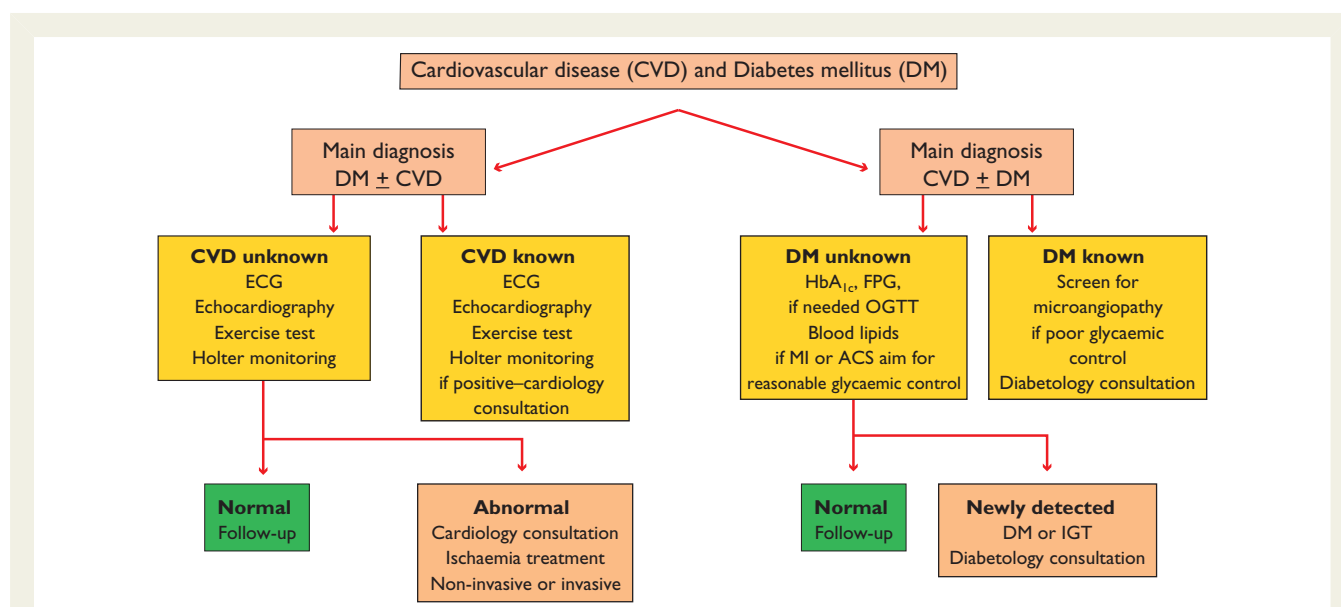


Figure 1 Investigational algorithm outlining the principles for the diagnosis and management of cardiovascular disease (CVD) in diabetes mellitus (DM) patients with a primary diagnosis of DM or a primary diagnosis of CVD. The recommended investigations should be considered according to individual needs and clinical judgement and are not meant as a general recommendation to be undertaken by all patients. ACS = acute coronary syndrome; ECG = electrocardiogram; FPG = fasting plasma glucose; HbA_{1c} = glycated haemoglobin A_{1c}; IGT = impaired glucose tolerance; MI = myocardial infarction; OGTT = oral glucose tolerance test.

related to CVD, which caused physicians in the fields of DM and cardiovascular medicine to join forces to research and manage these conditions (Figure 1). At the same time, this has encouraged organizations such as the ESC and EASD to work together and these guidelines are a reflection of that powerful collaboration.

The emphasis in these Guidelines is to provide information on the current state of the art in how to prevent and manage the diverse problems associated with the effects of DM on the heart and vasculature in a holistic manner. In describing the mechanisms of disease, we hope to provide an educational tool and, in describing the latest management approaches, an algorithm for achieving the best care for patients in an individualized setting. It should be noted that these guidelines are written for the management of the combination of CVD (or risk of CVD) and DM, not as a separate guideline for each condition. This is important considering that those who, in their daily practice, manage these patients frequently have their main expertise in either DM or CVD or general practice. If there is a demand for a more intricate analysis of specific issues discussed in the present Guidelines, further information may be derived from detailed guidelines issued by various professional organizations such as ESC, the European Atherosclerosis Society and EASD, e.g. on acute coronary care, coronary interventions, hyperlipidaemia or glucose lowering therapy, to mention only a few.

It has been a privilege for the Chairs to have been trusted with the opportunity to develop these guidelines whilst working with some of the most widely acknowledged experts in this field. We want to extend our thanks to all members of the Task Force who gave so much of their time and knowledge, to the referees who contributed a great deal to the final manuscript, and to members of the ESC and EASD committees that oversaw this project. Finally, we express our thanks to the guidelines team at the European Heart House, in particular Catherine Després, Veronica Dean and Nathalie Cameron, for their support in making this process run smoothly.

Stockholm and Leeds, April 2014

Lars Ryden Peter Grant

3. Abnormalities of glucose metabolism and cardiovascular disease

3.1 Definition, classification and diagnosis

DM is a condition defined by an elevated level of blood glucose. The classification of DM is based on recommendations from the World Health Organization (WHO) and the American Diabetes Association (ADA).^{2–6} Glycated haemoglobin A_{1c} (HbA_{1c}) has been recommended as a diagnostic test for DM,^{7,8} but there remain concerns regarding its sensitivity in predicting DM and HbA_{1c} values <6.5% do not exclude DM that may be detected by blood glucose measurement,^{7–10} as further discussed in Section 3.3. Four main aetiological categories of DM have been identified: type 1 diabetes (T1DM), T2DM, 'other specific types' of DM and 'gestational DM' (Table 3).²

Type 1 diabetes is characterized by deficiency of insulin due to destruction of pancreatic beta-cells, progressing to absolute insulin deficiency. Typically, T1DM occurs in young, slim individuals presenting with polyuria, thirst and weight loss, with a propensity to ketosis. However, T1DM may occur at any age,¹¹ sometimes with slow progression. In the latter condition, latent auto-immune DM in adults (LADA), insulin dependence develops over a few years. People who have auto-antibodies to pancreatic beta-cell proteins, such as glutamic-acid-decarboxylase, protein tyrosine phosphatase, insulin or zinc transporter protein, are likely to develop either acute-onset or slowly progressive insulin dependence.^{12,13} Auto-antibodies targeting pancreatic beta-cells are a marker of T1DM, although they

Table 3 Comparison of 2006 World Health Organization (WHO) and 2003/2011 and 2012 American Diabetes Association (ADA) diagnostic criteria

Diagnose/ measurement	WHO 2006 ³ /2011 ⁷	ADA 2003 and 2012 ^{5,6}
Diabetes		
HbA _{1c}	Can be used If measured ≥6.5% (48 mmol/mol) Recommended	Recommended ≥6.5% (48 mmol/mol)
FPG	≥7.0 mmol/L (≥126 mg/dL)	≥7.0 mmol/L (≥126 mg/dL)
2hPG	or ≥11.1 mmol/L (≥200 mg/dL)	or ≥11.1 mmol/L (≥200 mg/dL)
IGT		
FPG	<7.0 mmol/L (<126 mg/dL)	<7.0 mmol/L (<126 mg/dL)
2hPG	≥7.8–<11.1 mmol/L (≥140–<200 mg/dL)	Not required If measured 7.8–11.0 mmol/L (140–198 mg/dL)
IFG		
FPG	6.1–6.9 mmol/L (110–125 mg/dL)	5.6–6.9 mmol/L (100–125 mg/dL)
2hPG	If measured <7.8 mmol/L (<140 mg/dL)	--

FPG = fasting plasma glucose; IGT = impaired glucose tolerance; IFG = impaired fasting glucose; 2hPG = 2-h post-load plasma glucose.

are **not detectable in all patients and decrease with age**, compared with other ethnicities and geographic regions, T1DM is more common in Caucasian individuals.¹⁴

Type 2 diabetes is **characterized by a combination of IR and beta-cell failure**, in association with obesity (typically with an abdominal distribution) and sedentary lifestyle—major risk factors for T2DM. Insulin resistance and an impaired first-phase insulin secretion causing post-prandial hyperglycaemia characterize the early stage of T2DM. This is followed by a deteriorating second-phase insulin response and persistent hyperglycaemia in the fasting state.^{15,16} **T2DM typically develops after middle age and comprises over 90% of adults with DM**. However, with increasing obesity in the young and in non-Europid populations, there is a trend towards a decreasing age of onset.

Gestational diabetes develops during pregnancy. **After delivery, most return to a euglycaemic state, but they are at increased risk for overt T2DM in the future**. A meta-analysis reported that subsequent progression to DM is considerably increased after gestational DM.¹⁷ A large Canadian study found that the probability of DM developing after gestational DM was 4% at 9 months and 19% at 9 years after delivery.¹⁸

Other specific types of diabetes include: (i) single **genetic mutations** that lead to rare forms of DM such as maturity-onset DM of the young; (ii) **DM secondary to other pathological conditions or diseases** (pancreatitis, trauma or surgery of the pancreas) and (iii) **drug- or chemically induced DM**.

Disorders of glucose metabolism, impaired fasting glucose (IFG) and IGT, often referred to as 'pre-diabetes', reflect the natural history of progression from normoglycaemia to T2DM. It is common for such individuals to oscillate between different glycaemic states, as can be expected when the continuous variable PG is dichotomized. **IGT can only be recognized by the results of an oral glucose tolerance test (OGTT): 2-hour post-load plasma glucose (2hPG) ≥7.8 and <11.1 mmol/L (≥140 and <200 mg/dL)**. A standardized **OGTT is performed in the morning after an overnight fast (8–14 h)**. One blood sample should be taken before and one 120 min after intake,

Table 4 Cut-points for diagnosing DM, impaired glucose tolerance, and impaired fasting glucose based on other blood specimens than the recommended standard, venous plasma

Diagnosis	Venous plasma ^a mmol/L (mg/dL)	Venous blood mmol/L (mg/dL)	Capillary blood mmol/L (mg/dL)
IFG–FG	6.1 (110)	5.0 (90)	5.6 (101)
IGT–2hG	7.8 (140)	6.5 (117)	7.2 (130)
Diabetes–FG	7.0 (126)	5.8 (104)	6.5 (117)
Diabetes–2hG	11.1 (200)	9.4 (169)	10.3 (185)

FPG = fasting plasma glucose; FG = Fasting Glucose; IFG = impaired fasting glucose; IGT = impaired glucose tolerance; 2hG = 2-h post-load glucose; 2hPG = 2-h post-load plasma glucose.

^aStandard.

over 5 min, **of 75 g glucose dissolved in 250–300 mL water** (note that the timing of the test begins when the patient starts to drink).

Current clinical criteria issued by the World Health organization and American Diabetes Association.^{3,8} **The WHO criteria are based on fasting plasma glucose (FPG) and 2hPG concentrations**. They recommend use of an OGTT in the absence of overt hyperglycaemia.³ **The ADA criteria encourage the use of HbA_{1c}, fasting glycaemia and OGTT, in that order**.⁸ The argument for FPG or HbA_{1c} over 2hPG is primarily related to feasibility. **The advantages and disadvantages of using glucose testing and HbA_{1c} testing are summarized in a WHO report from 2011,⁷ and are still the subject of some debate** (see Section 3.3). The diagnostic criteria adopted by WHO and ADA (Table 3) for the intermediate levels of hyperglycaemia are similar for IGT but differ for IFG. **The ADA lower threshold for IFG is 5.6 mmol/L (101 mg/dL),⁸ while WHO recommends the original cut-off point of 6.1 mmol/L (110 mg/dL).**³

To standardize glucose determinations, venous plasma measures have been recommended.^{3,8} **Measurements based on venous whole blood tend to give results 0.5 mmol/L (9 mg/dL) lower than plasma values.** Since capillary blood is often used for point-of-care testing, it is important to underline that capillary values may differ from plasma values more in the post-load than in the fasting state. Therefore, a recent comparative study suggests that the cut-off points for DM, IFG and IGT differ when venous blood and capillary blood are used as outlined in Table 4.¹⁹

Classification depends on whether only FPG is measured or if it is combined with 2hPG. An individual with IFG in the fasting state may have IGT or even DM if investigated with an OGTT. **A normal FPG reflects an ability to maintain adequate basal insulin secretion,** in combination with hepatic insulin sensitivity sufficient to control hepatic glucose output. A post-load glucose level within the normal range requires an appropriate insulin secretory response and adequate insulin sensitivity in peripheral tissues. It is important to pay attention to the analytical method when interpreting samples. This applies to both glucose and HbA_{1c} determinations.

3.2 Epidemiology

The International Diabetes Federation's global estimates for 2011 (Table 5) suggest that 52 million Europeans aged 20–79 years have DM and that this number will increase to over 64 million by 2030.¹ In 2011, 63 million Europeans had IGT. A total of 281 million men and 317 million women worldwide died with DM in 2011, most from CVD. The healthcare expenditure for DM in Europe was about 75 billion Euros in 2011 and is projected to increase to 90 billion by 2030.

A problem when diagnosing T2DM is the lack of a unique biological marker—besides post-prandial plasma glucose (PG)—that would

separate IFG, IGT, or T2DM from normal glucose metabolism. T2DM develops following a prolonged period of euglycaemic IR, which progresses with the development of beta-cell failure to frank DM with increased risk of vascular complications. The present definition of DM is based on the level of glucose at which retinopathy occurs, but macrovascular complications such as coronary, cerebrovascular and peripheral artery disease (PAD) appear earlier and, using current glycaemic criteria, are often present at the time when T2DM is diagnosed. Over 60% of people with T2DM develop CVD, a more severe and costly complication than retinopathy. Thus, CVD risk should be given a higher priority when cut-points for hyperglycaemia are defined and should be re-evaluated based on the CVD risk.

The Diabetes Epidemiology: Collaborative analysis of Diagnostic criteria in Europe (DECODE) study (Figure 2) reported data on disorders of glucose metabolism in European populations.²⁰ The limited data on HbA_{1c} in these populations indicate major discrepancies, compared with results from an OGTT,²¹ although this was not confirmed in the Evaluation of Screening and Early Detection Strategies for T2DM and IGT (DETECT-2) as further elaborated upon in Section 3.3.²² In Europeans, the prevalence of DM rises with age in both genders. Thus <10% of people below 60 years, 10–20% between 60 and 69 years and 15–20% above 70 years have previously known DM and in addition similar proportions have screen-detected asymptomatic DM.²⁰ This means that the lifetime risk for DM is 30–40% in European populations. Similarly, the prevalence of IGT increases linearly from about 15% in middle aged to 35–40% in elderly Europeans. Even HbA_{1c} increases with age in both genders.²³

3.3 Screening for disorders of glucose metabolism

Type 2 diabetes mellitus does not cause specific symptoms for many years, which explains why approximately half of the cases of T2DM

Table 5 Burden of DM in Europe in 2011 and predictions for 2030¹

Variable	2011	2030
Total population (millions)	896	927
Adults (20–79 years; millions)	651	670
DM (20–79 years)		
European prevalence (%)	8.1	9.5
Number with DM (millions)	52.6	64.0
IGT (20–79 years)		
Regional prevalence (%)	9.6	10.6
Number with IGT (millions)	62.8	71.3
Type 1 DM in children (0–14 years)		
Number with type 1 DM (thousands)	115.7	–
Number newly diagnosed/year (thousands)	17.8	–
DM mortality (20–79 years)		
Number of deaths; men (thousands)	281.3	–
Number of deaths; women (thousands)	316.5	–
Healthcare expenditure due to DM (20–79 years, Europe)		
Total expenditure (billions of €)	75.1	90.2

DM = diabetes mellitus; IGT = impaired glucose tolerance.

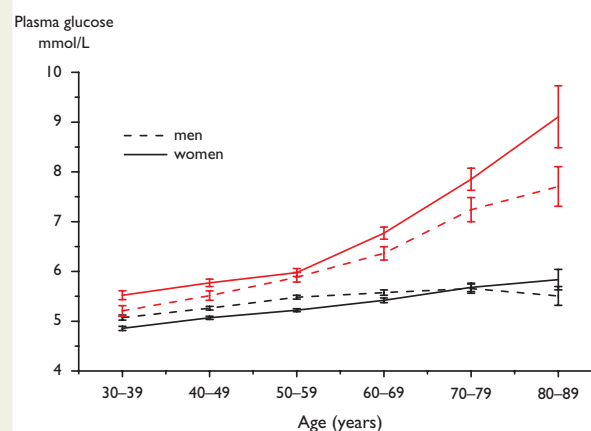


Figure 2 Mean FPG fasting (two lower lines) and 2hPG (two upper lines) concentrations (95% confidence intervals shown by vertical bars) in 13 European population-based cohorts included in the DECODE study.²⁰ Mean 2hPG increases particularly after the age of 50 years. Women have significantly higher mean 2hPG concentrations than men, a difference that becomes more pronounced above the age of 70 years. Mean FPG increases only slightly with age. FPG = fasting plasma glucose; 2hPG = 2-h post-load plasma glucose.

remain undiagnosed at any time.^{20,23} Population testing of blood glucose to determine CV risk is not recommended, due to the lack of affirmative evidence that the prognosis of CVD related to T2DM can be improved by early detection and treatment.^{24,25} Screening of hyperglycaemia for CV risk purposes should therefore be targeted to high-risk individuals. The Anglo-Danish-Dutch Study of Intensive Treatment in People with Screen Detected Diabetes in Primary Care (ADDITION) study provided evidence that the risk of CVD events is low in screen-detected people with T2DM. Screening may, however, facilitate CV risk reduction and early detection may benefit progression of microvascular disease, which may make screening for T2DM beneficial.²⁶ In addition, there is an interest in identifying people with IGT, since most will progress to T2DM and this progression can be retarded by lifestyle interventions.^{27–31} The diagnosis of DM has traditionally been based on the level of blood glucose that relates to a risk of developing micro- rather than macrovascular disease. The DETECT-2 study analysed results from 44 000 persons in nine studies across five countries.²² It was concluded that a HbA_{1c} of >6.5% (48 mmol/L) and an FPG of >6.5 mmol/L (117 mg/dL) together gave a better discrimination in relation to the view—adopted by the ADA⁶ and WHO⁷—that, **for general population, screening an HbA_{1c} >6.5% is diagnostic of DM, but between 6.0–6.5%, an FPG needs to be measured to establish a diagnosis.** Caveats exist in relation to this position, as extensively reviewed by Hare et al.³² Problems exist in relation to pregnancy, polycystic ovary syndrome,³³ haemoglobinopathies and acute illness mitigating against its use under such circumstances. Moreover, **the probability of a false negative test result, compared with the OGTT, is substantial when attempting to detect DM by measuring only FPG and/or HbA_{1c} in an Asian population.**³⁴ A study in Spanish people with high risk, i.e. >12/26 points in the FINnish Diabetes Risk Score (FINDRISC) study, revealed that 8.6% had undiagnosed T2DM by the OGTT, whilst only 1.4% had an HbA_{1c} >6.5%, indicating a further need to evaluate the use of HbA_{1c} as the primary diagnostic test in specific populations.⁹ There remains controversy regarding the approach of using HbA_{1c} for detecting undiagnosed DM in the setting of coronary heart disease and CV risk management,^{7–10,32} although advocates argue that HbA_{1c} in the range 6.0–6.5% requires lifestyle advice and individual risk factor management alone, and that further information on 2hPG does not alter such management.

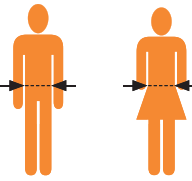
The approaches for early detection of T2DM and other disorders of glucose metabolism are: (i) **measuring PG or HbA_{1c}** to explicitly determine prevalent T2DM and impaired glucose regulation; (ii) using demographic and clinical characteristics and previous laboratory tests to determine the likelihood for T2DM and (iii) collecting questionnaire-based information that provides information on the presence of aetiological risk factors for T2DM. The last two approaches leave the current glycaemic state ambiguous and glycaemia testing is necessary in all three approaches, to accurately define whether T2DM and other disorders of glucose metabolism exist. However, the results from such a simple first-level screening can markedly reduce the numbers who need to be referred for further testing of glycaemia and other CVD risk factors. Option two is particularly suited to those with pre-existing CVD and women with previous gestational DM, while the third option is better suited to the general population and also for overweight/obese people.

Several DM risk scores for DM have been developed. Most perform well and it does not matter which one is used, as underlined

Type 2 diabetes risk assessment form

Circle the right alternative and add up your points.

<p>1. Age</p> <p>0 p. Under 45 years 2 p. 45–54 years 3 p. 55–64 years 4 p. Over 64 years</p> <p>2. Body mass Index</p> <p>0 p. Lower than 25 kg/m² 1 p. 25–30 kg/m² 3 p. Higher than 30 kg/m²</p> <p>3. Waist circumference measured below the ribs (usually at the level of the navel)</p> <table border="0"> <thead> <tr> <th>MEN</th> <th>WOMEN</th> </tr> </thead> <tbody> <tr> <td>0 p. Less than 94 cm</td> <td>Less than 80 cm</td> </tr> <tr> <td>3 p. 94–102 cm</td> <td>80–88 cm</td> </tr> <tr> <td>4 p. More than 102 cm</td> <td>More than 88 cm</td> </tr> </tbody> </table> <p>4. Do you usually have daily at least 30 min of physical activity at work and/or during leisure time (including normal daily activity)?</p> <p>0 p. Yes 2 p. No</p> <p>5. How often do you eat vegetables, fruit, or berries?</p> <p>0 p. Every day 1 p. Not every day</p>	MEN	WOMEN	0 p. Less than 94 cm	Less than 80 cm	3 p. 94–102 cm	80–88 cm	4 p. More than 102 cm	More than 88 cm	<p>6. Have you ever taken anti-hypertensive medication regularly?</p> <p>0 p. No 2 p. Yes</p> <p>7. Have you ever been found to have high blood glucose (e.g. in a health examination, during an illness, during pregnancy)?</p> <p>0 p. No 5 p. Yes</p> <p>8. Have any of the members of your immediate family or other relatives been diagnosed with diabetes (type 1 or type 2)?</p> <p>0 p. No 3 p. Yes: grandparent, aunt, uncle, or first cousin (but no own parent, brother, sister or child) 5 p. Yes: parent, brother, sister, or own child</p>
MEN	WOMEN								
0 p. Less than 94 cm	Less than 80 cm								
3 p. 94–102 cm	80–88 cm								
4 p. More than 102 cm	More than 88 cm								



Total risk score

☐ The risk of developing type 2 diabetes within 10 years is

Lower than 7	Low: estimated 1 in 100 will develop disease
7–11	Slightly elevated: estimated 1 in 25 will develop disease
12–14	Moderate: estimated 1 in 6 will develop disease
15–20	High: estimated 1 in 3 will develop disease
Higher than 20	Very High: estimated 1 in 2 will develop disease

Test designed by Professor Jaakko Tuomilehto, Department of Public Health, University of Helsinki, and Dr Jaana Lindström, MFS, National Public Health Institute.

Figure 3 FINnish Diabetes Risk Score (FINDRISC) to assess the 10-year risk of type 2 diabetes in adults. (Modified from Lindström et al.³⁶ available at: www.diabetes.fi/english).

by a recent systematic review.³⁵ The FINnish Diabetes Risk Score (www.diabetes.fi/english) is the most commonly used to screen for DM risk in Europe (Figure 3).

This tool, available in almost all European languages, predicts the 10-year risk of T2DM—including asymptomatic DM and IGT—with 85% accuracy.^{36,37} It has been validated in most European populations. It is necessary to separate individuals into three different scenarios: (i) the general population; (ii) people with assumed abnormalities (e.g. obese, hypertensive, or with a family history of DM) and (iii) patients with prevalent CVD. In the general population and people with assumed abnormalities, the appropriate screening strategy is to start with a DM risk score and to investigate individuals with a high value with an OGTT or a combination of HbA_{1c} and FPG.^{36,37} In CVD patients, no diabetes risk score is needed but an OGTT is indicated if HbA_{1c} and/or FPG are inconclusive, since people belonging to these groups may often have DM revealed only by an elevated 2hPG.^{38–41}

3.4 Disorders of glucose metabolism and cardiovascular disease

Both undiagnosed T2DM and other disorders of glucose metabolism are risk factors for CVD. The most convincing evidence for such relationship was provided by the collaborative DECODE study, analysing several European cohort studies with baseline OGTT data.^{42–44} **Increased mortality was observed in people with DM and IGT, identified by 2hPG, but not in people with IFG.** A high 2hPG predicted all-cause and CVD mortality after adjustment for other major

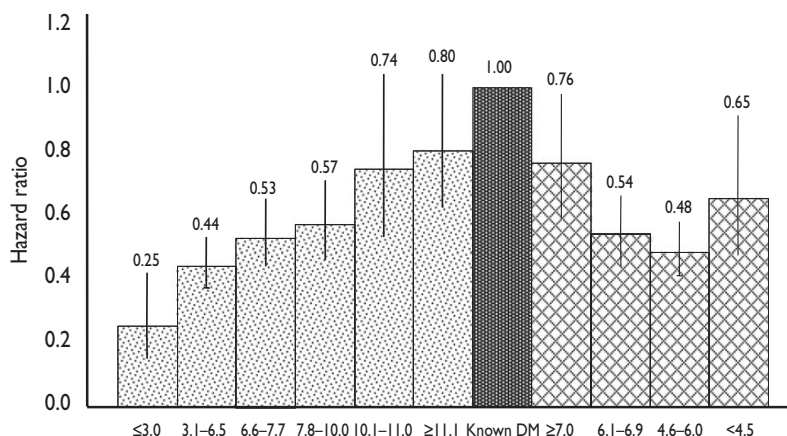


Figure 4 Hazard ratios and 95% confidence intervals (vertical bars) for CVD mortality for FPG (hatched bars) and 2hPG (dotted bars) intervals using previously diagnosed DM (dark bar) as the common reference category. Data are adjusted for age, sex, cohort, body mass index, systolic blood pressure, total cholesterol, and smoking. (Adapted from refs.^{42,43}).

CVD = cardiovascular disease; DM = diabetes mellitus; FPG = fasting plasma glucose; 2hPG = 2-h post-load plasma glucose.

Table 6 Prevention of T2DM by lifestyle intervention – the evidence

Study	Intervention	Patients (n)	Follow-up (years)	RRR ^a (%)
Da-Qing Study China ⁶²	Diet	130	6	31
	Exercise	141		46
	Diet + exercise	126		42
	Control	133		
Diabetes Prevention Study Finland ²⁷	Diet + physical activity	265	3.2	58
	Control	257		
US Diabetes Prevention Program Outcomes Study USA ²⁸	Diet + physical activity	1079	2.8	58
	Metformin	1073		31
	Placebo	1082		
Indian Diabetes Prevention Program India ³¹	Lifestyle	133	2.5	29
	Metformin	133		26
	Lifestyle + metformin	129		28
	Control	136		
Japanese trial in men with IGT Japan ⁶⁶	Diet + exercise	102	4	67
	Control	356		
Study on lifestyle-intervention and IGT Maastricht study The Netherlands ²⁹	Diet + physical activity	74	3	58
	Control	73		
European Diabetes Prevention Study Newcastle, UK ³⁰	Diet + physical activity	51	3.1	55
	Control	51		
Zensharen ^b Study Japan ³¹	Diet + physical activity	330	3	44
	Control	311		

IGT = impaired glucose tolerance; RRR = relative risk reduction; SLIM = Study on lifestyle-intervention and IGT Maastricht.

^aAbsolute risk reduction numbers would have added value but could not be reported since such information is lacking in several of the studies.

^bThe Zensharen study recruited people with IFG, while other studies recruited people with IGT.

cardiovascular risk factors, while a high FPG alone was not predictive once 2hPG was taken into account. The highest excess CVD mortality in the population was observed in people with IGT, especially those with normal FPG.⁴⁴ The relationship between 2hPG and

mortality was linear, but this relationship was not observed with FPG (Figure 4).

Several studies have shown that increasing HbA_{1c} is associated with increasing CVD risk.^{45–47} Studies that compared all three

glycaemic parameters—FPG, 2hPG and HbA_{1c}—simultaneously for mortality and CVD risk revealed that the association is strongest for 2hPG and that the risk observed with FPG and HbA_{1c} is no longer significant after controlling for the effect of 2hPG.^{48,49}

Women with newly diagnosed T2DM have a higher relative risk for CVD mortality than their male counterparts.^{20,50–52} A review on the impact of gender on the occurrence of coronary artery disease (CAD) mortality reported that the overall relative risk (the ratio of risk in women to risk in men) was 1.46 (95% CI 1.21–1.95) in people with DM and 2.29 (95% CI 2.05–2.55) in those without, suggesting that the well-known gender differential in CAD is reduced in DM.⁵³ A meta-analysis of 37 prospective cohort studies (*n* = 447 064 DM patients) aimed at estimating sex-related risk of fatal CAD, reported higher mortality in patients with DM than those without (5.4 vs. 1.6%, respectively).⁵⁴ The relative risk, or hazard ratio (HR), among people with and without DM was significantly greater among women (HR 3.50; 95% CI 2.70–4.53) than in men (HR 2.06; 95% CI 1.81–2.34). Thus the gender difference in CVD risk seen in the general population is much smaller in people with DM and the reason for this is still unclear. A recent British study revealed a greater adverse influence of DM *per se* on adiposity, Homeostasis Model Assessment of Insulin Resistance (HOMA-IR) and downstream blood pressure, lipids, endothelial dysfunction and systemic inflammation in women, compared with men, which may contribute to their greater relative risk of CAD.⁵⁵ Also, it seems that, compared with men, women have to put on more weight—and therefore undergo bigger changes in their risk factor status—to develop DM.⁵⁶

3.5 Delaying conversion to type 2 diabetes mellitus

Unhealthy dietary habits and a sedentary lifestyle are of major importance in the development of T2DM.^{57,58} As reviewed in the European evidence-based guideline for the prevention of T2DM,⁵⁹ randomized clinical trials (RCTs) demonstrate that lifestyle modification, based on modest weight loss and increased physical activity, prevents or delays progression in high-risk individuals with IGT. Thus, those at high risk for T2DM and those with established IGT should be given appropriate lifestyle counselling (Table 6). A tool kit, including practical advice for healthcare personnel, has recently been developed.⁶⁰ The seemingly lower risk reduction in the Indian and Chinese trials was due to the higher incidence of T2DM in these populations and the absolute risk reductions were strikingly similar between all trials: approximately 15–20 cases per 100 person-years. It was estimated that lifestyle intervention has to be provided to 6.4 high-risk individuals for an average of 3 years to prevent one case of DM. Thus the intervention is highly efficient.³¹ A 12-year follow-up of men with IGT who participated in the Malmö Feasibility Study⁶¹ revealed that all-cause mortality among men in the former lifestyle intervention group was lower (and similar to that in men with normal glucose tolerance) than that among men who had received ‘routine care’ (6.5 vs. 14.0 per 1000 person years; *P* = 0.009). Participants with IGT in the 6-year lifestyle intervention group in the Chinese Da Qing study had, 20 years later, a persistent reduction in the incidence of T2DM and a non-significant reduction of 17% in CVD death, compared with control participants.⁶² Moreover, the adjusted incidence of

severe retinopathy was 47% lower in the intervention than in the control group, which was interpreted as being related to the reduced incidence of T2DM.⁶³ During an extended 7-year follow-up of the Finnish DPS study,²⁷ there was a marked and sustained reduction in the incidence of T2DM in people who had participated in the lifestyle intervention (for an average of 4 years). In the 10-year follow-up, total mortality and CVD incidence were not different between the intervention and control groups but the DPS participants, who had IGT at baseline, had lower all-cause mortality and CVD incidence, compared with a Finnish population-based cohort of people with IGT.⁶⁴ During the 10-year overall follow-up of the US Diabetes Prevention Programme Outcomes Study, the incidence of T2DM in the original lifestyle intervention group remained lower than in the control group.⁶⁵

3.6 Recommendations for diagnosis of disorders of glucose metabolism

Diagnosis of disorders of glucose metabolism			
Recommendations	Class ^a	Level ^b	Ref. ^c
It is recommended that the diagnosis of diabetes is based on HbA _{1c} and FPG combined or on an OGTT if still in doubt.	I	B	2–5, 8, 10
It is recommended that an OGTT is used for diagnosing IGT.	I	B	2–5, 8, 10
It is recommended that screening for potential T2DM in people with CVD is initiated with HbA _{1c} and FPG and that an OGTT is added if HbA _{1c} and FPG are inconclusive.	I	A	36–41
Special attention should be considered to the application of preventive measures in women with disorders of glucose metabolism.	IIa	C	-
It is recommended that people at high risk for T2DM receive appropriate lifestyle counselling to reduce their risk of developing DM.	I	A	59, 60

CVD = cardiovascular disease; DM = diabetes mellitus; FPG = fasting plasma glucose; HbA_{1c} = glycated haemoglobin A_{1c}; IGT = impaired glucose tolerance; OGTT = oral glucose tolerance test; T2DM = type 2 diabetes mellitus.

^aClass of recommendation.

^bLevel of evidence.

^cReference(s) supporting levels of evidence.

4. Molecular basis of cardiovascular disease in diabetes mellitus

4.1 The cardiovascular continuum in diabetes mellitus

Type 2 diabetes mellitus is characterized by a state of long-standing IR, compensatory hyperinsulinaemia and varying degrees of elevated

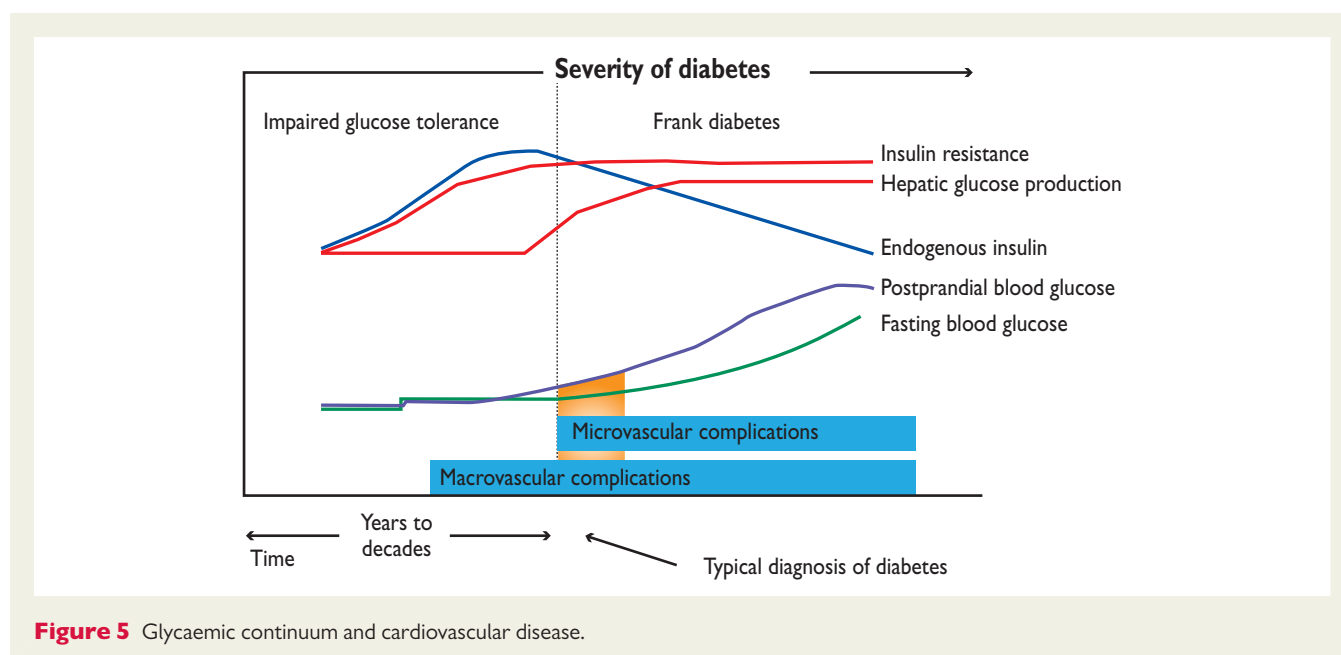


Figure 5 Glycaemic continuum and cardiovascular disease.

PG, associated with clustering of cardiovascular risk and the development of macrovascular disease prior to diagnosis (Figure 5). The early glucometabolic impairment is characterized by a progressive decrease in insulin sensitivity and increased glucose levels that remain below the threshold for a diagnosis of T2DM, a state known as IGT.

The pathophysiological mechanisms supporting the concept of a 'glycaemic continuum' across the spectrum of IFG, IGT, DM and CVD will be addressed in the following sections. The development

of CVD in people with IR is a progressive process, characterized by early endothelial dysfunction and vascular inflammation leading to monocyte recruitment, foam cell formation and subsequent development of fatty streaks. Over many years, this leads to atherosclerotic plaques, which, in the presence of enhanced inflammatory content, become unstable and rupture to promote occlusive thrombus formation. Atheroma from people with DM has more lipid, inflammatory changes and thrombus than those free from DM. These changes occur over a 20–30 year period and are mirrored by the molecular abnormalities seen in untreated IR and T2DM.

4.2 Pathophysiology of insulin resistance in type 2 diabetes mellitus

Insulin resistance has an important role in the pathophysiology of T2DM and CVD and both genetic and environmental factors facilitate its development. More than 90% of people with

T2DM are obese,⁶⁷ and the release of free fatty acids (FFAs) and cytokines from adipose tissue directly impairs insulin sensitivity (Figure 6). In skeletal muscle and adipose tissue, FFA-induced reactive oxygen species (ROS) production blunts activation of insulin receptor substrate 1 (IRS-1) and PI3K-Akt signalling, leading to down-regulation of insulin responsive glucose transporter 4 (GLUT-4).^{68,69}

4.3 Endothelial dysfunction, oxidative stress and vascular inflammation

FFA-induced impairment of the PI3K pathway blunts Akt activity and phosphorylation of endothelial nitric oxide synthase (eNOS) at

Ser¹¹⁷⁷, resulting in decreased production of nitric oxide (NO), endothelial dysfunction,⁷⁰ and vascular remodelling (increased intima-media thickness), important predictors of CVD (Figure 6).^{71,72} In turn, accumulation of ROS activates transcription factor NF-κB, leading to increased expression of inflammatory adhesion molecules and cytokines.⁶⁹ Chronic IR stimulates pancreatic secretion of insulin, generating a complex phenotype that includes progressive beta cell dysfunction,⁶⁸ decreased insulin levels and increased PG. Evidence supports the concept that hyperglycaemia further decreases endothelium-derived NO availability and affects vascular function via a number of mechanisms, mainly involving overproduction of ROS (Figure 6).⁷³ The mitochondrial electron transport chain is one of the first targets of high glucose, with a direct net increase in superoxide anion (O_2^-) formation. A further increase in O_2^- production is driven by a vicious circle involving ROS-induced activation of protein kinase C (PKC).⁷⁴ Activation of PKC by glucose leads to up-regulation of NADPH oxidase, mitochondrial adaptor p66^{Shc} and COX-2 as well as thromboxane production and impaired NO release (Figure 6).^{75–77} Mitochondrial ROS, in turn, activate signalling cascades involved in the pathogenesis of cardiovascular complications, including polyol flux, advanced glycation end-products (AGEs) and their receptors (RAGEs), PKC and hexosamine pathway (HSP) (Figure 6). Recent evidence suggests that hyperglycaemia-induced ROS generation is involved in the persistence of vascular dysfunction despite normalization of glucose levels. This phenomenon has been called 'metabolic memory' and may explain why macro- and microvascular complications progress, despite intensive glycaemic control, in patients with DM. ROS-driven epigenetic changes are particularly involved in this process.^{74,78}

4.4 Macrophage dysfunction

The increased accumulation of macrophages occurring in obese adipose tissue has emerged as a key process in metabolic inflammation and IR.⁷⁹ In addition, the insulin-resistant macrophage increases expression of the oxidized low-density lipoprotein (LDL) scavenger

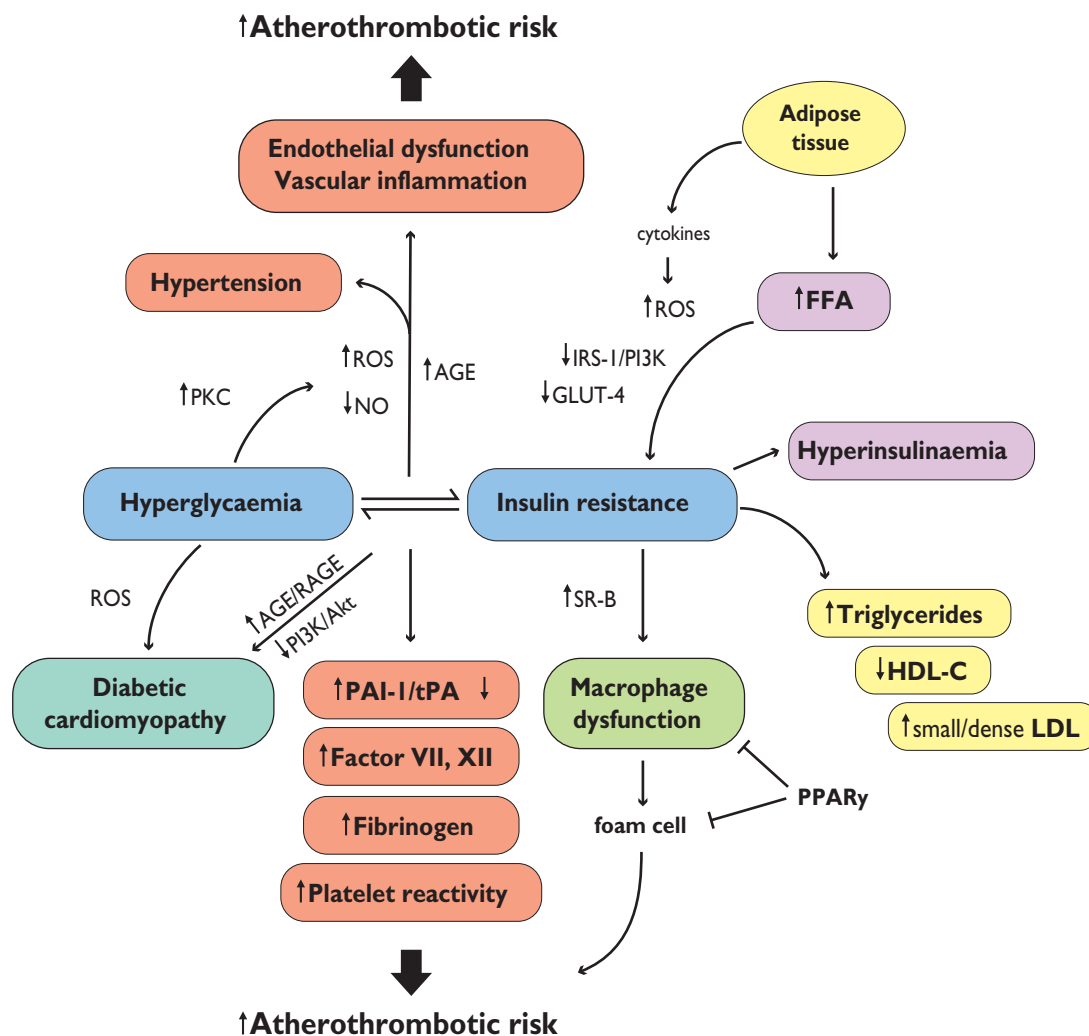


Figure 6 Hyperglycaemia, insulin resistance, and cardiovascular disease. AGE = advanced glyated end-products; FFA = free fatty acids; GLUT-4 = glucose transporter 4; HDL-C = high-density lipoprotein cholesterol; LDL = low-density lipoprotein particles; NO = nitric oxide; PAI-1 = plasminogen activator inhibitor-1; PKC = protein kinase C; PPAR γ = peroxisome proliferator-activated receptor γ ; PI3K = phosphatidylinositol 3-kinase; RAGE = AGE receptor; ROS = reactive oxygen species; SR-B = scavenger receptor B; tPA = tissue plasminogen activator.

receptor B (SR-B), promoting foam cell formation and atherosclerosis. These findings are reversed by peroxisome proliferator-activated receptor gamma (PPAR γ) activation, which enhances macrophage insulin signalling (Figure 6). In this sense it seems that macrophage abnormalities provide a cellular link between DM and CVD by both enhancing IR and by contributing to the development of fatty streaks and vascular damage.

4.5 Atherogenic dyslipidaemia

Insulin resistance results in increased FFA release to the liver due to lipolysis. Therefore, enhanced hepatic very low-density lipoprotein (VLDL) production occurs due to increased substrate availability, decreased apolipoprotein B-100 (ApoB) degradation and increased lipogenesis. In T2DM and the metabolic syndrome, these changes lead to a lipid profile characterized by high triglycerides (TGs), low

high-density lipoprotein cholesterol (HDL-C), increased remnant lipoproteins, apolipoprotein B (ApoB) synthesis and small, dense LDL particles (Figure 6).⁸⁰ This LDL subtype plays an important role in atherogenesis being more prone to oxidation. On the other hand, recent evidence suggests that the protective role of HDL may be lost in T2DM patients due to alterations of the protein moiety, leading to a pro-oxidant, inflammatory phenotype.⁸¹ In patients with T2DM, atherogenic dyslipidaemia is an independent predictor of cardiovascular risk, stronger than isolated high triglycerides or a low HDL cholesterol.⁸⁰

4.6 Coagulation and platelet function

In T2DM patients, IR and hyperglycaemia participate to the pathogenesis of a prothrombotic state characterized by increased plasminogen activator inhibitor-1 (PAI-1), factor VII and XII, fibrinogen and

reduced tissue plasminogen activator (tPA) levels (Figure 6).⁸² Among factors contributing to the increased risk of coronary events in DM, platelet hyper-reactivity is of major relevance.⁸³ A number of mechanisms contribute to platelet dysfunction, affecting the adhesion and activation, as well as aggregation, phases of platelet-mediated thrombosis. Hyperglycaemia alters platelet Ca^{2+} homeostasis, leading to cytoskeleton abnormalities and increased secretion of pro-aggregant factors. Moreover, hyperglycaemia-induced up-regulation of glycoproteins (Ib and IIb/IIIa), P-selectin and enhanced P2Y₁₂ signalling are key events underlying atherothrombotic risk in T1DM and T2DM (Figure 6).

4.7 Diabetic cardiomyopathy

In patients with T2DM, reduced IS predisposes to impaired myocardial structure and function and partially explains the exaggerated prevalence of heart failure in this population. Diabetic cardiomyopathy is a clinical condition diagnosed when ventricular dysfunction occurs in the absence of coronary atherosclerosis and hypertension. Patients with unexplained dilated cardiomyopathy were 75% more likely to have DM than age-matched controls.⁸⁴ Insulin resistance impairs myocardial contractility via reduced Ca^{2+} influx through L-type Ca^{2+} channels and reverse mode $\text{Na}^{2+}/\text{Ca}^{2+}$ exchange. Impairment of phosphatidylinositol 3-kinases (PI3K)/Akt pathway subsequent to chronic hyperinsulinaemia is critically involved in cardiac dysfunction in T2DM.⁸⁵

Together with IR, hyperglycaemia contributes to cardiac- and structural abnormalities via ROS accumulation, AGE/RAGE signalling and hexosamine flux.^{84,86} Activation of ROS-driven pathways affects the coronary circulation, leads to myocardial hypertrophy and fibrosis with ventricular stiffness and chamber dysfunction (Figure 6).⁸⁶

4.8 The metabolic syndrome

The metabolic syndrome (MetS) is defined as a cluster of risk factors for CVD and T2DM, including raised blood pressure, dyslipidaemia (high triglycerides and low HDL cholesterol), elevated PG and central obesity. Although there is agreement that the MetS deserves attention, there has been an active debate concerning the terminology and diagnostic criteria related to its definition.⁸⁷ However, the medical community agrees that the term 'MetS' is appropriate to represent the combination of multiple risk factors. Although MetS does not include established risk factors (i.e. age, gender, smoking) patients with MetS have a two-fold increase of CVD risk and a five-fold increase in development of T2DM.

4.9 Endothelial progenitor cells and vascular repair

Circulating cells derived from bone marrow have emerged as critical to endothelial repair. Endothelial progenitor cells (EPCs), a sub-population of adult stem cells, are involved in maintaining endothelial homeostasis and contribute to the formation of new blood vessels. Although the mechanisms whereby EPCs protect the cardiovascular system are unclear, evidence suggests that impaired function and reduced EPCs are features of T1DM and T2DM. Hence, these cells may become a potential therapeutic target for the management of vascular complications related to DM.⁸⁸

4.10 Conclusions

Oxidative stress plays a major role in the development of micro- and macrovascular complications. Accumulation of free radicals in the vasculature of patients with DM is responsible for the activation of detrimental biochemical pathways, leading to vascular inflammation and ROS generation. Since the cardiovascular risk burden is not eradicated by intensive glycaemic control associated with optimal multifactorial treatment, mechanism-based therapeutic strategies are needed. Specifically, inhibition of key enzymes involved in hyperglycaemia-induced vascular damage, or activation of pathways improving insulin sensitivity, may represent promising approaches.

5. Cardiovascular risk assessment in patients with dysglycaemia

The aim of risk assessment is to categorize the population into those at low, moderate, high and very-high CVD risk, to intensify preventive approaches in the individual. The 2012 Joint European Society guidelines on CVD prevention recommended that patients with DM, and at least one other CV risk factor or target organ damage, should be considered to be at very high risk and all other patients with DM to be at high risk.⁸⁹ Developing generally applicable risk scores is difficult, because of confounders associated with ethnicity, cultural differences, metabolic and inflammatory markers—and, importantly, CAD and stroke scores are different. All this underlines the great importance of managing patients with DM according to evidence-based, target-driven approaches, tailored to the individual needs of the patient.

5.1 Risk scores developed for people without diabetes

Framingham Study risk equations based on age, sex, blood pressure, cholesterol (total and HDL) and smoking, with DM status as a categorical variable,⁹⁰ have been validated prospectively in several populations.^{91,92} In patients with DM, results are inconsistent, underestimating CVD risk in a UK population and overestimating it in a Spanish population.^{93,94} Recent results from the Framingham Heart Study demonstrate that standard risk factors, including DM measured at baseline, are related to the incidence of CVD events after 30 years of follow-up.⁹⁵

The European Systematic Coronary Risk Evaluation (SCORE[®]) for fatal coronary heart disease and CVD was not developed for application in patients with DM.^{89,93}

The DECODE Study Group developed a risk equation for cardiovascular death, incorporating glucose tolerance status and FPG.⁹⁶ This risk score was associated with an 11% underestimation of cardiovascular risk.⁹³

The Prospective Cardiovascular Münster (PROCAM)⁹⁷ scoring scheme had poor calibration, with an observed/predicted events ratio of 2.79 for CVD and 2.05 for CAD.⁹⁸

The Myocardial Infarction Population Registry of Girona (REGICOR)⁹⁹ tables, applied to a Mediterranean (Spanish) population, underestimated CVD risk.⁹⁴

5.2 Evaluation of cardiovascular risk in people with pre-diabetes

Data from the DECODE study showed that high 2hPG, but not FPG, predicted all-cause mortality, CVD and CAD, after adjustment for other major cardiovascular risk factors (for further details see Section 3.2).^{43,100}

5.3 Risk engines developed for people with diabetes

The United Kingdom Prospective Diabetes Study (UKPDS) risk score for CAD has a good sensitivity (90%) in a UK population,^{101,102} overestimated risk in a Spanish population,⁹⁴ and had moderate specificity in a Greek population.¹⁰³ Moreover, this risk score was developed before the advent of modern strategies for CVD prevention.

The Swedish National Diabetes Register (NDR) was applied in a homogeneous Swedish population and reported a good calibration.¹⁰⁴

The Framingham Study. Stroke has only undergone validation in a Spanish group of 178 patients and overestimated the risk.^{105,106}

The UKPDS for stroke underestimated the risk of fatal stroke in a US population.¹⁰⁷

The Action in Diabetes and Vascular Disease: Preterax and Diamicon Modified Release Controlled Evaluation (ADVANCE) is a contemporary model for cardiovascular risk prediction, developed from the international ADVANCE cohort.¹⁰⁸ This model, which incorporates age at diagnosis, known duration of DM, sex, pulse pressure, treated hypertension, atrial fibrillation, retinopathy, HbA_{1c}, urinary albumin/creatinine ratio and non-HDL cholesterol at baseline, displayed an acceptable discrimination and good calibration during internal validation. The external applicability of the model was tested on an independent cohort of individuals with T2DM, where similar discrimination was demonstrated.

A recent meta-analysis reviewed 17 risk scores, 15 from predominantly white populations (USA and Europe) and two from Chinese populations (Hong Kong). There was little evidence to suggest that using risk scores specific to DM provides a more accurate estimate of CVD risk.¹⁰⁹ Risk scores for the evaluation of DM have good results in the populations in which they were developed, but validation is needed in other populations.

5.4 Risk assessment based on biomarkers and imaging

The Atherosclerosis Risk In Communities (ARIC) study prospectively evaluated whether adding C-reactive protein or 18 other novel risk factors individually to a basic risk model would improve prediction of incident CAD in middle-aged men and women. None of these novel markers added to the risk score.¹¹⁰ A Dutch study involving 972 DM patients evaluated baseline UKPDS risk score and the accumulation of advanced glycation end-products (AGEs) in skin¹¹¹ using auto-fluorescence. The addition of skin AGEs to the UKPDS risk engine resulted in re-classification of 27% of the patients from the low- to the high-risk group. The 10-year cardiovascular event rate was higher in patients with a UKPDS score >10% when skin AGEs were above the median (56 vs. 39%).¹¹² This technique may become a useful tool in risk stratification in DM but further information is needed for this to be verified.

In patients with T2DM, albuminuria is a risk factor for future CV events, CHF and all-cause, even after adjusting for other risk factors.¹¹³ Elevated circulating NT-proBNP is also a strong predictor of excess overall and cardiovascular mortality, independent of albuminuria and conventional risk factors.¹¹⁴

Subclinical atherosclerosis, measured by coronary artery calcium (CAC) imaging, has been found superior to established risk factors for predicting silent myocardial ischaemia and short-term outcome. CAC and myocardial perfusion scintigraphy findings were synergistic for the prediction of short-term cardiovascular events.¹¹⁵

Ankle-brachial index (ABI),¹¹⁶ carotid intima-media thickness and detection of carotid plaques,¹¹⁷ arterial stiffness by pulse wave velocity,¹¹⁸ and cardiac autonomic neuropathy (CAN) by standard reflex tests¹¹⁹ may be considered as useful cardiovascular markers, adding predictive value to the usual risk estimate.

Coronary artery disease (CAD) is often silent in DM patients and up to 60% of myocardial infarctions (MI) may be asymptomatic, diagnosed only by systematic electrocardiogram (ECG) screening.¹²⁰ Silent myocardial ischaemia (SMI) may be detected by ECG stress test, myocardial scintigraphy or stress echocardiography. Silent myocardial ischaemia affects 20–35% of DM patients who have additional risk factors, and 35–70% of patients with SMI have significant coronary stenoses on angiography whereas, in the others, SMI may result from alterations of coronary endothelium function or coronary microcirculation. SMI is a major cardiac risk factor, especially when associated with coronary stenoses on angiography, and the predictive value of SMI and silent coronary stenoses added to routine risk estimate.¹²¹ However, in asymptomatic patients, routine screening for CAD is controversial. It is not recommended by the ADA, since it does not improve outcomes as long as CV risk factors are treated.¹²² This position is, however, under debate and the characteristics of the patients who should be screened for CAD need to be better defined.¹²³ Further evidence is needed to support screening for SMI in all high-risk patients with DM. Screening may be performed in patients at a particularly high risk, such as those with evidence of peripheral artery disease (PAD) or high CAC score or with proteinuria, and in people who wish to start a vigorous exercise programme.¹²⁴

Cardiovascular target organ damage, including low ABI, increased carotid intima-media thickness, artery stiffness or CAC score, CAN and SMI may account for a part of the cardiovascular residual risk that remains, even after control of conventional risk factors. The detection of these disorders contributes to a more accurate risk estimate and should lead to a more intensive control of modifiable risk factors, particularly including a stringent target for LDL-cholesterol (LDL-C) of <1.8 mmol/L (~70 mg/dL).¹²⁵ In patients with SMI, medical treatment or coronary revascularization may be proposed on an individual basis. However the cost-effectiveness of this strategy needs to be evaluated.

5.5 Gaps in knowledge

- There is a need to learn how to prevent or delay T1DM.
- There is a need for biomarkers and diagnostic strategies useful for the early detection of CAD in asymptomatic patients.
- Prediction of CV risk in people with pre-diabetes is poorly understood.

5.6 Recommendations for cardiovascular risk assessment in diabetes

Cardiovascular risk assessment in diabetes			
Recommendations	Class ^a	Level ^b	Ref. ^c
It should be considered to classify patients with DM as at very high or high risk for CVD depending on the presence of concomitant risk factor and target organ damage.	IIa	C	-
It is not recommended to assess the risk for CVD in patients with DM based on risk scores developed for the general population.	III	C	-
It is indicated to estimate the urinary albumin excretion rate when performing risk stratification in patients with DM.	I	B	113
Screening for silent myocardial ischaemia may be considered in selected high risk patients with DM.	IIb	C	-

CVD = cardiovascular disease; DM = diabetes mellitus.

^aClass of recommendation.

^bLevel of evidence.

^cReference(s) supporting levels of evidence.

6. Prevention of cardiovascular disease in patients with diabetes

6.1 Lifestyle

A joint scientific statement from the ADA and EASD advocates lifestyle management (including healthy eating, physical activity and cessation of smoking) as a first measure for the prevention and/or management of T2DM, with targets of weight loss and reduction of cardiovascular risk.¹²⁶ An individualized approach to T2DM is also recommended by other organizations.¹²⁷ A recent Cochrane review concluded that data on the efficacy of dietary intervention in T2DM are scarce and of relatively poor quality.¹²⁸ The ADA position statement, *Nutrition Recommendations and Interventions for Diabetes* provides a further review of these issues.^{129,130}

Most European people with T2DM are obese, and weight control has been considered a central component of lifestyle intervention. 'Look AHEAD (Action for Health in Diabetes)' was a large clinical trial of the effects of long-term weight loss on glycaemia and prevention of CVD events in T2DM. One-year results of the intensive lifestyle intervention showed an average 8.6% weight loss, a significant reduction in HbA_{1c} and a reduction in several CVD risk factors—benefits that were sustained after four years.^{131,132} The trial was, however, stopped for reasons of futility in 2012, since no difference in CVD events was detected between groups. Weight reduction—or at least stabilization in overweight or moderately obese people—will still be an important component in a lifestyle programme and may

have pleiotropic effects. In very obese individuals, bariatric surgery causes long-term weight loss and reduces the rate of incident T2DM and mortality.¹³³

6.1.1 Diet

Dietary interventions recommended by the EASD Diabetes and Nutrition Study Group are less prescriptive than many earlier sets of dietary advice.⁵⁷ They acknowledge that several dietary patterns can be adopted and emphasize that an appropriate intake of total energy and a diet in which fruits, vegetables, wholegrain cereals and low-fat protein sources predominate are more important than the precise proportions of total energy provided by the major macronutrients. It is also considered that salt intake should be restricted.

It has been suggested that there is no benefit in a high-protein- over a high-carbohydrate diet in T2DM.¹³⁴ Specific dietary recommendations include limiting saturated and trans fats and alcohol intake, monitoring carbohydrate consumption and increasing dietary fibre. Routine supplementation with antioxidants, such as vitamins E and C and carotene, is not advised because of lack of efficacy and concern related to long-term safety.¹³⁵ For those who prefer a higher intake of fat, a Mediterranean-type diet is acceptable, provided that fat sources are derived primarily from monounsaturated oils—as shown by the Primary Prevention of Cardiovascular Disease with a Mediterranean Diet (PREDIMED) study using virgin olive oil.¹³⁶

*Recommended distributions of macronutrients:*⁵⁷

Proteins: 10–20% of total energy in patients without nephropathy (if nephropathy, less protein).

Saturated and transunsaturated fatty acids: combined < 10% of the total daily energy. A lower intake, < 8%, may be beneficial if LDL-C is elevated.

Oils rich in monounsaturated fatty acids are useful fat sources and may provide 10–20% total energy, provided that total fat intake does not exceed 35% of total energy.

Polyunsaturated fatty acids: up to 10% total daily energy.

Total fat intake should not exceed 35% of total energy. For those who are overweight, fat intake < 30% may facilitate weight loss. Consumption of two to three servings of—preferably—oily fish each week and plant sources of n-3 fatty acids (e.g. rapeseed oil, soybean oil, nuts and some green leafy vegetables) are recommended to ensure an adequate intake of n-3 fatty acids. Cholesterol intake should be < 300 mg/day and be further reduced if LDL-C is elevated. The intake of trans fatty acids should be as small as possible, preferably none from industrial origin and limited to < 1% of total energy intake from natural origin.

Carbohydrate may range from 45–60% of total energy. Metabolic characteristics suggest that the most appropriate intakes for individuals with DM are within this range. There is no justification for the recommendation of very low carbohydrate diets in DM. Carbohydrate quantities, sources and distribution should be selected to facilitate near-normal long-term glycaemic control. In those treated with insulin or oral hypoglycaemic agents, timing and dosage of the medication should match quantity and nature of carbohydrate. When carbohydrate intake is at the upper end of the recommended range, it is important to emphasize foods rich in dietary fibre and with a low glycaemic index.

Vegetables, legumes, fruits and wholegrain cereals should be part of the diet.

Dietary fibre intake should be >40 g/day (or 20 g/1000 Kcal/day), about half of which should be soluble. Daily consumption of ≥ 5 servings of fibre-rich vegetables or fruit and ≥ 4 servings of legumes per week can provide minimum requirements for fibre intake. Cereal-based foods should be wholegrain and high in fibre.

Alcohol drinking in moderate amounts, not exceeding two glasses or 20 g/day for men and one glass or 10 g/day for women,⁸⁹ is associated with a lower risk of CVD, compared with teetotallers and heavy alcohol drinkers, both in individuals with and without DM.¹³⁷ Excessive intake is associated with hypertriglyceridaemia and hypertension.⁸⁹

Coffee drinking: >4 cups/day is associated with a lower risk of CVD in people with T2DM,¹³⁸ but it should be noted that boiled coffee without filtering raises LDL-C and should be avoided.¹³⁹

6.1.2 Physical activity

Physical activity is important in the prevention of the development of T2DM in people with IGT and for the control of glycaemia and related CVD complications.^{140,141} Aerobic and resistance training improve insulin action and PG, lipids, blood pressure and cardiovascular risk.¹⁴² Regular exercise is necessary for continuing benefit.

Little is known about the best way to promote physical activity; however, data from a number of RCTs support the need for reinforcement by healthcare workers.^{143–145} Systematic reviews^{143,144} found that structured aerobic exercise or resistance exercise reduced HbA_{1c} by about 0.6% in T2DM. Since a decrease in HbA_{1c} is associated with a long-term decrease in CVD events and a reduction in microvascular complications,¹⁴⁶ long-term exercise regimens that lead to an improvement in glycaemic control may ameliorate the appearance of vascular complications. Combined aerobic and resistance training has a more favourable impact on HbA_{1c} than aerobic or resistance training alone.¹⁴⁷ In a recent meta-analysis of 23 studies, structured exercise training was associated with a 0.7% fall in HbA_{1c}, compared with controls.¹⁴³ Structured exercise of >150 min/week was associated with a fall in HbA_{1c} of 0.9% <150 min/week with a fall of 0.4%. Overall, interventions of physical activity advice were associated with lower HbA_{1c} levels only when combined with dietary advice.¹⁴⁷

6.1.3 Smoking

Smoking increases the risk of T2DM,¹⁴⁸ CVD and premature death,¹⁴⁹ and should be avoided. Stopping smoking decreases risk of CVD.¹⁵⁰ People with DM who are current smokers should be offered a structured smoking cessation programme including pharmacological support with, for example, bupropion and varenicline if needed. Detailed instruction on smoking cessation should be given according to the five A principles (Table 7) as is further elaborated in the 2012 Joint European Prevention guidelines.⁸⁹

Table 7 The strategic 'five As' for smoking cessation

A-ASK:	Systematically inquire about smoking status at every opportunity.
A-ADVISE:	Unequivocally urge all smokers to quit.
A-ASSESS:	Determine the person's degree of addiction and readiness to quit.
A-ASSIST:	Agree on a smoking cessation strategy, including setting a quit date, behavioural counselling, and pharmacological support.
A-ARRANGE:	Arrange a schedule for follow-up.

6.1.4 Gaps in knowledge

- Lifestyles that influence the risk of CVD among people with DM are constantly changing and need to be followed.
- The CVD risk, caused by the increasing prevalence of T2DM in young people due to unhealthy lifestyles, is unknown.
- It is not known whether the remission in T2DM seen after bariatric surgery will lead to a reduction in CVD risk.

6.1.5 Recommendations on life style modifications in diabetes

Life style modifications in diabetes			
Recommendations	Class ^a	Level ^b	Ref. ^c
Smoking cessation guided by structured advice is recommended in all subjects with DM and IGT.	I	A	148
It is recommended that in the prevention of T2DM and control of DM total fat intake should be $<35\%$, saturated fat $<10\%$, and monounsaturated fatty acids $>10\%$ of total energy.	I	A	57, 129, 132, 134
It is recommended that dietary fibre intake should be >40 g/day (or 20 g/1000 Kcal/day) in the prevention of T2DM and control of DM.	I	A	57, 129, 132, 134
Any diet with reduced energy intake can be recommended in lowering excessive body weight in DM.	I	B	129, 132
Vitamin or micronutrient supplementation to reduce the risk of T2DM or CVD in DM is not recommended.	III	B	129, 135
Moderate to vigorous physical activity of ≥ 150 min/week is recommended for the prevention and control of T2DM, and prevention of CVD in DM.	I	A	141, 142
Aerobic exercise and resistance training are recommended in the prevention of T2DM and control of DM, but best when combined.	I	A	144

CVD = cardiovascular disease; DM = diabetes mellitus; T2DM = type 2 diabetes mellitus.

^aClass of recommendation.

^bLevel of evidence.

^cReference(s) supporting levels of evidence.

6.2 Glucose control

Randomized controlled trials provide compelling evidence that the microvascular complications of DM are reduced by tight glycaemic control,^{151–153} which also exerts a favourable, although smaller, influence on CVD that becomes apparent after many years.^{154,155} However, intensive glucose control, combined with effective blood pressure control and lipid lowering, appear to markedly shorten the time needed to make improvements in the rate of cardiovascular events.¹⁵⁶

6.2.1 Microvascular disease (retinopathy, nephropathy and neuropathy)

Intensified glucose lowering, targeting an HbA_{1c} of 6.0–7.0%, (42–53 mmol/mol),¹⁵⁷ has consistently been associated with a decreased frequency and severity of microvascular complications. This applies to both T1DM and T2DM, although the outcomes are less apparent in T2DM with established complications, for which the number needed to treat (NNT) is high.^{158–162} Analyses from the Diabetes Control and Complications Trial (DCCT) and the UKPDS demonstrated a continuous relationship between increasing HbA_{1c} and microvascular complications, without an apparent threshold.^{146,163} In the DCCT, a decrease in HbA_{1c} of 2% (21.9 mmol/mol) significantly lowered the risk of the development and progression of retinopathy and nephropathy,¹⁵¹ although the absolute reduction was low at HbA_{1c} <7.5% (58 mmol/mol). The UKPDS reported a similar relationship in people with T2DM.^{146,152}

6.2.2 Macrovascular disease (cerebral, coronary and peripheral artery disease)

Although there is a strong relationship between glycaemia and microvascular disease, the situation regarding macrovascular disorders is less clear. Hyperglycaemia in the high normal range, with minor elevations in HbA_{1c},^{164,165} has been associated with increased cardiovascular risk in a dose-dependent fashion. However, the effects of improving glycaemia on cardiovascular risk remain uncertain and recent RCTs have not provided clear evidence in this area.^{159–162} The reasons, of which there are several, include the presence of multiple comorbidities in long-standing T2DM and the complex risk phenotype generated in the presence of IR (for further details see Section 4).

6.2.3 Medium-term effects of glycaemic control

Action to Control Cardiovascular Risk in Diabetes (ACCORD).

A total of 10 251 T2DM participants at high cardiovascular risk were randomized to intensive glucose control achieving an HbA_{1c} of 6.4% (46 mmol/mol), or to standard treatment achieving an HbA_{1c} of 7.5% (58 mmol/mol).¹⁵⁹ After a mean follow-up of 3.5 years the study was terminated due to higher mortality in the intensive arm (14/1000 vs. 11/1000 patient deaths/year), which was pronounced in those with multiple cardiovascular risk factors and driven mainly by cardiovascular mortality. As expected, the rate of hypoglycaemia was higher under intensive treatment and in patients with poorer glycaemic control, although the role of hypoglycaemia in the CVD outcomes is not entirely clear. Further analysis revealed that the higher mortality may have been due to fluctuations in glucose, in combination with an inability to control glucose according to target, despite aggressive glucose lowering treatment.¹⁶⁶ A recent extended follow-up of ACCORD did not support the hypothesis that severe symptomatic hypoglycaemia was related to the higher mortality.¹⁶⁷

Action in Diabetes and Vascular Disease: Preterax and Diamicon Modified Release Controlled Evaluation (ADVANCE).

A total of 11 140 T2DM participants at high cardiovascular risk were randomized to intensive or conventional glucose-lowering therapy.¹⁶⁰ The intensive arm achieved an HbA_{1c} of 6.5% (48 mmol/mol), compared with 7.3% (56 mmol/mol) in the standard arm. The primary endpoint (major macrovascular or microvascular complications) was reduced in the intensive arm (HR 0.90; 95% CI 0.82–0.98) due to a reduction in nephropathy. Intensive glycaemic control failed to influence the macrovascular component of the primary endpoint (HR 0.94; 95% CI 0.84–1.06). In contrast to ACCORD, there was no increase in mortality (HR 0.93; 95% CI 0.83–1.06) despite a similar decrease in HbA_{1c}. Severe hypoglycaemia was reduced by two thirds in the intensive arm of ADVANCE, compared with ACCORD, and HbA_{1c} lowering to target was achieved at a slower rate than in ACCORD. In addition, the studies had a different baseline CVD risk, with a higher rate of events in the control group of ADVANCE.

Veterans Administration Diabetes Trial (VADT). In this trial, 1791 T2DM patients were randomized to intensive or standard glucose control, achieving an HbA_{1c} of 6.9% (52 mmol/mol) in the intensive therapy group, compared with 8.4% (68 mmol/mol) in the standard therapy group.¹⁶¹ There was no significant reduction of the primary composite cardiovascular endpoint in the intensive therapy group (HR 0.88; 95% CI 0.74–1.05).

Outcome Reduction with an Initial Glargine Intervention Trial

(ORIGIN). This study randomized 12 537 people (mean age, 63.5 years) at high CVD risk plus IFG, IGT or T2DM to receive insulin glargine (with a target fasting blood glucose level of 5.3 mmol/L (≤ 95 mg/dL) or to standard care. After a median follow-up of 6.2 years, the rates of incident CV outcomes were similar in the insulin glargine and standard care groups. Rates of severe hypoglycaemia were 1.00 vs. 0.31 per 100 person-years. Median weight increased by 1.6 kg in the insulin glargine group and fell by 0.5 kg in the standard care group. There was no indication that insulin glargine was associated with cancer.¹⁶⁸

Conclusion. A meta-analysis of cardiovascular outcomes based on VADT, ACCORD and ADVANCE suggested that an HbA_{1c} reduction of ~1% was associated with a 15% relative risk reduction (RRR) in non-fatal MI but without benefits on stroke or all-cause mortality.¹⁶⁹ However, patients with a short duration of T2DM, lower baseline HbA_{1c} at randomization, and without a history of CVD seemed to benefit from more-intensive glucose-lowering strategies. This interpretation is supported by ORIGIN, which did not demonstrate benefit or detriment on cardiovascular end-points by early institution of insulin-based treatment, even though insulin glargine was associated with increased hypoglycaemia. This suggests that intensive glycaemic control should be appropriately applied in an individualized manner, taking into account age, duration of T2DM and history of CVD.

6.2.4 Long-term effects of glycaemic control

Diabetes Control and Complications Trial (DCCT) and Epidemiology of Diabetes Interventions and Complications (EDIC).

In DCCT, the rate of cardiovascular events was not significantly altered in the intensive-treatment group.¹⁵¹ After termination of the study, 93% of the cohort were followed for an additional 11 years under EDIC, during which the differences in HbA_{1c} disappeared.¹⁵⁴ During the combined 17-year follow-up, the risk of any cardiovascular event was reduced in the intensive group by 42% (9–63%; $P < 0.01$).

United Kingdom Prospective Diabetes Study (UKPDS). Although a clear reduction in microvascular complications was evident, the reduction in MI was only 16% ($P = 0.052$). In the extension phase of the study, a risk reduction in MI remained at 15%, which became significant as the number of cases increased. Furthermore, the beneficial effects persisted for any DM-related end point; MI and death from any cause was reduced by 13%.¹⁵⁵ It should be noted that this study was performed when lipid lowering and blood pressure were less effectively managed, partially due to the lack of availability of potent, currently available drugs. Thus UKPDS was performed when other important parts of a multifactorial management were less efficient. One may speculate that it may have been easier to verify a beneficial effect of glucose-lowering agents at that time, than in subsequently performed trials.

Conclusion. DCCT and UKPDS showed that, in T1DM and T2DM: (i) glycaemic control is important for reducing long-term macrovascular complications; (ii) a very long follow-up period is required to demonstrate an effect and (iii) early glucose control is important (metabolic memory).

6.2.5 Glycaemic targets

An HbA_{1c} target of <7.0% (<53 mmol/mol) to reduce microvascular disease is a generally accepted level.^{151–153,155,159} The evidence for an HbA_{1c} target in relation to macrovascular risk is less compelling, in part due to the complexities surrounding the chronic, progressive nature of DM and the effects of metabolic memory.^{153,155,169} Consensus indicates that an HbA_{1c} of $\leq 7\%$ should be targeted, but with acknowledgement of the need to pay attention to the individual requirements of the patient. Ideally, tight control should be instigated early in the course of the disorder in younger people and without attendant co-morbidities. Fasting plasma glucose (FPG) should be <7.2 mmol/L (<120 mg/dL) and post-prandial <9–10 mmol/L (<160–180 mg/dL) on an individualized basis. Successful glucose-lowering therapy is assisted by self-monitoring of blood glucose, most notably in patients with insulin-treated DM.¹⁷⁰ When near-normoglycaemia is the objective, post-prandial glycaemia needs to be taken into account in addition to fasting glycaemia. However, although post-prandial hyperglycaemia is associated with an increased incidence of CVD events (see section 3.4) it remains controversial as to whether treatment targets addressing post-prandial hyperglycaemia are of added benefit to CVD outcomes.^{171–174}

More stringent targets (e.g. HbA_{1c} 6.0–6.5% (42–48 mmol/mol)) might be considered in selected patients with short disease duration, long life expectancy and no significant CVD, if it can be achieved without hypoglycaemia or other adverse effects. As discussed above, the accumulated results from T2DM cardiovascular trials suggest that not everyone benefits from aggressive glucose management. It follows that it is important to individualize treatment targets.¹²⁶

6.2.6 Glucose-lowering agents

The choice of pharmacological agent, the combinations employed and the potential side-effects are related to the mode of action of the drug. The choice of agent, the conditions of their use and the role of combination therapy is beyond the scope of this document and has been extensively reviewed in the joint ADA/EASD guidelines.¹²⁶ In brief, therapeutic agents for managing hyperglycaemia can be broadly characterized as belonging to one of three groups: (i) insulin providers [insulin, sulphonylureas, meglitinides, glucagon-like peptide-1 (GLP-1) receptor agonists, dipeptidylpeptidase-4 (DPP-4) inhibitors]; (ii) insulin

sensitizers (metformin, pioglitazone) and (iii) glucose absorption inhibitors [alpha-glucosidase inhibitors, sodium-glucose co-transporter-2 (SGLT2) inhibitors]. The sulphonylureas, meglitinides and incretin mimetics (GLP-1 receptor agonists and DPP-4 inhibitors) all act by stimulating the pancreatic beta-cell to increase endogenous insulin secretion. The GLP-1 receptor agonists and the DPP-4 inhibitors have additional actions on the gastro-intestinal tract and brain, which have a beneficial effect on satiety (weight neutral for DPP-4 inhibitors, weight loss-associated with GLP-1 receptor agonists), although transient nausea occurring in about 20% of those treated may persist for 4–6 weeks after initiation of therapy. Pioglitazone is a PPAR- γ agonist with partial peroxisome proliferator-activated receptor alpha (PPAR α) effects, which lowers glucose by ameliorating insulin resistance, while metformin is a biguanide that exerts similar effects through AMP kinase activation. Both agents tend to reduce insulin requirements in insulin-treated T2DM and, in the PROspective pioglitazone Clinical Trial In macroVascular Events (PROActive) study, pioglitazone use was associated with prolonged reductions in insulin requirements.¹⁷⁵ Acarbose reduces glucose absorption from the gastro-intestinal tract, whilst the SGLT2 inhibitors act on the proximal renal tubule to reduce glucose absorption. The expected decrease in HbA_{1c} with each of the oral treatments, or with subcutaneous administration of GLP-1 agonists as monotherapy, is generally about 0.5–1.0%, although this can vary between individuals, depending on the duration of DM and other factors. Triple therapy—metformin plus two from pioglitazone, sulphonylurea, incretin mimetics, meglitinides and glucose absorption inhibitors—is commonly required as the disorder progresses.

In T1DM, intensive glucose-lowering therapy using a basal-bolus regimen, delivered either by multiple insulin injections or using an insulin pump, is the 'gold standard'.¹⁵¹ In T2DM, metformin is the first-line drug treatment, especially in overweight patients.¹²⁶ A concern over the use of metformin has been the risk of lactic acidosis, especially in patients with impaired renal function and hepatic disease. In systematic reviews of trial data with selected patients, lactic acidosis is not over-represented.¹⁷⁶ Despite this, metformin is not recommended if the estimated eGFR is <50 mL/min.¹⁷⁷ There is an ongoing debate as to whether these thresholds are too restrictive. The UK National Institute for Health and Clinical Excellence (NICE) guidelines are more flexible, allowing use down to a eGFR of 30 mL/min, with dose reduction advised at 45 mL/min.¹²⁷

To attain glucose targets, a combination of glucose-lowering drugs is often required soon after diagnosis. Early aggressive therapy seems to have a role in reducing cardiovascular complications, but has not been formally tested in prospective trials.

Cardiovascular safety of glucose-lowering agents (Table 8).

Concerns initiated by possible adverse cardiovascular effects of rosiglitazone¹⁷⁸ raised questions as to the cardiovascular safety of glucose-lowering drugs, particularly when used in combination. A 10-year post-trial follow-up of UKPDS revealed that patients treated with sulphonylurea-insulin had a risk reduction (RR) for MI of 0.85 (95% CI 0.74–0.97; $P = 0.01$) and for death of 0.87 (95% CI 0.79–0.96; $P < 0.007$).^{153,155} The corresponding RRs for metformin in overweight patients were 0.67 (95% CI 0.51–0.89; $P = 0.005$) and 0.73 (95% CI 0.59–0.89; $P = 0.002$). Although UKPDS indicated that metformin has a beneficial effect on CVD outcomes—which led to metformin being adopted as first line treatment in overweight T2DM—it is important to underline that, overall, there is no clear evidence to support this view and there is a suggestion that, in combination with sulphonylurea, there may be detrimental effects related

Table 8 Pharmacological treatment options for T2DM

Drug class	Effect	Weight change	Hypoglycaemia (monotherapy)	Comments
Metformin	Insulin sensitizer	Neutral/loss	No	Gastrointestinal side-effects, lactic acidosis, B12 deficiency. Contraindications, low eGFR, hypoxia, dehydration
Sulphonylurea	Insulin provider	Increase	Yes	Allergy Risk for hypoglycaemia and weight gain
Meglitinides	Insulin provider	Increase	Yes	Frequent dosing Risk for hypoglycaemia
Alfa-glucosidase inhibitor	Glucose absorption inhibitor	Neutral	No	Gastrointestinal side-effects Frequent dosing
Pioglitazone	Insulin sensitizer	Increase	No	Heart failure, oedema, fractures, urinary bladder cancer(?)
GLP-1 agonist	Insulin provider	Decrease	No	Gastrointestinal side-effects Pancreatitis Injectable
DPP-4 inhibitor	Insulin provider	Neutral	No	Pancreatitis
Insulin	Insulin provider	Increase	Yes	Injectable Risk for hypoglycaemia and weight gain
SGLT2 inhibitors	Blocks renal glucose absorption in the proximal tubuli	Decrease	No	Urinary tract infections

eGFR = estimated glomerular filtration rate; GLP-1 = glucagon-like peptide-1; DPP = Diabetes Prevention Program; SGLT2 = sodium glucose co-transporter 2.

to both morbidity and mortality. However, the results of this meta-analysis also suggest a benefit after a long duration of treatment in younger patients.¹⁷⁹ Pioglitazone reduced a secondary composite of all-cause mortality, fatal MI and stroke in the PROactive study (HR 0.84; 95% CI 0.72–0.98; $P = 0.027$) in T2DM patients at high risk of macrovascular disease.¹⁷⁵ However, because the primary outcome in PROactive did not achieve statistical significance, the interpretation of these results remains contentious. The use of pioglitazone is associated with fluid retention secondary to renal effects, and this is associated with peripheral oedema and worsening of established heart failure in susceptible individuals. Diuretic therapy can be initiated to ameliorate these side-effects. In the STOP-NIDDM trial, acarbose, when given to patients with IGT, reduced the number of CVD events, including cardiovascular mortality.¹⁷² Meglitinides have not been formally tested in T2DM but, in high-risk patients with IGT nateglinide, did not reduce either fatal or non-fatal cardiovascular events.¹⁸⁰ No outcome data from RCTs have so far been published for glucagon-like peptide 1 agonists, DPP-4 inhibitors or SGLT-2 inhibitors, but large prospective trials with cardiovascular outcomes are in progress for GLP-1 receptor agonists and DPP-4 inhibitors and for SGLT2 inhibitors.

6.2.7 Special considerations

Hypoglycaemia. Intensive glucose lowering increases the incidence of severe hypoglycaemia three- to four-fold in both T1DM and T2DM.^{151,162} Impaired hypoglycaemic awareness increases with duration of DM and is a significant risk factor for hypoglycaemia, which must be taken into account when glucose-lowering therapy is considered.¹⁸¹ In addition to the short-term risks of cardiac arrhythmia and cardiovascular events, longer-term risks include dementia and cognitive dysfunction.^{182,183} The outcome of glucose-lowering studies has

raised the question as to whether hypoglycaemia is an important risk factor for MI in patients with DM. Frier *et al.*¹⁸² have extensively reviewed this topic, providing evidence for a number of adverse effects of hypoglycaemia on the CV system, particularly in the presence of autonomic neuropathy. Insulin, meglitinides and sulphonylureas are particularly associated with hypoglycaemia, which is a common occurrence in both T1 and T2DM. Attention should be paid to avoidance of hypoglycaemia, whilst achieving glycaemic goals in an individualized manner.

Glucose lowering agents in chronic kidney disease. Around 25% of people with T2DM have chronic kidney disease (CKD) stages 3–4 (eGFR <50 mL/min). Aside from the increased CV risk associated with this condition, the use of glucose-lowering agents may need to be modified, either because a particular agent is contraindicated in CKD or because the dosage needs to be altered.¹⁸⁴ Metformin, acarbose and most sulphonylureas should be avoided in stage 3–4 CKD, whilst insulin therapy and pioglitazone can be used in their place as required. The DPP-4 inhibitors require dose adjustment with progressive CKD with the exception of linagliptin, which is well tolerated in these circumstances. The SGLT2 inhibitors have not been evaluated in CKD.

Elderly people. Older people have a higher atherosclerotic disease burden, reduced renal function and greater co-morbidity. Life expectancy is reduced, especially in the presence of long-term complications. Glycaemic targets for elderly people with long-standing or more complicated disease should be less ambitious than for younger, healthier individuals. If lower targets cannot be achieved with simple interventions, an HbA_{1c} of <7.5–8.0% (<58–64 mmol/mol) may be acceptable, transitioning upwards as age increases and capacity for self-care, cognitive, psychological and economic status and support systems decline.¹²⁶

Individualized care. The influences on quality of life, adverse effects of polypharmacy and inconvenience of intensified glucose-lowering regimens have to be carefully evaluated for each individual with DM (for further information see Section 9). From a public health perspective, even minor decreases in mean glycaemia may prove advantageous. On the other hand, the intensified glucose-lowering treatment may impose a considerable burden and possible harm on the individual. Each individual should be encouraged to achieve the best compromise between glucose control and vascular risk and, if intensified therapy is instituted, the patients must be informed and understand the benefits and risks.

6.2.8 Gaps in knowledge

- Long-term CVD outcomes for most glucose-lowering treatments are not known.
- The consequences of polypharmacy for quality of life and the most appropriate choice of treatment in DM-patients with comorbidities, particularly in the elderly, are unclear.
- The level of glycaemia (FPG, 2hPG, HbA_{1c}) at which CV benefits can be seen in T2DM is not known, since no studies with this aim have been carried out.

6.2.9 Recommendations for glycaemic control in diabetes

Glycaemic control in diabetes			
Recommendations	Class ^a	Level ^b	Ref. ^c
It is recommended that glucose lowering is instituted in an individualized manner taking duration of DM, co-morbidities and age into account.	I	C	-
It is recommended to apply tight glucose control, targeting a near-normal HbA _{1c} (<7.0% or <53 mmol/mol) to decrease microvascular complications in T1DM and T2DM.	I	A	151–153, 155, 159
A HbA _{1c} target of ≤7.0% (≤53 mmol/mol) should be considered for the prevention of CVD in T1 and T2 DM.	IIa	C	-
Basal bolus insulin regimen, combined with frequent glucose monitoring, is recommended for optimizing glucose control in T1DM.	I	A	151, 154
Metformin should be considered as first-line therapy in subjects with T2DM following evaluation of renal function.	IIa	B	153

CVD = cardiovascular disease; DM = diabetes mellitus; HbA_{1c} = glycated haemoglobin A_{1c}; T1DM = type 1 diabetes mellitus; T2DM = type 2 diabetes mellitus.

^aClass of recommendation.

^bLevel of evidence.

^cReference(s) supporting levels of evidence.

6.3 Blood pressure

The prevalence of hypertension is higher in patients with T1DM than in the general population (up to 49% in DCCT/EDIC)^{185,186} and more than 60% of patients diagnosed with T2DM have arterial hypertension.¹⁸⁷ According to current pathophysiological considerations, this is related to: (i) hyperinsulinaemia linked to increased renal reabsorption of sodium; (ii) increased sympathetic tone and (iii) increased renin-angiotensin-aldosterone system activity.¹⁸⁸ Obesity, aging and the appearance of renal disease further increase the prevalence of hypertension. DM and hypertension are additive risk factors for CVD. While the development of T2DM doubles the cardiovascular risk in men and more than triples the risk in women, hypertension causes a four-fold increase in cardiovascular risk in people with DM.^{189,190} Although treatment targets are presented, it should be recognised that blood pressure management needs to be implemented on an individualized basis. For example, multiple co-morbidities, increasing age, drug interactions and the pattern of vascular disease may all influence the therapeutic approach and individual target.

6.3.1 Treatment targets

In DM, the recommended level of blood pressure has been debated. In general, measures to lower elevated blood pressure should be applied in all patients with DM, due to the substantially enhanced cardiovascular risk associated with increased blood pressure levels in such patients. RCTs in T2DM have shown the positive effects on cardiovascular outcomes of lowering blood pressure at least below 140 mm Hg systolic and 85 mm Hg diastolic.^{191–194} The Hypertension Optimal Treatment (HOT) trial demonstrated that risk decreased when the diastolic target was below 80 mm Hg.¹⁹⁵ However, the mean diastolic blood pressure in this group was still above 80 and the systolic pressure was as high as 144 mm Hg. The UKPDS showed that ‘tight’ (mean 144/82), compared with ‘less tight’ (154/87) control reduced macrovascular events by 24%. In a *post-hoc* observational analysis of the UKPDS trial, DM-related mortality decreased 15% with each 10 mm Hg drop, down to a systolic blood pressure of 120 mm Hg, with no indication of a threshold.¹⁹⁶ In the more recent ACCORD trial, more than 4700 patients were assigned to intensive- (achieved mean systolic blood pressure 119 mm Hg) or standard treatment [mean systolic blood pressure (BP) 134 mm Hg] over a mean follow-up of 4.7 years. The relative reduction of the composite endpoint (non-fatal MI, non-fatal stroke, or CVD death) by the intensive treatment did not reach statistical significance.¹⁹² The average number of blood pressure-reducing drugs was 3.5 in the intensive group, against 2.1 in the standard group. The proportion of patients with serious side-effect—such as hypotension and declining renal function—increased from 1.3 to 3.3% with aggressive treatment. Since the risk–benefit ratio tipped towards harm, this study does not support a reduction of systolic blood pressure below 130 mm Hg. Bangalore *et al.*¹⁹⁷ reported a meta-analysis of 13 RCTs with 37 736 patients with DM, IFG or IGT who, in the intensive group, had a systolic pressure ≤135 mm Hg and, in the standard group, ≤140 mm Hg. The more intensive control related to a 10% reduction in all-cause mortality (95% CI 0.83–0.98), a 17% reduction in stroke but a 20% increase in serious adverse events. Systolic BP ≤130 mm Hg was related to a greater reduction in stroke but did not affect other cardiovascular events.

In summary, present evidence makes it reasonable to reduce blood pressure in patients with DM to $<140/85$ mm Hg. It should be noted that further reduction might be associated with an increased risk of serious adverse events, especially in patients of advanced age and with longer duration of T2DM. Thus the risks and benefits of more intensive blood pressure management need to be carefully considered on an individual basis.

6.3.2 Managing blood pressure-lowering

Lifestyle intervention including salt restriction and weight loss is the therapeutic basis for all patients with hypertension; however, it is usually insufficient for adequate blood pressure control (for details see Section 6.1).

Pharmacological treatment has only been tested in a few RCTs comparing cardiovascular outcomes with blood pressure-lowering agents and specifically targeting patients with DM.^{191,198,199} However, several RCTs with sizeable DM subgroups reported specifically on the outcome in this subgroup.^{200–207} It appears that blockade of the renin-angiotensin-aldosterone system (RAAS), by means of an angiotensin converting enzyme inhibitor (ACE-I) or an angiotensin-receptor-blocker (ARB), is of particular value, especially when treating hypertension in patients with DM at high cardiovascular risk.^{200,201,205–207} Evidence also supports the efficacy of an ACE-I, rather than a calcium channel blocker, as initial therapy when the intention is to prevent or retard the occurrence of microalbuminuria in hypertensive patients with DM.²⁰⁸ Dual RAAS blockade combining an ACE-I with an ARB did not show any further benefit in the ONgoing Telmisartan Alone and in combination with Ramipril Global Endpoint Trial (ONTARGET), but was associated with more adverse events. In the Aliskiren Trial in Type 2 Diabetes Using Cardio-Renal Endpoints (ALTITUDE) trial, the addition of aliskiren to RAAS blockade in patients with T2DM at high risk for cardiovascular and renal events did not result in a decrease in cardiovascular events and may even have been harmful.^{209,210} Since DM patients tend to have high blood pressure during the night, administration of antihypertensive drugs at bedtime should be considered—ideally after evaluation of the 24-ambulatory blood pressure profile of the patient.

A matter that has been intensively discussed over the past decades is whether the metabolic actions of various blood pressure-lowering drugs are important for long-term cardiovascular outcome. It is well established that the use of thiazides and beta-blockers is associated with an increased risk of developing T2DM, compared with treatment with calcium channel blockers and inhibitors of the RAAS.²¹¹ It is not known whether treatment with beta-blockers and/or thiazides or thiazide-like diuretics in patients with established T2DM has any metabolic adverse events of clinical importance. The observation from UKPDS, that control of hyperglycaemia—in contrast to an effective blood pressure control—had a relatively minor influence on cardiovascular outcome, indicates that negative metabolic effects may be less important when treating hypertension in patients with DM, at least as regards macrovascular complications. Thus, while drugs with negative metabolic effects—especially the combination

of a diuretic and a beta-blocker—should be avoided as first-line treatment in hypertensive patients with metabolic syndrome, the objective of lowering blood pressure seems more important than minor alterations in metabolic status in patients with established DM. A recent meta-analysis emphasized the priority of blood pressure lowering over choice of drug class.²¹² In the absence of cardiac comorbidity, beta-blockers are not the first choice for the treatment of hypertension.^{205,206} Appropriate blood pressure control does often require combined therapy with a RAAS inhibitor and a calcium channel blocker or a diuretic. The Avoiding Cardiovascular Events through Combination Therapy in Patients Living with Systolic Hypertension (ACCOMPLISH) trial indicated that the calcium channel antagonist amlodipine is superior to hydrochlorothiazide in combination treatment with an ACE-I.²⁰⁷ In 6946 patients with DM, the number of primary events was 307 in the group treated with amlodipine and 383 in the group treated with hydrochlorothiazide as the add-on to benazepril ($P = 0.003$), despite a similar reduction of blood pressure in both groups.

6.3.3 Conclusion

The main aim when treating hypertension in patients with DM should be to lower blood pressure to $<140/85$ mm Hg. To achieve this goal, a combination of blood pressure-lowering drugs is needed in most patients. In patients with hypertension and nephropathy with overt proteinuria, an even lower BP (SBP <130 mm Hg) may be considered if tolerated by the patient (see Section 8). All available blood pressure-lowering drugs can be used, but evidence strongly supports the inclusion of an inhibitor of the RAAS (ACE-I/ARB) in the presence of proteinuria. It should be borne in mind that many DM patients do not reach the recommended BP target.²¹³ It is also noteworthy that, in contrast to that reported with glycaemic control and statins,¹⁵⁵ there is no hypertensive legacy or memory effect.¹⁹⁴ As a consequence, sustained control and monitoring and consistent medical adjustment are recommended.

These main conclusions regarding treatment of patients with DM and hypertension are consistent with the Re-appraisal of the European Guidelines on Hypertension (2009)²¹⁴ and the updated European Guidelines for hypertension 2013.²¹⁵

6.3.4 Gaps in knowledge

- The consequences of blood pressure-lowering multi-drug combinations in the elderly are poorly understood.
- The evidence base for efficacy or harm for microvascular complications for both individual blood pressure-lowering drugs alone or in combination is weak.
- The understanding of the role of arterial stiffness in predicting CV risk in patients with DM, over and above the role of conventional risk factors is poor.
- Optimal blood pressure targets are unknown.
- Are the metabolic side-effects of beta-blockers or diuretics clinically relevant?

6.3.5 Recommendations for blood pressure control in diabetes

Blood pressure control in diabetes			
Recommendations	Class ^a	Level ^b	Ref. ^c
Blood pressure control is recommended in patients with DM and hypertension to lower the risk of cardiovascular events.	I	A	189–191, 193–195
It is recommended that a patient with hypertension and DM is treated in an individualized manner, targeting a blood pressure of <140/85 mmHg.	I	A	191–193, 195
It is recommended that a combination of blood pressure lowering agents is used to achieve blood pressure control.	I	A	192–195, 205–207
A RAAS blocker (ACE-I or ARB) is recommended in the treatment of hypertension in DM, particularly in the presence of proteinuria or micro-albuminuria.	I	A	200, 205–207
Simultaneous administration of two RAAS blockers should be avoided in patients with DM.	III	B	209, 210

ACE-I = angiotensin converting enzyme-inhibitors; ARB = angiotensin receptor blockers; DM = diabetes mellitus; RAAS = renin angiotensin aldosterone system.
^aClass of recommendation.
^bLevel of evidence.
^cReference(s) supporting levels of evidence.

6.4 Dyslipidaemia

6.4.1 Pathophysiology

In individuals with T1DM and good glycaemic control, the pattern of lipid abnormalities contrasts with that of T2DM since, in T1DM, serum TG is normal and high-density lipoprotein cholesterol (HDL-C) is within the upper normal range or slightly elevated. This pattern is linked to insulin therapy, which increases lipoprotein lipase activity in adipose tissue, and the turnover rate of very low-density lipoprotein (VLDL) particles. However, qualitative changes in low-density lipoprotein (LDL) and high-density lipoprotein (HDL) particles may potentially be atherogenic.

A cluster of lipid and apoprotein abnormalities accompanies T2DM, affecting all lipoprotein classes (Table 9). The two core components are a moderate elevation of fasting and non-fasting triglycerides (TGs) and low HDL-C. Other features comprise elevations of TG-rich lipoprotein (TRLs), including chylomicron and VLDL remnants, small dense LDL particles.

These components are not isolated abnormalities but are metabolically linked. Overproduction of large VLDL particles with increased secretion of both TGs and Apo B 100 leads to the generation of small, dense LDL particles and lowering of HDL-C. As

Table 9 Characteristics of dyslipidaemia in type 2 diabetes mellitus

- Dyslipidaemia is a major risk factor for CVD.
- Dyslipidaemia represents a cluster of lipid and lipoprotein abnormalities including elevation of both fasting and post-prandial TG, Apo B, small dense LDL particles, low HDL-C and Apo A.
- Increased waist circumference and elevation of TGs is a simple tool to capture high-risk subjects with metabolic syndrome.

Apo = apolipoprotein; CVD = cardiovascular disease; HDL-C = high-density lipoprotein cholesterol; LDL = low-density lipoprotein; TG = triglyceride; TRL = triglyceride-rich lipoprotein.

VLDL, remnant and LDL particles carry a single Apo B 100 molecule, the dyslipidaemia is characterized by elevation of the Apo B concentration. Therefore, the malignant nature of dyslipidaemia in T2DM is not always revealed by routine lipid measures, as LDL-C remains within a normal range and it may often be better-characterized by using non-HDL-C. Substantial evidence indicates that an imbalance between the hepatic import and export of lipids results in excess liver fat accumulation (non-alcoholic fatty liver disease). Increased flux of FFA comes from both the systemic FFA pools and *de novo* lipogenesis in the setting of IR.^{216,217} Thus the content of liver fat and hepatic IR seem to be driving the overproduction of large VLDL particles in people with T2DM.

Impaired clearance of large VLDL particles, linked to increased concentration of Apo C, contributes to a more robust hypertriglyceridaemia.²¹⁸ Thus dual metabolic defects contribute to the hypertriglyceridaemia in people with T2DM. Recent data suggest that part of the lipid oversupply to the liver in the presence of obesity may be due to a maladaptive response of adipose tissue to store circulating FFAs, leading to ectopic fat deposition and lipotoxicity that underlies dyslipidaemia in DM and IR.²¹⁹

6.4.2 Epidemiology

The European Action on Secondary Prevention through Intervention to Reduce Events (EUROASPIRE III)^{220,221} survey reported that the overall prevalence of high TG and low HDL-C has almost doubled, compared with the prevalence seen by EUROASPIRE II, due to the increase in T2DM and obesity. A population-based survey of 75 048 patients with T2DM in the National Diabetes register in Sweden reported that 49% of patients did not receive lipid-lowering drugs. Fifty-five per cent of those treated had a TG <1.7 mmol/L and around two-thirds a normal HDL-C.²²² Data from the same survey revealed that two-thirds of patients on lipid-lowering drugs achieved an LDL-C <2.5 mmol/L.²²³ However, in those with a history of CVD, more than 70% had LDL-C >1.8 mmol/L. Notably, only moderate doses of the different statins were used, highlighting the need for intensification of therapy and better management of the existing treatment gap.

Dyslipidaemia and vascular risk in type 2 diabetes mellitus. A wealth of data from case-control, mechanistic, genetic and large observational studies indicate that a causal association exists between

elevation of triglyceride-rich particles and their remnants, low HDL-C and CVD risk.^{224,225} Data from statin trials strengthen the position of low HDL as an independent CVD risk marker, even in patients with an LDL-C level that is not elevated.^{226,227} Data from the Fenofibrate Intervention and Event Lowering in Diabetes (FIELD) study and ACCORD demonstrated that cardiovascular event rates were significantly higher in those with dyslipidaemia (LDL-C 2.6 mmol/L (100 mg/dL), TG \geq 2.3 mmol/L and HDL-C \leq 0.88 mmol/L).^{228,229} In FIELD,²³⁰ the baseline variables best predicting CVD events over a 5-year follow-up were lipid ratios (non-HDL/HDL-C and total/HDL-C). Apo B–Apo A is related to CVD outcomes, but this ratio was not superior to traditional lipid ratios. Of the single baseline lipid and lipoprotein concentrations, HDL-C, Apo A, non-HDL-C and Apo B individually predicted CVD events, although Apo A and Apo B did not perform better than HDL-C or non-HDL-C. The power of serum TG to predict CVD events was attenuated by adjustment for HDL-C. These results were unexpected, since the dyslipidaemia in DM is a cluster of abnormalities featuring elevations of Apo B and small dense LDL particles. The data are, however, in full agreement with results from the Emerging Risk Factor Collaboration (ERFC) study,²³¹ based on 68 studies that included 302 430 participants without a history of CVD. In this analysis, non-HDL-C and Apo B each had very similar association with coronary heart disease irrespective of the presence of DM. The ERFC study reported that an increase of one standard deviation in HDL-C (0.38 mmol/L or 15 mg/dL) was associated with a 22% reduction in risk of coronary heart disease. HRs for non-HDL and HDL-C were similar to those observed for Apo B and Apo A and non-HDL-C was the best tool to capture the risk associated with elevation of triglyceride rich proteins in clinical practice. The use of Apo B and Apo B–Apo A are also advocated as CVD risk markers in T2DM.

6.4.3 Management of dyslipidaemia

Type 2 diabetes mellitus. Comprehensive and consistent data exist on the mechanism of action and efficacy of statins in the prevention of CVD events in T2DM.²³² The benefits of statin therapy in lowering LDL-C and reducing CVD events are seen in all subgroup analyses of major RCTs.²³³ In a meta-analysis of 14 RCTs covering 18 686 people with DM, the mean duration of follow-up was 4.3 years, with 3247 major vascular events. The study reported a 9% reduction in all-cause mortality and a 21% reduction in the incidence of major vascular outcomes per mmol/L of LDL-C lowering (RR 0.79; 99% CI 0.72–0.87; $P < 0.0001$), similar to that seen in non-DM. The magnitude of the benefit was associated with the absolute reduction in LDL-C, highlighting a positive relationship between LDL-C and CVD risk, and was seen at a starting LDL-C as low as 2.6 mmol/L.²³⁴

The results of the first meta-analyses of cardiovascular events of intensive vs. moderate statin therapy show a 16% risk reduction of coronary death or MI.²³⁵ Data from 10 RCTs, studying 41 778 patients followed for 2.5 years, showed that intensive statin dosage reduced the composite endpoint of CAD by 10% (95% CI 0.84–0.96; $P < 0.0001$), but did not reduce CVD mortality.²³² In a subgroup of patients with ACS, intensive statin therapy reduced both all-cause and CVD mortality. Intensive lowering of LDL-C

by statins had a beneficial effect on progression of atheroma in DM and non-DM.²³⁶

Intensification of LDL-C lowering can also be achieved by adding ezetimibe to a statin, however, there are still no data from an RCT that this combination has a significant impact on CVD outcome. The IMProved Reduction of Outcomes: Vytorin Efficacy International Trial (IMPROVE-IT: ClinicalTrials.gov: NCT00202878) is, however, under way. An analysis of pooled safety data comparing the efficacy and safety profile of combination therapy with ezetimibe/statin vs. statin monotherapy in DM and non-DM ($n = 21\,794$)²³⁷ reported that combination therapy provided larger effects on all major lipid measures. The Study of Heart and Renal Protection (SHARP) trial reported a 17% reduction of major atherosclerotic events in chronic kidney disease treated with simvastatin plus ezetimibe daily vs. placebo.²³⁸ In this context it should be emphasized that, although relative reduction of events may be similar for people with and without DM, the absolute benefit is greater in DM-patients due to their higher risk.

Type 1 diabetes mellitus. The Cholesterol Treatment Trialists (CTT) analysis included 1466 T1DM patients with an average age of 55 years and a majority with prior CVD events. This analysis showed a similar reduction of risk of CVD events (RR 0.79; 95% CI 0.62–1.01) to that seen in T2DM and with a P value for interaction of 1.0, verifying the result despite only a borderline significance in the subgroup.²³⁴ It should be recognized that no trial data exist on the efficacy of statin therapy in a younger population with T1DM. However, in T1DM, statin therapy should be considered on an individual basis in those at high risk for CVD events, irrespective of LDL-C concentration—for example T1DM patients with renal impairment.

Primary prevention. The Collaborative Atorvastatin Diabetes Study (CARDS) evaluated the benefits of a statin in patients with T2DM and at least one of the following risk factors: hypertension, current smoking, retinopathy, or albuminuria.²³⁹ In CARDS, 2838 T2DM patients were randomized to atorvastatin 10 mg/day or placebo. The study was terminated prematurely, due to a 37% reduction (95% CI -52 to -17; $P = 0.0001$) in the primary endpoint (first acute coronary heart disease event). The Heart Protection Study (HPS) recruited 2912 patients (mainly T2DM) without pre-existing CVD. Simvastatin (40 mg/day) reduced the composite primary endpoint by 33% ($P = 0.0003$; 95% CI 17–46).²⁴⁰ In the Anglo-Scandinavian Cardiac Outcomes Trial (ASCOT) subgroup analyses of DM patients free from CVD, 10 mg of atorvastatin reduced the rate of major CVD events and procedures by 23% (95% CI 0.61–0.98; $P = 0.04$).²⁴¹

Safety of statin therapy. Reports from major RCTs demonstrate that statins are safe and well-tolerated.²⁴² The frequency of adverse events, except for muscle symptoms, is rare. In the majority of cases of myopathy or rhabdomyolysis there are drug interactions with a higher-than-standard dose of statin.²⁴³ The combination of gemfibrozil and statins should be avoided due to pharmacokinetic interaction, but there are no safety issues with fenofibrate and statins.^{228,229}

A meta-analysis including 91 140 participants reported that statin therapy was associated with risk of new-onset T2DM (OR 1.09; 95% CI 1.0–1.2; $I^2 = 11\%$), which increased with age.²⁴⁴ The data

translate to one case of T2DM when 255 patients have been treated for 4 years. Over the same time, statins would prevent 5.4 CVD events for each mmol/L reduction in LDL-C. A meta-analysis of five statin trials reported that the risk of new onset DM increased with intensive statin (atorvastatin or simvastatin 80 mg daily) therapy (OR 1.12; 95% CI 1.04–1.22; $I^2 = 0\%$), compared with moderate (simvastatin 20 mg or pravastatin 40 mg) doses.²⁴⁵ In the intensive group, two additional cases of new-onset DM per 1000 patient years were observed, whereas the number of CVD events was 6.5 cases fewer. Recently the Food and Drug Administration (FDA) of the USA approved label changes on increases of blood glucose and HbA_{1c} for the statin class of drugs (www.fda.gov/downloads/Drugs/DrugSafety/UCM293474.pdf). The FDA still considers that the small risk of developing DM is clearly outweighed by the reduction of cardiovascular events.^{245,246} Further support for the safety of statins comes from a meta-analysis of 27 randomized trials that demonstrated that, in individuals with a five-year risk of major vascular events lower than 10%, each 1 mmol/L reduction in LDL-C produced an absolute reduction in major vascular events of about 11 per 1000 over five years, without an increase in incidence of cancer or deaths from other causes. This benefit greatly exceeds any known hazards of statin therapy.²⁴⁷

Residual risk in people on LDL-lowering therapy. T2DM patients at the LDL-C target remain at high risk of CVD events,²²⁴ and this residual risk is linked to many factors including elevation of TG-rich proteins, low HDL-C and small, dense LDL particles. It has been suggested that targeting elevated TG (>2.2 mmol/L) and/or low HDL-C (<1.0 mmol/L) may provide further benefits. In the FIELD study, fenofibrate therapy did not reduce the primary endpoint (CAD-related death and non-fatal MI), but total CVD events were reduced from 14 to 12.5% (HR 0.9; 95% CI 0.80–0.99; $P = 0.035$).^{228,248} In the ACCORD trial, 5518 patients were assigned to fenofibrate plus simvastatin (20–40 mg daily) or placebo without any additional effect on the primary endpoint. In a pre-specified subgroup analysis of people with TG >2.3 mmol/L (>204 mg/dL) and HDL-C <0.9 mmol/L (<34 mg/dL), cardiovascular risk was reduced by 31% in the fenofibrate-plus-simvastatin group (for interaction between patients with this lipid profile vs. those without, $P = 0.06$).²²⁹ A subgroup analysis of dyslipidaemic people (TG >2.3 mmol/L and HDL-C <0.9 mmol/L) in the FIELD study revealed a 27% reduction in CVD risk.²²⁸ In both FIELD and ACCORD, fenofibrate therapy was associated with robust reduction of TG (22%), whereas elevation of HDL-C remained less than expected (+2% and +2.4%, respectively). Meta-analyses have confirmed the clinical benefits of fibrates on major CVD events but not on cardiovascular mortality.^{249,250} The effects seem to be linked to improvement in TGs.²⁵⁰

Strategies to elevate high-density lipoprotein cholesterol. The level of HDL-C is inversely related to CVD in epidemiological studies, as well as in many statin trials.²¹⁸ Low levels of HDL-C are associated with increased levels of triglycerides and are often seen in patients with metabolic syndrome and/or DM. Targeting low HDL-C for CVD prevention is, however, not supported by evidence. Two recently reported RCTs, using the cholesteryl ester transfer protein (CETP) inhibitors torcetrapib and dalcetrapib,^{251,252} failed to reduce cardiovascular events despite a 30–40% increase in

HDL-C. One explanation for these findings may relate to abnormal functional characteristics of HDL particles. If this is true, merely increasing the number of such particles without any improvement of their function may not alter CVD risk.

The pharmacological tools currently available to raise HDL-C in DM patients remain limited. Fenofibrate has trivial efficacy in this regard, while niacin (N-ER) has potentially useful properties, increasing HDL-C by 15–30%, with an associated increase in Apo A-1,^{224,253} besides lowering TG (up to 35%), LDL-C (about 20%) and Apo B and lipoprotein a (Lp a) (about 30%). Although a study showed favourable effects on angiographic measures, and on reduction of carotid wall area quantified with magnetic resonance imaging after one year of therapy,²⁵⁴ two recent clinical studies did not confirm the usefulness of N-ER for cardiovascular prevention. The Atherothrombosis Intervention in Metabolic Syndrome with Low HDL/High Triglycerides: Impact on Global Health Outcomes (AIM-HIGH) study showed no additional benefit of N-ER in patients with metabolic syndrome.²⁵⁵ In the Heart Protection Study 2 Treatment of HDL to Reduce the Incidence of Vascular Events (HPS-2 THRIVE) trial, 25 673 patients with known vascular disease were randomized to placebo or N-ER/laropirant on a background of statin or statin/ezetimibe therapy. The trial was stopped prematurely after a median follow up of 3.9 years. At that time, 15.0% of patients in the control arm and 14.5% in the N-ER/laropirant arm (ns) had reached the primary endpoint, a composite of coronary death, non-fatal MI, stroke, or coronary revascularization. Moreover, there was a significant 3.7% absolute excess risk of DM complications and a significant 1.8% excess risk of new-onset DM. In addition, N-ER treatment caused a 1.4% higher risk of infection and a 0.7% higher risk of bleeding, including an increased risk of haemorrhagic stroke.²⁵⁶ Based on these results, the EMA has withdrawn the marketing licence for N-ER/laropirant.

So far, lifestyle intervention with smoking cessation, increased physical activity, weight reduction and decreased consumption of fast-absorbed carbohydrates remains the cornerstone of HDL-increasing therapy.

In patients with high TG (>5.4 mmol/L) lifestyle advice (with a focus on weight reduction and alcohol abuse if relevant) and improved glucose control are the main targets. Risks associated with TG are acute pancreatitis and polyneuropathy. In a pooled analysis of randomized trial data, use of statins was associated with a lower risk of pancreatitis in patients with normal or mildly elevated triglyceride levels. Fibrates were not protective and may even have enhanced the risk.²⁵⁷ Omega-3 fatty acids (2–4 g/day) may be used for TG-lowering in people with high levels.²⁵⁸ There is, however, no evidence that such supplements are of cardiovascular benefit in patients with DM.

6.4.4 Gaps in current knowledge

- The role of HDL particles in the regulation of insulin secretion in beta-cells needs further exploration.
- Efficiency and safety of drugs increasing or improving HDL-C particles is unclear.
- The relative contributions of HDL function and plasma HDL concentration in the pathogenesis of CVD should be clarified.

6.4.5 Recommendations on management of dyslipidaemia in diabetes

Dyslipidaemia in diabetes			
Recommendations	Class ^a	Level ^b	Ref. ^c
Statin therapy is recommended in patients with T1DM and T2DM at very high-risk (i.e. if combined with documented CVD, severe CKD or with one or more CV risk factors and/or target organ damage) with an LDL-C target of <1.8 mmol/L (<70 mg/dL) or at least a ≥50% LDL-C reduction if this target goal cannot be reached.	I	A	227, 234, 238
Statin therapy is recommended in patients with T2DM at high risk (without any other CV risk factor and free of target organ damage) with an LDL-C target of <2.5 mmol/L (<100 mg/dL).	I	A	227, 234
Statins may be considered in T1DM patients at high risk for cardiovascular events irrespective of the basal LDL-C concentration.	IIb	C	-
It may be considered to have a secondary goal of non-HDL-C <2.6 mmol/L (<100 mg/dL) in patients with DM at very high risk and of <3.3 mmol/L (<130 mg/dL) in patients at high risk.	IIb	C	-
Intensification of statin therapy should be considered before the introduction of combination therapy with the addition of ezetimibe.	IIa	C	-
The use of drugs that increase HDL-C to prevent CVD in T2DM is not recommended.	III	A	251, 252, 256

CV = cardiovascular; CVD = cardiovascular disease; DM = diabetes mellitus; HDL-C = high density lipoprotein cholesterol; LDL-C = low-density lipoprotein cholesterol; T1DM = type 1 diabetes mellitus, T2DM = type 2 diabetes mellitus.

^aClass of recommendation.

^bLevel of evidence.

^cReference(s) supporting levels of evidence.

6.5. Platelet function

Platelet activation plays a pivotal role in the initiation and progression of atherothrombosis.²⁵⁹ Abnormalities in the aggregation of platelets in DM *ex vivo* have been described by numerous groups,²⁶⁰ and both post-prandial and persistent hyperglycaemia have been identified as major determinants of *in vivo* platelet activation in the early and late phases of the natural history of T2DM.^{261,262}

6.5.1 Aspirin

Aspirin inhibits thromboxane (TX) A₂-dependent platelet activation and aggregation through irreversible inactivation of platelet cyclo-oxygenase 1 (COX-1) activity.²⁶³ No formal studies have specifically examined the dose- and time-dependence of its antiplatelet effect in patients with T2DM and aspirin is currently recommended at 75–162 mg once daily, i.e. at the same dose and dosing interval used in people without DM.^{263,264} However, once-daily administration of low-dose aspirin may be associated with incomplete inhibition of platelet COX-1 activity and TXA₂-dependent platelet function,^{265–267} perhaps due to increased platelet turnover in DM.²⁶⁸ Evidence to support this view indicates the potentially beneficial effects of sustained efficacy using twice-daily aspirin in people with DM and CVD.^{268,269}

Secondary prevention. The first collaborative overview of the Antiplatelet Trialists' Collaboration found that antiplatelet therapy (mostly with aspirin) is similarly effective among patients with pre-existing symptomatic CVD, regardless of the presence of DM.²⁷⁰ They analysed individual data on 'serious vascular events' (non-fatal MI, non-fatal stroke or vascular death) from approximately 4500 patients with DM in the randomized trials and found that treatment with antiplatelet drugs produced a

proportional reduction of about one quarter.²⁷⁰ Therefore there is no apparent reason to treat patients with DM and CVD differently from non-DM patients and low-dose aspirin is uniformly recommended for both the acute treatment of ischaemic syndromes and their secondary prevention.²⁶³

Primary prevention. Low-dose aspirin is recommended by several North American organizations for the primary prevention of cardiovascular events in adults with DM.^{264,271} However, direct evidence of its efficacy and safety in this setting is lacking or, at best, inconclusive.^{272,273}

Thus, in the most up-to-date meta-analysis, which includes three trials conducted specifically in patients with DM and six other trials in which such patients represent a subgroup within a broader population, aspirin was found to be associated with a non-significant 9% decrease in the risk of coronary events (RR 0.91; 95% CI 0.79–1.05) and a non-significant 15% reduction in the risk of stroke (RR 0.85; 95% CI 0.66–1.11).²⁶⁴ It should be emphasized that the total number of patients with DM enrolled in these nine trials was 11 787, with 10-year extrapolated coronary event rates ranging from as low as 2.5% to as high as 33.5%.²⁶⁴ These results have been interpreted as suggesting that aspirin probably produces a modest reduction in the risk of cardiovascular events, but the limited amount of available data precludes a precise estimate of the effect size. Consistent with this uncertainty, antiplatelet therapy with aspirin in adults at a low CVD risk is not recommended by the Fifth Joint Task Force of the European Society of Cardiology and Other Societies on CVD Prevention in Clinical Practice.⁸⁹

The risk–benefit ratio of aspirin. Based on data from a meta-analysis of the six primary prevention trials, aspirin was associated with a 55% increase in the risk of extracranial (mainly gastrointestinal) bleeding, both in people without- (the majority) and

with DM.²⁷⁴ In terms of the balance between the potential benefit and hazard of aspirin in primary prevention, these results probably represent a best-case scenario, as people at increased risk of gastrointestinal bleeding were excluded and elderly people were under-represented.²⁷⁴ In the same analyses, the presence of DM at baseline was associated with a two-fold increase in vascular events but also with a 50% increased risk of major extracranial bleeds during follow-up.²⁷⁴

Both the Endocrine Society Clinical Practice Guideline and the ADA/AHA/ACCF Scientific Statement favour aspirin use in adults with DM when the 10-year risk of cardiovascular events is > 10%.^{271,264} However, relatively little emphasis is placed in either statement on the need to evaluate the variable bleeding risk of the patient. While the annual risk of cardiovascular events can vary approximately 10-fold in DM,²⁶⁴ the annual risk of upper gastro-intestinal bleeding has been estimated to vary by up to 100-fold in the general population, depending on age and history of peptic ulcer disease.^{263,275}

6.5.2 P2Y12 receptor blockers

Clopidogrel, an irreversible blocker of the adenosine diphosphate (ADP) receptor P2Y₁₂, provides a valid alternative for patients who are aspirin-intolerant or have symptomatic peripheral vascular disease, because it has broad indications for long-term secondary prevention similar to aspirin.^{276,277} Moreover, clopidogrel (75 mg once daily) produced additive cardio-protective effects when combined with low-dose aspirin (75–160 mg once daily) in patients with ACS and those undergoing percutaneous coronary intervention (PCI).²⁷⁶ There is, however, evidence from the Clopidogrel for High Atherothrombotic Risk and Ischaemic Stabilization, Management and Avoidance (CHARISMA) study to indicate that clopidogrel, added to background aspirin, may have deleterious effects in patients with advanced nephropathy.²⁷⁸ More effective P2Y₁₂ blockers include prasugrel and ticagrelor, a reversible P2Y₁₂ blocker.²⁷⁶ In the TRITON-TIMI 38 trial, prasugrel (60 mg loading dose, followed by 10 mg daily) showed clear superiority over clopidogrel (300 mg loading dose, followed by 75 mg daily) in the prevention of recurrent ischaemic events post-acute coronary syndrome (ACS): however, in the general cohort, this benefit carried a risk of increased thrombolysis in myocardial infarction (TIMI) major bleeding.²⁷⁹ In a DM sub-study, a similar reduction in recurrent ischaemic events was seen, but in the DM cohort this was not accompanied by an increase in bleeding.²⁸⁰ Ticagrelor (180 mg loading dose, followed by 90 mg twice daily), was also more effective than clopidogrel (300–600 mg loading dose, followed by 75 mg daily) in reducing death from CV causes and total mortality at 12 months in a general post-ACS cohort,²⁸¹ and decreased ischaemic events in DM patients without causing increased bleeding.²⁸² Importantly, ticagrelor was shown to be superior to clopidogrel in ACS patients with renal impairment.²⁸³ There is no convincing evidence that either clopidogrel or the newer drugs are any more or less effective in people with DM than in those without.²⁷⁶ For the use of these drugs in connection to PCI, see Section 7.2.

6.5.3 Gaps in knowledge

- The optimal antithrombotic regimen for the primary prevention of CVD in DM is not established.

6.5.4 Recommendations for antiplatelet therapy in patients with diabetes

Antiplatelet therapy in patients with diabetes			
Recommendations	Class ^a	Level ^b	Ref. ^c
Antiplatelet therapy with aspirin in DM-patients at low CVD risk is not recommended.	III	A	272–274
Antiplatelet therapy for primary prevention may be considered in high risk patients with DM on an individual basis.	IIb	C	-
Aspirin at a dose of 75–160 mg/day is recommended as secondary prevention in DM.	I	A	270
A P2Y ₁₂ receptor blocker is recommended in patients with DM and ACS for 1 year and in those subjected to PCI (duration depending on stent type). In patients with PCI for ACS preferably prasugrel or ticagrelor should be given.	I	A	276, 277, 280, 282, 284
Clopidogrel is recommended as an alternative antiplatelet therapy in case of aspirin intolerance.	I	B	280, 285

ACS = acute coronary syndrome; CVD = cardiovascular disease; DM = diabetes mellitus; PCI = percutaneous coronary intervention.
^aClass of recommendation.
^bLevel of evidence.
^cReference(s) supporting levels of evidence.

6.6 Multifactorial approaches

6.6.1 Principles of multifactorial management

Patients with glucose perturbations are in need of early risk assessment to identify co-morbidities and factors that increase cardiovascular risk. This includes evaluation of: (i) risk factors (e.g. lifestyle habits including smoking, hypertension and dyslipidaemia); (ii) microvascular and macrovascular disease and autonomic dysfunction; (iii) co-morbidities (e.g. heart failure and arrhythmias); (iv) inducible ischaemia by means of exercise testing, stress echocardiography, or myocardial scintigraphy and (v) myocardial viability and LV function by means of echo-Doppler and/or magnetic resonance imaging.²⁸⁶ The reliability of exercise testing, stress echocardiography, or myocardial scintigraphy is of a particular concern in the detection of ischaemia in DM. Confounders are a high threshold for pain due to autonomic dysfunction, the multi-vessel nature of coronary disease, ECG abnormalities, co-existence of PAD and use of multiple medications.

The total risk for cardiovascular complications is, to a large extent, related to synergistic interactions between IR, beta-cell dysfunction and subsequent hyperglycaemia but also the accumulation of cardiovascular risk factors. Accordingly, successful risk prevention depends on a comprehensive detection and management of all modifiable risk factors, as can be visualized by the use of risk engines (e.g. the UKPDS).¹⁰¹ It should be noted, however, that such engines need to be continuously updated.²⁸⁷ Further information can be obtained in Section 5.

The feasibility of intensified, multifactorial treatment for patients with T2DM in general practice was studied in the Anglo-Danish-Dutch Study of Intensive Treatment in People With Screen Detected Diabetes in Primary Care (ADDITION).²⁸⁸ The incidence of a first cardiovascular event was 7.2% (13.5 per 1000 person-years) in the intensive care group and 8.5% (15.9 per 1000 person-years) in the routine care group (HR 0.83; 95% CI 0.65–1.05), and incidence of all-cause mortality was 6.2% (11.6 per 1000 person-years) and 6.7% (12.5 per 1000 person-years), respectively (HR 0.91; 95% CI 0.69–1.21). It was concluded that an intervention to promote early intensive management of patients with T2DM was associated with a small but non-significant reduction in the incidence of cardiovascular events and death.^{26,289} A caveat in respect of ADDITION was the only slightly better control of important cardiovascular risk factors (HbA_{1c}, cholesterol concentrations and blood pressure) in the intensive group. In contrast, the value of a multifactorial intervention in patients with DM and established microalbuminuria was demonstrated by the STENO 2 study which, in a highly specialized setting, randomized 160 participants to an intensive, target-driven multifactorial therapy or to conventional management. The targets in the intensively treated group were HbA_{1c} <6.5%, total cholesterol <4.5 mmol/L (175 mg/dL) and blood pressure <130/80 mm Hg. All patients in this group received RAAS blockers and low-dose aspirin. Although treatment targets were not always attained in the intensive-treatment group, their overall management was considerably better than in routinely handled patients. This resulted in a reduction in microvascular and macrovascular events of about 50% after 7.8 years of follow-up. The target most successfully attained was that for cholesterol, probably making crucial the role of statins in the overall prevention strategy.^{290,291} Subsequently, target-driven therapy was recommended to patients in both groups. They were followed for 13 years after randomization. By that time, patients originally allocated to the intensively managed group had an absolute mortality reduction of 20% and the

HR for death, compared with that in the conventional group, was 0.54 (95% CI 0.3–0.9; $P < 0.02$). The absolute risk reduction in cardiovascular events was 29%. In addition, there was a substantial reduction in diabetic nephropathy (relative risk 0.4; 95% CI 0.3–0.8; $P < 0.004$) and progression of retinopathy (relative risk 0.6; 95% CI 0.4–0.9; $P = 0.01$).¹⁵⁶ In a health-economic analysis, intensive patient management was reported as more cost-effective than conventional care. Since increased expenses relating to intensive care were driven by pharmacy and consultation costs, such treatment would be dominant (i.e. cost- and life-saving with the use of generic drugs in a primary care setting).²⁹²

Data from the Euro Heart Survey on Diabetes and the Heart support a multifactorial approach as a cornerstone of patient management. Among 1425 patients with known T2DM and CAD, 44% received evidence-based pharmacological therapy, defined as a combination of aspirin, beta-blockade, RAAS inhibitors and statins in the absence of contra-indications. Patients on such drug combination had a significantly lower all-cause mortality (3.5 vs. 7.7%; $P = 0.001$) and fewer combined cardiovascular events (11.6 vs. 14.7%; $P = 0.05$) after one year of follow up, compared with those who did not receive a full combination of such drugs.²¹³ The adjusted HR for the interaction between DM and treatment revealed that the use of evidence-based treatment in T2DM had an independent protective effect (HR for death: 0.4). An example of the inadequacy of a single drug approach to decrease the incidence of CVD originates from a study that randomized 37 overweight/obese insulin-resistant participants, still without DM, to fenofibrate, rosiglitazone, or a calorie-restricted diet. None of the tested treatments appeared to be a therapeutic intervention that, in isolation, had the capacity to normalize all—or at least a majority—of the metabolic disturbances (e.g. weight, insulin sensitivity, cholesterol, TG, post-load PG) in these patients at a greatly increased cardiovascular risk.²⁹³

Treatment targets are summarized in Table 10.

Table 10 Summary of treatment targets for managing patients with diabetes mellitus or impaired glucose tolerance and coronary artery disease

Blood pressure (mmHg) In case of nephropathy	<140/85 Systolic <130
Glycaemic control HbA _{1c} (%) ^a	Generally <7.0 (53 mmol/mol) On an individual basis <6.5–6.9% (48–52 mmol/mol)
Lipid profile mmol/l (mg/dL) LDL-cholesterol	Very high risk patients <1.8 mmol/L (<70 mg/dL) or reduced by at least 50% High risk patients <2.5 mmol/L (<100mg/dL)
Platelet stabilization	Patients with CVD and DM ASA 75–160 mg/day
Smoking Passive smoking	Cessation obligatory None
Physical activity	Moderate to vigorous ≥150 min/week
Weight	Aim for weight stabilization in the overweight or obese DM patients based on calorie balance, and weight reduction in subjects with IGT to prevent development of T2DM
Dietary habits Fat intake (% of dietary energy) Total Saturated Monounsaturated fatty acids Dietary fibre intake	<35% <10% >10% >40 g/day (or 20 g/1000 Kcal/day)

CVD = cardiovascular disease; DM = diabetes mellitus; HbA_{1c} = glycated haemoglobin A_{1c}; IGT = impaired glucose tolerance; LDL = low density lipoprotein; T2DM = type 2 diabetes mellitus.

^aDiabetes Control and Complication Trial standard.

6.6.2 Gaps in knowledge

- Pleiotropic effects of glucose-lowering therapies on CVD outcomes are not fully understood.

6.6.3 Recommendations for multifactorial risk management in diabetes

Multifactorial risk management in diabetes			
Recommendations	Class ^a	Level ^b	Ref. ^c
Risk stratification should be considered as part of the evaluation of patients with DM and IGT.	IIa	C	-
Cardiovascular risk assessment is recommended in people with DM and IGT as a basis for multifactorial management.	I	B	156, 213
Treatment targets, as listed in Table I0, should be considered in patients with DM and IGT with CVD.	IIa	B	156, 213

CVD = cardiovascular disease; DM = diabetes mellitus; HbA_{1c} = glycated haemoglobin A1c; IGT = impaired glucose tolerance; LDL = low density lipoprotein; T2DM = type 2 diabetes mellitus.

^aDiabetes Control and Complication Trial standard.

7. Management of stable and unstable coronary artery disease in patients with diabetes

7.1. Optimal medical treatment for patients with chronic coronary artery disease and diabetes

DM is associated with a poorer prognosis in patients with acute and stable CAD.^{294–296} This is apparent in patients with newly detected DM and IGT,²⁹⁷ and although the absolute risk is higher in men, the proportionate increase in risk is higher in women, in whom loss of cardioprotection occurs with DM.²⁹⁸ All patients with CAD, without previously known glucose perturbations, should, for the purpose of risk stratification and adapted management, have their glycaemic state evaluated. Elevated levels of HbA_{1c} and FPG may establish the diagnosis of DM,²⁹⁹ but a normal value does not exclude glucose abnormalities. Accordingly, and as detailed in Section 3.3, the appropriate screening method is an oral glucose tolerance test (OGTT),^{3,38} which should not be performed earlier than 4–5 days after an acute coronary event (ACS) (i.e. acute MI or unstable angina) to minimize false positive results.^{300,301}

In-hospital and long-term mortality after MI has declined, but the outcome is still poor amongst patients with DM. The reasons are partially unexplained but a higher prevalence of complications, in

combination with lack of appropriate evidence-based treatment, contributes.^{302,303}

Since very few pharmacological trials have been directed towards patients with DM, information on treatment efficacy is frequently based on subgroup analyses from existing trials. A disadvantage is the risk of looking at groups of patients with DM considered suitable for the trial but in which the DM phenotypes are not well defined. Moreover, patients with CVD often have a metabolic syndrome or undetected DM. With these limitations, available information favours a proportionately similar efficacy of cardiovascular risk management in DM and non-DM patients. Considering the higher risk for cardiovascular events, the absolute benefit is considerably higher in DM, and the NNT to avoid one cardiovascular event is lower in this population.²¹³

7.1.1 Beta-adrenergic blockers

As outlined in current European guidelines on patients with CAD, beta-blockers are advocated for the whole spectrum of CAD, with different levels of recommendations and different levels of evidence.^{304–308} Beta-blockers relieve symptoms of myocardial ischaemia (angina pectoris) in patients with stable CAD and they may provide prognostic benefits, as suggested from retrospective analysis of placebo-controlled trials.³⁰⁵ Beta-blockers are particularly effective in improving prognosis in post-MI patients with DM by reducing the likelihood of reinfarction, sudden death and ventricular arrhythmias.^{309,310} Beta-blockers may have negative metabolic effects—for example, by increasing IR and masking hypoglycaemic symptoms—and there seems to be a difference between non-vasodilating, beta 1-antagonists (e.g. metoprolol and atenolol) and beta-blockers with vasodilating properties (e.g. the β/α-adrenoblockers carvedilol and labetalol, and β1-blockers with modulation synthesis of NO, nebivolol), with the latter advocated as having a better glucometabolic profile.³¹¹ Overall the positive effects of beta-blockade on prognosis outweigh the negative glucometabolic effects.

7.1.2 Blockers of the renin-angiotensin-aldosterone system

Treatment with ACE-I or ARB should be started during hospitalization for ACS and continued thereafter in patients with DM and left ventricular ejection fraction (LVEF) <40%, hypertension, or chronic kidney disease,^{304,306,307} and considered in all patients with ST-elevation MI (STEMI). Patients with DM and stable CAD are also recommended an ACE-I.³⁰⁵ The Heart Outcomes Prevention Evaluation (HOPE) study showed a 25% reduction in MI, stroke, or cardiovascular death for patients with known vascular disease or DM randomized to placebo or ramipril. This finding was consistent in the pre-specified subgroup of patients with DM.³¹² A proportionately similar trend to benefit was observed in the subgroup of patients with DM in the EUROpean trial on Reduction Of cardiac events with Perindopril in stable coronary Artery disease (EUROPA) trial, recruiting a population at lower cardiovascular risk.³¹³ The ONTARGET trial compared the ACE-I ramipril and the ARB telmisartan in a high-risk population similar to that in HOPE. In this head-to-head comparison, telmisartan was found to be equivalent to ramipril as regards the primary

outcome—a composite of death from cardiovascular causes, MI, stroke or hospitalization for heart failure—while a combination of the two drugs caused adverse events without any increase in benefit.²¹⁰

7.1.3 Lipid-lowering drugs

The beneficial effect of statins in patients with CAD and DM is firmly established. Details on lipid-lowering therapy are outlined in Section 6.4.

7.1.4 Nitrates and calcium channel blockers

There is no evidence for a prognostic impact of nitrates but they may be used for symptomatic relief.^{304,306,307} Calcium channel blockers are efficacious in relieving ischaemic symptoms, and verapamil and diltiazem may prevent re-infarction and death.^{304–307} These drugs may be appropriate for long-term use in patients without heart failure, as an alternative to beta-blockers or when beta-blockers may be a less attractive choice, e.g. due to obstructive airways disease. The combination of these drugs and beta-blockers should be avoided, considering the risk for bradycardia, atrio-ventricular conduction disturbances or compromised LV function. An alternative is the use of a dihydropyridine calcium channel blocker, such as amlodipine, felodipine or nicardipine.

7.1.5 Ivabradine

The specific, heart-rate lowering, anti-anginal drug ivabradine inhibits the I_f current—the primary modulator of spontaneous diastolic depolarization in the sinus node. Ivabradine is indicated in the treatment of chronic stable angina in CAD patients with a contra-indication or intolerance to beta-blockers, or in combination with beta-blockers if the patient remains symptomatic or has a heart rate >70 bpm, especially if there is also left ventricular (LV) dysfunction. It can be used in selected patients with non-ST elevation ACS in the event of beta-blocker intolerance, or insufficient heart rate reduction despite maximal tolerated beta-blocker dose.^{305,306} High heart rate is associated with a worse outcome in patients with DM,³¹⁴ and ivabradine is effective in preventing angina in these patients without any safety concerns or adverse effects on glucose metabolism.³¹⁵

7.1.6 Antiplatelet and antithrombotic drugs (see also Sections 6.5 and 7.2)

In secondary prevention, antiplatelet therapy in the form of low-dose aspirin (75–160 mg) or clopidogrel (separately or in combination) reduces the risk of stroke, MI or vascular death, although the benefits are somewhat less in DM.³¹⁶ In patients with ACS without ST-segment elevation, glycoprotein IIb/IIIa receptor inhibitors seemed to be especially effective in patients with DM but this was not confirmed in the recent Early-ACS trial.³¹⁷

Other antiplatelet drugs, such as thienopyridines (ticlopidine, clopidogrel, prasugrel and ticagrelor) reduce the risk of cardiovascular events when added to aspirin in patients with ACS.^{284,304,307} The incidence of cardiovascular death, MI or stroke decreased from 11.4 to 9.3% (RR 0.80; 95% CI 0.72–0.90) an effect that was sustained in patients with DM.²⁸² In the Clopidogrel vs. Aspirin in Patients at

Risk of Ischaemic Events (CAPRIE) study—recruiting patients with recent ischaemic stroke, recent MI or established PAD—those with DM and vascular disease were provided better protection from serious cardiovascular events by clopidogrel than by aspirin. The annual event rate in patients with DM was 15.6% in those randomized to clopidogrel and 17.7% in those who received aspirin, i.e. an absolute risk reduction of 2.1% ($P = 0.042$), which corresponds to an RRR of 13% (RR 0.87; 95% CI 0.77–0.88) and with fewer bleeding complications. Due to the elevated event rates in patients with DM, the absolute benefit of clopidogrel is amplified in this clinical setting.²⁸⁵ In a subgroup analysis of the TRITON trial, patients with DM tended to have a greater reduction in ischaemic events, without an observed increase in major bleeding, with prasugrel than with clopidogrel.²⁸⁰ It is important to acknowledge that many trials do not separately report outcomes for patients with DM and recommendations are based on available evidence from trials including patients with and without DM.³¹⁸

7.1.7 Glucose control in acute coronary syndromes

Elevated plasma glucose (PG) during an ACS is associated with a more serious prognosis in patients with DM than without.^{319–323} Hyperglycaemia may relate to previously undetected glucose perturbations, but also to stress-induced catecholamine release increasing FFA concentrations, decreased insulin production and increasing IR and glycogenolysis,³⁰¹ with a negative impact on myocardial metabolism and function (for details see Section 4). Two strategies have been tested in an attempt to improve the prognosis in patients with an ACS.

Metabolic modulation by means of glucose-insulin-potassium (GIK), regardless of the presence of DM or PG, is based on the assumption that an increase in intracellular potassium stabilizes the cardiomyocyte and facilitates glucose transportation into the cells.³²⁴ Other potential benefits are decreased beta oxidation of FFAs, improved use of glucose for energy production and improved endothelial function and fibrinolysis.³⁰¹ RCTs failed to show mortality or morbidity benefits, as reviewed by Kloner and Nesto.³²⁴ This lack of effect may be due to increased PG or negative effects of the fluid load induced by the GIK-infusion. The Immediate Myocardial Metabolic Enhancement During Initial Assessment and Treatment in Emergency Care (IMMEDIATE) trial, randomizing patients after a median time of 90 minutes of suspected ACS to out-of-hospital emergency medical service administration of GIK or placebo, demonstrated a reduction of the composite outcome of cardiac arrest or in-hospital mortality with GIK treatment, but did not impact the pre-specified primary endpoint, i.e. progression of ACS to MI within 24 h.³²⁵

Glycaemic control has been tested in the RCTs 'Diabetes and Insulin–Glucose Infusion in Acute Myocardial Infarction' (DIGAMI)^{326,327} 1 and 2 and 'Hyperglycaemia: Intensive Insulin Infusion in Infarction' (HI-5).³²⁸ The first DIGAMI trial randomized 620 patients with DM and acute MI to a ≥ 24 -h insulin–glucose infusion, followed by multi-dose insulin, or to routine glucose-lowering therapy.³²⁶ Mortality after 3.4 years was 33% in the insulin group and 44% ($P = 0.011$) in the control group.³²⁹

DIGAMI 2 failed to demonstrate prognostic benefits. The most plausible reason for this discrepancy is that, in DIGAMI 1,^{326,330} admission HbA_{1c} decreased more (1.5%), from a higher level (9.1%), compared with 0.5% from 8.3% in DIGAMI 2.³²⁷ In addition, the use of beta-blockade, statins and revascularization was more extensive in DIGAMI 2.

The difference in glucose levels between the control and insulin groups in the HI-5 study was small and there was no reduction in mortality among patients treated with insulin.³²⁸ Pooled data from the three studies confirmed that insulin–glucose infusion did not reduce mortality in the absence of glucose control in patients with acute MI and DM (RR 1.07; 95% CI 0.85–1.36; $P = 0.547$).³³¹ Since neither DIGAMI 2 nor HI-5 achieved a difference in glucose control between the intensively treated and the control groups, it is still an open question as to whether glucose lowering is beneficial.

The Heart2D compared the effects of prandial (pre-meal insulin three times daily; $n = 557$) vs. basal glycaemic control (long-acting insulin once or twice daily; $n = 558$) on cardiovascular events in patients with T2DM. Glucose targets were a PPG of 7.5 mmol/L (135 mg/dL) and an FPG of 6.7 mmol/L (121 mg/dL) respectively. The basal group had a lower mean FPG (7.0 vs. 8.1 mmol/L; $P < 0.001$) but a similar daily fasting/pre-meal blood glucose (7.7 vs. 7.3 mmol/L; $P = 0.233$) vs. the prandial group and a similar level of HbA_{1c}. The study was stopped after an average follow-up of 963 days, due to lack of efficacy.¹⁷³

Some registry studies have suggested that there is a J- or U-shaped relationship between PG and prognosis,^{320,322,323} with the implication that hypoglycaemia, as well as hyperglycaemia, may be prognostically unfavourable. Compensatory mechanisms induced by hypoglycaemia, such as enhanced catecholamine release, may aggravate myocardial ischaemia and provoke arrhythmias.^{332,333} Recent data indicate that hypoglycaemic episodes identify patients at risk for other reasons (e.g. heart failure, renal dysfunction and malnutrition) and hypoglycaemia does not remain as an independent risk factor when correcting for such variables.^{334,335}

A reasonable conclusion, from DIGAMI 1,^{326,330} is that DM and acute MI will benefit from glycaemic control if hyperglycaemia is significant (>10 mmol/L or >180 mg/dL). An approximation towards normoglycaemia, with less stringent targets in those with severe co-morbidities, is a reasonable goal but exact targets are still to be defined. Insulin infusion is the most efficient way to achieve rapid glucose control. Glucose management in the long-term perspective is presented elsewhere in these guidelines (Section 6.2).

7.1.8 Gaps in knowledge

- The role and optimum level of glycaemic control in the outcome in ACS patients remain to be established.
- Is it possible to reduce final infarct size by means of very early GIK administration after symptoms indicating MI?

7.1.9 Recommendations for the management of patients with stable and unstable coronary artery disease and diabetes

Management of patients with stable and unstable coronary artery disease and diabetes			
Recommendations	Class ^a	Level ^b	Ref. ^c
It is recommended that patients with CVD are investigated for disorders of glucose metabolism.	I	A	294, 295
Beta-blockers should be considered to reduce mortality and morbidity in patients with DM and ACS.	IIa	B	309, 310
ACE-I or ARBs are indicated in patients with DM and CAD to reduce the risk for cardiovascular events.	I	A	210, 312, 313
Statin therapy is indicated in patients with DM and CAD to reduce the risk for cardiovascular events.	I	A	227
Aspirin is indicated in patients with DM and CAD to reduce the risk for cardiovascular events.	I	A	274, 316
Platelet P2Y ₁₂ receptor inhibition is recommended in patients with DM and ACS in addition to aspirin.	I	A	280, 282, 284, 285, 304, 307
Insulin-based glycaemic control should be considered in ACS patients with significant hyperglycaemia (>10 mmol/L or >180 mg/dL) with the target adapted to possible co-morbidities.	IIa	C	-
Glycaemic control, that may be accomplished by different glucose-lowering agents, should be considered in patients with DM and ACS.	IIa	B	326, 328, 330

ACE-I = angiotensin converting enzyme inhibitor; ACS = acute coronary syndrome; ADP = adenosine diphosphate; ARB = angiotensin receptor blockers; CAD = coronary artery disease; CVD = cardiovascular disease; DM = diabetes mellitus.

^aClass of recommendation.

^bLevel of evidence.

^cReference(s) supporting levels of evidence.

7.2. Revascularization

A quarter of myocardial revascularization procedures are performed in patients with DM. Revascularization in these patients is challenged by a more diffuse atherosclerotic involvement of epicardial vessels, a

higher propensity to develop re-stenosis after PCI and saphenous graft occlusion after coronary artery bypass graft surgery (CABG) and unremitting atherosclerotic progression causing new stenosis.³³⁶ This results in a higher risk, including long-term mortality, than seen in patients without DM, irrespective of revascularization modality (Figure 7).³³⁷ Evidence on the effect of myocardial revascularization in patients with DM has been obtained in the shifting context of a continued development of PCI, CABG and pharmacological treatments, making it difficult to establish adequate comparisons.^{308,338}

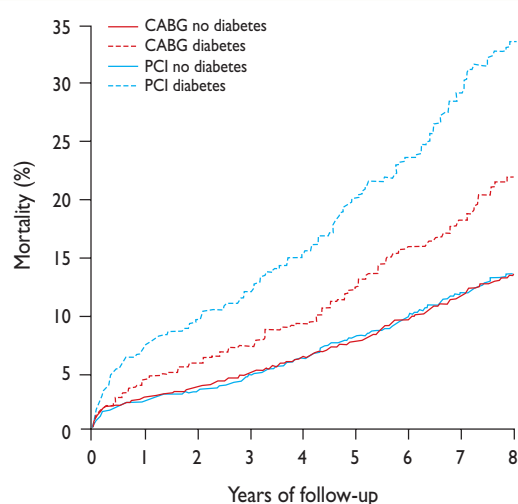


Figure 7:1 Mortality in patients assigned to coronary artery bypass graft or percutaneous coronary intervention by diabetes status in an analysis of 10 randomized trials. Reproduced with permission from Hlatky *et al.*³³⁷

7.2.1 Myocardial revascularization in stable and unstable coronary artery disease

Stable coronary artery disease. A randomized comparison of myocardial revascularization, either with CABG or PCI, vs. optimal medical treatment (OMT)—in DM patients considered eligible for either PCI or CABG—was performed in the Bypass Angioplasty Revascularization Investigation 2 Diabetes (BARI 2D) trial.³³⁹ Once PCI or CABG had been chosen as the most adequate potential revascularization technique, patients were randomized to OMT alone or to revascularization plus OMT. After five years, no significant differences were noted in the combined endpoint of death, MI or stroke between the OMT (12%) and revascularization (12%) arms. In the surgical group, freedom from major adverse cardiac and cerebrovascular events (MACCE) was significantly higher with CABG (78%) than with OMT alone (70%, $P = 0.01$), but there was no difference in survival (CABG 86%; OMT 84%; $P = 0.33$). In the PCI group, made up of patients with less-extensive CAD than in the CABG stratum, there were no significant differences in MACCE or survival between PCI and OMT. During subsequent follow-up, 38% of the patients assigned to OMT underwent at least one revascularization for symptomatic reasons, compared with 20% in the revascularization stratum, showing that an initial conservative strategy with OMT saved about 80% of interventions over the next five years.

Overall, except in specific situations such as left main coronary artery stenosis $\geq 50\%$, proximal LAD stenosis or triple vessel disease with impaired LV function, myocardial revascularization in patients with DM did not improve survival when compared with medical treatment. When transferring these results into general practice, it should be kept in mind that the results were obtained in a selected population. Patients were excluded if they required immediate revascularization or had left main coronary disease, a creatinine level > 2.0 mg/dL (> 177 μ mol/L), HbA_{1c} $> 13.0\%$, class III–IV heart failure or if they had undergone PCI or CABG within the previous 12 months.

Acute coronary syndromes. No interaction between the effect of myocardial revascularization and the presence of DM has been documented in trials on non-ST-elevation ACS management.^{340–342} An early invasive strategy improved outcomes in the overall population of these studies,^{303,340,342} with a greater benefit in patients with DM in the Treat angina with Aggrastat and determine Cost of Therapy with an Invasive or Conservative Strategy-Thrombolysis In Myocardial Infarction (TACTICS-TIMI 18) trial.³⁴² In STEMI patients, a pooled analysis of individual patient data ($n = 6315$) from 19 RCTs comparing primary PCI with fibrinolysis showed that patients with DM ($n = 877$; 14%) treated with reperfusion had an increased mortality, compared with those without DM. The benefits of a primary PCI, compared with fibrinolysis were, however, consistent in patients with and without DM.³⁴³ Patients with DM had significantly delayed initiation of reperfusion treatments and longer ischaemic times, probably related to atypical symptoms causing significant delays in the time for reperfusion treatment. However, the reduction in 30-day mortality observed in PCI-treated patients was most pronounced in this group. Owing to a higher absolute risk, the NNT to save one life at 30 days was significantly lower for DM (NNT 17; 95% CI 11–28) than for non-DM patients (NNT 48; 95% CI 37–60). A subgroup analysis of DM patients included in the Occluded Artery Trial (OAT) confirmed that, as in non-DM, revascularization of an occluded infarct-related artery 3–28 days after MI does not improve outcome.³⁴⁴

7.2.2 Type of intervention: coronary bypass graft vs. percutaneous intervention

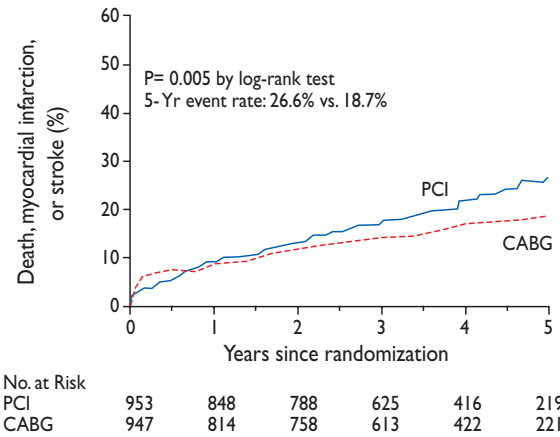
Higher repeat revascularization rates after PCI have been consistently found in DM patients included in RCTs comparing CABG and PCI. A meta-analysis based on individual data from 10 RCTs (7812 patients) comparing both types of revascularizations suggests a distinct survival advantage for CABG in DM patients (Figure 7:1).³³⁷ Five-year mortality was 20% with PCI, compared with 12% with CABG (odds ratio 0.7; 95% CI 0.6–0.9), whereas no difference was found for patients without DM; the interaction between the presence of DM and type of revascularization was significant. A specific comparison of the efficacy and safety of PCI and CABG in patients with DM was performed in the Coronary Artery Revascularization in Diabetes (CARDia) trial.³⁴⁵ The introduction of drug-eluting stents (DES) coincided with the enrolment period, leading to a mixed use of bare-metal stents (BMS) (31%) and DES (69%). After one year there was a non-significantly higher rate of the composite of death, MI and stroke (driven by a higher rate of MI) and significantly higher rates of repeat revascularization in the PCI group (2 vs. 12%, $P < 0.001$). The conclusions of the study were hampered by the limited size of the study population ($n = 510$).

The literature on CABG vs. PCI is confused by confounder bias in registries, the ongoing development of DES and, apart from the Future REvascularization Evaluation in patients with Diabetes mellitus: Optimal management of Multivessel disease (FREEDOM) trial, a lack of prospective RCTs. The implication is that much of the available information has to be derived from subgroup analyses in trials in populations in which patients with DM may be relatively few or selected. As a consequence of increased repeat revascularization in the SYNTAX trial,³⁴⁶ performed in the DES era (using paclitaxel-eluting stents), the rate of MACCE after one year was twice as high with PCI as it was with CABG. In the pre-specified subgroup with DM, the relative risk for repeat revascularization after one year was even higher (RR 3.2; 95% CI 1.8–5.7; $P < 0.001$). In patients with DM and complex lesions, i.e. high SYnergy between percutaneous coronary intervention with TAXus and cardiac surgery (SYNTAX) scores, one-year mortality was higher in the paclitaxel-eluting stent group (14% vs. 4%; $P = 0.04$).³⁴⁷ After five years of follow-up, the rates of MACCE were significantly higher in patients with DM, when comparing PCI with CABG (PCI: 46.5% vs. CABG: 29.0%; $P < 0.001$) as well as for repeat revascularization (PCI: 35.3% vs. CABG: 14.6%; $P < 0.001$). There was no difference in the composite of all-cause death/stroke/MI (PCI: 23.9% vs. CABG: 19.1%; $P = 0.26$). Similar results were seen—but with somewhat fewer events—among patients without DM. It was concluded that, although PCI is a potential treatment option in patients with less complex lesions, CABG should be the revascularization choice for patients with complex anatomic disease, especially with concurrent DM.³⁴⁸

In contrast, an analysis of DM patients included in the Angina With Extremely Serious Operative Mortality Evaluation (AWESOME) randomized trial and registry, which included high-risk patients for CABG (prior CABG, recent MI, LVEF $< 30\%$ or intra-aortic balloon pump treatment), showed no significant difference in three-year mortality between revascularization techniques.³⁴⁹ Data obtained in recent registries support a better outcome in patients with DM treated with CABG, compared with DES, even in terms

of mortality, at the expense of a higher stroke rate.³⁵⁰ In an analysis of 86 244 patients ≥ 65 years of age undergoing CABG and 103 549 patients undergoing PCI from 2004 to 2008, four-year survival was significantly higher with surgery and the association of surgery with improved survival was most marked in insulin-treated DM.³⁵¹ The Revascularization for unprotected left main coronary artery stenosis: comparison of percutaneous (MAIN COMPARE) study reported on the long-term outcome of 1474 patients with unprotected left main stenosis, treated with DES or CABG. In this specific setting, there was a similar rate of the composite endpoint death, Q-wave MI or stroke in the PCI and CABG arms and a significantly higher rate of repeat revascularizations in the DES arm. A subgroup analysis of the study comparing patients with ($n = 507$; 34%) and without DM did not reveal significant interactions between treatment outcomes and the presence or absence of DM after adjustment for co-variables.³⁵² In an observational study from real-world patients in the Swedish Coronary Angiography and Angioplasty Registry, comprising 94 384 consecutive stent implantations, PCI with new generation DES was associated with a 38% reduced risk for clinically meaningful re-stenosis and a 23% lower death rate, compared with older DES.³⁵³ These findings are supported by the outcome of a meta-analysis of 49 randomized controlled trials, including 50 844 patients, comparing different drug-eluting stents or drug elution with bare-metal stents.³⁵⁴ The FREEDOM trial randomized 1900 patients—a majority with three-vessel disease—to treatment with CABG or PCI with sirolimus-eluting and paclitaxel-eluting stents. Newer-generation stents could be used as long as the FDA approved them. All patients were prescribed currently recommended medical therapies for the control of LDL-C, systolic BP and HbA_{1c}. The primary results were a composite of total mortality and non-fatal MI or stroke. After a median of 3.8 years, the primary outcome occurred more frequently in the PCI group ($P = 0.005$), with a five-year rate of 26.6%, compared with 18.7% in the CABG group. The benefit of CABG was driven by differences in both MI ($P < 0.001$) and mortality ($P = 0.049$; Figure 7:2).

A - Primary Outcome



B - Death

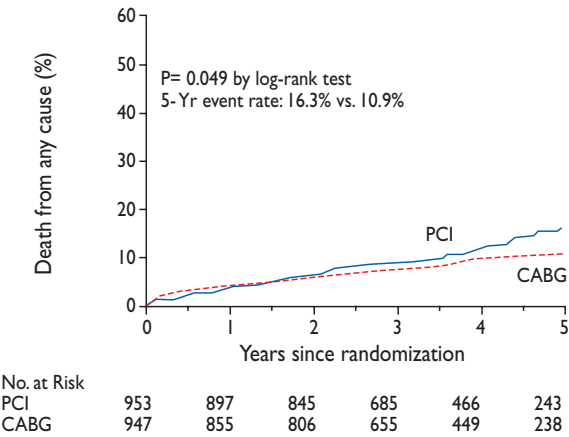


Figure 7:2 Kaplan-Meier estimates of the primary outcome and death. A: rates of the composite primary outcome of death, myocardial infarction or stroke and B: death from any cause truncated at five years after randomization. The P -value was calculated by means of the log-rank test on the basis of all available follow-up data. Reproduced by permission from Farkouh et al.³⁵⁵

It was concluded that CABG is superior to PCI for patients with DM and advanced CAD. There was no significant interaction based on SYNTAX score, since the absolute difference in the primary end points between PCI and CABG were similar in patients with low, intermediate and high SYNTAX scores. Given the wide variability of the patients enrolled in FREEDOM, the trial represents real-world practice. Further analysis revealed that CABG was a cost-effective strategy, compared with PCI.^{355,356} It can be concluded that a discussion with the patient, explaining the mortality benefit with CABG surgery, and an individualized risk assessment should be mandatory before the type of intervention is decided.³⁰⁸

7.2.3 Specific aspects of percutaneous and surgical revascularization in diabetes mellitus

The DIABETES trial demonstrated a 75% reduction in target vessel revascularization in DM patients treated with sirolimus-eluting stents (7%) vs. BMS (31%).³⁵⁷ This finding received further support from a meta-analysis of 35 trials comparing DES with BMS,³⁵⁸ which revealed a similar efficacy of sirolimus-eluting and paclitaxel-eluting stents in this regard (OR 0.29 for sirolimus; 0.38 for paclitaxel), *provided* that dual antiplatelet therapy after DES implantation was continued for >6 months. The risk of death associated with sirolimus-eluting stents was more than twice that associated with BMS in eight trials employing dual antiplatelet therapy for period of less than six months. In contrast, there was no increased risk associated with the use of DES in 27 trials with dual antiplatelet therapy maintained for more than six months. An analysis of registry data from the National Heart, Lung and Blood Institute Dynamic Registry revealed that, compared with BMS, DES were associated with fewer repeat revascularizations—to a similar extent in insulin-treated or non-insulin-treated DM.³⁵⁹ Finally, the second-generation everolimus-eluting stents were not superior in terms of target lesion failure after one year of follow-up in a head-to-head comparison with paclitaxel-eluting stents, while zotarolimus-eluting stents were inferior to sirolimus-eluting stents in patients with DM.^{360,361}

Antithrombotic treatment in DM patients undergoing coronary revascularization for stable angina or ACS is no different from those without DM.^{317,362,363} Initial trials in glycoprotein IIb/IIIa inhibitors reported an interaction with DM, but this was not confirmed in the recent Intracoronary Stenting and Antithrombotic Regimen: Rapid Early Action for Coronary Treatment (ISAR-REACT 2) trial performed in the clopidogrel era.³⁶⁴ Prasugrel is superior to clopidogrel in reducing the composite endpoint of cardiovascular death or MI or stroke without excess major bleeding. Similarly ticagrelor, in comparison with clopidogrel in the PLATelet inhibition and patient Outcomes (PLATO) trial, reduced the rate of ischaemic events in ACS patients, irrespective of the presence or absence of DM and glycaemic control, without an increase in major bleeding events.^{280,282}

Patients with DM who undergo CABG usually have extensive CAD and require multiple grafts. There is no randomized evidence regarding the use of one vs. two internal thoracic artery (ITA) conduits in DM. Although observational evidence suggests that using bilateral ITA conduits improves patient outcome without compromising sternal stability, their use is still under debate, given a higher prevalence of wound infection and mediastinitis with DM.³⁶⁵ A recent meta-analysis has shown that ITA harvesting by skeletonization (without the satellite veins and fascia) reduces the risk of

sternal wound infection, in particular in DM patients undergoing bilateral ITA grafting,³⁶⁶ although there are no randomized studies on this subject. A single-centre non-randomized study comparing CABG with bilateral ITA and PCI in DM reported improved outcomes (freedom from angina, re-intervention, or composite major adverse cardiac events) in the surgical group, but no difference in six-year survival (86% for CABG and 81% for PCI).³⁶⁷ Finally, more than 50% of patients with moderate-to-poor blood glucose control after cardiac surgery may not have been diagnosed as having DM during pre-operative assessment.³⁶⁸ This may lead to inadequate peri-operative glycaemic control, which is a predictor of in-hospital mortality and morbidity.

7.2.4 Myocardial revascularization and glucose-lowering treatments

Although hypoglycaemic medications may influence the safety of coronary angiography, as well as early and late outcomes of revascularization with PCI or CABG, few trials have addressed interactions with myocardial revascularization in DM.

The plasma half-life of metformin is 6.2 h. There is no adequate scientific support for the frequent practice of stopping metformin 24 to 48 h prior to angiography or PCI because of a potential risk of lactic acidosis, followed by restarting treatment 48 h later. More recent recommendations are less restrictive.³⁰⁸ Rather than stopping metformin treatment in all patients, a reasonable approach is to carefully monitor renal function after the procedure and to withhold metformin for 48 h if it deteriorates and until renal function has resumed its previous level.

Observational data reported concern over the use of sulphonylureas in patients treated with primary PCI for acute MI: this has not been confirmed by a *post hoc* analysis of the DIGAMI-2 trial, although the number of patients undergoing primary PCI in this trial was low.³⁶⁹ Arrhythmias and ischaemic complications were also less frequent in patients receiving gliclazide/glimepiride.³⁷⁰ Thiazolidinediones might be associated with lower re-stenosis rates after PCI with BMS,³⁷¹ but carry an increased risk of heart failure due to water retention in the kidney (see also Section 6.2.6).

No trial has demonstrated that the administration of insulin or GIK improves PCI outcome after STEMI. Observational data in patients undergoing CABG suggest that use of continuous intravenous insulin infusion to achieve *moderately* tight glycaemic control (6.6–9.9 mmol/L or 120–180 mg/dL) is independently associated with lower mortality and major complications than that observed after tighter (<6.6 mmol/L or <120 mg/dL) or more lenient (>9.9 mmol/L or >180 mg/dL) glycaemic control.³⁷² In the BARI 2D trial, outcomes were similar in patients receiving insulin sensitization vs. insulin provision to control blood glucose. In the CABG stratum, administration of insulin was associated with more cardiovascular events than insulin-sensitization medications.^{339,373}

7.2.5 Gaps in knowledge

- The optimal policy on metformin treatment in patients undergoing PCI is still uncertain.
- The role and optimum level of glycaemic control in the outcome during and after myocardial revascularization remain to be established.

7.2.6 Recommendations for coronary revascularization of patients with diabetes

Coronary revascularization of patients with diabetes			
Recommendations	Class ^a	Level ^b	Ref. ^c
Optimal medical treatment should be considered as preferred treatment in patients with stable CAD and DM unless there are large areas of ischaemia or significant left main or proximal LAD lesions.	IIa	B	339
CABG is recommended in patients with DM and multivessel or complex (SYNTAX Score >22) CAD to improve survival free from major cardiovascular events.	I	A	337, 339, 346, 350, 355, 374
PCI for symptom control may be considered as an alternative to CABG in patients with DM and less complex multivessel CAD (SYNTAX score ≤22) in need of revascularization.	IIb	B	347, 349, 350
Primary PCI is recommended over fibrinolysis in DM patients presenting with STEMI if performed within recommended time limits.	I	B	343
In DM patients subjected to PCI, DES rather than BMS are recommended to reduce risk of target vessel revascularization.	I	A	351, 352
Renal function should be carefully monitored after coronary angiography/PCI in all patients on metformin.	I	C	-
If renal function deteriorates in patients on metformin undergoing coronary angiography/PCI it is recommended to withhold treatment for 48 h or until renal function has returned to its initial level.	I	C	-

BMS = bare-metal stent; CABG = coronary artery bypass grafting; CAD = coronary artery disease; DES = drug-eluting stent; DM = diabetes mellitus; LAD = left anterior descending coronary artery; PCI = percutaneous coronary intervention; STEMI = ST-elevation myocardial infarction.

^aClass of recommendation.

^bLevel of evidence.

^cReference(s) supporting levels of evidence.

8. Heart failure and diabetes

Heart failure and T2DM frequently co-exist, each adversely affecting the natural course of the other. The prevalence of risk factors for heart failure is common in patients with DM, among which CAD and hypertension are the most important. In addition, dysglycaemia may in itself have an unfavourable effect on the myocardium. This has led to recognition of a clinical entity labelled as DM cardiomyopathy, in which compromised diastolic function is an early feature. An analysis of 987 patients with heart failure and preserved LVEF, enrolled in the Digitalis Investigation Group (DIG) ancillary study,³⁷⁵ revealed that T2DM was associated with significantly increased risk of developing adverse heart failure outcomes. The clinical approach to cardiomyopathy includes echocardiographic assessment of LV diastolic dysfunction, which can worsen during physical exercise.³⁷⁶ Insulin resistance, which characterizes the heart failure syndrome, regardless of aetiology, seems to be an important factor behind the elevated risk of DM development among heart failure patients. Despite strong evidence linking heart failure and DM, an optimal management of these co-existing conditions is still not fully evidence-based owing to a lack of clinical trials specifically addressing such patient populations.

8.1 Prevalence and incidence of heart failure in type 2 diabetes mellitus, and type 2 diabetes mellitus in heart failure

Prevalence and incidence of heart failure in diabetes mellitus.

The prevalence of heart failure in a general population is 1–4% and 0.3–0.5% of the patients have both heart failure and T2DM. Studies in heart failure populations reveal a prevalence of T2DM

from 12–30%, rising with age.^{377,378} T2DM is a major independent risk factor for the development of heart failure. In the Framingham study, the relative risk of heart failure in patients with T2DM (age 45–74 years) was doubled for men and six times as high in women.³⁷⁹ The high incidence of heart failure in patients with T2DM was also confirmed in the National Health and Nutrition Examination Survey, which revealed T2DM as an independent risk factor for heart failure, with an HR of 1.85 (95% CI 1.51–2.28) in T2DM, compared with non-DM.³⁸⁰ Boonman-de Winter *et al.*³⁸¹ who studied a Dutch group of 581 T2DM patients (aged >60 years) reported that 28% (95% CI 24–31%) had previously unknown heart failure; 5% with reduced LVEF and 23% with preserved LVEF. The prevalence increased rapidly with age, and heart failure with preserved LVEF was more common in women than men. Left ventricular dysfunction was diagnosed in 26% (95% CI 22–29%), and 25% (95% CI 22–29%) had diastolic dysfunction. This underlines the importance of looking for signs and symptoms of compromised myocardial function in patients with T2DM.

Several clinical correlates are independent risk factors for the development of heart failure in T2DM, including high HbA_{1c}, increased body mass index, advancing age, associated CAD, retinopathy, nephropathy and insulin use. Also, in recent studies, end-stage renal disease, nephropathy, proteinuria and albuminuria, retinopathy and duration of T2DM were associated with heart failure and its progression.³⁸²

Prevalence and incidence of diabetes mellitus in heart failure.

the prevalence of DM in a general population is 6–8% but, as reviewed by McDonald *et al.*, it is higher in people with symptomatic heart failure (12–30%) increasing towards 40% among hospitalized

patients.^{1,383} However, the heart failure populations are older than the general population. It should be noted that the prevalence of DM patients is lower in heart failure trials, indicating a selection bias towards younger and/or less sick DM patients. Information on the incidence of DM in heart failure populations is sparse but, in an elderly Italian population, new-onset DM occurred in 29% during three years of follow-up, compared with 18% in controls without heart failure.³⁸⁴ When people with two or more visits in the Reykjavik study ($n = 7060$) were followed over 30 years, DM and heart failure did not predict each other independently, although fasting glucose and BMI were significant risk factors, both for glucose disturbances and heart failure.³⁸⁵

Diabetes cardiomyopathy. Long-standing hyperglycaemia may—even in the absence of other risk factors such as CAD, valvular disease or hypertension—affect the myocardial tissue, increasing the risk of dysfunction. A reduction of LV compliance—an early sign of DM cardiomyopathy—may indeed already be detectable early in the course of DM.³⁸⁶ The frequent co-existence of hypertension and DM makes the contribution of the glucometabolic state to the diastolic dysfunction difficult to isolate. The pathogenic mechanisms involve accumulation of advanced glycation products, collagen formation and interstitial fibrosis, leading to impaired calcium homeostasis and impaired myocardial insulin signalling (See Section 4 for further details and references). These perturbations increase myocardial stiffness and reduce myocardial compliance.^{387,388} According to the recommendations of the ESC, LV diastolic dysfunction is identified by quantitative estimation of LV diastolic properties, using conventional Doppler parameters of the transmitral inflow of blood and tissue Doppler imaging of the mitral annulus. Deteriorating diastolic dysfunction is associated with a progressive increase in LV filling pressure which, in turn, has an impact on the transmitral flow pattern.³⁸⁹ It has been claimed—but not verified in longitudinal studies—that myocardial dysfunction may progress in a time-dependent fashion after the onset of diastolic dysfunction, leading to systolic dysfunction and the classical features of heart failure. Due to the frequent co-existence of DM, hypertension and CAD, it has been debated whether the myocardial dysfunction is primarily triggered by the glucometabolic disorder itself, rather than by the synergistic action of these factors. From a clinical perspective, prevention of the development of LV systolic dysfunction and subsequent heart failure is currently focussed on pharmacological treatment of the co-morbidities. It may also explain why meticulous blood pressure-lowering seems to be particularly effective in people with DM.

8.2 Diabetes mellitus and heart failure: morbidity and mortality

Heart failure was a major cause of hospitalization in patients with T2DM in the Hypertension, Microalbuminuria or Proteinuria, Cardiovascular Events and Ramipril (DIABHYCAR) trial, investigating hospitalizations in T2DM patients with albuminuria.³⁸² Conversely T2DM increased the risk of hospitalization in patients with heart failure in the Beta blocker STroke trial (BEST) trial³⁹⁰ (RR 1.16; 95% CI 1.02–1.32; $P = 0.027$). In Metoprolol CR/XL Randomized Intervention Trial in Congestive Heart Failure (MERIT-HF),³⁹¹ patients with heart failure and T2DM had one-year hospitalization of 31%, compared with 24% for those free from DM.

In the DIABHYCAR study, the combination of heart failure and T2DM resulted in a 12-fold higher annual mortality than among

patients with T2DM but without heart failure (36 vs. 3%).³⁸² BEST and Studies Of Left Ventricular Dysfunction (SOLVD) reported T2DM as an independent predictor of mortality, mostly in ischaemic heart failure.^{390,392} Also, the Danish Investigations and Arrhythmia ON Dofetilide (DIAMOND) and Candesartan in Heart Failure Assessment of Reduction in Mortality and Morbidity (CHARM) trials reported DM as an independent predictor of mortality, irrespective of aetiology.^{393,394}

8.3 Pharmacological management of heart failure in type 2 diabetes mellitus

Three neurohormonal antagonists—an ACE-I or ARB, a beta-blocker and a mineralocorticoid receptor antagonist (MRA)—comprise the important pharmacological agents for the treatment of all patients with systolic heart failure, including those with DM. They are usually combined with a diuretic for relieving congestion and may also be supplemented by ivabradine.³⁸⁹

Angiotensin-converting enzyme inhibitors and angiotensin receptor blockers. ACE-I is indicated in T2DM and heart failure, since it improves symptoms and reduces mortality. The SOLVD trial, using enalapril, showed a significant mortality reduction in DM with heart failure.³⁹² Mortality risk reduction in the high-dose vs. low-dose lisinopril groups was 14% in DM and 6% in non-DM in the Assessment of Treatment with Lisinopril And Survival (ATLAS) trial.³⁹⁵ In a meta-analysis, the risk ratio for death was the same in the ACE-I treated group as in the placebo-treated group in T2DM ($n = 2398$) and non-T2DM ($n = 10\,188$).³⁹⁶

Subgroup analyses of clinical trials indicate that the beneficial effects of ARBs are equivalent to those of ACE-I.^{397–400} An ARB can therefore be used as an alternative in ACE-I-intolerant patients. ACE-I and ARBs should not be combined in patients with an LVEF $< 40\%$, who are symptomatic despite optimal treatment with an ACE-I in combination with a beta-blocker. According to the 2012 ESC heart failure Guidelines, such patients should be prescribed an MRA (see below), which causes a larger morbidity and mortality reduction than that following addition of an ARB.³⁸⁹

When ACE-I and ARBs are used in patients with DM, surveillance of kidney function and potassium is mandatory, since nephropathy is a frequent occurrence.

Beta-blockers. In addition to an ACE-I (or, if not tolerated, an ARB) a beta-blocker should be given to all patients with an LVEF $\leq 40\%$. As an example, a subgroup analysis of the MERIT-HF trial shows that beta-blockers reduce mortality and hospital admission and improve symptoms without significant differences between T2DM and non-DM.³⁹¹ Further, two meta-analyses of major heart failure trials indicate that the RR of mortality in patients with DM receiving a beta-blocker was significantly improved (0.84 vs. 0.72).^{396,401} Beta-blockers also reduce hospitalizations for heart failure in both DM and non-DM.^{390,391,402,403} Despite this, people with T2DM are less likely to be discharged from hospital on a beta-blocker (OR 0.72; 95% CI 0.55–0.94) than non-DM with heart failure.⁴⁰⁴ The following beta-blockers are recommended in heart failure and T2DM: metoprolol succinate in the slow release form (MERIT-HF), bisoprolol [Cardiac Insufficiency Bisoprolol Study (CIBIS II)] and carvedilol [Carvedilol Prospective Randomized Cumulative Survival (COPERNICUS) and Carvedilol Or Metoprolol European Trial (COMET)].^{402,403,405,406}

Unwanted effects of beta-blockers in patients with DM and heart failure:

a) Hypoglycaemia. Evidence indicates that beta-blockers in DM alter counter-regulatory responses to hypoglycaemia with decreased tremor and palpitations but increased sweating.⁴⁰⁷ Prolonged hypoglycaemia has been described with non-cardio-selective beta-blockade (propranolol), but not with beta-1-selective agents or with carvedilol.^{408,409} Elderly DM patients on insulin ($n = 13\,559$), without heart failure, experienced an increased risk of serious hypoglycaemia with non-selective beta-blockade (RR 2.16; 95% CI 1.15–4.02) but not with beta-1-selective drugs (RR 0.86; 95% CI 0.36–1.33).⁴¹⁰

b) Negative metabolic effects. In hypertensive patients without heart failure, different beta-blockers may have varying effects on glycaemic indices, decreasing insulin sensitivity and increasing the risk of T2DM.⁴¹⁰ The marked clinical benefits of beta-blockers in patients with DM and heart failure outweigh the risks of hypoglycaemia and dyslipidaemia or decreased insulin sensitivity.

Mineralocorticoid receptor antagonists. To reduce the risk of hospitalization and premature death, a low-dose MRA is indicated in all patients with persisting symptoms [New York Heart Association (NYHA) Class II–IV] and an LVEF $\leq 35\%$, despite treatment with an ACE-I (or, if not tolerated, an ARB) and a beta-blocker.⁴¹¹ The mortality benefit of spironolactone⁴¹² and eplerenone⁴¹³ did not differ between patients with and without T2DM and heart failure. Surveillance of kidney function and potassium is mandatory, considering the increased risk of nephropathy in patients with DM.

Diuretics. The effect of diuretics on mortality and morbidity has not been investigated, but these drugs are useful for the relief of dyspnoea and oedema in heart failure with fluid overload, irrespective of the EF. Loop diuretics are recommended, rather than thiazides, which have been shown to promote hyperglycaemia.

Ivabradine. In a large, randomized, double-blind, placebo-controlled trial involving 6558 patients with heart failure in sinus rhythm and heart rate ≥ 70 bpm (3241 on ivabradine; 30% with T2DM), ivabradine demonstrated a significant reduction in composite endpoints of cardiovascular death and hospital admission for worsening heart failure. The beneficial difference was similar in a pre-specified subgroup analysis of patients with and without DM.⁴¹⁴

8.4 Non-pharmacological therapies for heart failure in diabetes mellitus

Cardiac resynchronization therapy and implantable cardioverter defibrillators. Cardiac resynchronization therapy is a guideline-recommended heart failure treatment, proved to reduce mortality in patients in NYHA function class III – IV, an LVEF $\leq 35\%$ despite optimal pharmacological treatment, in sinus rhythm and with a prolonged QRS duration (≥ 120 – 130 ms).⁴¹⁵ Despite a lack of subgroup analyses, there is no reason to believe that the effect of resynchronization therapy should be any different in patients with or without DM. Also, there is no additional benefit from implantable cardioverter defibrillators in a subgroup of patients with T2DM and heart failure, compared with patients free from this disease.⁴¹⁶

Cardiac transplantation is an accepted treatment for end-stage heart failure. The presence of DM is not a contra-indication, but the stringent selection criteria have to be acknowledged. The higher likelihood of cerebrovascular disease, decreased renal function and increased risk of infection has to be considered and may

contra-indicate heart transplantation more often in patients with than in those without DM.⁴¹⁷ DM was an independent risk factor for decreased 10-year survival in a large registry study of patients ($n = 22\,385$) transplanted between 1987 and 1999.⁴¹⁸

8.5 Glucose-lowering treatment in patients with heart failure

The impact of various glucose-lowering drugs on T2DM patients with heart failure was systematically reviewed by Gitt *et al.*⁴¹⁹ They noted that the only drugs addressed in RCTs were thiazolidinediones, while evidence on other compounds is largely based on subgroup analyses of larger intervention studies in systolic heart failure, observational studies or on registries.

The use of **metformin**, the recommended first-hand glucose lowering treatment, has previously been contra-indicated in patients with heart failure because of concerns regarding lactic acidosis. This drug has, however, been reported to be associated with lower mortality rates, lower rates of all-cause hospital admission and fewer adverse events,^{420,421} and an accumulation of lactic acidosis was not verified in a study by Masoudi *et al.*, who reported that 2.3% of metformin users had metabolic acidosis, in comparison with 2.6% in those not treated with metformin.⁴²² In a nested case-control study including patients with newly diagnosed heart failure and DM, who were either exposed to glucose-lowering drugs or not, the use of metformin [adjusted OR 0.65 (0.48–0.87)] or metformin with or without other agents [OR 0.72 (0.59–0.90)] was associated with lower mortality, while other oral glucose-lowering agents or insulin were neutral in this respect.⁴²³

Recommendations on **sulphonylureas** and heart failure are based on observational data. No relationship was seen between sulphonylurea and heart failure mortality in UKPDS,¹⁵² but in a large number of patients ($n = 12\,272$) in the Saskatchewan Health database, mortality (52 vs. 33%) and hospitalizations (85 vs. 77%) were higher among patients treated with sulphonylureas than with metformin during an average of 2.5 years of follow-up.⁴²⁴ A similar difference, to the disadvantage of sulphonylureas, was not confirmed in a study on Medicare beneficiaries, concluding that there was no association with such treatment (HR = 0.99; 95% CI 0.91–1.08) or insulin (HR = 0.96; 95% CI 0.88–1.05) and mortality.⁴²²

The PPAR γ -activating **thiazolidinediones** induce sodium retention and plasma volume expansion. The resulting fluid retention may provoke or worsen heart failure and cause increased numbers of hospitalizations.^{175,425,426} In the review by Gitt *et al.*,⁴¹⁹ it was stated that thiazolidinediones should not be used because of an increased event rate in patients with T2DM and established heart failure and a large increase in incident heart failure. Accordingly, this class of glucose-lowering drugs is discouraged when treating T2DM patients with heart failure.

There is a lack of information on the impact of **GLP-1 analogues or DPP-4 inhibitors** in patients with heart failure, although experimental and early clinical observations indicate favourable effects on myocardial performance.⁴²⁷

Regarding the use of **insulin**, a retrospective cohort study of 16 417 patients with DM and a primary diagnosis of heart failure did not reveal any association between the use of insulin and mortality (HR 0.96; 95% CI 0.88–1.05), in comparison with several other classes of glucose-lowering drugs.⁴²² In the ORIGIN trial, people at high CVD risk plus IFG, IGT or T2DM received insulin glargine or

standard care, which mainly included metformin and sulphonylurea treatment. During the 6.2-year-long follow-up period there was no difference in hospitalizations for heart failure.¹⁶⁸

8.6 Gaps in knowledge

- The impact of glucose-lowering drugs including metformin, GLP-1 analogues and DPP-IV inhibitors on the prevention of heart failure is unknown.

8.7 Recommendations for management of heart failure in diabetes

Management of heart failure in diabetes			
Recommendations	Class ^a	Level ^b	Ref. ^c
ACE-I is recommended in addition to beta-blockers, in patients with systolic heart failure and T2DM to reduce mortality and hospitalization.	I	A	391, 394–396
In patients with systolic heart failure and T2DM, who have a clear ACE-I intolerance due to side effects, an ARB may be used as an alternative to an ACE-I.	I	A	397–399
A beta-blocker is recommended in addition to an ACE-I (or an ARB if an ACE-I is not tolerated) in all patients with systolic heart failure and T2DM to reduce mortality and hospitalization.	I	A	391, 401–403, 405, 406
An MRA is recommended for all patients with persisting symptoms (NYHA Class II–IV) and an LVEF $\leq 35\%$ despite treatment with an ACE-I (or an ARB if an ACE-I is not tolerated) and a beta-blocker, to reduce the risk of heart failure hospitalization and premature death.	I	A	411–413
Addition of ivabradine to an ACE-I, beta-blocker and MRA may be considered in patients in sinus rhythm with T2DM with heart failure and LVEF $< 40\%$, who have persisting symptoms (NYHA Class II–IV) and a heart rate > 70 b.p.m. despite optimal tolerated dose of beta-blocker in addition to ACE (or ARB) and MRA.	IIb	B	414, 428
Thiazolidinediones should not be used in patients with heart failure and T2DM since water retention may worsen or provoke heart failure.	III	B	175, 425, 426

ACE-I = angiotensin converting inhibitor; ARB = angiotensin receptor blocker; LVEF = left ventricular ejection fraction; MRA = mineralocorticoid receptor antagonist; NYHA = New York Heart Association; T2DM = type 2 diabetes mellitus.

^aClass of recommendation.

^bLevel of evidence.

^cReference(s) supporting levels of evidence.

9. Arrhythmias: atrial fibrillation and sudden cardiac death

9.1 Diabetes mellitus and atrial fibrillation

Individuals with atrial fibrillation (AF) are at substantially increased risk of stroke and have twice the mortality rate from CVD as those in sinus rhythm.^{429,430} Diabetes mellitus is frequent in patients with AF. Community studies demonstrate the presence of DM in 13% of patients with AF.⁴³¹ DM and AF share common antecedents, such as hypertension, atherosclerosis and obesity; however, the independent role of DM as a risk factor for AF has not been established.

The Manitoba Follow-up Study estimated the age-specific incidence of AF in 3983 men.⁴³² DM was significantly associated with AF with a relative risk of 1.82 in univariate analysis. However, in the multivariable model, the association with DM was insignificant, suggesting that the increased risk may relate to ischaemic heart disease, hypertension or heart failure. In the Framingham Heart Study,⁴³³ DM was significantly associated with AF in both genders, even after adjustment for age and other risk factors (OR 1.4 for men and 1.6 for women). When developing a risk score for AF, the Framingham Heart study did not include DM as a significant predictor of AF.⁴³⁴ In another recent study, Nicholas *et al.* reported that DM was an independent predictor of AF in women only.⁴³⁵

A recent multi-centre study enrolling 11 140 DM patients confirmed that AF is relatively common in T2DM and demonstrated that when T2DM and AF co-exist, there is a substantially higher risk of all-cause mortality, cardiovascular death, stroke and heart failure.⁴³⁶ These findings suggest that AF identifies DM patients who are likely to obtain greater benefits from aggressive management of all cardiovascular risk factors. Because AF is asymptomatic—or only mildly symptomatic—in a substantial proportion of patients (about 30%), screening for AF can be recommended in selected patient groups with T2DM with any suspicion of paroxysmal or permanent AF by pulse palpation, routine 12-lead ECG, or Holter recordings.

Diabetes and risk of stroke in atrial fibrillation. Two recent systematic reviews have addressed the evidence base for stroke risk factors in AF and concluded that prior stroke/TIA/thromboembolism, age, hypertension, DM and structural heart disease are important risk factors.^{437,438}

Diabetes and stroke risk stratification schemes. The simplest scheme is the CHADS₂ [cardiac failure, hypertension, age, DM, stroke (doubled)] risk index. The 2010 ESC Guidelines for the management of AF, updated 2012, proposed a new scheme. The use of 'low', 'moderate' and 'high' risk has been re-emphasized, recognizing that risk is a continuum.^{439,440} The new scheme is expressed as an acronym CHA₂DS₂-VASc [cardiac failure, hypertension, age ≥ 75 (doubled), DM, stroke (doubled)-vascular disease, age 65–74 and sex category (female)]. It is based on a points system in which two points are assigned for history of stroke or TIA, or age ≥ 75 years and one point for the other variables. Heart failure is defined either as clinical heart failure or LV systolic dysfunction (EF $< 40\%$) and vascular disease as a history of MI, complex aortic plaque, or PAD.

Antithrombotic therapy in diabetes patients. A meta-analysis of 16 RCTs in 9874 patients was performed to characterize the efficacy of anticoagulant and antiplatelet agents for the prevention of

stroke in AF.⁴⁴¹ Oral anticoagulation was effective for primary and secondary prevention of stroke in studies comprising 2900 patients, with an overall 62% reduction of relative risk (95% CI 48–72). The absolute risk reduction was 2.7% per year for primary prevention and 8.4% per year for secondary prevention. Major extracranial bleeds were increased by anticoagulant therapy by 0.3% per year. Aspirin reduced risk of stroke by only 22% (95% CI 2–38), with an absolute risk reduction of 1.5% per year for primary prevention and 2.5% per year for secondary prevention. In five trials comparing anticoagulant therapy with antiplatelet agents in 2837 patients, warfarin was more effective than aspirin, with an RRR of 36% (95% CI 14–52). These responses were observed in both permanent and paroxysmal AF.

Supported by the results of several trials and the 2010 and in 2012 updated ESC Guidelines for management of AF,^{439,440} oral anticoagulation with vitamin K antagonists (VKAs)—or one of the new oral anticoagulants (NOAC; for further details see below)—are recommended in patients with AF. The choice of antithrombotic therapy should be based upon the absolute risk of stroke/thromboembolism and bleeding and the net clinical benefit for a given patient. Aspirin alone is not recommended for the prevention of thromboembolic disease in patients with DM and AF but, in patients unable or unwilling to use either VKAs or NOAC, the combination of aspirin and clopidogrel should be considered.⁴⁴² VKA or NOAC should be used if there are one or more stroke risk factors, provided there are no contra-indications following careful assessment of the risk–benefit ratio and an appreciation of the patient's values and preferences.^{439,440} It can be concluded that VKA or NOAC should be used in all AF patients with DM unless contra-indicated, and if accepted by the patient. With the use of VKA, an international normalized ratio (INR) of 2.0–3.0 is the optimal range for prevention of stroke and systemic embolism in patients with DM. A lower target INR (1.8–2.5) has been proposed for the elderly but this is not based on evidence.

In the ACTIVE W warfarin was superior to clopidogrel plus aspirin (RRR 0.40; 95% CI 18–56), with no difference in rates of bleeding.⁴⁴² The aspirin arm ACTIVE A aspirin found that major vascular events were reduced in patients receiving aspirin plus clopidogrel, compared with aspirin monotherapy (RR 0.89; 95% CI 0.81–0.98; $P = 0.01$).⁴⁴³ Thus, aspirin-plus-clopidogrel therapy may be considered as an interim measure if a VKA is unsuitable, but not as an alternative in patients at high bleeding risk. Combinations of VKA with antiplatelet therapy do not offer added beneficial effects on ischaemic stroke or vascular events and lead to more bleeding events,⁴³⁹ and such combinations should be avoided.

Two new classes of anticoagulants have been developed: oral direct thrombin inhibitors (e.g. dabigatran etexilate) and oral factor Xa inhibitors (e.g. rivaroxaban, apixaban, edoxiban, betrixiban). In the Randomized Evaluation of the Long-term anticoagulant therapy with dabigatran etexilate (RE-LY) study,⁴⁴⁴ dabigatran 110 mg *b.i.d.* was non-inferior to VKA for stroke prevention and systemic embolism with lower rates of major bleedings. Dabigatran 150 mg *b.i.d.* was associated with lower rates of stroke and systemic embolism with similar rates of major haemorrhages, compared with VKA therapy. The Apixaban VERsus acetylsalicylic acid to pRevent strOkES

(AVERROES) study was stopped early, due to clear evidence of a reduction in stroke and systemic embolism with apixaban 5 mg *b.i.d.*, compared with aspirin 81–324 mg once daily.⁴⁴⁵ A recent study, Apixaban for Reduction in Stroke and Other Thromboembolic Events in Atrial Fibrillation (ARISTOTLE), comparing warfarin with apixaban in patients with AF with a median CHADS₂ score of 2.1, showed that apixaban 5 mg *b.i.d.* was superior to warfarin in preventing stroke or systemic embolism, caused less bleeding and resulted in lower mortality.⁴⁴⁶ Twenty-four per cent of the patients had DM. The Rivaroxaban Once Daily Oral Direct Factor Xa Inhibition Compared with Vitamin K Antagonism for Prevention of Stroke and Embolism Trial in Atrial Fibrillation (ROCKET) trial, comparing warfarin with rivaroxaban, showed the non-inferiority of rivaroxaban to warfarin in preventing stroke, systemic embolism or major bleeding among the AF patients with a relatively high CHADS₂ score (median 3.5).⁴⁴⁷ These new drugs have the potential to be used as an alternative to warfarin, especially in patients intolerant to—or unsuitable for—VKAs. In analyses of pre-specified subgroups in the ROCKET trial, patients with DM had a level of protection similar to the overall study populations.

An assessment of bleeding risk should be carried out before starting anticoagulation. Using a real-world cohort of 3978 European patients with AF from the Euro Heart Survey, a new simple bleeding score known as 'Hypertension, Abnormal renal/liver function (1 point each), Stroke, Bleeding history or predisposition, Labile INR, Elderly (>65), Drugs/alcohol concomitantly (1 point each)' (HAS-BLED) was developed,⁴⁴⁸ which includes hypertension, abnormal renal/liver function, stroke, bleeding history or predisposition, labile international normalized ratio, elderly (>65 years), drugs/alcohol, as risk factors of bleeding. A score ≥ 3 indicates high risk and some caution and regular review of the patients is needed following the initiation of antithrombotic therapy.

9.2 Sudden cardiac death

Clinical studies of sudden cardiac death in diabetes mellitus.

Sudden cardiac death accounts for approximately 50% of all cardiovascular deaths. The majority are caused by ventricular tachyarrhythmia, often triggered by an ACS, which may occur without known cardiac disease or in association with structural heart disease.^{449,450} The published epidemiological studies in general population samples have shown that people with DM are at higher risk of sudden cardiac death. In the Framingham study, DM was associated with an increased risk of sudden cardiac death in all ages (almost four-fold) and was consistently greater in women than in men.⁴⁵¹ The Nurses' Health Study,⁴⁵² which included 121 701 women aged 30–55 years, followed for 22 years, reported that sudden cardiac death occurred as the first sign of heart disease in 69% of cases. DM was a strong risk factor, associated with three-fold increased risk of sudden death, while hypertension was associated with a 2.5-fold and obesity with a 1.6-fold increased risk. DM increases the RR for sudden cardiac death in different ethnic groups.^{453–455} A recent report from the ARIC investigators demonstrated that the magnitude of the relative increase in risk associated with DM was similar for sudden cardiac death and non-sudden cardiac death. In this study,

DM attenuated the gender difference in absolute risk of sudden cardiac death.⁴⁵⁶

DM increases the cardiovascular mortality in patients with heart failure and in survivors of MI. In an analysis of the CHARM programme, DM was an independent predictor of mortality—including sudden cardiac death—in patients with heart failure independent of EF.⁴⁵⁷ In a series of 3276 post-infarction patients from Germany and Finland, the incidence of sudden cardiac death was higher in T2DM with an HR of 3.8 (95% CI 2.4–5.8; $P < 0.001$).⁴⁵⁸ The incidence of sudden cardiac death in post-infarction patients with DM and a LVEF $> 35\%$ was equal to that of non-DM patients with an EF $\leq 35\%$. The incidence of sudden cardiac death was substantially increased among DM patients with an EF $< 35\%$, supporting the concept that a prophylactic implantable cardioverter defibrillator should be used in all symptomatic (NYHA Class II–IV) DM patients with an LVEF $< 35\%$ unless contra-indicated. T2DM patients with congestive heart failure or post MI should have their LVEF measured, to identify candidates for prophylactic implantable cardioverter defibrillator therapy. Similarly, secondary prophylaxis with implantable cardioverter defibrillator therapy is indicated in DM patients resuscitated from ventricular fibrillation or sustained ventricular tachycardia, as recommended in the Guidelines.⁴⁵⁹ All post-infarction patients with heart failure should also be treated with beta-blocking drugs, which are well established as reducing sudden cardiac death.^{449,450}

Pathophysiology of sudden cardiac death in diabetes mellitus. The causes underlying the increased vulnerability of the electrical substrate in DM are unclear and are likely to be consequent on several concomitant factors: (i) acute coronary occlusion and the presence and extent of CAD; (ii) myocardial fibrosis resulting in impaired LV filling (diastolic dysfunction) and systolic heart failure; (iii) microvascular disease and DM nephropathy; (iv) DM autonomic neuropathy; (v) abnormalities in electrical propagation in the myocardium reflected in ECG re-polarization and de-polarization abnormalities and (vi) obstructive sleep apnoea.^{459–466} Experimentally induced hypoglycaemia can also cause changes in cardiac electrophysiological properties. ‘Dead in bed’ syndrome is a term used to describe the unexpected death of young individuals with T1DM while sleeping, suggesting that hypoglycaemia may contribute to sudden cardiac death in DM.⁴⁶⁷

Jouven *et al.*,⁴⁵⁵ studied the RR of sudden cardiac death in groups of patients with different degrees of dysglycaemia and showed that higher values of glycaemia led to higher risk. Following adjustment for age, smoking habits, systolic blood pressure, heart disease and glucose-lowering treatment, even patients with borderline DM, defined as non-fasting glycaemia between 7.7 and 11.1 mmol/L (140 and 200 mg/dL), had an increased risk of sudden cardiac death (OR 1.24 compared with patients with normoglycaemia). The presence of microvascular disease, defined as retinopathy or proteinuria and female gender, increased risk in all groups. This study emphasizes that glucose intolerance seems to be a continuous variable directly related to the risk of sudden cardiac death, rather than supporting the previous view of risk being related to a specific threshold of glucose intolerance. This fits with the present concept that cardiovascular risk increases below present thresholds for DM already at glucose levels that have been considered fairly normal.

The Framingham investigators⁴⁶⁸ demonstrated, in a large community-based population that, after adjusting for co-variables, indices of reduced heart rate variability were influenced by plasma glucose. Hyperglycaemia—even mild—may be associated with lower heart rate variability.⁴⁶⁹ Similar findings were reported by the ARIC study,⁴⁷⁰ which showed that even patients with pre-diabetes have abnormalities of autonomic cardiac function and heart rate variability. These studies further confirm that glucose levels should be considered as a continuous variable influencing autonomic control of the heart. Unfortunately these studies were not designed to answer the question of whether reduced heart rate variability in DM is an independent predictor of sudden cardiac death. A recent study showed that measurement of autonomic markers, such as heart rate turbulence and deceleration capacity from 24-h Holter recordings, predicts the occurrence of cardiac death and sudden cardiac death among T2DM patients with recent MI.⁴⁷¹

Cardiovascular autonomic neuropathy was significantly associated with subsequent mortality in people with DM in a meta-analysis of 15 studies.⁴⁷² The Rochester DM neuropathy study was designed to define the risk factors for sudden cardiac death and the role of DM autonomic neuropathy in a population of 462 DM patients followed for 15 years.⁴⁷³ These data suggested that kidney dysfunction and atherosclerotic heart disease are the most important determinants of the risk of sudden cardiac death, whereas neither autonomic neuropathy nor QTc were independent predictors. This study did not include heart rate variability or other risk variables among the parameters introduced in multivariable analysis. In contrast, the results of the MONICA/KORA study reported that QTc was an independent predictor of sudden death, associated with a three-fold increase in patients with DM and a two-fold increase in those without.⁴⁷⁴ Measurements of heart rate variability and QTc may become valuable as predictors of sudden cardiac death in DM patients but evidence to support this as a general recommendation is still lacking.

On the basis of available evidence, it seems that all levels of glucose intolerance are associated with progressive development of a variety of abnormalities that adversely affect survival and predispose to sudden cardiac death. The identification of independent predictors of sudden cardiac death in DM has not progressed to a stage where it is possible to devise a risk stratification scheme for prevention.

Conclusions. Sudden cardiac death is a major cause of mortality in DM patients. While there are some risk factors for sudden cardiac death that may be specifically related to DM, such as microvascular disease and autonomic neuropathy, the focus should be on primary prevention of DM, atherosclerosis and CAD and secondary prevention of the cardiovascular consequences of these common conditions.

9.3 Gaps in knowledge

- Information is lacking on the long-term impact of glycaemic control on the QTc interval.
- What is the role of hypoglycaemia and other predictors in sudden cardiac death?

9.4 Recommendations for the management of arrhythmias in patients with diabetes mellitus

Management of arrhythmias in patients with diabetes mellitus			
Recommendations	Class ^a	Level ^b	Ref. ^c
Screening for AF should be considered since it is common in patients with DM and increases morbidity and mortality.	IIa	C	-
Oral anticoagulation with VKAs or a NOAC (e.g. dabigatran, rivaroxaban or apixaban) is recommended in DM patients with AF (paroxysmal and persistent) if not contraindicated.	I	A	439, 440, 442, 443, 445–447
Assessment of the risk of bleeding (i.e. HAS-BLED score) should be considered when prescribing antithrombotic therapy in patients with AF and DM.	IIa	C	-
Screening for risk factors for sudden cardiac death should be considered in patients with DM.	IIa	C	-
Implantable cardioverter defibrillators are recommended for patients with DM and ischaemic cardiomyopathy with LVEF <35% and those resuscitated from ventricular fibrillation or sustained ventricular tachycardia.	I	A	459
Beta-blockers are recommended for DM patients with heart failure and after acute MI to prevent sudden cardiac death.	I	A	391, 401–403, 405, 406, 449, 450

AF = atrial fibrillation; DM = diabetes mellitus; EF = ejection fraction; LV = left ventricular; NOAC = new oral anticoagulants; VKA = vitamin K antagonist.

^aClass of recommendation.

^bLevel of evidence.

^cReference(s) supporting levels of evidence.

10. Peripheral- and cerebrovascular disease

The definition of PAD used by the current ESC Guidelines includes atherosclerotic lesions in the extracranial carotid and vertebral, upper and lower extremity, mesenteric and renal arteries.⁴⁷⁵ The same definition will be used in the present document. Although abdominal aortic aneurysm is frequent in patients with DM, it is not included in the current PAD definition. Moreover, diagnosis and management of abdominal aortic aneurysm are carried out independent of the presence or absence of DM.

Table 11 History relevant to peripheral artery disease⁴⁷⁵

- Family history of CVD.
- Symptoms suggesting angina.
- Any walking impairment, e.g. fatigue, aching, cramping, or pain with localization to buttock, thigh, calf, or foot, particularly when symptoms are quickly relieved at rest.
- Any pain at rest localized to the lower legs or feet and its association with the upright or recumbent positions.
- Any poorly healing wounds of the extremities.
- Exertional pain in the upper extremities particularly if associated with dizziness or vertigo.
- Any transitory neurological symptom.
- History of abrupt onset hypertension, resistant hypertension (which may result from renal artery stenosis) or renal failure.
- Unusual or post-prandial abdominal pain particularly if related to eating and associated with weight loss.
- Erectile dysfunction.

CVD = cardiovascular disease.

10.1 Peripheral artery disease

Diabetes mellitus is a risk factor for the development of atherosclerosis at any vascular site, but particularly for lower extremity artery disease (LEAD), for which it increases risk two- to four-fold and for carotid artery disease. In LEAD, cigarette smoking, DM and hypertension are important risk factors. Although the association of DM with LEAD is inconsistent on multivariable analysis, it appears that the duration and severity of DM particularly influence the risk of gangrene and ulceration.^{476,477} In population studies, the presence of carotid artery stenosis was associated with DM and other classical risk factors, irrespective of age.^{478–480} DM is present in a significant proportion of patients with multi-site atherosclerosis, who have a worse prognosis than those with a single disease location.^{481,482} Patients with DM should undergo comprehensive screening for the presence of PAD at different vascular sites. Medical history and physical examination (Tables 11 and 12) are the cornerstones of diagnostic workup and should include a review of the different vascular beds and their specific symptoms,⁴⁷⁵ although many patients remain asymptomatic. Further diagnostic evaluation and treatment should be applied according to the ESC Guidelines on PAD.⁴⁷⁵ Briefly, in all DM patients, clinical screening to detect PAD should be performed annually and beneficial lifestyle changes encouraged.⁴⁸³ All patients with PAD should receive adequate lipid-lowering, antihypertensive and antiplatelet treatment,^{125,274,484,485} with optimal glycaemic control.^{154,291,486}

10.2 Lower extremity artery disease

Vascular obstructions are often located distally in patients with DM and typical lesions occur in the popliteal artery or in the vessels of the lower leg. In a cohort of 6880 patients over 65 years, one in five patients had LEAD, though only 10% were symptomatic.⁴⁸⁷ The incidence and prevalence of LEAD increase with age and

Table 12 Physical examination relevant to peripheral artery disease⁴⁷⁵

- Measurement of blood pressure in both arms and notation of asymmetry between the arms.
- Auscultation and palpation of the carotid and cervical areas.
- Palpation of the pulses at the upper extremities and if necessary, performance of Allen's test. The hands must be carefully inspected.
- Abdominal palpation and auscultation at different levels including the flanks and the iliac regions.
- Auscultation of the femoral arteries.
- Palpation of the femoral, popliteal, dorsalis pedis, and posterior tibial arteries.
- Inspection of the feet for colour, temperature, integrity of the skin. Recording of the presence of ulcerations.
- Additional findings suggestive of LEAD, including calf hair loss and skin changes, should be noted.
- ABI, calculated by dividing the systolic blood pressure at the tibial or dorsalis pedal level with the brachial pressure. An index of <0.9 is suggestive of LEAD.

ABI = ankle-brachial index; LEAD = lower extremity artery disease.

duration of DM. The National Health and Nutrition Examination Survey (NHANES II) determined pulse amplitudes in adults and diminished or absent pulsation of the dorsalis pedis artery was found in 16% of adults with DM aged 35–54 years and in 24% of those aged 55–74 years.⁴⁸⁸ In many older patients, LEAD is already present at the time of diagnosis of DM. Progression of LEAD may result in foot ulceration, gangrene and ultimate amputation of part of the affected extremity. DM accounts for approximately 50% of all non-traumatic amputations in the United States and a second amputation is common. Mortality is increased in patients with LEAD and three-year survival after an amputation is less than 50%.⁴⁸⁵ Early diagnosis of LEAD in patients with DM is important for the prevention of progression of LEAD, as well as for prediction of the overall cardiovascular risk.

Diagnosis. Symptoms suggestive of claudication are walking impairment, e.g. fatigue, aching, cramping, or pain with localization to buttock, thigh, calf, or foot, particularly when symptoms are quickly relieved at rest. Palpation of pulses and visual inspection of the feet are essential. Dependent rubor, pallor when the foot is elevated, delayed hyperaemia when the foot is lowered, absence of hair growth and dystrophic toenails are signs of limb ischaemia. An objective measure of LEAD is the ABI, calculated by dividing the systolic blood pressure at the posterior tibial or dorsalis pedal level with the brachial systolic blood pressure. An index of <0.9 is suggestive of LEAD, particularly in the presence of symptoms or clinical findings such as bruits or absent pulses. An ABI <0.8 indicates PAD, regardless of symptoms. Sensitivity of ABI measurement may be increased after exercise. Post-exercise ABI may identify significant LEAD, even in people with a normal resting ABI.⁴⁸⁹ An ABI >1.40 indicates poorly compressible vessels as a result of stiff arterial walls (medial calcinosis) that can impede the correct estimation of pressure in the artery, even in severe ischaemia of the extremities.

Primary and secondary prevention of LEAD in patients with DM consists of lifestyle changes (addressing obesity, smoking and lack of exercise) and control of risk factors, including hyperglycaemia, hyperlipidaemia and hypertension.

Treatment. In a systematic review of RCTs of exercise programmes in symptomatic claudication, supervised exercise therapy was effective in increasing walking time, compared with standard care.⁴⁹⁰ Combination therapy including drugs and exercise is often used. Although several drugs such as cilostazol, naftidrofuryl and pentoxifylline increase walking distance in patients with intermittent claudication, their role remains uncertain. In addition, statin therapy has been reported to be of benefit by increasing walking distance in patients with PAD.^{475,491} If conservative therapy is unsuccessful, revascularization should be considered. In case of disabling claudication with culprit lesions located at aorta/iliac arteries, revascularization should be the first choice, along with management of risk factors.⁴⁷⁵ An algorithm for the treatment of intermittent claudication is shown in Figure 8.

Critical limb ischaemia (CLI) is defined by the presence of ischaemic pain at rest and ischaemic lesions or gangrene attributable to arterial occlusive disease that is chronic and distinguishable from acute limb ischaemia. An algorithm for the management of CLI is provided in Figure 9.

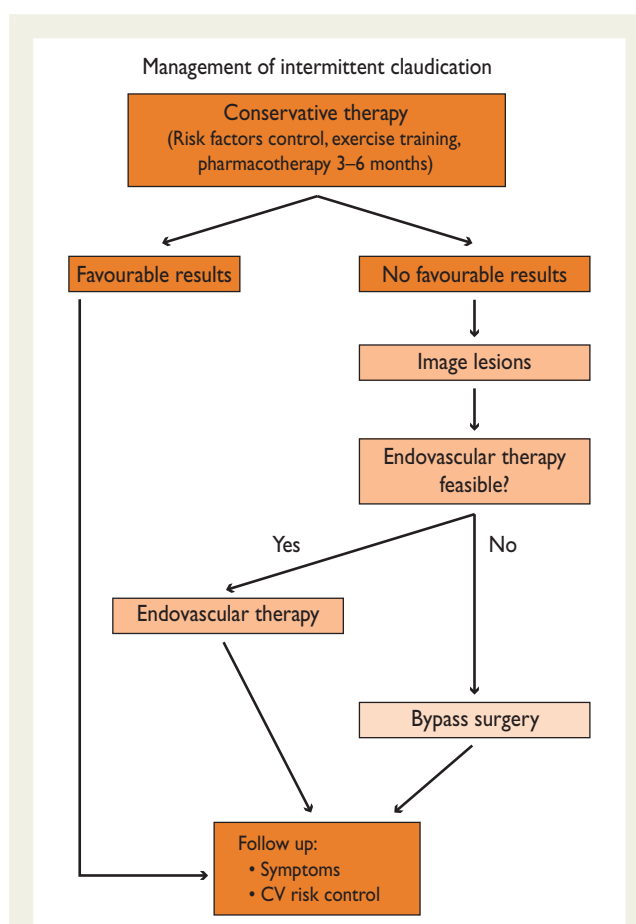


Figure 8 Algorithm for treatment of intermittent claudication (from Tendera et al.⁴⁷⁵ with permission). CV = cardiovascular.

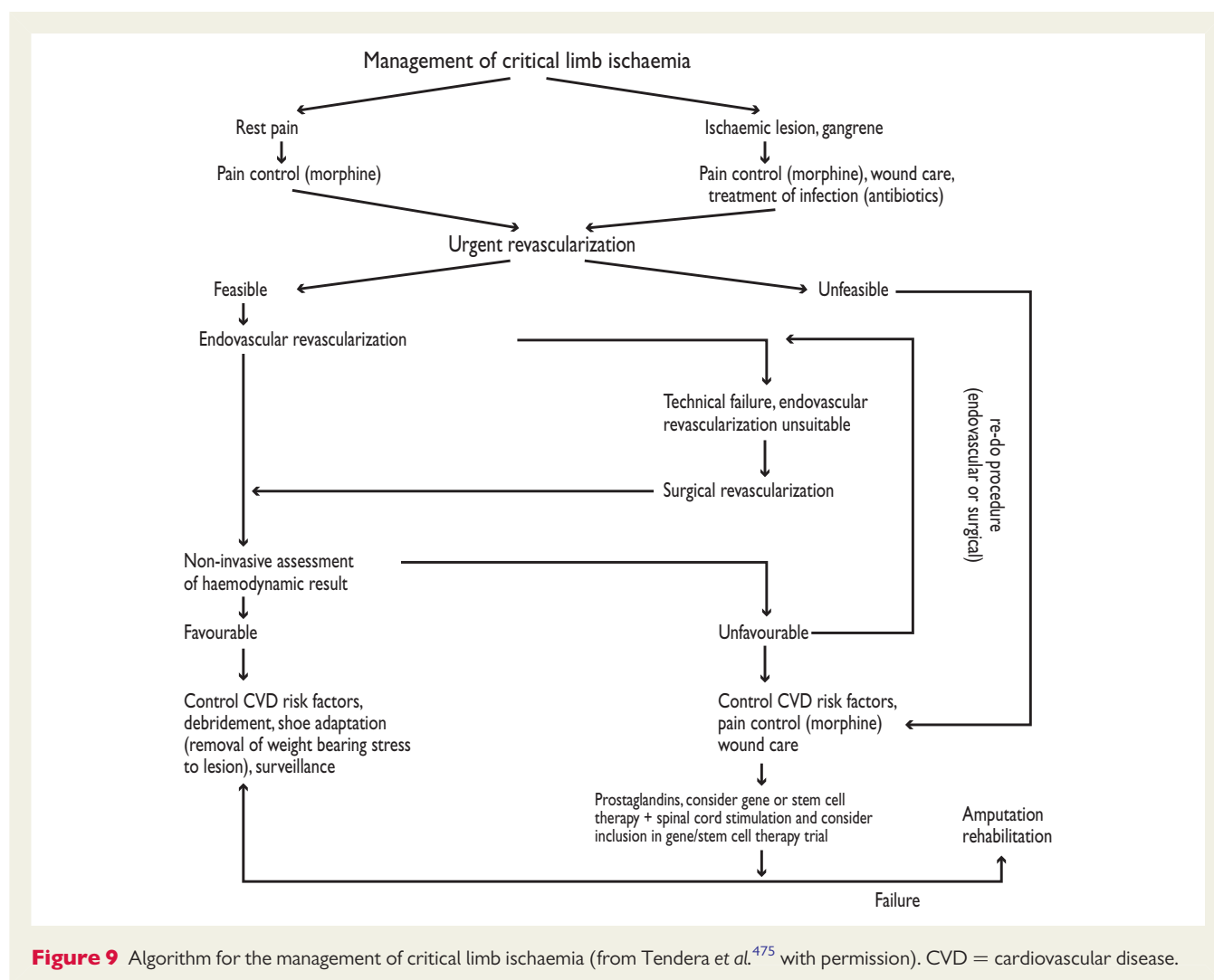


Figure 9 Algorithm for the management of critical limb ischaemia (from Tendera et al.⁴⁷⁵ with permission). CVD = cardiovascular disease.

Importantly, beta-blockers are not contra-indicated in patients with LEAD and DM. A meta-analysis of 11 RCTs found that beta-blockers do not adversely affect walking capacity or symptoms of intermittent claudication in patients with mild-to-moderate PAD.⁴⁹² At 32-month follow-up of 490 patients with PAD and prior MI, beta-blockers caused a 53% significant and independent decrease in new coronary events.⁴⁹³

Comprehensive management requires multidisciplinary care to control atherosclerotic risk factors, provision of revascularization where possible, optimization of wound care, wearing of appropriate shoes, treatment of infection and rehabilitation.⁴⁷⁵ The cornerstone of management is arterial reconstruction and limb salvage, which should be attempted without delay in all patients with critical limb ischaemia (CLI) when technically possible. The screening for—or assessment of—coronary or cerebrovascular diseases should not delay management of patients with CLI if clinically stable. Medical baseline therapy, including platelet inhibitors and statins, should be initiated according to principles outlined elsewhere in this document.^{475,494,495}

The choice of revascularization strategy depends primarily on the anatomy of the arterial lesion. Outcomes of endovascular iliac artery repair in DM have been reported as similar to or worse than those without DM, and long-term patency is lower.⁴⁹⁶ Long-term patency rates of intravascular interventions in the tibio-peroneal region are low in patients with and without DM, but may be sufficient in the short term to facilitate healing of foot ulcers.⁴⁹⁶

The diabetic foot is a specific clinical entity that may involve neuropathy, trauma, arterial disease, infection and inflammation, often in combination. The serious consequences are ulceration, gangrene and high rates of amputation. Typically, in DM patients, LEAD is diffuse and particularly severe in distal vessels. When arterial disease is suspected, clinical examination of pulses with measurement of ABI is indicated to assess ischaemia. When, due to a heavily calcified arterial wall, the ABI is inconclusive, toe pressure, distal Doppler waveform analyses, or transcutaneous oxygen can assess the arterial status. When ischaemia is present, imaging should be performed to plan revascularization, which should be

applied by the same criteria as for CLI. It is important to have direct flow to the foot to improve healing of ulcerations. Sufficient amputation is necessary in order to achieve adequate perfusion which, in combination with revascularization, will contain the ischaemic, inflammatory and infective process.

Follow-up should include patient education, smoking cessation, protective shoes, periodic foot care and reconstructive foot surgery as needed. The management of risk factors including glycaemic control and revascularization surveillance are mandatory.⁴⁹⁷

10.3 Carotid artery disease

Cerebrovascular disease is one of the leading causes of morbidity and mortality in Europe. DM is an independent risk factor for ischaemic stroke with an incidence 2.5–3.5 times higher than in people without DM.^{498,499} In this document, the discussion of stroke and transient ischaemic attack (TIA) prevention will be limited to the aspects related to carotid artery disease. It should be noted that only about 20% of all ischaemic strokes can be causally related to carotid artery stenosis.⁵⁰⁰ Although the presence of DM increases the likelihood of carotid artery disease, its presence does not change the general diagnostic and therapeutic approach.

Diagnosis. Carotid bruits are common in patients with carotid artery stenosis, although many remain asymptomatic regardless of lesion severity. Although the spectrum of symptoms is wide, only those who have suffered a stroke or TIA within the past six months are regarded as symptomatic.^{501,502} In this group of patients, the probability of recurrent stroke or TIA is high,⁵⁰³ therefore urgent imaging of the brain and supra-aortic vessels is mandatory in patients presenting with TIA or stroke. Duplex ultrasonography, computed tomography angiography and magnetic resonance imaging are indicated to evaluate carotid artery stenosis.

Treatment. Management depends on symptoms, severity of the lesion, prognosis for 5-year survival and the outcome of revascularization procedures. A management algorithm is shown in Figure 10.

Whilst carotid endarterectomy seems to offer a clear advantage over conservative treatment in patients with symptomatic carotid artery disease, the role of revascularization in asymptomatic patients remains less clear.⁴⁷⁵ It needs to be emphasized that most data in patients with no symptoms were collected before statins and antiplatelet agents became standard therapy. On the other hand, the results of both endarterectomy and carotid stenting have improved over time and the role of revascularization in this cohort needs to be reassessed.

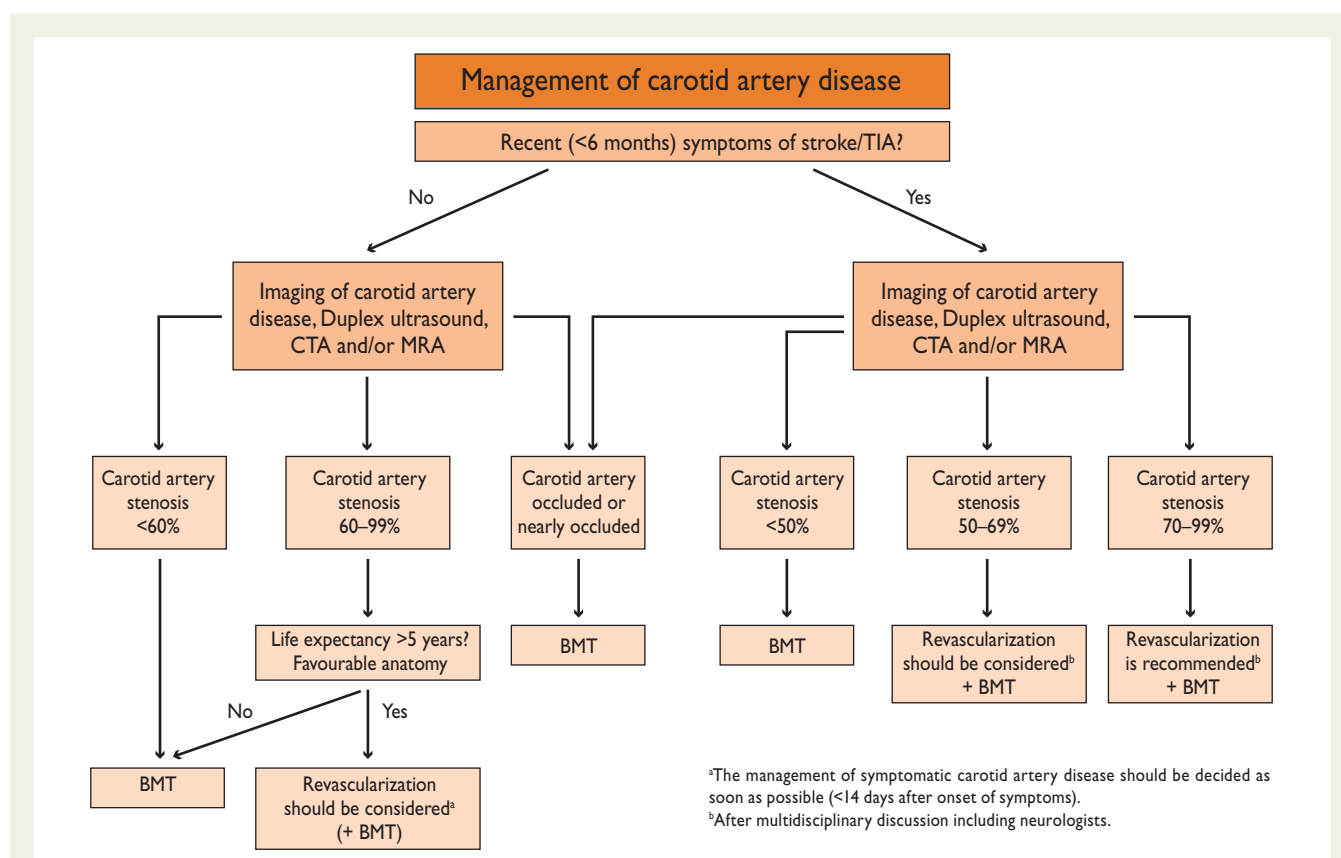


Figure 10 Algorithm for the management of extra cranial carotid artery disease (from Tendera et al.,⁴⁷⁵ with permission).

BMT = best medical therapy; CTA = computed tomography angiography; MRA = magnetic resonance angiography; TIA = transient ischaemic attack.

10.4 Gaps in knowledge

- In comparison with aspirin and clopidogrel, the efficacy of new antiplatelet drugs in patients with DM and PAD is not well known.
- There is a need for comparisons of endovascular and surgical interventions in different subsets of patients with DM and concomitant carotid or lower extremity artery disease.

10.5 Recommendations for management of peripheral artery disease in diabetes

Management of peripheral artery disease in diabetes			
Recommendations	Class ^a	Level ^b	Ref. ^c
It is recommended that patients with DM have annual screening to detect PAD and measurement of the ABI to detect LEAD.	I	C	-
It is recommended that all patients with PAD and diabetes who smoke are advised to stop smoking.	I	B	483
It is recommended that patients with PAD and DM have LDL-C lowered to <1.8 mmol/L (<70 mg/dL) or by ≥50% when the target level cannot be reached.	I	A	125
It is recommended that patients with PAD and DM have their blood pressure controlled to <140/85 mm Hg.	I	C	-
Antiplatelet therapy is recommended in all patients with symptomatic PAD and DM without contraindications.	I	A	274

ABI = ankle-brachial index; DM = diabetes mellitus; LDL-C = low-density lipoprotein cholesterol; LEAD = lower extremity artery disease; PAD = peripheral artery disease.
^aClass of recommendation.
^bLevel of evidence.
^cReference(s) supporting levels of evidence.

11. Microvascular disease in the eyes and kidneys

Diabetes mellitus is an important risk factor for both renal and cardiovascular outcomes and renal impairment—in the form of elevated urinary albumin excretion and/or impaired GFR—is itself an independent predictor of cardiovascular outcomes.^{161,504,505} Urinary albumin excretion and loss of glomerular filtration rate (GFR) are to some extent beneficially modifiable by interventions that lower blood glucose and blood pressure.

Retinopathy is the most frequent microvascular complication in DM. Although the incidence has declined slowly following the implementation of intensive treatment regimens, vision-threatening proliferative retinopathy affects 50% of people with T1DM and 29% with T2DM develop vision-threatening macular oedema.^{506–508} Rapidly progressive retinopathy indicates increased cardiovascular risk and the combination of retinopathy and nephropathy predicts excess

cardiovascular morbidity and mortality. In T2DM, advanced retinopathy more than doubles the risk of cardiovascular outcomes.⁵⁰⁹

11.1 Pathophysiology of microvascular disease

Renal neuropathic and ocular microvascular complications share some pathophysiological mechanisms that also affect the macrovascular endothelium. Chronic hyperglycaemia induces biochemical abnormalities causing protein glycation and overproduction of ROS, leading to vascular damage and responsive activation of tissue-specific growth/repair systems.⁵¹⁰ The phenotypic characteristics of microvascular damage in DM are progressive vascular occlusion and increased vascular permeability. In the retina, progressive vascular occlusion promotes aberrant responsive neovascularization, causing proliferative retinopathy as an advanced complication. At any stage of progressive vasoregression, increased vascular permeability causes retinal thickening, which is clinically significant when affecting the central macula.

In the kidney, endothelial dysfunction and increased vascular permeability are clinically represented by microalbuminuria, and vascular occlusion corresponds to a progressive decline in renal function as measured by GFR.

11.2 Treatment and treatment targets

Lifestyle intervention. There are no trials proving that lifestyle interventions alone have an effect on the prevention of nephropathy, neuropathy or retinopathy.

Glycaemic control. (see section 6.2.1) As primary intervention, strict glycaemic control prevents both microvascular and cardiovascular outcomes with a long-term beneficial effect, both in T1DM and T2DM.^{151,152,154,155} In secondary prevention, strict glycaemic control prevents progression of renal impairment in both groups.^{160,511}

Retinopathy. The recommended target for HbA_{1c} in both T1DM and T2DM is <7% (<53 mmol/mol).^{152,512–514} Beyond a certain level of retinal damage, euglycaemia no longer provides a benefit against progression of retinopathy. For T1DM, this level of damage is precisely defined (i.e. moderate non-proliferative diabetic retinopathy), while in T2DM the point of no return is unknown.⁵¹⁵ In T1DM, transient worsening of retinopathy due to euglycaemic re-entry (i.e. intensified insulin therapy after a prolonged period of insufficient glucose control) is outweighed by the long-term benefit of good glycaemic control.⁵¹⁵ In contrast, in T2DM, a similar deterioration is not a consistent feature of improved glycaemic control. Progressing retinopathy benefits from multifactorial treatment.¹⁵⁶ For further details, see Section 7.1.

Blood pressure – nephropathy. As a primary intervention, intensified blood pressure control using RAAS blockers prevents the onset of microalbuminuria in T2DM,^{191,193} but not in T1DM.^{516–518} As a secondary intervention, intensified blood pressure control using ACE-I to block the RAAS slowed progression of kidney disease in T1DM and reduced end-stage renal failure.^{519,520} A concomitant reduction in cardiovascular events was not demonstrated in these young patients, although it should be expected, considering the renal effects of ACE-I. In T2DM, high doses of ramipril prevented both renal and cardiovascular events.⁵²¹ ARBs reduced progression from microalbuminuria to proteinuria and prevented renal events but not cardiovascular death.^{522,523} The currently recommended blood pressure target is <140/85 mm Hg but in patients with hypertension and nephropathy

with overt proteinuria an even lower SBP (<130 mm Hg) may be considered if tolerated by the patient (see even Section 6.3.3).⁵²³

Blood pressure – retinopathy. Blood pressure control has beneficial effects on the progression of retinopathy. The recommended threshold is <140/85 mm Hg^{191,524} although other concomitant conditions, such as nephropathy, may require more intensive blood pressure control (systolic <130 mm Hg). Lowering blood pressure to this target does not adversely affect retinopathy. The Diabetic Retinopathy Candesartan Trials (DIRECT) studies investigated the effects of blood pressure-lowering with candesartan on the development and progression of retinopathy. There was a non-significant trend towards reduced progression of retinopathy, both in T1DM and T2DM.^{524,525}

Lipid-lowering and antiplatelet therapy – nephropathy. Interventions on blood lipids and platelet aggregation have not been documented as altering renal disease in DM. Fibrates and PPAR α agonists may reduce kidney function.⁵²⁶ In the FIELD study, fenofibrate reduced albuminuria and slowed estimated glomerular filtration rate (eGFR) loss over 5 years, despite initially and reversibly increasing plasma creatinine in T2DM.⁵²⁷

Recently, statin-plus-ezetimibe treatment provided cardiovascular protection in people with reduced kidney function including those with DM.²³⁸

Lipid-lowering and antiplatelet therapy – retinopathy. There are no clear target levels of lipids (cholesterol, triglycerides) for the prevention or retardation of retinopathy. In T2DM, the FIELD study reported that fenofibrate was associated with a reduction in requirement for laser therapy, although this effect appeared to be independent of effects on lipid levels. The ACCORD trial tested the outcome of lipid lowering, using combined statins and fenofibrate, on progression of retinopathy. Progression was defined as a three-step increase of the retinopathy level on to the Early Treatment of Diabetic Retinopathy Study severity scale, assessed by fundus photography from baseline, to the four-year study endpoint or pre-specified treatment events (photocoagulation or vitrectomy). The OR for reduction in progression of retinopathy by lipid treatment was 0.60 (95% CI 0.42–0.86; $P < 0.0056$). After 4 years the rates of progression of retinopathy were 7.3% with intensive glycaemia treatment, against 10.4% with standard therapy (adjusted OR 0.67; 95% CI 0.51–0.87; $P = 0.003$).⁵¹³

Patients with T2DM require antiplatelet agents for secondary prevention of CVD. There is no specific contra-indication against the use of aspirin or other antiplatelet agents, as they do not increase the incidence of intravitreal haemorrhages.⁵²⁸ At doses given for secondary prevention of CVD, aspirin is unlikely to improve retinopathy outcome. Erythropoietin treatment in patients with diabetic kidney disease warrants close monitoring for retinopathy progression and for cardiovascular risk.^{528,529}

Vision-threatening retinopathy. Severe non-proliferative or proliferative retinopathy or any level of DM-related macular oedema should immediately be referred to an experienced ophthalmologist. Vision-threatening proliferative retinopathy and macular oedema are treated by laser photocoagulation.^{528,530} In selected cases of severe non-proliferative DM-related retinopathy, laser photocoagulation may also be indicated. Selected cases of macular oedema with sub-foveal oedema and vision impairment <20/40 may benefit from intravitreal administration of ranibizumab, an inhibitor of vascular endothelial growth factor (VEGF). In four RCTs [Safety and Efficacy of Ranibizumab in Diabetic Macular Edema Study (RESOLVE), Ranibizumab

monotherapy or combined with laser versus laser monotherapy for diabetic macular edema (RESTORE), Ranibizumab Injection in Subjects With Clinically Significant Macular Edema (ME) With Center Involvement Secondary to Diabetes Mellitus (RIDE) and Ranibizumab Injection in Subjects With Clinically Significant Macular Edema (ME) With Center Involvement Secondary to Diabetes Mellitus (RISE)], one to two years of treatment with ranibizumab was more effective than sham or focal/grid laser therapy in improving best corrected visual acuity and reducing central retinal thickness in patients with visual impairment associated with diabetic macular oedema.^{531–533}

11.3 Gaps in knowledge

- The balance between the benefit to microvascular risk associated with tightening of glycaemic control and the risk of adverse CV outcomes is not understood.

11.4 Recommendations for management of microvascular disease in diabetes

Management of microvascular disease in diabetes

Recommendations	Class ^a	Level ^b	Ref. ^c
Screening for the presence of retinopathy should be considered on annual basis in patients with T2DM.	Ila	B	530
Multifactorial therapy is recommended when retinopathy is progressing rapidly.	I	B	156
An HbA _{1c} <7% and a blood pressure <140/85 mmHg are recommended for primary prevention of retinopathy related to DM.	I	A	152, 161, 191, 512–514, 524
Lipid lowering should be considered to reduce the progression of retinopathy, the need for laser treatment, and the need for vitrectomy.	Ila	B	513
It is recommended that proliferative DM retinopathy is treated by pan retinal laser photocoagulation.	I	A	530
Grid laser photocoagulation should be considered in clinically significant macular oedema.	Ila	B	532
Intravitreal anti-vascular endothelial growth factor therapy should be considered in patients with vision impairment and clinically significant macular oedema involving the fovea.	Ila	B	531, 532

BP = blood pressure; DM = diabetes mellitus; HbA_{1c} = glycated haemoglobin A_{1c}; T2DM = type 2 diabetes mellitus.

^aClass of recommendation.

^bLevel of evidence.

^cReference(s) supporting levels of evidence.

12. Patient-centred care

12.1 General aspects

The importance of multifactorial risk assessment and lifestyle management, including diet and exercise, in the prevention and treatment of DM and CVD has been emphasized in earlier sections. However, supporting patients in achieving and maintaining lifestyle changes on an individualized basis, using defined therapeutic goals and strategies, continues to be a substantial challenge. The intensive approach used successfully in clinical trials to prevent and treat DM and CVD is difficult to replicate in practice. Once intensive intervention stops, positive changes in lifestyle and risk factors may end, although ongoing booster sessions at intervals can maintain the effects.⁶⁵

Effective strategies for supporting patients in achieving positive lifestyle changes and improving self-management can be recommended. Patient-centred care is an approach that facilitates shared control and decision-making between patient and provider; it emphasizes a focus on the whole person and their experiences of illness within social contexts, rather than a single disease or organ system, and it develops a therapeutic alliance between patient and provider.⁵³⁴ Patient-centred care fosters a multifactorial approach, working within the context of patient priorities and goals, and allows for lifestyle changes and treatments to be adapted and implemented within cultural beliefs and behaviours. Providers should take into account age, ethnic and gender differences in DM and CVD, including lifestyle, disease prevalence and presentation, response to treatment and outcomes.

Understanding the patient's perspective and priorities enables providers and patients to jointly develop realistic and acceptable goals and programmes for behavioural change and self-management. A Cochrane Collaboration systematic review of 11 clinical trials ($n = 1532$) concluded that group-based (≥ 6 participants), patient-centred education resulted in clinically relevant, significant improvements in glycaemic control, DM knowledge, triglyceride concentrations, blood pressure, medication reduction and self-management for 12–14 months. Benefits for 2–4 years, including decreased DM-related retinopathy, were apparent when group classes were provided on an annual basis.⁵³⁵ Cognitive behavioural strategies, including problem-solving, goal-setting, self-monitoring, ongoing support and feedback/positive reinforcement in individual or group-based sessions are effective in facilitating behavioural change, especially when multiple strategies are used.^{536–538} However, a systematic review of studies on increasing physical activity found the positive effect of these strategies to be short-term (six months) and to decline thereafter;⁵³⁸ this may simply indicate the need for subsequent booster sessions beginning around six months. Similar patient-centred cognitive educational strategies, along with simplification of dosing regimens and increasing convenience, can be effective in improving medication adherence.^{539–541} Research is still needed regarding the most effective strategy combinations and the duration, intensity and timing of sessions.

For patients with greater reluctance or resistance towards making behavioural changes, motivational interviewing is patient-centred counselling with the purpose of working through ambivalence and fostering a patient-driven agenda. Motivational interviewing has been effective in helping patients to decrease body mass index and systolic blood pressure and increase physical activity and fruit and vegetable

consumption.⁵⁴² Motivational interviewing techniques are often adapted and incorporated within prevention programmes.⁵³⁷

Multifaceted strategies are most effectively delivered through multidisciplinary teams. The International Diabetes Federation, Diabetes Roundtable and Global Partnership for Effective Diabetes Management are advocates for multidisciplinary team care in DM,⁵⁴³ and such teams are essential components of successful disease-management programmes for CVD.⁵⁴⁴ Nurse-led multidisciplinary programmes, including nurse case-management, have been effective in improving multiple cardiovascular risk factors and adherence in patients with CVD and DM within primary and secondary care.^{536,537,545,546}

Patient-centred care emphasizes the person, their experiences, priorities and goals in managing various conditions, and the partnership between providers and patients. When this approach is used by a multidisciplinary team with skills in cognitive behavioural strategies, there will be increased success in supporting patients in achieving lifestyle changes and effectively self-managing their conditions. It is also important to recognise that single or limited interventions or sessions on behavioural change are not sufficient to maintain lifestyle changes and that ongoing support and booster sessions will be necessary for sustained change.

12.2 Gaps in Knowledge

- Effects of patient-centred interventions on outcome measures, including micro- and macrovascular complications, are not known.

12.3 Recommendations for patient-centred care in diabetes

Patient-centred care in diabetes			
Recommendations	Class ^a	Level ^b	Ref. ^c
Patient-centred care is recommended to facilitate shared control and decision-making within the context of patient priorities and goals.	I	C	-
Patient-centred cognitive behavioural strategies are recommended to help patients achieve lifestyle changes and practise self-management.	I	B	536–538, 544
Patient-centred cognitive behavioural strategies combined with simplification of dosing regimens should be considered to improve medication adherence.	IIa	B	539–541
Multidisciplinary teams and nurse-led programmes should be considered to support lifestyle change and self-management.	IIa	B	536, 537, 544, 545

^aClass of recommendation.

^bLevel of evidence.

^cReference(s) supporting levels of evidence.



The CME text '2013 ESC Guidelines on diabetes, pre-diabetes, and cardiovascular diseases' is accredited by the European Board for Accreditation in Cardiology (EBAC). EBAC works according to the quality standards of the European Accreditation Council for Continuing Medical Education (EACCME), which is an institution of the European Union of Medical Specialists (UEMS). In compliance with EBAC/EACCME Guidelines, all authors participating in this programme have disclosed any potential conflicts of interest that might cause a bias in the article. The Organizing Committee is responsible for ensuring that all potential conflicts of interest relevant to the programme are declared to the participants prior to the CME activities.

CME questions for this article are available at: European Heart Journal <http://www.oxfordjournals.org/eurheartj> and European Society of Cardiology <http://www.escardio.org/guidelines>.



13. References

- International Diabetes Federation 2011. Global Burden: Prevalence and Projections, 2011 and 2030. Available from <http://www.diabetesatlas.org/content/diabetes-and-impaired-glucose-tolerance>
- WHO Consultation. Definition, diagnosis and classification of diabetes mellitus and its complications. Part 1: diagnosis and classification of diabetes mellitus. Geneva: World Health Organization; 1999. Report no. 99.2. http://whqlibdoc.who.int/hq/1999/who_ncd_ncs_99.2.pdf
- World Health Organization (WHO) Consultation. Definition and diagnosis of diabetes and intermediate hyperglycaemia. 2006 http://www.who.int/diabetes/publications/Definition%20and%20diagnosis%20of%20diabetes_new.pdf
- Report of the Expert Committee on the Diagnosis and Classification of Diabetes Mellitus. *Diabetes Care* 1997;**20**:1183–1197.
- Genuth S, Alberti KG, Bennett P, Buse J, Defronzo R, Kahn R, Kitzmiller J, Knowler WC, Lebovitz H, Lernmark A, Nathan D, Palmer J, Rizza R, Saudek C, Shaw J, Steffes M, Stern M, Tuomilehto J, Zimmet P. Follow-up report on the diagnosis of diabetes mellitus. *Diabetes Care* 2003;**26**:3160–3167.
- Diagnosis and classification of diabetes mellitus. *Diabetes Care* 2012;**35** Suppl 1: S64–71.
- World Health Organization (WHO). Abbreviated report of a WHO consultation. Use of glycated hemoglobin (HbA1c) in the diagnosis of diabetes mellitus. 2011 http://www.who.int/diabetes/publications/diagnosis_diabetes2011/en/index.html
- Diagnosis and classification of diabetes mellitus. *Diabetes Care* 2010;**33** Suppl 1: S62–69.
- Costa B, Barrio F, Cabre JJ, Pinol JL, Cos FX, Sole C, Bolibar B, Castell C, Lindstrom J, Barengo N, Tuomilehto J. Shifting from glucose diagnostic criteria to the new HbA(1c) criteria would have a profound impact on prevalence of diabetes among a high-risk Spanish population. *Diabet Med* 2011;**28**:1234–1237.
- Pajunen P, Peltonen M, Eriksson JG, Ilanne-Parikka P, Aunola S, Keinänen-Kiukaanniemi S, Uusitupa M, Tuomilehto J, Lindstrom J. HbA(1c) in diagnosing and predicting Type 2 diabetes in impaired glucose tolerance: the Finnish Diabetes Prevention Study. *Diabet Med* 2011;**28**:36–42.
- Laakso M, Pyörälä K. Age of onset and type of diabetes. *Diabetes Care* 1985;**8**: 114–117.
- Gottschall A, Landin-Olsson M, Fernlund P, Lernmark A, Sundkvist G. Beta-cell function in relation to islet cell antibodies during the first 3 yr after clinical diagnosis of diabetes in type II diabetic patients. *Diabetes Care* 1993;**16**:902–910.
- Tuomilehto J, Zimmet P, Mackay IR, Koskela P, Vidgren G, Toivanen L, Tuomilehto-Wolf E, Kohtamäki K, Stengard J, Rowley MJ. Antibodies to glutamic acid decarboxylase as predictors of insulin-dependent diabetes mellitus before clinical onset of disease. *Lancet* 1994;**343**:1383–1385.
- Incidence and trends of childhood Type 1 diabetes worldwide 1990–1999. *Diabet Med* 2006;**23**:857–866.
- Kahn SE. The relative contributions of insulin resistance and beta-cell dysfunction to the pathophysiology of Type 2 diabetes. *Diabetologia* 2003;**46**:3–19.
- Mari A, Tura A, Natali A, Laville M, Laakso M, Gabriel R, Beck-Nielsen H, Ferrannini E. Impaired beta cell glucose sensitivity rather than inadequate compensation for insulin resistance is the dominant defect in glucose intolerance. *Diabetologia* 2010;**53**:749–756.
- Bellamy L, Casas JP, Hingorani AD, Williams D. Type 2 diabetes mellitus after gestational diabetes: a systematic review and meta-analysis. *Lancet* 2009;**373**: 1773–1779.
- Feig DS, Zinman B, Wang X, Hux JE. Risk of development of diabetes mellitus after diagnosis of gestational diabetes. *CMAJ: Canadian Medical Association journal = Journal de l'Association Médicale Canadienne* 2008;**179**:229–234.
- Carstensen B, Lindstrom J, Sundvall J, Borch-Johnsen K, Tuomilehto J. Measurement of blood glucose: comparison between different types of specimens. *Ann Clin Biochem* 2008;**45**(Pt 2):140–148.
- Age- and sex-specific prevalences of diabetes and impaired glucose regulation in 13 European cohorts. *Diabetes Care* 2003;**26**:61–69.
- Christensen DL, Witte DR, Kaduka L, Jorgensen ME, Borch-Johnsen K, Mohan V, Shaw JE, Tabak AG, Vistisen D. Moving to an A1C-based diagnosis of diabetes has a different impact on prevalence in different ethnic groups. *Diabetes Care* 2010;**33**:580–582.
- Colagiuri S, Lee CM, Wong TY, Balkau B, Shaw JE, Borch-Johnsen K. Glycemic thresholds for diabetes-specific retinopathy: implications for diagnostic criteria for diabetes. *Diabetes Care* 2011;**34**:145–150.
- Pani LN, Korenda L, Meigs JB, Driver C, Chamany S, Fox CS, Sullivan L, D'Agostino RB, Nathan DM. Effect of aging on A1C levels in individuals without diabetes: evidence from the Framingham Offspring Study and the National Health and Nutrition Examination Survey 2001–2004. *Diabetes Care* 2008;**31**:1991–1996.
- Saariisto TE, Barengo NC, Korpi-Hyövalti E, Oksa H, Puolijoki H, Saltevo JT, Vanhala M, Sundvall J, Saarikoski L, Peltonen M, Tuomilehto J. High prevalence of obesity, central obesity and abnormal glucose tolerance in the middle-aged Finnish population. *BMC Public Health* 2008;**8**:423.
- Engelgau MM, Colagiuri S, Ramachandran A, Borch-Johnsen K, Narayan KM. Prevention of type 2 diabetes: issues and strategies for identifying persons for interventions. *Diabetes Technol Ther* 2004;**6**:874–882.
- Griffin SJ, Borch-Johnsen K, Davies MJ, Khunti K, Rutten GE, Sandbaek A, Sharp SJ, Simmons RK, van den Donk M, Wareham NJ, Lauritzen T. Effect of early intensive multifactorial therapy on 5-year cardiovascular outcomes in individuals with type 2 diabetes detected by screening (ADDITION-Europe): a cluster-randomised trial. *Lancet* 2011;**378**:156–167.
- Tuomilehto J, Lindstrom J, Eriksson JG, Valle TT, Hamalainen H, Ilanne-Parikka P, Keinänen-Kiukaanniemi S, Laakso M, Louheranta A, Rastas M, Salminen V, Uusitupa M. Prevention of type 2 diabetes mellitus by changes in lifestyle among subjects with impaired glucose tolerance. *N Engl J Med* 2001;**344**:1343–1350.
- Knowler WC, Barrett-Connor E, Fowler SE, Hamman RF, Lachin JM, Walker EA, Nathan DM. Reduction in the incidence of type 2 diabetes with lifestyle intervention or metformin. *N Engl J Med* 2002;**346**:393–403.
- Roumen C, Corpeleijn E, Feskens EJ, Mensink M, Saris WH, Blaak EE. Impact of 3-year lifestyle intervention on postprandial glucose metabolism: the SLIM study. *Diabet Med* 2008;**25**:597–605.
- Penn L, White M, Oldroyd J, Walker M, Alberti KG, Mathers JC. Prevention of type 2 diabetes in adults with impaired glucose tolerance: the European Diabetes Prevention RCT in Newcastle upon Tyne, UK. *BMC Public Health* 2009;**9**:342.
- Gillies CL, Abrams KR, Lambert PC, Cooper NJ, Sutton AJ, Hsu RT, Khunti K. Pharmacological and lifestyle interventions to prevent or delay type 2 diabetes in people with impaired glucose tolerance: systematic review and meta-analysis. *BMJ* 2007;**334**:299–308.
- Hare MJ, Shaw JE, Zimmet PZ. Current controversies in the use of haemoglobin A(1c). *J Intern Med* 2011.
- Lerchbaum E, Schwetz V, Giuliani A, Obermayer-Pietsch B. Assessment of glucose metabolism in polycystic ovary syndrome: HbA1c or fasting glucose compared with the oral glucose tolerance test as a screening method. *Human Reproduction* 2013.
- Zhou X, Pang Z, Gao W, Wang S, Zhang L, Ning F, Qiao Q. Performance of an A1C and fasting capillary blood glucose test for screening newly diagnosed diabetes and pre-diabetes defined by an oral glucose tolerance test in Qingdao, China. *Diabetes Care* 2010;**33**:545–550.
- Abbasi A, Peelen LM, Corpeleijn E, van der Schouw YT, Stolk RP, Spijkerman AM, van der AD, Moons KG, Navis G, Bakker SJ, Beulens JW. Prediction models for risk of developing type 2 diabetes: systematic literature search and independent external validation study. *BMJ* 2012;**345**:e9900.
- Lindstrom J, Tuomilehto J. The diabetes risk score: a practical tool to predict type 2 diabetes risk. *Diabetes Care* 2003;**26**:725–731.
- Schwarz PE, Li J, Lindstrom J, Tuomilehto J. Tools for predicting the risk of type 2 diabetes in daily practice. *Horm Metab Res* 2009;**41**:86–97.
- Bartnik M, Ryden L, Malmberg K, Ohrvik J, Pyörälä K, Standl E, Ferrari R, Simoons-Soler J. Oral glucose tolerance test is needed for appropriate classification of glucose regulation in patients with coronary artery disease: a report from the Euro Heart Survey on Diabetes and the Heart. *Heart* 2007;**93**:72–77.
- Hage C, Lundman P, Ryden L, Mellbin L. Fasting glucose, HbA1c, or oral glucose tolerance testing for the detection of glucose abnormalities in patients with acute coronary syndromes. *Eur J Prev Cardiol* 2012.
- de Mulder M, Oemrawsingh RM, Stam F, Boersma E, Umans VA. Comparison of diagnostic criteria to detect undiagnosed diabetes in hyperglycaemic patients with acute coronary syndrome. *Heart* 2012;**98**:37–41.
- Doerr R, Hoffmann U, Otter W, Heinemann L, Hunger-Battefeld W, Kulzer B, Klinge A, Lodwig V, Amann-Zalan I, Sturm D, Tschoepe D, Stumpff J, Lohmann T, Schnell O. Oral glucose tolerance test and HbA(1c) for diagnosis of

- diabetes in patients undergoing coronary angiography: [corrected] the Silent Diabetes Study. *Diabetologia* 2011;**54**:2923–2930.
42. Glucose tolerance and mortality: comparison of WHO and American Diabetes Association diagnostic criteria. The DECODE study group. European Diabetes Epidemiology Group. Diabetes Epidemiology: Collaborative analysis Of Diagnostic criteria in Europe. *Lancet* 1999;**354**:617–621.
 43. The DECODE Study Group. Is the current definition for diabetes relevant to mortality risk from all causes and cardiovascular and noncardiovascular diseases? *Diabetes Care* 2003;**26**:688–696.
 44. Ning F, Tuomilehto J, Pyorala K, Onat A, Soderberg S, Qiao Q. Cardiovascular disease mortality in Europeans in relation to fasting and 2-h plasma glucose levels within a normoglycemic range. *Diabetes Care* 2010;**33**:2211–2216.
 45. Khaw KT, Wareham N, Bingham S, Luben R, Welch A, Day N. Association of hemoglobin A1c with cardiovascular disease and mortality in adults: the European prospective investigation into cancer in Norfolk. *Ann Intern Med* 2004;**141**:413–420.
 46. Selvin E, Steffes MW, Zhu H, Matsushita K, Wagenknecht L, Pankow J, Coresh J, Brancati FL. Glycated hemoglobin, diabetes and cardiovascular risk in nondiabetic adults. *N Engl J Med* 2010;**362**:800–811.
 47. Santos-Oliveira R, Purdy C, da Silva MP, dos Anjos Carneiro-Leao AM, Machado M, Einarson TR. Haemoglobin A1c levels and subsequent cardiovascular disease in persons without diabetes: a meta-analysis of prospective cohorts. *Diabetologia* 2011;**54**:1327–1334.
 48. Qiao Q, Dekker JM, de Vegt F, Nijpels G, Nissinen A, Stehouwer CD, Bouter LM, Heine RJ, Tuomilehto J. Two prospective studies found that elevated 2-hr glucose predicted male mortality independent of fasting glucose and HbA1c. *J Clin Epidemiol* 2004;**57**:590–596.
 49. Meigs JB, Nathan DM, D'Agostino RB Sr., Wilson PW. Fasting and postchallenge glycemia and cardiovascular disease risk: the Framingham Offspring Study. *Diabetes Care* 2002;**25**:1845–1850.
 50. Barrett-Connor EL, Cohn BA, Wingard DL, Edelstein SL. Why is diabetes mellitus a stronger risk factor for fatal ischemic heart disease in women than in men? The Rancho Bernardo Study. *JAMA* 1991;**265**:627–631.
 51. Juutilainen A, Kortelainen S, Lehto S, Ronnema T, Pyorala K, Laakso M. Gender difference in the impact of type 2 diabetes on coronary heart disease risk. *Diabetes Care* 2004;**27**:2898–2904.
 52. Hu G, Jousilahti P, Qiao Q, Peltonen M, Katoh S, Tuomilehto J. The gender-specific impact of diabetes and myocardial infarction at baseline and during follow-up on mortality from all causes and coronary heart disease. *J Am Coll Cardiol* 2005;**45**:1413–1418.
 53. Orchard TJ. The impact of gender and general risk factors on the occurrence of atherosclerotic vascular disease in non-insulin-dependent diabetes mellitus. *Ann Med* 1996;**28**:323–333.
 54. Huxley R, Barzi F, Woodward M. Excess risk of fatal coronary heart disease associated with diabetes in men and women: meta-analysis of 37 prospective cohort studies. *BMJ* 2006;**332**:73–78.
 55. Wannamethee SG, Papacosta O, Lawlor DA, Whincup PH, Lowe GD, Ebrahim S, Sattar N. Do women exhibit greater differences in established and novel risk factors between diabetes and non-diabetes than men? The British Regional Heart Study and British Women's Heart Health Study. *Diabetologia* 2012;**55**:80–87.
 56. Logue J, Walker JJ, Colhoun HM, Leese GP, Lindsay RS, McKnight JA, Morris AD, Pearson DW, Petrie JR, Philip S, Wild SH, Sattar N. Do men develop type 2 diabetes at lower body mass indices than women? *Diabetologia* 2011;**54**:3003–3006.
 57. Mann JI, De Leeuw I, Hermansen K, Karamanos B, Karlstrom B, Katsilambros N, Riccardi G, Rivellese AA, Rizkalla S, Slama G, Toeller M, Uusitupa M, Vessby B. Evidence-based nutritional approaches to the treatment and prevention of diabetes mellitus. *Nutr Metab Cardiovasc Dis* 2004;**14**:373–394.
 58. Burr JF, Rowan CP, Jamnik VK, Riddell MC. The role of physical activity in type 2 diabetes prevention: physiological and practical perspectives. *Phys Sportsmed* 2010;**38**:72–82.
 59. Paulweber B, Valensi P, Lindstrom J, Lalic NM, Greaves CJ, McKee M, Kissimova-Skarbek K, Liatis S, Cosson E, Szendroedi J, Sheppard KE, Charlesworth K, Felton AM, Hall M, Rissanen A, Tuomilehto J, Schwarz PE, Roden M, Paulweber M, Stadlmayr A, Kedenko L, Katsilambros N, Makrilakis K, Kamenov Z, Evans P, Gilis-Januszewska A, Lalic K, Jotic A, Djordjevic P, Dimitrijevic-Sreckovic V, Huhner U, Kulzer B, Puhl S, Lee-Barkey YH, Alkerwi A, Abraham C, Hardeman W, Acosta T, Adler M, Barengo N, Barengo R, Boavida JM, Christov V, Claussen B, Cos X, Deceukelier S, Djordjevic P, Fischer M, Gabriel-Sanchez R, Goldfracht M, Gomez JL, Handke U, Hauner H, Herbst J, Hermanns N, Herreburch L, Huber C, Huttunen J, Karadeniz S, Khalangot M, Kohler D, Kopp V, Kronsbein P, Kyne-Grzebalski D, Lalic N, Landgraf R, McIntosh C, Mesquita AC, Misina D, Muylle F, Neumann A, Paiva AC, Pajunen P, Peltonen M, Perrenoud L, Pfeiffer A, Polonen A, Raposo F, Reinehr T, Robinson C, Rothe U, Saaristo T, Scholl J, Spiers S, Stemper T, Stratmann B, Szybinski Z, Tankova T, Telle-Hjelset V, Terry G, Tolks D, Toti F, Undeutsch A, Valadas C, Velickiene D, Vermunt P, Weiss R, Wens J, Yilmaz T. A European evidence-based guideline for the prevention of type 2 diabetes. *Horm Metab Res* 2010;**42** Suppl 1:S3–36.
 60. Lindstrom J, Neumann A, Sheppard KE, Gilis-Januszewska A, Greaves CJ, Handke U, Pajunen P, Puhl S, Polonen A, Rissanen A, Roden M, Stemper T, Telle-Hjelset V, Tuomilehto J, Velickiene D, Schwarz PE, Acosta T, Adler M, Alkerwi A, Barengo N, Barengo R, Boavida JM, Charlesworth K, Christov V, Claussen B, Cos X, Cosson E, Deceukelier S, Dimitrijevic-Sreckovic V, Djordjevic P, Evans P, Felton AM, Fischer M, Gabriel-Sanchez R, Goldfracht M, Gomez JL, Hall M, Hauner H, Herbst J, Hermanns N, Herreburch L, Huber C, Huhner U, Huttunen J, Jotic A, Kamenov Z, Karadeniz S, Katsilambros N, Khalangot M, Kissimova-Skarbek K, Kohler D, Kopp V, Kronsbein P, Kulzer B, Kyne-Grzebalski D, Lalic K, Lalic N, Landgraf R, Lee-Barkey YH, Liatis S, Makrilakis K, McIntosh C, McKee M, Mesquita AC, Misina D, Muylle F, Paiva AC, Paulweber B, Peltonen M, Perrenoud L, Pfeiffer A, Raposo F, Reinehr T, Robinson C, Rothe U, Saaristo T, Scholl J, Spiers S, Stratmann B, Szybinski Z, Tankova T, Terry G, Tolks D, Toti F, Undeutsch A, Valadas C, Valensi P, Vermunt P, Weiss R, Wens J, Yilmaz T. Take action to prevent diabetes: the IMAGE toolkit for the prevention of type 2 diabetes in Europe. *Horm Metab Res* 2010;**42** Suppl 1:S37–55.
 61. Eriksson KF, Lindgarde F. No excess 12-year mortality in men with impaired glucose tolerance who participated in the Malmo Preventive Trial with diet and exercise. *Diabetologia* 1998;**41**:1010–1016.
 62. Li G, Zhang P, Wang J, Gregg EW, Yang W, Gong Q, Li H, Jiang Y, An Y, Shuai Y, Zhang B, Zhang J, Thompson TJ, Gerzoff RB, Roglic G, Hu Y, Bennett PH. The long-term effect of lifestyle interventions to prevent diabetes in the China Da Qing Diabetes Prevention Study: a 20-year follow-up study. *Lancet* 2008;**371**:1783–1789.
 63. Gong Q, Gregg EW, Wang J, An Y, Zhang P, Yang W, Li H, Jiang Y, Shuai Y, Zhang B, Zhang J, Gerzoff RB, Roglic G, Hu Y, Li G, Bennett PH. Long-term effects of a randomised trial of a 6-year lifestyle intervention in impaired glucose tolerance on diabetes-related microvascular complications: the China Da Qing Diabetes Prevention Outcome Study. *Diabetologia* 2011;**54**:300–307.
 64. Uusitupa M, Peltonen M, Lindstrom J, Aunola S, Ilanne-Parikka P, Keinonen-Kiukaanniemi S, Valle TT, Eriksson JG, Tuomilehto J. Ten-year mortality and cardiovascular morbidity in the Finnish Diabetes Prevention Study: secondary analysis of the randomized trial. *PLoS One* 2009;**4**:e5656.
 65. Knowler WC, Fowler SE, Hamman RF, Christophi CA, Hoffman HJ, Brenneman AT, Brown-Friday JO, Goldberg R, Venditti E, Nathan DM. 10-year follow-up of diabetes incidence and weight loss in the Diabetes Prevention Program Outcomes Study. *Lancet* 2009;**374**:1677–1686.
 66. Saito T, Watanabe M, Nishida J, Izumi T, Omura M, Takagi T, Fukunaga R, Bandai Y, Tajima N, Nakamura Y, Ito M. Lifestyle modification and prevention of type 2 diabetes in overweight Japanese with impaired fasting glucose levels: a randomized controlled trial. *Arch Intern Med* 2011;**171**:1352–1360.
 67. Hossain P, Kavar B, El Nahas M. Obesity and diabetes in the developing world: a growing challenge. *N Engl J Med* 2007;**356**:213–215.
 68. Saltiel AR, Kahn CR. Insulin signalling and the regulation of glucose and lipid metabolism. *Nature* 2001;**414**(6865):799–806.
 69. Kim JA, Montagnani M, Koh KK, Quon MJ. Reciprocal relationships between insulin resistance and endothelial dysfunction: molecular and pathophysiological mechanisms. *Circulation* 2006;**113**:1888–1904.
 70. Zeng G, Quon MJ. Insulin-stimulated production of nitric oxide is inhibited by wortmannin. Direct measurement in vascular endothelial cells. *J Clin Invest* 1996;**98**:894–898.
 71. Flammer AJ, Anderson T, Celermajer DS, Creager MA, Deanfield J, Ganz P, Hamburg NM, Luscher TF, Shechter M, Taddei S, Vita JA, Lerman A. The assessment of endothelial function: from research into clinical practice. *Circulation* 2012;**126**:753–767.
 72. Vlachopoulos C, Aznaouridis K, Stefanadis C. Prediction of cardiovascular events and all-cause mortality with arterial stiffness: a systematic review and meta-analysis. *J Am Coll Cardiol* 2010;**55**:1318–1327.
 73. Cosentino F, Hishikawa K, Katusic ZS, Luscher TF. High glucose increases nitric oxide synthase expression and superoxide anion generation in human aortic endothelial cells. *Circulation* 1997;**96**:25–28.
 74. Paneni F, Mocharla P, Akhmedov A, Costantino S, Osto E, Volpe M, Luscher TF, Cosentino F. Gene silencing of the mitochondrial adaptor p66(Shc) suppresses vascular hyperglycemic memory in diabetes. *Circulation Research* 2012;**111**:278–289.
 75. Cosentino F, Eto M, De Paolis P, van der Loo B, Bachschmid M, Ullrich V, Kouroedov A, Delli Gatti C, Joch H, Volpe M, Luscher TF. High glucose causes upregulation of cyclooxygenase-2 and alters prostanoid profile in human endothelial cells: role of protein kinase C and reactive oxygen species. *Circulation* 2003;**107**:1017–1023.
 76. Camici GG, Schiavoni M, Francia P, Bachschmid M, Martin-Padura I, Hersberger M, Tanner FC, Pellicci P, Volpe M, Anversa P, Luscher TF, Cosentino F. Genetic deletion of p66(Shc) adaptor protein prevents hyperglycemia-induced endothelial dysfunction and oxidative stress. *Proc Natl Acad Sci USA* 2007;**104**:5217–5222.

77. Cosentino F, Francia P, Camici GG, Pelicci PG, Luscher TF, Volpe M. Final common molecular pathways of aging and cardiovascular disease: role of the p66Shc prot. *Arterioscler Thromb Vasc Biol* 2008;**28**(4):622–628.
78. Ceriello A, Ihnat MA, Thorpe JE. Clinical review 2: The "metabolic memory": is more than just tight glucose control necessary to prevent diabetic complications? *J Clin Endocrinol Metab* 2009;**94**:410–415.
79. Romeo GR, Lee J, Shoelson SE. Metabolic syndrome, insulin resistance and roles of inflammation: mechanisms and therapeutic targets. *Arterioscler Thromb Vasc Biol* 2012;**32**:1771–1776.
80. Cannon CP. Mixed dyslipidemia, metabolic syndrome, diabetes mellitus and cardiovascular disease: clinical implications. *Am J Cardiol* 2008;**102**:5L–9L.
81. Sorrentino SA, Besler C, Rohrer L, Meyer M, Heinrich K, Bahlmann FH, Mueller M, Horvath T, Doerries C, Heinemann M, Flemmer S, Markowski A, Manes C, Bahr MJ, Haller H, von Eckardstein A, Drexler H, Landmesser U. Endothelial-vasoprotective effects of high-density lipoprotein are impaired in patients with type 2 diabetes mellitus but are improved after extended-release niacin therapy. *Circulation* 2010;**121**:110–122.
82. Grant PJ. Diabetes mellitus as a prothrombotic condition. *J Intern Med* 2007;**262**:157–172.
83. Ferreiro JL, Angiolillo DJ. Diabetes and antiplatelet therapy in acute coronary syndrome. *Circulation* 2011;**123**:798–813.
84. Bertoni AG, Tsai A, Kasper EK, Brancati FL. Diabetes and idiopathic cardiomyopathy: a nationwide case-control study. *Diabetes Care* 2003;**26**:2791–2795.
85. Poornima IG, Parikh P, Shannon RP. Diabetic cardiomyopathy: the search for a unifying hypothesis. *Circ Res* 2006;**98**:596–605.
86. Clark RJ, McDonough PM, Swanson E, Trost SU, Suzuki M, Fukuda M, Dillmann WH. Diabetes and the accompanying hyperglycemia impairs cardiomyocyte calcium cycling through increased nuclear O-GlcNAcylation. *J Biol Chem* 2003;**278**:44230–44237.
87. Alberti KG, Eckel RH, Grundy SM, Zimmet PZ, Cleeman JI, Donato KA, Fruchart JC, James WP, Loria CM, Smith SC Jr. Harmonizing the metabolic syndrome: a joint interim statement of the International Diabetes Federation Task Force on Epidemiology and Prevention; National Heart, Lung and Blood Institute; American Heart Association; World Heart Federation; International Atherosclerosis Society; and International Association for the Study of Obesity. *Circulation* 2009;**120**:1640–1645.
88. Jarajapu YP, Grant MB. The promise of cell-based therapies for diabetic complications: challenges and solutions. *Circ Res* 2010;**106**:854–869.
89. Perk J, De Backer G, Gohlke H, Graham I, Reiner Z, Verschuren M, Albus C, Benlian P, Boysen G, Cifkova R, Deaton C, Ebrahim S, Fisher M, Germano G, Hobbs R, Hoes A, Karadeniz S, Mezzani A, Prescott E, Ryden L, Schermer M, Syvanne M, Scholte op Reimer WJ, Vrints C, Wood D, Zamorano JL, Zannad F. European Guidelines on cardiovascular disease prevention in clinical practice (version 2012). The Fifth Joint Task Force of the European Society of Cardiology and Other Societies on Cardiovascular Disease Prevention in Clinical Practice (constituted by representatives of nine societies and by invited experts). Developed with the special contribution of the European Association for Cardiovascular Prevention & Rehabilitation (EACPR). *Eur Heart J* 2012;**33**:1635–1701.
90. Anderson KM, Odell PM, Wilson PWF, Kannel WB. Cardiovascular disease risk profiles. *Am Heart J* 1991;**121**:293–298.
91. D'Agostino RB Sr., Grundy S, Sullivan LM, Wilson P. Validation of the Framingham coronary heart disease prediction scores: results of a multiple ethnic groups investigation. *JAMA* 2001;**286**:180–187.
92. Ramachandran S, French JM, Vanderpump MP, Croft P, Neary RH. Using the Framingham model to predict heart disease in the United Kingdom: retrospective study. *BMJ* 2000;**320**:676–677.
93. Coleman RL, Stevens RJ, Retnakaran R, Holman RR. Framingham, SCORE and DECODE risk equations do not provide reliable cardiovascular risk estimates in type 2 diabetes. *Diabetes Care* 2007;**30**:1292–1293.
94. Jimeno Mollet J, Molist Brunet N, Franch Nadal J, Serrano Borraz V, Serrano Barragan L, Gracia Gimenez R. [Variability in the calculation of coronary risk in type-2 diabetes mellitus]. *Aten Primaria* 2005;**35**:30–36.
95. Pencina MJ, D'Agostino RB Sr., Larson MG, Massaro JM, Vasan RS. Predicting the 30-year risk of cardiovascular disease: the framingham heart study. *Circulation* 2009;**119**:3078–3084.
96. Balkau B, Hu G, Qiao Q, Tuomilehto J, Borch-Johnsen K, Pyorala K. Prediction of the risk of cardiovascular mortality using a score that includes glucose as a risk factor. The DECODE Study. *Diabetologia* 2004;**47**:2118–2128.
97. Assmann G, Cullen P, Schulte H. Simple scoring scheme for calculating the risk of acute coronary events based on the 10-year follow-up of the prospective cardiovascular Munster (PROCAM) study. *Circulation* 2002;**105**:310–315.
98. Stephens JW, Ambler G, Vallance P, Betteridge DJ, Humphries SE, Hurel SJ. Cardiovascular risk and diabetes. Are the methods of risk prediction satisfactory? *Eur J Cardiovasc Prev Rehabil* 2004;**11**:521–528.
99. Marrugat J, Solanas P, D'Agostino R, Sullivan L, Ordovas J, Cordon F, Ramos R, Sala J, Masia R, Rohlfis I, Elosua R, Kannel WB. (Coronary risk estimation in Spain using a calibrated Framingham function). *Rev Esp Cardiol* 2003;**56**:253–261.
100. Consequences of the new diagnostic criteria for diabetes in older men and women. DECODE Study (Diabetes Epidemiology: Collaborative Analysis of Diagnostic Criteria in Europe). *Diabetes Care* 1999;**22**:1667–1671.
101. Stevens RJ, Kothari V, Adler AI, Stratton IM. The UKPDS risk engine: a model for the risk of coronary heart disease in Type II diabetes (UKPDS 56). *Clin Sci (Lond)* 2001;**101**:671–679.
102. Guzzder RN, Gatling W, Mullee MA, Mehta RL, Byrne CD. Prognostic value of the Framingham cardiovascular risk equation and the UKPDS risk engine for coronary heart disease in newly diagnosed Type 2 diabetes: results from a United Kingdom study. *Diabet Med* 2005;**22**:554–562.
103. Protosaltis ID, Konstantinopoulos PA, Kamaratos AV, Melidonis AI. Comparative study of prognostic value for coronary disease risk between the U.K. prospective diabetes study and Framingham models. *Diabetes Care* 2004;**27**:277–278.
104. Cederholm J, Eeg-Olofsson K, Eliasson B, Zethelius B, Nilsson PM, Gudbjornsdottir S. Risk prediction of cardiovascular disease in type 2 diabetes: a risk equation from the Swedish National Diabetes Register. *Diabetes Care* 2008;**31**:2038–2043.
105. D'Agostino RB, Wolf PA, Belanger AJ, Kannel WB. Stroke risk profile: adjustment for antihypertensive medication. The Framingham Study. *Stroke* 1994;**25**:40–43.
106. Costa B, Cabre JJ, Martin F, Pinol JL, Basora J, Blade J. [The Framingham function overestimates stroke risk for diabetes and metabolic syndrome among Spanish population]. *Aten Primaria* 2005;**35**:392–398.
107. Kothari V, Stevens RJ, Adler AI, Stratton IM, Manley SE, Neil HA, Holman RR. UKPDS 60: risk of stroke in type 2 diabetes estimated by the UK Prospective Diabetes Study risk engine. *Stroke* 2002;**33**:1776–1781.
108. Kengne AP, Patel A, Marre M, Travert F, Lievre M, Zoungas S, Chalmers J, Colagiuri S, Grobbee DE, Hamet P, Heller S, Neal B, Woodward M. Contemporary model for cardiovascular risk prediction in people with type 2 diabetes. *Eur J Cardiovasc Prev Rehabil* 2011;**18**:393–398.
109. Channan P, Simmons RK, Sharp SJ, Griffin SJ, Wareham NJ. Cardiovascular risk assessment scores for people with diabetes: a systematic review. *Diabetologia* 2009;**52**:2001–2014.
110. Folsom AR, Chambless LE, Ballantyne CM, Coresh J, Heiss G, Wu KK, Boerwinkle E, Mosley TH Jr., Sorlie P, Diao G, Sharrett AR. An assessment of incremental coronary risk prediction using C-reactive protein and other novel risk markers: the atherosclerosis risk in communities study. *Arch Intern Med* 2006;**166**:1368–1373.
111. Meerwaldt R, Graaff R, Oomen PH, Links TP, Jager JJ, Alderson NL, Thorpe SR, Baynes JW, Gans RO, Smit AJ. Simple non-invasive assessment of advanced glycation endproduct accumulation. *Diabetologia* 2004;**47**:1324–1330.
112. Lutgers HL, Gerrits EG, Graaff R, Links TP, Sluiter WJ, Gans RO, Bilo HJ, Smit AJ. Skin autofluorescence provides additional information to the UK Prospective Diabetes Study (UKPDS) risk score for the estimation of cardiovascular prognosis in type 2 diabetes mellitus. *Diabetologia* 2009;**52**:789–797.
113. Gerstein HC, Mann JF, Yi Q, Zinman B, Dinneen SF, Hoogwerf B, Halle JP, Young J, Rashkow A, Joyce C, Nawaz S, Yusuf S. Albuminuria and risk of cardiovascular events, death and heart failure in diabetic and nondiabetic individuals. *JAMA* 2001;**286**:421–426.
114. Gaede P, Hildebrandt P, Hess G, Parving HH, Pedersen O. Plasma N-terminal pro-brain natriuretic peptide as a major risk marker for cardiovascular disease in patients with type 2 diabetes and microalbuminuria. *Diabetologia* 2005;**48**:156–163.
115. Anand DV, Lim E, Hopkins D, Corder R, Shaw LJ, Sharp P, Lipkin D, Lahiri A. Risk stratification in uncomplicated type 2 diabetes: prospective evaluation of the combined use of coronary artery calcium imaging and selective myocardial perfusion scintigraphy. *Eur Heart J* 2006;**27**:713–721.
116. Hanssen NM, Huijberts MS, Schalkwijk CG, Nijpels G, Dekker JM, Stehouwer CD. Associations between the ankle-brachial index and cardiovascular and all-cause mortality are similar in individuals without and with type 2 diabetes: nineteen-year follow-up of a population-based cohort study. *Diabetes Care* 2012;**35**:1731–1735.
117. Bernard S, Serusclat A, Targe F, Charriere S, Roth O, Beaune J, Berthezene F, Moulin P. Incremental predictive value of carotid ultrasonography in the assessment of coronary risk in a cohort of asymptomatic type 2 diabetic subjects. *Diabetes Care* 2005;**28**:1158–1162.
118. Cruickshank K, Riste L, Anderson SG, Wright JS, Dunn G, Gosling RG. Aortic pulse-wave velocity and its relationship to mortality in diabetes and glucose intolerance: an integrated index of vascular function? *Circulation* 2002;**106**:2085–2090.
119. Pop-Busui R, Evans GW, Gerstein HC, Fonseca V, Fleg JL, Hoogwerf BJ, Genuth S, Grimm RH, Corson MA, Prineas R. Effects of cardiac autonomic dysfunction on mortality risk in the Action to Control Cardiovascular Risk in Diabetes (ACCORD) trial. *Diabetes Care* 2010;**33**:1578–1584.

120. Valensi P, Lorgis L, Cottin Y. Prevalence, incidence, predictive factors and prognosis of silent myocardial infarction: a review of the literature. *Arch Cardiovasc Dis* 2011; **104**:178–188.
121. Cosson E, Nguyen MT, Chanu B, Banu I, Chiheb S, Balta C, Takbou K, Valensi P. Cardiovascular risk prediction is improved by adding asymptomatic coronary status to routine risk assessment in type 2 diabetic patients. *Diabetes Care* 2011; **34**: 2101–2107.
122. Young LH, Wackers FJ, Chyun DA, Davey JA, Barrett EJ, Taillefer R, Heller GV, Iskandrian AE, Wittlin SD, Filipchuk N, Ratner RE, Inzucchi SE. Cardiac outcomes after screening for asymptomatic coronary artery disease in patients with type 2 diabetes: the DIAD study: a randomized controlled trial. *JAMA* 2009; **301**: 1547–1555.
123. Gazzaruso C, Coppola A, Montalcini T, Valenti C, Pelissiero G, Solerte SB, Salvucci F, Gallotti P, Pujia A, Garzaniti A, Giustina A. Screening for asymptomatic coronary artery disease can reduce cardiovascular mortality and morbidity in type 2 diabetic patients. *Intern Emerg Med* 2012; **7**:257–266.
124. Marwick TH, Hordern MD, Miller T, Chyun DA, Bertoni AG, Blumenthal RS, Philippides G, Rocchini A. Exercise training for type 2 diabetes mellitus: impact on cardiovascular risk: a scientific statement from the American Heart Association. *Circulation* 2009; **119**:3244–3262.
125. Reiner Z, Catapano AL, De Backer G, Graham I, Taskinen MR, Wiklund O, Agewall S, Alegria E, Chapman MJ, Durrington P, Erdine S, Halcox J, Hobbs R, Kjekshus J, Filardi PP, Riccardi G, Storey RF, Wood D, Bax J, Vahanian A, Auricchio A, Baumgartner H, Ceconi C, Dean V, Deaton C, Fagard R, Filippatos G, Funck-Brentano C, Hasdai D, Hoes A, Kearney P, Knuuti J, Kolh P, McDonagh T, Moulin C, Poldermans D, Popescu BA, Sechtem U, Sirnes PA, Tendera M, Torbicki A, Vardas P, Widimsky P, Windecker S, Berkenboom G, De Graaf J, Descamps O, Gotcheva N, Griffith K, Guida GF, Gulec S, Henkin Y, Huber K, Kesaniemi YA, Lekakis J, Manolis AJ, Marques-Vidal P, Masana L, McMurray J, Mendes M, Pagava Z, Pedersen T, Prescott E, Rato Q, Rosano G, Sans S, Stalenhoef A, Tokgozoglu L, Viigimaa M, Wittekoek ME, Zamorano JL. ESC/EAS Guidelines for the management of dyslipidaemias: the Task Force for the management of dyslipidaemias of the European Society of Cardiology (ESC) and the European Atherosclerosis Society (EAS). *Eur Heart J* 2011; **32**:1769–1818.
126. Inzucchi SE, Bergenstal RM, Buse JB, Diamant M, Ferrannini E, Nauck M, Peters AL, Tsapas A, Wender R, Matthews DR. Management of hyperglycaemia in type 2 diabetes: a patient-centered approach. Position statement of the American Diabetes Association (ADA) and the European Association for the Study of Diabetes (EASD). *Diabetologia* 2012; **55**:1577–1596.
127. NICE Type 2 diabetes: the management of type 2 diabetes: NICE Clinical Guideline 87: National Institute for Health and Clinical Excellence 2009.
128. Nield L, Moore HJ, Hooper L, Cruickshank JK, Vyas A, Whittaker V, Summerbell CD. Dietary advice for treatment of type 2 diabetes mellitus in adults. *Cochrane Database Syst Rev* 2007; **3**:CD004097.
129. Bantle JP, Wylie-Rosett J, Albright AL, Apovian CM, Clark NG, Franz MJ, Hoogwerf BJ, Lichtenstein AH, Mayer-Davis E, Mooradian AD, Wheeler ML. Nutrition recommendations and interventions for diabetes: a position statement of the American Diabetes Association. *Diabetes Care* 2008; **31** Suppl 1:S61–78.
130. Executive summary: Standards of medical care in diabetes: 2013. *Diabetes Care* 2013; **36** Suppl 1:S4–10.
131. Pi-Sunyer X, Blackburn G, Brancati FL, Bray GA, Bright R, Clark JM, Curtis JM, Espeland MA, Foreyt JP, Graves K, Haffner SM, Harrison B, Hill JO, Horton ES, Jakicic J, Jeffery RW, Johnson KC, Kahn S, Kelley DE, Kitabchi AE, Knowler WC, Lewis CE, Maschak-Carey BJ, Montgomery B, Nathan DM, Patricio J, Peters A, Redmon JB, Reeves RS, Ryan DH, Safford M, Van Dorsten B, Wadden TA, Wagenknecht L, Wesche-Thobaben J, Wing RR, Yanovski SZ. Reduction in weight and cardiovascular disease risk factors in individuals with type 2 diabetes: one-year results of the look AHEAD trial. *Diabetes Care* 2007; **30**:1374–1383.
132. Wing RR. Long-term effects of a lifestyle intervention on weight and cardiovascular risk factors in individuals with type 2 diabetes mellitus: four-year results of the Look AHEAD trial. *Arch Intern Med* 2010; **170**:1566–1575.
133. Sjostrom L, Lindroos AK, Peltonen M, Torgerson J, Bouchard C, Carlsson B, Dahlgren S, Larsson B, Narbro K, Sjostrom CD, Sullivan M, Wedel H. Lifestyle, diabetes and cardiovascular risk factors 10 years after bariatric surgery. *N Engl J Med* 2004; **351**:2683–2693.
134. Sacks FM, Bray GA, Carey VJ, Smith SR, Ryan DH, Anton SD, McManus K, Champagne CM, Bishop LM, Laranjo N, Leboff MS, Rood JC, de Jonge L, Greenway FL, Loria CM, Obarzanek E, Williamson DA. Comparison of weight-loss diets with different compositions of fat, protein and carbohydrates. *N Engl J Med* 2009; **360**:859–873.
135. Hamer M, Chida Y. Intake of fruit, vegetables and antioxidants and risk of type 2 diabetes: systematic review and meta-analysis. *J Hypertens* 2007; **25**:2361–2369.
136. Estruch R, Ros E, Salas-Salvado J, Covas MI, Pharm D, Corella D, Aros F, Gomez-Gracia E, Ruiz-Gutierrez V, Fiol M, Lapetra J, Lamuela-Raventos RM, Serra-Majem L, Pinto X, Basora J, Munoz MA, Sorli JV, Martinez JA, Martinez-Gonzalez MA. Primary Prevention of Cardiovascular Disease with a Mediterranean Diet. *N Engl J Med* February 25, 2013.
137. Nothlings U, Ford ES, Kroger J, Boeing H. Lifestyle factors and mortality among adults with diabetes: findings from the European Prospective Investigation into Cancer and Nutrition-Potsdam study*. *Journal of Diabetes* 2010; **2**:112–117.
138. Bidel S, Hu G, Qiao Q, Jousilahti P, Antikainen R, Tuomilehto J. Coffee consumption and risk of total and cardiovascular mortality among patients with type 2 diabetes. *Diabetologia* 2006; **49**:2618–2626.
139. Jee SH, He J, Appel LJ, Whelton PK, Suh I, Klag MJ. Coffee consumption and serum lipids: a meta-analysis of randomized controlled clinical trials. *Am J Epidemiol* 2001; **153**:353–362.
140. Colberg SR, Sigal RJ, Fernhall B, Regensteiner JG, Blissmer BJ, Rubin RR, Chasan-Taber L, Albright AL, Braun B. Exercise and type 2 diabetes: the American College of Sports Medicine and the American Diabetes Association: joint position statement executive summary. *Diabetes Care* 2010; **33**:2692–6.
141. Sluik D, Buijsse B, Muckelbauer R, Kaaks R, Teucher B, Johnsen NF, Tjonneland A, Overvad K, Ostergaard JN, Amiano P, Ardanaz E, Bendinelli B, Pala V, Tumino R, Ricceri F, Mattiello A, Spijkerman AM, Monninkhof EM, May AM, Franks PW, Nilsson PM, Wennberg P, Rolandsson O, Fagherazzi G, Boutron-Ruault MC, Clavel-Chapelon F, Castano JM, Gallo V, Boeing H, Nothlings U. Physical Activity and Mortality in Individuals With Diabetes Mellitus: A Prospective Study and Meta-analysis. *Arch Intern Med* 2012; **172**:1–11.
142. Vanhees L, Geladas N, Hansen D, Kouidi E, Niebauer J, Reiner Z, Cornelissen V, Adamopoulos S, Prescott E, Borjesson M, Bjarnason-Wehrens B, Bjornstad HH, Cohen-Solal A, Conraads V, Corrado D, De Sutter J, Doherty P, Doyle F, Dugmore D, Ellingsen O, Fagard R, Giada F, Gielen S, Hager A, Halle M, Heidbuchel H, Jegier A, Mazic S, McGee H, Mellwig KP, Mendes M, Mezzani A, Pattyn N, Pelliccia A, Piepoli M, Rauch B, Schmidt-Trucksass A, Takken T, van Buuren F, Vanuzzo D. Importance of characteristics and modalities of physical activity and exercise in the management of cardiovascular health in individuals with cardiovascular risk factors: recommendations from the EACPR. Part II. *Eur J Prev Cardiol* 2012; **19**:1005–1033.
143. Snowling NJ, Hopkins WG. Effects of different modes of exercise training on glucose control and risk factors for complications in type 2 diabetic patients: a meta-analysis. *Diabetes Care* 2006; **29**:2518–2527.
144. Umpierre D, Ribeiro PA, Kramer CK, Leitao CB, Zucatti AT, Azevedo MJ, Gross JL, Ribeiro JP, Schaan BD. Physical activity advice only or structured exercise training and association with HbA1c levels in type 2 diabetes: a systematic review and meta-analysis. *JAMA* 2011; **305**:1790–1799.
145. Kirk AF, Barnett J, Mutrie N. Physical activity consultation for people with Type 2 diabetes: evidence and guidelines. *Diabet Med* 2007; **24**:809–816.
146. Stratton IM, Adler AI, Neil HA, Matthews DR, Manley SE, Cull CA, Hadden D, Turner RC, Holman RR. Association of glycaemia with macrovascular and microvascular complications of type 2 diabetes (UKPDS 35): prospective observational study. *BMJ* 2000; **321**:405–412.
147. Sigal RJ, Kenny GP, Boule NG, Wells GA, Prud'homme D, Fortier M, Reid RD, Tulloch H, Coyle D, Phillips P, Jennings A, Jaffey J. Effects of aerobic training, resistance training, or both on glycemic control in type 2 diabetes: a randomized trial. *Ann Intern Med* 2007; **147**:357–369.
148. Willi C, Bodenmann P, Ghali WA, Faris PD, Cornuz J. Active smoking and the risk of type 2 diabetes: a systematic review and meta-analysis. *JAMA* 2007; **298**: 2654–2664.
149. Ezzati M, Lopez AD. Estimates of global mortality attributable to smoking in 2000. *Lancet* 2003; **362**:847–852.
150. Brunnhuber K, Cummings K, Feit S, Sherman S, Woodcock J. *Putting evidence into practice: Smoking cessation* BMJ Group 2007.
151. The effect of intensive treatment of diabetes on the development and progression of long-term complications in insulin-dependent diabetes mellitus. The Diabetes Control and Complications Trial Research Group. *N Engl J Med* 1993; **329**: 977–986.
152. Intensive blood-glucose control with sulphonylureas or insulin compared with conventional treatment and risk of complications in patients with type 2 diabetes (UKPDS 33). UK Prospective Diabetes Study (UKPDS) Group. *Lancet* 1998; **352**: 837–853.
153. Effect of intensive blood-glucose control with metformin on complications in overweight patients with type 2 diabetes (UKPDS 34). UK Prospective Diabetes Study (UKPDS) Group. *Lancet* 1998; **352**:854–865.
154. Nathan DM, Cleary PA, Backlund JY, Genuth SM, Lachin JM, Orchard TJ, Raskin P, Zinman B. Intensive diabetes treatment and cardiovascular disease in patients with type 1 diabetes. *N Engl J Med* 2005; **353**:2643–2653.
155. Holman RR, Paul SK, Bethel MA, Matthews DR, Neil HA. 10-year follow-up of intensive glucose control in type 2 diabetes. *N Engl J Med* 2008; **359**:1577–1589.
156. Gaede P, Lund-Andersen H, Parving HH, Pedersen O. Effect of a multifactorial intervention on mortality in type 2 diabetes. *N Engl J Med* 2008; **358**:580–591.

157. Consensus statement on the worldwide standardization of the hemoglobin A1C measurement: the American Diabetes Association, European Association for the Study of Diabetes, International Federation of Clinical Chemistry and Laboratory Medicine and the International Diabetes Federation. *Diabetes Care* 2007;**30**: 2399–2400.
158. Adler AI, Stevens RJ, Manley SE, Bilous RW, Cull CA, Holman RR. Development and progression of nephropathy in type 2 diabetes: the United Kingdom Prospective Diabetes Study (UKPDS 64). *Kidney Int* 2003;**63**:225–232.
159. Gerstein HC, Miller ME, Byington RP, Goff DC Jr., Bigger JT, Buse JB, Cushman WC, Genuth S, Ismail-Beigi F, Grimm RH Jr., Probstfield JL, Simons-Morton DG, Friedewald WT. Effects of intensive glucose lowering in type 2 diabetes. *N Engl J Med* 2008;**358**:2545–2559.
160. Patel A, MacMahon S, Chalmers J, Neal B, Billot L, Woodward M, Marre M, Cooper M, Glasziou P, Grobbee D, Hamet P, Harrap S, Heller S, Liu L, Mancia G, Mogensen CE, Pan C, Poulter N, Rodgers A, Williams B, Bompoint S, de Galan BE, Joshi R, Travert F. Intensive blood glucose control and vascular outcomes in patients with type 2 diabetes. *N Engl J Med* 2008;**358**:2560–2572.
161. Duckworth W, Abraira C, Moritz T, Reda D, Emanuele N, Reaven PD, Zieve FJ, Marks J, Davis SN, Hayward R, Warren SR, Goldman S, McCarren M, Vitek ME, Henderson WG, Huang GD. Glucose control and vascular complications in veterans with type 2 diabetes. *N Engl J Med* 2009;**360**:129–139.
162. Hemmingsen B, Lund SS, Gluud C, Vaag A, Almdal T, Hemmingsen C, Wetterslev J. Intensive glycaemic control for patients with type 2 diabetes: systematic review with meta-analysis and trial sequential analysis of randomised clinical trials. *BMJ* 2011;**343**:d6898.
163. The absence of a glycemic threshold for the development of long-term complications: the perspective of the Diabetes Control and Complications Trial. *Diabetes* 1996;**45**:1289–1298.
164. Coutinho M, Gerstein HC, Wang Y, Yusuf S. The relationship between glucose and incident cardiovascular events. A metaregression analysis of published data from 20 studies of 95,783 individuals followed for 12.4 years. *Diabetes Care* 1999;**22**: 233–240.
165. Sarwar N, Gao P, Seshasai SR, Gobin R, Kaptoge S, Di Angelantonio E, Ingelsson E, Lawlor DA, Selvin E, Stampfer M, Stehouwer CD, Lewington S, Pennells L, Thompson A, Sattar N, White IR, Ray KK, Danesh J. Diabetes mellitus, fasting blood glucose concentration and risk of vascular disease: a collaborative meta-analysis of 102 prospective studies. *Lancet* 2010;**375**:2215–2222.
166. Bonds DE, Miller ME, Bergenstal RM, Buse JB, Byington RP, Cutler JA, Dudl RJ, Ismail-Beigi F, Kimel AR, Hoogwerf B, Horowitz KR, Savage PJ, Seaquist ER, Simmons DL, Sivitz WJ, Speril-Hillen JM, Sweeney ME. The association between symptomatic, severe hypoglycaemia and mortality in type 2 diabetes: retrospective epidemiological analysis of the ACCORD study. *BMJ* 2010;**340**:b4909.
167. Gerstein HC, Miller ME, Genuth S, Ismail-Beigi F, Buse JB, Goff DC Jr., Probstfield JL, Cushman WC, Ginsberg HN, Bigger JT, Grimm RH Jr., Byington RP, Rosenberg YD, Friedewald WT. Long-term effects of intensive glucose lowering on cardiovascular outcomes. *N Engl J Med* 2011;**364**:818–828.
168. Gerstein HC, Bosch J, Dagenais GR, Diaz R, Jung H, Maggioni AP, Pogue J, Probstfield J, Ramachandran A, Riddle MC, Ryden LE, Yusuf S. Basal insulin and cardiovascular and other outcomes in dysglycemia. *N Engl J Med* 2012;**367**:319–328.
169. Turnbull FM, Abraira C, Anderson RJ, Byington RP, Chalmers JP, Duckworth WC, Evans GW, Gerstein HC, Holman RR, Moritz TE, Neal BC, Ninomiya T, Patel AA, Paul SK, Travert F, Woodward M. Intensive glucose control and macrovascular outcomes in type 2 diabetes. *Diabetologia* 2009;**52**:2288–2298.
170. Farmer AJ, Wade AN, French DP, Simon J, Yudkin P, Gray A, Craven A, Goyder L, Holman RR, Mant D, Kinmonth AL, Neil HA. Blood glucose self-monitoring in type 2 diabetes: a randomised controlled trial. *Health Technol Assess* 2009;**13**:iii–iv, ix–xi, 1–50.
171. Cavalot F, Pagliarino A, Valle M, Di Martino L, Bonomo K, Massucco P, Anfossi G, Trovati M. Postprandial blood glucose predicts cardiovascular events and all-cause mortality in type 2 diabetes in a 14-year follow-up: lessons from the San Luigi Gonzaga Diabetes Study. *Diabetes Care* 2011;**34**:2237–2243.
172. Chiasson JL, Josse RG, Gomis R, Hanefeld M, Karasik A, Laakso M. Acarbose treatment and the risk of cardiovascular disease and hypertension in patients with impaired glucose tolerance: the STOP-NIDDM trial. *JAMA* 2003;**290**:486–494.
173. Raz I, Wilson PW, Strojek K, Kowalska I, Bozikov V, Gitt AK, Jermendy G, Campagne BN, Kerr L, Milicevic Z, Jacober SJ. Effects of prandial versus fasting glycemia on cardiovascular outcomes in type 2 diabetes: the HEART2D trial. *Diabetes Care* 2009;**32**:381–386.
174. Raz I, Ceriello A, Wilson PW, Battiou C, Sy EW, Kerr L, Jones CA, Milicevic Z, Jacober SJ. Post hoc subgroup analysis of the HEART2D trial demonstrates lower cardiovascular risk in older patients targeting postprandial versus fasting/premeal glycemia. *Diabetes Care* 2011;**34**:1511–1513.
175. Dormandy JA, Charbonnel B, Eckland DJ, Erdmann E, Massi-Benedetti M, Moules IK, Skene AM, Tan MH, Lefebvre PJ, Murray GD, Standl E, Wilcox RG, Wilhelmsen L, Betteridge J, Birkeland K, Golay A, Heine RJ, Koranyi L, Laakso M, Mokan M, Norkus A, Pirags V, Podar T, Scheen A, Scherbaum W, Schernthaner G, Schmitz O, Skrha J, Smith U, Taton J. Secondary prevention of macrovascular events in patients with type 2 diabetes in the PROactive Study (PROspective pioglitazone Clinical Trial In macroVascular Events): a randomised controlled trial. *Lancet* 2005;**366**:1279–1289.
176. Salpeter S, Greyber E, Pasternak G, Salpeter E. Risk of fatal and nonfatal lactic acidosis with metformin use in type 2 diabetes mellitus. *Cochrane Database Syst Rev* 2006;**1**:CD002967.
177. Holstein A, Stumvoll M. Contraindications can damage your health: is metformin a case in point? *Diabetologia* 2005;**48**:2454–2459.
178. Nissen SE, Wolski K. Effect of rosiglitazone on the risk of myocardial infarction and death from cardiovascular causes. *N Engl J Med* 2007;**356**:2457–2471.
179. Lamanna C, Monami M, Marchionni N, Mannucci E. Effect of metformin on cardiovascular events and mortality: a meta-analysis of randomized clinical trials. *Diabetes Obes Metab* 2011;**13**:221–228.
180. Holman RR, Haffner SM, McMurray JJ, Bethel MA, Holzhauer B, Hua TA, Belenkov Y, Boolell M, Buse JB, Buckley BM, Chacra AR, Chiang FT, Charbonnel B, Chow CC, Davies MJ, Deedwania P, Diem P, Einhorn D, Fonseca V, Fulcher GR, Gaciong Z, Gaztambide S, Giles T, Horton E, Ilkova H, Jensen T, Kahn SE, Krum H, Laakso M, Leiter LA, Levitt NS, Mareev V, Martinez F, Masson C, Mazzone T, Meaney E, Nesto R, Pan C, Prager R, Raptis SA, Rutten GE, Sandstrom H, Schaper F, Scheen A, Schmitz O, Sinay I, Soska V, Stender S, Tamas G, Tognoni G, Tuomilehto J, Villamil AS, Vozar J, Califf RM. Effect of nateglinide on the incidence of diabetes and cardiovascular events. *N Engl J Med* 2010;**362**:1463–1476.
181. Graveling AJ, Frier BM. Impaired awareness of hypoglycaemia: a review. *Diabetes Metab* 2010;**36** Suppl 3:S64–74.
182. Frier BM, Schernthaner G, Heller SR. Hypoglycemia and cardiovascular risks. *Diabetes Care* 2011;**34** Suppl 2:S132–7.
183. Warren RE, Frier BM. Hypoglycaemia and cognitive function. *Diabetes Obes Metab* 2005;**7**:493–503.
184. Abe M, Okada K, Soma M. Antidiabetic agents in patients with chronic kidney disease and end-stage renal disease on dialysis: metabolism and clinical practice. *Curr Drug Metab* 2011;**12**:57–69.
185. Cleary PA, Orchard TJ, Genuth S, Wong ND, Detrano R, Backlund JY, Zinman B, Jacobson A, Sun W, Lachin JM, Nathan DM. The effect of intensive glycemic treatment on coronary artery calcification in type 1 diabetic participants of the Diabetes Control and Complications Trial/Epidemiology of Diabetes Interventions and Complications (DCCT/EDIC) Study. *Diabetes* 2006;**55**:3556–3565.
186. Soedamah-Muthu SS, Colhoun HM, Abrahamian H, Chan NN, Mangili R, Reboli GP, Fuller JH. Trends in hypertension management in Type 1 diabetes across Europe, 1989/1990–1997/1999. *Diabetologia* 2002;**45**:1362–1371.
187. Nilsson PM, Cederholm J, Zethelius BR, Eliasson BR, Eeg-Olofsson K, Gudbj Rnsdottir S. Trends in blood pressure control in patients with type 2 diabetes: data from the Swedish National Diabetes Register (NDR). *Blood Press* 2011;**20**: 348–354.
188. Redon J, Cifkova R, Laurent S, Nilsson P, Narkiewicz K, Erdine S, Mancia G. Mechanisms of hypertension in the cardiometabolic syndrome. *J Hypertens* 2009;**27**: 441–451.
189. Mogensen CE. New treatment guidelines for a patient with diabetes and hypertension. *J Hypertens Suppl* 2003;**21**:S25–30.
190. Haffner SM, Lehto S, Ronnema T, Pyoral K, Laakso M. Mortality from coronary heart disease in subjects with type 2 diabetes and in nondiabetic subjects with and without prior myocardial infarction. *N Engl J Med* 1998;**339**:229–234.
191. Tight blood pressure control and risk of macrovascular and microvascular complications in type 2 diabetes: UKPDS 38. UK Prospective Diabetes Study Group. *BMJ* 1998;**317**:703–713.
192. Cushman WC, Evans GW, Byington RP, Goff DC Jr., Grimm RH Jr., Cutler JA, Simons-Morton DG, Basile JN, Corson MA, Probstfield JL, Katz L, Peterson KA, Friedewald WT, Buse JB, Bigger JT, Gerstein HC, Ismail-Beigi F. Effects of intensive blood-pressure control in type 2 diabetes mellitus. *N Engl J Med* 2010;**362**: 1575–1585.
193. Patel A, MacMahon S, Chalmers J, Neal B, Woodward M, Billot L, Harrap S, Poulter N, Marre M, Cooper M, Glasziou P, Grobbee DE, Hamet P, Heller S, Liu LS, Mancia G, Mogensen CE, Pan CY, Rodgers A, Williams B. Effects of a fixed combination of perindopril and indapamide on macrovascular and microvascular outcomes in patients with type 2 diabetes mellitus (the ADVANCE trial): a randomised controlled trial. *Lancet* 2007;**370**:829–840.
194. Holman RR, Paul SK, Bethel MA, Neil HA, Matthews DR. Long-term follow-up after tight control of blood pressure in type 2 diabetes. *N Engl J Med* 2008;**359**: 1565–1576.
195. Hansson L, Zanchetti A, Carruthers SG, Dahlof B, Elmfeldt D, Julius S, Menard J, Rahn KH, Wedel H, Westerling S. Effects of intensive blood-pressure lowering and low-dose aspirin in patients with hypertension: principal results of the

- Hypertension Optimal Treatment (HOT) randomised trial. HOT Study Group. *Lancet* 1998;**351**:1755–1762.
196. Adler AI, Stratton IM, Neil HA, Yudkin JS, Matthews DR, Cull CA, Wright AD, Turner RC, Holman RR. Association of systolic blood pressure with macrovascular and microvascular complications of type 2 diabetes (UKPDS 36): prospective observational study. *BMJ* 2000;**321**:412–419.
 197. Bangalore S, Kumar S, Lobach I, Messerli FH. Blood pressure targets in subjects with type 2 diabetes mellitus/impaired fasting glucose: observations from traditional and bayesian random-effects meta-analyses of randomized trials. *Circulation* 2011;**123**: 2799–2810.
 198. Tatti P, Pahor M, Byington RP, Di Mauro P, Guarisco R, Strollo G, Strollo F. Outcome results of the Fosinopril Versus Amlodipine Cardiovascular Events Randomized Trial (FACET) in patients with hypertension and NIDDM. *Diabetes Care* 1998;**21**:597–603.
 199. Estacio RO, Jeffers BW, Hiatt WR, Biggerstaff SL, Gifford N, Schrier RW. The effect of nisoldipine as compared with enalapril on cardiovascular outcomes in patients with non-insulin-dependent diabetes and hypertension. *N Engl J Med* 1998;**338**: 645–652.
 200. Niskanen L, Hedner T, Hansson L, Lanke J, Niklason A. Reduced cardiovascular morbidity and mortality in hypertensive diabetic patients on first-line therapy with an ACE inhibitor compared with a diuretic/beta-blocker-based treatment regimen: a subanalysis of the Captopril Prevention Project. *Diabetes Care* 2001; **24**:2091–2096.
 201. Lindholm LH, Hansson L, Ekblom T, Dahlöf B, Lanke J, Linjer E, Schersten B, Wester PO, Hedner T, de Faire U. Comparison of antihypertensive treatments in preventing cardiovascular events in elderly diabetic patients: results from the Swedish Trial in Old Patients with Hypertension-2. STOP Hypertension-2 Study Group. *J Hypertens* 2000;**18**:1671–1675.
 202. Hansson L, Hedner T, Lund-Johansen P, Kjeldsen SE, Lindholm LH, Syvertsen JO, Lanke J, de Faire U, Dahlöf B, Karlberg BE. Randomised trial of effects of calcium antagonists compared with diuretics and beta-blockers on cardiovascular morbidity and mortality in hypertension: the Nordic Diltiazem (NORDIL) study. *Lancet* 2000;**356**:359–365.
 203. Mancia G, Brown M, Castaigne A, de Leeuw P, Palmer CR, Rosenthal T, Wagener G, Ruilope LM. Outcomes with nifedipine GITS or Co-amlozide in hypertensive diabetics and nondiabetics in Intervention as a Goal in Hypertension (INSIGHT). *Hypertension* 2003;**41**:431–436.
 204. Whelton PK, Barzilay J, Cushman WC, Davis BR, Iamathi E, Kostis JB, Leenen FH, Louis GT, Margolis KL, Mathis DE, Moloo J, Nwachuku C, Panebianco D, Parish DC, Pressel S, Simmons DL, Thadani U. Clinical outcomes in antihypertensive treatment of type 2 diabetes, impaired fasting glucose concentration and normoglycemia: Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial (ALLHAT). *Arch Intern Med* 2005;**165**:1401–1409.
 205. Lindholm LH, Ibsen H, Dahlöf B, Devereux RB, Beevers G, de Faire U, Fyhrquist F, Julius S, Kjeldsen SE, Kristiansson K, Lederballe-Pedersen O, Nieminen MS, Omvik P, Oparil S, Wedel H, Aurup P, Edelman J, Snapinn S. Cardiovascular morbidity and mortality in patients with diabetes in the Losartan Intervention For Endpoint reduction in hypertension study (LIFE): a randomised trial against atenolol. *Lancet* 2002;**359**:1004–1010.
 206. Ostergren J, Poulter NR, Sever PS, Dahlöf B, Wedel H, Beevers G, Caulfield M, Collins R, Kjeldsen SE, Kristinsson A, McInnes GT, Mehlsen J, Nieminen M, O'Brien E. The Anglo-Scandinavian Cardiac Outcomes Trial: blood pressure-lowering limb: effects in patients with type II diabetes. *J Hypertens* 2008;**26**: 2103–2111.
 207. Weber MA, Bakris GL, Jamerson K, Weir M, Kjeldsen SE, Devereux RB, Velazquez EJ, Dahlöf B, Kelly RY, Hua TA, Hester A, Pitt B. Cardiovascular events during differing hypertension therapies in patients with diabetes. *J Am Coll Cardiol* 2010;**56**:77–85.
 208. Ruggerenti P, Fassi A, Ilieva AP, Bruno S, Iliev IP, Brusegan V, Rubis N, Gherardi G, Arnoldi F, Ganeva M, Ene-Iordache B, Gaspari F, Perna A, Bossi A, Trevisan R, Dodesini AR, Remuzzi G. Preventing microalbuminuria in type 2 diabetes. *N Engl J Med* 2004;**351**:1941–1951.
 209. Parving HH, Brenner BM, McMurray JJ, de Zeeuw D, Haffner SM, Solomon SD, Chaturvedi N, Persson F, Desai AS, Nicolaides M, Richard A, Xiang Z, Brunel P, Pfeffer MA. Cardioresenal end points in a trial of aliskiren for type 2 diabetes. *N Engl J Med* 2012;**367**:2204–2213.
 210. Yusuf S, Teo KK, Pogue J, Dyal L, Copland I, Schumacher H, Dagenais G, Sleight P, Anderson C. Telmisartan, ramipril, or both in patients at high risk for vascular events. *N Engl J Med* 2008;**358**:1547–1559.
 211. Reboli G, Gentile G, Angeli F, Verdecchia P. Exploring the optimal combination therapy in hypertensive patients with diabetes mellitus. *Expert Rev Cardiovasc Ther* 2009;**7**:1349–1361.
 212. Turnbull F, Neal B, Algert C, Chalmers J, Chapman N, Cutler J, Woodward M, MacMahon S. Effects of different blood pressure-lowering regimens on major cardiovascular events in individuals with and without diabetes mellitus: results of prospectively designed overviews of randomized trials. *Arch Intern Med* 2005; **165**:1410–1419.
 213. Anselmino M, Malmberg K, Ohrvik J, Ryden L. Evidence-based medication and revascularization: powerful tools in the management of patients with diabetes and coronary artery disease: a report from the Euro Heart Survey on diabetes and the heart. *Eur J Cardiovasc Prev Rehabil* 2008;**15**:216–223.
 214. Mancia G, Laurent S, Agabiti-Rosei E, Ambrosioni E, Burnier M, Caulfield MJ, Cifkova R, Clement D, Coca A, Dominiczak A, Erdine S, Fagard R, Farsang C, Grassi G, Haller H, Heagerty A, Kjeldsen SE, Kiowski W, Mallion JM, Manolis A, Narkiewicz K, Nilsson P, Olsen MH, Rahn KH, Redon J, Rodicio J, Ruilope L, Schmieder RE, Struijker-Boudier HA, van Zwieten PA, Viigimaa M, Zanchetti A. Reappraisal of European guidelines on hypertension management: a European Society of Hypertension Task Force document. *J Hypertens* 2009;**27**:2121–2158.
 215. 2013 ESH/ESC Guidelines for the management of arterial hypertension. *Eur Heart J* 2013;**34**:2159–2219.
 216. Adiels M, Olofsson SO, Taskinen MR, Boren J. Overproduction of very low-density lipoproteins is the hallmark of the dyslipidemia in the metabolic syndrome. *Arterioscler Thromb Vasc Biol* 2008;**28**:1225–1236.
 217. Fabbri S, Sullivan S, Klein S. Obesity and nonalcoholic fatty liver disease: biochemical, metabolic and clinical implications. *Hepatology* 2010;**51**:679–689.
 218. Taskinen MR, Adiels M, Westerbacka J, Soderlund S, Kahri J, Lundbom N, Lundbom J, Hakkarainen A, Olofsson SO, Orho-Melander M, Boren J. Dual metabolic defects are required to produce hypertriglyceridemia in obese subjects. *Arterioscler Thromb Vasc Biol* 2011;**31**:2144–2150.
 219. McQuaid SE, Hodson L, Neville MJ, Dennis AL, Cheeseman J, Humphreys SM, Ruge T, Gilbert M, Fielding BA, Frayn KN, Karpe F. Downregulation of adipose tissue fatty acid trafficking in obesity: a driver for ectopic fat deposition? *Diabetes* 2011;**60**:47–55.
 220. Kotseva K, Stagmo M, De Bacquer D, De Backer G, Wood D. Treatment potential for cholesterol management in patients with coronary heart disease in 15 European countries: findings from the EUROASPIRE II survey. *Atherosclerosis* 2008;**197**: 710–717.
 221. Kotseva K, Wood D, De Backer G, De Bacquer D, Pyorala K, Keil U. EUROASPIRE III: a survey on the lifestyle, risk factors and use of cardioprotective drug therapies in coronary patients from 22 European countries. *Eur J Cardiovasc Prev Rehabil* 2009; **16**:121–137.
 222. Eriksson M, Zethelius B, Eeg-Olofsson K, Nilsson PM, Gudbjornsdottir S, Cederholm J, Eliasson B. Blood lipids in 75,048 type 2 diabetic patients: a population-based survey from the Swedish National diabetes register. *Eur J Cardiovasc Prev Rehabil* 2011;**18**:97–105.
 223. Eliasson B, Svensson AM, Miftaraj M, Jonasson JM, Eeg-Olofsson K, Sundell KA, Gudbjornsdottir S. Clinical use and effectiveness of lipid lowering therapies in diabetes mellitus: an observational study from the Swedish National Diabetes Register. *PLoS One* 2011;**6**:e18744.
 224. Chapman MJ, Ginsberg HN, Amarencu P, Andreotti F, Boren J, Catapano AL, Descamps OS, Fisher E, Kovane PT, Kuivenhoven JA, Lesnik P, Masana L, Nordestgaard BG, Ray KK, Reiner Z, Taskinen MR, Tokgozoglu L, Tybjaerg-Hansen A, Watts GF. Triglyceride-rich lipoproteins and high-density lipoprotein cholesterol in patients at high risk of cardiovascular disease: evidence and guidance for management. *Eur Heart J* 2011;**32**:1345–1361.
 225. Miller M, Stone NJ, Ballantyne C, Bittner V, Criqui MH, Ginsberg HN, Goldberg AC, Howard WJ, Jacobson MS, Kris-Etherton PM, Lennie TA, Levi M, Mazzone T, Pennathur S. Triglycerides and cardiovascular disease: a scientific statement from the American Heart Association. *Circulation* 2011;**123**:2292–2333.
 226. Barter P, Gotto AM, LaRosa JC, Maroni J, Szarek M, Grundy SM, Kastelein JJ, Bittner V, Fruchart JC. HDL cholesterol, very low levels of LDL cholesterol and cardiovascular events. *N Engl J Med* 2007;**357**:1301–1310.
 227. Baigent C, Blackwell L, Emberson J, Holland LE, Reith C, Bhalra N, Peto R, Barnes EH, Keech A, Simes J, Collins R. Efficacy and safety of more intensive lowering of LDL cholesterol: a meta-analysis of data from 170,000 participants in 26 randomised trials. *Lancet* 2010;**376**:1670–1681.
 228. Scott R, O'Brien R, Fulcher G, Pardy C, D'Emden M, Tse D, Taskinen MR, Ehnholm C, Keech A. Effects of fenofibrate treatment on cardiovascular disease risk in 9,795 individuals with type 2 diabetes and various components of the metabolic syndrome: the Fenofibrate Intervention and Event Lowering in Diabetes (FIELD) study. *Diabetes Care* 2009;**32**:493–498.
 229. Ginsberg HN, Elam MB, Lovato LC, Crouse JR 3rd, Leiter LA, Linz P, Friedewald WT, Buse JB, Gerstein HC, Probstfield J, Grimm RH, Ismail-Beigi F, Biggar JT, Goff DC Jr., Cushman WC, Simons-Morton DG, Byington RP. Effects of combination lipid therapy in type 2 diabetes mellitus. *N Engl J Med* 2010;**362**: 1563–1574.
 230. Taskinen MR, Barter PJ, Ehnholm C, Sullivan DR, Mann K, Simes J, Best JD, Hamwood S, Keech AC. Ability of traditional lipid ratios and apolipoprotein ratios to predict cardiovascular risk in people with type 2 diabetes. *Diabetologia* 2010;**53**:1846–1855.

231. Di Angelantonio E, Sarwar N, Perry P, Kaptoge S, Ray KK, Thompson A, Wood AM, Lewington S, Sattar N, Packard CJ, Collins R, Thompson SG, Danesh J. Major lipids, apolipoproteins and risk of vascular disease. *JAMA* 2009;**302**:1993–2000.
232. Mills EJ, O'Regan C, Eyawo O, Wu P, Mills F, Berwanger O, Briel M. Intensive statin therapy compared with moderate dosing for prevention of cardiovascular events: a meta-analysis of >40 000 patients. *Eur Heart J* 2011;**32**:1409–1415.
233. Baigent C, Keech A, Kearney PM, Blackwell L, Buck G, Pollicino C, Kirby A, Sourjina T, Peto R, Collins R, Simes R. Efficacy and safety of cholesterol-lowering treatment: prospective meta-analysis of data from 90,056 participants in 14 randomised trials of statins. *Lancet* 2005;**366**:1267–1278.
234. Kearney PM, Blackwell L, Collins R, Keech A, Simes J, Peto R, Armitage J, Baigent C. Efficacy of cholesterol-lowering therapy in 18,686 people with diabetes in 14 randomised trials of statins: a meta-analysis. *Lancet* 2008;**371**:117–125.
235. Cannon CP, Steinberg BA, Murphy SA, Mega JL, Braunwald E. Meta-analysis of cardiovascular outcomes trials comparing intensive versus moderate statin therapy. *J Am Coll Cardiol* 2006;**48**:438–445.
236. Nicholls SJ, Tuzcu EM, Kalidindi S, Wolski K, Moon KW, Sipahi I, Schoenhagen P, Nissen SE. Effect of diabetes on progression of coronary atherosclerosis and arterial remodeling: a pooled analysis of 5 intravascular ultrasound trials. *J Am Coll Cardiol* 2008;**52**:255–262.
237. Leiter LA, Betteridge DJ, Farnier M, Guyton JR, Lin J, Shah A, Johnson-Levonas AO, Brudi P. Lipid-altering efficacy and safety profile of combination therapy with ezetimibe/statin vs. statin monotherapy in patients with and without diabetes: an analysis of pooled data from 27 clinical trials. *Diabetes Obes Metab* 2011;**13**:615–628.
238. Baigent C, Landray MJ, Reith C, Emberson J, Wheeler DC, Tomson C, Wanner C, Krane V, Cass A, Craig J, Neal B, Jiang L, Hooi LS, Levin A, Agodoa L, Gaziano M, Kasiske B, Walker R, Massy ZA, Feldt-Rasmussen B, Krairitichai U, Ophascharoensuk V, Fellstrom B, Holdaas H, Tesar V, Wiecek A, Grobbee D, de Zeeuw D, Gronhagen-Riska C, Dasgupta T, Lewis D, Herrington W, Mafham M, Majoni W, Wallendzus K, Grimm R, Pedersen T, Tobert J, Armitage J, Baxter A, Bray C, Chen Y, Chen Z, Hill M, Knott C, Parish S, Simpson D, Sleight P, Young A, Collins R. The effects of lowering LDL cholesterol with simvastatin plus ezetimibe in patients with chronic kidney disease (Study of Heart and Renal Protection): a randomised placebo-controlled trial. *Lancet* 2011;**377**:2181–2192.
239. Colhoun HM, Betteridge DJ, Durrington PN, Hitman GA, Neil HA, Livingstone SJ, Thomason MJ, Mackness MI, Charlton-Menys V, Fuller JH. Primary prevention of cardiovascular disease with atorvastatin in type 2 diabetes in the Collaborative Atorvastatin Diabetes Study (CARDS): multicentre randomised placebo-controlled trial. *Lancet* 2004;**364**:685–696.
240. Collins R, Armitage J, Parish S, Sleight P, Peto R. MRC/BHF Heart Protection Study of cholesterol-lowering with simvastatin in 5963 people with diabetes: a randomised placebo-controlled trial. *Lancet* 2003;**361**:2005–2016.
241. Sever PS, Poulter NR, Dahlof B, Wedel H, Collins R, Beevers G, Caulfield M, Kjeldsen SE, Kristinsson A, McInnes GT, Mehlsen J, Nieminen M, O'Brien E, Ostergren J. Reduction in cardiovascular events with atorvastatin in 2,532 patients with type 2 diabetes: Anglo-Scandinavian Cardiac Outcomes Trial: lipid-lowering arm (ASCOT-LLA). *Diabetes Care* 2005;**28**:1151–1157.
242. Armitage J. The safety of statins in clinical practice. *Lancet* 2007;**370**:1781–1790.
243. Catapano AL, Reiner Z, De Backer G, Graham I, Taskinen MR, Wiklund O, Agewall S, Alegria E, Chapman MJ, Durrington P, Erdine S, Halcox J, Hobbs R, Kjekshus J, Perrone Filardi P, Riccardi G, Storey RF, Wood D. ESC/EAS Guidelines for the management of dyslipidaemias: the Task Force for the management of dyslipidaemias of the European Society of Cardiology (ESC) and the European Atherosclerosis Society (EAS). *Atherosclerosis* 2011;**217** Suppl 1:S1–44.
244. Sattar N, Preiss D, Murray HM, Welsh P, Buckley BM, de Craen AJ, Seshasai SR, McMurray JJ, Freeman DJ, Jukema JW, Macfarlane PW, Packard CJ, Stott DJ, Westendorp RG, Shepherd J, Davis BR, Pressel SL, Marchioli R, Marfisi RM, Maggioni AP, Tavazzi L, Tognoni G, Kjekshus J, Pedersen TR, Cook TJ, Gotto AM, Clearfield MB, Downs JR, Nakamura H, Ohashi Y, Mizuno K, Ray KK, Ford I. Statins and risk of incident diabetes: a collaborative meta-analysis of randomised statin trials. *Lancet* 2010;**375**:735–742.
245. Preiss D, Seshasai SR, Welsh P, Murphy SA, Ho JE, Waters DD, DeMicco DA, Barter P, Cannon CP, Sabatine MS, Braunwald E, Kastelein JJ, de Lemos JA, Blazing MA, Pedersen TR, Tikkanen MJ, Sattar N, Ray KK. Risk of incident diabetes with intensive-dose compared with moderate-dose statin therapy: a meta-analysis. *JAMA* 2011;**305**:2556–2564.
246. Cannon CP. Balancing the benefits of statins versus a new risk-diabetes. *Lancet* 2010;**375**:700–701.
247. Mihaylova B, Emberson J, Blackwell L, Keech A, Simes J, Barnes EH, Voysey M, Gray A, Collins R, Baigent C. The effects of lowering LDL cholesterol with statin therapy in people at low risk of vascular disease: meta-analysis of individual data from 27 randomised trials. *Lancet* 2012;**380**:581–590.
248. Keech A, Simes RJ, Barter P, Best J, Scott R, Taskinen MR, Forder P, Pillai A, Davis T, Glasziou P, Drury P, Kesaniemi YA, Sullivan D, Hunt D, Colman P, d'Emden M, Whiting M, Ehnholm C, Laakso M. Effects of long-term fenofibrate therapy on cardiovascular events in 9795 people with type 2 diabetes mellitus (the FIELD study): randomised controlled trial. *Lancet* 2005;**366**:1849–1861.
249. Bruckert E, Labreuche J, Deplanque D, Touboul PJ, Amarenco P. Fibrates effect on cardiovascular risk is greater in patients with high triglyceride levels or atherogenic dyslipidemia profile: a systematic review and meta-analysis. *J Cardiovasc Pharmacol* 2011;**57**:267–272.
250. Jun M, Foote C, Lv J, Neal B, Patel A, Nicholls SJ, Grobbee DE, Cass A, Chalmers J, Perkovic V. Effects of fibrates on cardiovascular outcomes: a systematic review and meta-analysis. *Lancet* 2010;**375**:1875–1884.
251. Barter PJ, Caulfield M, Eriksson M, Grundy SM, Kastelein JJ, Komajda M, Lopez-Sendon J, Mosca L, Tardif JC, Waters DD, Shear CL, Revkin JH, Buhr KA, Fisher MR, Tall AR, Brewer B. Effects of torcetrapib in patients at high risk for coronary events. *N Engl J Med* 2007;**357**:2109–2122.
252. Schwartz GG, Olsson AG, Abt M, Ballantyne CM, Barter PJ, Brumm J, Chaitman BR, Holme IM, Kallend D, Leiter LA, Leitersdorf E, McMurray JJ, Mundt H, Nicholls SJ, Shah PK, Tardif JC, Wright RS. Effects of dalcetrapib in patients with a recent acute coronary syndrome. *N Engl J Med* 2012;**367**:2089–2099.
253. Chapman MJ, Redfern JS, McGovern ME, Giral P. Niacin and fibrates in atherogenic dyslipidemia: pharmacotherapy to reduce cardiovascular risk. *Pharmacol Ther* 2010;**126**:314–345.
254. Lee JM, Robson MD, Yu LM, Shirodaria CC, Cunningham C, Kyntintreas I, Digby JE, Bannister T, Handa A, Wiesmann F, Durrington PN, Channon KM, Neubauer S, Choudhury RP. Effects of high-dose modified-release nicotinic acid on atherosclerosis and vascular function: a randomized, placebo-controlled, magnetic resonance imaging study. *J Am Coll Cardiol* 2009;**54**:1787–1794.
255. Boden WE, Probstfield JL, Anderson T, Chaitman BR, Desvignes-Nickens P, Koprowicz K, McBride R, Teo K, Weintraub W. Niacin in patients with low HDL cholesterol levels receiving intensive statin therapy. *N Engl J Med* 2011;**365**:2255–2267.
256. HPS2-THRIVE. www.thrivestudy.org (21 August 2013).
257. Preiss D, Tikkanen MJ, Welsh P, Ford I, Lovato LC, Elam MB, LaRosa JC, DeMicco DA, Colhoun HM, Goldenberg I, Murphy MJ, MacDonald TM, Pedersen TR, Keech AC, Ridker PM, Kjekshus J, Sattar N, McMurray JJ. Lipid-modifying therapies and risk of pancreatitis: a meta-analysis. *JAMA* 2012;**308**:804–811.
258. Fruchart JC, Sacks FM, Hermans MP, Assmann G, Brown WV, Ceska R, Chapman MJ, Dodson PM, Fioretto P, Ginsberg HN, Kadowaki T, Lablanche JM, Marx N, Plutzky J, Reiner Z, Rosenson RS, Staels B, Stock JK, Sy R, Wanner C, Zambon A, Zimmet P. The Residual Risk Reduction Initiative: a call to action to reduce residual vascular risk in dyslipidaemic patient. *Diab Vasc Dis Res* 2008;**5**:319–335.
259. Davi G, Patrono C. Platelet activation and atherothrombosis. *N Engl J Med* 2007;**357**:2482–2494.
260. Ferroni P, Basili S, Falco A, Davi G. Platelet activation in type 2 diabetes mellitus. *J Thromb Haemost* 2004;**2**:1282–1291.
261. Santilli F, Formoso G, Sbraccia P, Averna M, Miccoli R, Di Fulvio P, Ganci A, Pulizzi N, Lattanzio S, Ciattoni G, Consoli A, Lauro R, Patrono C, Davi G. Postprandial hyperglycemia is a determinant of platelet activation in early type 2 diabetes mellitus. *J Thromb Haemost* 2010;**8**:828–837.
262. Davi G, Catalano I, Averna M, Notarbartolo A, Strano A, Ciattoni G, Patrono C. Thromboxane biosynthesis and platelet function in type II diabetes mellitus. *N Engl J Med* 1990;**322**:1769–1774.
263. Patrono C, Garcia Rodriguez LA, Landolfi R, Baigent C. Low-dose aspirin for the prevention of atherothrombosis. *N Engl J Med* 2005;**353**:2373–2383.
264. Pignone M, Alberts MJ, Colwell JA, Cushman M, Inzucchi SE, Mukherjee D, Rosenson RS, Williams CD, Wilson PW, Kirkman MS. Aspirin for primary prevention of cardiovascular events in people with diabetes: a position statement of the American Diabetes Association, a scientific statement of the American Heart Association and an expert consensus document of the American College of Cardiology Foundation. *Circulation* 2010;**121**:2694–2701.
265. Pulcinelli FM, Biasucci LM, Riondino S, Giubilato S, Leo A, Di Renzo L, Trifiro E, Mattiello T, Pitocco D, Liuzzo G, Ghirlanda G, Crea F. COX-1 sensitivity and thromboxane A2 production in type 1 and type 2 diabetic patients under chronic aspirin treatment. *Eur Heart J* 2009;**30**:1279–1286.
266. DiChiara J, Bliden KP, Tantry US, Hamed MS, Antonino MJ, Suarez TA, Bailon O, Singla A, Gurbel PA. The effect of aspirin dosing on platelet function in diabetic and nondiabetic patients: an analysis from the aspirin-induced platelet effect (ASPECT) study. *Diabetes* 2007;**56**:3014–3019.
267. Evangelista V, de Berardis G, Totani L, Avanzini F, Giorda CB, Brero L, Levantesi G, Marelli G, Pupillo M, Iacuitti G, Pozzoli G, di Summa P, Nada E, de Simone G, Dell'Elba G, Amore C, Manarini S, Pecce R, Maione A, Tognoni G, Nicolucci A. Persistent platelet activation in patients with type 2 diabetes treated with low doses of aspirin. *J Thromb Haemost* 2007;**5**:2197–2203.
268. Rocca B, Santilli F, Pitocco D, Mucci L, Petrucci G, Vitacolonna E, Lattanzio S, Mattoscio D, Zaccardi F, Liani R, Vazzana N, Del Ponte A, Ferrante E, Martini F,

- Cardillo C, Morosetti R, Mirabella M, Ghirlanda G, Davi G, Patrono C. The Recovery of Platelet Cyclooxygenase Activity Explains Interindividual Variability in Responsiveness to Low-Dose Aspirin in Patients With and Without Diabetes. *J Thromb Haemost* 2012;**10**:1220–1230.
269. Dillinger JG, Drissa A, Sideris G, Bal dit Sollier C, Voicu S, Manzo Silberman S, Logeart D, Drouet L, Henry P. Biological efficacy of twice daily aspirin in type 2 diabetic patients with coronary artery disease. *Am Heart J* 2012;**164**:600–606 e1.
 270. Collaborative overview of randomised trials of antiplatelet therapy: I: Prevention of death, myocardial infarction and stroke by prolonged antiplatelet therapy in various categories of patients. Antiplatelet Trialists' Collaboration. *BMJ* 1994;**308**:81–106.
 271. Rosenzweig JL, Ferrannini E, Grundy SM, Haffner SM, Heine RJ, Horton ES, Kawamori R. Primary prevention of cardiovascular disease and type 2 diabetes in patients at metabolic risk: an endocrine society clinical practice guideline. *J Clin Endocrinol Metab* 2008;**93**:3671–3689.
 272. Belch J, MacCuish A, Campbell I, Cobbe S, Taylor R, Prescott R, Lee R, Bancroft J, MacEwan S, Shepherd J, Macfarlane P, Morris A, Jung R, Kelly C, Connacher A, Peden N, Jamieson A, Matthews D, Leese G, McKnight J, O'Brien I, Semple C, Petrie J, Gordon D, Pringle S, MacWalter R. The prevention of progression of arterial disease and diabetes (POPADAD) trial: factorial randomised placebo controlled trial of aspirin and antioxidants in patients with diabetes and asymptomatic peripheral arterial disease. *BMJ* 2008;**337**:a1840.
 273. Ogawa H, Nakayama M, Morimoto T, Uemura S, Kanauchi M, Doi N, Jinnouchi H, Sugiyama S, Saito Y. Low-dose aspirin for primary prevention of atherosclerotic events in patients with type 2 diabetes: a randomized controlled trial. *JAMA* 2008;**300**:2134–2141.
 274. Baigent C, Blackwell L, Collins R, Emberson J, Godwin J, Peto R, Buring J, Hennekens C, Kearney P, Meade T, Patrono C, Roncaglioni MC, Zanchetti A. Aspirin in the primary and secondary prevention of vascular disease: collaborative meta-analysis of individual participant data from randomised trials. *Lancet* 2009;**373**:1849–1860.
 275. Hernandez-Diaz S, Garcia Rodriguez LA. Cardioprotective aspirin users and their excess risk of upper gastrointestinal complications. *BMC Med* 2006;**4**:22.
 276. Patrono C, Andreotti F, Arnesen H, Badimon L, Baigent C, Collet JP, De Caterina R, Gulba D, Huber K, Husted S, Kristensen SD, Morais J, Neumann FJ, Rasmussen LH, Siegbahn A, Steg PG, Storey RF, Van de Werf F, Verheugt F. Antiplatelet agents for the treatment and prevention of atherothrombosis. *Eur Heart J* 2011;**32**:2922–2932.
 277. A randomised, blinded, trial of clopidogrel versus aspirin in patients at risk of ischaemic events (CAPRIE). CAPRIE Steering Committee. *Lancet* 1996;**348**:1329–1339.
 278. Dasgupta A, Steinhilb SR, Bhatt DL, Berger PB, Shao M, Mak KH, Fox KA, Montalescot G, Weber MA, Haffner SM, Dimas AP, Steg PG, Topol EJ. Clinical outcomes of patients with diabetic nephropathy randomized to clopidogrel plus aspirin versus aspirin alone (a post hoc analysis of the clopidogrel for high atherothrombotic risk and ischemic stabilization, management and avoidance [CHARISMA] trial). *Am J Cardiol* 2009;**103**:1359–1363.
 279. Wiviott SD, Braunwald E, McCabe CH, Montalescot G, Ruzyllo W, Gottlieb S, Neumann FJ, Ardissino D, De Servi S, Murphy SA, Riesmeyer J, Weerakkody G, Gibson CM, Antman EM. Prasugrel versus clopidogrel in patients with acute coronary syndromes. *N Engl J Med* 2007;**357**:2001–2015.
 280. Wiviott SD, Braunwald E, Angiolillo DJ, Meisel S, Dalby AJ, Verheugt FW, Goodman SG, Corbalan R, Purdy DA, Murphy SA, McCabe CH, Antman EM. Greater clinical benefit of more intensive oral antiplatelet therapy with prasugrel in patients with diabetes mellitus in the trial to assess improvement in therapeutic outcomes by optimizing platelet inhibition with prasugrel-Thrombolysis in Myocardial Infarction 38. *Circulation* 2008;**118**:1626–1636.
 281. Wallentin L, Becker RC, Budaj A, Cannon CP, Emanuelsson H, Held C, Horrow J, Husted S, James S, Katus H, Mahaffey KW, Scirica BM, Skene A, Steg PG, Storey RF, Harrington RA, Freij A, Thorsen M. Ticagrelor versus clopidogrel in patients with acute coronary syndromes. *N Engl J Med* 2009;**361**:1045–1057.
 282. James S, Angiolillo DJ, Cornel JH, Erlinge D, Husted S, Kontny F, Maya J, Nicolau JC, Spinar J, Storey RF, Stevens SR, Wallentin L. Ticagrelor vs. clopidogrel in patients with acute coronary syndromes and diabetes: a substudy from the PLATElet inhibition and patient Outcomes (PLATO) trial. *Eur Heart J* 2010;**31**:3006–3016.
 283. James S, Budaj A, Aylward P, Buck KK, Cannon CP, Cornel JH, Harrington RA, Horrow J, Katus H, Keltai M, Lewis BS, Parikh K, Storey RF, Szumner K, Wojdyla D, Wallentin L. Ticagrelor versus clopidogrel in acute coronary syndromes in relation to renal function: results from the Platelet Inhibition and Patient Outcomes (PLATO) trial. *Circulation* 2010;**122**:1056–1067.
 284. Yusuf S, Zhao F, Mehta SR, Chrolavicius S, Tognoni G, Fox KK. Effects of clopidogrel in addition to aspirin in patients with acute coronary syndromes without ST-segment elevation. *N Engl J Med* 2001;**345**:494–502.
 285. Bhatt DL, Marso SP, Hirsch AT, Ringleb PA, Hacke W, Topol EJ. Amplified benefit of clopidogrel versus aspirin in patients with diabetes mellitus. *Am J Cardiol* 2002;**90**:625–628.
 286. Ng AC, Delgado V, Djaberi R, Schuijff JD, Boogers MJ, Auger D, Bertini M, de Roos A, van der Meer RW, Lamb HJ, Bax JJ. Multimodality imaging in diabetic heart disease. *Curr Probl Cardiol* 2011;**36**:9–47.
 287. van Dieren S, Peelen LM, Nothlings U, van der Schouw YT, Rutten GE, Spijkerman AM, van der AD, Sluik D, Boeing H, Moons KG, Beulens JW. External validation of the UK Prospective Diabetes Study (UKPDS) risk engine in patients with type 2 diabetes. *Diabetologia* 2011;**54**:264–270.
 288. Janssen PG, Gorter KJ, Stolk RP, Rutten GE. Randomised controlled trial of intensive multifactorial treatment for cardiovascular risk in patients with screen-detected type 2 diabetes: 1-year data from the ADDITION Netherlands study. *Br J Gen Pract* 2009;**59**:43–48.
 289. Simmons RK, Sharp SJ, Sandbaek A, Borch-Johnsen K, Davies MJ, Khunti K, Lauritzen T, Rutten GE, van den Donk M, Wareham NJ, Griffin SJ. Does early intensive multifactorial treatment reduce total cardiovascular burden in individuals with screen-detected diabetes? Findings from the ADDITION-Europe cluster-randomized trial. *Diabet Med* 2012;**29**:e409–e416.
 290. Gaede P, Vedel P, Parving HH, Pedersen O. Intensified multifactorial intervention in patients with type 2 diabetes mellitus and microalbuminuria: the Steno type 2 randomised study. *Lancet* 1999;**353**:617–622.
 291. Gaede P, Vedel P, Larsen N, Jensen GV, Parving HH, Pedersen O. Multifactorial intervention and cardiovascular disease in patients with type 2 diabetes. *N Engl J Med* 2003;**348**:383–393.
 292. Gaede P, Valentine WJ, Palmer AJ, Tucker DM, Lammert M, Parving HH, Pedersen O. Cost-effectiveness of intensified versus conventional multifactorial intervention in type 2 diabetes: results and projections from the Steno-2 study. *Diabetes Care* 2008;**31**:1510–1515.
 293. Abbasi F, Chen YD, Farin HM, Lamendola C, Reaven GM. Comparison of three treatment approaches to decreasing cardiovascular disease risk in nondiabetic insulin-resistant dyslipidemic subjects. *Am J Cardiol* 2008;**102**:64–69.
 294. Norhammar A, Tenerz A, Nilsson G, Hamsten A, Efendic S, Ryden L, Malmberg K. Glucose metabolism in patients with acute myocardial infarction and no previous diagnosis of diabetes mellitus: a prospective study. *Lancet* 2002;**359**:2140–2144.
 295. Bartnik M, Ryden L, Ferrari R, Malmberg K, Pyorala K, Simoons M, Standl E, Soler-Soler J, Ohrvik J. The prevalence of abnormal glucose regulation in patients with coronary artery disease across Europe. The Euro Heart Survey on diabetes and the heart. *Eur Heart J* 2004;**25**:1880–1890.
 296. Lenzen M, Ryden L, Ohrvik J, Bartnik M, Malmberg K, Scholte Op Reimer W, Simoons ML. Diabetes known or newly detected, but not impaired glucose regulation, has a negative influence on 1-year outcome in patients with coronary artery disease: a report from the Euro Heart Survey on diabetes and the heart. *Eur Heart J* 2006;**27**:2969–2974.
 297. Bartnik M, Malmberg K, Norhammar A, Tenerz A, Ohrvik J, Ryden L. Newly detected abnormal glucose tolerance: an important predictor of long-term outcome after myocardial infarction. *Eur Heart J* 2004;**25**:1990–1997.
 298. Meisinger C, Heier M, von Scheidt W, Kirchberger I, Hormann A, Kuch B. Gender-Specific short and long-term mortality in diabetic versus nondiabetic patients with incident acute myocardial infarction in the reperfusion era (the MONICA/KORA Myocardial Infarction Registry). *Am J Cardiol* 2010;**106**:1680–1684.
 299. International Expert Committee report on the role of the A1C assay in the diagnosis of diabetes. *Diabetes Care* 2009;**32**:1327–1334.
 300. Tenerz A, Norhammar A, Silveira A, Hamsten A, Nilsson G, Ryden L, Malmberg K. Diabetes, insulin resistance and the metabolic syndrome in patients with acute myocardial infarction without previously known diabetes. *Diabetes Care* 2003;**26**:2770–2776.
 301. Opie LH. Metabolic management of acute myocardial infarction comes to the fore and extends beyond control of hyperglycemia. *Circulation* 2008;**117**:2172–2177.
 302. Franklin K, Goldberg RJ, Spencer F, Klein W, Budaj A, Brieger D, Marre M, Steg PG, Gowda N, Gore JM. Implications of diabetes in patients with acute coronary syndromes. The Global Registry of Acute Coronary Events. *Arch Intern Med* 2004;**164**:1457–1463.
 303. Norhammar A, Malmberg K, Diderholm E, Lagerqvist B, Lindahl B, Ryden L, Wallentin L. Diabetes mellitus: the major risk factor in unstable coronary artery disease even after consideration of the extent of coronary artery disease and benefits of revascularization. *J Am Coll Cardiol* 2004;**43**:585–591.
 304. Bassand JP, Hamm CW, Ardissino D, Boersma E, Budaj A, Fernandez-Aviles F, Fox KA, Hasdai D, Ohman EM, Wallentin L, Wijns W. Guidelines for the diagnosis and treatment of non-ST-segment elevation acute coronary syndromes. *Eur Heart J* 2007;**28**:1598–1660.
 305. Fox K, Garcia MA, Ardissino D, Buszman P, Camici PG, Crea F, Daly C, De Backer G, Hjelm Dahl P, Lopez-Sendon J, Marco J, Morais J, Pepper J, Sechtem U, Simoons M, Thygesen K, Priori SG, Blanc JJ, Budaj A, Camm J, Dean V, Deckers J, Dickstein K, Lekakis J, McGregor K, Metra M, Osterspey A, Tamargo J, Zamorano JL. Guidelines on the management of stable angina pectoris: executive summary: The Task Force on the Management of Stable Angina Pectoris of the European Society of Cardiology. *Eur Heart J* 2006;**27**:1341–1381.

306. Hamm CW, Bassand JP, Agewall S, Bax J, Boersma E, Bueno H, Caso P, Dudek D, Gielen S, Huber K, Ohman M, Petrie MC, Sonntag F, Uva MS, Storey RF, Wijns W, Zahger D, Bax JJ, Auricchio A, Baumgartner H, Ceconi C, Dean V, Deaton C, Fagard R, Funck-Brentano C, Hasdai D, Hoes A, Knuuti J, Kolh P, McDonagh T, Moulin C, Poldermans D, Popescu BA, Reiner Z, Sechtem U, Sirnes PA, Torbicki A, Vahanian A, Windecker S, Achenbach S, Badimov L, Bertrand M, Botker HE, Collet JP, Crea F, Danchin N, Falk E, Goudevenos J, Gulba D, Hambrecht R, Herrmann J, Kastrati A, Kjeldsen K, Kristensen SD, Lancellotti P, Mehilli J, Merkely B, Montalescot G, Neumann FJ, Neyens L, Perk J, Roffi M, Romeo F, Ruda M, Swahn E, Valgimigli M, Vrints CJ, Widimsky P. ESC Guidelines for the management of acute coronary syndromes in patients presenting without persistent ST-segment elevation: The Task Force for the management of acute coronary syndromes (ACS) in patients presenting without persistent ST-segment elevation of the European Society of Cardiology (ESC). *Eur Heart J* 2011;**32**:2999–3054.
307. Steg PG, James SK, Atar D, Badano LP, Blomstrom-Lundqvist C, Borger MA, Di Mario C, Dickstein K, Ducrocq G, Fernandez-Aviles F, Gershlick AH, Giannuzzi P, Halvorsen S, Huber K, Juni P, Kastrati A, Knuuti J, Lenzen MJ, Mahaffey KW, Valgimigli M, van 't Hof A, Widimsky P, Zahger D. ESC Guidelines for the management of acute myocardial infarction in patients presenting with ST-segment elevation. *Eur Heart J* 2012;**33**:2569–2619.
308. Wijns W, Knuuti J, Lopez-Sendon J, Marco J, Menicanti L, Ostojic M, Piepoli MF, Pirlet C, Pomar JL, Reifart N, Ribichini FL, Schalij MJ, Sergeant P, Serruys PW, Silber S, Sousa Uva M, Taggart D. The Task Force on Myocardial Revascularisation of the European Society of Cardiology (ESC) and the European Association for Cardio-Thoracic Surgery (EACTS). Guidelines on myocardial revascularization. *Eur Heart J* 2010;**31**:2501–2555.
309. Malmberg K, Herlitz J, Hjalmarsson A, Ryden L. Effects of metoprolol on mortality and late infarction in diabetics with suspected acute myocardial infarction. Retrospective data from two large studies. *Eur Heart J* 1989;**10**:423–428.
310. Kjekshus J, Gilpin E, Cali G, Blackey AR, Henning H, Ross Jr. Diabetic patients and beta-blockers after acute myocardial infarction. *Eur Heart J* 1990;**11**:43–50.
311. Fonseca VA. Effects of beta-blockers on glucose and lipid metabolism. *Curr Med Res Opin* 2010;**26**:615–629.
312. Yusuf S, Sleight P, Pogue J, Bosch J, Davies R, Dagenais G. Effects of an angiotensin-converting-enzyme inhibitor, ramipril, on cardiovascular events in high-risk patients. The Heart Outcomes Prevention Evaluation Study Investigators. *N Engl J Med* 2000;**342**:145–153.
313. Daly CA, Fox KM, Remme WJ, Bertrand ME, Ferrari R, Simoons ML. The effect of perindopril on cardiovascular morbidity and mortality in patients with diabetes in the EUROPA study: results from the PERSUADE substudy. *Eur Heart J* 2005;**26**:1369–1378.
314. Anselmino M, Ohrvik J, Ryden L. Resting heart rate in patients with stable coronary artery disease and diabetes: a report from the euro heart survey on diabetes and the heart. *Eur Heart J* 2010;**31**:3040–3045.
315. Borer JS, Tardif JC. Efficacy of ivabradine, a selective I(f) inhibitor, in patients with chronic stable angina pectoris and diabetes mellitus. *Am J Cardiol* 2010;**105**:29–35.
316. Collaborative meta-analysis of randomised trials of antiplatelet therapy for prevention of death, myocardial infarction and stroke in high risk patients. *BMJ* 2002;**324**:71–86.
317. Giugliano RP, White JA, Bode C, Armstrong PW, Montalescot G, Lewis BS, van 't Hof A, Berdan LG, Lee KL, Strony JT, Hildemann S, Veltri E, Van de Werf F, Braunwald E, Harrington RA, Califf RM, Newby LK. Early versus delayed, provisional epifibatide in acute coronary syndromes. *N Engl J Med* 2009;**360**:2176–2190.
318. Valentine N, Van de Laar FA, van Driel ML. Adenosine-diphosphate (ADP) receptor antagonists for the prevention of cardiovascular disease in type 2 diabetes mellitus. *Cochrane Database Syst Rev* 2012;**11**:CD005449.
319. Capes SE, Hunt D, Malmberg K, Gerstein HC. Stress hyperglycaemia and increased risk of death after myocardial infarction in patients with and without diabetes: a systematic overview. *Lancet* 2000;**355**:773–778.
320. Kosiborod M, Inzucchi SE, Krumholz HM, Xiao L, Jones PG, Fiske S, Masoudi FA, Marso SP, Spertus JA. Glucometrics in patients hospitalized with acute myocardial infarction: defining the optimal outcomes-based measure of risk. *Circulation* 2008;**117**:1018–1027.
321. Norhammar AM, Ryden L, Malmberg K. Admission plasma glucose. Independent risk factor for long-term prognosis after myocardial infarction even in nondiabetic patients. *Diabetes Care* 1999;**22**:1827–1831.
322. Pinto DS, Skolnick AH, Kirtane AJ, Murphy SA, Barron HV, Giugliano RP, Cannon CP, Braunwald E, Gibson CM. U-shaped relationship of blood glucose with adverse outcomes among patients with ST-segment elevation myocardial infarction. *J Am Coll Cardiol* 2005;**46**:178–180.
323. Svensson AM, McGuire DK, Abrahamson P, Dellborg M. Association between hyper- and hypoglycaemia and 2 year all-cause mortality risk in diabetic patients with acute coronary events. *Eur Heart J* 2005;**26**:1255–1261.
324. Kloner RA, Nesto RW. Glucose-insulin-potassium for acute myocardial infarction: continuing controversy over cardioprotection. *Circulation* 2008;**117**:2523–2533.
325. Selker HP, Beshansky JR, Sheehan PR, Massaro JM, Griffith JL, D'Agostino RB, Ruthazer R, Atkins JM, Sayah AJ, Levy MK, Richards ME, Aufderheide TP, Braude DA, Pirrallo RG, Doyle DD, Frascione RJ, Kosiak DJ, Leaming JM, Van Gelder CM, Walter GP, Wayne MA, Woolard RH, Opie LH, Rackley CE, Apstein CS, Udelsion JE. Out-of-hospital administration of intravenous glucose-insulin-potassium in patients with suspected acute coronary syndromes: the IMMEDIATE randomized controlled trial. *JAMA* 2012;**307**:1925–1933.
326. Malmberg K, Ryden L, Efendic S, Herlitz J, Nicol P, Waldenstrom A, Wedel H, Welin L. Randomized trial of insulin-glucose infusion followed by subcutaneous insulin treatment in diabetic patients with acute myocardial infarction (DIGAMI study): effects on mortality at 1 year. *J Am Coll Cardiol* 1995;**26**:57–65.
327. Malmberg K, Ryden L, Wedel H, Birkeland K, Bootsma A, Dickstein K, Efendic S, Fisher M, Hamsten A, Herlitz J, Hildebrandt P, MacLeod K, Laakso M, Torp-Pedersen C, Waldenstrom A. Intense metabolic control by means of insulin in patients with diabetes mellitus and acute myocardial infarction (DIGAMI 2): effects on mortality and morbidity. *Eur Heart J* 2005;**26**:650–661.
328. Cheung NW, Wong VW, McLean M. The Hyperglycemia: Intensive Insulin Infusion in Infarction (HI-5) study: a randomized controlled trial of insulin infusion therapy for myocardial infarction. *Diabetes Care* 2006;**29**:765–770.
329. Malmberg K. Prospective randomised study of intensive insulin treatment on long term survival after acute myocardial infarction in patients with diabetes mellitus. DIGAMI (Diabetes Mellitus, Insulin Glucose Infusion in Acute Myocardial Infarction) Study Group. *BMJ* 1997;**314**:1512–1515.
330. Malmberg K, Ryden L, Hamsten A, Herlitz J, Waldenstrom A, Wedel H. Mortality prediction in diabetic patients with myocardial infarction: experiences from the DIGAMI study. *Cardiovasc Res* 1997;**34**:248–253.
331. Zhao YT, Weng CL, Chen ML, Li KB, Ge YG, Lin XM, Zhao WS, Chen J, Zhang L, Yin JX, Yang XC. Comparison of glucose-insulin-potassium and insulin-glucose as adjunctive therapy in acute myocardial infarction: a contemporary meta-analysis of randomised controlled trials. *Heart* 2010;**96**:1622–1626.
332. Fisher M. Impact of hypoglycaemia on coronary artery disease and hypertension. *Diabetes Nutr Metab* 2002;**15**:456–459.
333. Heller SR. Cardiac arrhythmias in hypoglycaemia. *Diabetes Nutr Metab* 2002;**15**:461–465.
334. Kosiborod M, Inzucchi SE, Goyal A, Krumholz HM, Masoudi FA, Xiao L, Spertus JA. Relationship between spontaneous and iatrogenic hypoglycemia and mortality in patients hospitalized with acute myocardial infarction. *JAMA* 2009;**301**:1556–1564.
335. Mellbin LG, Malmberg K, Waldenstrom A, Wedel H, Ryden L. Prognostic implications of hypoglycaemic episodes during hospitalisation for myocardial infarction in patients with type 2 diabetes: a report from the DIGAMI 2 trial. *Heart* 2009;**95**:721–727.
336. Alderman EL, Kip KE, Whitlow PL, Bashore T, Fortin D, Bourassa MG, Lesperance J, Schwartz L, Stadius M. Native coronary disease progression exceeds failed revascularization as cause of angina after five years in the Bypass Angioplasty Revascularization Investigation (BARI). *J Am Coll Cardiol* 2004;**44**:766–774.
337. Hlatky MA, Boothroyd DB, Bravata DM, Boersma E, Booth J, Brooks MM, Carrie D, Clayton TC, Danchin N, Flather M, Hamm CW, Hueb WA, Kahler J, Kelsey SF, King SB, Kosinski AS, Lopes N, McDonald KM, Rodriguez A, Serruys P, Sigwart U, Stables RH, Owens DK, Pocock SJ. Coronary artery bypass surgery compared with percutaneous coronary interventions for multivessel disease: a collaborative analysis of individual patient data from ten randomised trials. *Lancet* 2009;**373**:1190–1197.
338. Rana JS, Venkatchalam L, Selzer F, Mulukutla SR, Marroquin OC, Laskey WK, Holper EM, Srinivas VS, Kip KE, Kelsey SF, Nesto RW. Evolution of percutaneous coronary intervention in patients with diabetes: a report from the National Heart, Lung and Blood Institute-sponsored PTCA (1985–1986) and Dynamic (1997–2006) Registries. *Diabetes Care* 2010;**33**:1976–1982.
339. Frye RL, August P, Brooks MM, Hardison RM, Kelsey SF, MacGregor JM, Orchard TJ, Chaitman BR, Genuth SM, Goldberg SH, Hlatky MA, Jones TL, Molitch ME, Nesto RW, Sako EY, Sobel BE. A randomized trial of therapies for type 2 diabetes and coronary artery disease. *N Engl J Med* 2009;**360**:2503–2515.
340. Lagerqvist B, Husted S, Kontny F, Stahl E, Swahn E, Wallentin L. 5-year outcomes in the FRISC-II randomised trial of an invasive versus a non-invasive strategy in non-ST-elevation acute coronary syndrome: a follow-up study. *Lancet* 2006;**368**:998–1004.
341. Damman P, Hirsch A, Windhausen F, Tijssen JG, de Winter RJ. 5-year clinical outcomes in the ICTUS (Invasive versus Conservative Treatment in Unstable coronary Syndromes) trial: a randomized comparison of an early invasive versus selective invasive management in patients with non-ST-segment elevation acute coronary syndrome. *J Am Coll Cardiol* 2010;**55**:858–864.
342. Cannon CP, Weintraub WS, Demopolous LA, Vicari R, Frey MJ, Lakkis N, Neumann FJ, Robertson DH, DeLucca PT, DiBattiste PM, Gibson CM, Braunwald E. Comparison of early invasive and conservative strategies in patients

- with unstable coronary syndromes treated with the glycoprotein IIb/IIIa inhibitor tirofiban. *N Engl J Med* 2001;**344**:1879–1887.
343. Timmer JR, Ottavanger JP, de Boer MJ, Boersma E, Grines CL, Westerhout CM, Simes RJ, Granger CB, Zijlstra F. Primary percutaneous coronary intervention compared with fibrinolysis for myocardial infarction in diabetes mellitus: results from the Primary Coronary Angioplasty vs Thrombolysis-2 trial. *Arch Intern Med* 2007;**167**:1353–1359.
 344. Hochman JS, Lamas GA, Buller CE, Dzavik V, Reynolds HR, Abramsky SJ, Forman S, Ruzyllo W, Maggioni AP, White H, Sadowski Z, Carvalho AC, Rankin JM, Renkin JP, Steg PG, Mascette AM, Sopko G, Pfisterer ME, Leor J, Fridrich V, Mark DB, Knatterud GL. Coronary intervention for persistent occlusion after myocardial infarction. *N Engl J Med* 2006;**355**:2395–2407.
 345. Kapur A, Hall RJ, Malik IS, Qureshi AC, Butts J, de Belder M, Baumbach A, Angelini G, de Belder A, Oldroyd KG, Flather M, Roughton M, Nihoyannopoulos P, Bagger JP, Morgan K, Beatt KJ. Randomized comparison of percutaneous coronary intervention with coronary artery bypass grafting in diabetic patients. 1-year results of the CARDia (Coronary Artery Revascularization in Diabetes) trial. *J Am Coll Cardiol* 2010;**55**:432–440.
 346. Serruys PW, Morice MC, Kappetein AP, Colombo A, Holmes DR, Mack MJ, Stahle E, Feldman TE, van den Brand M, Bass EJ, Van Dyck N, Leadley K, Dawkins KD, Mohr FW. Percutaneous coronary intervention versus coronary-artery bypass grafting for severe coronary artery disease. *N Engl J Med* 2009;**360**:961–972.
 347. Banning AP, Westaby S, Morice MC, Kappetein AP, Mohr FW, Berti S, Glauber M, Kellett MA, Kramer RS, Leadley K, Dawkins KD, Serruys PW. Diabetic and nondiabetic patients with left main and/or 3-vessel coronary artery disease: comparison of outcomes with cardiac surgery and paclitaxel-eluting stents. *J Am Coll Cardiol* 2010;**55**:1067–1075.
 348. Kappetein AP, Head SJ, Morice MC, Banning AP, Serruys PW, Mohr FW, Dawkins KD, Mack MJ. Treatment of complex coronary artery disease in patients with diabetes: 5-year results comparing outcomes of bypass surgery and percutaneous coronary intervention in the SYNTAX trial. *Eur J Cardiothorac Surg* 2013.
 349. Sedlis SP, Morrison DA, Lorin JD, Esposito R, Sethi G, Sacks J, Henderson W, Grover F, Ramanathan KB, Weiman D, Saucedo J, Antakli T, Paramesh V, Pett S, Vernon S, Birjiniuk V, Welt F, Krucoff M, Wolfe W, Lucke JC, Mediratta S, Booth D, Murphy E, Ward H, Miller L, Kiesz S, Barbieri C, Lewis D. Percutaneous coronary intervention versus coronary bypass graft surgery for diabetic patients with unstable angina and risk factors for adverse outcomes with bypass: outcome of diabetic patients in the AWESOME randomized trial and registry. *J Am Coll Cardiol* 2002;**40**:1555–1566.
 350. Hannan EL, Wu C, Walford G, Culliford AT, Gold JP, Smith CR, Higgins RS, Carlson RE, Jones RH. Drug-eluting stents vs. coronary-artery bypass grafting in multivessel coronary disease. *N Engl J Med* 2008;**358**:331–341.
 351. Weintraub WS, Grau-Sepulveda MV, Weiss JM, O'Brien SM, Peterson ED, Kolm P, Zhang Z, Klein LW, Shaw RE, McKay C, Ritzenthaler LL, Popma JJ, Messenger JC, Shahian DM, Grover FL, Mayer JE, Shewan CM, Garratt KN, Moussa ID, Dangas GD, Edwards FH. Comparative effectiveness of revascularization strategies. *N Engl J Med* 2012;**366**:1467–1476.
 352. Kim WJ, Park DW, Yun SC, Lee JY, Lee SW, Kim YH, Lee CW, Park SW, Park SJ. Impact of diabetes mellitus on the treatment effect of percutaneous or surgical revascularization for patients with unprotected left main coronary artery disease: a subgroup analysis of the MAIN-COMPARE study. *JACC Cardiovasc Interv* 2009;**2**:956–963.
 353. Sarno G, Lagerqvist B, Frobert O, Nilsson J, Olivecrona G, Omerovic E, Saleh N, Venetianos D, James S. Lower risk of stent thrombosis and restenosis with unrestricted use of 'new-generation' drug-eluting stents: a report from the nationwide Swedish Coronary Angiography and Angioplasty Registry (SCAAR). *Eur Heart J* 2012;**33**:606–613.
 354. Palmerini T, Biondi-Zoccai G, Della Riva D, Stettler C, Sangiorgi D, D'Ascenzo F, Kimura T, Triguori C, Sabate M, Kim HS, De Waha A, Kedhi E, Smits PC, Kaiser C, Sardella G, Marullo A, Kirtane AJ, Leon MB, Stone GW. Stent thrombosis with drug-eluting and bare-metal stents: evidence from a comprehensive network meta-analysis. *Lancet* 2012;**379**:1393–1402.
 355. Farkouh ME, Domanski M, Sleeper LA, Siami FS, Dangas G, Mack M, Yang M, Cohen DJ, Rosenberg Y, Solomon SD, Desai AS, Gersh BJ, Magnuson EA, Lansky A, Boineau R, Weinberger J, Ramanathan K, Sousa JE, Rankin J, Bhargava B, Buse J, Hueb W, Smith CR, Muratov V, Bansilal S, King S 3rd, Bertrand M, Fuster V. Strategies for multivessel revascularization in patients with diabetes. *N Engl J Med* 2012;**367**:2375–2384.
 356. Magnuson EA, Farkouh ME, Fuster V, Wang K, Vilain K, Li H, Appelwick J, Muratov V, Sleeper LA, Boineau R, Abdallah M, Cohen DJ. Cost-Effectiveness of Percutaneous Coronary Intervention with Drug Eluting Stents versus Bypass Surgery for Patients with Diabetes and Multivessel Coronary Artery Disease: Results from the FREEDOM Trial. *Circulation* 2012.
 357. Sabate M, Jimenez-Quevedo P, Angiolillo DJ, Gomez-Hospital JA, Alfonso F, Hernandez-Antolin R, Goicolea J, Banuelos C, Escaned J, Moreno R, Fernandez C, Fernandez-Aviles F, Macaya C. Randomized comparison of sirolimus-eluting stent versus standard stent for percutaneous coronary revascularization in diabetic patients: the diabetes and sirolimus-eluting stent (DIABETES) trial. *Circulation* 2005;**112**:2175–2183.
 358. Stettler C, Allemann S, Wandel S, Kastrati A, Morice MC, Schomig A, Pfisterer ME, Stone GW, Leon MB, de Lezo JS, Goy JJ, Park SJ, Sabate M, Suttorp MJ, Kelbaek H, Spaulding C, Menichelli M, Vermeersch P, Dirksen MT, Cervinka P, De Carlo M, Erglis A, Chechi T, Ortolani P, Schlij MJ, Diem P, Meier B, Windecker S, Juni P. Drug eluting and bare metal stents in people with and without diabetes: collaborative network meta-analysis. *BMJ* 2008;**337**:a1331.
 359. Mulukutla SR, Vlachos HA, Marroquin OC, Selzer F, Holper EM, Abbott JD, Laskey WK, Williams DO, Smith C, Anderson WD, Lee JS, Srinivas V, Kelsey SF, Kip KE. Impact of drug-eluting stents among insulin-treated diabetic patients: a report from the National Heart, Lung and Blood Institute Dynamic Registry. *JACC Cardiovasc Interv* 2008;**1**:139–147.
 360. Kereiakes DJ, Cutlip DE, Applegate RJ, Wang J, Yaqub M, Sood P, Su X, Su G, Farhat N, Rizvi A, Simonton CA, Sudhif A, Kelbaek H, Abildgaard U, Villadsen A, Aaroe J, Thayssen P, Krusell LR, Christiansen EH, Botker HE, Kristensen SD, Ravkilde J, Madsen M, Sorensen HT, Rasmussen K, Thuesen L, Lassen JF. Outcome of sirolimus-eluting versus zotarolimus-eluting coronary stent implantation in patients with and without diabetes mellitus (a SORT OUT III Substudy). *Am J Cardiol* 2011;**108**:1232–1237.
 362. Primary versus tenecteplase-facilitated percutaneous coronary intervention in patients with ST-segment elevation acute myocardial infarction (ASSENT-4 PCI): randomised trial. *Lancet* 2006;**367**:569–578.
 363. Ellis SG, Tendera M, de Belder MA, van Boven AJ, Widimsky P, Janssens L, Andersen HR, Betriu A, Savonitto S, Adamus J, Peruga JZ, Kosmider M, Katz O, Neunteufl T, Jorgova J, Dorobantu M, Grinfeld L, Armstrong P, Brodie BR, Herrmann HC, Montalescot G, Neumann FJ, Effron MB, Barnathan ES, Topol EJ. Facilitated PCI in patients with ST-elevation myocardial infarction. *N Engl J Med* 2008;**358**:2205–2217.
 364. Kastrati A, Mehilli J, Neumann FJ, Dotzer F, ten Berg J, Bollwein H, Graf I, Ibrahim M, Pache J, Seyfarth M, Schuhlen H, Dirschinger J, Berger PB, Schomig A. Abciximab in patients with acute coronary syndromes undergoing percutaneous coronary intervention after clopidogrel pretreatment: the ISAR-REACT 2 randomized trial. *JAMA* 2006;**295**:1531–1538.
 365. Puskas JD, Sadiq A, Vassiliades TA, Kilgo PD, Lattouf OM. Bilateral internal thoracic artery grafting is associated with significantly improved long-term survival, even among diabetic patients. *Ann Thorac Surg* 2012;**94**:710–715.
 366. Deo SV, Shah IK, Dunlay SM, Erwin PJ, Locker C, Altarabsheh SE, Boilson BA, Park SJ, Joyce LD. Bilateral internal thoracic artery harvest and deep sternal wound infection in diabetic patients. *Ann Thorac Surg* 2013;**95**:862–869.
 367. Locker C, Mohr R, Lev-Ran O, Uretzky G, Frimerman A, Shaham Y, Shapira I. Comparison of bilateral thoracic artery grafting with percutaneous coronary interventions in diabetic patients. *Ann Thorac Surg* 2004;**78**:471–475.
 368. Ascione R, Rogers CA, Rajakaruna C, Angelini GD. Inadequate blood glucose control is associated with in-hospital mortality and morbidity in diabetic and non-diabetic patients undergoing cardiac surgery. *Circulation* 2008;**118**:113–123.
 369. Mellbin LG, Malmberg K, Norhammar A, Wedel H, Ryden L. The impact of glucose lowering treatment on long-term prognosis in patients with type 2 diabetes and myocardial infarction: a report from the DIGAMI 2 trial. *Eur Heart J* 2008;**29**:166–176.
 370. Zeller M, Danchin N, Simon D, Vahanian A, Lorgis L, Cottin Y, Berland J, Guert P, Wyart P, Deturck R, Tabone X, Machecourt J, Leclercq F, Drouet E, Mulak G, Bataille V, Cambou JP, Ferrieres J, Simon T. Impact of type of preadmission sulfonylureas on mortality and cardiovascular outcomes in diabetic patients with acute myocardial infarction. *J Clin Endocrinol Metab* 2010;**95**:4993–5002.
 371. Takagi T, Okura H, Kobayashi Y, Kataoka T, Taguchi H, Toda I, Tamita K, Yamamuro A, Sakanoue Y, Ito A, Yanagi S, Shimeno K, Waseda K, Yamasaki M, Fitzgerald PJ, Ikeno F, Honda Y, Yoshiyama M, Yoshikawa J. A prospective, multicenter, randomized trial to assess efficacy of pioglitazone on in-stent neointimal suppression in type 2 diabetes: POPPS (Prevention of In-Stent Neointimal Proliferation by Pioglitazone Study). *JACC Cardiovasc Interv* 2009;**2**:524–531.
 372. Bhamidipati CM, LaPar DJ, Stukenborg GJ, Morrison CC, Kern JA, Kron IL, Allawadi G. Superiority of moderate control of hyperglycemia to tight control in patients undergoing coronary artery bypass grafting. *J Thorac Cardiovasc Surg* 2011;**141**:543–551.
 373. Chaitman BR, Hardison RM, Adler D, Gebhart S, Grogan M, Ocampo S, Sopko G, Ramirez JA, Schneider D, Frye RL. The Bypass Angioplasty Revascularization

- Investigation 2 Diabetes randomized trial of different treatment strategies in type 2 diabetes mellitus with stable ischemic heart disease: impact of treatment strategy on cardiac mortality and myocardial infarction. *Circulation* 2009;**120**:2529–2540.
374. Mack MJ, Banning AP, Serruys PW, Morice MC, Taeymans Y, Van Nooten G, Possati G, Crea F, Hood KL, Leadley K, Dawkins KD, Kappetein AP. Bypass versus drug-eluting stents at three years in SYNTAX patients with diabetes mellitus or metabolic syndrome. *Ann Thorac Surg* 2011;**92**:2140–2146.
 375. Aguilar D, Deswal A, Ramasubbu K, Mann DL, Bozkurt B. Comparison of patients with heart failure and preserved left ventricular ejection fraction among those with versus without diabetes mellitus. *Am J Cardiol* 2010;**105**:373–377.
 376. Seferovic Mitrovic JP, Seferovic PM, Vujisic Tesic B, Petrovic M, Ristic AD, Lalic K, Jotic A, Tesic M, Giga V, Milic N, Singh S, Lalic NM. Predictors of diabetic cardiomyopathy in asymptomatic patients with type 2 diabetes. *Int J Cardiol* 2012;**156**:219–221.
 377. Thrainsdottir IS, Aspelund T, Thorgeirsson G, Gudnason V, Hardarson T, Malmberg K, Sigurdsson G, Ryden L. The association between glucose abnormalities and heart failure in the population-based Reykjavik study. *Diabetes Care* 2005;**28**:612–616.
 378. Bertoni AG, Hundley WG, Massing MW, Bonds DE, Burke GL, Goff DC Jr. Heart failure prevalence, incidence and mortality in the elderly with diabetes. *Diabetes Care* 2004;**27**:699–703.
 379. Kengne AP, Turnbull F, MacMahon S. The Framingham Study, diabetes mellitus and cardiovascular disease: turning back the clock. *Prog Cardiovasc Dis* 2010;**53**:45–51.
 380. He J, Ogden LG, Bazzano LA, Vupputuri S, Loria C, Whelton PK. Risk factors for congestive heart failure in US men and women: NHANES I epidemiologic follow-up study. *Arch Intern Med* 2001;**161**:996–1002.
 381. Boonman-de Winter LJ, Rutten FH, Cramer MJ, Landman MJ, Liem AH, Rutten GE, Hoes AW. High prevalence of previously unknown heart failure and left ventricular dysfunction in patients with type 2 diabetes. *Diabetologia* 2012;**55**:2154–2162.
 382. Vaur L, Gueret P, Lievre M, Chabaud S, Passa P. Development of congestive heart failure in type 2 diabetic patients with microalbuminuria or proteinuria: observations from the DIABHYCAR (type 2 DIABetes, Hypertension, Cardiovascular Events and Ramipril) study. *Diabetes Care* 2003;**26**:855–860.
 383. MacDonald MR, Petrie MC, Hawkins NM, Petrie JR, Fisher M, McKelvie R, Aguilar D, Krum H, McMurray JJ. Diabetes, left ventricular systolic dysfunction and chronic heart failure. *Eur Heart J* 2008;**29**:1224–1240.
 384. Amato L, Paolisso G, Cacciatore F, Ferrara N, Ferrara P, Canonico S, Varricchio M, Rengo F. Congestive heart failure predicts the development of non-insulin-dependent diabetes mellitus in the elderly. The Osservatorio Geriatrico Regione Campania Group. *Diabetes Metab* 1997;**23**:213–218.
 385. Thrainsdottir IS, Aspelund T, Gudnason V, Malmberg K, Sigurdsson G, Thorgeirsson G, Hardarson T, Ryden L. Increasing glucose levels and BMI predict future heart failure experience from the Reykjavik Study. *European journal of heart failure* 2007;**9**(10):1051–7.
 386. Jarnert C, Melcher A, Caidahl K, Persson H, Ryden L, Eriksson MJ. Left atrial velocity vector imaging for the detection and quantification of left ventricular diastolic function in type 2 diabetes. *Eur J Heart Fail* 2008;**10**:1080–1087.
 387. Liu JE, Palmieri V, Roman MJ, Bella JN, Fabsitz R, Howard BV, Welty TK, Lee ET, Devereux RB. The impact of diabetes on left ventricular filling pattern in normotensive and hypertensive adults: the Strong Heart Study. *J Am Coll Cardiol* 2001;**37**:1943–1949.
 388. Nagueh SF, Appleton CP, Gillebert TC, Marino PN, Oh JK, Smiseth OA, Waggoner AD, Flachskampf FA, Pellikka PA, Evangelisa A. Recommendations for the evaluation of left ventricular diastolic function by echocardiography. *Eur J Echocardiogr* 2009;**10**:165–193.
 389. McMurray JJ, Adamopoulos S, Anker SD, Auricchio A, Bohm M, Dickstein K, Falk V, Filippatos G, Fonseca C, Gomez-Sanchez MA, Jaarsma T, Kober L, Lip GY, Maggioni AP, Parkhomenko A, Pieske BM, Popescu BA, Ronnevik PK, Rutten FH, Schwitzer J, Seferovic P, Stepinska J, Trindade PT, Voors AA, Zannad F, Zeiher A. ESC Guidelines for the diagnosis and treatment of acute and chronic heart failure 2012: The Task Force for the Diagnosis and Treatment of Acute and Chronic Heart Failure 2012 of the European Society of Cardiology. Developed in collaboration with the Heart Failure Association (HFA) of the ESC. *Eur Heart J* 2012;**33**:1787–1847.
 390. Domanski M, Krause-Steinrauf H, Deedwania P, Follmann D, Ghali JK, Gilbert E, Haffner S, Katz R, Lindenfeld J, Lowes BD, Martin WV, McGrew F, Bristow MR. The effect of diabetes on outcomes of patients with advanced heart failure in the BEST trial. *J Am Coll Cardiol* 2003;**42**:914–922.
 391. Deedwania PC, Giles TD, Klibaner M, Ghali JK, Herlitz J, Hildebrandt P, Kjekshus J, Spinar J, Vitovec J, Stanbrook H, Wikstrand J. Efficacy, safety and tolerability of metoprolol CR/XL in patients with diabetes and chronic heart failure: experiences from MERIT-HF. *Am Heart J* 2005;**149**:159–167.
 392. Vermes E, Ducharme A, Bourassa MG, Lessard M, White M, Tardif JC. Enalapril reduces the incidence of diabetes in patients with chronic heart failure: insight from the Studies Of Left Ventricular Dysfunction (SOLVD). *Circulation* 2003;**107**:1291–1296.
 393. Gustafsson I, Brendorp B, Seibaek M, Burchardt H, Hildebrandt P, Kober L, Torp-Pedersen C. Influence of diabetes and diabetes-gender interaction on the risk of death in patients hospitalized with congestive heart failure. *J Am Coll Cardiol* 2004;**43**:771–777.
 394. Young JB, Dunlap ME, Pfeffer MA, Probstfield JL, Cohen-Solal A, Dietz R, Granger CB, Hradec J, Kuch J, McKelvie RS, McMurray JJ, Michelson EL, Olofsson B, Ostergren J, Held P, Solomon SD, Yusuf S, Swedberg K. Mortality and morbidity reduction with Candesartan in patients with chronic heart failure and left ventricular systolic dysfunction: results of the CHARM low-left ventricular ejection fraction trials. *Circulation* 2004;**110**:2618–2626.
 395. Ryden L, Armstrong PW, Cleland JG, Horowitz JD, Massie BM, Packer M, Poole-Wilson PA. Efficacy and safety of high-dose lisinopril in chronic heart failure patients at high cardiovascular risk, including those with diabetes mellitus. Results from the ATLAS trial. *Eur Heart J* 2000;**21**:1967–1978.
 396. Shekelle PG, Rich MW, Morton SC, Atkinson CS, Tu W, Maglione M, Rhodes S, Barrett M, Fonarow GC, Greenberg B, Heidenreich PA, Knabel T, Konstam MA, Steimle A, Warner Stevenson L. Efficacy of angiotensin-converting enzyme inhibitors and beta-blockers in the management of left ventricular systolic dysfunction according to race, gender and diabetic status: a meta-analysis of major clinical trials. *J Am Coll Cardiol* 2003;**41**:1529–1538.
 397. Dickstein K, Kjekshus J. Effects of losartan and captopril on mortality and morbidity in high-risk patients after acute myocardial infarction: the OPTIMAAL randomised trial. Optimal Trial in Myocardial Infarction with Angiotensin II Antagonist Losartan. *Lancet* 2002;**360**:752–760.
 398. Pfeffer MA, McMurray JJ, Velazquez EJ, Rouleau JL, Kober L, Maggioni AP, Solomon SD, Swedberg K, Van de Werf F, White H, Leimberger JD, Henis M, Edwards S, Zelenkofske S, Sellers MA, Califf RM. Valsartan, captopril, or both in myocardial infarction complicated by heart failure, left ventricular dysfunction, or both. *N Engl J Med* 2003;**349**:1893–1906.
 399. Granger CB, McMurray JJ, Yusuf S, Held P, Michelson EL, Olofsson B, Ostergren J, Pfeffer MA, Swedberg K. Effects of candesartan in patients with chronic heart failure and reduced left-ventricular systolic function intolerant to angiotensin-converting-enzyme inhibitors: the CHARM-Alternative trial. *Lancet* 2003;**362**:772–776.
 400. McMurray JJ, Holman RR, Haffner SM, Bethel MA, Holzhauser B, Hua TA, Belenkov Y, Boolell M, Buse JB, Buckley BM, Chacra AR, Chiang FT, Charbonnel B, Chow CC, Davies MJ, Deedwania P, Diem P, Einhorn D, Fonseca V, Fulcher GR, Gaciong Z, Gaztambide S, Giles T, Horton E, Ilkova H, Jennesen T, Kahn SE, Krum H, Laakso M, Leiter LA, Levitt NS, Mareev V, Martinez F, Masson C, Mazzone T, Meaney E, Nesto R, Pan C, Prager R, Raptis SA, Rutten GE, Sandstroem H, Schaper F, Scheen A, Schmitz O, Sinay I, Soska V, Stender S, Tamas G, Tognoni G, Tuomilehto J, Villamil AS, Vozar J, Califf RM. Effect of valsartan on the incidence of diabetes and cardiovascular events. *N Engl J Med* 2010;**362**:1477–1490.
 401. Haas SJ, Vos T, Gilbert RE, Krum H. Are beta-blockers as efficacious in patients with diabetes mellitus as in patients without diabetes mellitus who have chronic heart failure? A meta-analysis of large-scale clinical trials. *Am Heart J* 2003;**146**:848–853.
 402. The Cardiac Insufficiency Bisoprolol Study II (CIBIS-II): a randomised trial. *Lancet* 1999;**353**:9–13.
 403. Packer M, Coats AJ, Fowler MB, Katus HA, Krum H, Mohacs P, Rouleau JL, Tendera M, Castaigne A, Roecker EB, Schultz MK, DeMets DL. Effect of carvedilol on survival in severe chronic heart failure. *N Engl J Med* 2001;**344**:1651–1658.
 404. Wlodarczyk JH, Keogh A, Smith K, McCosker C. CHART: congestive cardiac failure in hospitals, an Australian review of treatment. *Heart Lung Circ* 2003;**12**:94–102.
 405. Hjalmarson A, Goldstein S, Fagerberg B, Wedel H, Waagstein F, Kjekshus J, Wikstrand J, El Allaf D, Vitovec J, Aldershvile J, Halinen M, Dietz R, Neuhaus KL, Janosi A, Thorgeirsson G, Dunselman PH, Gullestad L, Kuch J, Herlitz J, Rickenbacher P, Ball S, Gottlieb S, Deedwania P. Effects of controlled-release metoprolol on total mortality, hospitalizations and well-being in patients with heart failure: the Metoprolol CR/XL Randomized Intervention Trial in congestive heart failure (MERIT-HF). MERIT-HF Study Group. *JAMA* 2000;**283**:1295–1302.
 406. Poole-Wilson PA, Swedberg K, Cleland JG, Di Lenarda A, Hanrath P, Komajda M, Lubsen J, Lutiger B, Metra M, Remme WJ, Torp-Pedersen C, Scherhag A, Skene A. Comparison of carvedilol and metoprolol on clinical outcomes in patients with chronic heart failure in the Carvedilol Or Metoprolol European Trial (COMET): randomised controlled trial. *Lancet* 2003;**362**:7–13.
 407. MacDonald MR, Petrie MC, Fisher M, McMurray JJ. Pharmacologic management of patients with both heart failure and diabetes. *Curr Heart Fail Rep* 2009;**6**:126–132.
 408. Giugliano D, Acampora R, Marfella R, De Rosa N, Ziccardi P, Ragone R, De Angelis L, D'Onofrio F. Metabolic and cardiovascular effects of carvedilol and atenolol in non-insulin-dependent diabetes mellitus and hypertension. A randomized, controlled trial. *Ann Intern Med* 1997;**126**:955–959.

409. Shorr RI, Ray WA, Daugherty JR, Griffin MR. Antihypertensives and the risk of serious hypoglycemia in older persons using insulin or sulfonylureas. *JAMA* 1997; **278**:40–43.
410. Kostis JB, Sanders M. The association of heart failure with insulin resistance and the development of type 2 diabetes. *Am J Hypertens* 2005; **18**:731–737.
411. Pitt B, Zannad F, Remme WJ, Cody R, Castaigne A, Perez A, Palensky J, Wittes J. The effect of spironolactone on morbidity and mortality in patients with severe heart failure. Randomized Aldactone Evaluation Study Investigators. *N Engl J Med* 1999; **341**:709–717.
412. Fernandez HM, Leipzig RM. Spironolactone in patients with heart failure. *N Engl J Med* 2000; **342**:132.
413. Zannad F, McMurray JJ, Krum H, van Veldhuisen DJ, Swedberg K, Shi H, Vincent J, Pocock SJ, Pitt B. Eplerenone in patients with systolic heart failure and mild symptoms. *N Engl J Med* 2011; **364**:11–21.
414. Swedberg K, Komajda M, Bohm M, Borer JS, Ford I, Dubost-Brama A, Lerebours G, Tavazzi L. Ivabradine and outcomes in chronic heart failure (SHIFT): a randomised placebo-controlled study. *Lancet* 2010; **376**:875–885.
415. Dickstein K, Vardas PE, Auricchio A, Daubert JC, Linde C, McMurray J, Ponikowski P, Priori SG, Sutton R, van Veldhuisen DJ. 2010 focused update of ESC Guidelines on device therapy in heart failure: an update of the 2008 ESC Guidelines for the diagnosis and treatment of acute and chronic heart failure and the 2007 ESC Guidelines for cardiac and resynchronization therapy. Developed with the special contribution of the Heart Failure Association and the European Heart Rhythm Association. *Eur J Heart Fail* 2010; **12**:1143–1153.
416. Bardy GH, Lee KL, Mark DB, Poole JE, Packer DL, Boineau R, Domanski M, Troutman C, Anderson J, Johnson G, McNulty SE, Clapp-Channing N, Davidson-Ray LD, Fraulo ES, Fishbein DP, Luceri RM, Ip JH. Amiodarone or an implantable cardioverter-defibrillator for congestive heart failure. *N Engl J Med* 2005; **352**:225–237.
417. Mehra MR, Kobashigawa J, Starling R, Russell S, Uber PA, Parameshwar J, Mohacs P, Augustine S, Aaronson K, Barr M. Listing criteria for heart transplantation: International Society for Heart and Lung Transplantation guidelines for the care of cardiac transplant candidates: 2006. *J Heart Lung Transplant* 2006; **25**:1024–1042.
418. Kilic A, Weiss ES, George TJ, Arnaoutakis GJ, Yuh DD, Shah AS, Conte JV. What predicts long-term survival after heart transplantation? An analysis of 9,400 ten-year survivors. *Ann Thor Surg* 2012; **93**:699–704.
419. Gitt AK, Halle M, Hanefeld M, Kellner M, Marx N, Meier JJ, Schumm-Draeger PM, Bramlage P, Tschope D. Should antidiabetic treatment of type 2 diabetes in patients with heart failure differ from that in patients without? *Eur J Heart Fail* 2012; **14**:1389–1400.
420. Eurich DT, McAlister FA, Blackburn DF, Majumdar SR, Tsuyuki RT, Varney J, Johnson JA. Benefits and harms of antidiabetic agents in patients with diabetes and heart failure: systematic review. *BMJ* 2007; **335**:497.
421. Aguilar D, Chan W, Bozkurt B, Ramasubbu K, Deswal A. Metformin use and mortality in ambulatory patients with diabetes and heart failure. *Circulation*. Heart failure 2011; **4**:53–58.
422. Masoudi FA, Inzucchi SE, Wang Y, Havranek EP, Foody JM, Krumholz HM. Thiazolidinediones, metformin and outcomes in older patients with diabetes and heart failure: an observational study. *Circulation* 2005; **111**:583–590.
423. MacDonald MR, Eurich DT, Majumdar SR, Lewsey JD, Bhagra S, Jhund PS, Petrie MC, McMurray JJ, Petrie JR, McAlister FA. Treatment of type 2 diabetes and outcomes in patients with heart failure: a nested case-control study from the U.K. General Practice Research Database. *Diabetes Care* 2010; **33**:1213–1218.
424. Eurich DT, Majumdar SR, McAlister FA, Tsuyuki RT, Johnson JA. Improved clinical outcomes associated with metformin in patients with diabetes and heart failure. *Diabetes Care* 2005; **28**:2345–2351.
425. Gerstein HC, Yusuf S, Bosch J, Pogue J, Sheridan P, Dinccag N, Hanefeld M, Hoogwerf B, Laakso M, Mohan V, Shaw J, Zinman B, Holman RR. Effect of rosiglitazone on the frequency of diabetes in patients with impaired glucose tolerance or impaired fasting glucose: a randomised controlled trial. *Lancet* 2006; **368**:1096–1105.
426. Home PD, Pocock SJ, Beck-Nielsen H, Gomis R, Hanefeld M, Jones NP, Komajda M, McMurray JJ. Rosiglitazone evaluated for cardiovascular outcomes: an interim analysis. *N Engl J Med* 2007; **357**:28–38.
427. Sokos GG, Nikolaidis LA, Mankad S, Elahi D, Shannon RP. Glucagon-like peptide-1 infusion improves left ventricular ejection fraction and functional status in patients with chronic heart failure. *J Card Fail* 2006; **12**:694–699.
428. Swedberg K, Komajda M, Böhm M, Borer J, Robertson M, Tavazzi L, Ford I. Effects on Outcomes of Heart Rate Reduction by Ivabradine in Patients With Congestive Heart Failure: Is There an Influence of Beta-Blocker Dose? Findings From the SHIFT (Systolic Heart failure treatment with the I(f) inhibitor ivabradine Trial) Study. 2012. *J Am Coll Cardiol*. 2012; **59**:1938–1945
429. Go AS, Hylek EM, Phillips KA, Chang Y, Henault LE, Selby JV, Singer DE. Prevalence of diagnosed atrial fibrillation in adults: national implications for rhythm management and stroke prevention: the AnTicoagulation and Risk Factors in Atrial Fibrillation (ATRIA) Study. *JAMA* 2001; **285**:2370–2375.
430. Psaty BM, Manolio TA, Kuller LH, Kronmal RA, Cushman M, Fried LP, White R, Furberg CD, Rautaharju PM. Incidence of and risk factors for atrial fibrillation in older adults. *Circulation* 1997; **96**:2455–2461.
431. Levy S, Maarek M, Coumel P, Guize L, Lekieffre J, Medvedowsky JL, Sebaoun A. Characterization of different subsets of atrial fibrillation in general practice in France: the ALFA study. The College of French Cardiologists. *Circulation* 1999; **99**:3028–3035.
432. Krahn AD, Manfreda J, Tate RB, Mathewson FA, Cuddy TE. The natural history of atrial fibrillation: incidence, risk factors and prognosis in the Manitoba Follow-Up Study. *Am J Med* 1995; **98**:476–484.
433. Benjamin EJ, Levy D, Vaziri SM, D'Agostino RB, Belanger AJ, Wolf PA. Independent risk factors for atrial fibrillation in a population-based cohort. The Framingham Heart Study. *JAMA* 1994; **271**:840–844.
434. Schnabel RB, Sullivan LM, Levy D, Pencina MJ, Massaro JM, D'Agostino RB Sr., Newton-Cheh C, Yamamoto JF, Magnani JW, Tadros TM, Kannel WB, Wang TJ, Ellinor PT, Wolf PA, Vasan RS, Benjamin EJ. Development of a risk score for atrial fibrillation (Framingham Heart Study): a community-based cohort study. *Lancet* 2009; **373**:739–745.
435. Nichols GA, Reinier K, Chugh SS. Independent contribution of diabetes to increased prevalence and incidence of atrial fibrillation. *Diabetes Care* 2009; **32**:1851–1856.
436. Du X, Ninomiya T, de Galan B, Abadir E, Chalmers J, Pillai A, Woodward M, Cooper M, Harrap S, Hamet P, Poulter N, Lip GY, Patel A. Risks of cardiovascular events and effects of routine blood pressure lowering among patients with type 2 diabetes and atrial fibrillation: results of the ADVANCE study. *Eur Heart J* 2009; **30**:1128–1135.
437. Hughes M, Lip GY. Stroke and thromboembolism in atrial fibrillation: a systematic review of stroke risk factors, risk stratification schema and cost effectiveness data. *Thromb Haemost* 2008; **99**:295–304.
438. Independent predictors of stroke in patients with atrial fibrillation: a systematic review. *Neurology* 2007; **69**:546–554.
439. Camm AJ, Kirchhof P, Lip GY, Schotten U, Savelieva I, Ernst S, Van Gelder IC, Al-Attar N, Hindricks G, Prendergast B, Heidbuchel H, Alfieri O, Angelini A, Atar D, Colonna P, De Caterina R, De Sutter J, Goette A, Gorennek B, Haldal M, Hohloser SH, Kolh P, Le Heuzey JY, Ponikowski P, Rutten FH. Guidelines for the management of atrial fibrillation: the Task Force for the Management of Atrial Fibrillation of the European Society of Cardiology (ESC). *Eur Heart J* 2010; **31**:2369–2429.
440. Camm AJ, Lip GY, De Caterina R, Savelieva I, Atar D, Hohnloser SH, Hindricks G, Kirchhof P. 2012 focused update of the ESC Guidelines for the management of atrial fibrillation: an update of the 2010 ESC Guidelines for the management of atrial fibrillation: developed with the special contribution of the European Heart Rhythm Association. *Europace* 2012; **14**:1385–1413.
441. Hart RG, Benavente O, McBride R, Pearce LA. Antithrombotic therapy to prevent stroke in patients with atrial fibrillation: a meta-analysis. *Ann Intern Med* 1999; **131**:492–501.
442. Connolly S, Pogue J, Hart R, Pfeffer M, Hohnloser S, Chrolavicius S, Yusuf S. Clopidogrel plus aspirin versus oral anticoagulation for atrial fibrillation in the Atrial Fibrillation Clopidogrel Trial with Irbesartan for prevention of Vascular Events (ACTIVE W): a randomised controlled trial. *Lancet* 2006; **367**:1903–1912.
443. Connolly SJ, Pogue J, Hart RG, Hohnloser SH, Pfeffer M, Chrolavicius S, Yusuf S. Effect of clopidogrel added to aspirin in patients with atrial fibrillation. *N Engl J Med* 2009; **360**(20):2066–78.
444. Connolly SJ, Ezekowitz MD, Yusuf S, Eikelboom J, Oldgren J, Parekh A, Pogue J, Reilly PA, Themeles E, Varrone J, Wang S, Alings M, Xavier D, Zhu J, Diaz R, Lewis BS, Darius H, Diener HC, Joyner CD, Wallentin L. Dabigatran versus warfarin in patients with atrial fibrillation. *N Engl J Med* 2009; **361**:1139–1151.
445. Connolly SJ, Eikelboom J, Joyner C, Diener HC, Hart R, Golitsyn S, Flaker G, Avezum A, Hohnloser SH, Diaz R, Talajic M, Zhu J, Pais P, Budaj A, Parkhomenko A, Jansky P, Commerford P, Tan RS, Sim KH, Lewis BS, Van Mieghem W, Lip GY, Kim JH, Lanas-Zanetti F, Gonzalez-Hermosillo A, Dans AL, Munawar M, O'Donnell M, Lawrence J, Lewis G, Afzal R, Yusuf S. Apixaban in patients with atrial fibrillation. *N Engl J Med* 2011; **364**:806–817.
446. Granger CB, Alexander JH, McMurray JJ, Lopes RD, Hylek EM, Hanna M, Al-Khalidi HR, Ansell J, Atar D, Avezum A, Bahit MC, Diaz R, Easton JD, Ezekowitz JA, Flaker G, Garcia D, Gerdal M, Gersh BJ, Golitsyn S, Goto S, Hermosillo AG, Hohnloser SH, Horowitz J, Mohan P, Jansky P, Lewis BS, Lopez-Sendon JL, Pais P, Parkhomenko A, Verheugt FW, Zhu J, Wallentin L. Apixaban versus warfarin in patients with atrial fibrillation. *N Engl J Med* 2011; **365**:981–992.
447. Patel MR, Mahaffey KW, Garg J, Pan G, Singer DE, Hacke W, Breithardt G, Halperin JL, Hankey GJ, Piccini JP, Becker RC, Nessel CC, Paolini JF,

- Berkowitz SD, Fox KA, Califf RM. Rivaroxaban versus warfarin in nonvalvular atrial fibrillation. *N Engl J Med* 2011;**365**:883–891.
448. Pisters R, Lane DA, Nieuwlaar R, de Vos CB, Crijns HJ, Lip GY. A novel user-friendly score (HAS-BLED) to assess 1-year risk of major bleeding in patients with atrial fibrillation: the Euro Heart Survey. *Chest* 2010;**138**:1093–1100.
 449. Huikuri HV, Castellanos A, Myerburg RJ. Sudden death due to cardiac arrhythmias. *N Engl J Med* 2001;**345**:1473–1482.
 450. Priori SG, Aliot E, Blomstrom-Lundqvist C, Bossaert L, Breithardt G, Brugada P, Camm AJ, Cappato R, Cobbe SM, Di Mario C, Maron BJ, McKenna WJ, Pedersen AK, Ravens U, Schwartz PJ, Trusz-Gluzza M, Vardas P, Wellens HJ, Zipes DP. Task Force on Sudden Cardiac Death of the European Society of Cardiology. *Eur Heart J* 2001;**22**:1374–1450.
 451. Kannel WB, Wilson PW, D'Agostino RB, Cobb J. Sudden coronary death in women. *Am Heart J* 1998;**136**:205–212.
 452. Albert CM, Chae CU, Grodstein F, Rose LM, Rexrode KM, Ruskin JN, Stampfer MJ, Manson JE. Prospective study of sudden cardiac death among women in the United States. *Circulation* 2003;**107**:2096–2101.
 453. Balkau B, Jouven X, Ducimetiere P, Eschwege E. Diabetes as a risk factor for sudden death. *Lancet* 1999;**354**:1968–1969.
 454. Curb JD, Rodriguez BL, Burchfiel CM, Abbott RD, Chiu D, Yano K. Sudden death, impaired glucose tolerance and diabetes in Japanese American men. *Circulation* 1995;**91**:2591–2595.
 455. Jouven X, Lemaître RN, Rea TD, Sotoodehnia N, Empana JP, Siscovick DS. Diabetes, glucose level and risk of sudden cardiac death. *Eur Heart J* 2005;**26**:2142–2147.
 456. Kucharska-Newton AM, Couper DJ, Pankow JS, Prineas RJ, Rea TD, Sotoodehnia N, Chakravarti A, Folsom AR, Siscovick DS, Rosamond WD. Diabetes and the risk of sudden cardiac death, the Atherosclerosis Risk in Communities study. *Acta Diabetol* 2010;**47**(Suppl 1):161–168.
 457. MacDonald MR, Petrie MC, Varyani F, Ostergren J, Michelson EL, Young JB, Solomon SD, Granger CB, Swedberg K, Yusuf S, Pfeffer MA, McMurray JJ. Impact of diabetes on outcomes in patients with low and preserved ejection fraction heart failure: an analysis of the Candesartan in Heart failure: Assessment of Reduction in Mortality and morbidity (CHARM) programme. *Eur Heart J* 2008;**29**:1377–1385.
 458. Junttila MJ, Barthel P, Myerburg RJ, Makikallio TH, Bauer A, Ulm K, Kiviniemi A, Tulppo M, Perkiomaki JS, Schmidt G, Huikuri HV. Sudden cardiac death after myocardial infarction in patients with type 2 diabetes. *Heart Rhythm* 2010;**7**:1396–1403.
 459. Zipes DP, Camm AJ, Borggrefe M, Buxton AE, Chaitman B, Fromer M, Gregoratos G, Klein G, Moss AJ, Myerburg RJ, Priori SG, Quinones MA, Roden DM, Silka MJ, Tracy C, Smith SC Jr., Jacobs AK, Adams CD, Antman EM, Anderson JL, Hunt SA, Halperin JL, Nishimura R, Ornato JP, Page RL, Riegel B, Blanc JJ, Budaj A, Dean V, Deckers JW, Despres C, Dickstein K, Lekakis J, McGregor K, Metra M, Morais J, Osterspey A, Tamargo JL, Zamorano JL. ACC/AHA/ESC 2006 Guidelines for Management of Patients With Ventricular Arrhythmias and the Prevention of Sudden Cardiac Death: a report of the American College of Cardiology/American Heart Association Task Force and the European Society of Cardiology Committee for Practice Guidelines (writing committee to develop Guidelines for Management of Patients With Ventricular Arrhythmias and the Prevention of Sudden Cardiac Death): developed in collaboration with the European Heart Rhythm Association and the Heart Rhythm Society. *Circulation* 2006;**114**:e385–e484.
 460. O'Brien IA, McFadden JP, Corral RJ. The influence of autonomic neuropathy on mortality in insulin-dependent diabetes. *Q J Med* 1991;**79**:495–502.
 461. Forsen A, Kangro M, Sterner G, Norrgren K, Thorsson O, Wollmer P, Sundkvist G. A 14-year prospective study of autonomic nerve function in Type 1 diabetic patients: association with nephropathy. *Diabet Med* 2004;**21**:852–858.
 462. Veglio M, Chinaglia A, Cavallo-Perin P. QT interval, cardiovascular risk factors and risk of death in diabetes. *J Endocrinol Invest* 2004;**27**:175–181.
 463. Rozanski GJ, Xu Z. A metabolic mechanism for cardiac K⁺ channel remodelling. *Clin Exp Pharmacol Physiol* 2002;**29**:132–137.
 464. Ewing DJ, Campbell IW, Clarke BF. The natural history of diabetic autonomic neuropathy. *The Quarterly Journal of Medicine* 1980;**49**:95–108.
 465. Gerritsen J, Dekker JM, TenVoorde BJ, Bertelsmann FW, Kostense PJ, Stehouwer CD, Heine RJ, Nijpels G, Heethaar RM, Bouter LM. Glucose tolerance and other determinants of cardiovascular autonomic function: the Hoorn Study. *Diabetologia* 2000;**43**:561–570.
 466. Ewing DJ, Boland O, Neilson JM, Cho CG, Clarke BF. Autonomic neuropathy, QT interval lengthening and unexpected deaths in male diabetic patients. *Diabetologia* 1991;**34**:182–185.
 467. Gill GV, Woodward A, Casson IF, Weston PJ. Cardiac arrhythmia and nocturnal hypoglycaemia in type 1 diabetes: the 'dead in bed' syndrome revisited. *Diabetologia* 2009;**52**:42–45.
 468. Singh JP, Larson MG, O'Donnell CJ, Wilson PF, Tsuji H, Lloyd-Jones DM, Levy D. Association of hyperglycemia with reduced heart rate variability (The Framingham Heart Study). *Am J Cardiol* 2000;**86**:309–312.
 469. Valensi P, Extramiana F, Lange C, Cailleau M, Haggui A, Maison Blanche P, Tichet J, Balkau B. Influence of blood glucose on heart rate and cardiac autonomic function. The DESIR study. *Diabet Med* 2011;**28**:440–449.
 470. Schroeder EB, Chambless LE, Liao D, Prineas RJ, Evans GW, Rosamond WD, Heiss G. Diabetes, glucose, insulin and heart rate variability: the Atherosclerosis Risk in Communities (ARIC) study. *Diabetes Care* 2005;**28**:668–674.
 471. Barthel P, Bauer A, Muller A, Junk N, Huster KM, Ulm K, Malik M, Schmidt G. Reflex and tonic autonomic markers for risk stratification in patients with type 2 diabetes surviving acute myocardial infarction. *Diabetes Care* 2011;**34**:1833–1837.
 472. Maser RE, Mitchell BD, Vinik AI, Freeman R. The association between cardiovascular autonomic neuropathy and mortality in individuals with diabetes: a meta-analysis. *Diabetes Care* 2003;**26**:1895–1901.
 473. Suarez GA, Clark VM, Norell JE, Kottke TE, Callahan MJ, O'Brien PC, Low PA, Dyck PJ. Sudden cardiac death in diabetes mellitus: risk factors in the Rochester diabetic neuropathy study. *J Neurol Neurosurg Psychiatry* 2005;**76**:240–245.
 474. Ziegler D, Zentgraf CP, Perz S, Rathmann W, Haastert B, Doring A, Meisinger C. Prediction of mortality using measures of cardiac autonomic dysfunction in the diabetic and nondiabetic population: the MONICA/KORA Augsburg Cohort Study. *Diabetes Care* 2008;**31**:556–561.
 475. Tendera M, Aboyans V, Bartelink ML, Baumgartner I, Clement D, Collet JP, Cremonesi A, De Carlo M, Erbel R, Fowkes FG, Heras M, Kownator S, Minar E, Ostergren J, Poldermans D, Rimbaut V, Roffi M, Rother J, Sievert H, van Sambeek M, Zeller T, Bax JJ, Auricchio A, Baumgartner H, Ceconi C, Dean V, Deaton C, Fagard R, Funck-Brentano C, Hasdai D, Hoes A, Knuuti J, Kolh P, McDonagh T, Moulin C, Popescu B, Reiner Z, Sechtem U, Sirnes PA, Torbicki A, Vahanian A, Windecker S, Agewall S, Blinc A, Bulvas M, Cosentino F, De Backer T, Gottsater A, Gulba D, Guzik TJ, Jonsson B, Kesmarky G, Kitsiou A, Kuzmick W, Larsen ML, Madaric J, Mas JL, McMurray JJ, Micari A, Mosseri M, Muller C, Naylor R, Norrving B, Oto O, Pasierski T, Plouin PF, Ribichini F, Riccio JB, Ruilope L, Schmid JP, Schwehr U, Sol BG, Sprynger M, Tiefenbacher C, Tsouffis C, Van Damme H. ESC Guidelines on the diagnosis and treatment of peripheral artery diseases: Document covering atherosclerotic disease of extracranial carotid and vertebral, mesenteric, renal, upper and lower extremity arteries: the Task Force on the Diagnosis and Treatment of Peripheral Artery Diseases of the European Society of Cardiology (ESC). *Eur Heart J* 2011;**32**:2851–2906.
 476. Fowkes FG, Housley E, Riemersma RA, Macintyre CC, Cawood EH, Prescott RJ, Ruckley CV. Smoking, lipids, glucose intolerance and blood pressure as risk factors for peripheral atherosclerosis compared with ischemic heart disease in the Edinburgh Artery Study. *Am J Epidemiol* 1992;**135**:331–340.
 477. Criqui MH. Peripheral arterial disease: epidemiological aspects. *Vasc Med* 2001;**6**:3–7.
 478. Bots ML, Breslau PJ, Briet E, de Bruyn AM, van Vliet HH, van den Ouweland FA, de Jong PT, Hofman A, Grobbee DE. Cardiovascular determinants of carotid artery disease. The Rotterdam Elderly Study. *Hypertension* 1992;**19**:717–720.
 479. Mathiesen EB, Joakimsen O, Bonna KH. Prevalence of and risk factors associated with carotid artery stenosis: the Tromso Study. *Cerebrovasc Dis* 2001;**12**:44–51.
 480. O'Leary DH, Polak JF, Kronmal RA, Kittner SJ, Bond MG, Wolfson SK Jr., Bommer W, Price TR, Gardin JM, Savage PJ. Distribution and correlates of sonographically detected carotid artery disease in the Cardiovascular Health Study. The CHS Collaborative Research Group. *Stroke* 1992;**23**:1752–1760.
 481. Ferrières J, Cambou JP, Gayet JL, Herrmann MA, Leizorovicz A. Prognosis of patients with atherothrombotic disease: a prospective survey in a non-hospital setting. *Int J Cardiol* 2006;**112**:302–307.
 482. Alberts MJ, Bhatt DL, Mas JL, Ohman EM, Hirsch AT, Rother J, Salette G, Goto S, Smith SC Jr., Liao CS, Wilson PW, Steg PG. Three-year follow-up and event rates in the international REDuction of Atherothrombosis for Continued Health Registry. *Eur Heart J* 2009;**30**:2318–2326.
 483. Hobbs SD, Bradbury AWW. Smoking cessation strategies in patients with peripheral arterial disease: an evidence-based approach. *Eur J Vasc Endovasc Surg* 2003;**26**:341–347.
 484. Leal J, Gray AM, Clarke PM. Development of life-expectancy tables for people with type 2 diabetes. *Eur Heart J* 2009;**30**:834–839.
 485. Campbell WB, Ponette D, Sugiono M. Long-term results following operation for diabetic foot problems: arterial disease confers a poor prognosis. *Eur J Vasc Endovasc Surg* 2000;**19**:174–177.
 486. Stettler C, Allemann S, Juni P, Cull CA, Holman RR, Egger M, Krahenbuhl S, Diem P. Glycemic control and macrovascular disease in types 1 and 2 diabetes mellitus: Meta-analysis of randomized trials. *Am Heart J* 2006;**152**:27–38.
 487. Diehm C, Allenberg JR, Pittrow D, Mahn M, Tepohl G, Haberl RL, Darius H, Burghaus I, Trampisch HJ. Mortality and vascular morbidity in older adults with asymptomatic versus symptomatic peripheral artery disease. *Circulation* 2009;**120**:2053–2061.

488. Mensah GA, Brown DW, Croft JB, Greenlund KJ. Major coronary risk factors and death from coronary heart disease: baseline and follow-up mortality data from the Second National Health and Nutrition Examination Survey (NHANES II). *Am J Prev Med* 2005;**29**:68–74.
489. de L II, Hoeks SE, van Gestel YR, Klein J, Bax JJ, Verhagen HJ, van Domburg RT, Poldermans D. The prognostic value of impaired walking distance on long-term outcome in patients with known or suspected peripheral arterial disease. *Eur J Vasc Endovasc Surg* 2009;**38**:482–487.
490. Ashworth NL, Chad KE, Harrison EL, Reeder BA, Marshall SC. Home versus center based physical activity programs in older adults. *Cochrane Database Syst Rev* 2005;**1**: CD004017.
491. Momsen AH, Jensen MB, Norager CB, Madsen MR, Vestersgaard-Andersen T, Lindholt JS. Drug therapy for improving walking distance in intermittent claudication: a systematic review and meta-analysis of robust randomised controlled studies. *Eur J Vasc Endovasc Surg* 2009;**38**:463–474.
492. Radack K, Deck C. Beta-adrenergic blocker therapy does not worsen intermittent claudication in subjects with peripheral arterial disease. A meta-analysis of randomized controlled trials. *Arch Intern Med* 1991;**151**:1769–1776.
493. Aronow WS, Ahn C. Effect of beta blockers on incidence of new coronary events in older persons with prior myocardial infarction and symptomatic peripheral arterial disease. *Am J Cardiol* 2001;**87**:1284–1286.
494. Randomized trial of the effects of cholesterol-lowering with simvastatin on peripheral vascular and other major vascular outcomes in 20,536 people with peripheral arterial disease and other high-risk conditions. *J Vasc Surg* 2007;**45**:645–654.
495. Catalano M, Born G, Peto R. Prevention of serious vascular events by aspirin amongst patients with peripheral arterial disease: randomized, double-blind trial. *J Intern Med* 2007;**261**:276–284.
496. Luscher TF, Creager MA, Beckman JA, Cosentino F. Diabetes and vascular disease: pathophysiology, clinical consequences and medical therapy: Part II. *Circulation* 2003;**108**:1655–1661.
497. Lepantalo M, Apelqvist J, Setacci C, Ricco JB, de Donato G, Becker F, Robert-Ebadi H, Cao P, Eckstein HH, De Rango P, Diehm N, Schmidli J, Teraa M, Moll FL, Dick F, Davies AH. Chapter V: Diabetic foot. *Eur J Vasc Endovasc Surg* 2011;**42**:S60–74.
498. Kannel WB, McGee DL. Diabetes and cardiovascular disease. The Framingham study. *JAMA* 1979;**241**:2035–2038.
499. Giorda CB, Avogaro A, Maggini M, Lombardo F, Mannucci E, Turco S, Alegiani SS, Raschetti R, Velussi M, Ferrannini E. Incidence and risk factors for stroke in type 2 diabetic patients: the DAI study. *Stroke* 2007;**38**:1154–1160.
500. Grau AJ, Weimar C, Bugge F, Heinrich A, Goertler M, Neumaier S, Glahn J, Brandt T, Hacke W, Diener HC. Risk factors, outcome and treatment in subtypes of ischemic stroke: the German stroke data bank. *Stroke* 2001;**32**:2559–2566.
501. Randomised trial of endarterectomy for recently symptomatic carotid stenosis: final results of the MRC European Carotid Surgery Trial (ECST). *Lancet* 1998;**351**:1379–1387.
502. Barnett HJ, Taylor DW, Eliasziw M, Fox AJ, Ferguson GG, Haynes RB, Rankin RN, Clagett GP, Hachinski VC, Sackett DL, Thorpe KE, Meldrum HE, Spence JD. Benefit of carotid endarterectomy in patients with symptomatic moderate or severe stenosis. North American Symptomatic Carotid Endarterectomy Trial Collaborators. *N Engl J Med* 1998;**339**:1415–1425.
503. Rothwell PM, Giles MF, Flossmann E, Lovelock CE, Redgrave JN, Warlow CP, Mehta Z. A simple score (ABCD) to identify individuals at high early risk of stroke after transient ischaemic attack. *Lancet* 2005;**366**:29–36.
504. Mogensen CE. Microalbuminuria predicts clinical proteinuria and early mortality in maturity-onset diabetes. *N Engl J Med* 1984;**310**:356–360.
505. Ninomiya T, Perkovic V, de Galan BE, Zoungas S, Pillai A, Jardine M, Patel A, Cass A, Neal B, Poulter N, Mogensen CE, Cooper M, Marre M, Williams B, Hamet P, Mancia G, Woodward M, MacMahon S, Chalmers J. Albuminuria and kidney function independently predict cardiovascular and renal outcomes in diabetes. *J Am Soc Nephrol* 2009;**20**:1813–1821.
506. Klein R, Klein BE. Are individuals with diabetes seeing better?: a long-term epidemiological perspective. *Diabetes* 2010;**59**:1853–1860.
507. Klein R, Knudtson MD, Lee KE, Gangnon R, Klein BE. The Wisconsin Epidemiologic Study of Diabetic Retinopathy XXIII: the twenty-five-year incidence of macular edema in persons with type 1 diabetes. *Ophthalmology* 2009;**116**:497–503.
508. Wong TY, Mwamburi M, Klein R, Larsen M, Flynn H, Hernandez-Medina M, Ranganathan G, Wirostko B, Pleil A, Mitchell P. Rates of progression in diabetic retinopathy during different time periods: a systematic review and meta-analysis. *Diabetes Care* 2009;**32**:2307–2313.
509. Gerstein HC, Ambrosius WT, Danis RP, Ismail-Beigi F, Cushman W, Calles J, Banerji M, Schubart U, Chew EY. Diabetic Retinopathy, its Progression and Incident Cardiovascular Events in the ACCORD Trial. *Diabetes Care* 2012.
510. Giacco F, Brownlee M. Oxidative stress and diabetic complications. *Circ Res* 2010;**107**:1058–1070.
511. de Boer IH, Rue TC, Cleary PA, Lachin JM, Molitch ME, Steffes MW, Sun W, Zinman B, Brunzell JD, White NH, Danis RP, Davis MD, Hainsworth D, Hubbard LD, Nathan DM. Long-term renal outcomes of patients with type 1 diabetes mellitus and microalbuminuria: an analysis of the Diabetes Control and Complications Trial/Epidemiology of Diabetes Interventions and Complications cohort. *Arch Intern Med* 2011;**171**:412–420.
512. Beulens JW, Patel A, Vingerling JR, Cruickshank JK, Hughes AD, Stanton A, Lu J, Mc GTSA, Grobbee DE, Stolk RP. Effects of blood pressure lowering and intensive glucose control on the incidence and progression of retinopathy in patients with type 2 diabetes mellitus: a randomised controlled trial. *Diabetologia* 2009;**52**:2027–2036.
513. Chew EY, Ambrosius WT, Davis MD, Danis RP, Gangaputra S, Greven CM, Hubbard L, Esser BA, Lovato JF, Perdue LH, Goff DC Jr., Cushman WC, Ginsberg HN, Elam MB, Genuth S, Gerstein HC, Schubart U, Fine LJ. Effects of medical therapies on retinopathy progression in type 2 diabetes. *N Engl J Med* 2010;**363**:233–244.
514. Ismail-Beigi F, Craven T, Banerji MA, Basile J, Calles J, Cohen RM, Cuddihy R, Cushman WC, Genuth S, Grimm RH Jr., Hamilton BP, Hoogwerf B, Karl D, Katz L, Krikorian A, O'Connor P, Pop-Busui R, Schubart U, Simmons D, Taylor H, Thomas A, Weiss D, Hramiak I. Effect of intensive treatment of hyperglycaemia on microvascular outcomes in type 2 diabetes: an analysis of the ACCORD randomised trial. *Lancet* 2010;**376**:419–430.
515. The effect of intensive diabetes treatment on the progression of diabetic retinopathy in insulin-dependent diabetes mellitus. The Diabetes Control and Complications Trial. *Arch Ophthalmol* 1995;**113**:36–51.
516. Bilous R, Chaturvedi N, Sjolie AK, Fuller J, Klein R, Orchard T, Porta M, Parving HH. Effect of candesartan on microalbuminuria and albumin excretion rate in diabetes: three randomized trials. *Ann Intern Med* 2009;**151**:11–20, W3–4.
517. Mauer M, Zinman B, Gardiner R, Suissa S, Sinaiko A, Strand T, Drummond K, Donnelly S, Goodyer P, Gubler MC, Klein R. Renal and retinal effects of enalapril and losartan in type 1 diabetes. *N Engl J Med* 2009;**361**:40–51.
518. Penno G, Chaturvedi N, Talmud PJ, Cotroneo P, Manto A, Nannipieri M, Luong LA, Fuller JH. Effect of angiotensin-converting enzyme (ACE) gene polymorphism on progression of renal disease and the influence of ACE inhibition in IDDM patients: findings from the EUCLID Randomized Controlled Trial. *EURODIAB Controlled Trial of Lisinopril in IDDM. Diabetes* 1998;**47**:1507–1511.
519. Should all patients with type 1 diabetes mellitus and microalbuminuria receive angiotensin-converting enzyme inhibitors? A meta-analysis of individual patient data. *Ann Intern Med* 2001;**134**:370–379.
520. Lewis EJ, Hunsicker LG, Bain RP, Rohde RD. The effect of angiotensin-converting-enzyme inhibition on diabetic nephropathy. The Collaborative Study Group. *N Engl J Med* 1993;**329**:1456–1462.
521. Effects of ramipril on cardiovascular and microvascular outcomes in people with diabetes mellitus: results of the HOPE study and MICRO-HOPE substudy. Heart Outcomes Prevention Evaluation Study Investigators. *Lancet* 2000;**355**:253–259.
522. Brenner BM, Cooper ME, de Zeeuw D, Keane WF, Mitch WE, Parving HH, Remuzzi G, Snapinn SM, Zhang Z, Shahinfar S. Effects of losartan on renal and cardiovascular outcomes in patients with type 2 diabetes and nephropathy. *N Engl J Med* 2001;**345**:861–869.
523. Lewis EJ, Hunsicker LG, Clarke WR, Berl T, Pohl MA, Lewis JB, Ritz E, Atkins RC, Rohde R, Raz I. Renoprotective effect of the angiotensin-receptor antagonist irbesartan in patients with nephropathy due to type 2 diabetes. *N Engl J Med* 2001;**345**:851–860.
524. Sjolie AK, Klein R, Porta M, Orchard T, Fuller J, Parving HH, Bilous R, Chaturvedi N. Effect of candesartan on progression and regression of retinopathy in type 2 diabetes (DIRECT-Protect 2): a randomised placebo-controlled trial. *Lancet* 2008;**372**:1385–1393.
525. Chaturvedi N, Porta M, Klein R, Orchard T, Fuller J, Parving HH, Bilous R, Sjolie AK. Effect of candesartan on prevention (DIRECT-Prevent 1) and progression (DIRECT-Protect 1) of retinopathy in type 1 diabetes: randomised, placebo-controlled trials. *Lancet* 2008;**372**:1394–1402.
526. Herz M, Gaspari F, Perico N, Viberti G, Urbanowska T, Rabbia M, Wiecezorek Kirk D. Effects of high dose aloglitazar on renal function in patients with type 2 diabetes. *Int J Cardiol* 2011;**151**:136–142.
527. Davis TM, Ting R, Best JD, Donoghoe MW, Drury PL, Sullivan DR, Jenkins AJ, O'Connell RL, Whiting MJ, Glasziou PP, Simes RJ, Kesaniemi YA, GebSKI VJ, Scott RS, Keech AC. Effects of fenofibrate on renal function in patients with type 2 diabetes mellitus: the Fenofibrate Intervention and Event Lowering in Diabetes (FIELD) Study. *Diabetologia* 2011;**54**:280–290.
528. Silva PS, Cavallerano JD, Sun JK, Aiello LM, Aiello LP. Effect of systemic medications on onset and progression of diabetic retinopathy. *Nat Rev Endocrinol* 2010;**6**:494–508.
529. Pfeffer MA, Burdmann EA, Chen CY, Cooper ME, de Zeeuw D, Eckardt KU, Feys JM, Ivanovich P, Kewalramani R, Levey AS, Lewis EF, McGill JB, McMurray JJ, Parfrey P, Parving HH, Remuzzi G, Singh AK, Solomon SD, Toto R. A trial of

- darbepoetin alfa in type 2 diabetes and chronic kidney disease. *N Engl J Med* 2009; **361**:2019–2032.
530. Fong DS, Aiello L, Gardner TW, King GL, Blankenship G, Cavallerano JD, Ferris FL 3rd, Klein R. Diabetic retinopathy. *Diabetes Care* 2003;**26**:226–229.
 531. Massin P, Bandello F, Garweg JG, Hansen LL, Harding SP, Larsen M, Mitchell P, Sharp D, Wolf-Schnurrbusch UE, Gekkieva M, Weichselberger A, Wolf S. Safety and efficacy of ranibizumab in diabetic macular edema (RESOLVE Study): a 12-month, randomized, controlled, double-masked, multicenter phase II study. *Diabetes Care* 2010;**33**:2399–2405.
 532. Mitchell P, Bandello F, Schmidt-Erfurth U, Lang GE, Massin P, Schlingemann RO, Sutter F, Simader C, Burian G, Gerstner O, Weichselberger A. The RESTORE study: ranibizumab monotherapy or combined with laser versus laser monotherapy for diabetic macular edema. *Ophthalmology* 2011;**118**:615–625.
 533. Frampton JE. Ranibizumab: in diabetic macular oedema. *Drugs* 2012;**72**:509–523.
 534. Lewin SA, Skea ZC, Entwistle V, Zwarenstein M, Dick J. Interventions for providers to promote a patient-centred approach in clinical consultations. *Cochrane Database Syst Rev* 2001;**4**:CD003267.
 535. Deakin T, McShane CE, Cade JE, Williams RD. Group based training for self-management strategies in people with type 2 diabetes mellitus. *Cochrane Database Syst Rev* 2005;**2**:CD003417.
 536. Lindstrom J, Louheranta A, Manninen M, Rastas M, Salminen V, Eriksson J, Uusitupa M, Tuomilehto J. The Finnish Diabetes Prevention Study (DPS): Lifestyle intervention and 3-year results on diet and physical activity. *Diabetes Care* 2003;**26**:3230–3236.
 537. Wood DA, Kotseva K, Connolly S, Jennings C, Mead A, Jones J, Holden A, De Bacquer D, Collier T, De Backer G, Faergeman O. Nurse-coordinated multidisciplinary, family-based cardiovascular disease prevention programme (EUROACTION) for patients with coronary heart disease and asymptomatic individuals at high risk of cardiovascular disease: a paired, cluster-randomised controlled trial. *Lancet* 2008; **371**:1999–2012.
 538. Tierney S, Mamas M, Woods S, Rutter MK, Gibson M, Neyses L, Deaton C. What strategies are effective for exercise adherence in heart failure? A systematic review of controlled studies. *Heart Fail Rev* 2012;**17**:107–115.
 539. Haynes RB, Ackloo E, Sahota N, McDonald HP, Yao X. Interventions for enhancing medication adherence. *Cochrane Database Syst Rev* 2008;**2**:CD000011.
 540. Bangalore S, Kamalakkannan G, Parkar S, Messerli FH. Fixed-dose combinations improve medication compliance: a meta-analysis. *Am J Med* 2007;**120**:713–719.
 541. van Dulmen S, Sluijs E, van Dijk L, de Ridder D, Heerdink R, Bensing J. Patient adherence to medical treatment: a review of reviews. *BMC Health Serv Res* 2007;**7**:55.
 542. Rubak S, Sandbaek A, Lauritzen T, Christensen B. Motivational interviewing: a systematic review and meta-analysis. *Br J Gen Pract* 2005;**55**:305–312.
 543. Aschner P, LaSalle J, McGill M. The team approach to diabetes management: partnering with patients. *Int J Clin Pract Suppl* 2007;22–30.
 544. McAlister FA, Stewart S, Ferrua S, McMurray JJ. Multidisciplinary strategies for the management of heart failure patients at high risk for admission: a systematic review of randomized trials. *J Am Coll Cardiol* 2004;**44**:810–819.
 545. Allen JK, Dennison CR. Randomized trials of nursing interventions for secondary prevention in patients with coronary artery disease and heart failure: systematic review. *J Cardiovasc Nurs* 2010;**25**:207–220.
 546. Berra K. Does Nurse Case Management Improve Implementation of Guidelines for Cardiovascular Disease Risk Reduction? . *J Cardiovasc Nurs* 2011;**26**:145–167.