observed in the atenolol group could be related to more favourable changes in confounding factors, as compared with the control group. Interestingly, although we did not assess triglyceride levels (a potentially modifiable confounding variable) at follow-up, the latter might be expected to increase only in the beta-blockade group, which, in contrast with Yildiz et al.’s fears, might have limited the favourable autonomic mediated effect on CRP serum levels shown in atenolol treated patients.

References


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The consensus is clearly needed for the definition of stress hyperglycaemia in acute myocardial infarction

We enjoyed reading the article of Bauters et al. about new relation of stress hyperglycaemia with left ventricular remodelling. Stress hyperglycaemia has been proved to be the independent prognostic marker of worse outcome in numerous critical illnesses, including acute myocardial infarction (AMI). Interestingly, the admission hyperglycaemia has been studied very differently in AMI even in last year or two:

(i) as a blood glucose level <10 vs. >10 mmol/L (180 mg/dL);
(ii) in comparison between tertiles of glycaemia;
(iii) by comparing groups with the admission glucose of <7.8 vs. >7.8 mmol/L and <11.1 vs. >11.1 mmol/L;
(iv) or groups with the admission glucose of <7.8 vs. 7.8–11.0 mmol/L vs. >11.1 mmol/L;
(v) or with/without first fasting glucose level after admission of >7.7 mmol/L;
(vi) or sextiles of glycaemia.

Thus, AMI has been an important disease, glycaemia being the vital parameter, stress hyperglycaemia has prognostic value, and consensus is clearly needed for the definition of stress hyperglycaemia.

For studying pathophysiological processes, it may not be so useful only to choose a glycaemic value above which ‘stress hyperglycaemia begins’, if it depends on diabetes mellitus definition, because the definition of diabetes mellitus has been changed and may be expected to change. It may be more rational for scientific purposes to analyse tertiles–sextiles (depending on the number of patients studied).

On the contrary, using, for example, quartiles may not be fully applicable for practititioner and another method probably should be employed in addition: authors may determine the best cut-off value of glycaemia for mortality in their own AMI patients. Using meta-analysis, this may allow the cardiological community to find a concentration of glucose that is good to introduce in routine risk stratification in AMI patients all over the world, as well as more precise value for risk stratification according to age, gender, race, and so on.

We propose that authors should analyse their database in two ways: both by using tertiles and best cut-off value of glycaemia for mortality in AMI patients.

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The consensus is clearly needed for the definition of stress hyperglycaemia in acute myocardial infarction: reply

We thank Dr Koracevic Goran for his comments on the definition of stress hyperglycaemia. We agree that different cut-off values have been used in the recent literature to define stress hyperglycaemia. As stated in our article, as there is no consensus, we used the median as the threshold value defining stress hyperglycaemia. However, we also performed statistical analyses using glycaemia on admission as a continuous variable. Using this approach, stress hyperglycaemia was associated with left ventricular