INTRODUCTION

Numerous prospective studies showed that all of the major cardiovascular risk factors such as smoking, hypertension and high serum cholesterol continue to act as independent contributors to cardiovascular disease in patients with diabetes. Clustering of various metabolic risk factors of metabolic syndrome (MS) occurs commonly in type 2 diabetes.\(^1,2\)

Coronary artery disease (CAD) is a condition in which atherosclerotic plaques build up in the coronary arteries causing varying degrees of luminal obstruction.\(^3\) CAD worldwide is largely driven by modifiable risk factors, such as smoking, lack of physical activity, and diets high in fat and salt.\(^4,5\) The INTERHEART study showed that smoking, hypertension, abdominal obesity, lack of physical inactivity, and a high-risk diet were responsible for a significant component of myocardial infarction risk. Elevated levels of blood pressure and hypercholesterolemia the leading causes of CAD; tobacco, obesity, and physical inactivity remain important contributors.

Hyperglycemia appears to accelerate atherogenesis, possibly by enhanced formation of glycosylated proteins and advanced glycation products and/or by increasing endothelial dysfunction.\(^6\) These direct consequences of hyperglycemia probably contribute to the microvascular disease underlying nephropathy and retinopathy, and they may promote macrovascular disease as well.\(^6,7\) Yoon et al.,
showed strong correlation between MS and severity of CAD.\(^8\)

South Asians are more prone to develop MS because of their high percentage of body fat, abdominal obesity, and insulin resistance. Most experts appear to believe that the increased cardiovascular risk seen in these subjects is probably due to the clustering of risk factors.\(^9\)\(^,\)\(^10\) Many epidemiological and clinical studies have confirmed the association between MS and increased risk CAD, which is the leading cause of mortality worldwide. Morbidity and mortality from CAD are higher in patients with MS; therefore, early assessment of the risk of CAD in patients with MS is desirable because it could lead to improved patient or physician adherence to risk-reducing behaviors or interventions and improve clinical outcomes. There are reports in the literature on the association of inflammatory markers and insulin resistance with severity of disease. There are very few studies showing association of hemoglobin A1c (HbA1c) and fasting blood sugar (FBS) with the severity of CAD in India.

**Aims and objectives**
To evaluate coronary angiography profile in patients of diabetes mellitus.

**MATERIALS AND METHODS**

**Study area**
Nil Ratan Sircar Medical College and Hospital, A.J.C. Bose Road, Kolkata – 700014. This study was pre-approved by the Institutional Ethics Committee for the final permission.

**Study population**
Adult patients of both sexes admitted in the Department of Cardiology with presumed diagnosis of CAD who underwent coronary angiography (CAG) for diagnostic or therapeutic purpose.

**Study period**
From June 2018 to February 2021.

**Sample size**
Six hundred.

**Study design**
Observational, cross-sectional, hospital-based, single center study.

**Parameters to be studied**
1. Detailed clinical history and thorough clinical examination
2. Laboratory investigations such as lipid profile, blood sugar, HbA1c, cardiac enzymes, and serum creatinine
3. Imaging studies, for example, chest X-ray (CXR) and Echocardiography
4. CAG and SYNTAX score calculation.

**Inclusion criteria**
Adult patients of suspected CAD who are undergoing CAG for any or diagnostic or therapeutic purpose.

**Exclusion criteria**
1. Patients with previously diagnosed CAG abnormalities
2. Presence of severe renal, lung, and liver comorbidities.

**RESULTS**
Average Syntax score was higher in the body mass index (BMI) <23 kg/m\(^2\) group compared to 23–<25 kg/m\(^2\). This may be due to few very low syntax scores in this group, which resulted in the average score. Syntax scores were higher in the next two groups, being highest in the BMI \(\geq 30\) kg/m\(^2\) group. Studies with a larger patient population are needed to further evaluate these findings.

Applying Kruskal – Wallis test, the P-value found is 0.039, so HbA1C values are significantly different between these three groups. Patients with Syntax score \(\geq 33\) are found to have much higher values of HbA1c compared to those with Syntax score of \(\leq 22\). Higher HbA1c value is associated with more complex CAD. However, the difference between groups A and B as well as between B and C were not statistically significant (post-hoc Dunn’s test).

Applying Kruskal – Wallis test, the P-value found is 0.0126, so FBS values are significantly different between these 3 groups.

Fasting blood glucose level in Syntax score \(\geq 33\) group (group A) was significantly higher compared to the group of Syntax score \(\leq 22\). Thus, higher FBS level is associated with more complex CAD (statistically significant by post-hoc Dunn’s test).

Hypertensive patients constituting almost 37% study population had a Syntax score of 20.98±14.17 compared to non-hypertensives whose Syntax score was 14.09±9.63, having a highly significant P<0.0005. Hence, hypertensive patients presenting with chest pain are prone to have more complex CAD.

**DISCUSSION**
The current study was conducted in the Department of Cardiology, N R S Medical College and Hospital, Kolkata from June 2018 to February 2021 and included patients presenting in the Cardiology emergency or OPD with
cough, chest pain. The study included total of 600 patients. All the patients underwent CAG and the findings are divided according to the severity and complexity of disease based on Syntax score. Syntax score divided the study population into three categories:
- Low score ≤2
- Intermediate score 23–32 and
- High score ≥33.

Out of the 600 patients, 420 (69.75%) had low Syntax score (≤22), 115 (19.33%) had intermediate Syntax score (23–32) and 65 (10.92%) had high Syntax score of ≥33. Average Syntax score was higher in the body mass index (BMI) <23 kg/m² group compared to 23–<25 kg/m² (Table 1).

Median HbA1c value in group A is 6.88±1.33, B is 6.64±1.49 and C is 6.42±1.77 and the p value found is 0.0392, so HbA1c values are significantly different between these three groups. Thus, higher HbA1c is associated with more severe and complex CAD (Table 2).

Patients with SS of ≥33 had a median FBS level of 167.54±80.95 mg/dl, SS of 23–32 had median FBS of 134.30±70.83, and SS ≤22 had median FBS of 133.73±96.11 with a P=0.0126 which is statistically significant. Thus, higher FBS is associated with more severe CAD (Table 3).

Relationship between various risk factors of CAD and Syntax score are being discussed in the following text (Table 4). 15% of the study population had both diabetes and MS, 18.33% had only diabetes, 13.33% had only MS without diabetes and the remaining 53.33% had none.

Approximately 37% of the study population had systemic hypertension and they had a median syntax score of 20.98±14.17 compared to 14.09±9.63 in non-hypertensive patients (73%) with a P<0.0005 which is highly significant statistically. This finding strongly indicates that hypertension is a strong risk factor for atherosclerotic CAD. This finding matches with the literature.

15% of the study population had combined diabetes mellitus (DM) and MS and this group had median syntax score of 20.97±9.32. Patient group having only MS constituting 13.33% of patient pool had a median syntax score of 21.21±14.94 and those having only DM (18.33%) had median Syntax score of 19.72±13.52. The group that had none of DM or MS (53.33%) had median syntax score of 13.16±10.14. The difference among

### Table 1: ABI and BMI relationship with syntax score

<table>
<thead>
<tr>
<th>BMI (kg/m²)</th>
<th>No. of patients</th>
<th>Average syntax score</th>
<th>Average ABI</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;23</td>
<td>50</td>
<td>15.7</td>
<td>0.85</td>
</tr>
<tr>
<td>23–&lt;25</td>
<td>77</td>
<td>12.9</td>
<td>0.94</td>
</tr>
<tr>
<td>25–&lt;30</td>
<td>350</td>
<td>16.1</td>
<td>0.95</td>
</tr>
<tr>
<td>≥30</td>
<td>123</td>
<td>16.5</td>
<td>0.95</td>
</tr>
</tbody>
</table>

ABI: Ankle-brachial index, BMI: Body mass index

### Table 2: With HbA1C

<table>
<thead>
<tr>
<th>SYNTAX score</th>
<th>Group A ≥33</th>
<th>Group B 23–32</th>
<th>Group C ≤22</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No (%), HbA1C</td>
<td>No (%), HbA1C</td>
<td>No (%), HbA1C</td>
</tr>
<tr>
<td></td>
<td>65 (10.9), 6.8±1.3</td>
<td>115 (19.3), 6.6±1.5</td>
<td>420 (69.7), 6.4±1.8</td>
</tr>
</tbody>
</table>

HbA1C: Hemoglobin A1c

### Table 3: Relationship of syntax score with FBS

<table>
<thead>
<tr>
<th>SYNTAX score</th>
<th>Group A ≥33</th>
<th>Group B 23–32</th>
<th>Group C ≤22</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No (%), FBS</td>
<td>No (%), FBS</td>
<td>No (%), FBS</td>
</tr>
<tr>
<td></td>
<td>65 (10.9), 167.5±80.9</td>
<td>115 (19.3), 134.3±70.8</td>
<td>420 (69.7), 133.7±96.1</td>
</tr>
</tbody>
</table>

FBS: Fasting blood sugar

### Table 4: Relation between different risk factors and SYNTAX score

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Present</th>
<th>Absent</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SYNTAX score</td>
<td>SYNTAX score</td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td>20.98±14.17</td>
<td>14.09±9.6</td>
<td>&lt;0.0005*</td>
</tr>
<tr>
<td>Smoking</td>
<td>17.00±11.65</td>
<td>14.80±11.9</td>
<td>0.3106</td>
</tr>
<tr>
<td>Family h/o CAD</td>
<td>18.27±12.71</td>
<td>15.79±11.5</td>
<td>0.2095</td>
</tr>
</tbody>
</table>

Mann Whitney’s U test was used to check statistical significance.
these groups is statistically significant (<0.0001). So, the presence of DM and/or MS in a patient presenting with angina is a strong risk factor for more severe and complex CAD.

Mahalle et al.,¹ studied association of MS with severity of CAD. It included 300 patients with known CAD above 25 years of age. Single vessel disease (SVD), double vessel disease (DVD), and triple vessel disease (TVD) were present in 22.3%, 25.3%, and 52.3% subjects, respectively. In a study from India by Sukhija et al., reported SVD in 11%, DVD in 27%, and TVD in 45% among 82 patients undergoing angiography. Rana et al.,² also reported more involvement of CAD in DM versus non-DM individuals (SVD [19% vs. 14%], DVD [9% vs. 7%], and TVD [9% vs. 5%] P<0.0001 for all). Others have also observed similar findings. These results support the hypothesis of a greater severity of angiographic proven CAD in diabetic than in non-diabetic patients. Diabetics suffer from higher prevalence of diffuse and extensive coronary atherosclerosis.

Diabetic patients had a significantly smaller minimal lumen diameter in the infarct-related artery than non-diabetic patients. Reference segment diameters in all infarct-related arteries were also significantly smaller in diabetic than nondiabetic patients. de Sousa et al., studied “Comparison of CAG findings in diabetic and non-diabetic women with non-ST-segment-elevation acute coronary syndrome” (¹¹) found that the diffuse pattern of atherosclerotic disease in diabetic patients. In GUSTO-I study, diabetic and non-diabetic patients exhibited similar percent diameter and percent area stenosis at early angiography. Diabetic patients had a significantly smaller minimal lumen diameter in the infarct-related artery than non-diabetic patients.

Limitations of the study
As the prevalence of coronary artery disease is quite high, higher number of patients would be better. Additional risk factors like dysliidemia was not included. We did not separate acute coronary syndrome from stable ischemic heart disease.

CONCLUSION

This study has re-established the association of several risk factors with atherosclerotic CAD such as HbA1c and FBS. Patients having DM and/or MS are found to have more severe form of CAD than those who do not have either of these.

ACKNOWLEDGMENT

None.

REFERENCES


Authors Contribution:
AS- Concept preparation, coordination, implementation of study, statistical analysis, preparation of first manuscript; MK- Preparation of final manuscript, review of literature; RKS- Concept, supervision of study, final editing, discussion

Work attributed to:
Nil Ratan Sircar Medical College, Kolkata - 700 014, West Bengal, India

Orcid ID:
Dr. Avishek Saha- https://orcid.org/0000-0002-5510-171X
Dr. Madhumita Kuila- https://orcid.org/0000-0002-2048-6352
Dr. Ranjan Kumar Sharma- https://orcid.org/0000-0003-0925-2389

Source of Support: Nil, Conflict of Interest: None declared.