



Original Article / Özgün Araştırma

Evaluation of Platelet Indices in Diabetic Patients with Myocardial Bridges

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Abstract

Objectives: Myocardial bridges (MB) are a congenital anomaly in which part of the epicardial coronary artery is intramuscular, known as the presence of myocardium, which causes narrowing of the artery during heart contraction. We aimed to evaluate hemogram parameters (especially platelet indices) in diabetic patients with myocardial bridges.

Methods: We reviewed angiograms performed between May 2017 and August 2019 at Bolu Abant İzzet Baysal University Medical Faculty Hospital. After appropriate exclusions, diabetic patients were divided into groups with myocardial bridges and normal coronary artery groups. A total of 124 patients were included in the study and hemogram parameters of these two groups were compared. Kolmogorov Smirnov test was used to examine the normality of variables. Data were compared using univariate tests including independent samples t-test, Mann-Whitney U-test and chi-square test.

Results: Compared to control group PDW (17.7 (15.9-19.5) vs.17.4 (16.2-18.9) % p=0.047), MPV (8.3 (6.6-11.4) vs. 7.5 (6.6-8.7) Fl p<0.001), PCT (0.2 (0.16-0.25) vs. 0.18 (0.13-0.24) p=0.004), and Neutrophil-Lymphocyte Ratio (NLR) (1.71 (0.82-9.14) vs. 1.43 (0.78-5.75) p=0.036) were significantly higher in MB patients. There was no significant difference between the two groups in terms of other biochemical and hemogram values.

Conclusion: Common, simple and inexpensive platelet indices were found to be increased in myocardial bridge diabetic patients.

Keyword: Atherosclerosis, myocardial bridges, diabetes mellitus, platelet indices, inflammation.

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Miyokardiyal Kas Bandı Olan Diyabetik Hastalarda Trombosit İndekslerinin Değerlendirilmesi

Öz

Amaç: Miyokardiyal kas bandı, epikardiyal koroner arterin bir kısmının kalp kasılması sırasında arterin daralmasına neden olan miyokard varlığı olarak bilinen kas içi olduğu konjenital bir anomalidir. Miyokardiyal kas bandı olan diyabetli hastalarda hemogram parametrelerini (özellikle trombosit indeksleri) değerlendirmeyi amaçladık.

Yöntemler: Mayıs 2017-Ağustos 2019 tarihleri arasında Bolu Abant İzzet Baysal Üniversitesi Tıp Fakültesi Hastanesi'nde yapılan anjiyogramları gözden geçirdik. Uygun dışlamalardan sonra, diyabetik hastalar miyokardiyal kas bandı olan grup ve normal koroner arter gruplarına ayrıldı. Çalışmaya toplam 124 hasta dahil edildi ve bu iki grubun hemogram parametreleri karşılaştırıldı. Değişkenlerin normalliğini incelemek için Kolmogorov Smirnov testi kullanıldı. Veriler bağımsız örneklem t-testi, Mann-Whitney U-testi ve ki-kare testi gibi tek değişkenli testler kullanılarak karşılaştırıldı.

Bulgular: Kontrol grubu ile kıyaslandığında PDW (17.7 (15.9-19.5) vs. 17.4 (16.2-18.9) % p=0.047), MPV (8.3 (6.6-11.4) vs. 7.5 (6.6-8.7) Fl p<0.001), PCT (0.2 (0.16-0.25) vs. 0.18 (0.13-0.24) p=0.004) ve Nötrofil-Lenfosit Oranı (NLR) (1.71 (0.82-9.14) vs. 1.43 (0.78-5.75) p=0.036) miyokardiyal kas bandı hastalarında anlamlı olarak daha yüksek bulundu. İki grup arasında diğer biyokimyasal ve hemogram değerleri açısından anlamlı fark yoktu.

Sonuç: Miyokardiyal kas bandı olan diyabetik hastalarda yaygın, basit ve ucuz trombosit indekslerinde artış olduğu bulundu.

Anahtar kelimeler: Ateroskleroz, miyokardiyal kas bandı, diabetes mellitus, trombosit indeksleri, inflamasyon.

INTRODUCTION

A myocardial bridge (MB) is a congenital anomaly¹ of the myocardium that covers the coronary artery, which causes the artery to narrow during systole². MB, which is the most common congenital coronary anomaly, has a prevalence of less than 5% following routine angiography³. MB was first identified in 1737⁴; modern medicine has determined that MB accelerates atherosclerosis⁵. The condition is also more widespread in patients with coronary artery disease (CAD)⁵. Feeding of the myocardium may be impaired by MB and may cause ischemia due to the shortening of the diastolic phase secondary to tachycardia in addition to the atherosclerosis induced by the bridge⁵. MB may cause chest pain upon exertion, arrhythmias, dyspnea, left heart failure, coronary spasm, acute coronary syndromes, and even sudden cardiac death¹. Various investigations have demonstrated that MB may lead to ischemia. MBs can be identified using several diagnostic techniques, such as computed tomography, magnetic resonance imaging, coronary angiography, intravascular ultrasound, and fractional flow reserve^{6,7}. The

gold standard for diagnosing MB is angiography that reveals a systolic milking effect produced by systolic compression of the intramyocardial segment³. The prevalence of MB is higher in young patients with fewer comorbidities and stable CAD⁵. MB is associated with coronary endothelial dysfunction and the early stages of atherosclerosis⁸, and the atherosclerosis that develops proximal to the bridge results from shear stress⁹.

Diabetes mellitus (DM) is a complex cardiometabolic disease that occurs at a worldwide rate of approximately 8.5%¹⁰. DM is associated with an increased prevalence of cardiovascular events¹¹. The risk of cardiovascular disease (CVD) and death is two to three times higher in diabetics¹². DM may have a key role in the progression of atherosclerosis in the proximal segment of MB¹³.

Platelets play a significant role in death-causing thrombosis and atherosclerosis¹⁴. Platelet height increases inflammation and is associated with atherosclerosis¹⁵. The mean platelet volume (MPV), platelet distribution width

(PDW), and plateletcrit (PCT) derived from a complete blood count (CBC) are indices specific to platelet morphology and proliferation kinetics¹⁶. Studies have shown that there is a relationship between platelet indices and CAD¹⁷. Platelet indices may also aid in the diagnosis and prognosis of many diseases and conditions, such as CVD. Therefore, in this study, we aimed to evaluate the platelet indices in diabetic MB patients.

METHODS

Patient Selection

We reviewed angiograms performed between May 2017 and August 2019 at Bolu Abant İzzet Baysal University Medical Faculty Hospital. A Siemens Axiom Artis diagnostic device (Siemens Healthcare GmbH, Forchheim, Germany) was used to perform the coronary angiography. These procedures were carried out to identify ischemic heart disease based on clinical indications. The study was conducted in accordance with the ethical approval of the University Ethics Committee. (Date: 14/10/2019 Decision number: 2019/218). Two cardiologists who were blinded to the study's details visually evaluated the coronary angiography images recorded in a digital format to identify MB. Any patients diagnosed with MB were included in the study. The following baseline demographic data and clinical cardiovascular risk factors were obtained from the institution database and patient files: hypertension, dyslipidemia, DM, smoking or former smoking, a family history of CAD, weight, and height. There was no significant difference in demographic parameters between the MB patients and the control group with normal coronary angiography. The study excluded the following patients: participants with a history of chronic diseases, such as heart failure (ejection fraction <50%), liver or kidney failure, acute and chronic lung disease, or obstructive sleep apnea; chronic inflammation; previous coronary artery bypass grafting; any

percutaneous coronary intervention; acute coronary syndrome; significant valve disease; atrial fibrillation; hypertension; autoimmune diseases; myocarditis; pericarditis; any active infection; cancer; hypo/hyperthyroidism; stroke; developmental or intellectual delays; delirium; dementia; electrolyte imbalances; and any hematological abnormality, including sickle cell anemia or thrombocytopenia; those currently being treated with antiplatelet/anticoagulant agents, steroids, or immunosuppressive therapy; and patients who were pregnant, current smokers, or were under 18 years of age.

Statistical Analysis

SPSS software was used for statistical analysis (SPSS 22.0 for Windows, IBM Co, Chicago, IL, USA). The distribution normality was determined by the Kolmogorov Smirnov test. Normal variables were compared with the T-test and expressed as mean \pm standard deviation. Mann Whitney U test was used for variables showing the abnormal distribution and expressed as median (IQR: interquartile interval). A chi-square test was used to compare nonparametric variables. A p-value lower than 0.05 was considered statistically significant.

RESULTS

All patients were diabetic. The diagnosis of DM was based on a previous history of DM. We enrolled 124 individuals including 62 MB patients (mean age: 54 [range: 35–76] years) and 62 control participants (mean age: 57 [range: 44–77] years). The mean age, frequencies of sex, and body mass index were not significantly different between diabetic patients with MB and the control group. (Table I).

Table I: General characteristics of the study groups

Baseline characteristics	Diabetic Myocardial Bridge Group (n=62)	Control Group (n=62)	P value
Age (years)	54 (35-76)	57 (44-77)	0.231
Male/female	40/22	33/29	0.205
Left ventricular ejection fraction (%)	59.9±3.5	59.8± 2.7	0.908
Heart rate	75 (64-100)	76 (62-107)	0.617
Systolic Blood Pressure(mmHg)	120 (108-140)	125 (90-138)	0.146
Diastolic Blood Pressure (mmHg)	70 (60-82)	76 (60-90)	0.277
Hemoglobin A1c (%)	7.1 (4.9-10.4)	6.7 (6.0-10.6)	0.816
Body Mass Index	27.6 (21.2-39.8)	31.0 (20.1-39.3)	0.136

The PDW (17.7% [range: 15.9–19.5%] vs. 17.4% [range: 16.2–18.9%]; p=0.047), MPV (8.3 [range: 6.6–11.4] vs. 7.5 [range: 6.6–8.7] fL; p<0.001), PCT (0.2 [range: 0.16–0.25] vs. 0.18 [range: 0.13–0.24]; p=0.004), and the neutrophil-lymphocyte ratio (NLR; 1.71 [range: 0.82–9.14] vs. 1.43 [range: 0.78–5.75]; p=0.036) were significantly higher in MB patients than they were in the control group. However, there were no significant differences among the groups in terms of other biochemical and hemogram values. (Table II).

Table II: Laboratory data of study groups

	Diabetic Myocardial Bridge Group (n=62)	Control (n=62)	p
MEDIAN (Min-Max.)			
LDL-cholesterol (mg/dL)	109.2 (37.8-189.7)	123.2 (72-210.9)	0.051
Triglyceride (mg/dL)	146.5 (66-634)	158.5 (70-548)	0.932
Total cholesterol (mg/dL)	195 (91-293)	211 (97.6-395)	0.352
HDL-cholesterol (mg/dL)	42.9 (22.8-86.1)	46.6 (27.3-72.5)	0.900
GFR(%)	85.1 (60-118.3)	89.6 (55-120)	0.133
ALT (u/l)	22.5 (8-51)	20 (12-55)	0.216
AST (u/l)	21 (13-97)	22 (7-48)	0.233
TSH	1.23 (0.3-3.9)	1.6 (0.3-4.21)	0.455
CRP (mg/L)	0.83 (0.01-5)	1.54 (0.1-7.6)	0.354
WBC, (u/mm ³)	7.5 (4.3-12.8)	7.4 (4.5-12.9)	0.434
Hemoglobin (gr/dL)	14.7 (10.6-17.5)	13.8 (9.6-19.8)	0.114
MCV	86.6 (64.6-96.7)	86.4 (79-94)	0.472
RDW (%)	15.2 (14.1-16.8)	15.3 (12.8-16.8)	0.659
Neutrophil, (u/mm ³)	4.1 (2.0-9.3)	3.9 (0.02-8.0)	0.065
Lymphocyte, (u/mm ³)	2.4 (0.8-4.6)	2.7 (0.01-4.0)	0.369
Monocyte, (u/mm ³)	0.6 (0.01-0.9)	0.5 (0.2-4.3)	0.487
Basophils, (u/mm ³)	0.07 (0.01-0.16)	0.07 (0.01-0.21)	0.568
Eosinophil, (u/mm ³)	0.13 (0.01-1.38)	0.16 (0.03-0.82)	0.899
Platelet counts (Plt) (k/mm ³)	243 (178-333)	241.5 (163-362)	0.536
PDW (%)	17.7 (15.9-19.5)	17.4 (16.2-18.9)	0.047
MPV (fL)	8.3 (6.6-11.4)	7.5 (6.6-8.7)	<0.001
PCT	0.2 (0.16-0.25)	0.18 (0.13-0.24)	0.004
Neutrophil Lymphocyte Ratio (NLR)	1.71 (0.82-9.14)	1.43 (0.78-5.75)	0.036
Platelet Lymphocyte Rate (PLR)	106 (63.5-252.1)	85.6 (60.5-40857.1)	0.161

LDL: low-density lipoprotein, HDL: high-density lipoprotein, GFR: glomerular filtration rate, ALT: alanine aminotransferase, AST: aspartate aminotransferase, TSH: Thyroid-stimulating hormone, CRP: C reactive protein, WBC: White blood count, MCV: Mean Corpuscular Volume,

RDW: Red cell distribution width, PDW: Platelet distribution width, MPV: Mean platelet volume, PCT: plateletcrit.

DISCUSSION

To our knowledge, this is the first study to investigate platelet indices in diabetic patients with MB. The PDW, MPV, and PCT values were significantly higher in diabetic patients with MB than they were in the control group participants. Our findings also showed an increase in the index and activation of platelets in diabetic MB patients. The frequency of MB on coronary angiography was 5.2% in our study, while the prevalence of MB in diabetic patients was 1.7%. MB is a risk factor for coronary atherosclerosis¹³ and has been reported to trigger the development of coronary atherosclerosis, especially in elderly DM patients¹³.

Changes in endothelial cell morphology occur due to the shear stress of blood flow both before and after the bridge segment¹⁸ because MB changes the hemodynamics of coronary flow. Any alteration in coronary flow hemodynamics may lead to endothelial dysfunction, which causes atherosclerosis¹⁹ by promoting various harmful abnormalities in arterial vessels, including vasoconstriction, inflammation, and thrombosis²⁰. Studies have shown that DM causes endothelial dysfunction²¹. It has also been reported that chronic inflammation plays an important role in the pathogenesis of many chronic diseases, such as DM²². The coexistence of endothelial dysfunction and chronic inflammation may accelerate atherosclerosis with a synergistic effect.

The NLR is currently being evaluated as a new marker of inflammation; it has been suggested as a new biomarker of cardiovascular events and prognosis²³. In our study, this parameter was elevated in MB patients. Platelets also play a major role in the pathogenesis of atherothrombosis²⁴. Platelet indices are platelet

activation markers and may help in the diagnosis and prognosis of many diseases, including CVD²⁵. An increase in the MPV and PDW values in diabetic patients is thought to be related to the incidence of diabetic vascular complications²⁶.

The platelet indices are practical, cheap, and readily accessible parameters that can be easily estimated by a complete blood count and are associated with a range of medical conditions and pathologies²⁷. The platelet size reflects platelet activity and is measured using the MPV²⁸. Large platelets have higher reactivity and produce more prothrombotic factors²⁹.

Study limitations

Retrospective design is the most important limitation of this study.

CONCLUSIONS

Our findings showed an increase in the PDW, MPV, and PCT platelet indices in diabetic MB patients. Routine hematological analyses are important, simple, effortless, and cost-effective tests that may be predictive of MB. Future prospective large-scale, randomized controlled trials will be required to confirm our findings.

Ethics Committee Approval: The study was conducted in accordance with the ethical approval of the University Ethics Committee. (Date: 14/10/2019 Decision number: 2019/218).

Declaration of Conflicting Interests: The authors declare that they have no conflict of interest.

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