



A COMPARATIVE ASSESSMENT OF CLINICAL PROFILE AND IN-HOSPITAL OUTCOMES OF ST-ELEVATION MYOCARDIAL INFARCTION IN DIABETIC AND NON-DIABETIC PATIENTS: A CROSS-SECTIONAL ANALYTICAL STUDY

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ABSTRACT

Background: Diabetes mellitus is a major cardiovascular risk factor that significantly alters the clinical presentation and prognosis of ST-elevation myocardial infarction (STEMI). Diabetic patients often present with atypical symptoms and experience worse short-term outcomes compared to non-diabetic patients. This study was conducted to compare the clinical profile and in-hospital outcomes of STEMI in diabetic and non-diabetic patients.

Objectives: To compare the clinical presentation, infarct characteristics, and in-hospital outcomes of STEMI among diabetic and non-diabetic patients.

Materials and Methods: This cross-sectional analytical study was conducted at a tertiary care teaching hospital over a period of six months. A total of 80 patients diagnosed with STEMI were included, comprising 40 diabetic and 40 non-diabetic patients. Data regarding demographic characteristics, risk factors, clinical presentation, electrocardiographic findings, echocardiographic parameters, in-hospital complications, and mortality were collected using a predesigned proforma. Statistical analysis was performed using appropriate tests, and a p value of less than 0.05 was considered statistically significant.

Results: Diabetic patients presented at a significantly higher mean age compared to non-diabetic patients. Silent or painless myocardial infarction was significantly more common among diabetics. Extensive anterior wall myocardial infarction and reduced left ventricular ejection fraction were observed more frequently in the diabetic group. Diabetic patients had a higher prevalence of systemic hypertension and higher Killip class at presentation. In-hospital complications, including cardiac failure and life-threatening arrhythmias, were significantly more frequent among diabetic patients. In-hospital mortality was higher in diabetics compared to non-diabetics.

Conclusion: Diabetes mellitus is associated with an adverse clinical profile and poorer in-hospital outcomes in patients with STEMI. Early recognition of atypical presentations and aggressive management strategies are essential to improve short-term outcomes in diabetic patients with STEMI.

Keywords: ST-Elevation Myocardial Infarction, Diabetes Mellitus, Silent Myocardial Infarction, In-Hospital Outcomes, Left Ventricular Dysfunction, Killip Classification.

INTRODUCTION

ST-elevation myocardial infarction (STEMI) remains one of the most severe manifestations of acute coronary syndrome and continues to be a leading cause of in-hospital morbidity and mortality worldwide. Despite advances in reperfusion strategies and pharmacological therapy, outcomes after STEMI vary significantly depending on patient-

related risk factors, among which diabetes mellitus plays a critical role. Diabetes mellitus is a well-established independent risk factor for coronary artery disease and is consistently associated with worse clinical outcomes following STEMI. Multiple studies have demonstrated that patients with diabetes presenting with STEMI have higher rates of in-hospital complications and mortality compared to non-diabetic patients, even when treated with contemporary reperfusion strategies such as primary percutaneous coronary intervention (PCI) (Schaaf et al., 2005) (Dziewierz et al., 2022) [1,2].

Diabetic patients often exhibit atypical or silent presentations of myocardial infarction due to



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autonomic neuropathy, which may delay diagnosis and timely reperfusion, thereby worsening prognosis (Chandiramani & Mehran, 2019) [3]. In addition, diabetes is associated with diffuse multivessel coronary artery disease, impaired microvascular perfusion, endothelial dysfunction, and a pro-thrombotic state, all of which contribute to adverse in-hospital outcomes following STEMI (Claessen et al., 2010) [4].

It has also been demonstrated that hyperglycemia upon presentation, whether brought on by pre-existing diabetes or a stress reaction, is a significant predictor of greater myocardial injury, cardiogenic shock, and worse in-hospital mortality in patients with STEMI (Khalfallah et al., 2020) [5]. Additionally, in-hospital mortality and comorbidities are substantially higher in diabetic patients with acute metabolic decompensation, such as diabetic ketoacidosis or hyperosmolar states during STEMI (Almutairi et al., 2025) [6].

A comparison of STEMI patients with and without diabetes is crucial because of these variations in clinical presentation, infarct features, and early prognosis. For diabetic patients who come with STEMI, understanding differences in symptom profile, infarct site, comorbidities, and in-hospital mortality may aid in early detection, risk classification, and management strategy optimization. Therefore, the purpose of this study is to compare the clinical characteristics and in-hospital outcomes of STEMI in patients with and without diabetes in a tertiary care setting.

MATERIALS AND METHODS

Study Design

The present study was conducted as a cross-sectional analytical study to compare the clinical profile and in-hospital outcomes of ST-elevation myocardial infarction in diabetic and non-diabetic patients in the Departments of General Medicine and Cardiology in a tertiary care hospital at Ariyur, Puducherry.

Study Duration

The study was conducted over a period of six months after obtaining approval from the Scientific Research Committee and the Institutional Ethics Committee. Written informed consent was obtained from all participants in English and the local language. Patient confidentiality was maintained, and no additional invasive procedures were performed solely for research purposes.

Study Population and Sample Size

All adult patients aged more than 18 years admitted with a diagnosis of ST-elevation myocardial infarction during the study period were screened for eligibility. A total of 80 patients were included in the study, comprising 40 diabetic and 40 non-diabetic patients. Consecutive sampling was adopted, and eligible patients were enrolled until the required

sample size was achieved.

Diagnostic Criteria

ST-elevation myocardial infarction was diagnosed based on the presence of characteristic ST-segment elevation in at least two contiguous leads on a 12-lead electrocardiogram along with compatible clinical symptoms suggestive of acute myocardial infarction.

Diabetes mellitus was defined as a known history of diabetes on treatment or newly diagnosed diabetes based on glycated hemoglobin (HbA1c) \geq 6.5 percent or fasting plasma glucose \geq 126 mg/dL. Non-diabetic patients were defined as those without a prior diagnosis of diabetes and having HbA1c $<$ 6.5 percent. HbA1c was measured in all patients, including those without a prior history of diabetes, to assess glycemic status and detect previously undiagnosed diabetes or prediabetes.

Inclusion Criteria

Patients aged more than 18 years with electrocardiographically confirmed ST-elevation myocardial infarction who provided informed consent were included in the study.

Exclusion Criteria

Patients with a prior history of myocardial infarction, previous coronary revascularization (PCI or CABG), cardiogenic shock at presentation, severe valvular or structural heart disease, end-stage renal disease, or contraindications to standard STEMI therapy were excluded from the study.

Data Collection and Clinical Assessment

Data were collected using a pre-designed semi-structured proforma. Sociodemographic details including age, sex, and occupation were recorded. A detailed clinical history was obtained with emphasis on presenting symptoms such as chest pain, breathlessness, palpitations, and syncope. Duration of diabetes and treatment compliance were documented among diabetic patients.

A thorough general and systemic examination was performed at admission. Pulse rate, blood pressure, and cardiovascular findings were recorded. Killip classification was assessed at presentation based on clinical signs of heart failure [7].

Assessment of Cardiovascular Risk Factors

Cardiovascular risk factors including systemic hypertension, smoking status, dyslipidemia, and family history of coronary artery disease were evaluated. Dyslipidemia was defined as abnormal lipid profile values or prior use of lipid-lowering therapy. A positive family history of coronary artery disease was defined as documented coronary artery disease in a first-degree relative before 55 years in males or 65 years in females.

Laboratory Investigations

All patients underwent laboratory investigations at admission, including fasting blood sugar, random blood sugar, glycated hemoglobin (HbA1c), and a

complete lipid profile comprising total cholesterol, LDL cholesterol, HDL cholesterol, and triglycerides. High-sensitivity C-reactive protein (hs-CRP) was measured in all patients to assess systemic inflammatory status and its association with clinical outcomes.

Electrocardiographic Evaluation

A standard 12-lead electrocardiogram was performed at admission to confirm the diagnosis of STEMI and to localize the infarct territory. Infarct location was categorized as anterior wall, inferior wall, lateral wall, posterior wall, or extensive anterior wall myocardial infarction based on electrocardiographic findings.

Echocardiographic Evaluation

Two-dimensional echocardiography was performed during hospitalization to evaluate regional wall motion abnormalities and to calculate left ventricular ejection fraction. Left ventricular systolic function was categorized according to ejection fraction values. Killip classification was correlated with echocardiographic findings.

Treatment and Outcome Assessment

All patients received treatment as per standard institutional protocol, including thrombolysis, coronary angiography, and percutaneous coronary intervention when indicated. Patients were monitored throughout hospitalization. In-hospital outcomes including cardiac failure, life-threatening arrhythmias, pericarditis, thromboembolic events, duration of hospital stay, and mortality were recorded.

Statistical Analysis

Data were entered into a master chart and analyzed using appropriate statistical software. Continuous variables were expressed as mean \pm standard deviation, while categorical variables were expressed as frequencies and percentages. Independent t-test was used to compare continuous variables between diabetic and non-diabetic groups. Chi-square test or Fisher's exact test was used to analyze categorical variables. A p-value less than 0.05 was considered statistically significant.

RESULTS

Study Population

A total of 80 patients diagnosed with ST-elevation myocardial infarction were included in the study. Among them, 40 patients (50%) were classified as diabetic and 40 patients (50%) as non-diabetic based on clinical history and HbA1c criteria.

Demographic Characteristics

Baseline demographic characteristics of the study population were given in table 1. The mean age of diabetic patients was 59.2 ± 8.6 years, whereas the mean age in the non-diabetic group was 51.4 ± 7.9 years. This difference was statistically significant ($p < 0.05$). The majority of diabetic patients (80%) were aged ≥ 50 years, while a greater proportion of non-

diabetic patients (45%) were below 50 years of age. Males constituted the majority in both groups; however, female representation was higher in the diabetic group (35%) compared to the non-diabetic group (20%), and this difference reached statistical significance ($p < 0.05$).

Cardiovascular Risk Factor Profile

Cardiovascular risk and biochemical profile given in table 2 shows that systemic hypertension was significantly more prevalent among diabetic patients (70%) compared to non-diabetic patients (40%) ($p < 0.05$). In contrast, smoking was more commonly observed among non-diabetic patients (65%) than diabetic patients (35%) ($p < 0.05$).

Dyslipidemia was identified in 60% of diabetic patients compared to 35% of non-diabetic patients, demonstrating a statistically significant difference ($p < 0.05$). A positive family history of coronary artery disease was present in 45% of diabetic patients and 25% of non-diabetic patients ($p < 0.05$).

Clustering of two or more major cardiovascular risk factors was significantly more common among diabetic patients (65%) compared to non-diabetic patients (45%) ($p < 0.05$), indicating a higher cumulative cardiovascular risk burden among diabetics.

Glycemic Status and Inflammatory Markers

The mean HbA1c among diabetic patients was $8.4 \pm 1.2\%$, significantly higher than the non-diabetic group ($5.6 \pm 0.4\%$) ($p < 0.001$). Among non-diabetic patients, 30% were found to have HbA1c values in the prediabetic range (5.7–6.4%), despite no prior diagnosis of diabetes.

Fasting blood glucose and random blood glucose values were significantly elevated in diabetic patients compared to non-diabetic patients ($p < 0.001$).

High-sensitivity C-reactive protein (hs-CRP) levels were markedly elevated among diabetic patients, with a mean value of 6.8 ± 2.1 mg/L compared to 3.9 ± 1.6 mg/L in non-diabetic patients ($p < 0.001$), indicating a higher inflammatory burden in the diabetic group.

Lipid Profile

Mean triglyceride levels were significantly higher among diabetic patients compared to non-diabetic patients ($p < 0.05$). HDL cholesterol levels were significantly lower in diabetic patients ($p < 0.05$). LDL cholesterol levels were moderately elevated in diabetics but did not show a statistically significant difference when compared to non-diabetics.

These findings indicate a pattern consistent with diabetic dyslipidemia characterized by elevated triglycerides and reduced HDL cholesterol.

Clinical Presentation

Typical chest pain was reported in 75% of non-diabetic patients compared to 45% of diabetic patients ($p < 0.05$). Silent or painless myocardial infarction was significantly more common among diabetic patients (55%) compared to non-diabetic patients (25%) ($p < 0.05$).

Breathlessness as a primary symptom was observed in 40% of diabetic patients compared to 20% of non-diabetic patients ($p < 0.05$). Syncope and palpitations were less frequently observed and did not demonstrate statistically significant differences (Figure 1 & Table 3).

Electrocardiographic Findings and Echocardiographic Assessment

Anterior wall myocardial infarction was the most frequent infarct location in both groups. Extensive anterior wall myocardial infarction was significantly more common among diabetic patients (30%) compared to non-diabetic patients (15%) ($p < 0.05$). Inferior wall myocardial infarction was more frequently observed in non-diabetic patients (40%) compared to diabetic patients (20%) ($p < 0.05$). Lateral and posterior wall infarctions were less common and did not show significant intergroup differences.

The mean left ventricular ejection fraction was significantly lower in diabetic patients ($43.6 \pm 7.4\%$) compared to non-diabetic patients ($49.8 \pm 6.9\%$) ($p < 0.05$).

Left ventricular systolic dysfunction (LVEF $< 40\%$) was observed in 35% of diabetic patients compared to 15% of non-diabetic patients ($p < 0.05$). Regional wall motion abnormalities were more extensive among diabetic patients (85%) compared to non-diabetic patients (65%) ($p < 0.05$) (Table 4 & 5).

Higher Killip class (II–IV) at presentation was significantly more common among diabetic patients (65%) compared to non-diabetic patients (40%) ($p < 0.05$), indicating more severe hemodynamic compromise at admission [7].

In-Hospital Complications

In-hospital complications were observed in 60% of diabetic patients compared to 35% of non-diabetic patients ($p < 0.05$).

Cardiac failure was significantly more common in diabetics (35%) than in non-diabetics (15%) ($p < 0.05$). Life-threatening arrhythmias were observed in 25% of diabetic patients compared to 10% of non-diabetic patients ($p < 0.05$).

Pericarditis and thromboembolic events occurred more frequently among diabetic patients; however, the differences did not achieve statistical significance (Table 6).

In-Hospital Mortality and Duration of Stay

The mean duration of hospital stay was significantly longer among diabetic patients (7.6 ± 2.1 days) compared to non-diabetic patients (5.8 ± 1.7 days) ($p < 0.05$).

In-hospital mortality was significantly higher among diabetic patients (20%) compared to non-diabetic patients (5%) ($p < 0.05$) (Table 7, Figure2).

Among patients who expired, the majority had higher Killip class at presentation, reduced ejection fraction, elevated hs-CRP levels, and multiple cardiovascular risk factors (Figure3).

Table 1: Baseline demographic characteristics of the study population

Variable	Diabetic group (n = 40)	Non-diabetic group (n = 40)	P value
Mean age (years)	59.2 ± 8.6	51.4 ± 7.9	< 0.05
Age group < 50 years	8 (20%)	18 (45%)	
Age group ≥ 50 years	32 (80%)	22 (55%)	
Male	26 (65%)	32 (80%)	
Female	14 (35%)	8 (20%)	
Occupation (manual workers)	22 (55%)	25 (62.5%)	NS

Table 2: Cardiovascular risk and biochemical profile

Variable	Diabetic (n=40)	Non-diabetic (n=40)	P value
Hypertension	28 (70%)	16 (40%)	< 0.05
Smoking	14 (35%)	26 (65%)	< 0.05
Dyslipidemia	24 (60%)	14 (35%)	< 0.05
Family history of CAD	18 (45%)	10 (25%)	< 0.05
Mean HbA1c (%)	8.4 ± 1.2	5.6 ± 0.4	< 0.001
Mean hs-CRP (mg/L)	6.8 ± 2.1	3.9 ± 1.6	< 0.001
≥ 2 risk factors	26 (65%)	18 (45%)	< 0.05

Table 3: Clinical presentation of STEMI in study groups

Presenting symptom	Diabetic group (n = 40)	Non-diabetic group (n = 40)	P value
Typical chest pain	18 (45%)	30 (75%)	< 0.05
Silent / painless MI	22 (55%)	10 (25%)	< 0.05
Breathlessness	16 (40%)	8 (20%)	< 0.05
Syncope	6 (15%)	2 (5%)	NS
Palpitations	5 (12.5%)	4 (10%)	NS

Table 4: Electrocardiographic infarct location

Infarct location	Diabetic group (n = 40)	Non-diabetic group (n = 40)	P value
Anterior wall MI	16 (40%)	12 (30%)	
Extensive anterior wall MI	12 (30%)	6 (15%)	<0.05
Inferior wall MI	8 (20%)	16 (40%)	<0.05
Lateral wall MI	3 (7.5%)	4 (10%)	NS
Posterior wall MI	1 (2.5%)	2 (5%)	NS

Table 5: Echocardiographic findings and Killip classification

Parameter	Diabetic group (n = 40)	Non-diabetic group (n = 40)	P value
Mean LVEF (%)	43.6 ± 7.4	49.8 ± 6.9	<0.05
LVEF <40%	14 (35%)	6 (15%)	<0.05
RWMA present	34 (85%)	26 (65%)	<0.05
Killip class I	14 (35%)	24 (60%)	
Killip class II-IV	26 (65%)	16 (40%)	<0.05

Table 6: In-hospital complications

Complication	Diabetic group (n = 40)	Non-diabetic group (n = 40)	P value
Cardiac failure	14 (35%)	6 (15%)	<0.05
Life-threatening arrhythmia	10 (25%)	4 (10%)	<0.05
Pericarditis	4 (10%)	2 (5%)	NS
Thromboembolism	3 (7.5%)	1 (2.5%)	NS
Any complication	24 (60%)	14 (35%)	<0.05

Table 7: In-hospital outcomes and mortality

Outcome	Diabetic group (n = 40)	Non-diabetic group (n = 40)	P value
Mean hospital stay (days)	7.6 ± 2.1	5.8 ± 1.7	<0.05
Survived	32 (80%)	38 (95%)	
In-hospital mortality	8 (20%)	2 (5%)	<0.05

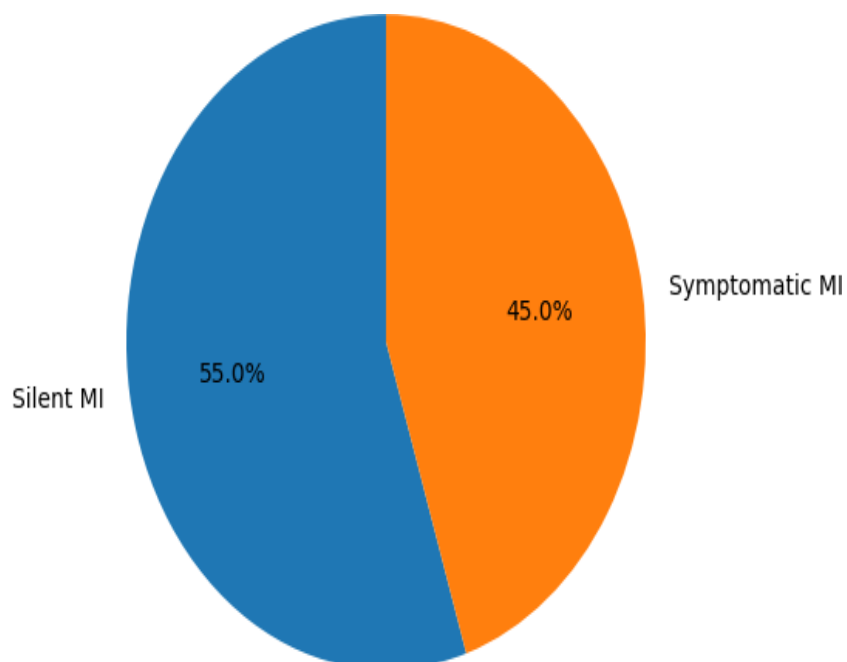


Figure 1 - Clinical Presentation of STEMI in Diabetic Patients

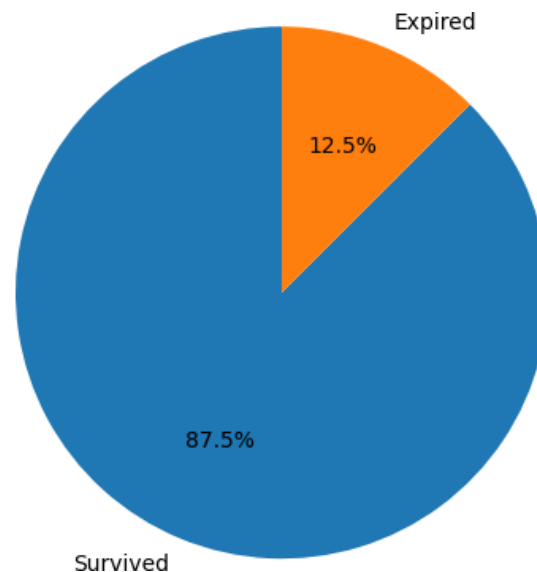


Figure 2 - In-hospital Outcome in Study Population

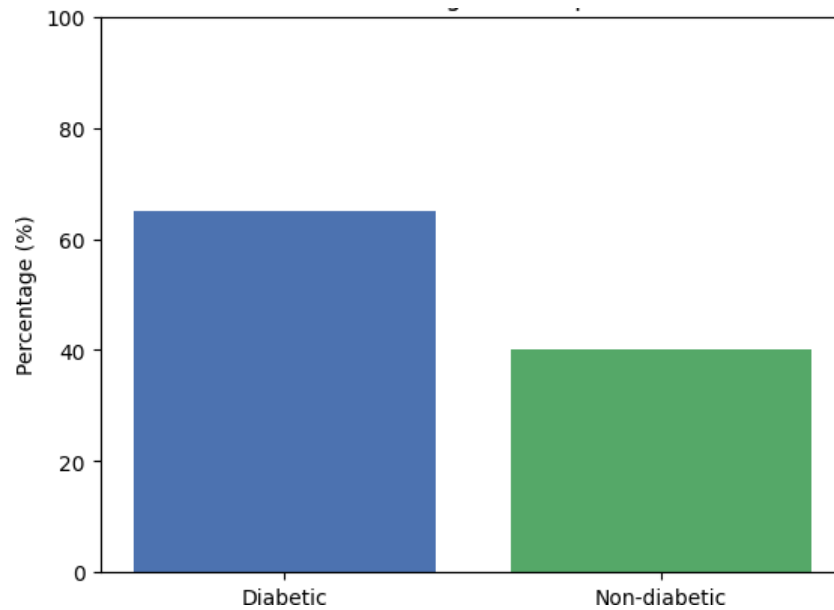


Figure 3 - Patients Presenting with Killip Class II-IV

DISCUSSION

In the present study, diabetic patients with ST-elevation myocardial infarction demonstrated a distinct clinical profile and significantly worse in-hospital outcomes compared to non-diabetic patients. These findings reinforce the well-established role of diabetes mellitus as an independent determinant of adverse cardiovascular outcomes in acute myocardial infarction.

Diabetic patients had a considerably greater mean age at presentation than non-diabetic patients. This finding is in line with earlier research demonstrating that while diabetes speeds up atherosclerosis,

symptoms of coronary artery disease may manifest later because of altered pain perception and slow disease progression, which can result in myocardial infarction later in life (Dziewierz et al., 2022) [2]. The increased proportion of female patients with diabetes provides more evidence that diabetes negates the cardioprotective benefits of estrogen, raising cardiovascular risk and enhancing outcomes for women (Chandiramani & Mehran, 2019) [3]. Significantly higher prevalence of systemic hypertension among diabetic patients was observed in this study, reflecting the clustering of cardiovascular risk factors commonly seen in diabetes. Conversely, smoking was more prevalent

among non-diabetic patients, indicating differing risk profiles between the two groups. Similar patterns have been reported in large observational studies where diabetes frequently coexists with hypertension and dyslipidemia, contributing to increased cardiovascular morbidity (Claessen et al., 2010) [4].

In the present study, painless or silent myocardial infarction was significantly more common among diabetic patients. This finding aligns with earlier reports attributing atypical presentation in diabetics to autonomic neuropathy and impaired nociception, which often result in delayed hospital presentation and delayed initiation of reperfusion therapy (Schaaf et al., 2005) [1]. Breathlessness as a presenting symptom was also more frequent among diabetics, likely reflecting early left ventricular dysfunction and diastolic impairment.

Electrocardiographic analysis revealed that extensive anterior wall myocardial infarction was more common among diabetic patients, whereas inferior wall myocardial infarction predominated in non-diabetics. This pattern has been described in previous studies and may be related to diffuse multivessel coronary artery disease and involvement of the left anterior descending artery in diabetics (Claessen et al., 2010) [4]. Diabetic patients are known to have more extensive coronary involvement with impaired collateral formation, leading to larger infarct sizes.

Echocardiographic findings in the present study showed significantly lower left ventricular ejection fraction and more extensive regional wall motion abnormalities among diabetic patients. These findings are consistent with earlier studies demonstrating that diabetes is associated with diabetic cardiomyopathy, microvascular dysfunction, and impaired myocardial recovery following infarction (Chandiramani & Mehran, 2019) [3]. Higher Killip classes at presentation among diabetics further indicate a greater degree of hemodynamic compromise and heart failure at admission [7].

This study found that diabetes individuals were much more likely to experience in-hospital problems such as heart failure and life-threatening arrhythmias. These results are consistent with earlier research showing that diabetes is linked to increased myocardial susceptibility during acute ischemia, autonomic imbalance, and electrical instability (Dziewierz et al., 2022) [2]. Due to the combined effects of metabolic abnormalities, delayed presentation, and severe cardiac involvement, the total complication risk was significantly higher in diabetics.

In-hospital mortality was significantly higher among diabetic patients compared to non-diabetic patients. This observation is consistent with multiple large-

scale studies and registries that have identified diabetes as a strong independent predictor of short-term and long-term mortality following STEMI (Schaaf et al., 2005) (Dziewierz et al., 2022) [1,2]. The longer duration of hospital stay among diabetics further reflects increased morbidity and resource utilization in this high-risk group.

CONCLUSIONS

Diabetes mellitus significantly influences the clinical presentation and in-hospital outcomes of patients with ST-elevation myocardial infarction. Diabetic patients tend to present at an older age, more frequently with silent myocardial infarction, extensive anterior wall involvement, reduced left ventricular function, and higher Killip class. They experience a greater burden of in-hospital complications and significantly higher mortality compared to non-diabetic patients. Early recognition of atypical presentations, aggressive risk stratification, and optimized management strategies are essential to improve outcomes in diabetic patients presenting with STEMI.

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