

because it deals with the difficult-to-solve technical issues of high dilutions, hormesis and paradoxical reversal of the effects of drugs. One would therefore expect the related questions to be addressed not through subjective opinions and jeering, but rather on the experiential ground, through patient and critical comparison of data and results.

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Disclosure

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LETTER

Short-term mortality in acute coronary syndrome: effect of dysglycaemia and smoking

To the Editor:

Coronary artery disease (CAD) is a major cause of morbidity and mortality burden in the developing world, including India (1).

There is growing evidence that dysglycaemia, irrespective of the history of diabetes, is associated with adverse outcomes in coronary artery bypass graft surgery patients (2–4).

Diabetes mellitus or impaired glucose tolerance, smoking or tobacco use in any form, not only predisposes to development of acute coronary syndrome (ACS) but also affects the

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Table 1 Mortality in different subgroups

Sex	Euglycaemic and non-smokers			Euglycaemics and smokers			Dysglycaemic and non-smokers			Dysglycaemic and smokers		
	Total	Mortality	Per cent	Total	Mortality	Per cent	Total	Mortality	Per cent	Total	Mortality	Per cent
Female	41	5	12.2	1	1	100	43	4	9.3	5	2	40
Male	79	6	7.6	99	10	10.1	15	1	6.7	81	9	11.1

long-term prognosis of the patients; however, their effect on short-term prognosis is not well assessed. Therefore, this study was planned to describe the potential effect of dysglycaemia and smoking on short-term mortality in patients with ACS.

Short-term mortality data (during first week of acute coronary episode) of 364 patients with ACS were collected from the coronary care unit (CCU) of our hospital over a period of 7 months (January–July 2009). These cases were then analysed as regards to their smoking and dysglycaemic status. The fasting and 2 h postprandial blood glucose levels were used to assess the glycaemic status of the patients after the CCU admission.

Out of 364 CAD patients, 144 (39.5%) patients were having dysglycaemia, and 86 (59.7%) of dysglycaemic patients were smokers. Mortality appears higher in the presence of both smoking and dysglycaemia, with potential gender differences in effects (see Table 1). Glycometabolic state at hospital admission is an important risk marker for mortality in patients with acute myocardial infarction, whether or not they have known diabetes mellitus. The presence of elevated blood glucose levels, diabetes mellitus or both contributes to more than 3 million cardiovascular deaths worldwide each year (5).

Both acute phase hyperglycaemia (stress hyperglycaemia) and diabetes are associated with adverse outcomes in ACS (6,7).

Our descriptive data support the idea that dysglycaemia and smoking status potentially accounts for excess mortality. Both smoking and dysglycaemia are modifiable risk factors, which can be controlled by lifestyle modification in many patients.

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LETTER

The complexity of managing an ageing population

Linked Comment: Arendts. *Int J Clin Pract* 2014; **68**: 406.

To the Editor:

The paper by Arendts et al. examining the impact of allied health intervention in older patients highlights the complexity of managing an ageing population. Their robust study suggests that early multidisciplinary assessment does not shorten length of stay (1). However, using length of stay alone may not accurately represent the value of such

assessment: comprehensive, multidisciplinary assessment has been shown to have an impact on other indices such as mortality or institutionalisation (2). As Arendts notes, factors that contribute to inpatient length of stay include increasing age, disability and complexity. Indeed, as pressure mounts to deliver services efficiently, patients with less complex needs are increasingly managed in ambulatory

or day-care settings (3). This will have the unintended effect of increasing average inpatient length of stay as the proportion of inpatients with complex needs grows.

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