

1-year survival decreased in a similar fashion ($P < 0.001$ for both). Hyperglycemia also correlated with the presence of left ventricular failure on admission. Poor outcomes were associated with hyperglycemia in a number of patient subsets, including those with or without the following conditions: ST-segment elevation MI, heart failure on admission, or reperfusion therapy.

The authors outline some factors that might have influenced their results, including the possibility that many hyperglycemic nondiabetic patients are undiagnosed diabetics. They conclude, however, that metabolic control of blood glucose should be a therapeutic target in nondiabetic patients with acute MI, and not just in those with diabetes and MI. How this goal is to be achieved is yet to be determined.

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Original article Kadri Z *et al.* (2005) Major impact of admission glycaemia on 30-day and one-year mortality in non diabetic patients admitted for myocardial infarction: results from the nationwide French USIC 2000 study. *Heart* [doi: 10.1136/hrt.2005.073791]

Delayed ASD closure could benefit asymptomatic children

Atrial septal defect (ASD) can cause chronic right chamber volume overload, leading to arrhythmias and impaired left ventricular function. ASD closure has been shown to be less effective after long-term volume overload, leading to the belief that early intervention is best, even in asymptomatic patients. The procedure is associated with risks, however, especially in the very young. Santoro *et al.* suggest that up to early adulthood, age does not affect the extent of cardiac remodeling following percutaneous ASD closure, and that the benefits of delayed closure could outweigh any potential risks.

In this nonrandomized study, 46 asymptomatic patients with ASD diameter >20 mm, an invasively measured pulmonary to systemic circulation flow ratio ($Q_p:Q_s$) of $>1.5:1$, or both, underwent transcatheter closure between March 2000 and March 2004 (25 aged <16 years [median 8 years], and 21 aged >16 years [median 38 years]). In both age-groups, right chamber size reduced to normal size within just a few weeks. At

6 months there were no significant differences between the two age-groups in either time course or extent of cardiac remodeling. Both groups displayed increases in left ventricular transverse diameter ($P < 0.05$) and reductions in right atrial volume, right ventricular transverse diameter and right ventricular : left ventricular diameter ratio ($P < 0.001$ for all). Left atrial volume and left ventricular ejection fraction did not change significantly in either group.

The authors conclude that positive cardiac remodeling begins very soon after percutaneous closure of large ASD, and is unaffected by the magnitude and duration of volume overload. Additional, longer-term studies are needed, with larger patient populations and more-specific endpoints.

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Original article Santoro G *et al.* (2005) Similar cardiac remodelling after transcatheter atrial septal defect closure in children and young adults. *Heart* [doi: 10.1136/hrt.2005.070169]

ICD therapy for patients with arrhythmogenic right ventricular dysplasia

Although recent studies have proved that implantable cardioverter-defibrillators (ICDs) can prevent sudden cardiac death (SCD) in patients with arrhythmogenic right ventricular dysplasia (ARVD), the risk factors for SCD and indications for placement of these devices are not clearly defined. ICDs can be implanted for primary prevention of SCD when patients have a history of syncope or nonsustained ventricular arrhythmia, or for secondary prevention following sustained ventricular arrhythmia.

Piccini *et al.* evaluated the degree of benefit to patients from ICD placement, in terms of event-free survival at follow-up (mean 4.4 ± 2.9 years). They studied a series of 67 patients diagnosed with definite ($n=55$) or probable ($n=12$) ARVD according to international task force criteria.

Their analyses showed that patients with definite ARVD gained the most benefit from ICD placement, as 40 (73%) individuals received an appropriate intervention in response to an episode of ventricular tachycardia, ventricular fibrillation or both. Almost one-third of patients with probable ARVD also received