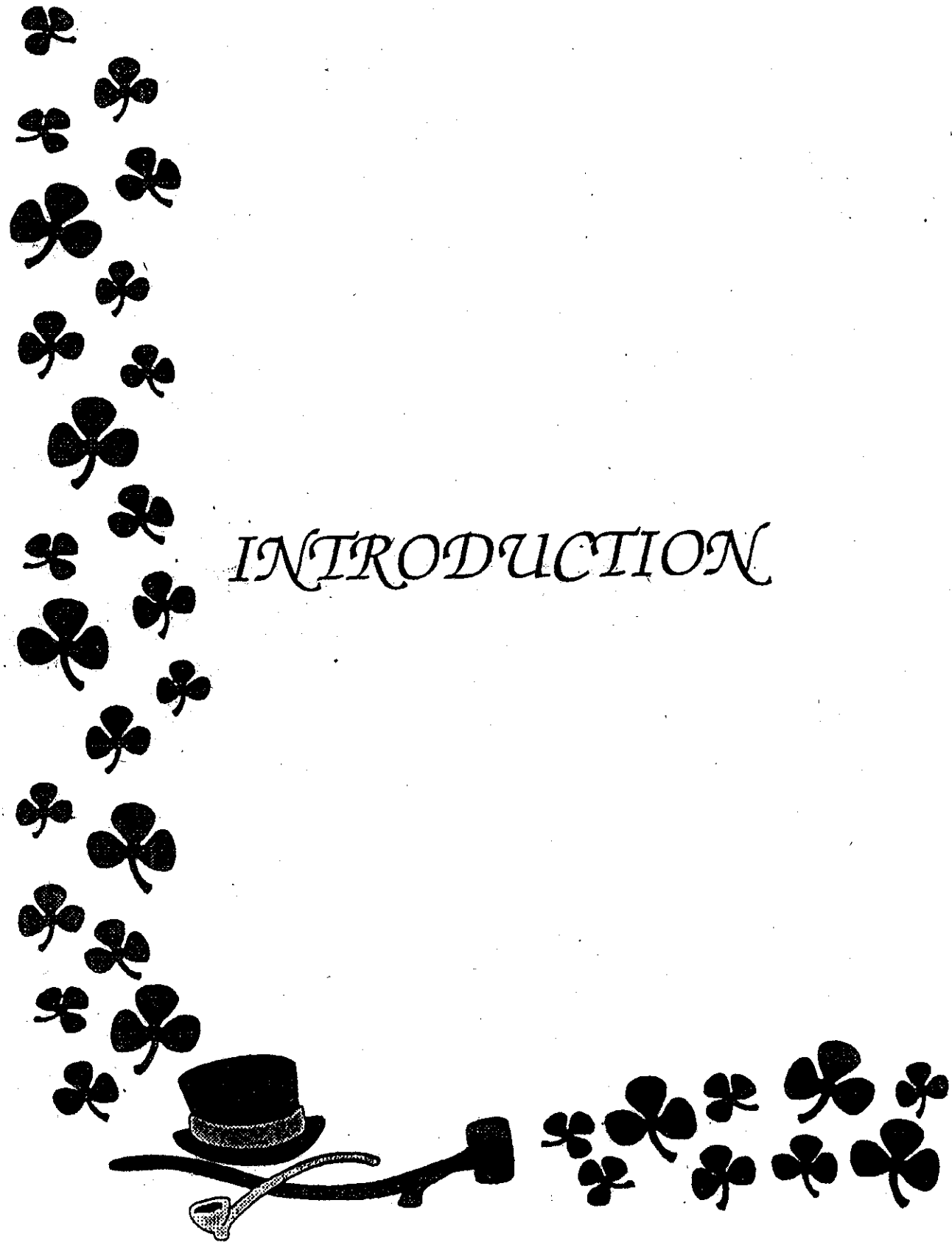
# INTRODUCTION



# *INTRODUCTION*

*Weiner et al., (1987)* defined silent coronary artery disease as exereise induced ST segment depression without chest pain, but there is controvrsy regarding its mechanism and prognostic significance.

*Cohn, (1985)* has proposed three types classification for silent myocardial ischemia, type I are totally asympatomatic subject. Type II occurs in patients asymptomatic after myocardial infarction and type III are patients with angina who have additional episodes of myocardial ischaemia that are silent. Little is known about the prognosis of type I, the norwegian study however confirms that asymptomatic patient with exercise induced silent myocardial ischemia developed angina or infarction and they recommended angiography for these asympatomatic patients, especially in the presence of multiple coronary risk factors *(Reisman et al., 1985)*.

Patients with D.M have an increased risk for cardiovascular disease and myocardial infarction. Acute myocardial infarction in diabetics may present without pain or with acute acidosis, sudden hypotenion, syncope, vomiting or cerebrovascular accidant *(Niakan, 1986)*.

The prevalence of painless myocardial ischemia in diabetics compaired with non diabetics was found to be increased by some investigators *(Nesto, 1988)* but not by others *(Chipkin et al., 1987)*.

Autonomic neuropathy is associated with an increased incidence of silent myocardial ischaemia and sudden death due to impaired sensation of pain *(O'Sullivan JJ et al., 1991)*.

## *Aim of The Work*

Is to assess the silent ischaemic changes via E.C.G. studies and its relation to autonomic neuropathy which will be proved via clinical tests.