INTRODUCTION

Acute coronary syndrome (ACS) covers the spectrum of clinical conditions ranging from unstable angina (UA) to ST-segment elevation myocardial infarction (STEMI) and non ST-segment elevation myocardial infarction (NSTEMI). Coronary artery disease (CAD) remains the leading cause of death in the world. One of every 5 deaths is due to CAD, accounting for more than 452 000 deaths in 2006. [1] Diabetes is a significant risk factor for ACS and adds to the overall burden of cardiovascular disease. [2]

People with diabetes mellitus (DM) have an increased prevalence of atherosclerosis and coronary artery disease and experience higher morbidity and mortality after ACS than people without DM. [3] Diabetes significantly increases all-cause death and the incidence of new MI, stroke, heart failure during a 2-year mean follow up in patients who were hospitalized for ACS. [3]

The availability of cardiac markers with enhanced sensitivity for myocardial damage enables clinician to diagnose myocardial infarction (MI), [4] as well as risk stratification of ACS patient. Abnormal levels of creatin kinase myocardial band

fraction (CK-MB), cardiac troponin I (cTnI), cardiac troponin T (cTnT) predict increased risk of complications, [5] even if patients do not have CK-MB elevation, cTnT and cTnI aid early risk stratification in patients with ACS, particularly those without ST segment elevation. [6]