

**New concept of myocardial longitudinal strain reserve assessed by a dipyridamole infusion using 2D-strain echocardiography: the impact of diabetes and age, and the prognostic value.**

Thomas Cognet, Paul-Louis Vervueren, Laurent Dercle, Delphine Bastié, Rainui Richaud, Matthieu Berry, Pauline Marchal, Matthieu Gautier, Audrey Fouilloux, Michel Galinier, et al.

► **To cite this version:**

Thomas Cognet, Paul-Louis Vervueren, Laurent Dercle, Delphine Bastié, Rainui Richaud, et al.. New concept of myocardial longitudinal strain reserve assessed by a dipyridamole infusion using 2D-strain echocardiography: the impact of diabetes and age, and the prognostic value.. Cardiovascular Diabetology, BioMed Central, 2013, 12 (1), pp.84. 10.1186/1475-2840-12-84 . inserm-00835538

**HAL Id: inserm-00835538**

**<https://www.hal.inserm.fr/inserm-00835538>**

Submitted on 19 Jun 2013

**HAL** is a multi-disciplinary open access archive for the deposit and dissemination of scientific research documents, whether they are published or not. The documents may come from teaching and research institutions in France or abroad, or from public or private research centers.

L'archive ouverte pluridisciplinaire **HAL**, est destinée au dépôt et à la diffusion de documents scientifiques de niveau recherche, publiés ou non, émanant des établissements d'enseignement et de recherche français ou étrangers, des laboratoires publics ou privés.

**ORIGINAL INVESTIGATION**

**Open Access**

# New concept of myocardial longitudinal strain reserve assessed by a dipyridamole infusion using 2D-strain echocardiography: the impact of diabetes and age, and the prognostic value

Thomas Cognet<sup>1,2,3,7\*</sup>, Paul-Louis Vervueren<sup>2,4</sup>, Laurent Derclé<sup>1</sup>, Delphine Bastié<sup>1,3</sup>, Rainui Richaud<sup>1,3</sup>, Matthieu Berry<sup>2,3</sup>, Pauline Marchal<sup>1,2,3</sup>, Matthieu Gautier<sup>2,3</sup>, Audrey Fouilloux<sup>1,2,3</sup>, Michel Galinier<sup>2,5</sup>, Didier Carrié<sup>2,3,6</sup>, Pierre Massabuau<sup>2,3</sup>, Isabelle Berry<sup>1,5</sup> and Olivier Lairez<sup>1,2,3</sup>

## Abstract

**Aims:** Although dipyridamole is a widely used pharmacological stress agent, the direct effects on myocardium are not entirely known. Diabetic cardiomyopathy can be investigated by 2D-strain echocardiography. The aim of this study was to assess myocardial functional reserve after dipyridamole infusion using speckle-tracking echocardiography.

**Methods:** Seventy-five patients referred for dipyridamole stress myocardial perfusion gated SPECT (MPGS) were examined by echocardiography to assess a new concept of longitudinal strain reserve (LSR) and longitudinal strain rate reserve (LSRR) respectively defined by the differences of global longitudinal strain (GLS) and longitudinal strain rate between peak stress after dipyridamole and rest. Twelve patients with myocardial ischemia were excluded on the basis of MPGS as gold standard.

**Results:** Mean LSR was  $-2.28 \pm 2.19\%$  and was more important in the 28 (44%) diabetic patients ( $-3.27 \pm 1.93\%$ ;  $p = 0.001$ ). After multivariate analyses, only diabetes improved LSR ( $p = 0.011$ ) after dipyridamole infusion and was not associated with glycaemic control ( $p = 0.21$ ), insulin therapy ( $p = 0.46$ ) or duration of the disease ( $p = 0.80$ ). Conversely, age ( $p = 0.002$ ) remained associated with a decrease in LSR. LSRR was also correlated to age ( $p = 0.005$ ). Patients with a LSR  $< 0\%$  have a better survival after 15 months (log-rank  $p = 0.0012$ ).

**Conclusion:** LSR explored by 2D speckle-tracking echocardiography after dipyridamole infusion is a simple and new concept that provides new insights into the impact of diabetes and age on the myocardium with a potential prognostic value.

**Keywords:** Dipyridamole, Speckle-tracking echocardiography, Diabetes, Strain reserve

## Introduction

Dipyridamole is a widely used pharmacological agent to test coronary reserve in patients referred for stress myocardial perfusion imaging. The mechanism of stress with dipyridamole implies a coronary vasodilatation, which leads to the detection of myocardial ischemia through

coronary steal phenomena. Dipyridamole mainly increases the flow supply in the subendocardial layer by decreasing vascular resistance [1], but the resulting effects on myocardium and especially on myocardial strain have not been explored yet. The myocardial functional reserve between peak stress and rest reflects the ability of the myocardium to improve its function during stress testing. Stress testing is recommended in order to detect myocardial ischemia [2], but the role of the myocardial functional reserve during stress remains undervalued even if it provides important information in some

\* Correspondence: thomascognet31@gmail.com

<sup>1</sup>Department of Nuclear Medicine, University Hospital of Rangueil, Toulouse, France

<sup>2</sup>Department of Cardiology, University Hospital of Rangueil, Toulouse, France  
Full list of author information is available at the end of the article

situations such as hypertrophic cardiomyopathy or hypothyroidism [3,4]. At the same time, the ability of two-dimensional (2D) strain echocardiography to precisely assess myocardial function provides new possibilities for an accurate measurement of the myocardial function reserve in stress conditions [5,6] and especially in diabetes in which longitudinal strain is altered at baseline [7]. Actually, diabetic patients have early myocardial damage at baseline that requires to be detected by means of modern tools such as biomarkers and imaging [8].

The aim of this study was to assess the effects of dipyridamole on the myocardium in a population of patients referred for myocardial perfusion imaging by gated single-photon emission computed tomography (MPGS) and to explore the myocardial functional reserve with dipyridamole by means of a longitudinal strain reserve with speckle-tracking echocardiography.

## Methods

### Study population

Patients referred for MPGS with previous or non-coronary artery disease (CAD) and without history of myocardial infarction were prospectively included from March to September 2011. All patients underwent a complete physical exam before inclusion. Exclusion criteria were documented allergies to dipyridamole, asthma, systolic blood pressure < 90 mmHg, decompensated heart failure or acute angina, significant valvular disease, hypertrophic cardiomyopathy, atrial fibrillation and the possibility to induce stress by effort. All patients were informed of the study design and agreed to the protocol before inclusion. Patients with identified MPGS ischemia were also excluded of the analysis.

### Dipyridamole testing and MPGS protocols

All enrolled patients underwent MPGS with intravenous dipyridamole pharmacologic stress using the standardized protocols from the European Association of Nuclear Medicine / European Society of Cardiology guidelines [9]. Caffeinated beverages, foods and medications, and medications containing methylxanthine were avoided for at least 12 hours prior to stress testing. Dipyridamole was given as a continuous infusion intravenously at 0.6 mg/kg over the course of 4 minutes. Arterial pressure was recorded before infusion, every 2 minutes during stress and also at the peak of dipyridamole effects (8 minutes). Stress MPGS was performed for all patients with a weight-adjusted dose of 300–400 MBq of <sup>99m</sup>Tc-tetrofosmin injected 3 minutes after the completion of the dipyridamole infusion. MPGS was acquired 15 to 30 minutes after a radiotracer injection using a Symbia T6 (Siemens Healthcare, Erlangen, Germany) double-headed gamma camera equipped with low-energy, high-resolution collimators. Data was acquired for 180° with 64 frames of

30 and 20 second durations at stress and at rest, respectively; a 64 × 64 matrix; 8-frame gating; and a 20% window centred on the 140-keV photo peak of <sup>99m</sup>Tc. Rest MPGS was performed only if stress MPGS was considered as pathological, with a 2-fold-higher dose of <sup>99m</sup>Tc-tetrofosmin injected at least 3 hours after the stress testing. All patients underwent low-dose CT using a Symbia T6 system (Siemens Healthcare, Erlangen, Germany) for attenuation correction (130 keV, 30 to 45 mAs).

### Echocardiographic protocol

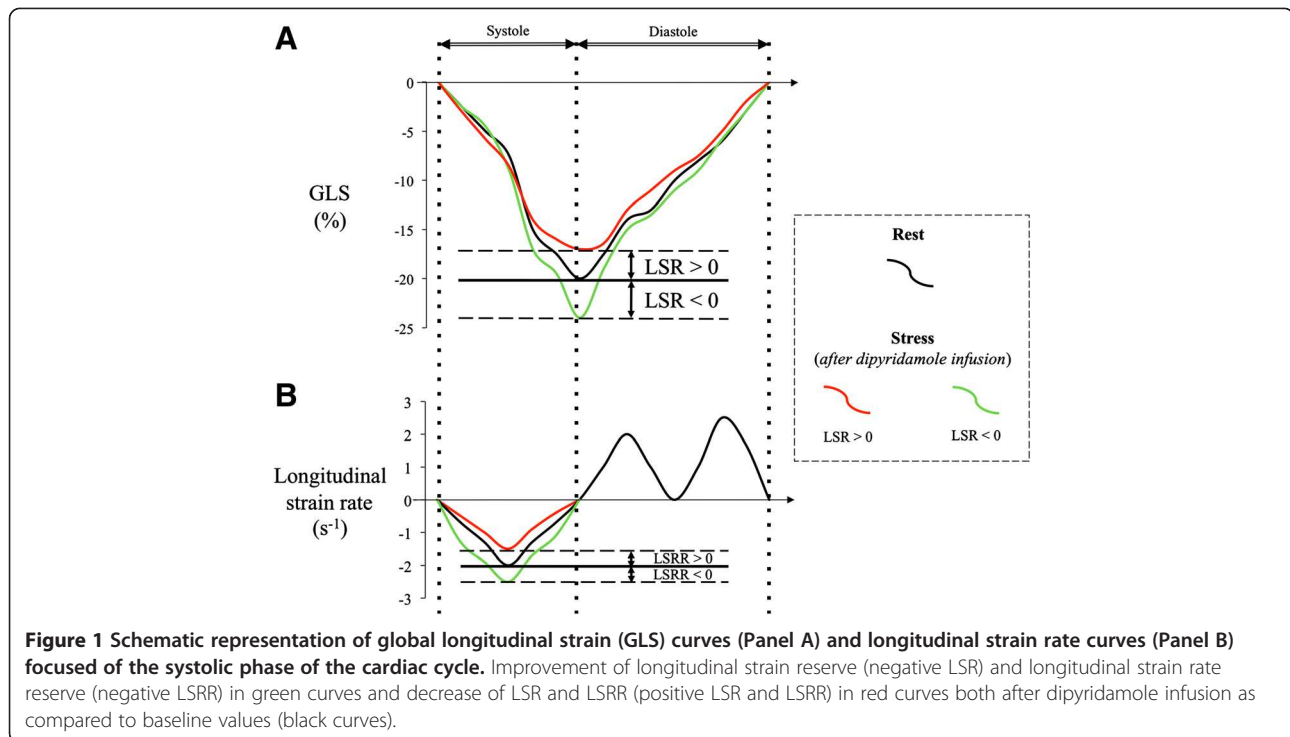
Echocardiography for all patients was performed at rest and 3 minutes after the completion of the dipyridamole infusion, i.e. at peak of stress, with a Imagic KM 60 (Kontron Medical, Saint-Germain en Laye, France) using a 2.5 MHz transducer. A complete two-dimensional grey scale echocardiography including the three standard apical views (four, three and two chambers) with a frame rate > 75 frame/s was performed for each patient. Left ventricle ejection fraction (LVEF) and volumes were assessed before and after the dipyridamole infusion as diastolic parameters. Myocardial strain was measured using speckle-tracking echocardiography.

### Data analysis and interpretation

The 17-segments model, as defined by the American Society of Echocardiography, was used to examine both echocardiography and MPGS [10]. The apex segment was then excluded for the analysis.

For the echocardiography, digital data of 3 consecutive heart cycles were recorded and transferred to a personal computer with My Lab Desk workstation (Kontron Medical, Saint-Germain en Laye, France) for offline analysis. The endocardial border was defined manually in end systole and automatically tracked frame by frame. Operator assessed optimal evaluation of both quality of tracking and region of interest. Global longitudinal strain (GLS) was obtained by averaging all segmental longitudinal strain curves computed from the conventional apical two-, three- and four-chamber views. Longitudinal strain reserve (LSR) was defined by the difference between peak systolic global longitudinal strain at the peak of vasodilatation with dipyridamole and at rest. The longitudinal strain rate was determined for the left ventricle as the maximal strain rate value (calculated as the temporal derivative of strain) during the ejection phase. The longitudinal strain rate reserve (LSRR) was similarly obtained (Figure 1). Left ventricular ejection fraction (LVEF) was assessed by transthoracic echocardiography using the conventional apical two- and four-chamber views and the modified Simpson's method.

For MPGS studies, off-line analysis was performed on Syngo MI Applications software (Siemens Healthcare, Erlangen, Germany). The images were assessed visually



and by applying automated methods. A single blinded observer interpreted echocardiographic and MPGS studies. Myocardial ischemia was defined by at least one reversible myocardial perfusion defect between stress and rest myocardial perfusion gated-SPECT and was expressed by the number of segments affected.

#### Follow up

Data about the occurrence of adverse events were obtained from medical records by direct patients' interviews or from the referring physician. The primary end point was defined by all-cause mortality. Patients unable to be interviewed up to 6 months at the date of follow-up were considered as lost to follow-up.

#### Statistical analysis

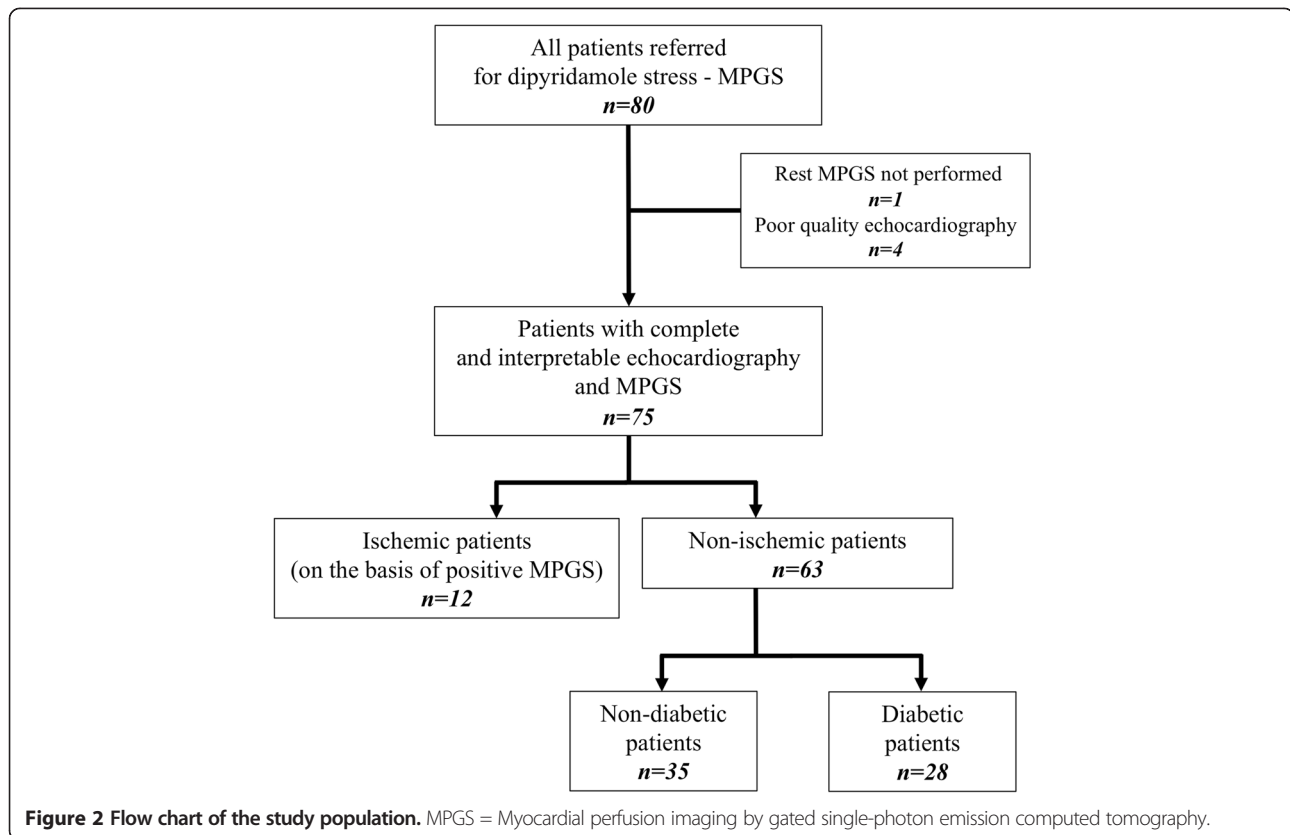
Data were expressed as mean  $\pm$  SD. Nominal values were expressed as numbers and percentages. Normality was tested by the Kolmogorov-Smirnov test. The association between the mean values of continuous normally distributed variables were compared using unpaired and paired Student's *t* test and the Mann-Whitney rank sum test was used when the samples were not normally distributed or had unequal variances. Comparison between multiple groups was performed with a variance analysis (ANOVA). Nominal variables were investigated by the  $\chi^2$  test. Linear regression analysis was used to investigate the relation between LSR-LSRR and variables. Conventional variables correlated with LSR with a *p* value  $<$  0.05 at first univariate analyses were used to build the

final multivariate stepwise model. Receiver operating characteristic (ROC) curves were computed to determine optimal cut-off point for longitudinal strain reserve as well as to calculate area under the curve (AUC) to determine prognostic significance. Multivariate Cox regression model was built to identify echocardiographic parameters associated with all-cause mortality. Survival curve was determined according to the Kaplan-Meier method, and cumulative event rates compared by means of the log-rank test. Differences were considered statistically significant for *p*-values of  $<$  0.05. All analyses were performed on SPSS software version 20 (SPSS Inc., Chicago, Illinois).

## Results

### Population

Eighty patients were prospectively included. Four patients (5%) were excluded from the analysis due to a poor resolution of 2D echocardiography as a consequence of poor ultrasonic window (obesity or pulmonary disease) that did not allow speckle-tracking imaging and 1 (<1%) due to refusal of gated-SPECT after echocardiography. Among the 75 other patients included, 12 were excluded for MPGS ischemia with at least one or more reversible defect segment (Figure 2). Male represented 59% of the 63 patients finally enrolled in the study. The mean age was  $70 \pm 11$  years with a median age of 71 ranging from 46 to 90 years old. Twenty-six patients (41%) had a previous history of coronary artery disease and 28 (44%) suffered from diabetes. Diabetes lasted less than five years in 10/28 patients. Thirty-nine patients



(62%) reported a NYHA stage 2 and the mean LVEF was  $51 \pm 14\%$ . Baseline characteristics are presented in Table 1.

#### Blood pressure and heart rate during stress

Hemodynamic during dipyridamole infusions and echocardiographic examinations remained unchanged for all patients. The decrease of systolic blood pressure with dipyridamole after stress testing was not only insignificant for the whole population ( $136 \pm 22$  at rest vs.  $130 \pm 21$  mmHg after dipyridamole infusion,  $p = 0.14$ ) but the diabetic patients in comparison to the non-diabetics also showed a non-significant variation of systolic blood pressure ( $-3.8 \pm 12.4$  vs.  $-2.9 \pm 31.6$  mmHg;  $p = 0.88$ , respectively). Results are similar regarding the diastolic blood pressure ( $p = 0.09$ ). The mean heart rate increased from  $70 \pm 14$  beats/min at rest to  $80 \pm 18$  beats/min after the dipyridamole infusion ( $p < 0.001$ ) showing the pharmacological effect of dipyridamole. No examination had to be stopped for safety reasons.

#### Effects of dipyridamole on strain reserve

The effects of dipyridamole on LSR according to baseline characteristics, coronary risk factors, dyspnea and medications are presented in Table 2. In our general population, the mean GLS before dipyridamole infusion

was  $-14.5 \pm 4.2\%$  and reached  $-16.8 \pm 4.5\%$  at the maximum effect of vasodilatation. Consequently, the mean LSR was  $-2.28 \pm 2.19\%$ . LSR did not depend on systolic blood pressure ( $p = 0.99$ ), diastolic blood pressure ( $p = 0.57$ ) or heart rate ( $p = 0.85$ ) changes during stress, as LSRR with  $p$ -values of 0.89, 0.57 and 0.17, respectively for systolic blood pressure, diastolic blood pressure and heart rate.

By univariate analysis, only age was associated with a decrease of LSR after dipyridamole infusion whereas patients with diabetes, higher Body Mass Index (BMI) and current smoking showed an improvement of LSR (Table 3). Increasing age was significantly correlated to a decrease of LSR ( $p < 0.0001$ ) as presented in Figure 3. As shown in Table 4, no difference was observed between diabetic and non-diabetic patients for GLS before stress ( $-13.9 \pm 3.7$  vs.  $-15.0 \pm 4.5\%$ ;  $p = 0.30$ ) and after the dipyridamole infusion ( $-17.2 \pm 4.2$  vs.  $-16.5 \pm 4.8\%$ ;  $p = 0.55$ ) but LSR was higher in the diabetic population ( $-3.27 \pm 1.93$  vs.  $-1.49 \pm 2.08\%$ ;  $p = 0.001$ ). Moreover, GLS of diabetic increased significantly by 24% in stress conditions ( $p = 0.003$ ). Among the 28 patients with diabetes, 22 of them presented also overweight, defined as a BMI  $> 25$  kg/m<sup>2</sup> ( $p < 0.004$ ). GLS before dipyridamole infusion was not different between patients with or without overweight ( $-14.2 \pm 3.6$  vs.  $-15.0 \pm 4.9\%$ ;  $p = 0.43$ ) but LSR

**Table 1 Baseline characteristics**

Variable	All patients (n=63)	Diabetic (n=28)	Non-diabetic (n=35)	p-value
Age (yrs)	70 ± 11	70±10	72±10	<b>0.04</b>
Male (%)	37 (59)	18 (64)	19 (54)	0.42
BMI (kg/m <sup>2</sup> )	26.3 ± 3.9	28.1±4.0	24.8±3.2	<b>0.001</b>
SBP (mmHg)	137 ± 21	135±16	138±24	0.55
DBP (mmHg)	76±11	75±12	77±11	0.64
HR (beats/min)	70 ± 14	69±12	71±16	0.59
<b>Dyspnea status (%)</b>				
NYHA I	12 (19)	7 (25)	5 (14)	0.83
NYHA II	39 (62)	16 (57)	23 (66)	0.65
NYHA III	12 (19)	5 (18)	7 (20)	0.72
<b>Coronary risk factors (%)</b>				
Hypertension	45 (71)	19 (48)	26 (71)	0.58
Current smoking	27 (43)	12 (43)	15 (43)	0.99
Hypercholesterolemia	32 (51)	14 (50)	18 (51)	0.91
Family history of cardiovascular disease	4 (6)	2 (7)	2 (5)	0.82
<b>Previous coronary artery disease (%)</b>	26 (41)	11 (39)	15 (43)	0.78
<b>Medications (%)</b>				
ACE inhibitors/ARB	38 (62)	16 (57)	22 (63)	0.44
Beta-blockers	30 (48)	12 (43)	18 (51)	0.50
Calcium antagonists	25 (40)	10 (36)	15 (43)	0.56
<b>Diabetic characteristics</b>				
Duration of diabetes (yrs)	-	12.0±8.8	-	-
HbA1c (%)	-	7.0±2.4	-	-
Insulin therapy (%)	-	20 (71)	-	-
Oral therapy (%)	-	12 (43)	-	-
Metformin therapy (%)	-	8 (29)	-	-
Retinopathy (%)	-	11 (39)	-	-
Peripheral arterial disease (%)	-	15 (54)	-	-
Supra aortic	-	6 (21)	-	-
Lower limb	-	11 (39)	-	-

Values are presented as n (%) or mean ± SD.

BMI = body mass index; SBP = systolic blood pressure; DBP = diastolic blood pressure; HR = heart rate; ACE = angiotensin-converting enzyme; ARB = angiotensin receptor blocker; LVEF = left ventricle ejection fraction; LVEDV and LVESV = left ventricle end diastolic and end systolic volume.

was significantly higher in patients with overweight ( $-2.83 \pm 1.85$  vs.  $-1.50 \pm 2.42\%$ ;  $p = 0.016$ ). After a multivariate analysis, only age ( $p = 0.001$ ) remained independently associated with a decrease of LSR after the dipyridamole infusion. Conversely, LSR remained significantly improved only in diabetic patients ( $p = 0.008$ ). Among all echocardiographic parameters at baseline and after stress, including systolic, diastolic, hemodynamic and speckle-tracking parameters, only LSR was modified according to the diabetic status (Table 4). LSR was not correlated to the duration of diabetes ( $p = 0.80$ ) or HbA1c level ( $p = 0.21$ ) and was not influenced by

dedicated treatments especially insulin therapy ( $p = 0.46$ ), the presence of retinopathy ( $p = 0.43$ ) or peripheral vascular disease ( $p = 0.34$ ).

LSRR was only associated with aging ( $p = 0.005$ ) and was not influenced by diabetes ( $p = 0.57$ ). Moreover, longitudinal strain rate increased by 16% between baseline and peak stress in the diabetic population ( $p = 0.11$ ).

#### Prognosis and follow-up

During a mean follow-up of  $15 \pm 5$  months, 6 (10%) patients reached the primary endpoint. Only one patient was lost to follow-up and was excluded for survival



**Table 2 Effects of dipyridamole on longitudinal strain reserve**

	Coef. 95% for LSR	
		p-value
<b>Baseline characteristics</b>		
Age (yrs) *	-0.49	<0.0001
Male †	-2.45	0.46
Female	-2.04	
BMI (kg/m <sup>2</sup> ) *	0.25	<b>0.045</b>
<b>Dyspnea status †</b>		
NYHA I	-2.33	0.98
NYHA II	-2.30	
NYHA III	-2.17	
<b>Coronary risk factors †</b>		
Hypertension	-2.33	0.77
No hypertension	-2.15	
Diabetic	-3.27	<b>0.001</b>
Non-diabetic	-1.49	
Current smoking	-2.92	<b>0.045</b>
No current smoking	-1.80	
Hypercholesterolemia	-2.29	0.98
No hypercholesterolemia	-2.27	
Family history of cardiovascular disease	-0.90	0.19
No family history of cardiovascular disease	-2.38	
<b>Previous coronary artery disease (CAD) †</b>		
CAD	-2.02	0.43
No CAD	-2.46	
<b>Medications †</b>		
ACE inhibitors/ARB	-2.50	0.44
No ACE inhibitors/ARB	-2.07	
Beta-blockers	-1.80	0.10
No beta-blockers	-2.72	
Calcium antagonists	-2.00	0.41
No calcium antagonists	-2.47	

LSR = longitudinal strain reserve; BMI = body mass index; ACE = angiotensin-converting enzyme; ARB = angiotensin receptor blocker.

\*: Spearman correlation.

†: ANOVA.

analysis. After multivariate analysis, only the left ventricle end systolic volume at stress (HR: 1.047 [95% C.I: 1.018 – 1.075];  $p = 0.001$ ; Table 5), the difference of left ventricle end systolic volumes between stress and rest (HR: 1.065 [95% C.I: 1.019 – 1.113];  $p = 0.005$ ) and a positive LSR (HR: 15.493 [95% C.I: 1.419 – 169.182];  $p = 0.025$ ) remained independently associated with all-cause mortality. ROC curve analysis in Figure 4 identified positive LSR (cut-off value of 0%) as a predictor of all-cause mortality with a sensitivity of 89% and a specificity of 50%, for an area under the curve of  $AUC = 0.79$  ( $p = 0.021$ ).

The Kaplan-Meier analysis showed better survival in patients with a negative LSR (log-rank  $p = 0.012$ ). All cause-mortality in the diabetic population was associated with a lower LSR ( $-0.59 \pm 1.17$  vs.  $-3.60 \pm 1.77\%$ ;  $p = 0.028$ ) but prognosis was not significantly better in the diabetic population compared to the non-diabetic since they have a better LSR ( $p = 0.102$  vs.  $p = 0.446$ ).

## Discussion

LSR assessed with dipyridamole, defined by the difference between GLS after and before a dipyridamole infusion, is a new concept of myocardial functional reserve. Our study shows a LSR increase in patients with diabetes that decreases with aging with a potential interest in prognosis evaluation.

2D-strain echocardiography with speckle-tracking imaging enables a general analysis of the left ventricle at rest or during stress [11]. Regional analysis during MPGS and perfusion echocardiography with dipyridamole are complementary for the assessment of CAD [12] but for the first time, we are reporting the effects of dipyridamole on global longitudinal strain by means of 2D-speckle tracking echocardiography. This study highlights a new concept of LSR during stress with dipyridamole. Palmieri and al. previously experienced a myocardial reserve by means of Doppler tissue imaging. Despite different pharmacological effects, low doses of dobutamine in patients with type 1 diabetes have similar effects, compared to dipyridamole in our study, by improving both global longitudinal strain and longitudinal strain rate of at least 29% [13].

Different deformation modalities such as longitudinal strain [14,15] or torsion [16-18] can be modified by left ventricular load but even if dipyridamole has several systemic effects that can lead to hemodynamic changes [19], we show that there are no blood pressure impacts or heart rate variations on LSR.

After a multivariate analysis, only aging is associated with a decrease of LSR during stress with dipyridamole. This result is consistent with the consequences of aging on myocardial deformation at rest: global longitudinal strain declines at rest with aging in a healthy population [20], especially in basal segments [21]. Consistent results were also found with longitudinal strain rate in baseline [22]. These results could be partly explained by a reduced coronary flow reserve with aging [23] as described with myocardial ischemia [24]. Therefore, LSR may reflect the physiological age of the myocardium.

Conversely, diabetes is associated with an increase in LSR whereas GLS before the dipyridamole infusion in the diabetic patients is lower but not statistically different than non-diabetic patients. These results at baseline are different from the studies of Ernande et al. in which GLS was impaired at rest in patients with diabetes [25], even sometimes before diastolic dysfunction [26]. This

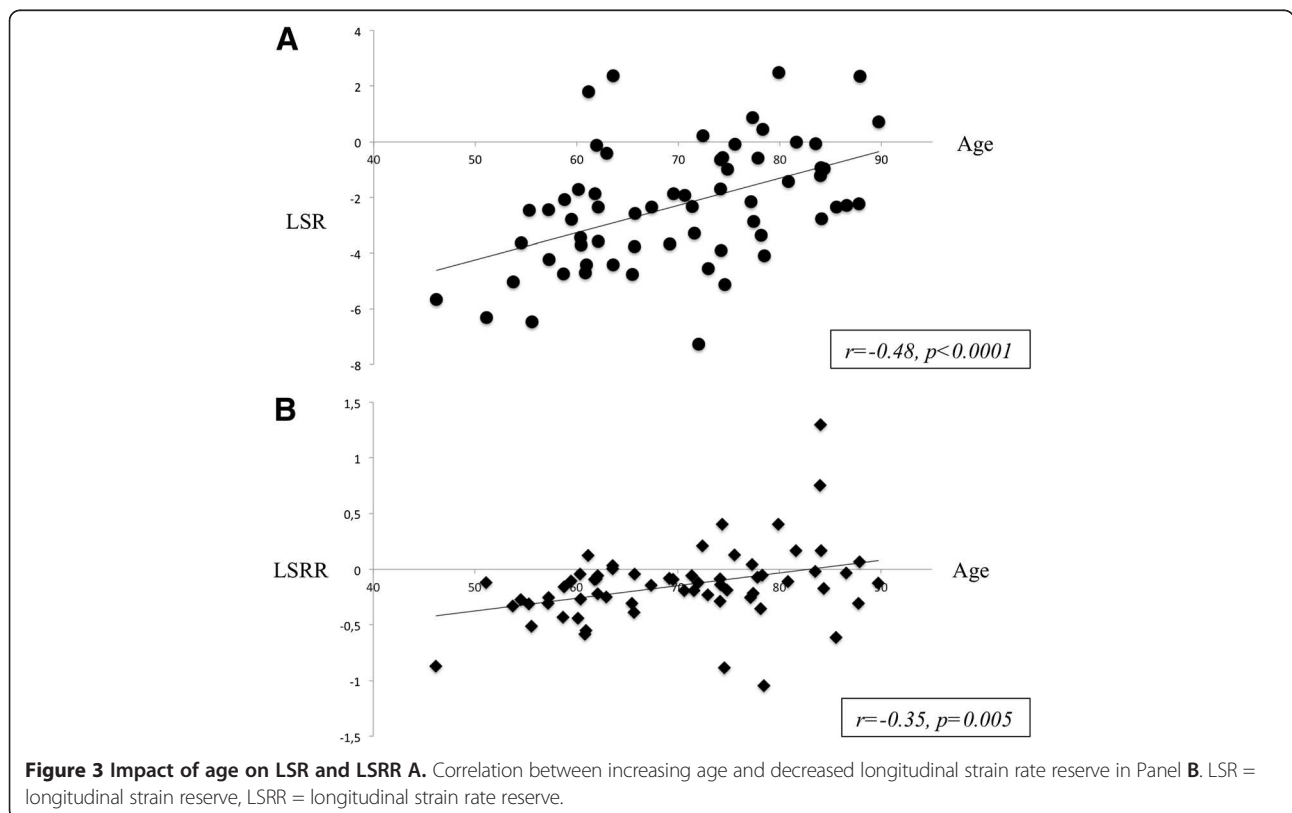
**Table 3 Univariate and multivariate linear regression model for longitudinal strain reserve**

	Multivariate analysis			
	Coef. [95% CI]	p-value	Coef. [95% CI]	p-value
Age	<b>-0.10 [-0.14 - -0.05]</b>	<b>&lt;0.0001</b>	<b>-0.08 [-0.13 - -0.04]</b>	<b>0.001</b>
Gender (Male)	0.42 [-0.71 - 1.54]	0.46		
BMI	<b>0.14 [0.01 - 0.28]</b>	<b>0.045</b>		
Hypertension	0.18 [-1.05 - 1.41]	0.77		
Diabetic	<b>1.79 [0.77 - 2.81]</b>	<b>0.001</b>	<b>1.33 [0.36 - 2.30]</b>	<b>0.008</b>
Current smoking	<b>1.11 [0.02 - 2.20]</b>	<b>0.045</b>		
Hypercholesterolemia	0.02 [-1.09 - 1.13]	0.98		
Family history of cardiovascular disease	-1.48 [-3.72 - 0.77]	0.19		
ACE inhibitors/ARB	0.44 [-0.70 - 1.57]	0.44		
Beta-blockers	-0.92 [-2.01 - 0.17]	0.10		
Calcium antagonists	-0.47 [-1.60 - 0.66]	0.41		
Previous CAD	-0.44 [-1.57 - 0.68]	0.43		

BMI = body mass index; ACE = angiotensin-converting enzyme; ARB = angiotensin receptor blocker; MPGS = myocardial perfusion gated SPECT; CAD = coronary artery disease.

difference for GLS at rest could be explained by the recent description of impaired coronary microvascular function in type 2 diabetic patients without CAD [27]. Our smaller population of diabetic patients and a population partly composed of patients with previous CAD might explain this difference. Several studies confirm the endothelial dysfunction secondary to diabetes [28] but

we show, for the first time, the mechanic consequences of this endothelial dysfunction in diabetic patients, which lead to an exacerbated response to arterial vasodilatation induced by dipyridamole. These results are consistent with the hemodynamic findings of Picchi and al. who previously described an increased basal coronary blood flow at rest in diabetes as a cause of decreased coronary flow





**Table 4 Echocardiographic parameters according to diabetic status**

Echocardiographic parameters	All patients (n=63)	Diabetic (n=28)	Non-diabetic (n=35)	p-value
<b>Rest</b>				
LVEF (%)	50.7±14.4	49.8±13.0	51.4±15.5	0.66
EDV (ml)	103.7±46.9	106.7±46.6	101.2±47.6	0.65
ESV (ml)	53.7±39.4	56.6±36.7	51.3±41.8	0.60
TVI LVOT (cm)	22.7±6.0	19.3±5.0	19.3±5.5	0.96
GLS (%)	-14.5±4.2	-13.9±3.7	-15.0±4.5	0.30
Longitudinal Strain rate (s <sup>-1</sup> )	-1.19±0.35	-1.15±0.26	-1.22±0.40	0.43
E (cm.s <sup>-1</sup> )	77±25	78±26	75±25	0.60
A (cm.s <sup>-1</sup> )	81±29	79±28	82±29	0.77
E/A (cm.s <sup>-1</sup> )	1.07±0.58	1.14±0.57	1.01±0.59	0.41
DT (s)	205±86	197±88	210±85	0.56
<b>Stress</b>				
LVEF (%)	54.6±13.9	54.3±14.0	54.9±13.9	0.89
EDV (ml)	98.8±41.6	98.8±36.3	98.9±45.9	0.99
ESV (ml)	48.8±35.6	48.6±31.6	48.9±38.9	0.97
TVI LVOT (cm)	22.7±6.0	23.0±5.0	22.5±6.8	0.76
GLS (%)	-16.8±4.5	-17.2±4.2	-16.5±4.8	0.55
Longitudinal Strain rate (s <sup>-1</sup> )	-1.34±0.44	-1.33±0.52	-1.35±0.37	0.86
E (cm.s <sup>-1</sup> )	84±23	83±23	85±23	0.75
A (cm.s <sup>-1</sup> )	89±33	88±32	89±35	0.85
E/A (cm.s <sup>-1</sup> )	1.13±0.77	1.15±0.61	1.10±0.89	0.83
DT (s)	179±73	177±76	180±71	0.87
<b>Δ (stress – rest)</b>				
Δ LVEF (%)	3.9±8.4	4.6±9.8	3.5±7.2	0.60
Δ EDV (ml)	-4.8±25.3	-7.9±30.0	-2.3±20.9	0.39
Δ ESV (ml)	-4.9±20.5	-8.0±24.1	-2.4±17.0	0.28
Δ TVI LVOT (cm)	3.4±2.5	3.7±2.6	3.2±2.3	0.39
LSR (%)	-2.28±2.19	-3.27±1.93	-1.49±2.08	<b>0.001</b>
LSRR (s <sup>-1</sup> )	-0.15±0.34	-0.17±0.43	-0.12±0.26	0.57

LVEF = left ventricle ejection fraction; EDV = end diastolic volume; ESV = end systolic volume, TVI LVOT = time-velocity integral in the left ventricular outflow tract, GLS = global longitudinal strain; DT = mitral deceleration time, LSR = longitudinal strain reserve; LSRR = longitudinal strain rate reserve.

reserve with adenosine. Interestingly, as we described with GLS, coronary blood flow is not altered after adenosine in the diabetic group compared to the non-diabetic group [29]. The lack of any decrease in systolic or diastolic blood pressure in the diabetic group might also explain these results. Actually, reduced myocardial perfusion with vasodilator in diabetic patient is associated with a significant decrease in blood pressure, a consequence of autonomic neuropathy [30]. Coronary metabolic vasodilatation mainly depends on both nitric oxide metabolism, which is impaired in diabetic patients [31], and on adenosine pathways. The predominant vasodilatation effects of dipyridamole through A<sub>2A</sub>-adenosine receptors, which are increased in the hearts of diabetic rats, [32] could explain the increase

of LSR in the diabetic population. LSR is not influenced by duration of diabetes in contrast to baseline [33]. Glycaemic control, treatments and vascular disease other than CAD do not influence either LSR. In parallel, left ventricular diastolic function is impaired precociously in patients with insulin resistance and glucose metabolism disorders even without overt diabetes [34] but the diastolic functional reserve defined by Jellis et al. is not altered by diabetes during effort conditions [35]. Diabetes seems to alter first the contractile function as described with dobutamine stress echocardiography [36] while myocardial perfusion seems to be maintained [37]. This hypothesis may explain the improvement of the LSR in diabetic patients. As a result, LSR appears to be an interesting and sensitive tool to

**Table 5 Echocardiographic parameters associated with all-cause mortality in a multivariate Cox regression model**

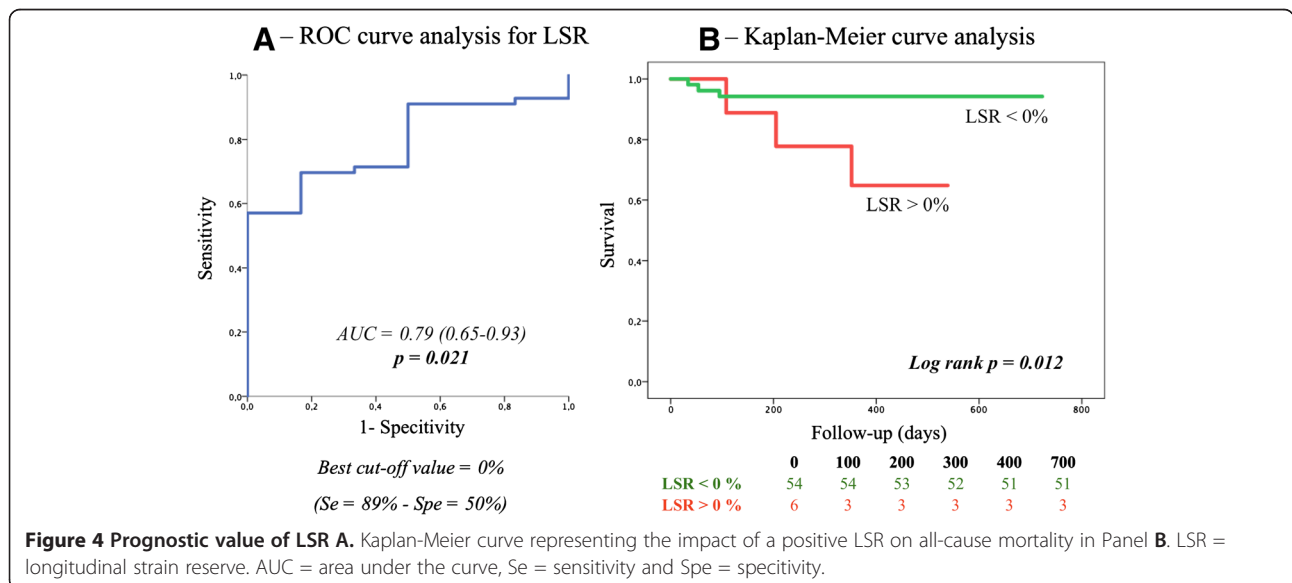
	Univariate analysis		Multivariate analysis	
	HR [95% CI]	p-value	HR [95% CI]	p-value
<b>Rest</b>				
LVEF (%)	0.889 [0.821 - 0.964]	<b>0.004</b>		
EDV (ml)	1.019 [1.007 - 1.031]	<b>0.002</b>		
ESV (ml)	1.020 [1.007 - 1.033]	<b>0.002</b>		
GLS (%)	1.335 [1.091 - 1.633]	<b>0.005</b>		
<b>Stress</b>				
LVEF (%)	0.898 [0.839 - 0.960]	<b>0.002</b>		
EDV (ml)	1.026 [1.012 - 1.040]	<b>&lt;0.0001</b>		
ESV (ml)	1.034 [1.017 - 1.051]	<b>&lt;0.0001</b>	1.047 [1.018 - 1.075]	<b>0.001</b>
GLS (%)	1.481 [1.155 - 1.899]	<b>0.002</b>		
<b>Δ (stress – rest)</b>				
Δ LVEF (%)	0.962 [0.874 - 1.059]	0.430		
Δ EDV (ml)	1.003 [0.970 - 1.037]	0.862		
Δ ESV (ml)	1.044 [1.006 - 1.084]	<b>0.022</b>	1.065 [1.019 - 1.113]	<b>0.005</b>
LSR (%)	1.395 [0.973 - 2.001]	0.070		
LSR > 0	6.012 [1.211 - 29.856]	<b>0.028</b>	15.493 [1.419 - 169.182]	<b>0.025</b>

LVEF = left ventricle ejection fraction; EDV = end diastolic volume; ESV = end systolic volume, TVI LVOT = time-velocity integral in the left ventricular outflow tract, GLS = global longitudinal strain; LSR = longitudinal strain reserve; LSRR = longitudinal strain rate reserve.

explore the impact of diabetes on myocardium non-invasively, regardless of the characteristics of the diabetes.

Strain rate is load dependent and reflects the regional difference in contractility [38]. In our study, LSRR is not influenced by hemodynamic changes induced by dipyridamole. Therefore, LSRR reflects changes in contractility due to myocardial injury only. Moreover, in diabetes, the stability of longitudinal strain rate with stress and the

insignificant increase in LSRR between diabetic and non-diabetic patients results in a homogeneous and stable regional contractility. This may be the consequence of an overall and homogeneous myocardial injury. Because subendocardial longitudinal fibres are the most vulnerable in pathological conditions, we deliberately focused our analysis on longitudinal deformation [39]. Longitudinal strain is the most reliable and studied parameter of deformation modalities and the comparison of radial strain



results in diabetic populations is not reliable among different studies [25,40].

A positive LSR that reflects lack of myocardial functional reserve after dipyridamole infusion appears promising to predict all-cause mortality in a population of patients referred for MPGS even when ischemia is excluded. The cut-off value of 0% of LSR is easy to measure and allows therefore a rapid and reliable evaluation in routine clinical practice.

However, our study has several limitations. First, presence of autonomic neuropathy [41] but also abdominal visceral adipose tissue [42], and the evaluation of aortic stiffness [43] or oxidative stress [44], all associated with myocardial function impairment, could have provided important information. In parallel, our population of diabetic patients is too small to define subset groups according to glycaemic control that could influence evolution of LSR and LSRR during follow up. Unfortunately, ischemia cannot be ruled out with certainty and therefore might interfere with our results. MPGS is an efficient and validated exam to assess ischemia and CAD and even if patients with at least only one reversible defect segment were excluded, pluritruncular patients could lead to false negative tests. Moreover, coronary angiography should have been interesting to differentiate respective impacts of epicardial coronary artery disease and microvascular dysfunction on strain reserve among patients with diabetes.

Finally, further prospective studies are necessary to define the interaction between diabetes and LSR and a potential prognostic value in diabetic patients. The use of the selective adenosine A<sub>2A</sub> receptor agonist vasodilator stress agent could be interesting in this context [45]. However, the present results suggest that addition of LSR to dipyridamole stress myocardial contrast perfusion echocardiography could improve its prognostic value [46].

## Conclusion

LSR assessed after a dipyridamole infusion is a new concept of stress examination using speckle-tracking imaging. LSR increases in the diabetic population and warrants special attention for examinations in the elderly population. Myocardial function reserve assessed by LSR after dipyridamole with speckle-tracking echocardiography may be of interest for the evaluation of both prognosis and impact of co-morbidities.

## Consent

Written informed consent was obtained from the patient for publication of this report and any accompanying images.

## Abbreviations

2D: Two-dimensional; MPGS: Myocardial perfusion imaging by gated single-photon emission computed tomography; CAD: Coronary artery disease; GLS: Global longitudinal strain; LSR: Longitudinal strain reserve; LSRR: Longitudinal strain rate reserve; LVEF: Left ventricle ejection fraction; AUC: Area under the curve; BMI: Body mass index.

## Competing interests

Doctor Lairez received research support (equipment and software) from Kontron for speckle-tracking echocardiography. However, the current study was not supported by those grants.

## Authors' contributions

TC researched and analyzed data and wrote the manuscript. PLV performed the statistical analysis. LD recorded follow-up information. DB, RR, MB, PM, MG, AF researched data. MG, DC, PM, IB contributed to discussion and reviewing. O.L. led the study, revised the manuscript and gave final approval of the version to be published. All authors read and approved the final manuscript.

## Author details

<sup>1</sup>Department of Nuclear Medicine, University Hospital of Rangueil, Toulouse, France. <sup>2</sup>Department of Cardiology, University Hospital of Rangueil, Toulouse, France. <sup>3</sup>Cardiac Imaging Centre, University Hospital of Rangueil, Toulouse, France. <sup>4</sup>Laboratory of Epidemiology, CJF-INSERM, 94-06, Toulouse, France. <sup>5</sup>Medical School of Rangueil, University Paul Sabatier, Toulouse, France. <sup>6</sup>Medical School of Purpan, University Paul Sabatier, Toulouse, France. <sup>7</sup>Department of Cardiology, Toulouse University Hospital, 1, avenue Jean Poulhès, TSA 50032, 31059, Toulouse Cedex 9, France.

Received: 19 March 2013 Accepted: 28 May 2013

Published: 7 June 2013

## References

1. Sakanashi M, Noguchi K, Kato T, Matsuzaki T, Kinjo N, Ikema S, Miyagi H, Moromizato H, Nakasone J, Kinjo Y: **Investigation on the effect of dipyridamole and papaverine on regional blood flow and cardiac hemodynamics in anesthetized dogs.** *Arzneimittelforschung* 1989, **39**:1119-1123.
2. Douglas PS, Garcia MJ, Haines DE, Lai WW, Manning WJ, Patel AR, Picard MH, Polk DM, Ragosta M, Parker Ward R, Weiner RB: **ACCF/AHA/ASNC/HFSA/HRS/SCAI/SCCM/SCCT/SCMR 2011 Appropriate Use Criteria for Echocardiography. A Report of the American College of Cardiology Foundation Appropriate Use Criteria Task Force, American Society of Echocardiography, American Heart Association, American Society of Nuclear Cardiology, Heart Failure Society of America, Heart Rhythm Society, Society for Cardiovascular Angiography and Interventions, Society of Critical Care Medicine, Society of Cardiovascular Computed Tomography, Society for Cardiovascular Magnetic Resonance American College of Chest Physicians.** *J Am Soc Echocardiogr* 2011, **24**:229-267.
3. Ha JW, Ahn JA, Kim JM, Choi EY, Kang SM, Rim SJ, Jang Y, Shim WH, Cho SY, Oh JK, Chung N: **Abnormal longitudinal myocardial functional reserve assessed by exercise tissue Doppler echocardiography in patients with hypertrophic cardiomyopathy.** *J Am Soc Echocardiogr* 2006, **19**:1314-1319.
4. Akcakoyun M, Kaya H, Kargin R, Pala S, Emiroglu Y, Esen O, Karapinar H, Kaya Z, Esen AM: **Abnormal left ventricular longitudinal functional reserve assessed by exercise pulsed wave tissue Doppler imaging in patients with subclinical hypothyroidism.** *J Clin Endocrinol Metab* 2009, **94**:2979-2983.
5. Cullen MW, Pellikka PA: **Recent advances in stress echocardiography.** *Curr Opin Cardiol* 2011, **26**:379-384.
6. Moonen M, Lancellotti P, Zacharakis D, Pierard L: **The value of 2D strain imaging during stress testing.** *Echocardiography* 2009, **26**:307-314.
7. Andersson C, Gislason GH, Weeke P, Hoffmann S, Hansen PR, Torp-Pedersen C, Sogaard P: **Diabetes is associated with impaired myocardial performance in patients without significant coronary artery disease.** *Cardiovasc Diabetol* 2010, **9**:3.
8. Zhao CT, Wang M, Siu CW, Hou YL, Wang T, Tse HF, Yiu KH: **Myocardial dysfunction in patients with type 2 diabetes mellitus: role of endothelial progenitor cells and oxidative stress.** *Cardiovasc Diabetol* 2012, **11**:147.

9. Hesse B, Tagil K, Cuocolo A, Anagnostopoulos C, Bardies M, Bax J, Bengel F, Busemann Sokole E, Davies G, Dondi M, et al: **EANM/ESC procedural guidelines for myocardial perfusion imaging in nuclear cardiology.** *Eur J Nucl Med Mol Imaging* 2005, **32**:855–897.
10. Cerqueira MD, Weissman NJ, Dilsizian V, Jacobs AK, Kaul S, Laskey WK, Pennell DJ, Rumberger JA, Ryan T, Verani MS: **Standardized myocardial segmentation and nomenclature for tomographic imaging of the heart: a statement for healthcare professionals from the Cardiac Imaging Committee of the Council on Clinical Cardiology of the American Heart Association.** *Circulation* 2002, **105**:539–542.
11. Ryo K, Tanaka H, Kaneko A, Fukuda Y, Onishi T, Kawai H, Hirata K: **Efficacy of longitudinal speckle tracking strain in conjunction with isometric handgrip stress test for detection of ischemic myocardial segments.** *Echocardiography* 2012, **29**:411–418.
12. Wei K, Crouse L, Weiss J, Villanueva F, Schiller NB, Naqvi TZ, Siegel R, Monaghan M, Goldman J, Aggarwal P, et al: **Comparison of usefulness of dipyridamole stress myocardial contrast echocardiography to technetium-99m sestamibi single-photon emission computed tomography for detection of coronary artery disease (PB127 Multicenter Phase 2 Trial results).** *Am J Cardiol* 2003, **91**:1293–1298.
13. Palmieri V, Capaldo B, Russo C, Iaccarino M, Di Minno G, Riccardi G, Celentano A: **Left ventricular chamber and myocardial systolic function reserve in patients with type 1 diabetes mellitus: insight from traditional and Doppler tissue imaging echocardiography.** *J Am Soc Echocardiogr* 2006, **19**:848–856.
14. Di Bello V, Talini E, Dell'Omo G, Giannini C, Delle Donne MG, Canale ML, Nardi C, Palagi C, Dini FL, Penno G, et al: **Early left ventricular mechanics abnormalities in prehypertension: a two-dimensional strain echocardiography study.** *Am J Hypertens* 2010, **23**:405–412.
15. A'Roch R, Gustafsson U, Johansson G, Poelaert J, Haney M: **Left ventricular strain and peak systolic velocity: responses to controlled changes in load and contractility, explored in a porcine model.** *Cardiovasc Ultrasound* 2012, **10**:22.
16. A'Roch R, Gustafsson U, Poelaert J, Johansson G, Haney M: **Left ventricular twist is load-dependent as shown in a large animal model with controlled cardiac load.** *Cardiovasc Ultrasound* 2012, **10**:26.
17. Weiner RB, Weyman AE, Khan AM, Reingold JS, Chen-Tournoux AA, Scherrer-Crosbie M, Picard MH, Wang TJ, Baggish AL: **Preload dependency of left ventricular torsion: the impact of normal saline infusion.** *Circ Cardiovasc Imaging* 2010, **3**:672–678.
18. Park HE, Chang SA, Kim HK, Shin DH, Kim JH, Seo MK, Kim YJ, Cho GY, Sohn DW, Oh BH, Park YB: **Impact of loading condition on the 2D speckle tracking-derived left ventricular dyssynchrony index in nonischemic dilated cardiomyopathy.** *Circ Cardiovasc Imaging* 2010, **3**:272–281.
19. Javadi H, Shariati M, Mogharrabi M, Asli IN, Jallalat S, Hooman A, Seyedabadi M, Assadi M: **The association of dipyridamole side effects with hemodynamic parameters, ECG findings, and scintigraphy outcomes.** *J Nucl Med Technol* 2010, **38**:149–152.
20. Sun JP, Lee AP, Wu C, Lam YY, Hung MJ, Chen L, Hu Z, Fang F, Yang XS, Merlino JD, Yu CM: **Quantification of left ventricular regional myocardial function using two-dimensional speckle tracking echocardiography in healthy volunteers - A multi-center study.** *Int J Cardiol* 2012.
21. Reckefuss N, Butz T, Horstkotte D, Faber L: **Evaluation of longitudinal and radial left ventricular function by two-dimensional speckle-tracking echocardiography in a large cohort of normal probands.** *Int J Cardiovasc Imaging* 2011, **27**:515–526.
22. Dalen H, Thorstensen A, Aase SA, Ingul CB, Torp H, Vatten LJ, Stoylen A: **Segmental and global longitudinal strain and strain rate based on echocardiography of 1266 healthy individuals: the HUNT study in Norway.** *Eur J Echocardiogr* 2010, **11**:176–183.
23. Galderisi M, Rigo F, Gherardi S, Cortigiani L, Santoro C, Sicari R, Picano E: **The impact of aging and atherosclerotic risk factors on transthoracic coronary flow reserve in subjects with normal coronary angiography.** *Cardiovasc Ultrasound* 2012, **10**:20.
24. Eguchi M, Kim YH, Kang KW, Shim CY, Jang Y, Dorval T, Kim KJ, Sweeney G: **Ischemia-reperfusion injury leads to distinct temporal cardiac remodeling in normal versus diabetic mice.** *PLoS One* 2012, **7**:e30450.
25. Ernande L, Rietzschel ER, Bergerot C, De Buyzere ML, Schnell F, Groisne L, Ovize M, Croisille P, Moulin P, Gillebert TC, Derumeaux G: **Impaired myocardial radial function in asymptomatic patients with type 2 diabetes mellitus: a speckle-tracking imaging study.** *J Am Soc Echocardiogr* 2010, **23**:1266–1272.
26. Ernande L, Bergerot C, Rietzschel ER, De Buyzere ML, Thibault H, Pignonblanc PG, Croisille P, Ovize M, Groisne L, Moulin P, et al: **Diastolic dysfunction in patients with type 2 diabetes mellitus: is it really the first marker of diabetic cardiomyopathy?** *J Am Soc Echocardiogr* 2011, **24**:1268–1275 e1261.
27. Marciano C, Galderisi M, Gargiulo P, Acampa W, D'Amore C, Esposito R, Capasso E, Savarese G, Casaretti L, Lo Iudice F, et al: **Effects of type 2 diabetes mellitus on coronary microvascular function and myocardial perfusion in patients without obstructive coronary artery disease.** *Eur J Nucl Med Mol Imaging* 2012, **39**:1199–1206.
28. Hirase T, Node K: **Endothelial dysfunction as a cellular mechanism for vascular failure.** *Am J Physiol Heart Circ Physiol* 2012, **302**:H499–H505.
29. Picchi A, Limbruno U, Focardi M, Cortese B, Micheli A, Boschi L, Severi S, De Caterina R: **Increased basal coronary blood flow as a cause of reduced coronary flow reserve in diabetic patients.** *Am J Physiol Heart Circ Physiol* 2011, **301**:H2279–H2284.
30. Taskiran M, Fritz-Hansen T, Rasmussen V, Larsson HB, Hilsted J: **Decreased myocardial perfusion reserve in diabetic autonomic neuropathy.** *Diabetes* 2002, **51**:3306–3310.
31. Williams SB, Cusco JA, Roddy MA, Johnstone MT, Creager MA: **Impaired nitric oxide-mediated vasodilation in patients with non-insulin-dependent diabetes mellitus.** *J Am Coll Cardiol* 1996, **27**:567–574.
32. Grden M, Podgorska M, Szutowicz A, Pawelczyk T: **Altered expression of adenosine receptors in heart of diabetic rat.** *J Physiol Pharmacol* 2005, **56**:587–597.
33. Nakai H, Takeuchi M, Nishikage T, Lang RM, Otsuji Y: **Subclinical left ventricular dysfunction in asymptomatic diabetic patients assessed by two-dimensional speckle tracking echocardiography: correlation with diabetic duration.** *Eur J Echocardiogr* 2009, **10**:926–932.
34. Dinh W, Lankisch M, Nickl W, Scheyer D, Scheffold T, Kramer F, Krahn T, Klein RM, Barroso MC, Futh R: **Insulin resistance and glycemic abnormalities are associated with deterioration of left ventricular diastolic function: a cross-sectional study.** *Cardiovasc Diabetol* 2010, **9**:63.
35. Jellis CL, Stanton T, Leano R, Martin J, Marwick TH: **Usefulness of at rest and exercise hemodynamics to detect subclinical myocardial disease in type 2 diabetes mellitus.** *Am J Cardiol* 2011, **107**:615–621.
36. Cadeddu C, Nocco S, Piano D, Deidda M, Cossu E, Baroni MG, Mercurio G: **Early impairment of contractility reserve in patients with insulin resistance in comparison with healthy subjects.** *Cardiovasc Diabetol* 2013, **12**:66.
37. Mourmoura E, Vial G, Laillet B, Rigaudiere JP, Hinger-Favier I, Dubouchaud H, Morio B, Demaison L: **Preserved endothelium-dependent dilatation of the coronary microvasculature at the early phase of diabetes mellitus despite the increased oxidative stress and depressed cardiac mechanical function ex vivo.** *Cardiovasc Diabetol* 2013, **12**:49.
38. Teske AJ, De Boeck BW, Melman PG, Sieswerda GT, Doevendans PA, Cramer MJ: **Echocardiographic quantification of myocardial function using tissue deformation imaging, a guide to image acquisition and analysis using tissue Doppler and speckle tracking.** *Cardiovasc Ultrasound* 2007, **5**:27.
39. Mizuno R, Fujimoto S, Saito Y, Nakamura S: **Depressed recovery of subendocardial perfusion in persistent heart failure after complete revascularisation in diabetic patients with hibernating myocardium.** *Heart* 2009, **95**:830–834.
40. Ng AC, Delgado V, Bertini M, van der Meer RW, Rijzewijk LJ, Shanks M, Nucifora G, Smit JW, Diamant M, Romijn JA, et al: **Findings from left ventricular strain and strain rate imaging in asymptomatic patients with type 2 diabetes mellitus.** *Am J Cardiol* 2009, **104**:1398–1401.
41. Piya MK, Shivu GN, Tahrani A, Dubb K, Abozguia K, Phan TT, Narendran P, Pop-Busui R, Frenneaux M, Stevens MJ: **Abnormal left ventricular torsion and cardiac autonomic dysfunction in subjects with type 1 diabetes mellitus.** *Metabolism* 2011, **60**:1115–1121.
42. Ichikawa R, Daimon M, Miyazaki T, Kawata T, Miyazaki S, Maruyama M, Chiang SJ, Suzuki H, Ito C, Sato F, et al: **Influencing factors on cardiac structure and function beyond glycemic control in patients with type 2 diabetes mellitus.** *Cardiovasc Diabetol* 2013, **12**:38.
43. van Schinkel LD, Auger D, van Elderen SG, Ajmone Marsan N, Delgado V, Lamb JJ, Ng AC, Smit JW, Bax JJ, Westenberg JJ, de Roos A: **Aortic stiffness is related to left ventricular diastolic function in patients with diabetes mellitus type 1: assessment with MRI and speckle tracking strain analysis.** *Int J Cardiovasc Imaging* 2013, **29**:633–641.
44. Reinhard H, Hansen PR, Wiinberg N, Kjaer A, Petersen CL, Winther K, Parving HH, Rossing P, Jacobsen PK: **NT-proBNP, echocardiographic abnormalities**

and subclinical coronary artery disease in high risk type 2 diabetic patients. *Cardiovasc Diabetol* 2012, **11**:19.

45. Murray JJ, Weiler JM, Schwartz LB, Busse WW, Katial RK, Lockey RF, McFadden ER Jr, Pixton GC, Barrett RJ: **Safety of binodenoson, a selective adenosine A2A receptor agonist vasodilator pharmacological stress agent, in healthy subjects with mild intermittent asthma.** *Circ Cardiovasc Imaging* 2009, **2**:492–498.
46. Gaibazzi N, Reverberi C, Lorenzoni V, Molinaro S, Porter TR: **Prognostic value of high-dose dipyridamole stress myocardial contrast perfusion echocardiography.** *Circulation* 2012, **126**:1182–1184.

doi:10.1186/1475-2840-12-84

**Cite this article as:** Cognet *et al.*: New concept of myocardial longitudinal strain reserve assessed by a dipyridamole infusion using 2D-strain echocardiography: the impact of diabetes and age, and the prognostic value. *Cardiovascular Diabetology* 2013 **12**:84.

**Submit your next manuscript to BioMed Central  
and take full advantage of:**

- **Convenient online submission**
- **Thorough peer review**
- **No space constraints or color figure charges**
- **Immediate publication on acceptance**
- **Inclusion in PubMed, CAS, Scopus and Google Scholar**
- **Research which is freely available for redistribution**

Submit your manuscript at  
[www.biomedcentral.com/submit](http://www.biomedcentral.com/submit)

