We thank Dr de la Hera and colleagues for their insightful comment on our study. We fully agree with their opinion: diabetic patients with a higher risk should be identified and correct selection should be made using a diagnostic technique that can identify patients really at high risk. Also, strict control of cardiovascular risk factors should be achieved by conventional medical treatment, but only in certain scenarios (left main or proximal anterior descending disease, 3-vessel disease with left ventricular dysfunction or a high ischemic burden) should revascularization therapy be performed in addition to conventional medical therapy.

There is no firm evidence that the multidetector computed tomography-based approach to screening for asymptomatic cardiac ischemia can improve clinical outcome in diabetic patients. On the contrary, the FACTOR64 trial demonstrated that screening for coronary artery disease in asymptomatic diabetic patients with good metabolic control does not confer better outcomes. Our study was not done to prove longitudinal outcomes by multidetector computed tomography, but to evaluate the prevalence and severity of coronary artery lesions, which may improve prediction of future coronary events, in asymptomatic diabetic patients. Currently, we do not have solid evidence supporting routine screening of asymptomatic diabetic patients by multidetector computed tomography. Namely, we need to wait the answer until the natural course of coronary vascular events in our asymptomatic patients with or without coronary stenosis will be clarified.

We also concur with their point of view: what we really need to do is to identify the 4 scenarios as described. A diagnostic technique with high specificity as a functional imaging test, like stress echocardiography or single-photon emission computed tomography, may be useful for detecting the 4 scenarios. However, according to the Standards of Medical Care in Diabetes 2015 by the American Diabetes Association, the screening of high cardiovascular disease risk but asymptomatic patients with myocardial perfusion imaging followed by invasive coronary angiography is not recommended, because these high-risk patients should already be receiving intensive medical therapy, an approach that provides similar benefit as invasive revascularization. We need to find the approach with the ultimate balance of benefit, cost, and risks of such an approach in asymptomatic patients, in the modern setting of aggressive cardiovascular disease risk factor control.

References

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