after an oral 75 g glucose challenge in 35.7%. Among non-diabetic patients, 26.1% had impaired glucose tolerance (IGT), from these 41.7% also had impaired fasting glucose (IFG) ≥100 mg/dl. Among subjects with normal glucose tolerance, 23.5% had IFG. Thus, the overall prevalence of abnormal glucose metabolism was 65.3% in the investigated patients with sonographically proven PAD.

To the best of our knowledge this is the first study reporting the prevalence of IFG, IGT and diabetes in patients with sonographically proven PAD. In the light of our data screening for abnormal glucose metabolism in individuals with PAD appears mandatory. On the one hand, PAD progresses more rapidly in patients with diabetes than in non-diabetic individuals [2,3] and aggressive risk factor intervention is mandatory in patients with the combination of PAD and diabetes. In particular, the diagnosis of diabetes in individuals with PAD might affect the goal for LDL lowering therapy [4]. On the other hand, a great proportion (up to 70%) of patients with IFG and IGT will eventually develop diabetes. Lifestyle interventions aiming at modest weight loss (5–10% of body weight) and moderate-intensity physical activity (~30 min daily) are warranted to address the high diabetes risk of these patients [5].

The authors of this manuscript have certified that they comply with the Principles of Ethical Publishing in the International Journal of Cardiology [6].

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Tako-tsubo syndrome: Report of a case with mild electrocardiographic changes but with multiple wall motion abnormalities

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In tako-tsubo cardiomyopathy the electrocardiographic changes during chest pain are often similar to those found in the anterior precordial leads in patients with acute anterior ST-elevation myocardial infarction (STEMI). In typical cases the echocardiographic examination will usually show hyperkinesia of basal segments with akinesia of the apex and midventricular wall according to ECG repolarization changes. The ultimate diagnosis is made in the cardiac catheterization laboratory by absence of obstructive coronary artery disease at angiography and by typical ballooning

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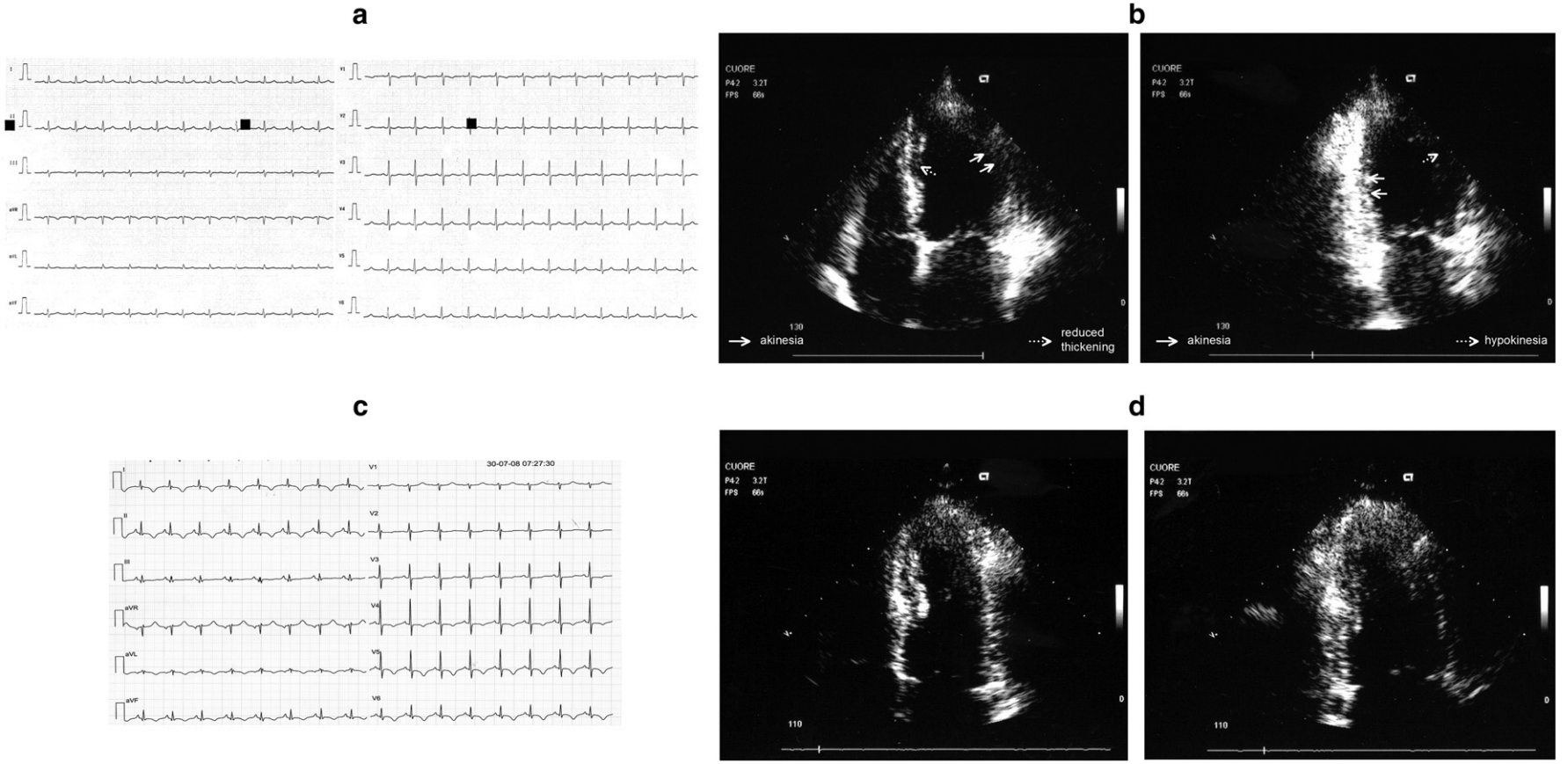

Fig. 1. a and b: comparison between electrocardiogram and echocardiogram performed during anginal pain. Discrepancy was observed between the ECG pattern showing only mild repolarization changes and the ECHO examination showing wall motion abnormalities of the mid-segments of the left ventricle. c and d: ischemic T wave inversion in inferior and precordial leads found on the second day is in contrast with the full restoring of normal wall motion of the left ventricle at the same day of ECHO examination.