

TABLE 1 The Strengths and Limitations for the Japanese “+10 for Your Health” Guideline

Strengths	Limitations
1. Great motivator to initiate for the inactive	1. Not easy to sustain, as it tends to be overlooked as a daily routine
2. In line with increasing evidence of minimum amount of exercise, such as 15-min walking or 5-min running	2. Significant health benefits from 10 min of walking has not been scientifically documented; “+15” may be better than “+10”
3. Easy to start and to accomplish	3. May be too short to have aerobic effects—most of the 10 min may be spent just in warming up
4. Most welcome by the elderly and disabled for this proposal	4. Younger adults gain less benefits and have less enjoyment
5. Easy to squeeze into one's schedule	5. Not enough time for socialization
6. Any exercise of 10 min duration counts	6. Confusion with nonexercise activity

a no-brainer to expect a miracle, once one starts to move “+10” regularly. As Chinese philosopher Lao-tzu said, “A journey of a thousand miles starts with your single step,” (1) a 10-min dedicated brisk walk is worth every bit of the 1,000 steps it requires. Proof of these benefits will be experienced by the Japanese, who grabbed the low lying fruit of 10 min of exercise and declined to wait for the full 30-min prize, as if they knew “a bird in hand is worth two in the bush”.

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Is the Long-Term Outcome of PCI or CABG in Insulin-Treated Diabetic Patients Really Worse Than Non-Insulin-Treated Ones?



(Comparison of Two Treatments for Multivessel Coronary Artery Disease in Individuals With Diabetes) trial, found that in patients with diabetes and multivessel coronary artery disease, the rate of major adverse cardiovascular events (death, myocardial infarction, or stroke) is higher in patients treated with insulin than it is in those not treated with insulin. Their work is excellent, and the results deserved to be considered given the large number of patients with diabetes and multivessel coronary artery disease who are being treated with insulin. However, the investigators overlooked several issues that might influence the results that we shall discuss in the following text.

First, the patients were simply categorized into insulin-treated diabetes mellitus (ITDM) and non-ITDM according to their baseline use of insulin (either alone or in combination with other oral antidiabetic medication). However, the investigators ignored the duration of insulin treatment and the dose of insulin. Also, the kinds of oral antidiabetic medications were unreported both in the ITDM and non-ITDM groups.

Second, the hemoglobin A_{1c} was significantly higher in ITDM patients at baseline, which indicated that ITDM patients were undertreated in the study. But, why did this situation occur? Possibly because of one of the following: poor self-monitoring of blood glucose; worsening medical condition; insufficient insulin dose; or more severe insulin resistance. Moreover, the quality of blood glucose control was not reported either. From the original paper, we could not assess the following queries: How many patients discontinued insulin treatment? How often did the hypoglycemia happen? What would the hemoglobin A_{1c} be within the 5-year follow-up?

Furthermore, the prevalence of peripheral neuropathy was considerably low in the study compared with prior studies (1,2). There were only 5.2% peripheral neuropathy in non-ITDM patients, and 14.3% in ITDM patients. How do the investigators explain this?

Ultimately, this was a post-hoc analysis based on the FREEDOM trial. Though a multivariable Cox

In a recent issue of the *Journal*, Dangas et al. (1), after analyzing 1,850 subjects from the FREEDOM

regression was used to adjust the confounding factors, the residual confounding still should not be ignored because this method is not powerful enough to fully adjust for unmeasured patient difference (3). Falsification hypotheses might be a more effective statistical method in observation studies (4).

In other words, whether the rate of major adverse cardiovascular events were really higher in patients treated with insulin compared with the rates for those not treated with insulin still needs more rigorous trials.

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