**Background.** Coronary heart disease (CHD) is the leading cause of death in persons with diabetes mellitus (DM). Insulin resistance, a defining feature of type 2 DM, is associated with a cluster of metabolic and biochemical abnormalities including hyperglycemia, arterial hypertension, atherogenic dyslipidemia, inflammation, endothelial dysfunction, and impaired fibrinolysis. Each of these abnormalities promotes the development of atherosclerosis and clinical cardiovascular diseases. Longitudinal epidemiologic studies report a similar incidence of cardiovascular and all-cause mortality between persons who have diabetes without evidence of prior coronary heart disease and persons who have CHD without prior DM. As a result, DM is often termed a CHD risk equivalent. However, the growing incidence of type 2 DM in young adults and adolescents requires that any claims about diabetes as a CHD risk equivalent be qualified by the age of the affected person.

**The objective** of our study was to conduct the comparative analysis the profile of cardiovascular risk factors in patients with CHD and normal and impaired carbohydrate metabolism.

**Materials and methods.** Under a supervision there were 142 patients. With the aim of estimation of frequency of different forms of CHD depending on the state of carbohydrate metabolism such groups were formed: the first group – 83 patients with type 2 diabetes mellitus (DM), second group – 34 patients with impaired glucose tolerance (IGT), the third group is 25 patients with a normal carbohydrate metabolism. For the exposure of ischemic changes of myocardium conducted ambulatory ECG monitoring with the obligatory achievement of submaximal heart frequency in the process of research. The baseline examination included interview and detailed clinic physical examination. Participants completed standardized questionnaires and interviews to assess demographic characteristics, cardiovascular disease risk factors, and lifestyle risk factors. Systolic and diastolic blood pressure (SBP and DBP, respectively) was measured in duplicate and averaged. Hypertension was defined as SBP≥140 mm Hg or DBP≥90 mm Hg or a
physician diagnosis of hypertension plus the use of antihypertensive medications. Participants who were free from prevalent clinical cardiovascular disease were identified as having subclinical disease if they had any of the following measurements: ankle-brachial index <0.9; carotid stenosis >25%; major ECG abnormalities based on Minnesota code; and Rose questionnaire positive for claudication or angina in the absence of a clinical diagnosis of angina or claudication.

**Results.** Silent myocardial ischemia was educed in 19 (22.9%) patients with type 2 DM, in 3 (8.8%) persons with IGT and in 2 (8.0%) patients with a normal carbohydrate metabolism. Smoking, burdened heredity, violation in the haemostatic system more often happened in the group of patients with type 2 DM and silent myocardial ischemia in comparing to the patients with type 2 DM without CHD. The profile of population cardiovascular risk factors in patients with CHD and type 2 DM belongs to most unfavorable. In the same time for patients with early violations of carbohydrate metabolism and normal carbohydrate metabolism such profile statistically does not differentiate meaningfully. **Conclusions.** Patients with type 2 DM and silent myocardial ischemia as compared to patients with type 2 DM without CHD more expressed violations of indexes of population cardiovascular risk factors have for certain.