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### Immediate versus deferred coronary angioplasty in non-ST-elevation acute coronary syndromes: Reply

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## The authors' reply

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reducing periprocedural MI are well documented.<sup>6,7</sup>

The results of this study must be interpreted with caution and any change in clinical practice resisted until alternative methods of assessing periprocedural MI (eg, novel biomarkers like N-terminal pro-B-type natriuretic peptide,<sup>8</sup> intra-coronary multi-channel ECG recording<sup>9</sup> and myocardial scintigraphy) and the optimal timing of coronary intervention have been further evaluated in patients with ACS. Newer antithrombotic and second-generation antiplatelet agents may also confer benefit in this situation.

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**Competing interests:** None.

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**The authors' reply:** Immediate percutaneous coronary intervention (PCI) is currently thought to be useful for ischaemia at early onset, thereby minimising detrimental consequences of vessel occlusion. By selecting only those patients with onset of chest pain within 6 h (median 3 h) we included a consecutive series of acutely unstable patients. By definition this restricted the inclusion rate.<sup>1</sup>

Moreover, the use of creatine kinase-MB as an end point is questioned by Kumar *et al*.<sup>2</sup> However, meta-analysis showed that less periprocedural tissue necrosis is associated with an improved clinical course.<sup>3</sup> This and other evidence led to the consensus that PCI-related ischaemic events have adverse effects on patient outcome.<sup>4</sup> However, it must be kept in mind that our study was not powered to detect a difference in survival. For this, one would need a trial with at least 10 000 patients to demonstrate an effect on mortality.

In addition, Kumar *et al* point to differences in baseline characteristics which do not favour the immediate PCI group. Although the prevalence of hypertension and previous coronary artery bypass grafting, was higher in the immediate group, adjustment for these differences by multivariate analyses did not alter the results of the study. Other baseline factors like TIMI flow favoured the immediate PCI group.<sup>1</sup>

At the time of patient inclusion, a loading dose of 300 mg clopidogrel was customary. Nowadays, the protocol in our hospital is to use a high loading dose when patients apply

for immediate PCI. It is only recently that this practice has been advocated by the cardiac societies.<sup>5</sup> The addition of abciximab to aspirin and clopidogrel was—wrongly—thought to provide sufficient periprocedural protection in the immediate treated group.<sup>6</sup> Furthermore, virtually all patients were pretreated with atorvastatin 80 mg.

We agree with the authors that the results of our study should be interpreted with care, in particular because of the small sample size. Nevertheless, we would like to emphasize that there is absolutely no evidence demonstrating the clinical superiority of immediate PCI over the deferred approach (beyond 24 h).

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