Background: Recurrent myocardial infarction (reMI) remains a limitation of fibrinolytic therapy. We hypothesized that following fibrinolytic administration, performance of percutaneous coronary intervention (PCI) during the index hospitalization is associated with lower rates of recurrent MI and death compared to conservative management. Methods: Since June 2000 consecutive pts with ACS have been enrolled into the ACOS-Registry in 154 hospitals in Germany. We analysed the impact of first day PCI in diabetics with NSTEMI in hospital outcome. Results: Out of 12154 consecutive patients with ACS, 4954 (41%) presented with NSTEMI (1567 diabetics). First day PCI was performed in 4131 (32%) of patients. Mortality was also lower in patients treated with PCI vs. patients without PCI (1.6% vs. 4.5%, p<0.001). Mortality was also lower in patients treated with PCI (p=0.0001; Figure). Similar results were seen across the low, intermediate, and high TIMI risk scores (Figure). Both PCI and recurrent MI remained associated with 2 year mortality in a model adjusting for age, anterior MI, pulse on admission, and gender (PCI hazard ratio=0.51, p<0.001; recurrent MI hazard ratio=1.95, p<0.001). Conclusion: Following thrombolytic administration, PCI during the index hospitalization was associated with a lower rate of in-hospital recurrent MI and improved 2 year survival.

Prosppective Study of Primary Percutaneous Intervention and Abciximab in Patients With ST Elevation Myocardial Infarction Complicated by Cardiogenic Shock

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Background: Patients presenting with ST-elevation myocardial infarction (STEMI) complicated by cardiogenic shock have a high mortality despite early interventional therapy. Antithrombotic therapy with potent UNA-platelet inhibition with abciximab has been shown to reduce ischemic complications after PCI and improve outcome. Therefore we performed a prospective multicenter study to evaluate a routine strategy of primary percutaneous intervention (PCI) and adjunctive therapy with abciximab in patients with STEMI complicated by cardiogenic shock.

Methods: Forty patients with STEMI < 12 hrs were enrolled in this trial. All patients received abciximab before or in the cath-lab before start of the PCI. Half of the patients had prior CAG or ICA or CTA were imputed on enrollment in the study. A 3-vestibled device was present in 72.5% of the patients. An occluded infarct-vestibule (TIMI 0/1 flow) before PCI was observed in 85%. The patients were prospectively followed for 30-day outcome. Results: The intervention was successful in 99.5% of the patients, 80% had TIMI 3 flow after the PCI. A stent was implanted in 85% of the patients. Major bleeding complications were observed in 5% of the patients. The 30-day mortality rate was 4.9%. In patients < 70 yrs (n=309) mortality was 4.1%, while in all tertile (n=1011) of the patients > 75 yrs died. Conclusion: A routine strategy of primary PCI and adjunctive therapy with abciximab in patients with STEMI complicated by cardiogenic shock is safe and associated with a high rate of successful interventions and seems to improve outcome in patients ≥ 75.

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Reduction in Hospital Mortality by First Day Percutaneous Coronary Intervention for Non-ST Elevation Myocardial Infarction: Results of the ACOS-Registry

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Background: Current studies have reported a reduction in mortality by first day PCI in patients (pts) with acute coronary syndromes (ACS) without persistent ST-elevation. Data on outcome of high risk diabetics with non-ST-elevation myocardial infarction (NSTEMI) in clinical practice do not yet exist.

Methods: Since June 2000 consecutive pts with ACS have been enrolled into the ACOS-Registry in 154 hospitals in Germany. We analysed the impact of first day PCI in diabetics with NSTEMI in hospital outcome. Results: Out of 12154 consecutive patients with ACS, 4954 (41%) presented with NSTEMI (1567 diabetics). First day PCI was performed in 4131 (32%) of patients. Mortality was also lower in patients treated with PCI vs. patients without PCI (1.6% vs. 4.5%, p<0.001). Mortality was also lower in patients treated with PCI (p=0.0001; Figure). Similar results were seen across the low, intermediate, and high TIMI risk scores (Figure). Both PCI and recurrent MI remained associated with 2 year mortality in a model adjusting for age, anterior MI, pulse on admission, and gender (PCI hazard ratio=0.51, p<0.001; recurrent MI hazard ratio=1.95, p<0.001). Conclusion: Following thrombolytic administration, PCI during the index hospitalization was associated with a lower rate of in-hospital recurrent MI and improved 2 year survival.

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Improved Functional Status and Quality of Life After Invasive Management of Non-ST-Segment Elevation Acute Myocardial Infarction

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Background: While recent studies suggest that clinical outcomes may be improved by invasive management following non-ST-segment elevation acute myocardial infarction (AMI), it remains unclear whether functional status and quality of life (QOL) are affected by an invasive strategy.

Methods: We randomized 63 patients to invasive vs. non-invasive management following non-ST-segment elevation AMI. Functional status was assessed using maximal exercise endurance on a treadmill at 12 months and the Duke Activity Status Index (DASI) at 1 month. Quality of life was assessed using the SF-36 (SF-36). Results: Patients were predominantly middle-aged men (56.3 ± 12.0 years, 81.4% male). Of the patients randomized to an invasive strategy, 78.6% received angiography. Of the patients randomized to the non-invasive strategy, 0.1% received functional testing. Cumulative revascularization rates were similar in both groups (24.4 vs. 20.0% respectively). Maximal exercise endurance (sec) at 12-months did not show a significant difference between the two arms (622.1 vs. 666.7, P=NS). The invasive arm was found to have improved functional status by a mean difference of 6.8 (P<0.05) in DASI Score between 12-months and baseline. The invasive arm was also found to have improved QOL with the general health and physical functioning measures of the SF-36 showing a trend toward improved QOL (mean difference = -0.7, P=0.10, +0.2, P=0.10, respectively). The SF-36 anginal stability and angina frequency measures showed a significant