POSTER SESSION

1050 Management of Acute Coronary Syndromes: Considerations for Special Populations

Sunday, March 17, 2002, 3:00 p.m.-5:00 p.m.
Georgia World Congress Center, Hall G
Presentation Hour: 4:00 p.m.-5:00 p.m.

1050-38 Disparate Clinical Outcomes of Diabetic and Nondiabetic Patients Undergoing Primary Angioplasty for Acute Myocardial Infarction: Is Diabetes Mellitus an Independent Predictor of Poor Outcome?

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Background: Prior studies examining the effect of diabetes mellitus (DM) on outcome after primary angioplasty in AMI are limited by small size & have been inconclusive.
Methods: We compared baseline characteristics & angiographic & clinical outcomes between DM (n=626) & non-DM (n=3116) pts enrolled in the PAMI trials.
Results: DM pts were older (64 vs 60 yrs), more likely to be female (37 vs 25%), present with Killip class > 1 (18 vs 13%), & have a history of HTN (63 vs 44%), heart failure (6 vs 2%), CVA (9 vs 5%), PVD (12 vs 5%), prior MI (20 vs 14%), prior PTCA (15 vs 9%), & prior CABG (7 vs 4%). They were less likely to be smokers (28 vs 43%) & have SBP <100 mmHg (27 vs 32%). DM pts had longer onset-to-presentation (172 vs 156 min), & door-to-balloon times (163 vs 156 min) & lower LVEF (47 vs 49%), but were more likely to have baseline TIMI-flow >1 (36 vs 30%; p<0.05 for all). They had more multivessel disease (60 vs 47%, p<0.0001) but were equally likely to have angiographic thrombus (64 vs 63%), anterior MI (43 vs 42%), & less likely to undergo PCI (88 vs 91%, p=0.01). Technical success (95 vs 97%), stent use (31 vs 34%) & final TIMI-3 flow (92 vs 93%) were similar between groups. DM pts were more likely to develop pulmonary edema (8 vs 5%), sustained hypotension (8 vs 6%), & to require dialysis (1.4 vs 0.3%) & CABG (11 vs 8%) during hospitalization. They had higher rates of in-hospital death (4.6 vs 2.6%, p=0.005), but similar rates of reinfarction (1.3 vs 0.9%), ischemic TVR (I-TVR; 2.0 vs 3.2%), & MACE (7 vs 6%). During 1-yr follow-up, DM pts had similar rates of I-TVR (16 vs 19%), but higher reinfarction (6 vs 3%, p=0.005), death (10 vs 6%, p=0.001), & MACE (25 vs 20%; p=0.014). In multivariate analysis, DM was independently associated with 1-yr reinfarction (OR = 1.9; CI = 1.2 – 2.9), but not with in-hospital death (OR=1.1, CI=0.6-2.0) or MACE (OR=1.0, CI=0.7-1.5), or 1-yr death (OR=1.4, CI=0.96-2.1) or MACE (OR=1.1, CI=0.9-1.4).
Conclusions: DM pts undergoing primary angioplasty have worse baseline clinical features and unfavorable in-hospital & 1-year outcomes compared to non-DM pts. The presence of DM independently increases the risk of reinfarction during 1-yr follow-up, though the higher death rate may be explained by comorbid risk factors.

1050-39 Does Abciximab and Stenting Improve Outcomes in Elderly Patients Undergoing Primary PCI for Acute Myocardial Infarction: Data From the CADILLAC Trial

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Background: Elderly patients (75 yrs or greater) constitute a growing subset of patients presenting with AMI. Previous trials have demonstrated worse acute and long-term outcomes in elderly patients with AMI. The CADILLAC Trial did not exclude patients on the basis of age and utilized lower profile stents along with abciximab. Whether newer stents and 2b3a inhibitors improve outcomes in elderly patients with AMI is unknown.
Methods: 2082 AMI patients of any age w/in 12 hrs of symptom onset (excl. cardiogenic shock) were randomized at 76 sites to primary PTCA, PTCA with abcix, stent alone, or stent with abcix.
Results: Elderly patients (75 yrs or >) comprised 13.1% (273/2082) of all patients enrolled in the CADILLAC trial. At 30 days, elderly patients had higher mortality (4.8% vs 1.6%,p=.002) and MACE (9.2% vs 5.1%,p=.012). Elderly pts assigned to stenting had higher mortality at 30 days compared to stent pts <75 yrs (6.6% vs 1.6%, p=.002). At 1-year elderly pts, demonstrated greater mortality (11% vs 3%, p<.001) and increased MACE (21.6% vs 15.6%,p=.016).
Conclusion: Elderly patients with AMI continue to have worse outcomes even with adjunctive 2b3a inhibitors and contemporary low-profile stents. A 1-year mortality of 11% in elderly patients suggests treatment strategies beyond stenting and abciximab may be required in this high-risk subgroup

6-Month Outcomes	PTCA<75 yrs	PTCA >75 yrs	Stent<75 yrs	Stent ≥75 yrs
N	909	136	899	137
Death	2.6%*	7.4%	2.2**	10.2%
MACE	16.3%	24.3%	9.7%	13.9%
Ischemic TVR	13.3%	16.2%+	6.6%	3.7%
Disabling CVA	0.4%	0.7%	0.8%	1.5%
All Strokes	0.8%	1.5%	1.3%	2.9%

***p=.01 PTCA<75 vs PTCA≥75yrs ; **p<.001 stent <75 vs stent ≥75yrs; +p<.001 PTCA≥75 vs stent ≥75yrs**

1050-40 Excessive Hospital Mortality of ST Elevation Myocardial Infarction in Female Diabetics: Results of the MITRA and MIR Registries

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Background: Patients with known diabetes and acute ST-elevation myocardial infarction (STEMI) are on increased risk of hospital mortality. Recent studies have shown an increased risk in female STEMI patients. It is unknown, if female gender has an impact on the hospital course of diabetic STEMI patients.
Methods: We analysed the prospective data of 6502 / 28401 (23%) STEMI-patients with known diabetes of the MITRA- and MIR-registries to identify the impact of female gender on acute treatment and hospital outcome of STEMI in diabetics.
Results: Diabetic STEMI patients were less likely to receive reperfusion therapy (OR 0.82, p<0.01) and ß-blockers (OR 0.80, p<0.01) as compared to non-diabetics. Out of the 6502 diabetic patients with STEMI 3043 (23%) were female. After correcting for baseline differences in diabetics with STEMI, female gender was an independent determinant against acute reperfusion therapy (OR 0. 72, 0.65-0.81) and ß-blocker therapy (OR 0.83, 0.74-0.93). After correction for these differences in acute therapy in a multivariate analysis, female diabetics had a significantly increased hospital mortality as compared to male diabetics (OR 1.27, 1.09-1.49).
Conclusion: Female diabetic STEMI patients were less likely to receive acute reperfusion therapy than diabetic men. Within the diabetic STEMI patients with already increased risk of hospital mortality compared to non-diabetics, female diabetics had a 27% increased hospital mortality as compared to male diabetics.

	Female diabetics	Male diabetics	p
Age	75	68	<0.001
Acute Reperfusion	34.2 %	47.5 %	<0.001
Aspirin	89.2 %	92.1 %	<0.001
ß-blockers	47.9 %	57.8 %	<0.05
ACE-inhibitors	62.8 %	63.7 %	<0.001

1050-41 Does Gender Independently Influence the Treatment and Outcomes of Patients With Early Reinfarction After Fibrinolysis?

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Despite the high-risk nature of patients who sustain in-hospital reinfarction (re-MI) after fibrinolytic therapy for acute myocardial infarction, surprisingly little is known about how gender modulates the treatment and outcomes of this important subset of patients. Accordingly, we analyzed the 13,028 men and 3,921 women in ASSENT-2 to examine this issue.
The table provides key data according to gender of the 4.0% of patients who sustained re-MI (female vs. male incidence: 4.8% vs 3.7%; p = 0.002).
Although rates of urgent revascularization were similar, women with re-MI less often received repeat fibrinolysis despite similar total ST elevation on the re-MI ECG and timing of re-MI. This pattern persisted even after adjustment for baseline and bleeding prior to re-MI (odds ratio [OR]: 0.57, 95% confidence interval [CI]: 0.4 - 0.9). Although women with re-MI had higher mortality both at 30 days and 1 year, their apparent excess mortality was eliminated after adjustment for baseline covariates (30 days OR: 1.45, 95% CI: 0.9-2.5; 1 year OR: 0.98, 95% CI: 0.6 - 1.6). Additional adjustment for re-MI treatment strategy further reduced the apparent survival disadvantage in women (30 days OR: 1.29, 95% CI: 0.8 - 2.2; 1 year OR: 0.84, 95% CI: 0.5 - 1.4).
We conclude that the worse outcomes in women with re-MI are largely due to their unfavorable baseline risk profile. Our results suggest a true gender bias exists in the use of repeat fibrinolysis. Further investigation is required to assess its impact on the worse outcomes in women.

	Men (n=481)	Women (n=189)	p
Age (years)*	64 (54-72)	69 (60-76)	<0.001
Hypertension	37%	61%	<0.001
Diabetes	16%	24%	0.03
In-hospital bleeding prior to re-MI	17%	29%	0.001
Time to re-MI (days)*	3 (1-4)	3 (1-5)	0.11
Re-MI total ST elevation (mV)*	8 (5-14)	7 (4-13)	0.25
Re-MI peak CK>5x normal	37%	39%	0.67
Repeat fibrinolysis	41%	31%	0.02
PTCA or CABG <48 hours after re-MI	34%	31%	0.47
Death at 30 days	14%	24%	0.004
Death at 1 year	20%	27%	0.04

*Median (25th-75th percentiles)