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Compared efficacy and safety of a standard versus a loading dose of clopidogrel at the acute stage of myocardial infarction in elderly patients. The FAST-MI registry data.

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Background: Data are lacking on the efficacy and safety of a loading dose of clopidogrel in the elderly with acute myocardial infarction (AMI).

Aim: To determine 30-day and one-year mortality, as well as in-hospital bleeding risk in elderly patients with AMI according to the use of a loading dose of clopidogrel (≥ 300 mg).

Methods: FAST-MI is a nationwide registry carried out over a 1-month period from 2005, involving consecutive patients with AMI admitted to ICUs < 48 hours from symptom onset in 223 participating centers. We assessed impact of clopidogrel loading dose on bleeding, the need for blood transfusion and 12-month survival in elderly patients (aged ≥ 75 years).

Results: 791 elderly patients were included (Mean age 81 ± 4 years, 48 % women; 35% STEMI). 59% (466 patients) have received a clopidogrel loading dose (≥ 300mg). Follow up > 98% complete. Major bleeding and blood transfusions were not significantly different in patients having received a loading dose of clopidogrel or a conventional 75 mg dose, respectively 3.7 % vs. 3.2 (p>0.05) and 6.2 % vs. 5.4 (p>0.05). Early and one-year mortality were also not significantly different. Using multivariate analyses: Clopidogrel loading dose was not associated with a significant increase major bleeding or transfusion (OR=1.09; 95%CI:0.50-2.40, p=0.82); and 12-month mortality (OR=0.95; 95%CI:0.65-1.29, p=0.61).

Conclusion: The present data show that in elderly patients admitted for AMI use of a loading dose of clopidogrel was not associated with increased in-hospital bleeding, need for transfusion, or mortality. These results persisted after multivariate adjustment. Large-scale randomized trials are still needed to identify the optimal loading dose of clopidogrel for elderly patients admitted for AMI.

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ST-elevation myocardial infarction admission during "ON-" versus "OFF-" hours: is there an impact on outcome for primary PCI?

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Background: It has been suggested that delays, quality and outcome of reperfusion therapy provided to ST-Elevation Myocardial Infarction (STEMI) patients during OFF-hours (nights and weekends) are worse than during ON-hours (day working hours).

Methods: We studied 736 consecutive STEMI patients transferred for primary percutaneous coronary angioplasty (PCI) to a single large volume urban Primary PCI center. Characteristics and clinical outcome of patients admitted during ON-hours (Monday through Friday 8 am-6 pm) were compared to OFF-hours patients (admitted during night shifts and weekends). Clinical outcome was 1 year death and death or MI.

Results: STEMI patients undergoing primary PCI were admitted more frequently during OFF-hours (n=449; 61.1 %) than ON-hours (n=287; 38.9 %), with no major differences in characteristics or treatment between the two groups. Use of radial approach and the rate of stenting during PCI was 83.3% and 88.1% in ON-hours patients vs. 88.2% and 88.1% in OFF-hours patients. There was no impact of time of admission on in-hospital mortality or after adjustment for baseline characteristics OR 1.54; CI [0.71-3.35]. Time from symptom onset to first medical contact was shorter during OFF-hours than ON-hours (105 min [50-225] vs. 114 min [60-367]; p=0.06). Time from first medical contact to sheath insertion was also identical between the 2 groups (101 min [80-155] and 105 min [78-155]; p=0.61 respectively). Time to TIMI 3 flow and duration of procedure were also similar. At one year, all cause mortality and the composite end point of death or MI was 8.3% and 12.2% for OFF-hours patients vs. 7.0% and 10.8% in ON-hours patients, p=0.4 and p=0.3 respectively.

Conclusion: In a well-organized urban STEMI network, were 61% of patients referred for primary PCI are admitted during “OFF” hours, admission time does not impact quality of care or outcomes.

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No reflow after primary percutaneous coronary angioplasty in ST elevation myocardial infarction: incidence and risk factors

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Background: After urgent percutaneous coronary intervention (PCI) in ST elevation myocardial infarction (STEMI), a sizable proportion of patients achieve epicardial but not myocardial reperfusion. This condition known as no reflow phenomenon is associated with a worse prognosis.

Aim: To determine the incidence and clinical and angiographic risk factors of No reflow. Population, methods and results: Our cohort included 900 consecutive patients with STEMI (mean age 59.2± 13.3 years, 87.7 % males) referred to our service for primary or rescue PCI. Patients presented with anterior myocardial infarction in 62.2% of cases, cardiovascular risk factors were: smoking: 87.7%, diabetes: 31.1%, hypertension: 37.7% and dyslipidemia: 20%. Patients had an intimal TIMI flow = 0 before the procedure in 90.1% of cases and they achieve a TIMI 3 flow after PCI in 65.5 % of cases. No reflow phenomenon occurred in 24.4 % of patients and were associated to poorer in hospital prognosis with more frequent major cardiovascular events (cardiac insufficiency, chock, re-infarction and death) (17.6% vs 6.1%, p<0.01). Identified independent predictor factors of no reflow phenomenon were final TIMI flow inferior to 3 (68.2 vs 22.1% p<0.01, RR=3.6), presence of multiple thrombus fragments or thrombus in front of the culprit lesion (65.1% vs 31%, p<0.01, RR=2.9) and longer delay to intervention (11.5± 6.1 vs 7.7± 5.7 hours, RR=1.8). Thrombus aspiration was the only therapeutic measure reducing the risk of no reflow phenomenon in this cohort (16.3% vs 35.8%, p<0.01).

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