come was assessed for perioperative adverse cardiac events including death, STEMI, NSTEMI, stent thrombosis, and target vessel revascularization (TVR). NSTEMI was defined by meeting two of the following criteria: chest pain > 30 minutes, new ECG changes consistent with ischemia and troponin or CK-MB elevation > 2 times the upper limit of normal. Major bleeding, defined as postoperative transfusion or need for reoperation, was also assessed.

Results: The study population consisted of 32 men and 14 women with a mean age of 68 years. 37% of patients had diabetes. PCI was successful and uncomplicated in all patients. A total of 58 lesions were treated with 62 stents, of which 55% were heparin coated. Clopidogrel was stopped at a median of 6 days prior to surgery. Following NCS, there were no deaths, STEMI or stent thrombosis. The only perioperative complication was one NSTEMI (2.2%) which led to TVR of a new lesion. Two patients (4.3%) required postoperative blood transfusion.

Conclusion: NCS can be safely performed after coronary stenting utilizing a therapeutic strategy of delaying surgery for greater than 5 weeks, discontinuing clopidogrel beforehand, and using heparin coated stents in high-risk patients.

**1063-54** Long-Term Clopidogrel Therapy Is Particularly Beneficial for Patients Requiring Repeat Revascularization After an Initial Percutaneous Coronary Intervention

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**Background:** Long-term clopidogrel improves clinical outcome after PCI. We hypothesized that long-term therapy may be particularly beneficial among patients developing recurrent stenosis (restenosis).

**Methods:** CREDO was a randomized, double-blind, placebo-controlled trial comparing clopidogrel pretreatment (300mg) and 1yr therapy (75mg/d), with no pretreatment and 11thn clopidogrel [control] after PCI. All patients received aspirin. The 1yr primary endpoint was a composite of death, MI, and stroke. We performed a post-hoc analysis evaluating the clinical efficacy of long-term clopidogrel compared with placebo among patients having 0, 1, or ≥2 revascularization procedures (clinical therapy, index PCI, or index PCI and subsequent PCI or CABG).

**Results:** Of 1874 patients enrolled, 2.5%, 76.7%, and 16.4% had 0, 1, and ≥2 procedures respectively. For the overall study population, the primary endpoint was significantly reduced with long-term clopidogrel compared to control (8.5% vs 11.5%, RRR 26.9%, p=0.025). Patients who did not undergo the index PCI (medical therapy or CABG) had no overt benefit with clopidogrel. Those who underwent only the index PCI had a trend in primary events reduction with clopidogrel (7.7% vs 9.6%, RRR 21.7%, p=0.19). In contrast, those requiring repeat revascularization had marked benefit with long-term clopidogrel (15.4% vs 24.1%, RRR 42.4%, p=0.05).

**Conclusions:** Long-term clopidogrel after PCI particularly benefits those requiring repeat revascularization.

**1063-55** A Pharmacodynamics-Epidemiologic Study of the Interaction Between Atorvastatin and Clopidogrel Following Percutaneous Coronary Interventions

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**Background:** Clopidogrel is commonly used following PCI to prevent thrombotic complications. A theoretical concern has been raised that atorvastatin by inhibition of the CYP3A4 enzyme may competitively inhibit the metabolism of the produg clopidogrel potentially negating these benefits. However, no clinical studies have tested this hypothesis.

**Methods:** Using the computerized administrative databases from the Province of Quebec, we identified all patients who had PCI between 1998 and 2000, survived until hospital discharge and received a prescription for clopidogrel within 7 days of a PCI. The relative risk (RR) of the composite endpoint of death, hospitalizations due to myocardial infarction or unstable angina, repeat revascularization procedures and stroke during the next 30 days was compared between patients receiving and not receiving a prescription for atorvastatin concurrently. Rates were adjusted by a multivariable logistic regression model for other medications, disease severity, associated comorbidities and demographic variables.

**Results:** There were 3,545 patients included in the analysis, 858 exposed and 2,687 not exposed to atorvastatin. Adjusted 30 day RR were increased to 2.04 (95% CI 1.29, 3.23) in patients prescribed atorvastatin with clopidogrel compared to those not prescribed atorvastatin. Other CYP3A4 inhibitors (RR 1.85, 95% CI 1.28, 2.69), male gender (RR 1.57, 95% CI 1.04, 3.30), previous MI (RR 2.67, 95% CI 1.15, 6.14), and heart failure (RR 2.53, 95% CI 1.17, 5.47) were also associated with increased risks while the use of aspirin or ticlopidine (RR 0.81, 95% CI 0.41, 0.91) was protective. Limiting the analysis to only patients receiving both clopidogrel and statins again showed an increased risk with atorvastatin (RR 1.98, 95% CI 1.22, 3.21).

**Conclusion:** An association between the concomitant use of atorvastatin and clopidogrel and adverse cardiovascular events following PCI has been found. The significance of this putative interaction merits further study.

**1063-56** A Randomized Comparison of Cilostazol Versus Clopidogrel After Coronary Stenting: The Preliminary Results

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**Background:** Although cilostazol, cyclic adenosine monophosphate phosphodiesterase inhibitor, is used to prevent subacute stent thrombosis, its safety and efficacy have not been compared with clopidogrel in a randomized manner.

**Methods:** Patients (n=651) who underwent coronary stenting were randomly assigned to receive cilostazol (n=325, 477 lesions) or clopidogrel (n=326, 495 lesions) in addition to 200 mg aspirin. Loading dose (cilostazol 200mg or clopidogrel 300mg) was administered immediately after coronary stenting. Study drugs were given for one month (cilostazol 100mg bid or clopidogrel 75mg qd). The primary endpoint consisted of subacute stent thrombosis or major adverse cardiac events (death, myocardial infarction, repeat intervention) within 30 days. The secondary end points were peripheral vascular complication, major bleeding, and any adverse events (neutropenia, thrombocytopenia, skin rash, liver dysfunction, and gastrointestinal trouble) requiring termination of study drugs during treatment period.

**Results:** Study populations included 83 patients (12.7%) with primary stenting for acute myocardial infarction. Subacute stent thrombosis occurred in 2 patients (0.6%) of cilostazol group and 2 patient (0.6%) of clopidogrel group (p=0.99). Four deaths occurred during follow-up in 2 patients (0.6%) of cilostazol group and 2 patient (0.6%) of clopidogrel group (p=0.99). The primary end point was reached in 1.0% of cilostazol group and 1.9% of clopidogrel group (p=0.99). The bleeding and vascular complication was seen in 0.6% of cilostazol group and 0.3% of clopidogrel group. Serious hematologic complications were not observed in the two groups. Study drug-related side effects requiring cessation of study drugs were not statistically different between two groups (0.6 % vs. 0.3 %, p=0.56).

**Conclusions:** Preliminary results of this ongoing study show that the regimen with cilostazol and aspirin appears to be safe and as effective as clopidogrel and aspirin in preventing thrombotic complication after coronary stenting.

**1063-57** Baseline Platelet Count Correlates With Ischemic Events and Mortality at Follow-Up After Percutaneous Coronary Intervention

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**Background:** Role of baseline platelet count and outcome after PCI has not been well established. It is possible that higher baseline platelet count may be associated with increased ischemic complications.

**Methods:** We analyzed 4,232 consecutive patients who had PCI between July 1999 and July 2002 from the database for peri-procedural events and survival at 365-days. Thrombocytopenic patients (platelet<150,000) were excluded from the study. The remaining patients were divided into two groups: Normal platelet count group (n=1,735) and high platelet count group (platelet count > 320,000, 90th percentile, n=497).

**Results:** There were no differences in procedural, clinical success, minor complications, or CKMB release between the two groups. The maximum ACT modestly correlated with the platelet count (r=0.1, p<0.0001). The incidence of stent thrombosis was higher in patients with high platelet count compared to normal platelet count(6.0% vs 0.1%, p=0.02). But, there was no difference noted in target vessel revascularization on follow-up. The platelet count correlates with risk of stent thrombosis (r-statistic=0.68, p=0.0014). Patients with high platelet count have a higher 365-day mortality (normal platelet: 1.3%; high platelet: 3.2%; Hazard Ratio 2.5 [1.3, 4.5], p=0.0000). This difference persisted regardless of whether glycoprotein IIb/IIa was used (p=0.0074). Proportional hazard model adjusting for age, hemoglobin, clinical syndrome, creatinine, liver disease, diabetes, use of Glycoprotein IIb/IIa inhibitors and age shows that high platelet count strongly predicts:

**Conclusions:** Baseline elevated platelet count is an independent predictor of long term survival after PCI, perhaps partly related to increased risk of stent thrombosis and short term MACE. Therefore, lifelong use of oral dual antiplatelet therapy may be indicated in this high risk subgroup post PCI.