patients who survive for 30 days remarkably well and during the next 9 years, 53% remain alive. Readily available baseline characteristics identify patients at increased risk for late mortality.

2:30 p.m. 815-4

Long-Term Survivors of Cardiogenic Shock Enjoy Good Functional Capacity, and a Strategy of Early Revascularization Is Protective Against Functional Class Deterioration and Death
Krishnan Ramanathan, Lynn A. Sleeper, Michael H. Picard, Harvey D. White, Thierry H. LeJemtel, Vladimir Dzavik, Deborah Tormey, Nancy E. Avis, Judith S. Hochman, New York University School of Medicine, New York, NY

Background: A strategy of emergency revascularization (ERV) in patients with cardiogenic shock (CS) complicating an acute myocardial infarction (MI) improves 12-month survival compared to initial medical stabilization with possible delayed revascularization (IMS). Due to the critical nature of CS patients pre-revascularization, it is unclear whether this survival benefit is associated with good or poor functional class and quality of life (QoL).

Methods: Our study cohort (n=126) was patients with at least one phone interview at 2-weeks post discharge (baseline), 6 and 12-months post-MI. Data were collected for a predefined secondary endpoint of the SHOCK trial using standardized instruments.

Results: At 1-year post-MI 87% of survivors were in NYHA I. The QOL score and the distributions of NYHA functional class (FC) were similar in the 2 treatment assignments at all time points (p>0.1). The proportion of patients at 1-year with improvement in FC was similar in the 2 treatments (18% overall), in the IMS group fewer remained stable (44% vs 71%) and more deteriorated or died (34% vs 15%). Proportion of patients in NYHA III/IV at 2-week (baseline) and 1-year was similar (67% vs 71%), in contrast the NYHA III/IV patients decreased (23% and 11%) due to deaths, significantly more in the IMS group (treatment group comparison of NYHA III/IV vs Death: p=0.036 for 6 and 12-months post-MI). Univariate correlates of a good outcome (not developing NYHA III/IV or Death) at 1-year post-MI were treatment assignment to ERV and NYHA III/IV at baseline (p=0.046 for both). Only treatment assignment to ERV was significant in a multivariate model for good outcome at 1-year post-MI OR=0.31 (95%CI 0.13-0.76, p=0.01).

Conclusion: Patients who initially survive cardiogenic shock have good long-term survival with high functional capacity. Patients assigned to ERV have a lower rate of deterioration in FC than IMS patients. A strategy of ERV is an independent strong predictor of 1-year post-MI survival with good FC. ERV in the acute setting is a superior strategy with respect to 1-year post MI survival and FC.

2:45 p.m. 815-5

Impact of an Open Artery Late After Infarction: Angiographic Results of the DECOPI Randomized Trial
Philippe Gabriel Steg, Christophe Thuillier, Dominique Hambert, Jacques Puel, S. Champagne, Damien Cosine, Khallil Khallilie, Pierre Cazaux, Damien Logeant, Michel Slama, Sylvie Chevert, Lionel Brucker, for the DECOPI investigators, Hopital Bichat, Paris, France

Background: the value of late revascularization of the infarct vessel after myocardial infarction beyond the time window compatible with myocardial salvage remains debated

Methods: DECOPI is a randomized trial enrolling patients with angiographically proven occlusion of the infarct vessel 2 to 15 days after onset, randomized to angioplasty or medical therapy. Left ventricular and coronary angiography were repeated at 6 months. Follow-up was clinical for 2 years. The primary endpoint was combined cardiovascular death, non-fatal myocardial infarction and ventricular tachyarrhythmias.

Results: 212 patients were randomized. In the angioplasty arm, 80.4% of the patients had placement of a stent and 9.4% a GpIIb/IIIa blocker. TIMI 3 flow was reestablished in 82% of the patients at the end of the procedure. After a mean follow-up of 34 months, there was no difference in the primary endpoint between angioplasty and medical therapy (7.3 vs8.7%, NS). At 6 month angiography, the infarct artery was patent in 82.1% vs 32.7% in the angioplasty and medical groups respectively (p<0.0001). However, there was a 12% reocclusion and a 47% restenosis rate in the angioplasty arm and a 32% spontaneous recanalization rate in the medical arm. Left ventricular ejection fraction was 3.5% higher in the angioplasty arm (p=0.025).

When patients are categorized on the basis of patency at 6-month, independently of randomization, patients with a patent infarct artery have markedly improved outcomes: lower subsequent mortality (1% vs 9.1% (p=0.032), 6% higher left ventricular ejection fraction (p=0.004) and a trend towards a lower incidence of the primary endpoint (2% vs 6.1%, p=0.18)

Conclusion: These results suggest that there is little clinical benefit to routine late recanalization of the infarct artery. However, recanalization is associated with improved ejection fraction. Patients with a patent vessel at 6-months appear to fare substantially better than patients with occlusion. This suggests that prevention of reocclusion and restenosis are key to the clinical benefit of late recanalization.

2:30 p.m. 815-6

Long-Term Results of Primary Nonfacilitated Percutaneous Coronary Intervention in Acute Myocardial Infarction Patients Transferred for Up to 100 Kilometers: Results of a Real-Life Registry
Maciej Karcz, Pawel Bektka, Cezary Kepka, Ewa Kiezycka, Andrzej Ciszelewski, Zbigniew Chmielak, Marcin Demkow, Artur Debski, Michal Ciszelewski, Adam Witkowski, Witold Ruzyllo, National Institute of Cardiology, Warsaw, Poland

Background: Concern remains as to whether benefit of primary percutaneous coronary intervention (pPCI) is not abolished by treatment delay in patients (pts) with acute myocardial infarction (AMI) who have to be transferred to pPCI at an invasive center from community hospitals.

Methods: A prospective registry of consecutive unselected patients treated with pPCI within 12 hours of AMI in a single very high-volume tertiary center was interrogated. Before/during transport patients were pretreated with aspirin and usually heparin but not with fibrinolytics or glycoprotein receptor inhibitors. Long-term survival was established by telephone contact and through National Death Registry.

Results: From 02/2001 through 01/2002 pPCI was performed in 602 pts including 457 pts transferred from community hospitals (transfer distance ranged 3-100 kilometers (kms), exceeded 30 kms in 40% pts). Transferred pts did not differ significantly from nontransferred pts with the exception of older age (61 vs. 54 yrs, p<0.02), longer time from onset of pain to admission to our center (3.2 vs. 2.2 hrs, p=0.0005), and lower incidence of shock on admission (3% vs. 9%). The overall incidence of “not-low-risk” characteristics was the same (70%). Rates of stenting (75% transferred vs. 82% nontransferred) and abciximab use in cathlab (48% vs. 53%) were high and comparable in both groups. TIMI 3 flow was achieved in 83% and 85% pts after pPCI, respectively (NS). One-year follow up was 100% complete. Mortality was similar in transferred and nontransferred pts (6% and 7%, respectively).

Conclusion: Patients with AMI transferred from distant hospitals for up to 100 kms for nonfacilitated primary coronary intervention have good one-year survival (similar to that of patients originally admitted to an invasive center) even though transport to an invasive center results in treatment delay.