1172-96  Stent or Percutaneous Transluminal Coronary Angioplasty for Occluded Coronary Arteries in Patients With Acute Myocardial Infarction Ineligible for Thrombolysis (STOPAMI-3) Trial

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The evaluation of various reperfusion therapies in acute myocardial infarction (AMI) has been confined to patients (pts) eligible for thrombolytic (T). For pts ineligible for T, it is not known the degree of myocardial salvage (MS) that can be achieved with mechanical reperfusion. We investigated MS in AMI pts ineligible for T by comparing 2 interventional strategies, coronary stenting (CS) and PTCA. Of the 611 pts enrolled in this randomized trial, 206 were assigned to CS and 305 to PTCA, both plus abciximab. Eligibility for T was defined as the presence of at least one of the following criteria: non-ST-elevation AMI, left arrival at hospital (>12 hours from symptom onset), and contraindications to T. Technetium-99m sestamibi scintigraphy was done at admission and 7-14 days after intervention. The primary endpoint was salvage index (the ratio of the degree of MS to the initial perfusion defect). Both methods led to a comparable MS and reduced final infarct size (salvage index: 0.84 vs. 0.82 with PTCA; p=0.05; Table). At 1-year follow-up, mortality was 42% higher (19.6 vs. 13.6%) and TLR-patients treated with stents had a 3.7-fold higher restenosis rate (50.0 vs. 16.7%, p=0.05). Six-month mortality rates were comparable (Fig. right). The combined rate of death and recurrent MI was 19.5% in both groups.

Conclusion: A considerable amount of myocardium at risk can be salvaged with mechanical reperfusion in AMI pts not eligible for T. Both types of interventions, CS and PTCA enable comparable angiographic and clinical results.

1172-97 Prehospital Thrombolysis Accelerates Myocardial Reperfusion Compared to Percutaneous Coronary Intervention for ST-Segment Elevation Myocardial Infarction: Results of the START in Berlin Pilot Study

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Purpose: Randomized trials had proven superiority of PCI over thrombolysis (TL) in AMI when performed with similar time delays. However prehospital (p) initiation of fibrinolitics saves critical time compared to in hospital administration. START is the first prospective, randomized study measuring the extent of earliest possible myocardial reperfusion by pTL compared with PCI. Methods: Patients (Pts) (n=368) with STEMI less than 6 hours, enrolled from Oct. 2000 to Mar. 2002. 88 Pts were enrolled (44-pTL, 44-PCI). There were no differences between the two groups regarding baseline characteristics. Initial time delay was shorter with pTL (mean: 110.1±61.7 min vs. 155.3±61.7 min, p<0.001). Pts receiving pTL had higher TIMI 3 flow rates at any timepoint (n=368, p<0.001), higher cTnT levels (n=368, p<0.001), and higher cTnI levels (n=368, p<0.001). At 90min, 180min and 180min (MICU180) as well as just before start of TL or PCI, after 90min and 180min. Results: From Oct 2000 to March 2002, 80 Pts were enrolled (44-pTL, 44-PCI). There were no differences between the two groups regarding baseline characteristics. pTL enabled earlier, more complete ST resolution (n=368, p<0.001) and a higher cTnT levels (n=368, p<0.001), cTnI levels (n=368, p<0.001) and a higher cTnI levels (n=368, p<0.001). Conclusion: Initiated very early in the prehospital setting, pTL can achieve better reperfusion compared to PCI. Considering facilitated PCI as a future strategy for optimal management of AMI, pTL should be included in the pharmacological pretreatment.

1172-98 Angiographic and Clinical Outcomes of Patients Treated With Primary or Rescue Angioplasty in Saphenous Vein Graft for Acute Myocardial Infarction


Background: Little is known about the efficacy of primary or rescue angioplasty for acute myocardial infarction (AMI) related to saphenous vein graft (SVG) lesion. Objective: We compared in-hospital and 1-year outcomes of pts undergoing angioplasty in the first 24 hours of an AMI related to either SVG or native artery (NA) lesions. Methods: From Jan. 1996 to June 2001, 558 pts underwent a primary or rescue PCI for AMI. In 52 pts, the infarct-related vessel was a SVG. Results: Pts in the SVG gp had more often prior MI (78.4 vs. 61.7, p=0.001) and lower cTnI levels (n=61, p<0.001) and lower cTnI levels (n=61, p<0.001). At 1-year follow-up, mortality was 42% higher (19.6 vs 13.6%) and TLR-

Conclusion: PCI for AMI related to SVG lesion can be successful. However, the angiographic success is lower and clinical outcomes are worse in pts treated in SVG as compared to pts treated in native vessels.

1172-99 What Is the Frequency, Functional, and Clinical Significance of Complex Lesions in Non-Infarct-Related Arteries in Acute ST-Segment Elevation Myocardial Infarction?

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Observational data suggests that the diffuse nature of coronary disease may be represented by multiple unostorable coronary lesions in patients with acute myocardial infarction (AMI). We analyzed their existence, location, functional and clinical significance in 430 patients presenting within 6 hours of acute ST elevation MI. Coronary angiograms and ECGs were obtained 50 min after experimental fibrinolysis and systematically analyzed by at least two observers blinded to other patient data. In-core angiographic and ECG laboratory. Complex lesions in non-infarct related arteries (nlRA) were identified according to prior criteria, i.e. stenosis >50% with one of the following: overhanging edges, markedly irregular borders, ulceration or thrombus. Baseline ST elevation ECGs were obtained 60 min after experimental fibrinolysis and systematically analyzed by at least two observers blinded to other patient data. Complex lesions in non-infarct related arteries (nlRA) were identified according to prior criteria, i.e. stenosis >50% with one of the following: overhanging edges, markedly irregular borders, ulceration or thrombus. Baseline ST elevation ECGs were obtained 60 min after experimental fibrinolysis and systematically analyzed by at least two observers blinded to other patient data. Complex lesions in non-infarct related arteries (nlRA) were identified according to prior criteria, i.e. stenosis >50% with one of the following: overhanging edges, markedly irregular borders, ulceration or thrombus. Baseline ST elevation ECGs were obtained 60 min after experimental fibrinolysis and systematically analyzed by at least two observers blinded to other patient data. Complex lesions in non-infarct related arteries (nlRA) were identified according to prior criteria, i.e. stenosis >50% with one of the following: overhanging edges, markedly irregular borders, ulceration or thrombus. Baseline ST elevation ECGs were obtained 60 min after experimental fibrinolysis and systematically analyzed by at least two observers blinded to other patient data. Complex lesions in non-infarct related arteries (nlRA) were identified according to prior criteria, i.e. stenosis >50% with one of the following: overhanging edges, markedly irregular borders, ulceration or thrombus. Baseline ST elevation ECGs were obtained 60 min after experimental fibrinolysis and systematically analyzed by at least two observers blinded to other patient data.