1097-99 Underuse of Reperfusion Therapy in Female Patients: Insights From the TETAMI Study and Registry (The Safety and Efficacy of Subcutaneous Enoxaparin Versus Intravenous Unfractionated Heparin and of Tirofiban Versus Placebo in the Treatment of Acute Myocardial Infarction)

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Women have higher mortality rates following STEMI, yet fewer are considered eligible for reperfusion therapy. The international TETAMI study was designed to assess the efficacy and safety of antithrombotic therapy in STEMI patients ineligible for reperfusion, and a concurrent registry tracked patients at the same centers which were either reperfused or not reperfused and ineligible for TETAMI.

Methods: We studied the predictors for reperfusion or non reperfusion therapy in 2542 patients form the TETAMI study and registry. Patients with Killip class 4 were excluded. Endpoint data for the composite double endpoint of death & MI and death alone were analyzed. A multivariate analysis was performed to determine the influence of age, gender, timing from symptoms to admission, Killip class 1 versus 2/3, gender and country.

Results: Overall a higher proportion of male patients received reperfusion therapy. This was the case in all countries studied except South Africa. Europe had the lowest rate of reperfusion therapy in female patients. Male reperfused patients had the lowest rates of both death and death & MI. However multivariate analysis reveals that this is accounted for, with a level of 5% confidence, by the greater age and later presentation of women.

Conclusions: Multivariate analysis reveals that reperfusion therapy is less frequently given to women because women are older and present to the hospital at a later stage. Awareness should be increased in order to shorten this delay in presentation for women.

	Reperfused (n=1146)		Non-reperfused (n=1396)	
	Male (n=896)	**Female (n=250)**	**Male (n=990)**	**Female (n=405)**
Age (mean, yrs)	58.1	67.4	60.4	69.3
Male vs female ratio:				
Overall (%)	78.2	21.8	71.0	29.0
South America (%)	77.4	22.6	74.1	25.9
Europe (%)	80.7	19.3	69.5	30.5
South Africa (%)	71.8	28.2	71.9	28.1
Rest of the World* (%)	75.6	24.4	68.7	31.3
Endpoint				
Death/MI (%)	5.8	7.6	8.3	13.6
Death (%)	3.7	6.4	6.2	11.4

1097-100 Evidence for Early Reperfusion and Preservation of Myocardium: A New Salvage Subset

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We studied 4,049 patients in ASSENT 3 who received fibrinolytic therapy to evaluate the relationship between aborted MI (by CK), QRS score and 30-day mortality. Aborted MI was detected [peak CK less than or equal to 2x upper normal] in, 569 patients (14.1% of this population). ST segments and QRS scores were measured in four technically suitable sequential ECGs (baseline, 60 and 180 minutes post thrombolytic, and discharge) by a core lab blinded to clinical outcomes. These data reveal that patients with aborted MI have a shorter time to treatment, higher frequency of early ST resolution and clear confirmatory evidence of preserved myocardium from their QRS score. An particularly low risk subset within the aborted MI group i.e. the 53% of patients with >70% ST resolution at 60 min exists whose 30 day mortality was 1.0% vs 6.1% for other aborted MI patients (p=0.001) emphasizing the value of subset analysis. These novel observations provide additional insight into the process of early risk stratification following fibrinolysis for AMI.

	Aborted MI (n=569)	Non-aborted MI (n=3480)	p value
Age-yrs (Median:25-75%)	62 (53,71)	60 (51,69)	
Female (%)	29%	22%	<0.001
Time to treatment (Median: hr)	2.5 (1.8, 3.5)	2.8 (2.0, 3.9)	<0.001
>70% ST resolution - 60 min	53%	30%	<0.001
>70% ST resolution - 180 min	58%	53%	<0.001
>70% ST resolution - D/C	74%	74%	ns
Mean QRS score (SD) - baseline	2.92 (2.79)	3.34 (2.99)	0.001
Mean QRS score (SD) - D/C	3.25 (3.06)	5.60 (3.78)	<0.001

1097-101 Glycoprotein IIb/IIIa Inhibitors After Full Dose Thrombolysis in Rescue Angioplasty for Acute Myocardial Infarction: To Give or Not Give?

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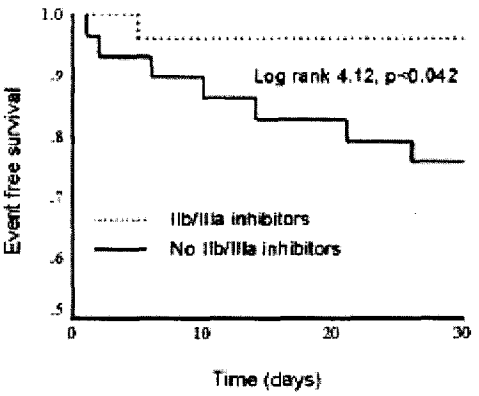
Background: Percutaneous coronary intervention after failed thrombolysis (rescue angioplasty) in patients with acute myocardial infarction (AMI) is an established procedure. Few data are available concerning the safety and efficacy of glycoprotein IIb/IIIa inhibitors in these patients. Methods: We compared the clinical outcomes of 53 consecutive AMI patients who underwent rescue angioplasty between 1/1997 and 12/2001. A total of 24 were treated concomitantly with a glycoprotein IIb/IIIa inhibitor and 29 patients were not. Results: Baseline clinical characteristics between the two groups were similar and comparable for all variables, with exception of a significantly larger percentage of patients with prior angioplasty in the IIb/IIIa group (3% vs. 28%, p=0.04). In-hospital outcomes regarding major and minor bleeding complications, death and urgent revascularization were similar. By multivariate analysis, no treatment with a IIb/IIIa was an independent predictor of worse outcome (RR:7.3; CI=1.4-26.2, p=0.026). The composite of death, urgent revascularization and emergency bypass surgery is shown in the Fig. Conclusions: Patients who undergo rescue angioplasty due to failed thrombolysis and are concomitantly treated with glycoprotein IIb/IIIa inhibitors are at a lower risk of in-hospital death and repeat urgent revascularization procedures. The administration of glycoprotein IIb/IIIa inhibitors after full dose thrombolysis did not increase the risk of bleeding complications.



1097-102 Outcome of Patients With Acute Myocardial Infarction Admitted to Hospitals With and Without Facilities for Primary Percutaneous Coronary Intervention: Data From the AMI-Florence Registry

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Background Primary percutaneous coronary intervention (P-PCI) is an effective reperfusion treatment in patients (pts) with acute myocardial infarction (AMI). However, it is unclear whether the outcome of pts with AMI transferred from the community hospitals to tertiary centers for P-PCI is different from that of pts treated with on-site P-PCI. **Methods** Data are derived from the AMI-Florence Registry, a prospective observational registry including all the Florence area residents who experienced ST-segment elevation AMI from 3.1.2000 to 2.28.2001 and were admitted to hospital within 12 h from symptom onset. Florence area includes 5 community hospitals and 2 tertiary centers with specific programs for P-PCI.

Results This analysis refers to the 432 pts treated with P-PCI. Of these pts, 286 were directly admitted to the 2 centers with P-PCI facilities (Group 1) and 146 were initially admitted to the 5 community hospitals and then transferred to the 2 centers with invasive facilities (Group 2). In term of risk factors and clinical characteristics, a lower prevalence of prior angina was observed in Group 1 (27.7% vs 44.5%, p=.004); Killip class >1 was observed in 19% of Group 1 and 25% of Group 2 (p=.09); cardiogenic shock was present in 6% of Group 1 and 5.5% of Group 2 (p=.66). Median time from symptom onset to admission was 135 min in Group 1 and 121 min in Group 2; median door-to-balloon time was 30 min in Group 1 and 115 min in Group 2 (p=.001). Door-to-balloon time was < 60 min in 81% of Group 1 and 19% of Group 2 (p=.0001). TIMI grade 3 flow was restored in 95.1% of Group 1 and 93.8% of Group 2 (p=ns). Left ventricular ejection fraction at discharge was exactly the same in both Groups (mean 45± 12%). Six-month mortality was 8.7% in Group 1 and 10.3% in Group 2. Comparing mortality in pts with door-to-balloon time ≥ 60 min and <60 min, no significant difference was observed in both patient Groups. **Conclusion** Pts transferred from hospitals without P-PCI facilities have an outcome which is similar to the one of pts directly admitted to hospitals with P-PCI facilities. Our data support a policy of transferring patients initially admitted to community hospitals to centers which offer P-PCI.