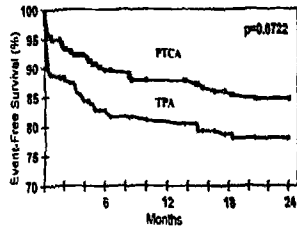


infarction (MI) have demonstrated improved short-term outcome for the PTCA patients, however few data exist regarding long-term outcome. The PAMI-I trial randomized 395 patients within 12 hours of MI to reperfusion with tPA or primary PTCA. The primary endpoint was combined death or recurrent MI. In hospital, one month, six month, one and 2 year events were recorded by means of physician or nurse visits, questionnaire or telephone contact, with the following clinical events recorded: Non-protocol PTCA, CABG, recurrent MI or death.

By 2 years, non-protocol PTCA or CABG was performed more commonly in tPA treated patients (56 vs 39%, $p < 0.0012$). When considered separately, death (9.5 vs 6.1%) or recurrent MI (14 vs 9.7%) was not significantly different between tPA and PTCA treated patients. However, 24 month survival without reinfarction tended to favor the PTCA group (85.6 vs 79%, $p = 0.07$).



Thus, primary PTCA of AMI is associated with reduced need for non-protocol revascularization and favorable event-free survival over 2 years.

11:00

743-3 Lack of Long Term Prognostic Significance of Infarct-Related Artery Patency at Late (> 1 Month) Angiography After Acute Myocardial Infarction in Medically-Treated Patients. An Incentive for Early Recanalization After Myocardial Infarction

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Recent data from the SAVE trial suggest that infarct-related artery (IRA) patency assessed in the first days after myocardial infarction (AMI) has important prognostic significance. To assess the very long term (15 years) prognostic significance of IRA patency determined late (> 1 month) after MI, we analyzed the 15-year follow-up of 142 consecutive pts who underwent coronary angiography 2.9 ± 1.3 months after AMI (range 1-6 months) in the year 1980 and were treated medically in the first 6 months following angiography.

Baseline parameters: age 47 ± 9 yrs, 91% men, anterior MI: 44%, preceding angina: 31%, residual angina: 35%, 1-vessel disease 45%, patent IRA (TIMI grade 3): 35%, LVEF 52 ± 12%.

Results: By Cox multivariate analysis, the only independent predictors of cardiac survival were LV end-diastolic volume (EDV) ($p < 0.01$) and LVEF ($p = 0.05$), while IRA patency had no prognostic significance ($p = 0.65$). In the subset of patients with single-vessel disease ($n = 62$) IRA patency was related to long term follow-up by univariate analysis ($p < 0.05$); after multivariate analysis, however, only LVEF was related to long term outcome.

Thus our study fails to demonstrate a prognostic significance for infarct-related artery patency determined more than one month after AMI. These results suggest that recanalization of an occluded IRA should be performed sufficiently early after the acute episode to achieve beneficial clinical effects.

11:15

743-4 Primary PTCA Results in Similar In-Hospital Outcomes in Females and Males Presenting With Acute MI

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Thrombolytic studies have demonstrated that females have an increased risk of intracranial bleeding and death compared to males. Few data exist regarding gender differences when a mechanical reperfusion strategy is utilized.

We examined the clinical and angiographic characteristics of the 810 males and 290 females in the Primary Angioplasty in Myocardial Infarction II study to determine whether females had higher in-hospital mortality and morbidity compared to males. There were no differences between females and males in relation to incidence of anterior MI, HTN, prior CABG, prior MI, smoking or extent of CAD. Females were older (63.9 vs 58.8%, $p = 0.0001$), had a higher incidence of diabetes mellitus (21 vs 13%, $p = 0.005$), and were less likely to be thrombolytic eligible (62 vs 72%, $p = 0.001$).

Despite these baseline differences, in-hospital outcomes were similar between the two groups as follows:

	Males	Females	P Value
Successful PTCA	85%	97%	0.27
Death	3%	3%	0.45
Reinfarction	4%	5%	0.72
Reocclusion	5%	6%	0.42
USA/Recath	14%	18%	0.14
CHF	8%	10%	0.27
CVA	0.9%	1%	0.49
CABG	5.5%	6.6%	0.31
VT or VF	11%	11%	0.85

Thus, avoiding thrombolytic therapy and performing primary PTCA for AMI allows females high rates of reperfusion, low rates of stroke and a prognosis similar to males.

11:30

743-5 3,073 Danish Citizen With Acute Myocardial Infarction Showed No Sex Related Difference in Short and Long Term Prognosis

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Background: The prevailing view regarding prognosis after acute myocardial infarction is that females fare worse than males.

Purpose: The purpose of the present study is to describe in hospital (15 days) and ten year prognosis after AMI in the two sexes in different age groups.

Methods: 3,073 patients with AMI from 16 coronary care units covering a fifth of the total Danish population were registered from June 1, 1979 to August 15, 1981. Deaths were recorded October 1, 1990 at the National Person Registration Office: cause of death was recorded from the death certificate and admission with recurrent infarction at the Central County Patient Registry. Mortality was separated into in hospital (15-days) and after discharge (day 15 to 10-year). The patients were separated into three age groups (< 50 years, 50-65 years and > 65 years).

Results: 24% females and 76% males were registered at index admission. The ratio females/males with age < 50 years was 1:5.9, with age 50-65 years was 1:4.4 and with age > 65 years 1:2.0. Median age for females was 66 years, for males 61 years.

Age:	< 50 years	50-65 years	> 65 years
Gender:	Females/males	Females/males	Females/males
Mortality before day 15	13%/9%	17%/12%	15%/22%
	NS	NS	NS
Mortality after day 15	22%/35%	52%/53%	73%/76%
	NS	NS	NS
Reinfarction after day 15	45%/50%	50%/61%	57%/63%
	NS	$p = 0.02$	NS
Mortality after reinfarction	60%/55%	72%/65%	88%/86%
	NS	NS	NS

No differences in causes of death was found between the genders.

Conclusion: No sex related difference exists regarding short and long term mortality after AMI.

11:45

743-6 Influence of Gender on Short and Long Term Survival After Acute Myocardial Infarction

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A number of studies have shown an increased risk associated with female gender following an acute myocardial infarction (MI).

The TRACE (Trandolapril Cardiac Evaluation) Register includes 6676 consecutive patients with an enzyme confirmed acute myocardial infarction (MI) screened for entry into the TRACE trial. Medical history and complications of MI were obtained for all patients. Left ventricular systolic function was determined by echocardiography in a core laboratory as wall motion index (WMI) within 6 days of the infarction. Survival data were available for all except 5 patients after 2-3 years. Thirty three % of patients were female. Females less often received thrombolytic therapy than males (34%/44% (female/male)), more often had congestive heart failure (60%/50%), more often had diabetes (14%/9%), more often hypertension (28%/20%), and were older (mean age 72 years/67 years). Thirty day survival was lower for females than for males (84 ± 2%/89 ± 1%, ± 95% CI). At 1 year the difference had increased to 72 ± 2%/79 ± 1% and at 3 years to 59 ± 2%/67 ± 1%. This difference