regimens. No major and one significant minor bleed have been observed in hospital in 62 patients.

Conclusions: IV RPR 109891 achieved platelet inhibition with a clear dose-response and deserves further study as part of a continuous IV followed by oral strategy for treatment of acute coronary syndromes.

1028-111 Sustained Platelet GP IIb/IIIa Blockade With Oral Orbofiban: Interim Safety and Tolerability Results of the SOAR Study

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Background: SOAR (Safety of Orbofiban in Acute Coronary Research) is a randomized, placebo-controlled study comparing four dosage levels of the oral platelet GP IIb/IIIa inhibitor Orbofiban to placebo in patients hospitalized with unstable angina (>6 hours but ≤120 hours) or myocardial infarction. Patients (n = 259) were randomized to receive Orbofiban (30, 40, 50 mg BID or 50 mg QD) or placebo for up to 3 months. All patients received concomitant aspirin (162 mg/day).

Methods: Patients were assessed for adverse events (AE) and bleeding events (BE) during initial hospitalization and at follow up visits.

Results: At the time of this interim analysis, there were a total of 130 patients completing a minimum of 1 month treatment. The withdrawal rates were as follows:

	P	30 BID	40 BID	50 BID	50 QD
BE withdrawal (%)	0	1 (1%)	2 (4%)	0	2 (4%)
AE withdrawal (%)	4 (9%)	9 (16%)	6 (11%)	8 (16%)	6 (12%)

Bleeding events by treatment were as follows:

	P	30 BID	40 BID	50 BID	50 QD
Insignificant	4	7	7	10	4
Mild	1	2	6	4	7
Severe	0	1	0	0	0
Total (%)	5 (12)	10 (20)	13 (28)	14 (31)	11 (24)

Conclusion: Orbofiban produced dose-related increases in insignificant and mild bleeding events but was well tolerated during chronic therapy.

1028-112 Primary Reperfusion in Acute Myocardial Infarction With ReoPro and Heparin: Interim Results of ReoMI Pilot Study

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ReoMI (ReoPro in MI) is a multicenter pilot study to assess the efficacy of ReoPro in attaining primary reperfusion in acute myocardial infarction. Patients with acute Q-wave MI, presenting within 6 hours of chest pain are treated with aspirin (325 mg po), heparin (70 u/kg iv) and ReoPro bolus (0.25 mg/kg iv) followed by continuous infusion (0.10 mg/kg) in the emergency room. All patients undergo acute coronary angiography and intervention if clinically indicated. Primary end point is ability to attain TIMI grade II or III flow at angiography. Secondary endpoints include acute procedural success rate, in-hospital death, reinfarction, emergency re-intervention and bleeding complications. At the time of submission 20 patients (mean age 57 y, 17 males) from 6 centers have been enrolled in the study. Average time between administration of ReoPro and baseline angiogram was 42 minutes.

TIMI flows at baseline angiography were as follows:
TIMI 0: 8/20, TIMI I: 7/20, TIMI II: 2/20, TIMI III: 3/20

Time between Reopro and angiogram:
<30 minutes: TIMI II or III flow in 0/11 patients
≥30 minutes: TIMI II or III flow in 5/9 patients

Coronary intervention was successfully performed in 19 patients. Composite secondary endpoints of death (1), recurrent MI (0), emergent revascularization (1) and significant bleeding complications (2) occurred in 3/20 patients. One month followup data will be presented.

Conclusion: Interim analysis suggests that ReoMI strategy yields TIMI II/III flow in less than 50% patients, though reperfusion may be time dependent.

1029 Angioplasty and Stenting in Acute Myocardial Infarction

Monday, March 30, 1998, Noon–2:00 p.m.
Georgia World Congress Center, West Exhibit Hall Level
Presentation Hour: 1:00 p.m.–2:00 p.m.

1029-149 Efficacy of Invasive Strategy for the Management of the Post-Infarction Cardiogenic Shock

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Background: Primary angioplasty seems to improve the prognosis of post-infarction cardiogenic shock (CS). Our aim was to evaluate whether invasive management of acute myocardial infarction (AMI) complicated with CS reduces the in-hospital mortality.

Methods: From 1651 patients with AMI admitted to our Coronary Care Unit from January 1994 to April 1997, 139 patients (8.4%) developed CS unrelated to mechanical complications. The strategy of management was considered invasive if a coronary angiography (intending to revascularize) was indicated in the first 24 hours after the coronary event evolving in CS. Every other strategy, including thrombolysis, was considered conservative. Forty-three patients who developed CS insidiously were excluded, because a definite event which could lead to a certain actuation at a particular moment could not be indentified.

Results: Ninety-six patients were included. The strategy was invasive in 61 patients (64%) and conservative in 31 (32%); four patients (4%) were unclassified because they died shortly after their admission. The in-hospital mortality of the invasive strategy was lower than the conservative (70 vs. 90%; OR 0.3 [0.1–0.8]; $p < 0.05$). However, after adjusting by other predictors of mortality, such as age and prior ischemic heart disease, the strategy of management was not an independent predictor of in-hospital mortality (Table).

In-hospital mortality	*OR*	*CI 95%*	*p*
Age (OR per 5 year increase)	1.55	1.15–2.10	0.003
Prior ischemic heart disease	3.30	1.07–11.11	0.04
Invasive strategy	0.81	0.15–3.65	0.78

Conclusions: The lower mortality of patients managed invasively might be due to being younger, having less prior ischemic disease or other factors rather than the efficacy inherent to the treatment. The role of invasive strategy of post-infartion CS needs further evaluation.

1029-150 One Year Survival Among Patients With Myocardial Infarction Complicated by Cardiogenic Shock Alive at 30 Days, and the Impact of Early Revascularization: Results From GUSTO-1

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Thirty-day survival is increased in patients (pts) with myocardial infarction (MI) complicated by cardiogenic shock who undergo early revascularization, even after adjusting for differences in baseline characteristics and other sources of bias. However, longer term survival rates and the duration of benefit of early revascularization are unknown. We analyzed 30-day survivors in GUSTO-1 and identified 1321 pts who had had shock (Group 1) and 36,333 who did not (Group 2). Group 1 pts were older and sicker in many ways. At 1 yr, 88.0% of Group 1 were alive vs 97.4% of Group 2 ($p < 0.0001$). Among Group 1 pts, 44% had undergone revascularization within 30 days (Group 1A), and 56% had not (Group 1B). At 1 yr, 91.7% of Group 1A pts were alive vs 85.3% of Group 1B ($p = 0.0001$). Multivariate logistic regression analysis of Group 1 pts revealed that revascularization within 30 days of MI was an important independent predictor of survival to 1 yr (odds ratio 0.41 [0.25, 0.67], $p = 0.0001$).

Conclusions: Among pts with MI complicated by shock, most who survive 30 days (83%) are alive at 1 year. Early revascularization is associated with improved survival in shock pts for at least 1 year, even among 30-day survivors. The high survival rate and persistent benefits of early revascularization support an early aggressive revascularization strategy among such pts.