Safety of the Combination of Oral Anticoagulant and Antiplatelet Therapy in Cardiovascular Disease: A Meta-Analysis
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Both oral anticoagulant (AC) and antiplatelet (AP) therapy are effective in reducing mortality in patients (pts) with cardiovascular disease. The outcome of the trials of combined AC/AP compared to AC alone, AP alone or placebo is promising, but its safety is a matter of concern.

In the 6 published trials of combined AC/AP directly comparing reference therapy (AC, AP or placebo), 4,874 pts were randomized. High intensity AC (AC) INR ≥ 2.5 was combined with high (≥ 500 mg aspirin qd) dose AP (AP) in 3 trials, and with low (≤ 100 mg aspirin qd) dose AP (AP) in 2 trials. Low intensity AC (ad) INR ≤ 2.5 was combined with ap in 4 trials. Major bleeding (≥5% C).

Thus, combined low intensity oral anticoagulant/low dose aspirin therapy shows the lowest major bleeding (5/100 pt yrs), not significantly different from low intensity oral anticoagulant therapy alone. This combination therapy now undergoes large scale evaluation of clinical efficacy and safety.

Enhanced Coronary Vasodilatation to Endothelin-B Receptors Activation in Experimental Congestive Heart Failure
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Thoracic inferior vena cava constriction (TIVCC) is an experimental model of cardiac failure characterized by an enhanced coronary vasoconstriction to the ET-1. The relationship between on-trial LDL-C levels and A%DS was weak: r = 0.38, p = 0.08. However, a strong relationship was seen between % change in LDL-C and A%DS (∆%DS = 3.18 + 0.071 x ∆%LDL-C; r = 0.74, p < 0.0005). According to the equation, a 44% reduction of LDL-C is needed to arrest coronary progression.

Conclusions: Reducing LDL-cholesterol by a percentage from the baseline level appears to be a more reasonable goal in coronary patients than aiming for the same target level in all. The emphasis on target levels in the current guidelines seems open to question.

Indications for Lipid Management
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Orange County Convention Center, Hall E
Presentation Hour: 3:00 p.m.-4:00 p.m.

What Should Be the Goal of LDL-Cholesterol Lowering in Coronary Patients: A Fixed Level or a Percent Reduction?
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NCEP guidelines stipulate that LDL-cholesterol (LDL-C) should be reduced to the same level in all coronary patients, to ≤ 100 mg/dL. But a recent secondary analysis of the 4S data showed that the decrease in LDL-C with simvastatin (32–35%) and the decrease in relative risk (32–35%) were comparable across all quartiles of baseline LDL-C, despite differences in on-trial LDL-C (Lancet 1995;345:1274). To test the hypothesis that the reduction in LDL-C correlates better with outcome than the on-treatment level of LDL-C, we examined the 24 control and treatment groups from the 11 cholesterol-lowering coronary angiographic trials (PATS, SCOR, STARS, Lifestyle, MARS, COAT, HARP, SCOT, MAAS, FHRS and PLACE-1) with quantitative measurements of lesion percent diameter stenosis change (∆%DS). Mean ∆%DS ranged from +5.8 (progression) to −2.5 (regression), mean on-treatment LDL-C varied from 86 to 242 mg/dL and change in LDL-C ranged from +3% to −53%. Linear regression analysis was performed with the groups weighted according to their size.

Results: The relationship between on-trial LDL-C levels and ∆%DS was weak: r = 0.38, p = 0.08. However, a strong relationship was seen between % change in LDL-C and ∆%DS (∆%DS = 3.18 + 0.071 x ∆%LDL-C; r = 0.74, p < 0.0005). According to the equation, a 44% reduction of LDL-C is needed to arrest coronary progression.

Conclusions: Reducing LDL-cholesterol by a percentage from the baseline level appears to be a more reasonable goal in coronary patients than aiming for the same target level in all. The emphasis on target levels in the current guidelines seems open to question.