RESULTS: Inhibition of 5 μM ADP-induced platelet aggregation showed a trend towards a dose–relationship over the dose-range tested. Bleeding time prolongation factor never exceeded 2. Tolerance was good at all doses tested.

CONCLUSION: In this multicenter dose-range study in atherosclerotic patients, clopidogrel demonstrated a dose-related activity. The dose of 75 mg once daily was chosen for the phase III international study CAPRIE (Clopidogrel vs. Aspirin in Patients at Risk of Ischemic Events) currently on-going in over 15,000 patients.

S74-84 Safety of the Combination of Oral Anticoagulant and Antiplatelet Therapy in Cardiovascular Disease: A Meta-Analysis
Freek W.A. Verheugt. Department of Cardiology, University Hospital Nijmegen, Nijmegen, The Netherlands

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 (AC) INR ≤ 2.5 was combined with ap in 4 trials. Major bleeding (85% 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.

S74-85 Enhanced Coronal Vasoconstriction to Endothelin-B Receptors Activation in Experimental Congestive Heart Failure
Charles R. Cannon, John C. Burnett Jr., Amir Lerman, Mayo Clinic, Rochester, MN

Thoracic inferior vena cava constriction (TVCC) is an experimental model of heart failure characterized by a decrease in cardiac output and an increase in plasma endothelin (ET) concentrations. ET, a coronary vasoconstrictor, mediates its activity through two specific receptors (ET-A and ET-B), which undergo large scale evaluation of clinical efficacy and safety.

The relationship between on-trial LDL-C levels and Δ%DS was weak: r = 0.36, p = 0.088. However, a strong relationship was seen between % change in LDL-C and Δ%DS (Δ%DS = 3.18 + 0.071 x %ΔLDL-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.

935-105 What Should Be the Goal of LDL-Cholesterol Lowering in Coronary Patients; a Fixed Level or a Percent Reduction?
David Waters, Justine Hollery, Gilbert R. Thompson. Hartford Hospital, Hartford, CT; Hammersmith Hospital, London, UK

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 (32–39%) and the decrease in relative risk (32–36%) 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, CCAF, HARP, SCORF, MARS, HARS-1) with quantitative measurements of lesion percent diameter stenosis change (Δ%DS). Mean Δ%DS ranged from +5.8 (progression) to −2.5 (regression), mean on-trial 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 Δ%DS was weak: r = 0.36, p = 0.088. However, a strong relationship was seen between % change in LDL-C and Δ%DS (Δ%DS = 3.18 + 0.071 x %ΔLDL-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.

935-106 Physician Compliance With National Cholesterol Education Panel Guidelines in Patients With Myocardial Infarction
Ori Ben-Yehuda, Parul Desai, Daniel G. Blanchard. University of California, San Diego, CA

Lowering elevated LDL-Cholesterol (LDL-C) in patients with documented CAD reduces morbidity and mortality. NCEP guidelines in this population are based on LDL-C levels, with a target level of < 100 mg/dl. In order to assess physician compliance with NCEP guidelines, we reviewed the care of all patients under 75 years of age discharged with the diagnosis of acute MI in 1994 in our institution. Mean follow-up was 9.6 ± 0.8 months (range 4–15). Of 114 patients with the diagnosis of acute MI, 30 (26%) had known hypercholesterolemia. The majority of patients had LDL-C levels in the target range on follow-up. In 7/30 (23%) no therapy was instituted, while in 17/30 (57%) target LDL-C level was either not achieved or not documented. Of the 84 patients (74%) without known hyperlipidemia, six had evaluation and therapy per NCEP guidelines. An incomplete evaluation (only total-C or HDL-C) was performed in 44/84 (52%) while 16/84 (19%) had no lipid evaluation at all. No therapy was instituted in 18/84 (21%) who met NCEP criteria for therapy.

Overall, 12/114 (11%) patients were evaluated according to NCEP guidelines and had documentation of achieving treatment goals. In contrast, 100% of patients were prescribed ASA (p < 0.001), another recommended therapy in patients with CAD. Thus physician compliance with NCEP guidelines in this study was low, with most patients not having LDL-C based evaluation and therapy. Greater effort has to be made in educating physicians in lipid management post MI.

935-107 Should Lipid-Lowering Drugs Be Part of Initial Therapy in the Secondary Prevention of CHD?
Christie M. Ballantyne, M. Stewart West, Suzanne M. Jaax, Lynne W. Scott, J. Alan Herd, Peter H. Jones, John A. Farmer, Antonio M. Gotto, Jr., Baylor College of Medicine, Houston, TX

The 1993 NCEP recommends that dietary therapy (Step I Diet) be tried for up to 12 wk in drug-eligible adults with CHD to achieve their LDL-C goal of ≤ 100 mg/dl; drugs are considered when LDL-C > 130 mg/dl persists. We used enrollment screening data from the secondary-prevention Lipoprotein...