1960

BENESTENT-II trial: final results of visit II & III: a 7-month fol'


The BENESTENT-II Trial is a randomized trial comparing the outcome after balloon angioplasty, with the effect of Heparin-coated Palmaz-Schatz stent (10, 15, and 20 mm long) on the long-term effect of Major Adverse Cardiac Events (MACE: Death, MI, Target Lesion Revascularisation [TLR]), in pts with stable or stabilized unstable angina pectoris with one or more de novo lesions. The secondary objectives are to assess the Cost-effectiveness and the restenosis rate. To that purpose a 1:1 sub-randomization to either clinical or angiographic follow-up was carried out. Concomitant medications consist of Aspirin (100 mg) and Ticlopidin (250 mg, 30 days) in the stent group. Between August 22th '95 and March 7th '96, 827 patients were randomized to either treatment with stent (414) or balloon (413). Forty three percent of the patients had unstable angina, 51% stable and 6% silent ischemia. 15% underwent multiple lesion treatment. 54% of the lesions were B2 lesions (AHAVACC). In the balloon group 13.4% of the patients received a bail-out stent according to preset stringent criteria: procedural success was 97% in the stent group and 85% in the balloon group according to the actual allocation protocol.

It remains to be demonstrated whether elective stenting will be at long-term more cost-effective than balloon.

1961

Study of time intervals in myocardial ischaemic syndromes (STIMIS)

T.E.H. Hooghoudt 1, E.J.P. Lamfers 1, A. Uppelschoten 1, F.W.A. Verheugt 2, 1Canisius Wilhelmina Hospital Nijmegen, The Netherlands, 2University Hospital St. Radboud Nijmegen, The Netherlands

Early repercussion in acute myocardial infarction improves long term prognosis. Treatment within the “Golden Hour” saves up to 7 lives per 100 treated patients. Prehospital thrombolysis has been practiced in Nijmegen since 1987. STIMIS was designed to assess the actual time intervals from onset of chest pain to treatment. Methods: since Oct, 1995 all patients first seen by a general practitioner (GP), and presenting with typical chest pain, were eligible for STIMIS, whether or not a transtelephonic EKG (TT-EKG) had been transmitted by the ambulance staff, whether or not the diagnosis was misdiagnosed or not. Any EKG's received were immediately interpreted. The time of all relevant events from onset of pain to treatment were registered on specially designed charts. Results (n = 500): 292 TT-EKG's were received; 73 (25%) fulfilled the criteria of acute myocardial infarction (AMI). 63 Patients received thrombolytic therapy at home, 36 were treated in hospital. Within one hour 24% (n = 16) of the home treated patients and none of the hospital treated patients received thrombolysis (p = 0.0034). Within two hours these data are 70% (n = 44) and 17% (n = 8) respectively (p = 0.0007).

Preshospital time intervals

<table>
<thead>
<tr>
<th>Time Event</th>
<th>Preshospital time intervals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest pain - GP arrival</td>
<td>1:15</td>
</tr>
<tr>
<td>GP arrival - Ambulance arrival</td>
<td>0:20</td>
</tr>
<tr>
<td>Ambulance arrival - TT-EKG</td>
<td>0:10</td>
</tr>
<tr>
<td>TT-EKG - Diagnosis</td>
<td>0:03</td>
</tr>
<tr>
<td>Diagnosis-Thrombolysis</td>
<td>0:05</td>
</tr>
<tr>
<td>Diagnosis - Departure</td>
<td>0:10</td>
</tr>
<tr>
<td>Departure - Hospital door</td>
<td>0:12</td>
</tr>
<tr>
<td>Time to treatment</td>
<td>1:30</td>
</tr>
</tbody>
</table>

Conclusions: In the current setting in Nijmegen, with 12 ambulances equipped with TT-EKG transmitters and EKG confirmation by cardiology residents, a time gain of 2 minutes is obtained when thrombolysis is administered at home. Moreover 70% of home treated patients receive thrombolysis within 2 hours, in comparison with only 17% of the in-hospital treated patients.

1962

Factors of importance for time to start of thrombolysis in acute myocardial infarction

U. Stenestrand, L. Wallentin 1 on behalf of the National Registry of Coronary Care in Sweden. Department of Cardiology University Hospital, Linköping, Sweden, 1Department of Cardiology University Hospital Uppsala, Sweden

Time to start of thrombolysis is of utmost importance for outcome in acute myocardial infarction (MI). We investigated clinical factors influencing time to treatment in routine care.

Method: The Swedish national registry for coronary care includes every patient admitted to participating CCUs. Clinical background, treatment, complications and key time points were recorded in 1604 patients with acute MI treated with thrombolysis within 12 hours after start of pain in 19 hospitals in 1995. Results:

- Time intervals (n = 1964)
  - Beginning of pain – start of treatment: 2.15 hours
  - Start of pain – arrival hospital: 1.15 hours
  - Arrival hospital – start of treatment: 0.65 hours

Significance of univariate (uni) and multivariate (multi) regression analysis:

- Multi: p = 0.001
- Uni: p = 0.005
- NS: p > 0.05

Conclusions: Delay to thrombolysis is above 3.3 hours in half of patients and is prolonged in older age, diabetes mellitus, Q-waves or LBBB and shorted at ST-elevation. Of the delay 2/3 occurs before arrival to hospital which mainly is influenced by age. Hospital organisation and diseases related factors have the largest impact on delay in hospital. Reduced times to treatment will necessitate measures both before and after arrival to hospital.

1963

Indication for thrombolysis in acute myocardial infarction: determinants for decision making in daily clinical practice


Recent trials demonstrated that thrombolytic therapy is beneficial in a much wider range of patients with acute myocardial infarction (AMI), e.g. patients with late presentation (6-12 h) and the elderly. However, it remains unclear how these guidelines are implemented in clinical practice. Methods: "The 60-Minutes Myocardial Infarction Project" is a prospective multicenter registry in Germany, which enrolled all patients with proven Q-wave MI in 136 hospitals (27 months, n = 14,980). 50.5% of patients received thrombolysis. Indication for thrombolytic therapy was analyzed with respect to 15 relevant factors by a multivariate logistic regression expressed as odds ratios (OR) and 95%-confidence intervals (CI). Results:

- Diagnostic ECG or LBBB on admission: 71.0 (4.79, 3.67-6.25)
- Systolic blood pressure <90 mm Hg: 11.1 (1.90, 1.11-1.62)
- Previous infarction: 13.3 (0.76, 0.77-0.96)
- Female gender: 31.7 (0.80, 0.70-0.90)
- Relative contraindications: 22.5 (0.23, 0.23-0.35)
- Diastolic blood pressure <70 mm Hg: 37.7 (0.27, 0.24-0.31)
- Prehospital delay <6 h: 12.5 (0.23, 0.17-0.31)

An OR > 1 refers to a higher chance to be treated with thrombolysis.

Conclusions: A diagnostic ECG on admission is the most important determinant in the decision making to administer thrombolytic agents in AMI. Pts. with high-risk or high-benefit impairment are more likely to be treated with thrombolysis. Female gender is an independent risk factor not to receive thrombolytic therapy. Physicians tend to be restrictive, if relative contraindications are present. Despite documented benefit, fibrinolytic therapy is withheld in pts. with previous infarction, higher age and late presentation.