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Early coronary patency evaluation of a platelet glycoprotein receptor antagonist (abciximab) in primary PTCA: the GRAPE-pilot study

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The best treatment of acute myocardial infarction (AMI) is achieving early patency of the infarct related artery (IRA). The results of thrombolysis and primary PTCA are already known. There is hardly any information about the effect of platelet glycoprotein receptor antagonists on early patency in AMI. In the GRAPE (Glycoprotein Receptor Antagonist Patency Evaluation) pilot trial we studied 41 patients (pts) with <6 hour AMI eligible for primary PTCA and with a total of 15 min >50% IRA diameter stenosis or occlusion. At hospital admission all pts were given oral aspirin 160 mg, 5,000 IU liver heparin together with a bolus of abciximab (ReoPro) 0.25 mg/kg followed by a 12 hour infusion of 10 mcg/min. As soon as possible the pts were brought to the cathetherisation lab to undergo angiography and, if necessary, primary PTCA. Results: Median time between abciximab bolus and first injection for angiography was 45 minutes (range 10-90). The culprit lesion was found to be the RCA in 17 pts, the LAD in 21 pts. At first IRA injection there was a TIMI flow grade 3 in 12 (30%) pts. Two pts (5%) showed TIMI flow grade 2, in 27 (65%) pts the IRA was totally occluded (TIMI flow grade 0 and 1). Conclusion: These preliminary data suggest, that abciximab given early in patients with a large AMI eligible to primary PTCA can achieve IRA patency in a third of the pts.

A Randomized, Placebo-Controlled Crossover Trial of ReoPro Alone or Combined with Low-Dose Plasminogen Activator for Coronary Reperfusion in Patients with Acute Myocardial Infarction: Preliminary Results

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We have previously observed rapid initiation of coronary flow by ReoPro without exogenous plasminogen activators (EPA) in patients (pts) with acute coronary occlusion. In an ongoing double-blind, placebo-controlled, crossover trial of ReoPro alone or in conjunction with low-dose Activase, 26 pts within 6 hr of onset of acute myocardial infarction (AMI) and ST-segment elevation have received abciximab (325 mg PC) and heparin (70 Units/kg bolus plus 7 Units/kg/hr continuous infusion), 20 pts have been randomized to blinded ReoPro 0.25-1 mg IV bolus to placebo. The primary objective is to document infarct-related artery (IRA) patency within 60-90 min after ReoPro alone; the effect of adjunctive Activase on IRA patency is the secondary goal. Protocol: Angiography of the IRA is performed at 60-90 min (Angio # 1) after initial therapy, and then again 60 min after the randomization. Culprit lesions were identified based on the ECG ischemic region and culprit vessel by catheterization and guidewire. The IRA flow was assessed by TIMI-REV. Results: Of 26 pts, 21 had TIMI 0 or 1 flow (81%) at the initial therapy, and 9 of 21 pts (43%) had TIMI 0 or 1 flow at the randomization. Of the 9 pts in THR grade 0-5 were 58, 12, 16, 12, 2, and 3. Conclusion: These early results suggest, that abciximab given early in patients with acute myocardial infarction to primary PTCA can achieve IRA patency in the majority of the pts.

Anchographic Results from Platelet Receptor Inhibition for Ischemic Syndrome Management in Patients with Documented Unstable Angina or Non-Q-Wave MI (PRISM-Plus)

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The angiographic (angi) study in PRISM-Plus was designed to examine the effect of intravenous (IV) a non-peptide platelet GP IIb/IIIa receptor blocker, compared to heparin (HeP) on angiographically documented intracoronary thrombus. 1188 pts with documented unstable angina or non-Q-wave MI were randomized to HeP or to CTH and had angiography a mean of 65% 47 (9-57) after the randomization. Culprit lesions were identified based on the ECG ischemic region and the details of coronary anatomy and analyzed by thrombus Lab, blinded to treatment, TTH was analyzed using the TIMI-THR grade: 0=absent, 1=possible, 2=small (<0.5 x normal lumen diameter (NLD) at the greatest dimension), 3=medium (0.5-1.5 x NLD), 4=large (>1.5 x NLD). There were 270 pts (23%). Flow past the culprit lesion was assessed using TIMI-THR flow grade. The primary and secondary angiographic endpoint were the % of pts with each grade of THR and TIMI flow past the culprit lesion. Results: For 580 pts in CTH, the % of pts in THR grade 0-5 was 58, 12, 12, 2, and 4, but were 53, 12, 9, 17, and 3 for 588 pts in HeP (p=0.002). Conclusion: In PRISM-Plus, compared to HeP alone, the CTH significantly reduced the