

Medically Treated NSTEMI ACS Patients 'Forgotten'

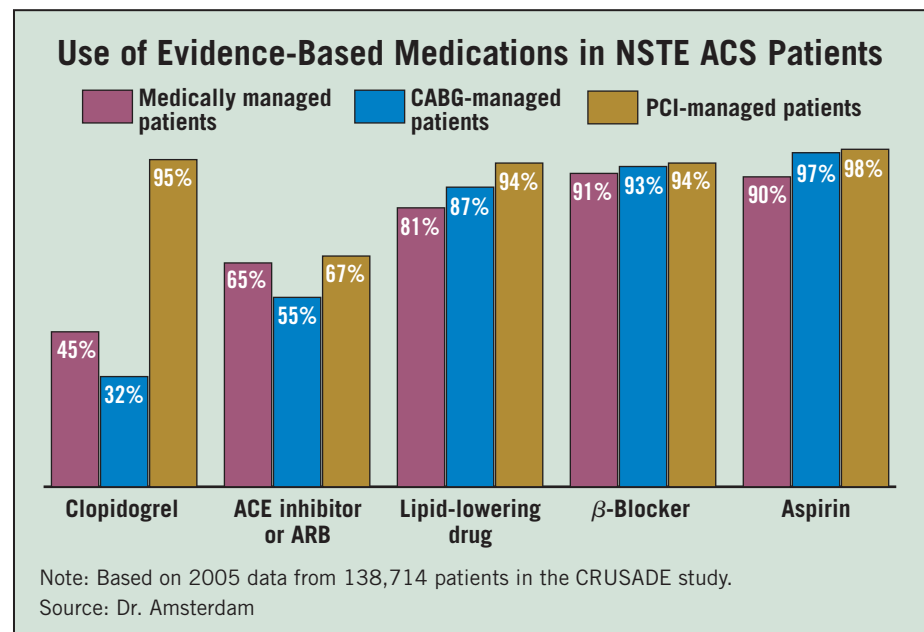
BY BRUCE JANCIN
Denver Bureau

NEW ORLEANS — A large proportion of patients with non-ST-elevation acute coronary syndrome get medical management without coronary angiography despite contemporary guidelines emphasizing an invasive strategy—yet this highest-mortality group of patients is paradoxically least likely to receive evidence-based pharmacotherapy, Dr. Ezra A. Amsterdam reported at the annual scientific session of the American College of Cardiology.

He presented an analysis of CRUSADE quality improvement registry data involving 138,714 patients with non-ST-elevation acute coronary syndrome (NSTEMI ACS) treated at 547 U.S. hospitals during 2002-2005. Twenty-one percent underwent cardiac catheterization without revascularization, 39.5% received percutaneous coronary revascularization, 10.9% had bypass surgery, and 28.6% received medical management only.

During the study period the use of solely medical management declined from 30.6% of all patients in 2002 to 25.6% in 2005, while percutaneous coronary intervention (PCI) rose from 36.2% to 42.1% in accord with current guideline recommendations.

The guidelines also call for routine use of certain evidence-based drugs in NSTEMI ACS patients regardless of whether they are managed invasively or noninvasively.



But while there was an encouraging trend for greater use of these evidence-based medications over the years in medically managed patients, their usage remained significantly less than in patients who received PCI or bypass surgery (see chart), noted Dr. Amsterdam, professor of medicine and director of the cardiac care unit at the University of California, Davis.

In tandem with the more intensive use of evidence-based medications during the study period, unadjusted in-hospital mortality in patients managed solely medically declined from 8.0% to 6.6%, he added.

Discussant Dr. Robert A. Harrington

described patients with NSTEMI ACS who are managed solely medically as "almost a forgotten population."

"There's been so much emphasis in contemporary cardiology placed on the role of the invasive management strategy and coronary revascularization that we often forget that upwards of one-third of patients presenting with an ACS will ultimately be treated medically," said Dr. Harrington, director of cardiovascular clinical trials at the Duke Clinical Research Institute, Durham, N.C.

With NSTEMI ACS patients accounting for more than 1 million hospital admissions

per year in the United States, the CRUSADE evidence for often-suboptimal management of the large portion managed solely medically is an "incredibly important" concern, he added.

The key unanswered question raised by the CRUSADE findings is why these medically managed patients, who are at such high risk, are being treated less aggressively than those undergoing revascularization in terms of the use of evidence-based medications? Part of the answer may lie in the fact that they tend to be older and have more comorbid conditions, Dr. Harrington observed.

"Should these CRUSADE results change practice today? I think absolutely they should because what they're telling us is we need to have an ongoing continuing emphasis on understanding evidence-based prescribing," the cardiologist said. "We know we're doing a good job of caring for these patients, but we clearly can do better."

CRUSADE (Can Rapid Risk Stratification of Unstable Angina Patients Suppress Adverse Outcomes with Early Implementation of the ACC/AHA Guidelines) was sponsored by grants from Schering Plough Corp., Millenium Pharmaceuticals, Bristol-Myers Squibb, and Sanofi. As of January, CRUSADE merged with the Genentech-sponsored NRM (National Registry for Myocardial Infarction) to form the ACTION (Acute Coronary Treatment and Intervention Outcomes Network) registry. ■

Long-Term Benefit of Clopidogrel Seen in Non-STEMI Patients

BY SHERRY BOSCHERT
San Francisco Bureau

SAN FRANCISCO — Long-term use of adenosine diphosphate receptor blockade therapy may be beneficial to patients with non-ST-segment elevation myocardial infarction who have had prior MI, stroke, or peripheral artery disease, Dr. Marc Sabatine said at a meeting sponsored by the California chapter of the American College of Cardiology.



In the few years since the ADP receptor blocker clopidogrel entered the medical armamentarium, studies have shown that acute therapy significantly reduces the risk of death, MI, or stroke in patients with non-ST-elevation acute coronary syndrome or ST-segment elevation MI (STEMI), and that the benefits appear within 24 hours. Other data show that this treatment is not useful for primary prevention of coronary syndromes and that there is variability in patient responses to clopidogrel.

A secondary analysis of the large Clopidogrel in Unstable Angina to Prevent Recurrent Events (CURE) trial, which established clopidogrel's efficacy for non-ST-elevation acute coronary syn-

drome in 2001, found that a greater reduction in cardiovascular death, MI, or stroke seen initially in patients randomized to clopidogrel instead of placebo continued to be significant up to nearly 1 year (Circulation 2003;107:966-72).

"This suggests that the benefit continues to accrue over time, and that treatment out to at least a year makes sense," said Dr. Sabatine and Women's Hospital, Boston. He is on advisory boards for and has received research funds and honoraria from the companies that market clopidogrel, Bristol-Myers Squibb and Sanofi-Aventis.

In the large Clopidogrel for High Atherothrombotic Risk and Ischemic Stabilization, Management, and Avoidance (CHARISMA) study, patients who had a history of atherosclerosis or risk factors for it and were on daily aspirin therapy were randomized to dual-platelet therapy with the addition of clopidogrel or placebo. Follow-up to an average of 2.5 years showed no difference in the risk for cardiovascular death, MI, or stroke between groups, however (Am. Heart J. 2004;148:263-8).

That's because the results with clopidogrel affected two subgroups in opposite ways. The drug significantly reduced risk in patients with a history of atherosclerosis but increased overall risk in patients with no more than risk factors for atherosclerosis such as diabetes or hypertension (N. Engl. J. Med. 2006;354:1706-17). A 1%-2% increase in moderate to severe bleeding with long-term clopidogrel use was not offset by reductions in death, MI, or stroke in the latter subgroup. Subgroup analyses are not definitive, but this "does start to fit with our prior notion that dual-antiplatelet therapy is most efficacious in those with an acute thrombus, either a complete occlusion as in STEMI or subtotal occlusion as in non-ST-elevation acute coronary syndromes," he said at the meeting, also sponsored by the University of California, San Francisco. "If you just have risk factors but never manifested atherosclerosis, there's no benefit."

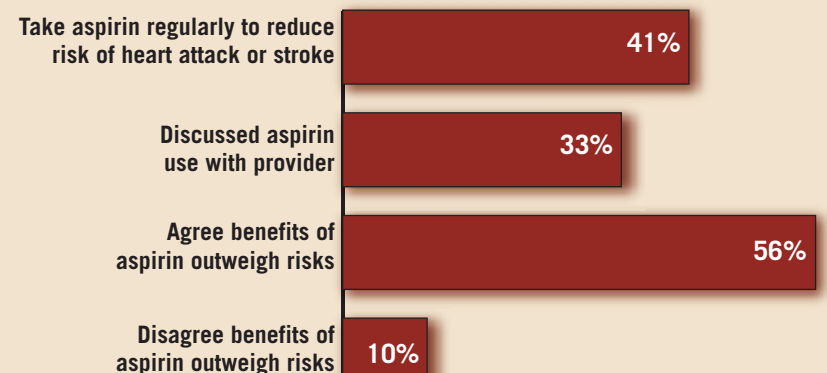
There are no data yet on long-term use of clopidogrel for STEMI. The pivotal trials lasted only weeks, he noted. ■

'This suggests that [clopidogrel's] benefit continues to accrue over time, and that treatment out to at least a year makes sense.'

DR. SABATINE

DATA WATCH

Minority of Adults Take Aspirin to Prevent Heart Attack



Note: Data based on a survey conducted Oct. 21-29, 2004, of 1,299 people aged ≥40 years.
Source: Health Behavior News Service