Immediate versus deferred coronary angioplasty in non-ST-elevation acute coronary syndromes: Reply
Riezebos, R.K.; Laarman, G.J.; Tijssen, J.G.P.

Published in:
Heart

DOI:
10.1136/hrt.2009.175430

Citation for published version (APA):

General rights
It is not permitted to download or to forward/distribute the text or part of it without the consent of the author(s) and/or copyright holder(s), other than for strictly personal, individual use, unless the work is under an open content license (like Creative Commons).

Disclaimer/Complaints regulations
If you believe that digital publication of certain material infringes any of your rights or (privacy) interests, please let the Library know, stating your reasons. In case of a legitimate complaint, the Library will make the material inaccessible and/or remove it from the website. Please Ask the Library: http://uba.uva.nl/en/contact, or a letter to: Library of the University of Amsterdam, Secretariat, Singel 425, 1012 WP Amsterdam, The Netherlands. You will be contacted as soon as possible.
The authors' reply
R K Riezebos, G J Laarman and J G P Tijssen

Heart 2009 95: 1456
doi: 10.1136/hrt.2009.175430

Updated information and services can be found at:
http://heart.bmj.com/content/95/17/1456.full.html

References

These include:

This article cites 6 articles, 5 of which can be accessed free at:
http://heart.bmj.com/content/95/17/1456.full.html#ref-list-1

Article cited in:
http://heart.bmj.com/content/95/17/1456.full.html#related-urls

Email alerting service

Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Topic Collections

Articles on similar topics can be found in the following collections

Hypertension (12368 articles)
Interventional cardiology (7250 articles)
Percutaneous intervention (487 articles)
Epidemiology (5270 articles)

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://journals.bmj.com/cgi/subSCRIBE
reducing periprocedural MI are well documented. 

The results of this study must be interpreted with caution and any change in clinical practice resisted until alternative methods of assessing periprocedural MI (eg, novel biomarkers like N-terminal pro-B-type natruetric peptide, intra-coronary multi-channel ECG recording and myocardial scintigraphy) and the optimal timing of coronary intervention have been further evaluated in patients with ACS. Newer antithrombotic and second-generation anti-platelet agents may also confer benefit in this situation.

A Kumar, D H Roberts
Lancashire Cardiac Centre, BFW Hospitals NHS Trust, Blackpool, UK

Correspondence to: Dr R K Kumar, Department of Cardiology, Lancashire Cardiac Centre, BFW Hospitals NHS Trust, Whinney Heys Road, Blackpool FY3 8NR, UK; dr.kumar2@bfwhospitals.nhs.uk

Competing interests: None.


REFERENCES


The authors’ reply: Immediate percutaneous coronary intervention (PCI) is currently thought to be useful for ischaemia at early onset, thereby minimising detrimental consequences of vessel occlusion. By selecting only those patients with onset of chest pain within 6 h (median 3 h) we included a consecutive series of acutely unstable patients. By definition this restricted the inclusion rate.

Moreover, the use of creatine kinase-MB as an end point is questioned by Kumar et al. However, meta-analysis showed that less periprocedural tissue necrosis is associated with an improved clinical course. This and other evidence led to the consensus that PCI-related ischaemic events have adverse effects on patient outcome. However, it must be kept in mind that our study was not powered to detect a difference in survival. For this, one would need a trial with at least 10 000 patients to demonstrate an effect on mortality.

In addition, Kumar et al point to differences in baseline characteristics which do not favour the immediate PCI group. Although the prevalence of hypertension and previous coronary artery bypass grafting, was higher in the immediate group, adjustment for these differences by multivariate analyses did not alter the results of the study. Other baseline factors like TIMI flow favoured the immediate PCI group.

At the time of patient inclusion, a loading dose of 300 mg clopidogrel was customary. Nowadays, the protocol in our hospital is to use a high loading dose when patients apply for immediate PCI. It is only recently that this practice has been advocated by the cardiovascular societies. The addition of abciximab to aspirin and clopidogrel was—wrongly—thought to provide sufficient periprocedural protection in the immediate treated group.

Furthermore, virtually all patients were pretreated with atorvastatin 80 mg. We agree with the authors that the results of our study should be interpreted with care, in particular because of the small sample size. Nevertheless, we would like to emphasise that there is absolutely no evidence demonstrating the clinical superiority of immediate PCI over the deferred approach (beyond 24 h).

R K Riezebos, G J Laarman, J G P Tijsen
Onze Lieve Vrouwe Gasthuis, Amsterdam, The Netherlands; King’s College Hospital, London, UK; Academic Medical Centre, University of Amsterdam, Amsterdam, The Netherlands

Correspondence to: Dr R K Riezebos, Onze Lieve Vrouwe Gasthuis, Department of Cardiology, PO Box 95500, 1090 HM, Amsterdam, The Netherlands; R.K.Riezebos@xx4all.nl

Heart 2009;95:1456. doi:10.1136/hrt.2009.175430

REFERENCES


