New Evidence Fuels Rewrite

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from the Invasive versus Conservative Treatment in Unstable Coronary Syndrome (ICTUS) trial, which showed that after 1 and 3 years of follow-up patients randomized to a selective invasive strategy had similar outcomes compared with patients managed with a routine invasive strategy (Lancet. 2007;369:827-35).

The guidelines also noted that despite this finding in favor of a conservative strategy, a meta-analysis of seven trials including ICTUS found that overall an early invasive strategy led to fewer deaths or new coronary events (J. Am. Coll. Card. 2006;48:1319-25).

The guidelines call the conservative strategy preferable for certain patients, such as women who are at low risk of death or STEMI. That is because in low-risk women, the risk of complications from coronary catheterization, such as puncture site bleeding, exceeds the potential benefit from a percutaneous intervention, she said.

An important step when deciding between an invasive or conservative strategy is an early risk assessment of the patient. Although the guidelines allow physicians to make a qualitative assessment of high, intermediate, or low risk, on the basis of factors such as cardiac markers (especially troponin level), ECG, clinical findings, pan, and history, they recommend going further and using one of the formal scoring systems that have been validated during the past few years: the Thrombolysis in Myocardial Infarction (TIMI), Global Registry of Acute Coronary Events (GRACE), or Platelet IIb/IIIa in Unstable Angina: Receptor Suppression Using Integrilin Therapy (PURSUIT) score.

“We thought it was a little early to say that everyone has to use a formal scoring system on every patient, but we’re pushing people in that direction,” said Dr. Jefrey L. Anderson, the associate chief of cardiology at LDS Hospitals in Salt Lake City and also the chairman of the guidelines committee.

“We hope that people will become more familiar with scoring the next few years and that eventually” it will be used routinely, he said in an interview.

Other important, new elements in the guidelines deal with antithrombotic and anticoagulant therapy. In addition to daily aspirin, which is continued indefinitely, all patients should start on clopidogrel as soon as possible and continue it for about a year if they were treated conservatively or get a bare-metal coronary stent, and continue for at least a year on clopidogrel if they receive a drug-eluting coronary stent.

Two new anticoagulant drugs have been introduced since the 2002 guidelines, fonaparinux (Arixtra) and bivalirudin (Angiomax), and these are deemed alternatives to the low-molecular-weight heparin enoxaparin (Lovenox) and unfractionated heparin.

The new set of guidelines also call for treatment with a glycoprotein IIb/IIIa inhibitor, for example eptifibatide (Integrilin), tirofiban (Aggrastat), or abciximab (ReoPro) for recurrent angina or prior to diagnostic angiography or coronary stenting.

Overall, the antithrombotic and anticoagulant options are numerous and complex. The guidelines “try to walk a physician through, step by step, but in some cases they can choose one option or another.” To simplify things, I recommend that a physician, group, or hospital decide on a particular strategy and try to focus on using that to make it easier for everyone,” commented Dr. Anderson, who is also a professor of medicine at the University of Utah.

The guidelines also call for aggressive, ongoing medical management after the patient is discharged. At the core of the regimen is an ACE inhibitor, or an angiotensin receptor blocker for ACE inhibitor-intolerant patients.

A new addition in the guidelines is use of an aldosterone receptor blocker, either spironolactone or eplerenone (Inspra). For patients with a left ventricular ejection fraction of 40% or less and either symptomatic heart failure or diabetes, as long as they do not have significant renal dysfunction or hyperkalemia.

Other elements of the discharge regimen include following established U.S. guidelines for blood pressure and serum lipids, and a strong push for smoking cessation.

Hormone therapy should not be started in postmenopausal women, and in general should stop in postmenopausal women who were on hormonal therapy at the time of their coronary event.

Supplements with antioxidant vitamins C and E and folic acid in the Post-MI Treatment with an NSAID (aside from aspirin) should be stopped when a patient is first admitted.

If a drug of this type is required by the patient at discharge, it should be used at the lowest effective dose for the shortest possible time.

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**Post-MI Depression Affects More Women Than Men**

**O R L A N D O — A** higher incidence of depression after a myocardial infarction in women, compared with men, contributes to the worse outcomes that women face, according to a study.

“It’s important to identify and treat symptoms of depression at the time of hospitalization for myocardial infarction,” Dr. Susmita Parashar said at a conference on cardiovascular disease epidemiology and prevention sponsored by the American Heart Association.

Dr. Parashar, of Emory University, Atlanta, and associates used data on 2,411 acute MI patients at 17 U.S. centers during January 2003-June 2004 in the Post-MI Registry Evaluating Myocardial Infarction Events and Recovery study. Patients with a documented MI were assessed for depression at initial hospitalization and at follow-up with the Patients Health Questionnaire (PHQ).

During initial hospitalization, 29% of 752 women in the registry were diagnosed with depression by the PHQ, compared with a prevalence of 19% among 1,531 men, a statistically significant difference.

When adjusted for covariates, the rate at baseline, women were 18% more likely to need rehospitalization during 12 months of follow-up versus men, a significant difference.

In a second analysis that adjusted for age and race and several clinical factors at baseline including diabetes, hypertension, and smoking history, women were 20% more likely to be hospitalized during follow-up, compared with men.

—Mitchell L. Zoler