STOCKHOLM — A routine early invasive strategy in patients with non-ST-segment elevation acute coronary syndrome has been shown for the first time to reduce the long-term risks of death or nonfatal MI. Following a follow-up in the Randomized Intervention Trial of Unstable Angina (RITA) showed a significant 22% reduction in the relative risk of the combined end point of death or nonfatal MI and a 24% reduction in all-cause mortality with a strategy of early coronary angiography followed by revascularization, as compared with a conservative strategy of symptom-driven angiography, reported Keith A.A. Fox, Duke of Edinburgh Professor of Cardiology at the University of Edinburgh.

The trial was a British Heart Foundation-sponsored multicenter U.K. trial in which 1,810 patients with non-ST-elevation ACS were randomized to intervention within 72 hours or to a conservative management strategy. The incidence of death or nonfatal MI at a median of 5 years of follow-up was 16.6% in the early intervention arm and 20.0% with conservative management.

All-cause mortality was 12.1% with early intervention vs. 15.1% with a conservative strategy. There were 62 cardiovascular deaths in the early intervention arm and 90 in the comparison group. A key finding at 5 years was that the benefits of an early invasive strategy were concentrated in patients with a high baseline risk of death or MI. Indeed, the benefits of the interventional strategy were statistically significant only for those in the upper half of risk.

“W hat is perhaps remarkable is that patients in the top eighth in terms of risk had a profound 56% reduction in the odds of death or MI with the early invasive intervention strategy; those in the lowest quartile of risk had no evidence of benefit,” he said. “The clinical implications are that a strategy of routine angiography and intervention is appropriate for all moderate- and high-risk patients with non-ST-elevation ACS.”

This is consistent with current European Society of Cardiology and American College of Cardiology/American Heart Association guidelines for management of non-ST-elevation ACS. Dr. Fox noted because the data analysis in RITA-3 was by intention to treat and a substantial number of patients in the conservative arm eventually underwent a revascularization procedure, the 5-year results probably underestimate considerably the true benefits of an early invasive strategy, he added.

Discussant Freek Verheugt, M.D., said an early invasive strategy is preferable because it reduces the risks of acute MI and rehospitalization.

An early invasive strategy didn’t show a significant mortality benefit in a meta-analysis of seven clinical trials (JAMA 2005;293:1095-104), including the 1-year RITA-3 results. Nor did it reduce 1-year mortality, compared with a more conservative strategy in the recently published Invasive Versus Conservative Treatment in Unstable Coronary Syndromes (ICTUS) trial involving 1,180 high-risk troponin-positive patients (Circulation. 2005;112:1095-104) in which Dr. Verheugt was a co-investigator. And in RITA-3, the P value for all-cause mortality at 3 years was 0.054—clearly statistically significant, noted Dr. Verheugt, professor and chairman of cardiology at University Medical Center, Nijmegen, the Netherlands.

Proteinuria Linked to MIDeaths

STOCKHOLM — Patients with proteinuria following a myocardial infarction had significantly worse outcomes than did patients without proteinuria, according to findings in 583 patients.

Treatment with an ACE inhibitor was especially effective at improving outcomes in patients with proteinuria after a myocardial infarction, Powell O. Jose said in a poster presentation at the annual meeting of the European Society of Cardiology.

“Assessing proteinuria in patients following an MI may improve their risk stratification,” said Mr. Jose and his associates in their poster presentation. In addition, “proteinuria may define a patient subset that’s most likely to benefit from ACE inhibitor therapy following an MI,” said Mr. Jose, a researcher at Brigham and Women’s Hospital in Boston.

The analysis used data collected in the Survival and Ventricular Enlarge ment (SAVE) trial, one of the first studies to establish the efficacy of an ACE inhibitor in patients with left ventricular dysfunction after an MI (N. Engl. J. Med. 1993;327:669-77).

The post hoc analysis by Mr. Jose and associates focused on 583 of the 2,213 patients in the SAVE trial who were assessed for proteinuria with a dipstick test when they entered the study. The results showed that patients with high levels of proteinuria who were treated with captopril dropped total mortality by 54%, compared with placebo, whereas in patients without proteinuria, mortality during follow-up was 20%.

The analysis also examined the impact of the ACE inhibitor treatment used in the study, a regimen of 10-mg captopril t.i.d., which was compared with placebo. In patients with proteinuria at baseline, treatment with captopril dropped total mortality by 54%, compared with placebo, whereas in patients without proteinuria, mortality during follow-up was 20%.

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