

Which is the best reperfusion strategy for patients with high-risk myocardial infarction?

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Systemic thrombolysis and primary percutaneous coronary intervention (PCI) are both effective treatments for acute ST-elevation myocardial infarction. Several randomized trials have shown that primary PCI is superior to thrombolytic therapy in acute myocardial infarction (AMI). Despite these findings, thrombolytic therapy remains an acceptable alternative for most patients, yet it may not be ideal for higher-risk AMI patients. Advanced age, diabetes mellitus, anterior infarction, severe tachycardia, shock and comorbidities are associated with early mortality rates ranging from 10 to 58% in patients treated with thrombolytic agents.

This review will examine the data comparing primary PCI and systemic thrombolysis in the different clinical conditions which identify patients at high risk in the setting of AMI.

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Introduction

Systemic thrombolysis and primary percutaneous coronary intervention (PCI) are both effective treatments for acute ST-elevation myocardial infarction (STEMI). Several randomized comparisons have shown that primary PCI is superior to thrombolytic therapy in achieving reperfusion and reducing mortality¹⁻³ in acute myocardial infarction (AMI). Despite these findings, thrombolytic therapy remains the mainstay of therapy for AMI, partly due to the fact that the majority of hospitals lack of PCI capabilities.

Although trials and registries suggest substantial benefit for routine primary angioplasty in some settings¹⁻⁴, whether routine use for all patients would be worthwhile is controversial for several reasons. Firstly, modeling experiments suggest that even relatively small, high-risk subgroups may be critically influential in determining the overall outcome of a clinical trial⁵. Secondly, most patients with AMI have excellent outcomes with thrombolytic therapy, and the marginal benefits of primary angioplasty in these patients may be modest, even in the best settings, and may be outweighed by the adverse impact of delaying reperfusion on account of the transport to an angioplasty-capable center. Therefore, although thrombolytic therapy remains an acceptable alternative for most patients, it may not be ideal for higher-risk patients.

Advanced age, diabetes mellitus, anterior infarction, shock, and comorbidities are associated with early mortality rates ranging from 10 to 58% in patients treated with thrombolytic agents⁶.

A recent study⁷, using a validated logistic regression model in order to estimate the distribution of mortality risk in a community-based sample of 1058 patients, suggested that high-risk populations with AMI are much more likely to benefit from primary angioplasty than low-risk populations.

This review will examine the data comparing primary PCI and systemic thrombolysis in the different clinical conditions which identify patients at high risk in the setting of AMI.

Advanced age

In the last decades the number of elderly patients being treated for symptomatic coronary artery disease has been steadily increasing⁸⁻¹⁰. Patients > 75 years of age comprise 36% of all patients with AMI and 60% of all deaths from myocardial infarction, 9-fold higher than younger patients¹¹⁻¹⁷.

Reperfusion therapy, including thrombolytic therapy and primary angioplasty, is underutilized in eligible elderly patients with AMI. This is especially true in high-risk patients, like elderly patients with large anterior myocardial infarction complicated

by heart failure and hypotension, who have the most to gain from aggressive therapy¹⁸.

Although older patients, who received thrombolytic therapy or primary angioplasty, had a lower mortality at 1 year compared with those who did not receive a reperfusion strategy, only those treated with primary angioplasty had better survival at 30 days^{19,20}. For this reason, the effectiveness of thrombolytic therapy in elderly patients has recently been questioned^{21,22}, based also on data from the Medicare Cooperative Cardiovascular Project registry²³. The FTT (Fibrinolytic Therapy Trialists) performed a meta-analysis of nine randomized, placebo-controlled studies of the use of thrombolytic therapy in 5754 patients aged ≥ 75 years with AMI²⁴. The initial meta-analysis showed a non-significant reduction in mortality at 35-day follow-up in patients treated with thrombolytic therapy vs placebo (24.3 vs 25.3%). On the other hand, a more recent meta-analysis of FTT data, cited by White¹⁹ and by Estess and Topol²⁵ showed that among patients aged ≥ 75 years with AMI, mortality at 35-day follow-up was significantly reduced: from 29% on placebo to 26% on thrombolytic therapy ($p = 0.03$). On the contrary, three observational studies^{20,23,26} have suggested that the use of thrombolytic therapy in patients > 75 years with AMI may be associated with adverse outcomes.

Primary coronary angioplasty is an alternative tool to accomplish reperfusion of the infarct-related vessel with a lower risk of intracerebral hemorrhage, when compared with thrombolytic therapy^{1,2,24,27}. In a pooled analysis of three randomized studies of primary angioplasty vs thrombolysis in elderly patients (> 70 years), angioplasty was more effective²⁸. Furthermore, the high incidence of comorbidity and contraindications to thrombolytic therapy makes primary PCI an attractive reperfusion modality in this AMI patient group.

On the other hand, PCIs carry an increased procedural risk in older patients when compared with those of younger age²⁹ and the place of primary coronary angioplasty in elderly patients with AMI has not yet been determined in a randomized comparison as most studies recruited only few elderly patients. Recently, a prospective randomized trial³⁰ comparing primary coronary angioplasty with intravenous streptokinase therapy in ≥ 76 years AMI patients with no contraindications to thrombolytic therapy did not demonstrate any benefit with regard to 30-day survival (relative risk-RR 4.0, 95% confidence interval-CI 0.9 to 24.6, $p = 0.04$): conversely, the incidence of the predefined composite endpoint of death, recurrent infarction and stroke after 30 days was significantly lower in the angioplasty-treated patient group (RR 4.3, 95% CI 1.2 to 20.0, $p = 0.01$). The long-term follow-up data showed a statistically significant benefit with regard to survival after 1 year (RR 3.4, 95% CI 1.0 to 13.5, $p = 0.03$) and the combined clinical endpoint of death, recurrent AMI or stroke (RR 5.2, 95% CI 1.7 to 18.1, $p = 0.001$) of angioplasty treatment over thrombolytic therapy. Previ-

ously, Zijlstra et al.³¹ randomized 395 patients (mean age 60 years) with AMI to treatment with PCI or streptokinase therapy. At 5-year follow-up, mortality was 13% in the PCI group vs 24% in the streptokinase group (a 46% significant reduction by primary angioplasty). Non-fatal reinfarction occurred in 6% of the PCI group vs 22% of the streptokinase group (a 73% significant reduction by PCI). In the Cooperative Cardiovascular Project³², a retrospective cohort study showed that 18 645 patients with AMI (mean age 73 years) were treated with thrombolytic therapy and 2038 (mean age 73 years) were treated with primary PCI. The 30-day mortality was 8.7% in patients treated with PCI vs 11.9% in patients treated with thrombolytic therapy ($p = 0.001$). The 1-year mortality was 14.4% in patients treated with PCI vs 17.6% in patients treated with thrombolytic therapy ($p = 0.001$). Finally, Averano et al.³³ randomized 451 thrombolytic-eligible patients (mean age 64 years) with AMI to PCI or thrombolytic therapy in 11 community hospitals without on-site cardiac surgery. At 6-week follow-up, the primary endpoint of death, recurrent myocardial infarction, and stroke was 10.7% in the PCI-treated group vs 17.7% in the thrombolytic therapy group ($p = 0.03$).

A paucity of data exists regarding the outcome after primary PCI of the specific subset of very elderly patients (≥ 80 years), with the only published study being that of Laster et al.³⁴. These investigators reviewed the cumulative experience of primary PCI (mean time to reperfusion of 4.3 ± 2.8 hours) in 55 patients (mean age 83.3 ± 2.3 years) over a period of 13 years. Overall, the 30-day mortality rate was 16%. The mortality rate was 67% for patients with cardiogenic shock on presentation and 10% for patients without cardiogenic shock. The 1-year actuarial survival rate was 67%. These data seem to be confirmed by the observational data of centers performing systematic primary angioplasty in Italy. A single center registry of 55 octogenarian and older patients treated with primary PCI in Florence reported a 30-day mortality of 16% including patients with cardiogenic shock at presentation and 4% in those without cardiogenic shock³⁵; a recent extension of the registry, including 342 patients > 75 years, reported a 30-day mortality of 15% including shock patients.

Nowadays, tenecteplase seems to be the best available candidate for thrombolytic therapy in elderly patients. The ASSENT-2 (Assessment of the Safety and Efficacy of a New Thrombolytic) trial³⁶, in patients > 75 years, showed a lower incidence of intracranial hemorrhage in patients treated with tenecteplase compared to alteplase (1.7 vs 2.6%), and also a trend toward lower mortality (17.4 vs 19.3%, $p = 0.286$). Due to its higher fibrin specificity, tenecteplase was also associated with lower non-intracranial bleeding³⁶. Furthermore, in terms of lytic efficacy, tenecteplase is at least as effective as alteplase in angiographic studies^{37,38}.

From the available data, it is not possible to conclude whether thrombolytic therapy is beneficial or

detrimental in patients > 75 years with AMI. However, the data favor the use of PCI, especially in high-risk elderly patients.

Diabetes mellitus

The prevalence of ischemic heart disease complicating diabetic syndromes is growing rapidly as is the prevalence of the syndrome itself.

Coronary atherosclerotic disease in diabetic patients differs in several aspects from coronary disease in non-diabetic patients. Endothelial dysfunction, platelet and coagulation abnormalities contribute to the accelerated atherosclerotic process and to the development of coronary thrombosis. Coronary specimens taken from diabetic patients exhibit a larger content of lipid-rich atheroma, a greater macrophage infiltration, and more thrombosis than tissue from patients without diabetes. These differences suggest a greater vulnerability for plaque disruption and coronary thrombosis in patients with diabetes mellitus than in the general population^{39,40}.

Hyperglycemia alone is associated with an increased risk of heart failure, cardiogenic shock, and death after AMI and is an independent prognostic factor for no-reflow, along with age, gender, absence of pre-infarction angina, complete occlusion of the culprit lesion, and anterior AMI⁴¹.

Acute coronary syndromes, including AMI and sudden death, are indeed twice as frequent in diabetic than in non-diabetic coronary patients⁴⁰ and their management in this group of high-risk patients remains a difficult challenge.

In a major international trial involving more than 40 000 patients designed to evaluate four fibrinolytic strategies for the treatment of AMI, the 30-day mortality was 6.2% among patients without diabetes and 10.5% among patients with diabetes. Indeed, by pooling the data from several large fibrinolytic trials with a total of more than 80 000 patients, the 1-month mortality was increased by 1.7 times among diabetics⁴². Notably, mortality was highest among those treated with insulin. Undoubtedly less known is the fact that fibrinolysis saved 37 lives per 1000 patients with diabetes at 35 days, compared with 15 per 1000 patients without diabetes²⁴. Thus, the absolute benefit is more than doubled for fibrinolytic therapy among diabetics.

Despite its tremendous benefit, patients with diabetes were less likely to receive fibrinolytic therapy⁴³, as evidenced in the SAVE (Survival and Ventricular Enlargement) study. In this trial, of the 2231 patients enrolled, fibrinolytic therapy was administered in 733 (32.9%).

Diabetic patients undergoing PCI exhibit similar angiographic success rates to non-diabetic patients, but show a trend toward higher in-hospital mortality rates, higher rates of urgent revascularization, and greater in-

cidence of acute coronary occlusions. Diabetes is an independent predictor of clinical outcome, as the early and late mortality rates⁴⁴, with higher incidences of death, AMI and repeated revascularization at long-term follow-up, also after primary PCI.

Until now, the optimal strategy for coronary revascularization in diabetic patients remains to be determined. The addition of stent implantation to balloon angioplasty in diabetic patients is feasible with favorable procedural and in-hospital success rates. However, long-term outcomes after stenting remain worse because of a higher incidence of major adverse cardiac events and, above all, of restenosis rate as compared to non-diabetic patients⁴⁵. The increased risk of restenosis after angioplasty and/or stenting in diabetic patients is primarily due to an exaggerated reactive intimal hyperplasia that causes increased late lumen loss and decreased vessel lumen area⁴⁶. In a recent pooled analysis of several major recent stent trials, Cutlip et al.⁴⁷ found diabetes to be the strongest clinical predictor for restenosis, with almost 50% increased risk for target lesion revascularization at 1-year follow-up. Considering the higher rate of restenosis and the current prevalence of diabetes among patients who undergo PCI (e.g., a prevalence of 18 to 30% in most series), a simple calculation would show that 30 to 40% of the patients who sustain clinical restenosis and eventually undergo target vessel revascularization are those with diabetes mellitus⁴⁸. Thus, the reduction of restenosis rate among diabetic patients will have a major favorable impact on the global outcome of catheter-based coronary interventions.

The liberal use of glycoprotein IIb/IIIa inhibitors favorably affects the results of PCI and stenting in diabetic patients. Pooled data from EPIC, EPILOG, and EPISTENT trials showed that abciximab decreases the 1-year mortality of diabetics to the rate observed in placebo-treated non-diabetic patients⁴⁹⁻⁵¹. Subgroup analysis, however, suggests that clinical benefits may be not as sustained in diabetic patients as in the general population. Clearly, further investigations are needed to explain the interaction of glycoprotein IIb/IIIa inhibition and diabetes in patients undergoing PCI.

In conclusion, whether stents and glycoprotein IIb/IIIa inhibitors will modify these features is still controversial. Treatment advances such as improvements in interventional techniques, gene therapy and drug-eluting stents may substantially modify this scenario in the near future.

Renal insufficiency

Cardiovascular diseases are the leading cause of death among patients with renal insufficiency (RI). Patients with varying degrees of renal failure make up an increasing percentage of the population undergoing PCI⁵². Unfortunately, the management of AMI in this

subset of patients is particularly problematic. Although the existence of RI in patients undergoing PCI in the non-AMI setting is associated with a poor prognosis⁵², the outcomes of primary PCI in patients with AMI and RI have not been well characterized since such patients are typically excluded from clinical trials^{53,54}.

Several observational series have found that patients with a baseline creatinine level > 1.5 mg/dl who undergo PCI experience a significantly lower procedural success rate, and at least a 5-fold increase in major in-hospital adverse events, and a nearly 4 times higher mortality rate on long-term follow-up than patients with a baseline creatinine level < 1.5 mg/dl. In a large retrospective analysis of patients undergoing elective PCI, RI was found to have a negative prognostic impact, similar to that of diabetes mellitus, on cardiovascular morbidity and mortality⁵⁵.

A recent study by Sadeghi et al.⁵⁶ demonstrated that, in patients undergoing primary PCI for AMI, the presence of RI at baseline was associated with a striking increase in short-term and late mortality, similar to the excess risk of anterior vs non-anterior myocardial infarction location. Despite the association of RI with multiple high-risk features known to affect the prognosis of patients after primary angioplasty, RI was one of the strongest independent predictors of diminished survival, especially in the early phase of post-AMI. The presence of baseline RI was also strongly associated with a significant increase in major hemorrhagic complications and the need for blood product transfusion as well as severe restenosis and infarct-related artery re-occlusion.

Nonetheless, the impact of baseline RI on mortality was independent of age, sex, medication use, and other covariates when evaluated in a multivariable model. Unique metabolic abnormalities of chronic RI, including insulin resistance, dyslipidemia, homocysteinemia, hyperuricemia, and increased atherosclerotic, thrombotic, and oxidative stress⁵⁷⁻⁶¹, may contribute to the independent excess cardiovascular risk in these patients. In addition, the procedural success rate was lower in patients with RI owing to a higher rate of periprocedural complications, which may have contributed to their worse long-term prognosis.

Radiocontrast toxicity may also contribute to clinical deterioration after primary PCI in AMI. Depending on the definition used, a contrast-induced nephropathy occurs in about 1 to 15% of a general PCI population and in 20 to 40% of patients with preexisting RI⁶²⁻⁶⁴. All attempts must be made to prevent contrast nephropathy, including adequate hydration⁶⁵, minimizing contrast use⁶⁴, use of low-osmolar contrast⁶⁶, and possible administration of N-acetylcysteine⁶⁷. Patients with baseline RI warrant close surveillance and intensive medical management, including tight control of diabetes, hypertension, and dyslipidemia⁵⁷, dietary modification, and potentially frequent stress testing for early recognition of disease progression. Whether the incidence or prog-

nostic implications of RI after fibrinolytic therapy are different from those after primary PCI also deserves further study. Novel approaches are required for patients with RI to favorably affect their otherwise poor prognosis.

Shock

The incidence of cardiogenic shock complicating AMI remains approximately 7 to 8%, according to the recent literature⁶⁸. Retrospective studies suggest that early PCI may improve the outcome in patients with cardiogenic shock⁶⁹⁻⁷². The randomized SHOCK (Should We Emergently Revascularize Occluded Coronaries for Cardiogenic Shock) trial⁷³ showed that a strategy of early revascularization, either with surgery or PCI as deemed appropriate by the treating cardiologist, increased the 1-year survival from 34 to 47% ($p = 0.025$) compared with initial aggressive medical therapy in 302 patients with shock due to left ventricular dysfunction complicating AMI. In this trial, the success rate of PCI was relatively low (76%) but consistent with previous retrospective shock studies⁷⁴, and not unexpected given that most patients had diffuse disease, occluded arteries, and were hemodynamically unstable. Stents were used in 34% of the patients, mainly to salvage a failed balloon PCI, and were largely first-generation devices implanted without the benefit of current adjunctive techniques. Similarly, glycoprotein IIb/IIIa inhibitor and thienopyridine use was infrequent but increased during the nearly 6-year trial period. Potentially, the increased use of stenting and adjunctive therapies that improve coronary blood flow might further extend the benefits of PCI⁷⁵⁻⁷⁸.

The SHOCK trial also suggested a lack of benefit for early revascularization in patients ≥ 75 years of age. However, the numbers were small, with only 12 PCI patients ≥ 75 years of age.

Although PCI tended to be successful less often in elderly patients, successful PCI seems to be associated with increased survival. Dzavik et al.⁷⁹ reported higher survival rates for the 17% of patients ≥ 75 years of age in the SHOCK registry who were clinically selected to undergo early revascularization compared with those with late or no revascularization.

Further trials are needed to assess the impact of modern, innovative technologies and pharmacological treatment⁸⁰ in this high-risk subgroup of patients. However, at the moment, the prognosis of patients with AMI and cardiogenic shock remains extremely guarded.

Anterior wall myocardial infarction

Some prospective randomized trials have established the superiority of primary PCI over fibrinolytic

treatment even in patients with anterior wall AMI. These excellent PCI results are also duplicated in smaller hospitals where there may be delays in getting the cardiac catheterization team to the laboratory, as demonstrated by a recent study⁸¹ aimed to compare the outcome of patients with anterior wall myocardial infarction, without cardiogenic shock on admission, treated with primary PCI or thrombolytic therapy. The data of all patients with myocardial infarction hospitalized in coronary care units operating in Israel during three consecutive national surveys were analyzed⁸¹. A total of 1038 patients with anterior wall myocardial infarction were treated by reperfusion (886 received thrombolytic therapy, 152 primary PCI). Overall, the outcome of patients treated using primary PCI was better compared to patients treated with thrombolysis, with a 68% RR reduction of 30-day mortality (mortality at 30 days: 2 vs 6.3%, $p = 0.04$). A subanalysis of patients according to age showed that the beneficial effect of primary PCI on mortality was mainly clustered among the younger AMI patients.

Late presentation

The benefits of intravenous thrombolysis appear to be dependent on the time elapsed between symptom onset and initiation of treatment²⁴, and when treatment is established in the first 2 hours, survival increases dramatically⁸². In this respect, it is noteworthy that the ability of certain thrombolytic agents to recanalize the infarct-related artery appears to decrease with time^{83,84}. Prehospital thrombolysis appears safe and effective and is associated with a substantial gain in time to treatment⁸⁵. The CAPTIM (Comparison of Angioplasty and Prehospital Thrombolysis in Acute Myocardial Infarction) trial⁸⁶ was set up to compare prehospital thrombolysis and primary PCI in patients with STEMI and did not demonstrate any difference in the combined endpoint of death, reinfarction, and disabling stroke at 30 days between the two groups.

Previous retrospective analyses of cohort and trial data have suggested that outcomes after primary PCI may be relatively independent of the time between symptom onset and reperfusion but are related to the time elapsed between admission and PCI^{87,88}. Consistent with these data, Zijlstra et al.⁸⁹, in a pooled-analysis of several randomized trials comparing primary angioplasty and thrombolysis, found a direct relationship between time from symptom onset to treatment only in patients treated with thrombolysis, but not with primary angioplasty. A major limitation of these studies is that they did not stratify patients according to the risk of death.

Conversely, recent studies and clinical trials⁹⁰ suggest that time since symptom onset should be considered when one selects reperfusion therapy. A meta-

analysis by De Luca et al.⁹¹ showed that, in patients with STEMI treated with primary angioplasty, symptom-onset-to-balloon time, but not door-to-balloon time, was related to mortality, particularly in non-low-risk patients and a symptom-onset-to-balloon time > 4 hours was identified as an independent predictor of 1-year mortality. Consistent with these data, a previous study⁹² found, in a population of 1332 patients undergoing primary angioplasty, a relationship between time delay and mortality in high-risk patients. A possible explanation for these findings is that the duration of coronary occlusion is a main determinant of the infarct size, as demonstrated in animal models^{93,94}. Therefore, late reperfusion is expected to result in less myocardial salvage and higher mortality rate. Furthermore, a delay in reperfusion may be associated with an organized intracoronary thrombus in comparison with an early reperfusion, resulting in a higher incidence of distal embolization.

Transfer for primary percutaneous coronary intervention versus on-site thrombolysis

Observational studies reported few complications during transfer for primary PCI and no correlation between transfer distance and adverse outcomes⁹⁵. Moreover, reported randomized trials have shown improved outcomes with transfer AMI patients for primary PCI^{96,97}.

A recent trial⁹⁸ demonstrated that also patients with high-risk AMI at hospitals without PCI capabilities might have an improved outcome if transferred for emergency PCI rather than being treated with on-site thrombolytic therapy. This trial randomized 138 patients before the study ended (71 to transfer for PCI with a mean time of 52 min, and 67 to thrombolysis). At 30 days, a 38% reduction in major adverse cardiac events was observed for the transfer group; however, because of the inability to recruit the necessary sample size, this did not achieve statistical significance (8.4 vs 13.6%, $p = 0.331$). Considering that the number of patients enrolled is very small, these findings need to be confirmed in a large trial before any general recommendations can be made.

Conclusions

Collected data from the literature suggest that high-risk patients, especially when presenting precociously, have the greatest benefit from primary PCI when compared with thrombolysis. Therefore, an early identification of the high-risk group may allow most of the benefits identified in population-wide angioplasty trials. The possibility of transferring high-risk patients for primary PCI to a center with interventional facilities need to be ascertained.

Riassunto

La trombolisi e l'angioplastica primaria sono entrambi efficaci trattamenti in caso di infarto miocardico acuto (IMA) con sopraslivellamento del tratto ST.

Diversi studi randomizzati di controllo hanno tuttavia dimostrato come l'angioplastica primaria sia superiore al trattamento trombolitico in termini di ripercussione e mortalità. Malgrado ciò, la trombolisi rimane il trattamento più utilizzato in caso di IMA, perché la maggior parte degli ospedali non è provvisto di emodinamica. La trombolisi però, sebbene possa essere considerata un'alternativa accettabile per molti pazienti con IMA, può non costituire il trattamento ideale per i pazienti ad alto rischio. È noto infatti che l'età avanzata, il diabete, l'infarto anteriore, lo shock e le comorbilità sono condizioni che traggono un maggior beneficio dalla procedura di angioplastica primaria, mentre sono associate ad una mortalità che varia dal 10 al 58% in pazienti trattati con agenti trombolitici.

I pazienti con più di 75 anni costituiscono il 36% di tutti i pazienti con diagnosi di IMA e il 60% di tutti i decessi per infarto miocardico. È ormai documentato che la terapia ripercussiva, sia essa la trombolisi o l'angioplastica, è sottoutilizzata in pazienti anziani con IMA. Ciò è soprattutto vero per i pazienti ad alto rischio, come i pazienti anziani con infarto anteriore esteso complicato da scompenso cardiaco ed ipotensione, che potrebbero maggiormente avvantaggiarsi di una strategia terapeutica più aggressiva. Recenti studi hanno dimostrato che i pazienti anziani sottoposti a terapia ripercussiva hanno una migliore sopravvivenza ad 1 anno rispetto a quelli che non sono trattati ed in particolare che i pazienti anziani trattati con angioplastica primaria hanno una mortalità più bassa a 30 giorni rispetto a quelli trombolisati.

Le sindromi coronariche acute e la morte improvvisa sono 2 volte più frequenti in pazienti diabetici rispetto ai non diabetici. Il miglior trattamento ripercussivo per questo gruppo di pazienti ad alto rischio rimane ancora controverso ed occorre precisare che molti studi di comparazione tra angioplastica e fibrinolisi in corso di IMA in pazienti diabetici sono stati eseguiti senza l'utilizzo di stent o di inibitori della glicoproteina IIb/IIIa che potrebbero, in un prossimo futuro, essere determinanti.

Il trattamento dell'IMA per i pazienti con insufficienza renale è particolarmente problematico. Sebbene sia ormai chiaro che la presenza di insufficienza renale in caso di IMA sia associata ad una peggiore prognosi, gli outcome dell'angioplastica primaria in caso di insufficienza renale non sono stati ancora ben delineati in quanto spesso questi pazienti ad alto rischio sono esclusi dai grandi trial clinici.

Attualmente lo shock cardiogeno in corso di IMA costituisce un fattore prognostico negativo estremamente severo. Sebbene lo SHOCK trial abbia dimostrato i benefici di una precoce terapia invasiva in questo

sottogruppo di pazienti, ulteriori studi sono necessari per confermare i favorevoli risultati dell'angioplastica primaria vs la terapia trombolitica.

Differente invece è il caso dell'IMA anteriore in cui diversi trial prospettici e studi *post-hoc* hanno ormai ampiamente dimostrato la superiorità dell'angioplastica primaria sulla fibrinolisi.

In conclusione, i dati della letteratura suggeriscono che i pazienti ad alto rischio con IMA, specialmente se si presentano precocemente in ospedale, hanno maggiori vantaggi, in termini di mortalità, quando sono trattati con angioplastica primaria.

References

1. Grines CL, Browne KF, Marco J, et al. A comparison of immediate coronary angioplasty with thrombolytic therapy for acute myocardial infarction. The Primary Angioplasty in Myocardial Infarction Study Group. *N Engl J Med* 1993; 328: 673-9.
2. Zijlstra F, de Boer JM, Hoorntje JC, Reijnders S, Reiber JH, Suryapranata H. A comparison of immediate coronary angioplasty with intravenous streptokinase in acute myocardial infarction. *N Engl J Med* 1993; 328: 680-4.
3. Weaver W, Simes R, Betriu A, et al. Comparison of primary coronary angioplasty and intravenous thrombolytic therapy for acute myocardial infarction: a quantitative review. *JAMA* 1997; 278: 2093-8.
4. Magid DJ, Calonge BN, Rumsfeld JS, et al, for the National Registry of Myocardial Infarction 2 and 3 Investigators. Relation between hospital primary angioplasty volume and mortality for patients with acute MI treated with primary angioplasty vs thrombolytic therapy. *JAMA* 2000; 284: 3131-8.
5. Ioannidis J, Lau J. The impact of high-risk patients on the results of clinical trials. *J Clin Epidemiol* 1997; 50: 1089-98.
6. Lee KL, Woodlief LH, Topol EJ, et al. Predictors of 30-day mortality in the era of reperfusion for acute myocardial infarction: results from an international trial of 41 021 patients. GUSTO-I Investigators. *Circulation* 1995; 91: 1659-68.
7. Kent DM, Schmid CH, Lau J, Selker HP. Is primary angioplasty for some as good as primary angioplasty for all? *J Gen Intern Med* 2002; 17: 887-94.
8. Dalstra JA, Reitsma JB. Coronary artery disease and atherosclerosis in the Netherlands: data on morbidity and mortality. The Hague: The Netherlands Heart Foundation, 1997.
9. Thompson RC, Holmes DR. Percutaneous transluminal coronary angioplasty in the elderly. *Clin Geriatr Med* 1996; 12: 181-94.
10. Goldberg RJ, McCormick D, Gurwitz JH, Yarzebski J, Lessard D, Gore JM. Age-related trends in short- and long-term survival after myocardial infarction: a 20-year population-based perspective (1975-1995). *Am J Cardiol* 1998; 82: 1311-7.
11. Maggioni AP, Maseri A, Fresco C, et al. Age-related increase in mortality among patients with first myocardial infarctions treated with thrombolysis. The Investigators of the Gruppo Italiano per lo Studio della Sopravvivenza nell'Infarto Miocardico (GISSI-2). *N Engl J Med* 1993; 329: 1442-8.
12. Devlin W, Cragg D, Jacks M, Friedman H, O'Neill W, Grines C. Comparison of outcome in patients with acute

- myocardial infarction aged > 75 years with that in younger patients. *Am J Cardiol* 1995; 75: 573-6.
13. Maynard C, Every NR. Thrombolysis versus primary angioplasty in older patients with acute myocardial infarction. *Drugs Aging* 1999; 14: 427-35.
14. Haase KK, Schiele R, Wagner S, et al. In-hospital mortality of elderly patients with acute myocardial infarction: data from the MITRA (Maximal Individual Therapy in Acute Myocardial Infarction) registry. *Clin Cardiol* 2000; 23: 831-6.
15. Hannan EL, Racz MJ, Arani DT, Ryan TJ, Walford G, McCallister BD. Short- and long-term mortality for patients undergoing primary angioplasty for acute myocardial infarction. *J Am Coll Cardiol* 2000; 36: 1194-201.
16. Gillum RF. Trends in acute myocardial infarction and coronary heart disease death in the United States. *J Am Coll Cardiol* 1994; 23: 1273-7.
17. Rich MW. Treatment of acute myocardial infarction. *Am J Geriatr Cardiol* 2001; 10: 328-36.
18. Aronow WS. Thrombolytic therapy is indicated for patients over 75 years of age with ST-elevation acute myocardial infarction: antagonist viewpoint. *Am J Geriatr Cardiol* 2003; 12: 348-50.
19. White HD. Thrombolytic therapy in the elderly. *Lancet* 2000; 356: 2028-30.
20. Berger AK, Radford MJ, Wang Y, Krumholz HM. Thrombolytic therapy in older patients. *J Am Coll Cardiol* 2000; 36: 366-74.
21. Gottlieb S, Goldbourt U, Boyko V, Barbash G, Mandelzweig L, Behar S. Improvement in the prognosis of patients with acute myocardial infarction in the 1990s compared with the prethrombolytic era: an analysis by age subgroups. *Am J Geriatr Cardiol* 1995; 4: 17-31.
22. Krumholz HM, Murillo JE, Chen J, et al. Thrombolytic therapy for eligible elderly patients with acute myocardial infarction. *JAMA* 1997; 277: 1683-8.
23. Thiemann DR, Coresh J, Schulman SP, Gerstenblith G, Oetgen WJ, Powe NR. Lack of benefit for intravenous thrombolysis in patients with myocardial infarction who are older than 75 years. *Circulation* 2000; 101: 2239-46.
24. Fibrinolytic Therapy Trialists' (FTT) Collaborative Group. Indications for fibrinolytic therapy in suspected acute myocardial infarction: collaborative overview of early mortality and major morbidity results from all randomised trials of more than 1000 patients. *Lancet* 1994; 343: 311-22.
25. Estess JM, Topol EJ. Fibrinolytic treatment for elderly patients with acute myocardial infarction. *Heart* 2002; 87: 308-11.
26. Soumerai SB, McLaughlin TJ, Ross-Degnan D, Christiansen CL, Gurwitz JH. Effectiveness of thrombolytic therapy for acute myocardial infarction in the elderly: cause for concern in the old-old. *Arch Intern Med* 2002; 162: 561-8.
27. Gibbons RJ, Holmes DR, Reeder GS, Bailey KR, Hopfer-Spirger MR, Gersh BJ. Immediate angioplasty compared with the administration of a thrombolytic agent followed by conservative treatment for myocardial infarction. The Mayo Coronary Care Unit and Catheterization Laboratory Groups. *N Engl J Med* 1993; 328: 685-91.
28. O'Neill WW, de Boer MJ, Gibbons RJ, et al. Lessons from the pooled outcome of the PAMI, Zwolle and Mayo Clinic randomized trials of primary angioplasty versus thrombolytic therapy of acute myocardial infarction. *J Invasive Cardiol* 1998; 10 (Suppl A): 4A-10A.
29. Batchelor WB, Anstrom KJ, Muhlbauer LH, et al. Contemporary outcome trends in the elderly undergoing percutaneous coronary interventions: results in 7472 octogenarians. National Cardiovascular Network Collaboration. *J Am Coll Cardiol* 2000; 36: 723-30.
30. de Boer MJ, Ottervanger JP, van't Hof AW, et al, for the Zwolle Myocardial Infarction Study Group. Reperfusion therapy in elderly patients with acute myocardial infarction: a randomized comparison of primary angioplasty and thrombolytic therapy. *J Am Coll Cardiol* 2002; 39: 1723-8.
31. Zijlstra F, Hoorntje JC, de Boer MJ, et al. Long-term benefit of primary angioplasty as compared with thrombolytic therapy for acute myocardial infarction. *N Engl J Med* 1999; 341: 1413-9.
32. Berger AK, Schulman KA, Gersh BJ, et al. Primary coronary angioplasty vs thrombolysis for the management of acute myocardial infarction in elderly patients. *JAMA* 1999; 282: 341-8.
33. Aversano T, Aversano LT, Passamani E, et al, for the Atlantic Cardiovascular Patient Outcomes Research Team (C-PORT). Thrombolytic therapy vs primary percutaneous coronary intervention for myocardial infarction in patients presenting to hospitals without on-site cardiac surgery: a randomized controlled trial. *JAMA* 2002; 287: 1943-51.
34. Laster SB, Rutherford BD, Giorgi LV, et al. Results of direct percutaneous transluminal coronary angioplasty in octogenarians. *Am J Cardiol* 1996; 77: 10-3.
35. Antoniucci D, Valenti R, Santoro GM, et al. Systematic primary angioplasty in octogenarian and older patients. *Am Heart J* 1999; 138 (Part 1): 670-4.
36. Assessment of the Safety and Efficacy of a New Thrombolytic Investigators. Single-bolus tenecteplase compared with front-loaded alteplase in acute myocardial infarction: the ASSENT-2 double-blind randomised trial. *Lancet* 1999; 354: 716-22.
37. Cannon CP, McCabe CH, Gibson CM, et al. TNK-tissue plasminogen activator in acute myocardial infarction: results of the Thrombolysis in Myocardial Infarction (TIMI) 10A dose-ranging trial. *Circulation* 1997; 95: 351-6.
38. Cannon CP, Gibson CM, McCabe CH, et al. TNK-tissue plasminogen activator compared with front-loaded alteplase in acute myocardial infarction: results of the TIMI 10B trial. *Thrombolysis in Myocardial Infarction (TIMI) 10B Investigators. Circulation* 1998; 98: 2805-14.
39. Moreno PR, Murcia AM, Palacios IF, et al. Coronary composition and macrophage infiltration in atherectomy specimens from patients with diabetes mellitus. *Circulation* 2000; 102: 2180-2.
40. Falk E, Shah PK, Fuster V. Coronary plaque disruption. *Circulation* 1995; 92: 657-71.
41. Iwakura K, Ito H, Ikushima M, et al. Association between hyperglycemia and the no-reflow phenomenon in patients with acute myocardial infarction. *J Am Coll Cardiol* 2003; 41: 1-7.
42. Mak KH, Topol EJ. Emerging concepts in the management of acute myocardial infarction in patients with diabetes mellitus. *J Am Coll Cardiol* 2000; 35: 563-8.
43. Pfeffer MA, Moyer LA, Braunwald E, et al. Selection bias in the use of thrombolytic therapy in acute myocardial infarction. The SAVE Investigators. *JAMA* 1991; 266: 528-32.
44. Bolognese L, Carrabba N, Santoro GM, Valenti R, Buonamici P, Antoniucci D. Angiographic findings, time course of regional and global left ventricular function, and clinical outcome in diabetic patients with acute myocardial infarction treated with primary percutaneous transluminal coronary angioplasty. *Am J Cardiol* 2003; 91: 544-9.
45. Elezi S, Kastrati A, Pache J, et al. Diabetes mellitus and the clinical and angiographic outcome after coronary stent placement. *J Am Coll Cardiol* 1998; 32: 1866-73.
46. Kornowski R, Mintz GS, Kent KM, et al. Increased restenosis in diabetes mellitus after coronary interventions is due to exaggerated intimal hyperplasia. A serial intravascular ultrasound study. *Circulation* 1997; 95: 1366-9.

47. Cutlip DE, Chauhan MS, Baim DS, et al. Clinical restenosis after coronary stenting: perspectives from multicenter clinical trials. *J Am Coll Cardiol* 2002; 40: 2082-9.
48. Kornowski R, Fuchs S. Optimization of glycemic control and restenosis prevention in diabetic patients undergoing percutaneous coronary interventions. *J Am Coll Cardiol* 2004; 43: 15-7.
49. The EPIC Investigators. Use of a monoclonal antibody directed against the platelet glycoprotein IIb/IIIa receptor in high-risk coronary angioplasty. *N Engl J Med* 1994; 330: 956-61.
50. Kleiman NS, Lincoff AM, Kereiakes DJ, et al. Diabetes mellitus, glycoprotein IIb/IIIa blockade, and heparin: evidence for a complex interaction in a multicenter trial. EPILOG Investigators. *Circulation* 1998; 97: 1912-20.
51. Randomised placebo-controlled and balloon-angioplasty-controlled trial to assess safety of coronary stenting with use of platelet glycoprotein-IIb/IIIa blockade. The EPISTENT Investigators. Evaluation of Platelet IIb/IIIa Inhibitor for Stenting. *Lancet* 1998; 352: 87-92.
52. Rubenstein MH, Harrell LC, Sheynberg BV, Schunkert H, Bazari H, Palacios IF. Are patients with renal failure good candidates for percutaneous coronary revascularization in the new device era? *Circulation* 2000; 102: 2966-72.
53. Stone GW, Grines CL, Cox DA, et al, for the Controlled Abciximab and Device Investigation to Lower Late Angioplasty Complications (CADILLAC) Investigators. Comparison of angioplasty with stenting, with or without abciximab, in acute myocardial infarction. *N Engl J Med* 2002; 346: 957-66.
54. Grines CL, Cox DA, Stone GW, et al. Coronary angioplasty with or without stent implantation for acute myocardial infarction. Stent Primary Angioplasty in Myocardial Infarction Study Group. *N Engl J Med* 1999; 341: 1949-56.
55. Best PJ, Lennon R, Ting HH, et al. The impact of renal insufficiency on clinical outcomes in patients undergoing percutaneous coronary interventions. *J Am Coll Cardiol* 2002; 39: 1113-9.
56. Sadeghi HM, Stone GW, Grines CL, et al. Impact of renal insufficiency in patients undergoing primary angioplasty for acute myocardial infarction. *Circulation* 2003; 108: 2769-75.
57. Luke RG. Chronic renal failure - a vasculopathic state. *N Engl J Med* 1998; 339: 841-3.
58. Becker BN, Himmelfarb J, Henrich WL, Hakim RM. Re-assessing the cardiac risk profile in chronic hemodialysis patients: a hypothesis on the role of oxidant stress and other non-traditional cardiac risk factors. *J Am Soc Nephrol* 1997; 8: 475-86.
59. Fliser D, Pacini G, Engelleiter R, et al. Insulin resistance and hyperinsulinemia are already present in patients with incipient renal disease. *Kidney Int* 1998; 53: 1343-7.
60. Iribarren C, Folsom AR, Eckfeldt JH, McGovern PG, Nieto FJ. Correlates of uric acid and its association with asymptomatic carotid atherosclerosis: the ARIC Study. Atherosclerosis Risk in Communities. *Ann Epidemiol* 1996; 6: 331-40.
61. Venkatesan J, Henrich WL. Anemia, hypertension, and myocardial dysfunction in end-stage renal disease. *Semin Nephrol* 1997; 17: 257-69.
62. Parfrey PS, Griffiths SM, Barrett BJ, et al. Contrast material-induced renal failure in patients with diabetes mellitus, renal insufficiency, or both: a prospective controlled study. *N Engl J Med* 1989; 320: 143-9.
63. Gruberg L, Mintz GS, Mehran R, et al. The prognostic implications of further renal function deterioration within 48 h of interventional coronary procedures in patients with pre-existent chronic renal insufficiency. *J Am Coll Cardiol* 2000; 36: 1542-8.
64. McCullough PA, Wolyn R, Rocher LL, Levin RN, O'Neill WW. Acute renal failure after coronary intervention: incidence, risk factors, and relationship to mortality. *Am J Med* 1997; 103: 368-75.
65. Solomon R, Werner C, Mann D, D'Elia J, Silva P. Effects of saline, mannitol, and furosemide to prevent acute decreases in renal function induced by radiocontrast agents. *N Engl J Med* 1994; 331: 1416-20.
66. Barrett BJ, Carlisle EJ. Metaanalysis of the relative nephrotoxicity of high- and low-osmolality iodinated contrast media. *Radiology* 1993; 188: 171-8.
67. Tepel M, van der Giet M, Schwarzfeld C, Laufer U, Liermann D, Zidek W. Prevention of radiographic-contrast-agent-induced reductions in renal function by acetylcysteine. *N Engl J Med* 2000; 343: 180-4.
68. Goldberg RJ, Gore JM, Thompson CA, Gurwitz JH. Recent magnitude of and temporal trends (1994-1997) in the incidence and hospital death rates of cardiogenic shock complicating acute myocardial infarction: the Second National Registry of Myocardial Infarction. *Am Heart J* 2001; 141: 65-72.
69. Antoniucci D, Valenti R, Santoro GM, et al. Systematic direct angioplasty and stent-supported direct angioplasty therapy for cardiogenic shock complicating acute myocardial infarction: in-hospital and long-term survival. *J Am Coll Cardiol* 1998; 31: 294-300.
70. Hochman JS, Boland J, Sleeper LA, et al. Current spectrum of cardiogenic shock and effect of early revascularization on mortality: results of an international registry. SHOCK Registry Investigators. *Circulation* 1995; 91: 873-81.
71. Webb JG. Interventional management of cardiogenic shock. *Can J Cardiol* 1998; 14: 233-44.
72. Perez-Castellano N, Garcia E, Serrano J, et al. Efficacy of invasive strategy for the management of acute myocardial infarction complicated by cardiogenic shock. *Am J Cardiol* 1999; 83: 989-93.
73. Hochman JS, Sleeper LA, White HD, et al, for the SHOCK Investigators. Should We Emergently Revascularize Occluded Coronaries for Cardiogenic Shock. One-year survival following early revascularization for cardiogenic shock. *JAMA* 2001; 285: 190-2.
74. Webb JG, Lowe AM, Sanborn TA, et al, for the SHOCK Investigators. Percutaneous coronary intervention for cardiogenic shock in the SHOCK trial. *J Am Coll Cardiol* 2003; 42: 1380-6.
75. Chan AW, Chew DP, Bhatt DL, Moliterno DJ, Topol EJ, Ellis SG. Long-term mortality benefit with the combination of stents and abciximab for cardiogenic shock complicating acute myocardial infarction. *Am J Cardiol* 2002; 89: 132-6.
76. Giri S, Mitchel J, Azar RR, et al. Results of primary percutaneous transluminal coronary angioplasty plus abciximab with or without stenting for acute myocardial infarction complicated by cardiogenic shock. *Am J Cardiol* 2002; 89: 126-31.
77. Hasdai S, Harrington RA, Hochman JS, et al. Platelet glycoprotein IIb/IIIa blockade and outcome of cardiogenic shock complicating acute coronary syndromes without persistent ST-segment elevation. *J Am Coll Cardiol* 2000; 36: 685-92.
78. Zeymer U, Tebbe U, Weber M, et al, for the ALKK Study Group. Prospective evaluation of early abciximab and primary percutaneous intervention for patients with ST elevation myocardial infarction complicated by cardiogenic shock: results of the REO-SHOCK trial. *J Invasive Cardiol* 2003; 15: 385-9.
79. Dzavik V, Sleeper L, Cocke TP, et al, for the SHOCK Investigators. Early revascularization is associated with improved survival in elderly patients with acute myocardial in-

- farction complicated by cardiogenic shock: a report from the SHOCK Trial Registry. *Eur Heart J* 2003; 24: 828-37.
80. Bertrand ME, McFadden E. Cardiogenic shock: is there light at the end of the tunnel? *J Am Coll Cardiol* 2003; 42: 1387-8.
81. Solodky A, Assali AR, Behar S, Boyko V, Battler A, Kornowski R. Anterior wall myocardial infarction in real world: does reperfusion strategy make any differences? *Catheter Cardiovasc Interv* 2004; 61: 79-83.
82. Boersma E, Maas AC, Deckers JW, Simoons ML. Early thrombolytic treatment in acute myocardial infarction: reappraisal of the golden hour. *Lancet* 1996; 348: 771-5.
83. Steg PG, Laperche T, Golmard JL, et al. Efficacy of streptokinase, but not tissue-type plasminogen activator, in achieving 90-minute patency after thrombolysis for acute myocardial infarction decreases with time to treatment. PERM Study Group. *Prospective Evaluation of Reperfusion Markers. J Am Coll Cardiol* 1998; 31: 776-9.
84. Chesebro J, Knatterud G, Roberts R, et al. Thrombolysis in Myocardial Infarction (TIMI) Trial, Phase I: A comparison between intravenous tissue plasminogen activator and intravenous streptokinase. Clinical findings through hospital discharge. *Circulation* 1987; 76: 142-54.
85. Morrison LJ, Verbeek PR, McDonald AC, Sawadsky BV, Cook DJ. Mortality and prehospital thrombolysis for acute myocardial infarction: a meta-analysis. *JAMA* 2000; 283: 2686-92.
86. Bonnefoy E, Lapostolle F, Leizorovicz A, et al, for the Comparison of Angioplasty and Prehospital Thrombolysis in Acute Myocardial Infarction Study Group. Primary angioplasty versus prehospital fibrinolysis in acute myocardial infarction: a randomised study. *Lancet* 2002; 360: 825-9.
87. Berger PB, Ellis SG, Holmes DR Jr, et al. Relationship between delay in performing direct coronary angioplasty and early clinical outcome in patients with acute myocardial infarction: results from the Global Use of Strategies to Open Occluded Arteries in Acute Coronary Syndromes (GUSTO-IIb) trial. *Circulation* 1999; 100: 14-20.
88. Cannon CP, Gibson CM, Lambrew CT, et al. Relationship of symptom-onset-to-balloon time and door-to-balloon time with mortality in patients undergoing angioplasty for acute myocardial infarction. *JAMA* 2000; 283: 2941-7.
89. Zijlstra F, Patel A, Jones M, et al. Clinical characteristics and outcome of patients with early (< 2 h), intermediate (2-4 h) and late (> 4 h) presentation treated by primary coronary angioplasty or thrombolytic therapy for acute myocardial infarction. *Eur Heart J* 2002; 23: 550-7.
90. Steg PG, Bonnefoy E, Chabaud S, et al, for the Comparison of Angioplasty and Prehospital Thrombolysis in Acute Myocardial Infarction (CAPTIM) Investigators. Impact of time to treatment on mortality after prehospital fibrinolysis or primary angioplasty. *Circulation* 2003; 108: 2851-6.
91. De Luca G, Suryapranata H, Zijlstra F, et al, for the Zwolle Myocardial Infarction Study Group. Symptom-onset-to-balloon time and mortality in patients with acute myocardial infarction treated by primary angioplasty. *J Am Coll Cardiol* 2003; 42: 991-7.
92. Antoniucci D, Valenti R, Migliorini A, et al. Relation of time to treatment and mortality in patients with acute myocardial infarction undergoing primary coronary angioplasty. *Am J Cardiol* 2002; 89: 1248-52.
93. Flameng W, Lesaffre E, Vanhaecke J. Determinants of infarct size in non-human primates. *Basic Res Cardiol* 1990; 85: 392-403.
94. Reimer KA, Vander Heide RS, Richard VJ. Reperfusion in acute myocardial infarction: effects of timing and modulating factors in experimental models. *Am J Cardiol* 1993; 72: 13G-21G.
95. Gore JM, Corrao JM, Goldberg RJ, et al. Feasibility and safety of emergency interhospital transport of patients during early hours of acute myocardial infarction. *Arch Intern Med* 1989; 149: 353-5.
96. Vermeer F, Oude Ophuis AJ, vd Berg EJ, et al. Prospective randomised comparison between thrombolysis, rescue PTCA, and primary PTCA in patients with extensive myocardial infarction admitted to a hospital without PTCA facilities: a safety and feasibility study. *Heart* 1999; 82: 426-31.
97. Widimsky P, Groch L, Zelizko M, Aschermann M, Bednar F, Suryapranata H. Multicentre randomized trial comparing transport to primary angioplasty vs immediate thrombolysis vs combined strategy for patients with acute myocardial infarction presenting to a community hospital without a catheterization laboratory. The PRAGUE study. *Eur Heart J* 2000; 21: 823-31.
98. Grines CL, Westerhausen DR, Grines LL, et al. A randomized trial of transfer for primary angioplasty versus on-site thrombolysis in patients with high-risk myocardial infarction. The Air Primary Angioplasty in Myocardial Infarction Study. *J Am Coll Cardiol* 2002; 39: 1713-9.