

Acute Coronary Syndromes in 2011 and 2012

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Dear Editor,

Nowadays, the invasive approach plays a crucial role in the management of acute coronary syndromes, according to the recommendations in clinical practice guidelines. This tendency was reflected in some papers published in *Revista Española de Cardiología* in 2011 and 2012. Regarding ST-segment elevation acute coronary syndromes, regional programs on primary coronary angioplasty have been developed across Spain. Time delay until reperfusion, however, remains the main drawback of these programs. For instance, Badalona's experience shows that in only 27% of the patients transferred from other hospitals for primary angioplasty the coronary artery was opened within the time limits recommended in the guidelines, i.e. in less than 2 hours from the first medical contact¹. Therefore, fibrinolysis should not be ruled out as an alternative treatment in some cases. Furthermore, data from cardiac magnetic resonance imaging did not evidence significant differences in left ventricular volumes and function between patients treated with primary angioplasty or pharmaco-invasive strategy (initial fibrinolysis followed by routine coronary angioplasty 24 hours later) in a single hospital registry². Prediction of prognosis is a matter

of concern. The 4 most known prognostic scores (TIMI, PAMI, CADILLAC and GRACE) were compared in patients managed with either primary or rescue coronary angioplasty³. All 4 scores (particularly TIMI, CADILLAC and GRACE) had an excellent accuracy to predict mortality at 30 days and 1 year; prediction of reinfarction or new revascularization, however, was very poor with any score.

The invasive management has been extended to populations previously excluded from this treatment, such as elderly patients. In a retrospective study on very old patients (≥ 85 years) with non-ST-segment elevation acute coronary syndrome, the invasive approach reduced mortality and any ischemic event at 3 years compared with a matched population managed with a conservative strategy⁴. Despite the favorable results of the invasive strategy in any type of acute coronary syndrome, secondary prevention should not be overlooked. In this sense, the opening of a cardiac catheterization laboratory and the subsequent increase of coronary intervention procedures for myocardial infarction, improved mortality at 30 days but not between 30 days and 2 years after adjusting for ACE inhibitor, beta-blocker and statin treatment⁵.

Keywords

Acute Coronary Syndrome; Coronary Balloon Angioplasty; Myocardial Infarction.

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