released soon by the European Society of Cardiology, (namely non-ST-segment elevation acute coronary syndromes).

References


Jean-Pierre Bassand
Centre Hospitalier Universitaire Jean Minjoz
Boulevard Fleming
Besançon
France
Tel: +33 381 66 85 39
Fax: +33 381 66 85 82
E-mail address: jean-pierre.bassand@ufc-chu.univ-fcomte.fr

Michal Tendera
3rd Division of Cardiology
Silesian School of Medicine
ul. Ziolowa 47
40-635 Katowice
Poland

Silvia G. Priori
Associate Professor of Cardiology
Department of Cardiology
University of Pavia
Italy
Department of Molecular Cardiology
Salvatore Maugeri Foundation
Pavia
Italy

doi:10.1093/eurheartj/ehi562

Online publish-ahead-of-print 5 October 2005

ESC guidelines for percutaneous coronary interventions

Recently, the European Heart Journal published the new ESC guidelines for percutaneous coronary interventions (PCIs).1 With regard to the treatment of ST-elevation myocardial infarction, most of the recommendations corroborate with AHA/ACC and ESC guidelines for the treatment of STEMI, stating that primary angioplasty is the preferred reperfusion strategy, if high quality intervention facilities are available timely. In case these criteria cannot be met, thrombolysis is a good alternative, especially if treatment can be initiated within 3 h of symptom onset. With regard to the preferred treatment post-thrombolysis, the PCI guidelines are in contrast with the last year’s AHA/ACC guidelines. Although the AHA/ACC guidelines recommend a selective invasive strategy, (i.e. in the case of recurrent ischaemia and/or haemodynamic instability), the recently published PCI guidelines report to have strong evidence for the benefit of a routine invasive strategy in patients within 24 h after successful thrombolysis in case intervention facilities are at hand. The evidence for this strategy is mainly based on observational data from registries and subgroup analyses; however, four recently performed randomized trials including 1031 patients were also used as a reference.2-5 Although all these randomized trials suggest an advantage of an early routine invasive strategy, they cannot be clustered to support the general statement that a routine intervention within the first 24 h after thrombolysis is warranted, as they reflect different types of interventions with a varying timing and different indications for the intervention. Three of them reflect studies within a time window of expected myocardial salvage. Two of these were safety and feasibility studies2-3 of fibrinolytic pretreatment, i.e. facilitated primary angioplasty. This is a promising treatment option, but evidence regarding its efficacy is lacking and large clinical trials such as the ASSENT-4 are eagerly awaited. One trial4 reported a benefit of an invasive strategy performed within 3–6 h of thrombolysis, but the achieved advantage was at least in part due to increased event rates after a routinely performed repeat angiography. In contrast to such a routine invasive approach early after fibrinolysis, we do agree with the guidelines that in cases of clinically failed fibrinolysis randomized studies support rescue interventions, especially in large infarctions. With respect to a routine intervention beyond the time window of expected myocardial salvage, the OAT trial will be the first clinical trial to address routine opening of an occluded infarct artery. The only trial mentioned in the guidelines studying the effect of a routine invasive strategy beyond this time window was the GRACIA,5 which included both open and occluded arteries. This does not allow for the generalized statement that routine intervention is warranted in patients after successful thrombolysis. The currently running APRICOT-3 is the first trial in the present era that will focus on these patients only. Although a routine invasive strategy after thrombolysis seems to be an attractive treatment strategy, further clinical trials are warranted. Otherwise, implementation in daily clinical practice comes too early; insights based on robust evidence to refine the one-liner ‘lyse now, stent later’ may then be too late.

References


Hendrik-Jan Dieker
Radboud University Nijmegen
Medical Centre Heartcentre, Department of Cardiology 670
Geert Grooteplein 10
PO Box 9101
6500 HB Nijmegen
The Netherlands
Tel: +31 (0)24 3616785
Fax: +31 (0)24 3540800
E-mail address: h.dieker@cardio.umcn.nl

Marc A. Brouwer
Radboud University Nijmegen
Medical Centre Heartcentre, Department of Cardiology 670
The Netherlands

Freek W.A. Verheugt
Radboud University Nijmegen
Medical Centre Heartcentre, Department of Cardiology 670
The Netherlands