LETTERS TO THE EDITOR

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Guidelines for the diagnosis and treatment of non-ST-segment elevation acute coronary syndromes

An issue, which is not addressed by the guidelines, is whether, in the absence of Sgarbossa's criteria, the association of acute coronary syndrome (ACS) type chest pain and left bundle branch block (LBBB) falls within the province of non-ST-segment elevation ACS (nSTE-ACS) or whether it falls within the province of acute myocardial infarction. Strictly speaking, it is only when Sgarbossa's criteria are met that the association of ACS-type chest pain and LBBB should be categorized as ST-segment elevation myocardial infarction (STEMI). Conversely, given the fact that, in the absence of Sgarbossa's criteria, there is no concordant ST segment deviation, the association of ACS-type chest pain and LBBB should, strictly speaking, be categorized as nSTE-ACS. However, in view of the poor sensitivity of Sgarbossa's criteria for the diagnosis of myocardial infarction and the current recommendation that LBBB, irrespective of compliance with Sgarbossa's criteria, should be sufficient justification for thrombolysis provided it is 'new or presumably new', what is not known is whether LBBB which is non-compliant with Sgarbossa's criteria (i.e. non-ST-segment elevation LBBB) is as prevalent in nSTE-ACS as it is in acute myocardial infarction, and whether, in the presence of ACS-type chest pain and non-ST-segment elevation LBBB, it is possible to distinguish between acute myocardial infarction and nSTE-ACS. These issues should be addressed urgently, so that clinicians confronted with the association of ACS-type chest pain and non-ST-segment elevation LBBB should be able to make an informed decision whether to manage the patient along the lines recommended for acute myocardial infarction or along the lines recommended for acute coronary syndromes.

The absence of a policy statement is even more glaring in the instance of old left bundle branch block (old LBBB), given the fact that, in one study, the proportion of acute myocardial infarction (AMI) patients presenting with old LBBB (30/1125) was virtually identical with the proportion of AMI patients presenting with new LBBB (34/1125). Conversely, given the fact that as many as 86% of nSTE-ACS patients have unstable angina (UA) rather than enzymatically proven AMI, allowance for the fact that some patients with old LBBB might fit into the UA category should be reflected in an enrollment policy for nSTE-ACS which explicitly includes bundle branch block (both LBBB and right bundle branch block) as opposed to one which does not.

References

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Guidelines for the diagnosis and treatment of non-ST-segment elevation acute coronary syndromes: The Task Force for the Diagnosis and Treatment of Non-ST-Segment Elevation Acute Coronary Syndromes of the European Society of Cardiology

‘Guidelines for the diagnosis and treatment of non-ST-segment elevation acute coronary syndromes: The Task Force for the Diagnosis and Treatment of Non-ST-Segment Elevation Acute Coronary Syndromes of the European Society of Cardiology’ recently published in European Heart Journal1 rightly dedicates space to the pitfalls that can be encountered when reading presentation ECGs. However, we wish to draw attention to what we think is an important omission. No reference is made in this context to acute aortic syndrome (AAS)—a condition in which inappropriate administration of aggressive anti-thrombotic therapy may have catastrophic consequences.2 It is common knowledge that AAS can occasionally cause STEMI via coronary artery dissection.