Abstract: P770

Pre-hospital thrombolysis in the code st elevation myocardial infarction age

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INTRODUCTION: In all cases of acute coronary syndrome (ACS) with ST-segment elevation, primary percutaneous coronary intervention (PCI) is the preferred reperfusion strategy, provided it can be performed within 120 min from ST-elevation myocardial infarction (STEMI) diagnosis. Otherwise, the reperfusion strategy is the early prehospital fibrinolysis and immediately, transfer to a PCI-capable centre.

PURPOSE: We aim to define the features of patients (P) with STEMI who undergo thrombolysis at present, to assess the use of the new antiplatelet co-therapy with fibrinolysis and the complications surrounding.

METHODS: Prospective observational study, including consecutively all P admitted to coronary care unit (CCU) of our centre for STEMI. We determine those who underwent prehospital fibrinolysis from January 2012 to December 2017.

RESULTS: Of 1325 P with STEMI, 41 prehospital thrombolysis was performed due to primary PCI cannot be offered in a timely manner. The mean age was 60 +/- 11 years. P were 85% males. The prevalence of cardiovascular risk factors: hypertension 48.8%, diabetes 14.6%, dyslipidaemia 43.9%, smokers 48.8%, ex-smokers 26.8%. A 7.3% of P had previous ischemic heart disease. None had previously known peripheral arterial disease or atrial fibrillation (AF). The localization of STEMI with thrombolysis was anterior 36.5%, inferior 58.5%, right ventricle was affect in 15% of cases. The mean left and right ventricle and ejection fraction, measure by echocardiography, was 48.5% +/- 11.1 and 57.8 +/- 5.5 respectively. The P presented a Class I of the Killip classification in 73.2% of cases.

The periprocedural pharmacotherapy was aspirin in 100% of the cases. As a second anti-platelet therapy, a 48.7% of P received clopidogrel, prasugrel 31.7% and ticagrelor 19.5% (administration occurred previously to telephone contact with the interventional cardiologist). The mean time from the beginning of symptoms to administration of thrombolysis was 171 +/- 106 minutes. In all cases, an angiography was performed within 24 hours, 20 (48.7%) of them urgently, due to the absence of reperusion. In 34p (82.9%), percutaneous revascularization was performed, 64% with drug-eluting stent.

There weren't mechanical complications, major haemorrhages or deaths during admission in CCU. In the subsequent follow-up, one patient died due to a new ACS.

CONCLUSIONS: The reperfusion strategy for P with STEMI in our health area (where exist a STEMI code), was mostly primary PCI. However, there was a small percentage of patients (3%) who underwent fibrinolysis, as a matter of time, in the pre-hospital setting. In all patients with fibrinolytic therapy, a routine early angiography was performed, which 50% were rescue PCI due a failed fibrinolysis. There weren't haemorrhagic complications, even in cases of concomitant treatment with potent antiplatelet therapies (which were administered prior to know that primary PCI cannot be offered in a timely manner).