Letters to the Editor

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Rescue therapy for failed thrombolysis

I read with interest the paper by Ronner et al. and the editorial by Mahadevan et al.1,2 In their article the authors have presented a single-centre retrospective study of patients who were admitted or transferred with myocardial infarction and underwent rescue therapy within 24 h for failed thrombolysis. In this study three rescue therapies were used after failed thrombolysis (PCI 74%, re-thrombolysis 39%, and GP IIb/IIIa receptor blockers 53%). The incidence of bleedings was increased in all combination rescue groups. The authors concluded that administration of platelet GP IIb/IIIa receptor blockers as part of rescue therapy was clearly related to bleeding risk. It remains unproven whether an efficacy benefit outweighs the bleeding risk in failed thrombolysis.

Unfortunately, the study was not randomized and retrospective. An important bias in this study was also the absence of a baseline selection. In our previous prospective randomised studies,3 we showed that rescue thrombolysis determined 77.7% of reperfusion in 35 patients with failed thrombolysis vs 26.6% (12 patients) in a placebo group. Mortality was significantly reduced in the rescue thrombolysis group (6.6% vs 17.7%). Bleedings (major and minor) were higher in the re-thrombolysis group than the placebo group (46.6% vs 7%). When we used GP IIb/IIIa receptor blockers vs placebo in prospective randomised (single blind) patients with failed thrombolysis,4-6 we observed that of the 42 patients receiving GP IIb/IIIa inhibitors 39 of them demonstrated reperfusion as checked by subsequent coronaryography, while the 42 patients receiving placebo did not show any reperfusion and were referred to rescue PCI. The bleedings (minor and major) were similar in both groups, as well as the mortality. Two patients (receiving abciximab) showed platelet reduction in the GP IIb/IIIa group. In addition, we observed that patients receiving rescue GP IIb/IIIa inhibitors presented a lower incidence of restenosis (6 vs 12 patients), and a lower incidence of stent implant (12 vs 18 patients). The patients received, as GP IIb/IIIa inhibitors, all the drugs available to date (tirofiban, eptifibatide, abciximab). No significant difference was observed between the three drugs in reperfusion incidence. Our data suggested the possible use of GP IIb/IIIa receptor antagonists in failed thrombolysis. This protocol could be used in patients admitted to hospital without an interventional laboratory. The incidence of bleedings was acceptable as was the high incidence of reperfusion in this high-risk group. In addition, this treatment allowed us to perform subsequent PCI in stable patients under routine conditions.

References


P. Di Pasquale
Division of Cardiology, ‘Paolo Borsellino’, G.F. Ingrassia Hospital, Palermo, Italy