Enzymatic evidence of impaired reperfusion in diabetic patients after thrombolytic therapy for acute myocardial infarction: A role for plasminogen activator inhibitor?

R P Gray, J S Yudkin, D L Patterson

Abstract

Objective—To compare the activity of plasminogen activator inhibitor (PAI-1) in diabetic and non-diabetic patients admitted with acute myocardial infarction and to determine whether PAI-1 activity influences reperfusion after thrombolytic therapy.

Design—Prospective study of patients admitted with acute myocardial infarction.

Setting—District general hospital.

Main outcome measures—Reperfusion assessed by time to peak release of creatine kinase-MB isoenzyme.

Results—Baseline PAI-1 activity and antigen concentrations were significantly higher in diabetic patients (n = 45) than in non-diabetic patients (n = 110) (24 ± 6 (6-9) vs 18 ± 6 (7-9) AU/ml (AU = arbitrary units) (p = 0.0001) and 58 ± 8 (13-1-328-8) vs 41-0 (10-9-125-4) ng/ml (p = 0.004). Time to peak release of creatine kinase-MB was calculated in 123 (80%) patients. In 98 who received thrombolytic therapy the median time to peak enzyme release was 15-5 h (7-5-24 h) in diabetic patients (n = 26) and 12 h (5-26 h) in non-diabetic patients (n = 72) (p = 0.005). In those with a time to peak release of ≤12 h, initial fibrinolytic therapy was successful in 22/36 (61%) patients and the median time to peak enzyme release was 15-5 h (7-5-24 h) in diabetic patients (n = 12) and 12 h (5-26 h) in non-diabetic patients (n = 54) (p = 0.001). In multiple regression analysis both diabetes (p = 0.0001) and PAI-1 activity at admission (p = 0.029) were independently related to successful reperfusion. In 13 patients with evidence of reinfarction in hospital PAI-1 activity on day 3 was 26-7 (6-4) AU/ml compared with 21-7 (6-3) AU/ml in those without evidence of reinfarction (p = 0.032).

Conclusion—Both raised PAI-1 activity on admission and diabetes were associated with a reduced likelihood of enzymatic evidence of reperfusion after thrombolytic therapy. Increased PAI-1 activity on day 3 was associated with an increased risk of reinfarction. Diabetic patients had a higher PAI-1 activity on admission. This may partly explain their reduced likelihood of reperfusion.

(Reprint from Br Heart J 1993;70:530–536)

Thrombolytic therapy is now the treatment of choice for patients with acute myocardial infarction and has been shown to reduce mortality and improve left ventricular function. However, not all patients treated with thrombolytic therapy have successful reperfusion of the thrombosed artery and therapy is further limited by reocclusion and reinfarction in 10–25% of patients. The reasons for the resistance to lysis and the occurrence of reocclusion are unclear. Factors such as platelet activation associated with thrombocytopenia, and the procoagulant effects of plasmin probably contribute. In addition recent evidence suggests that the fibrinolytic system, and in particular plasminogen activator inhibitor (PAI-1), may be important. Both Sane et al. and Barbash et al. showed a relation between raised PAI-1 activity on admission with acute myocardial infarction and reduced likelihood of a patent infarct related artery after thrombolytic therapy with recombinant tissue plasminogen activator. Increased activity of PAI-1 has also been shown to predict the recurrence of infarction in young survivors of myocardial infarction.

In diabetic patients mortality and morbidity from acute myocardial infarction are high. Non-insulin-dependent diabetic patients have previously been reported to have increased PAI-1 activity, which may play a part in determining the outcome from myocardial infarction.

We studied admission levels of PAI-1 activity and outcome from thrombolytic therapy for acute myocardial infarction in 155 patients, both diabetic and non-diabetic, admitted to a district general hospital. The aims of this study were to determine whether (a) PAI-1 activity influences the response to thrombolytic therapy and (b) whether PAI-1 activity is higher in diabetic patients with acute myocardial infarction than in non-diabetic patients—a factor that might influence the outcome of thrombolytic therapy in diabetic patients.

Patients and methods

Over a two year period we studied 155 patients admitted with acute myocardial infarction to the Whittington Hospital. They accounted for 60% of all admissions with acute myocardial infarction over the period. Patients were excluded if an initial blood sample was not obtained before the administration of thrombolytic therapy, if they presented more than 24 hours after the onset of chest pain, or if myocardial infarction was not confirmed by World Health Organisation
criteria. The proportion of diabetic patients was similar in those who were studied (29%) and those who were excluded (25%). There were 45 diabetic patients. In 33 diabetes had already been diagnosed (median duration of diabetes 5 (0-5-25) years). Twelve cases of diabetes were newly diagnosed on the basis of admission hyperglycaemia (plasma glucose >11.0 mmol/l) and increased glycated haemoglobin (8-5% measured by agar gel electrophoresis). At the time of admission 13 of the diabetic patients were treated by diet alone, 11 were treated with oral hypoglycaemic agents (eight a sulphonylurea, two metformin and one a combination of a sulphonylurea plus metformin) and nine were treated with insulin, of these nine, three were insulin dependent or ketosis prone. All were admitted within 24 h of the onset of chest pain and myocardial infarction was diagnosed according to World Health Organisation criteria.

On admission to hospital and before thrombolytic therapy was given venous blood samples for estimation of PAI-1 activity and antigen and plasma fibrinogen were taken from an antecubital vein through a 21 G needle. PAI-1 activity and antigen were also measured on days 1, 2, and 3 between 0800 and 0830 h and on days 1 and 2 between 1700 and 1800 h. Blood samples were collected into tubes containing sodium citrate (nine parts of blood were mixed with one part of 3.8% sodium citrate), centrifuged for 15 min at 3000 g and 4°C, and then stored at -70°C until analysis. Creatine kinase MB isoenzyme was measured every 4 h for the first 24 h, every 8 h for the next 24 h, and every 12 h for the next 24 h. The cumulative release of creatine kinase-MB isoenzyme was calculated by a modification of Sobel et al's method according to the following equation:

\[ E(t) = E(0) + \sum_{i=1}^{n} \frac{1}{2} [E(t_i - 1) + E(t_i)]d_i \]

where \( E(t) = \) enzyme level at time \( t \), \( t_i = \) time after onset of symptoms (hours), \( T = \) time of sample CK-MB concentration equals zero for the first time after peak sample CK-MB concentration has been achieved; otherwise \( T = \) time of last available sample; \( kd = \) dissociation constant = 0.095 IU/h, \( t_i \) the area under the graph of \( E(t), t_i \), \( E(t)dt \), is approximated by

The time to peak release of creatine kinase-MB isoenzyme release was calculated by plotting the creatine kinase-MB (IU/l) against time in hours. Time zero (0 h) was the time of onset of chest pain. We constructed time activity curves using a curve fitting procedure on a computer programme (Stat Graphics II) and we calculated the time to peak enzyme release for each patient. Reinfarction was defined as the recurrence of chest pain and electrocardiographic evidence of reinfarction in hospital in patients with enzymatic evidence of reperfusion after thrombolytic therapy.

To determine normal ranges of PAI-1 activity and antigen in diabetic and non-diabetic patients without ischaemic heart disease we took venous blood samples without stasis between 0830 and 0930 in 15 diabetic and 20 non-diabetic individuals with no clinical or electrocardiographic evidence of ischaemic heart disease or hypertension.

ASSAYS

Plasma glucose was measured by a glucose oxidase method (Beckman, Brea, CA, USA). Glycated haemoglobin was measured by agar gel electrophoresis (Coming Medical, Halstead, Essex). PAI-1 activity was measured by a chromogenic assay (Kabi Diagnostica, Molndal, Sweden). In this assay a fixed amount of tissue plasminogen activator (t-PA) is added in excess to undiluted plasma and forms an inactive complex with PAI-1. Plasminogen is then activated to plasmin by residual t-PA in the presence of a stimulator. The amount of plasmin is directly proportional to the residual t-PA activity and inversely proportional to the PAI-1 activity of the sample. The amount of plasmin is determined by measuring the amidolytic activity of plasmin on the chromogenic substrate S-2403. The intra-assay coefficient of variation (cv) was 4.5% and the inter-assay cv was 8%. PAI-1 antigen was measured by an enzyme linked immunosorbent assay (Biopool AB, Umea, Sweden). This assay quantifies active, latent, and complexed human endothelial type PAI-1. The within assay cv was 4.5% and the between assay cv was 7.5%. Plasma fibrinogen was measured according to the Clauss method (Boehringer Mannheim Diagnostica, Meylan, France). Creatine kinase-MB isoenzyme was measured by an immunological method (Boehringer Mannheim Diagnostica, Meylan, France).

STATISTICAL ANALYSIS

Results are expressed as mean (SD) for normally distributed data and median and range for skewed data. Differences between groups were tested by unpaired Student's t tests for normally distributed data and Mann-Whitney U tests for skewed data. Within group differences were tested by paired Student's t tests for normally distributed data and Wilcoxon rank tests for skewed data. Relations between variables were assessed by Pearson's correlation for normally distributed data and Spearman rank correlation for skewed data. Differences between proportions were assessed by \( \chi^2 \) analysis. Multiple regression analysis was used to study the independent relation between variables after logarithmic transformation of skewed data. A p value <0.05 was regarded as significant.

Results

Table 1 shows the characteristics of the patients. Diabetic and non-diabetic patients were comparable in age, site of infarction, the proportion with a history of previous myocardial infarction, the proportion receiving
thrombolytic therapy, time from onset of symptoms to receiving thrombolytic therapy, and infarct size as assessed by cumulative release of creatine kinase-MB isoenzyme. In patients receiving thrombolytic therapy the time to peak creatine kinase-MB enzyme release was significantly prolonged in diabetic patients than in non-diabetic patients.

Admission values for both PAI-1 activity and antigen were significantly higher in diabetic patients than in non-diabetic patients and in both these groups compared with controls (table 2). The distribution of admission sample time was not significantly different in the diabetic and non-diabetic groups. As we have previously shown there were no differences in PAI-1 activity or antigen concentrations between those patients with previously known or newly diagnosed diabetes (p = 0.49 and 0.90 respectively) or between those treated with insulin, oral hypoglycaemic agents, or diet alone (p = 0.89 and 0.22 respectively). There was a positive correlation between PAI-1 activity and antigen (r = 0.50; p = 0.0001) in those admitted with acute myocardial infarction. One hundred and eighteen patients (87 non diabetic and 31 diabetic) received thrombolytic therapy. During the period of this study our hospital was participating in a randomised study of thrombolytic agents in acute myocardial infarction (ISIS III) and consequently the thrombolytic agents used were streptokinase in 75 (55 non-diabetic and 20 diabetic), anistreplase in 19 (13 non-diabetic and six diabetic), and alteplase (rt-PA) in 24 (19 non diabetic and five diabetic). Figures 1 and 2 show PAI-1 activity after admission. In patients who received thrombolytic therapy PAI-1 activity increased significantly on day 1 and fell towards admission values on days 2 and 3 (fig 1A). In those not receiving thrombolytic therapy PAI-1 activity also increased on day 1 but this was only significant in the diabetic patients (figure 1B). The trend in PAI-1 antigen concentration was similar but was significant only in the non-diabetic patients receiving thrombolytic therapy and diabetic patients not receiving thrombolytic therapy (figs 2A and B).

It was possible to calculate time to peak creatine kinase-MB isoenzyme release in 124 patients of whom 98 (79 non-diabetic and 45 streptokinase or anistreplase and 15 alteplase) and 26 diabetic (21 streptokinase or anistreplase and five alteplase) received thrombolytic therapy. In the remaining 31 patients it was not possible to calculate time to peak enzyme release because insufficient samples were available in 24 and seven died within 24 h of admission. There was a significant positive correlation between the median time from onset of chest pain and the time to peak enzyme release (r = 0.42; p = 0.0001), but there was no difference between the median time from onset of chest pain to administration of thrombolytic therapy in the two groups (4 h (0.5–22) in non-diabetic patients compared with 5 h (2 to 18) in diabetic subjects). There was no difference in time to peak enzyme release between those with a history of previous infarction and those without (13.5 (6.22) h v 13 (5–26) h). Among those receiving thrombolytic therapy diabetic patients had a significantly longer time to peak enzyme release than non diabetic patients (table 1 and fig 3). When we took a cut off of time to peak of ≤12 h as indicating likely successful reperfusion,24–26 65% (47/72) of the non-diabetic patients showed evidence of reperfusion compared with 23% (6/26) of the diabetic patients (Z2 = 13.4, 1 df; p < 0.001). There was enzymatic evidence of reperfusion in 55% of those receiving streptokinase or anistreplase and in 0% of those receiving alteplase (NS). There was no difference in time to peak enzyme release between non-diabetic and diabetic patients not receiving thrombolytic therapy (19 (6–24) (n = 17) v 17 (10–24) (n = 8) with only 12% (2/17) of non-diabetic and 25% (2/8) of diabetic patients showing enzymatic evidence of reper-

<table>
<thead>
<tr>
<th>Table 1 Characteristics of diabetic and non-diabetic patients admitted with acute myocardial infarction*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetic (n = 45)</td>
</tr>
<tr>
<td>Age (years)</td>
</tr>
<tr>
<td>Sex (M:F)</td>
</tr>
<tr>
<td>Site of infarction:</td>
</tr>
<tr>
<td>Anterior</td>
</tr>
<tr>
<td>Inferior</td>
</tr>
<tr>
<td>% with previous myocardial infarction</td>
</tr>
<tr>
<td>Time from onset chest pain to thrombolytic therapy (hours)</td>
</tr>
<tr>
<td>CK-MB cumulative release (IU/I)</td>
</tr>
<tr>
<td>PK Ast (IU/I)</td>
</tr>
<tr>
<td>Time to peak CK-MB release after thrombolysis (h)*</td>
</tr>
<tr>
<td>Time to peak CK-MB release without thrombolysis (h)^</td>
</tr>
<tr>
<td>% Receiving thrombolytic therapy</td>
</tr>
<tr>
<td>Admission plasma glucose (mmol/l)</td>
</tr>
<tr>
<td>Glycated haemoglobin (%)</td>
</tr>
<tr>
<td>Newly diagnosed diabetes</td>
</tr>
<tr>
<td>Duration of known diabetes (years)</td>
</tr>
<tr>
<td>Treatment for diabetes:</td>
</tr>
<tr>
<td>Diet</td>
</tr>
<tr>
<td>Oral hypoglycaemic</td>
</tr>
<tr>
<td>Insulin</td>
</tr>
</tbody>
</table>

*Values are mean (SD) for normally distributed data and median (range) for skewed data, CK, creatine kinase; Ast, separate aspartate transaminase.

†In 98 patients who received thrombolysis. ‡In 25 patients who did not receive thrombolysis.
Enzymatic evidence of impaired reperfusion in diabetic patients after thrombolytic therapy for acute myocardial infarction

1 Figure

(a) PAI-1 activity after acute myocardial infarction in diabetic (○) and non-diabetic (●) patients given thrombolytic agents. (B) PAI-1 activity after acute myocardial infarction in diabetic (○) and non-diabetic (●) patients treated with thrombolytic agents.

Discussion

We confirmed our previous finding that PAI-1 activity on admission with acute myocardial infarction was significantly higher in diabetic patients than in non-diabetic ones. We also found that increased PAI-1 activity was associated with both enzymatic evidence of failure of reperfusion after thrombolytic therapy and the likelihood of in hospital reinfarction. These findings therefore suggest that a high baseline PAI-1 activity may indicate unsuccessful thrombolysis not only with alteplase but also with other thrombolytic agents (80% of our patients received streptokinase or anistreplase).

We found that the diabetic patients were significantly less likely to show enzymatic evidence of reperfusion after thrombolytic therapy and that this was associated with high values of PAI-1 activity at admission. In view of our finding that diabetic patients with acute myocardial infarction had significantly higher baseline PAI-1 values than the non-diabetic patients, it is tempting to speculate that raised circulating PAI-1 concentrations, either directly or by reflecting high PAI-1 activity in the region of the thrombus, may in some way unfavourably alter the balance

1 Figure 1. (A) PAI-1 activity after acute myocardial infarction in diabetic (○) and non-diabetic (●) patients given thrombolytic agents. (B) PAI-1 activity after acute myocardial infarction in diabetic (○) and non-diabetic (●) patients treated with thrombolytic agents.
between thrombosis and fibrinolysis and that this may account at least in part for the poor outcome from myocardial infarction in diabetic patients. In addition to PAI-1 activity, diabetes was also a significant independent determinant of reperfusion, which suggests that factors other than PAI-1 are also involved in determining reperfusion. Previous studies have described haemostatic abnormalities in diabetic patients including increased platelet aggregation and raised concentrations of fibrinogen, which together with reduced fibrinolytic activity caused by increased PAI-1 activity may lead to a pro-thrombotic state and reduce the likelihood of successful reperfusion in these patients. However, we found no difference between fibrinogen concentrations in patients with successful and unsuccessful reperfusion.

The mechanisms whereby PAI-1 activity may influence the outcome after thrombolytic therapy are still unknown. Pharmacological recombinant tissue plasminogen activator (alteplase) concentrations range from 1 to 3 μg/ml and so it is likely that with standard

Figure 2 (A) PAI-1 antigen after acute myocardial infarction in diabetic (○) and non-diabetic (●) patients treated with thrombolytic agents. (B) PAI-1 antigen after acute myocardial infarction in diabetic (○) and non-diabetic (●) patients not treated with thrombolytic agents.

Figure 3 Time to peak creatine kinase-MB isoenzyme release in diabetic and non-diabetic patients treated with thrombolytic agents (calculated from time of onset of symptoms). The box encloses the 25th to 75th centiles and the 10th and 90th centiles are also indicated.

Figure 4 PAI-1 activity at admission in patients with acute myocardial infarction with successful and unsuccessful reperfusion. (○) Diabetic and (●) non-diabetic patients. The box encloses the 25th to 75th centiles and the 10th and 90th centiles are also indicated.
Enzymatic evidence of impaired reperfusion in diabetic patients after thrombolytic therapy for acute myocardial infarction

Table 3 Multiple regression analysis for determinants of reperfusion in subjects receiving thrombolytic therapy

<table>
<thead>
<tr>
<th>Variable in model</th>
<th>Variable added</th>
<th>F change</th>
<th>Multiple $r^2$</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>Diabetes</td>
<td>15.6</td>
<td>0.14</td>
<td>0.000</td>
</tr>
<tr>
<td>Diabetes, admission PAI-1 activity</td>
<td>Admission PAI-1 activity</td>
<td>4.92</td>
<td>0.18</td>
<td>0.029</td>
</tr>
<tr>
<td>Diabetes, admission PAI-1 activity, TFOS</td>
<td>TFOS</td>
<td>12.2</td>
<td>0.28</td>
<td>0.001</td>
</tr>
<tr>
<td>Diabetes, admission PAI-1 activity, TFOS, time from onset of chest pain to administration of thrombolytic therapy</td>
<td>Thrombolytic agent</td>
<td>0.009</td>
<td>0.28</td>
<td>0.924</td>
</tr>
</tbody>
</table>

Table 4 PAI-1 activity (AU/ml) in subjects with and without evidence of reperfusion

<table>
<thead>
<tr>
<th>PAI-1</th>
<th>Reinfarction ($n = 13$)</th>
<th>No reinfarction ($n = 85$)</th>
<th>p</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>On admission</td>
<td>20.6 (11.0)</td>
<td>20.1 (7.9)</td>
<td>NS</td>
<td></td>
</tr>
<tr>
<td>Day 1</td>
<td>25.0 (10.1)</td>
<td>27.4 (7.4)</td>
<td>NS</td>
<td></td>
</tr>
<tr>
<td>Day 2</td>
<td>24.6 (8.9)</td>
<td>20.7 (6.9)</td>
<td>NS</td>
<td></td>
</tr>
<tr>
<td>Day 3</td>
<td>26.7 (6.4)</td>
<td>21.7 (6.3)</td>
<td>0.032</td>
<td></td>
</tr>
</tbody>
</table>

Values are mean (SD).
PAI-1, plasminogen activator inhibitor; AU, arbitrary unit.

Rapold et al found no difference in PAI-1 concentrations measured up to 24 hours after acute myocardial infarction between patients with and without clinical evidence of reocclusion. Lucore et al showed that after infusion of alteplase, tissue plasminogen activator concentrations 7-fold greater than baseline were effectively neutralised by PAI-1.suggesting that PAI-1 activity after the infusion of thrombolytic therapy might influence the occurrence of reocclusion after initial successful reperfusion. Though like others we found no relation between baseline PAI-1 concentrations and the occurrence of reinfarction, PAI-1 activity on day 3 was significantly higher in patients with clinical evidence of reinfarction than in those without evidence of reinfarction.

In view of these findings suggesting that increased PAI-1 activity may influence the outcome of thrombolytic therapy, an important question is whether increased PAI-1 activity can be influenced by treatment. In non-diabetic sedentary patients cessation of smoking, physical training, and weight reduction were associated with a reduction in PAI-1 concentrations. In addition to its effects on blood glucose metabolism metformin has recently been shown to have favourable effects on fibrinolysis, lipid metabolism, and blood pressure. However, more long-term studies will be required to evaluate the clinical significance of these findings. Another important consideration is whether those with raised PAI-1 activity on admission with acute myocardial infarction and in particular diabetic patients require higher doses or continuous infusions of thrombolytic agent to achieve successful reperfusion. It is important, however, to recognise the limitations of this study. While an early time to peak creatinine kinase-MB isoenzyme release has been shown to be a valid index of reperfusion it is not specific and it is therefore possible that we are misclassifying some patients by this method. Early time to peak enzyme release has also been seen in patients with subtotal occlusion, patients with well developed collateral flow to the infarct zone, and in those with early spontaneous reperfusion. Another limitation of the prediction of reperfusion based on time to peak analysis is that its discriminating power depends on the duration of the ischaemic period before reperfusion because the peak value might be missed if this interval is prolonged. In addition, it was not possible to calculate time to peak enzyme release in 20% of the patients. Furthermore, the finding of similar reperfusion rates with alteplase and streptokinase in this study does not accord with other studies. However,
when we repeated the analysis with another criterion of reperfusion we found similar results. Moreover, any misclassification would be likely to weaken any relation between PAI-1 and reperfusion. The findings in this study need to be confirmed with a more sensitive index of reperfusion such as early coronary angiography.

We found that diabetic patients had less enzymatic evidence of reperfusion and raised PAI-1 activity on admission with acute myocardial infarction than non-diabetic patients. In multiple regression analysis both admission PAI-1 activity and diabetes were independently related to reperfusion. Therefore the raised PAI-1 activity in diabetic patients compared with non-diabetic patients might be in part explain the poor outcome of diabetic patients after myocardial infarction.

However, PAI-1 and fibrinogen were the only variables measured and other fibrinolytic variables that were not measured in this study could produce similar effects.

4 TIMI Study Group. Thrombolysis in Myocardial Infarction trial (TIMI), phase 1: a comparison between intravenous tissue plasminogen activator and intravenous streptokinase. Circulation 1987;76:142-54.