The decision over whether to treat acute myocardial infarction (AMI) with a balloon or infusion of fibrinolytics remains controversial. During the past few years profound changes in both treatment modalities have substantially changed the arguments surrounding this long-standing debate. The evidence shows that the alternative use of primary angioplasty or fibrinolysis is rarely an option, either because angioplasty is simply not available or because the patient is not eligible for fibrinolysis. This evidence reflects the difference in “applicability” of each treatment—that is, the proportion of patients in whom only one of the treatments would be suitable versus patients in whom either treatment would be appropriate. As a matter of fact, primary angioplasty is applicable to almost all victims of AMI (82–90% of patients randomised to primary angioplasty actually undergo the procedure), but it is not available to the majority of patients. Conversely, fibrinolysis is a widely available treatment but “applicable” to a variable percentage of patients which does not reach 50%. The large number of patients with AMI to whom fibrinolysis is not administered represents a big challenge for the future, and perhaps the most rational and undisputed argument in favour of the use of primary angioplasty.

The best reperfusion treatment is one that achieves the highest rate of early, complete and sustained infarct related artery patency in the largest number of patients, but with the lowest rate of undesirable effects. The results obtained with both treatments, in the way they were applied before the latest breakthroughs in the field, can be represented by a geometrically opposing relation between “applicability” and “efficacy” (fig 1).

UNCONTROVERSIAL EVIDENCE IN FAVOUR OF FIBRINOLYTIC TREATMENT

Clinical trials and experience have identified the following landmarks in the reperfusion treatment of ST segment elevation AMI.

- The daily administration of 162.5 mg of aspirin orally from the first day of AMI and continued for 30 days reduces the 30 day vascular mortality rate by 23% without risk of stroke.  
- Intravenous infusion of streptokinase within six hours after AMI onset reduces 30 day total vascular mortality by 25%, but at the cost of 2–3 strokes per 100 patients treated and 3 severe bleedings requiring transfusion per 1000 patients treated. Combined treatment with aspirin has synergistic effects and will prevent 52 vascular deaths per 1000 patients treated and reduce significantly the risk of reinfarction.  
- The initial benefit of streptokinase treatment on mortality is maintained at 10 year follow up.  
- The use of recombinant tissue plasminogen activator (rt-PA) using the “accelerated” dosing schedule plus heparin (instead of streptokinase) prevents another 10 deaths but causes two more strokes per 1000 patients treated.  
- Pre-hospital fibrinolysis can reduce one year mortality and should be considered when transport time exceeds 60 minutes.  
- The combination of full dose of abciximab and half dose reteplase reduces non-fatal complications of AMI, but yields similar mortality rate compared with reteplase alone.

EVIDENCE IN FAVOUR OF PRIMARY ANGIOPLASTY: CONSENSUS STATEMENTS

All the randomised clinical trials of primary angioplasty have shown a reduced incidence of stroke, recurrent ischaemia, and need for new target vessel revascularisation (TVR) compared to fibrinolysis, even in low risk patients. In selected subsets, primary angioplasty preserves left ventricular ejection fraction and benefits patients with anterior AMI treated up to 24 hours after symptom onset. The favourable effects on mortality and reinfarction appear to be more pronounced among high risk patients, in particular those with haemodynamic evidence of failure. Benefits in this setting are also apparent from non-randomised data. A quantitative overview by Weaver and colleagues pooling 2606 patients showed that the mortality reduction obtained with primary angioplasty compared to fibrinolysis was approximately 32% (table 1). If this result can be reproduced everywhere, the magnitude of such treatment effect would be similar to that observed when fibrinolysis was used instead of placebo. However, these excellent results...
derive from the experience of selected centres working under the specific requirements of randomised investigation and may not be easily achieved in the community setting, as is suggested by the results of large national registries.

The GUSTO II-B trial addressed this particular issue by testing the effect of angioplasty when performed mainly in low volume centres on a low risk population. In fact, GUSTO II-B showed a less favourable outcome of angioplasty than expected from other trials, which was caused by a higher event rate in the angioplasty arm rather than by a lower event rate in the fibrinolysis arm. Furthermore, 36% of patients allocated to fibrinolysis received an angioplasty before discharge, which may blunt the differences between the two strategies at six months. Crossover to angioplasty in patients initially randomized to fibrinolysis has been observed in the one year analysis of the SHOCK trial.

The mortality reduction obtained with the emergency revascularisation strategy compared to the approach involving initial medical stabilisation was not significant at 30 days (46.7% vs 56%, p = 0.11), but became so at six months (50.3% vs 63.1%, p = 0.027) and increased further at one year (55% vs 70%, p = 0.008). Albeit a negative study statistically, the number of lives saved per 1000 patients treated with the strategy of emergency revascularisation is the highest ever reported in a reperfusion trial (tables 1 and 2). The recent availability of long term results of primary angioplasty trials confirms the long lasting efficacy of the invasive approach also in patients without haemodynamic failure, despite some initial concern that early benefit may not be sustained (table 2).

NEW PERSPECTIVES IN REPERFUSION THERAPY

It is recognised that the success rate and durability of mechanical revascularisation procedures and the efficacy and safety of fibrinolytics have both improved. Primary angioplasty has been observed in the one year analysis of the SHOCK trial.

Table 1 Event rate at short term follow up, number needed to treat, and events avoided per 1000 patients treated in randomised clinical trials comparing primary angioplasty and fibrinolysis.

<table>
<thead>
<tr>
<th>30-day events</th>
<th>PTCA (%), n</th>
<th>Lysis (%), n</th>
<th>p Value</th>
<th>OR (95%CI)</th>
<th>ARR%</th>
<th>NNT</th>
<th>NEA x 1000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weaver</td>
<td>4.4%, 57/1290</td>
<td>6.5%, 86/1316</td>
<td>0.02</td>
<td>0.66 (0.46 to 0.94)</td>
<td>2.1</td>
<td>47</td>
<td>21/1000</td>
</tr>
<tr>
<td>GUSTO II-B</td>
<td>5.7%, 32/565</td>
<td>7.0%, 40/573</td>
<td>0.37</td>
<td>0.80 (0.49 to 1.30)</td>
<td>1.3</td>
<td>77</td>
<td>13/1000</td>
</tr>
<tr>
<td>SHOCK</td>
<td>46.7%, 71/152</td>
<td>56%, 84/150</td>
<td>0.11</td>
<td>0.83 (0.67 to 1.04)</td>
<td>9.3</td>
<td>11</td>
<td>91/1000</td>
</tr>
<tr>
<td>C-PORT</td>
<td>5.3%, 12/225</td>
<td>6.2%, 14/226</td>
<td>0.7</td>
<td>Not available</td>
<td>0.9</td>
<td>111</td>
<td>9/1000</td>
</tr>
<tr>
<td>DANAMI-2</td>
<td>6.6%, 52/790</td>
<td>7.6%, 59/782</td>
<td>0.35</td>
<td>Not available</td>
<td>1.0</td>
<td>100</td>
<td>10/1000</td>
</tr>
<tr>
<td>Mortality or non-fatal reinfarction</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weaver</td>
<td>7.2%, 94/1290</td>
<td>11.9%, 156/1316</td>
<td>&lt;0.001</td>
<td>0.58 (0.44 to 0.76)</td>
<td>4.7</td>
<td>21</td>
<td>48/1000</td>
</tr>
<tr>
<td>GUSTO II-B</td>
<td>9.6%, 54/565</td>
<td>12.1%, 70/573</td>
<td>0.08</td>
<td>0.72 (0.49 to 1.05)</td>
<td>3.1</td>
<td>32</td>
<td>31/1000</td>
</tr>
<tr>
<td>C-PORT</td>
<td>9.8%, 22/225</td>
<td>16.8%, 38/226</td>
<td>0.03</td>
<td>0.52 (0.30 to 0.89)</td>
<td>7</td>
<td>14</td>
<td>71/1000</td>
</tr>
<tr>
<td>DANAMI-2†</td>
<td>8.0%, 63/790</td>
<td>13.7%, 107/782</td>
<td>0.003</td>
<td>Not available</td>
<td>5.7</td>
<td>18</td>
<td>55/1000</td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weaver</td>
<td>0.7%, 9/1290</td>
<td>2.0%, 26/1316</td>
<td>0.007</td>
<td>0.35 (0.14 to 0.77)</td>
<td>1.3</td>
<td>77</td>
<td>13/1000</td>
</tr>
<tr>
<td>PAMI</td>
<td>0.0, 0</td>
<td>3.5%, 7/200</td>
<td>0.01</td>
<td>Not available</td>
<td>3.5</td>
<td>29</td>
<td>34/1000</td>
</tr>
<tr>
<td>Zijlstra†</td>
<td>0.7%, 1/152</td>
<td>2.0%, 3/149</td>
<td>0.6</td>
<td>0.32 (0.01 to 4.08)</td>
<td>1.3</td>
<td>77</td>
<td>13/1000</td>
</tr>
<tr>
<td>GUSTO II-B</td>
<td>1.1%, 6/565</td>
<td>1.9%, 11/573</td>
<td>0.34</td>
<td>0.54 (0.17 to 1.63)</td>
<td>0.8</td>
<td>125</td>
<td>8/1000</td>
</tr>
<tr>
<td>C-PORT</td>
<td>1.3%, 3/225</td>
<td>3.5%, 8/226</td>
<td>0.13</td>
<td>Not available</td>
<td>2.2</td>
<td>45</td>
<td>22/1000</td>
</tr>
<tr>
<td>DANAMI-2†</td>
<td>1.1%, 8/790</td>
<td>2.0%, 15/782</td>
<td>0.15</td>
<td>Not available</td>
<td>0.9</td>
<td>111</td>
<td>9/1000</td>
</tr>
<tr>
<td>Haemorrhagic stroke</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weaver</td>
<td>0.1%, 1/1290</td>
<td>1.1%, 15/1316</td>
<td>&lt;0.001</td>
<td>0.07 (0.0 to 0.43)</td>
<td>1</td>
<td>100</td>
<td>10/1000</td>
</tr>
<tr>
<td>PAMI</td>
<td>0.0, 0</td>
<td>2.0%, 4/200</td>
<td>0.05</td>
<td>Not available</td>
<td>2</td>
<td>50</td>
<td>20/1000</td>
</tr>
<tr>
<td>Zijlstra</td>
<td>0.7%, 1/152</td>
<td>1.3%, 2/149</td>
<td>0.98</td>
<td>0.49 (0.01 to 9.47)</td>
<td>0.6</td>
<td>166</td>
<td>6/1000</td>
</tr>
<tr>
<td>GUSTO II-B</td>
<td>0.0, 0</td>
<td>1.4%, 8/573</td>
<td>0.007</td>
<td>Not available</td>
<td>1.4</td>
<td>71</td>
<td>14/1000</td>
</tr>
</tbody>
</table>

† The SHOCK trial did not compare PTCA with lysis, but a strategy of emergency revascularisation versus initial medical stabilisation.

‡ Includes disabling stroke.

ARR, absolute risk reduction; NEA × 1000, number of events avoided per 1000 patients treated; NNT, number needed to treat.
enhanced by the use of coronary stents and the availability of glycoprotein IIb/IIIa inhibitors, or the combined use of both, while new fibrinolytic regimens offer better results than those obtained with streptokinase or even with front loaded rt-PA.

**New infusive schemes**

New fibrinolytic drugs are being developed and evaluated with the aim of improving pharmacological reperfusion. Initial studies suggested that lytic therapy may be as effective as primary angioplasty.

**Efficacy**

The combined use of fibrinolytics with glycoprotein IIb/IIIa inhibitors appears encouraging at first glance. In the TIMI 14 trial a high rate of TIMI 3 flow grade was observed at 90 minutes after the infusion of 50 mg of alteplase and a full dose of abciximab plus low dose heparin. This promising finding relates to only 87 patients included in the dose finding and dose confirmation phases of the study, which included angiography at 90 minutes. Out of the 34 patients studied in the dose finding phase, a TIMI 3 flow was observed in 22 patients (76%), 3% of patients died, 3% suffered major bleeding, and 27% needed an urgent revascularisation procedure. Moreover, 59% of these patients underwent angioplasty before discharge, 18% as an emergency rescue procedure.

The IMPACT-AMI trial failed to detect a dose–response relation using a combination of epifibatide (Integrilin) and 100 mg of alteplase. On the contrary, the group treated with epifibatide had a tendency towards increased incidence of in-hospital adverse events (51% vs 39%) and mortality (11% vs 0%), despite a significantly higher rate of TIMI 3 flow grade at 90 minutes (66% vs 39%). Despite the discrepancy between the excellent angiographic results and the less impressive clinical outcome in these small sized studies, these preliminary results primed a new large scale trial which was recently published. GUSTO V was powered to detect a 15% reduction in mortality and randomised 16 588 patients to either standard lytic treatment with reteplase or a combination of half dose reteplase with full dose abciximab. The results obtained with the combination therapy did not lower the mortality rate (5.6%) compared to standard fibrinolysis (5.9%). Non-fatal complications of AMI were significantly reduced, at the cost of higher rates of non-intracranial bleeding. Thus, the relation between patency and survival is not as straightforward as initially anticipated; furthermore, the failure to reduce mortality in the megatrials performed in this new era of reperfusion has diverted attention to the reduction in non-fatal clinical events.

**Drug delivery**

Ease and speed of delivery of fibrinolytic drugs have been improved with the use of a single bolus of mutant forms of rt-PA. Recently, the results of two megatrials (ASSENT-2 and InTime-II) have been presented. Both studies confirmed that the bolus injection of TNK-tPA and lanoteplase was as effective as the long lasting infusion of rt-PA. However, lanoteplase caused a significantly higher rate of intracranial bleeding compared to rt-PA in InTime-II (1.13% v 0.62%, p = 0.003); that was not the case for TNK-tPA (0.93%) when compared to rt-PA (0.94%) in ASSENT-2.

**Safety**

Clinical studies aimed at assessing the efficacy and safety of combinations of potent thrombolytic treatments have caused thousands of intracranial bleeds. Furthermore, the inappropriate administration of a fibrinolytic agent may not be without complications. Indeed, nearly 4.1% of patients who receive fibrinolysis have non-coronary syndromes and the 30 day mortality of these patients was 9.5% versus 1.2% of those allocated to placebo in the ASSET trial (p < 0.01). The underutilisation of fibrinolytics in the real world as shown in NRMI-2 may reflect a certain “fear to treat”, particularly in

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**Table 2** Event rate at long term follow up, number needed to treat, and events avoided per 1000 patients treated in randomised clinical trials comparing primary angioplasty and fibrinolysis

<table>
<thead>
<tr>
<th>Long term events</th>
<th>PTCA (%)</th>
<th>Lysis (%)</th>
<th>p Value</th>
<th>Odds ratio (95% CI)</th>
<th>ARR</th>
<th>NNT</th>
<th>NEA × 1000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mortality</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weaver 6 months*</td>
<td>6.1</td>
<td>8.1</td>
<td>0.055</td>
<td>0.73 (0.52 to 0.98)</td>
<td>2</td>
<td>50</td>
<td>20/1000</td>
</tr>
<tr>
<td>Zijlstra 5 years</td>
<td>6.2</td>
<td>9.5</td>
<td>0.21</td>
<td>Not available</td>
<td>3.3</td>
<td>30</td>
<td>33/1000</td>
</tr>
<tr>
<td>SHOCK 5 years†</td>
<td>13.4</td>
<td>23.9</td>
<td>0.01</td>
<td>0.54 (0.36 to 0.87)</td>
<td>10</td>
<td>5</td>
<td>100/1000</td>
</tr>
<tr>
<td>SHOCK 1 year‡</td>
<td>55.0</td>
<td>70.0</td>
<td>0.008</td>
<td>Not available</td>
<td>15</td>
<td>7</td>
<td>143/1000</td>
</tr>
<tr>
<td>CPORT 6 months§</td>
<td>6.2</td>
<td>7.1</td>
<td>0.72</td>
<td>Not available</td>
<td>0.9</td>
<td>111</td>
<td>9/1000</td>
</tr>
<tr>
<td><strong>Reinfarction</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weaver 6 months</td>
<td>4.4</td>
<td>9.7</td>
<td>0.0001</td>
<td>0.43 (0.3 to 0.6)</td>
<td>5.3</td>
<td>19</td>
<td>53/1000</td>
</tr>
<tr>
<td>Zijlstra 5 years</td>
<td>6.1</td>
<td>22.0</td>
<td>0.0001</td>
<td>0.27 (0.15 to 0.52)</td>
<td>6</td>
<td>6</td>
<td>167/1000</td>
</tr>
<tr>
<td>CPORT 6 months</td>
<td>5.3</td>
<td>10.6</td>
<td>0.04</td>
<td>Not available</td>
<td>5.3</td>
<td>19</td>
<td>53/1000</td>
</tr>
<tr>
<td><strong>Mortality or non-fatal reinfarction</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weaver 6 months</td>
<td>6.8</td>
<td>13.4</td>
<td>0.0001</td>
<td>0.47 (0.43 to 0.7)</td>
<td>6.6</td>
<td>15</td>
<td>67/1000</td>
</tr>
<tr>
<td>Zijlstra 5 years</td>
<td>14.9</td>
<td>23.0</td>
<td>0.034</td>
<td>Not available</td>
<td>8.1</td>
<td>12</td>
<td>83/1000</td>
</tr>
<tr>
<td>CPORT 6 months†</td>
<td>22.4</td>
<td>46.0</td>
<td>0.0001</td>
<td>0.13 (0.43 to 0.91)</td>
<td>24</td>
<td>4</td>
<td>250/1000</td>
</tr>
<tr>
<td><strong>New revascularisation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zijlstra 5 years</td>
<td>32.8</td>
<td>54.0</td>
<td>0.001</td>
<td>Not available</td>
<td>21.2</td>
<td>5</td>
<td>200/1000</td>
</tr>
<tr>
<td>CPORT 6 months‡</td>
<td>46.4</td>
<td>71.1</td>
<td>&lt;0.001</td>
<td>Not available</td>
<td>24.7</td>
<td>4</td>
<td>300/1000</td>
</tr>
<tr>
<td><strong>Recurrence of ischaemia</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zijlstra 5 years</td>
<td>36.4</td>
<td>48.0</td>
<td>0.026</td>
<td>Not available</td>
<td>11.6</td>
<td>9</td>
<td>111/1000</td>
</tr>
<tr>
<td>CPORT 6 months</td>
<td>52.0</td>
<td>89.5</td>
<td>&lt;0.001</td>
<td>Not available</td>
<td>37.5</td>
<td>3</td>
<td>333/1000</td>
</tr>
</tbody>
</table>

| *Data on 2635 patients. Presented at the American Heart Association meeting in Atlanta, October 1999.|
| †The SHOCK trial did not compare PTCA with lysis, but a strategy of emergency revascularisation versus initial medical stabilisation.|
| ‡Includes disabling stroke. For explanation of abbreviations see table 1.|

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high risk patients. This concern will lead physicians to accept the natural history of the disease rather than to prescribe the reperfusion treatment that is available to most cardiologists, which can be lifesaving, but will potentially induce a severe complication. From a safety standpoint, lytic treatment may therefore be perceived as being more hazardous than the invasive approach.

Primary stented angioplasty and new antiplatelet agents

The systematic use of coronary stents during primary angioplasty was shown to reduce the incidence of reocclusion and the need for new TVR compared to balloon dilatation. The rate of TIMI 3 flow grade did not improve nor did systematic stent implantation reduce the incidence of reinfarction and mortality in the large STENT-PAMI and CADILLAC trials. In the TIMI-14 study the administration of a bolus of alteplase alone or a bolus followed by a 30 minute infusion of rt-PA and abciximab was far less effective (TIMI 3 flow grade at 90 minutes: 48% and 62%, respectively) than the same bolus followed by a 60 minute infusion (TIMI 3 flow grade 74%, p < 0.02). Even with the addition of abciximab, this indicates that the concentration of the lytic agent must be maintained for at least 60 minutes. Therefore, the time delay needed for the optimal lytic regimen to be effective may be not much shorter than that for primary angioplasty.

Following primary angioplasty, a longer time delay could result in a larger infarct size and a lower left ventricular ejection fraction, but apparently this does not adversely affect the mortality rates increase with increasing time, in particular beyond the third to fourth hour after symptom onset. On the contrary, with lytic treatment, reperfusion rates decrease and the mortality rates increase with increasing time, in particular beyond the third to fourth hour after symptom onset. Short term mortality strongly depends on the quality and time frame of reperfusion. Angioplasty yields a higher degree of TIMI 3 flow grade than fibrinolysis and this translates in a better short term outcome. Long term survival largely depends on left ventricular function; this in turn depends on the extent of myocardial damage, which increases as reperfusion is delayed. Thus angioplasty may be better for patients admitted late—that is, more than four hours after onset of symptoms—in whom 30 day mortality with angioplasty remains under 5% but rises to over 12% with lysis. The transportation of high risk patients to hospitals offering invasive facilities should be considered since the additional treatment delay does not seem to jeopardise the result of mechanical reperfusion.

Patients subgroups

Primary angioplasty applied to selected candidates may prove more beneficial than its indiscriminate use, particularly in patients with small low risk AMI. Available data support the use of primary angioplasty over fibrinolysis in high risk patients and in patients with haemodynamic impairment (class I indication). Indirect data suggest that the mechanical approach is a better alternative than fibrinolysis in clinical subsets such as the elderly, patients with right ventricular involvement, patients with AMI caused by the occlusion of vein grafts, late presenters, or subjects who are ineligible for

**CONTEMPORARY ANGIOPLASTY AND FIBRINOLYSIS: ARE THEY TRULY EQUIVALENT?**

Whenever primary angioplasty and fibrinolysis are to be evaluated as potentially equivalent, the following issues should be considered.

**Time delay**

Setting up for and performing primary angioplasty requires more time than starting an intravenous infusion. In randomised clinical trials, the in-hospital delay in starting fibrinolysis was on average 45–50 minutes shorter than the time needed to start angioplasty. The in-hospital procedure related delay for primary angioplasty must be no longer than 90 minutes according to the American Heart Association/American College of Cardiology recommendations. In nearly 90% of cases, the invasive strategy results in immediate TIMI 3 flow grade of the infarct related artery, while with lytic agents there is an additional delay before their effect starts. In the TIMI-14 study the administration of a bolus of alteplase alone or a bolus followed by a 30 minute infusion of rt-PA and abciximab was far less effective (TIMI 3 flow grade at 90 minutes: 48% and 62%, respectively) than the same bolus followed by a 60 minute infusion (TIMI 3 flow grade 74%, p < 0.02). Even with the addition of abciximab, this indicates that the concentration of the lytic agent must be maintained for at least 60 minutes. Therefore, the time delay needed for the optimal lytic regimen to be effective may be not much shorter than that for primary angioplasty.

Following primary angioplasty, a longer time delay could result in a larger infarct size and a lower left ventricular ejection fraction, but apparently this does not adversely affect the patency rate of the infarct related artery or the six month clinical outcome. Hospital mortality rates remain low and predictable in patients treated within 12 hours of symptom onset unless they present with cardiogenic shock. On the contrary, with lytic treatment, reperfusion rates decrease and the mortality rates increase with increasing time, in particular beyond the third to fourth hour after symptom onset. Short term mortality strongly depends on the quality and time frame of reperfusion. Angioplasty yields a higher degree of TIMI 3 flow grade than fibrinolysis and this translates in a better short term outcome. Long term survival largely depends on left ventricular function; this in turn depends on the extent of myocardial damage, which increases as reperfusion is delayed. Thus angioplasty may be better for patients admitted late—that is, more than four hours after onset of symptoms—in whom 30 day mortality with angioplasty remains under 5% but rises to over 12% with lysis. The transportation of high risk patients to hospitals offering invasive facilities should be considered since the additional treatment delay does not seem to jeopardise the result of mechanical reperfusion.

**Patients subgroups**

Primary angioplasty applied to selected candidates may prove more beneficial than its indiscriminate use, particularly in patients with small low risk AMI. Available data support the use of primary angioplasty over fibrinolysis in high risk patients and in patients with haemodynamic impairment (class I indication). Indirect data suggest that the mechanical approach is a better alternative than fibrinolysis in clinical subsets such as the elderly, patients with right ventricular involvement, patients with AMI caused by the occlusion of vein grafts, late presenters, or subjects who are ineligible for
fibrinolysis. However, subgroup analysis should be considered
with caution since data fragmentation reduces the statistical
power and may cause type II errors. Proper randomised trials
are needed if these indications are to be fully legitimised.

**Number needed to treat and number needed to harm**
The demonstration of a significant reduction in mortality of
about 25% with fibrinolytic agents has required the random-
isation of more than 10 000 patients in each of the initial
studies. Later on, the GUSTO-I study enquired 41 021 patients
to obtain a further 14.6% risk reduction in mortality with
rt-PA versus streptokinase (95% confidence interval (CI) 5.9%
to 21.3%, p = 0.001). Equivalence trials have randomised
more than 31 000 patients to show that new fibrinolytic agents
‘do not cause a clinically significant excess in events’. Assuming
a 30 day mortality rate of 7% in patients treated with fibrinolysis, about 12 000 patients would need to
to be randomised to show a worthwhile 20% relative risk reduc-
tion with any alternative treatment. Primary angioplasty has
been shown to have favourable effects on end points such as
mortality and reinfarction, even in smaller sized studies. These
considerations would support the contention that mega-trials
on direct angioplasty are no longer necessary, but this position
has not gained universal acceptance.

Most potentially effective lytic drugs have been tested in
large clinical trials which were funded by companies with a
vested interest in orienting medical care at large. Regrettably,
there has not been enough interest to support prospective
randomised clinical trials comparing angioplasty and fibrino-
lolysis that are large enough to provide unequivocal results.
The largest randomised study of this kind, GUSTO II-B,
included only 1138 patients and showed a non-significant
mortality reduction of 18.6%, resulting in 13 lives saved per
1000 patients.

A useful tool for the interpretation and comparison of out-
comes is the ‘number needed to treat’ (NNT). NNT is
calculated as the reciprocal of the absolute outcome difference
between two treatment groups and offers an ingenious measure-
ment of the ‘therapeutic effort to clinical yield’ ratio. The
NNT to prevent one death, reinfarction, stroke or a
combined end point in the short term, according to the most
relevant trials comparing angioplasty and fibrinolysis, is
shown in table 1. Similar calculations in regard to long term
results are given in table 2.

When using angioplasty instead of fibrinolysis in 1000
patients, 21 more lives would be saved and 13 strokes avoided
within the first month after AMI. Even though the debated
32% mortality reduction obtained in the combined analysis of
these trials may not be representative of current practice, the
magnitude of the benefit obtained with angioplasty in the real
world seems at least as important as the benefit obtained with
front loaded rt-PA compared to streptokinase. In GUSTO V the
absolute risk reduction in mortality was 0.3, resulting in 3 lives
saved per 1000 patients treated with combined therapy instead
of rt-PA only (NNT = 333). Long term analysis shows that
angioplasty would save 20 more lives than fibrinolysis per 1000
patients at six months, 33 at two years, and 100 at five
years. Furthermore, 200 new TVRs would be prevented at two
years and 300 at five years after the index AMI.

A similar analysis can be applied to determine the adverse
effects of medical interventions (‘number needed to harm’). Out
of 1000 patients treated with fibrinolysis, 8 would have
suffered from stroke in GUSTO II-B and 34 in PAMI (table 1).
Such an event is fatal in 40% of patients and causes severe
morbidity in the remainder, reducing the net clinical benefit
of fibrinolysis.

**Applicability: the true frontier of reperfusion treatment
in the “real world”**
Because the limitations to the applicability of each form of
reperfusion treatment are different, we believe that they rarely
present as an equivalent alternative.

The major limitation of primary angioplasty is the difficulty
in setting up the programme, performing the procedures in a
timely fashion, and reproducing the results of clinical trials.
However, a similar frontier exists for fibrinolytic treatment. In
the NRII-2 study only 31% of the 272 651 patients analysed were
eligible for reperfusion, 3% had formal contraindications, 41%
presented after six hours, and 25% had non-diagnostic ECG;
Furthermore, 24% of eligible patients were not given
reperfusion treatment. Not surprisingly, unadjusted mortality
in patients not receiving reperfusion treatment was nearly
three times higher than in treated patients. Had angioplasty
been available, these patients could have benefited from
reperfusion treatment.

Results from the NRII-2 study can be considered to be
representative of cardiology practice in the USA. Despite
differences between countries in eligibility criteria, time delay,
lytic agents, and treatment strategies, the major findings in
NRII-2 are largely reproduced in Western Europe and
Canada, confirming the under utilisation of reperfusion treat-
ment. Overall fibrinolysis is given to only 66% of eligible
patients, and the use of invasive procedures ranges from 2.5–
11% of AMI patients between community and academic
institutions. Among European countries, the UK has
reported the largest use of fibrinolytic agents: 71.6% of
patients with suspected AMI, ranging from 49–85% in differ-
ent hospitals, in the context of limited availability of
invasive facilities. Other countries use lytic agents less often,
perhaps in part because angioplasty is more readily available.
In Germany fibrinolysis is given in 36–42% of patients while
angioplasty is used in 10–25% of cases. In France 37% of
AMI patients receive reperfusion treatment, either by means
of systemic lysis (32–45%) or angioplasty (13–43%). Other
reports from Israel, Italy, Scandinavia or Spain indicate
that fibrinolysis is given to 35–45% of patients. Data
from Australia and New Zealand state an eligibility rate of
53%, lysis being actually given in 43%, with a predominant
use of streptokinase (78%) over rt-PA (15.7%), and a growth
in surgery or angioplasty from 8.7% in 1986 to 17.4% in
1994. Despite these differences in management of AMI
among western countries, there are no significant differences
in short term outcome, perhaps because the proportion of
reperfused patients is similar. Thus in daily practice, half of
the patients with AMI do not receive reperfusion treatment.
Reperfusion is rarely denied because of formal contraindica-
tions but usually because of late arrival, non-diagnostic ECG
changes, advanced age or other various reasons that raise a
‘fear to treat’ in about 25–35% of potentially eligible cases.
Under all these circumstances, angioplasty, when
available, is not an ‘alternative’ to lysis but the sole
opportunity for reperfusion. Paradoxically, the results of
angioplasty in this large patient subgroup, which represent an
ideal and undisputed setting for its use, are mostly
unknown.

Therefore, increasing the availability of primary angiop-
plasty, or shaping the triangle of fig 1 into a rectangle, would
be a worthwhile effort. As mentioned earlier, patient
transportation to high workload tertiary centres is a safe and
valuable therapeutic approach and, at least in theory, it may
prove a more rational and cost effective option than the
emergence of a widespread network of low volume centres in which
optimal results may not be achieved. Such a strategy has been investigated in a large randomised study in Europe (DANAMI-2). The study randomly assigned AMI patients to front loaded rt-PA or angioplasty in interventional centres, or to rt-PA versus transportation for angioplasty elsewhere in non-invasive centres, and was prematurely stopped on 1 October 2001 after a planned interim analysis because of the benefit observed in the invasive strategy of the study (table 1). In the USA, a recent small randomised trial has shown that the better outcome of angioplasty over fibrinolysis can also be obtained in community hospitals without on-site cardiac surgery.24

Which yardstick for measuring treatment effect?
If reperfusion strategies are considered as nearly equivalent, then the accuracy of the measurement of their respective effects becomes of major relevance. Randomisation is the best tool for testing two treatment strategies; however, in this particular case, the method may have some pitfalls that must be acknowledged. On the one hand, randomisation precludes enrolment of patients who are ineligible for fibrinolysis. This represents a group of patients at particularly high risk in whom angioplasty is likely (but was not proven) to be beneficial. On the other hand, double blinded analysis and outcome adjudication is problematic. In patients assigned to angioplasty, information on coronary anatomy and ventricular function is immediately available and complications may be diagnosed and managed readily, leading to a more proactive management of patients treated invasively.

ANCILLARY BENEFIT OF THE INVASIVE APPROACH
While the primary goal of any kind of reperfusion therapy is to save lives by re-establishing effective myocardial perfusion, some potential additional benefits are granted only with the invasive approach. Admittedly, these ancillary benefits only pertain to the few patients who have prompt access to the invasive treatment.

The invasive approach enables the use of a variety of tools such as stents, ultrasound imaging, thrombectomy or aspiration devices, and provides the possibility of intracoronary or local drug delivery, all of which may in the future prove to be useful adjunctive agents to optimise reperfusion. Invasive diagnostic tools may also help to gain additional insights into the “mysteries” of reperfusion at the tissue level”—that is, why one out of four patients who achieve a brisk epicardial TIMI 3 coronary flow does not have tissue reperfusion.25

The immediate knowledge of the coronary anatomy and left ventricular function facilitates accurate risk stratification and allows the most appropriate individual treatment strategy to be selected and implemented. New standards of care after AMI have ensued and reduced the length of hospital stay and the need for further diagnostic testing.26 27 28 29

Primary angioplasty is cost saving compared to fibrinolysis.28 29 30 31 This is mainly because of the lower incidence of in-hospital reinfarction, recurrent ischaemia, stroke, and shorter hospital stay.28 29

Late reocclusion of the infarct related artery with or without reinfarction occurs in nearly 30% of patients after fibrinolysis and bears a negative prognosis and a high mortality rate.2 4 5 6 12 This likely explains the lack of survival benefit between fibrinolysed and control patients 10 years after discharge in the GISSI study.4 6 12 Conversely, with contemporary primary angioplasty and stenting, reocclusion and reinfarction rates are as low as 1–5%.4 14 15

As has been determined from postmortem examination41 and has been recently confirmed in vivo,42 AMI may not always be the consequence of a thrombotic coronary occlusion. Acute events such as plaque rupture, spontaneous dissections or intramural plaque haemorrhage associated with spasm are the cause of AMI in nearly 30% of cases, a figure which is close to the percentage of cases in which optimal lytic therapy is ineffective.4 17 Under those pathophysiological circumstances, fibrinolysis and antiplatelet agents, even when given at doses that go beyond their “safety ceiling”, will never work, because the substratum on which these drugs act is non-existent.20

CONCLUSIONS AND FUTURE DIRECTIONS
Currently available evidence does not fully support the contention that either the immediately invasive approach or combined antithrombotic or pharmacomechanical strategies are clearly superior to fibrinolysis in reducing mortality. We need to learn from appropriately powered randomised clinical trials whether or not primary angioplasty is beneficial when applied to subgroups of patients who otherwise do not receive reperfusion treatment. When appropriate, current guidelines should be revised to incorporate specific recommendations for these specific patient subsets.

In the meanwhile, primary angioplasty cannot be advocated as the first therapeutic approach where it is not performed on a regular basis by experienced operators. Reperfusion by lytic treatment remains the therapy of choice for AMI in most cases, although its efficacy and applicability in the real world remain far from optimal.

Rather than taking a dogmatic approach to either form of reperfusion treatment, percutaneous coronary intervention and/or drugs should be used as needed to increase the overall impact of reperfusion treatment in the community, taking advantage of the best, locally available potential of each approach.11 The real challenge is to increase the proportion of
patients with AMI receiving reperfusion treatment and to “do more for more patients” rather than “do more for fewer patients”. Pre-hospital diagnosis and treatment of AMI are important. At a time when mortality from AMI has decreased to lower levels, pre-hospital treatment will likely be the only way to reduce mortality any further. Immediate treatment with lytic and/or antiplatelet drugs and transportation for angioplasty seem to be the most rational approach. stenting and glycoprotein IIb/IIIa inhibitors during angioplasty does not reduce mortality. Instead of being used indiscriminately, these tools should be considered in unfavourable patient or lesion subsets, such as the presence of a large thrombotic burden after wire crossing or subtotal flow after angioplasty.

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Figure 2 Streptokinase can still be used as a first choice treatment in low risk patients (as currently done in many patients treated in South America, UK, Australia, New Zealand, and the Netherlands), while patients presenting with higher clinical risk would benefit from the use of the more expensive recombinant tissue plasminogen activator (rt-PA). The combination of recombinant t-PA and a glycoprotein IIb/IIIa inhibitor (abciximab) will reduce the clinical complications of acute myocardial infarction, but will not reduce mortality. Reserving lytics (PTCA) can be reserved for high risk patients who did not achieve reperfusion or have a poor clinical course. Primary angioplasty should be preferred for patients presenting with haemodynamic failure, advanced age (> 75 years) or presenting late (more than 4–5 hours after symptom onset). The previous administration of half doses of lytic treatment is desirable when it can be given out of hospital by first aid providers, or in the emergency department when access to the catheterisation laboratory is delayed. The use of stents and glycoprotein IIb/IIIa inhibitors during angioplasty does not reduce mortality. Instead of being used indiscriminately, these tools should be considered in unfavourable patient or lesion subsets, such as the presence of a large thrombotic burden after wire crossing or subtotal flow after angioplasty.

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14 The most recent megatrial of rural hospitals. The advantages of primary angioplasty were marginal and not sustained at six months.
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16 The most recent megatrial of rural hospitals. The advantages of primary angioplasty were marginal and not sustained at six months.
Impressive demonstration of the superiority of primary angioplasty over fibrinolysis on survival at long term follow up (5-12 years).


Excellent editorial review that addresses the discrepancies between the complete degree of angiographic epicardial reperfusion and tissue reperfusion.


Interesting observations about the non-thrombotic origin of a number of total acute coronary occlusions that may not be relieved by lytic agents.