Can we trigger an acute coronary syndrome?
R A Kloner

While both physical exertion and anger can contribute to acute coronary syndromes, these triggers differ in their clinical and sociodemographic correlates.

There is an expanding literature that suggests that acute myocardial infarction and death from coronary artery disease can be triggered by a number of natural as well as man-made triggers. Natural triggers include circadian fluctuations (with an increase in myocardial infarction and cardiac death in the morning associated with the first few hours after the wake-up time), seasonal fluctuations (with an increase in cardiac events during the winter months) and natural disasters (such as earthquakes and blizzards).

MAN-MADE TRIGGERS

Man-made triggers have been studied in detail and include heavy and moderate physical activity, emotional upset (including anger, as described in the accompanying manuscript by Strike et al), overeating, lack of sleep, sexual activity, and the use of cocaine and other illicit substances. Certain man-made events may trigger cardiac events. For example, we recently observed that there was an increase in ischaemic heart disease death rates during the millennium celebration of the New Year versus other New Years’ celebration. Another report of an increase in cardiac events induced by a man-made event was the increase in acute myocardial infarction and sudden death reported in Israel at the time of Iraqi missile attacks. We were surprised to learn that some man-made unnatural disasters that we hypothesised might be associated with an increase in death due to ischaemic heart disease were not. An example is the terrorist attacks of 11 September 2001. A review of death certificate data from New York City did not reveal an increase in death from ischaemic heart disease on the day of the attacks compared to that same day during previous years. We cannot rule out the possibility that some deaths in the twin towers were cardiac in nature—it may have been that these events were masked by death from trauma/fire. We cannot rule out the possibility that there will be long term health problems because of the attack. However, simply watching the news about 9/11 on television was apparently not a sufficient stressor to induce an increase in cardiac deaths in the New York City population. The riots in Los Angeles following the Rodney King conviction also were not associated with an increase in cardiac events.

Triggers that are associated with an increase in acute myocardial infarction and ischaemic heart disease death may share certain common mechanisms. They are in general associated with increases in sympathetic activity and catecholamine release—the so called “fight or flight” response. Both physical and emotional stress may precipitate sympathetic activity and catecholamine release leading to a number of haemodynamic changes, including an increase in heart rate, blood pressure, vascular resistance, and ventricular contractility. These factors can increase shear stress of blood against a vulnerable atherosclerotic plaque, contributing to rupture of the plaque and subsequent myocardial infarction. In addition, these haemodynamic factors can increase oxygen demand (increase heart rate, contractility, and blood pressure) at the same time they reduce oxygen supply (an increase in coronary resistance or frank coronary spasm; an increase in platelet aggregability). Furthermore, stimulation of the sympathetic nervous system may trigger arrhythmias with or without concomitant ischaemia.

PHYSICAL EXERTION AND ANGER

The present paper byStrike et al extends our knowledge of two specific known triggers—physical exertion and anger. Their work confirms previous reports by verifying that both physical exertion and anger contributed to acute coronary syndromes (primarily ST elevation acute myocardial infarction), but each trigger differed somewhat in their clinical and sociodemographic correlates. Specifically, acute myocardial infarction associated with physical exertion was more likely to occur in patients who were not socially deprived. These patients were more likely to develop a Q wave ST elevation myocardial infarction with greater enzyme release compared to patients who were sedentary before their coronary events. These patients were also more likely to have a higher GRACE score—which includes a history of congestive heart failure. Coronary events in these patients typically occurred in the afternoon and were unlikely to be associated with premonitory symptoms.

When anger was the trigger the patients tended to be younger, have lower socioeconomic status, have premonitory symptoms, and were more likely to present with ST elevation myocardial infarction rather than non-ST elevation myocardial infarction or unstable angina. Troponin release was not as great in this group. There was a trend towards more hypertension in patients who had anger versus exertion as a trigger.

Thus each of these triggers was associated with a different clinical presentation and
Thrombosis

STAMPS IN CARDIOLOGY

M K Davies
A Hollman