高リスク患者はACSに対する積極的な治療の恩恵を被る

FIR Collaboration：非ST上昇急性冠症候群に対しては選択的な侵襲治療よりもルーチンの侵襲治療の方が良い

FIR Collaboration: Routine invasive strategy better than selective invasive care for non-ST acute coronary syndrome

非ST上昇急性冠症候群患者に対するより積極的な治療により保存的治療よりも長期予後が改善すると第59回American College of Cardiology学会で発表、Journal of the American College of Cardiologyに掲載された。FIR共同トライアル（FRISC-II、RITA-3およびICTUSスタディのメタ解析）では個々の患者のデータを解析し、重度の症状または虚血の徴候を有する患者に対するより積極的なルーチンの侵襲的（RI）治療（全患者に早期の冠動脈造影を施行し適応の場合には血行再建術を施行する）または保存的な選択侵襲的（SI）治療（標準的な薬物療法と特異的な症例にのみ冠動脈造影を施行）の長期予後を明らかにした。5年後の心血管死および非致死性心筋梗塞（MI）発現率はRI治療群の方が低かった。特に、RI群に割り付けられた患者2,721人中14.7%が心血管死または非致死性MIを発現したのに対し、SI群患者2,746人におけるその割合は17.9%であった。治療効果が最も著明に認められたのは非致死性MI単独であり、RI群の10%に認められたのに対しSI群におけるその割合は12.9%であった。心血管死単独および総死亡もRI群において少なかった。

Full Text

A more aggressive treatment approach to patients with non-ST elevation acute coronary syndrome (ACS) leads to better long-term outcomes than more conservative care, according to research presented at the American College of Cardiology's 59th annual scientific session.

The FIR Trial Collaboration is the first meta-analysis of all relevant studies containing five-year data. The lead investigators from each of the studies (FRISC-II, RITA-3 and ICTUS) collaboratively analyzed the individual patient data to determine the long-term outcomes of using either a more aggressive routine invasive (RI) strategy - consisting of early coronary angiography for every patient followed by revascularization, if indicated - or a more conservative selective invasive (SI) strategy-consisting of standard medical treatment and coronary angiography only for specific cases-in patients with severe symptoms or signs of ischemia.

At the five-year mark, patients receiving the RI strategy had lower incidences of cardiovascular death and non-fatal myocardial infarction. Specifically, 14.7 percent of the 2,721 patients randomized to the RI group experienced either cardiovascular death or non-fatal myocardial infarction, compared with 17.9 percent of the 2,746 patients in the SI group. The most marked treatment effect was seen for non-fatal myocardial infarction alone, which occurred in 10 percent of the RI cohort and 12.9 percent of the SI cohort, but the researchers also saw both a lower number of cardiovascular deaths alone and a lower number of deaths from any cause in the RI group.

"The reason why we need this combined 'meta-analysis' of all the trials, and based on individual patient data, is that there is inconsistency in the findings of the individual studies," said Dr. Keith A. Fox, the British Heart Foundation Professor of Cardiology at the Centre for Cardiovascular Science at the University of Edinburgh, United Kingdom, and the study's lead researcher. "It is only with this combined analysis that we can get a conclusive result. The study has demonstrated that there is a clear impact on reduced CV death and myocardial infarction."

In addition to discovering that an RI strategy produced better long-term results than a SI strategy, the team also uncovered an unexpected finding: not all patients benefited equally. Those in the highest risk group - based on a number of variables including age, diabetes, and previous myocardial infarction, among others - benefitted the most from undergoing the RI strategy. The researchers note that risk can be estimated at the bedside using a simple scale based upon the patient's characteristics (age, diabetes, ECG signs of ischemia, hypertension, prior myocardial infarction and Body Mass Index).

While Fox notes that this finding highlights a common paradox in medical treatment - that the majority of patients who receive interventions are low risk - he adds that the study lends support to the idea of systematically risk-stratifying patients in order to determine who should receive an intervention.

"If patients are high risk and without contraindication but they are not going for an invasive strategy, we need to ask 'why,'" Fox said.

The need for risk stratification is supported by guidelines including the American College of Cardiology/American Heart Association Guidelines.

The meta-analysis was conducted using resources from each of the host institutions for their respective studies. The original studies were supported as disclosed in the original publications.

This study is simultaneously published in the Journal of the American College of Cardiology and online.

ACC2010特集

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