

完全血行再建術はMI後の予後を改善する (Presentation #4023)

CvLPRIT: 血行再建術の際の責任病変を超えた治療により心筋梗塞後の予後が改善する

CvLPRIT: Moving beyond the culprit lesion during revascularization improves outcome following myocardial infarction

心筋梗塞(MI)の治療を受けている患者に、有意狭窄全ての完全血行再建を行うことにより梗塞の原因となる"責任病変"のみの血行再建を行うよりも予後が改善する、との新たなスタディ結果が2014年European Society of Cardiology Congressホットラインセッションで発表された。CvLPRITにはインターベンションを行っているUK循環器センターを受診したMI患者296人が組み入れられた。PCI治療前に患者は、梗塞の責任冠動脈(IRA)のみにインターベンションを施行される群(146人)またはIRAに加え有意狭窄が認められた非IRAの両者に完全に血行再建術を施行する群(150人)にランダムに割り付けられた。総死亡、MI再発、心不全および虚血により血行再建術を必要としたことからの主要な心イベント(MACE)の複合エンドポイントに基づくと、1年後の予後は完全血行再建術群においてIRAのみに血行再建術を施行された患者群よりも有意に良好であった。MACEはIRAのみの群の21.2%に発現したのに対し、完全血行再建術群では10.0%であった($p=0.009$)。この差は早期に出現した(30日後で $p=0.055$)。施術時間と造影剤使用量は完全血行再建術群で有意に大であったにもかかわらず、完全血行再建術群の患者において脳卒中、重大な出血または造影剤による腎不全が増加することはないかった。

Full Text

In patients being treated for myocardial infarction (MI), complete revascularization of all significantly blocked arteries leads to better outcomes compared to a strategy of unblocking just the "culprit" artery responsible for the infarct, according to a new study presented during a Hot Line session at ESC Congress 2014.

Results of the Complete versus Lesion only Primary-PCI Trial (CvLPRIT), presented as a congress Hot Line may be practice-changing when considered together with some other recent trials, said study investigator Anthony Gershlick, MD, from University Hospitals of Leicester NHS Trust, Glenfield Hospital, in Leicester, England.

"Until now there have been conflicting data regarding the optimal management of patients who, whilst undergoing primary percutaneous coronary intervention (P-PCI) after myocardial infarction (MI) are also found to have lesions in their non-infarct related artery (N-IRA)," noted Professor Gershlick.

"Current guidelines from ESC and AHA/ACC recommend treating the infarct-related artery (IRA) only, but the results of our study demonstrate a highly significant benefit with a strategy of complete revascularization instead. These findings should suggest strongly that all lesions be treated before the patient is discharged," he added.

CvLPRIT included 296 heart attack patients who presented at seven UK interventional cardiology centers. Prior to treatment with P-PCI the patients were randomized to receive IRA-only revascularization ($n=146$) or to have complete revascularization of both the IRA as well as all N-IRAs ($n=150$) that were shown to be significantly blocked.

For patients in the complete revascularization group, the IRA was treated first, followed by the N-IRAs - preferably in the same sitting, but definitely during the same index hospital admission.

The study found that one year after the procedure, patients in the complete revascularization group had significantly better outcomes compared to those who had only their IRA revascularized, based on a composite endpoint of major adverse cardiac events (MACE) including: all-cause mortality, recurrent MI, heart failure and ischemic-driven revascularization. MACE occurred in 21.2% of the IRA-only arm versus 10.0% of the complete revascularization group (hazard ratio [HR] 0.45; $p=0.009$), and the difference between the two groups was seen early ($p=0.055$ at 30 days).

Not surprisingly, procedure time and contrast volume load were significantly higher in the complete revascularization group compared to the IRA-only group (55 vs. 41 min., $p<0.0001$; and 250 vs. 190 ml, $p<0.0001$, respectively), but despite this, the complete revascularization patients had no increase in stroke, major bleeding or contrast-induced nephropathy, said Professor Gershlick.

The CvLPRIT results correlate strongly with those of the earlier Preventive Angioplasty in Myocardial Infarction (PRAMI) Trial, which was presented during last year's ESC Hot Line session.

"The PRAMI trial reported clear clinical benefit in treating both IRA and N-IRAs at the index P-PCI, but there was some criticism of the trial design," said Professor Gershlick. "As a result, PRAMI has not led to widespread changes in clinical practice, with IRA-only revascularization at P-PCI remaining by far the more common practice."

However, he said the results of CvLPRIT reinforce the PRAMI results and strengthen the argument for a strategy of complete revascularization at the time of a patient's index hospital admission.

"The early separation of the curves in CvLPRIT suggests a delayed staged out-patient complete strategy may not be as effective," he added.

The sponsor was the University Hospitals of Leicester NHS Trust. The main study was funded by the British Heart Foundation, with the CMR sub-study supported by the National Institute of Health Research.

Dr. Gershlick reports advisory board/meeting travel assistance/ lecture bureau: Medtronic Corp, Boston Scientific, Abbott vascular, Daiichi Sankyo, Medicines Company.

Conference News

[News 01]

薬剤によりいくつかの術後合併症が減少する

[News 02]

MI後のdarapladib投与はその後のリスクを低下させない

[News 03]

新しいクラスの薬剤は心不全においてACE阻害薬よりも優れている

[News 04]

Serelaxinは心不全の院内増悪を軽減する

[News 05]

完全血行再建術はMI後の予後を改善する

[News 06]

4極リードによりCRT合併症が減少する

[News 07]

CRTにおいて代替のリード位置は安全である

[News 08]

新たな生分解性の薄いステントは有望であることが示された

[News 09]

血行再建術を回避しても安全な患者の見極め

[News 10]

試験薬はスタチンと共に作用しコレステロールを低下させる

[News 11]

糖尿病患者においてロスバスタチンはアトルバスタチンよりも選択肢として優れている可能性がある

[News 12]

ロスバスタチンは冠動脈内プラーク体積を小さくさせる

[News 13]

アミオダロンはアブレーション後の短期回復を改善する

[News 14]

リバーロキサパンを用いた前治療により除細動が早められる可能性がある

[News 15]

鉄の経静脈的補給は心不全症状を改善する

[News 16]

合剤はMI後治療へのアドヒアランスを上昇させる