

# Delayed angioplasty -- big bucks, no bang

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In a subset of patients suffering heart attack, adding stents to clot-busting medical therapy after the optimal treatment window ends isn't justified, say researchers from Duke University Medical Center.

In a follow-up to last year's widely reported Occluded Artery Trial (OAT), which reported that catheterization didn't seem to prevent second heart attacks if it were used more than 3 days after the initial heart attack, a group of Duke researchers looked more closely at 951 patients to see if there were other benefits from the procedure.

Their findings were presented today at a late-breaking trials session of the American Heart Association's annual meeting in Orlando.

Each year, about one million people suffer heart attacks in the United States, and studies suggest that for many of them, the best treatment is speedy use of clot-busting drugs or percutaneous coronary intervention (PCI), a catheter-based procedure that uses stents and balloons to open up blocked arteries. Ideally, the procedures should begin within 12 hours of the initial attack. But in real life, that doesn't always happen because patients delay seeking help and arrive at emergency departments too late for timely care.

Last year, OAT researchers who had followed 2,166 heart attack patients for up to five years told the American Heart Association annual meeting that PCI applied 3 to 28 days after the initial attack apparently didn't make any long-term difference in preventing second heart attacks, death, or development of heart failure.

All participants in OAT had experienced heart attacks, were considered high-risk, but were stable with one completely blocked artery. All of the patients received state-of-the-art drug therapy, but half also got the late PCI.

Focusing on a representative subset of 951 patients in the OAT trial, Dr. Daniel Mark, a cardiologist and director of outcomes research at the Duke Clinical Research Institute, led a team that measured various aspects of quality of life, including physical functioning, emotional and social well-being, activity level and the presence and intensity of pain. They also calculated the medical costs the U.S. patients incurred during that period. They were looking for secondary benefits that might further justify the high cost of PCI.

Mark said that the patients who got PCI plus standard medical therapy enjoyed slightly better physical functioning and less pain four months into treatment, but that these benefits did not last over time. In addition, the team discovered that it cost \$10,000 more in doctor and hospital costs to treat the PCI patients.

“What we have here is one of those cases where less is more,” says Mark. “While it may seem that going an extra step in opening up clogged arteries late in the game makes sense, we know that clinically, it doesn’t seem to offer the advantages we expected. In addition, the minimal initial benefits that patients with PCI enjoyed diminished over time. Coupling that with the higher cost, we now know that adding PCI to standard medical care in opening blocked arteries more than a day after a heart attack is not good value. In an era when the high cost of health care is the subject of intense debate, this study offers us one way we can offer high quality care for less money.”

Source: Duke University

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