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**JACC**

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# Inside This Issue of JACC

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Step	Minutes
1. First arrival with patient at triage or into CTED corridor	0
2. ED physician contacts catheter lab or cardiac catheterization unit with call	5
3. ED physician returns to cath lab	10
4. Final check and verbal consent	15
5. Catheterization begins	20

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## Treatment Standards for Acute Infarction

### Improving Door-to-Balloon Times

Improving door to balloon times for patients with ST-segment elevation myocardial infarction (STEMI) can significantly improve outcomes, but many facilities often exceed the recommended 90-min guideline. Bradley and colleagues studied 11 hospitals that have been able to consistently achieve the <90 min recommendation to determine the best practices for achieving this goal. They describe several critical innovations; the most effective appears to be prehospital electrocardiograms with prompt activation of the catheterization laboratory by emergency department physicians. Interdisciplinary collaboration and the adoption of explicit strategies for overcoming institutional inertia are required to consistently achieve the 90-min guideline. [See page 1236. See figure.](#)

## Treatment Standards for Acute Infarction

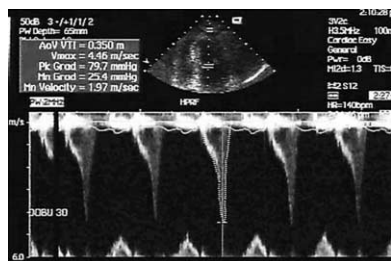
### Adherence to Guidelines Leads to Mortality Improvements

The Guidelines Applied in Practice (GAP) Project is one of several initiatives that seek to improve the quality of healthcare through the use of standardized, evidence-based protocols. Demonstration of a mortality benefit has not previously been done. Eagle and colleagues compared the care delivered and the mortality rates for acute myocardial infarction before and after implementation of the GAP project at several hospitals. Mortality was improved at all three time intervals studied, with a 21% to 26% relative reduction. The mortality benefit was greatest when a disease specific discharge tool was used; this form, signed by the patient and the physician, details the medications prescribed and the plan for future follow-up. This study lends support to the burgeoning movement to link reimbursement to quality measures by showing that these measures can improve mortality. [See page 1242.](#)

## Chronic Coronary Disease

### Only Large Areas of Viable, Non-Perfused Myocardium Increase Risk

Revascularization improves survival in patients with ischemic cardiomyopathy, but there remains uncertainty in determining which patients will derive the greatest benefit. Positron emission tomography (PET) is able to accurately measure both myocardial perfusion (using ammonia as the tracer) and myocardial viability (using uptake of glucose). Desideri and colleagues report on the results of nearly 200 subjects with ischemic cardiomyopathy who underwent PET scanning but did not undergo revascularization for a variety of reasons. Small areas of viable, non-perfused myocardium did not affect survival, but those subjects in which >20% of the myocardium was viable but not perfused had significantly decreased survival. This suggests that in patients with co-morbid conditions that increase the risk of revascularization, a cut-off of 20% viable, non-perfused myocardium may serve as an important risk stratifier. [See page 1264.](#)



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## Chest Pain and Normal Coronaries

### Etiology of Chest Pain in Patients With Normal Angiograms

Many patients with classical angina-like chest pain have angiographically normal coronary arteries; the etiology of this pain is unknown. Madaric and colleagues hypothesized that these patients might have an over-vigorous response to adrenergic stimulation. They tested this by performing dobutamine echocardiography with special attention to the appearance of elevated intraventricular flow velocities (IFV) suggesting dynamic outflow tract obstructions. No patient had inducible wall motion abnormalities, and all had normal resting echocardiograms, but one-half did develop IFV  $>3$  m/s with dobutamine. Chronic treatment with a beta-blocker reduced the frequency of angina like pain and the inducible IFV. This study suggests that some patients may develop increased wall stress and dynamic outflow tract obstruction in response to physiologic increases in adrenergic stimulation; this may be the etiology of their chest pain. [See page 1270.](#) [See figure.](#)

## Heart Rhythm Disorders

### Elevated CRP Levels Predict AF Recurrence

Predicting which patients will remain in normal sinus rhythm after cardioversion from atrial fibrillation (AF) is difficult. There is histologic evidence that suggests that inflammation may contribute to the development, or maintenance, of AF. Malouf and colleagues measured pre-cardioversion C-reactive protein (CRP) levels in patients referred for cardioversion and followed them for reversions. Arrhythmia recurrence was associated with significantly higher pre-cardioversion CRP levels, and was the only independent predictor of AF recurrence. These data suggests that high CRP levels are associated with an increased risk of AF recurrence and support the hypothesis that anti-inflammatory interventions may help to maintain normal sinus rhythm after CV. [See page 1284.](#)

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