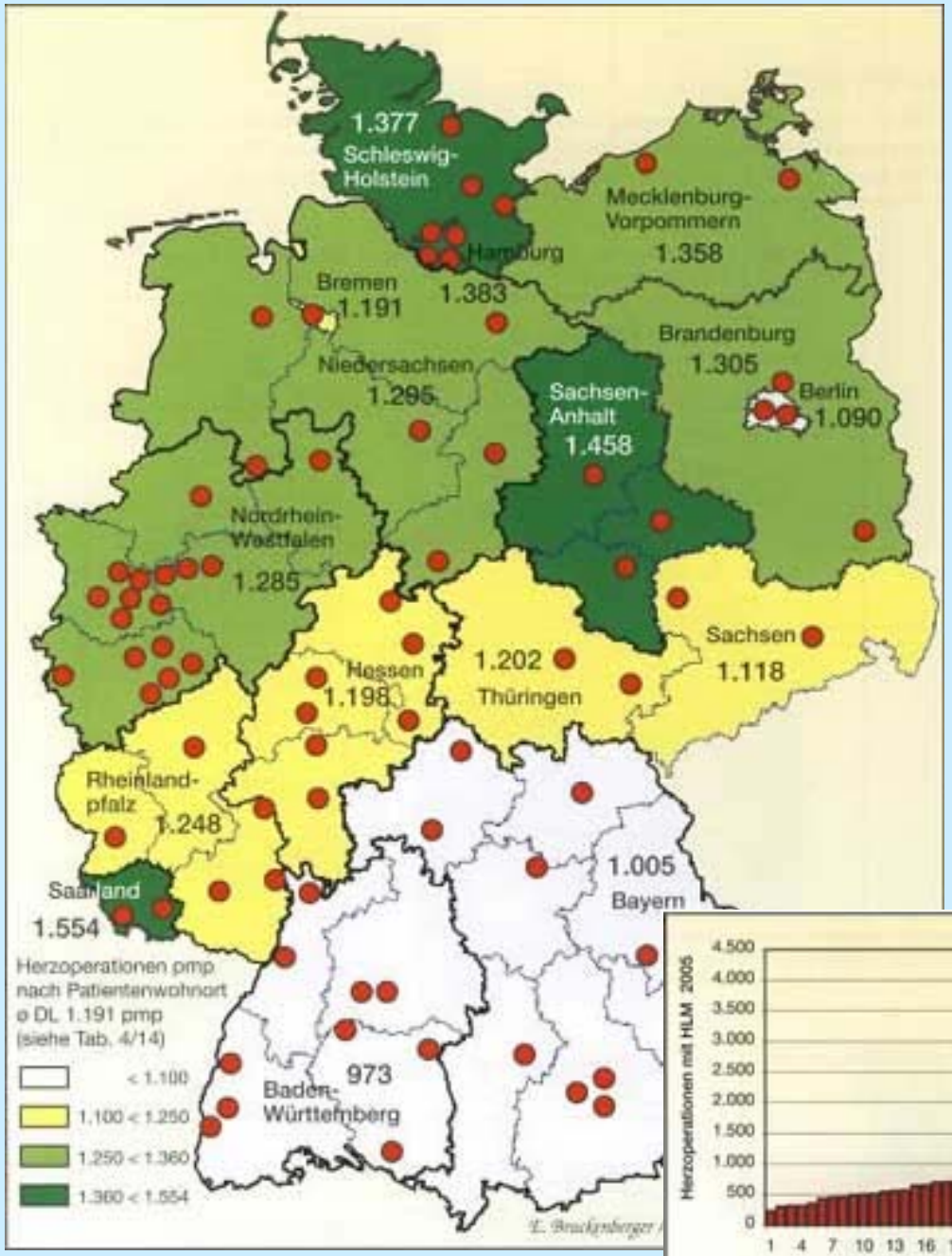
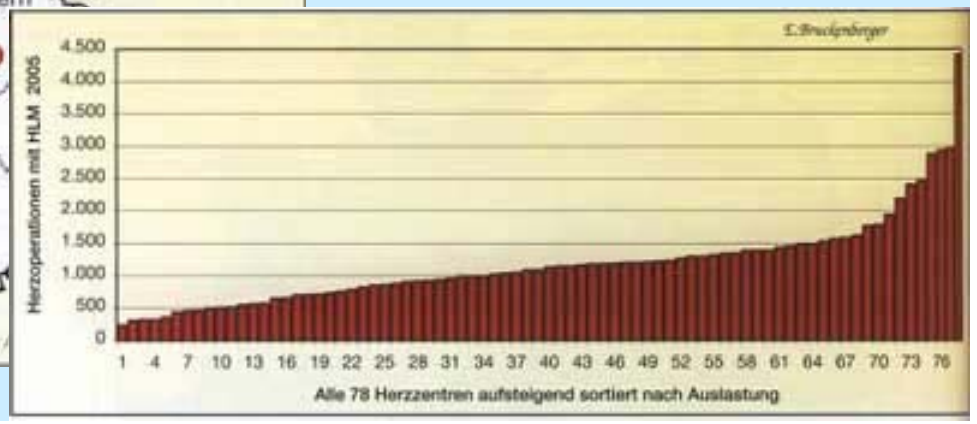
Chirurgische Optionen beim akuten Koronarsyndrom

Henning Warnecke
Schüchtermann-Klinik
Bad Rothenfelde


1.377
Schleswig-Holstein
Hamburg
1.383
Bremen
1.191
Mecklenburg-Vorpommern
1.358
Niedersachsen
1.295
Brandenburg
1.305
Berlin
1.090
Sachsen-Anhalt
1.458
Nordrhein-Westfalen
1.285
Hessen
1.198
1.202
Thüringen
Sachsen
1.118
Rheinland-pfalz
1.248
Saarland
1.554
1.005
Bayern
973
Baden-Württemberg
Herzoperationen pmp
nach Patientenwohnort
ø DL 1.191 pmp
(siehe Tab. 4/14)
< 1.100
1.100 < 1.250
1.250 < 1.360
1.360 < 1.554


Herzoperationen mit HLM 2005
4.500
4.000
3.500
3.000
2.500
2.000
1.500
1.000
500
0
1 4 7 10 13 16 19 22 25 28 31 34 37 40 43 46 49 52 55 58 61 64 67 70 73 76
Alle 78 Herzzentren aufsteigend sortiert nach Auslastung

New York State Database
n = 32099
1991 - 1996

Appropriate timing of surgical intervention after transmural acute myocardial infarction

Daniel C. Lee, MD
Mehmet C. Oz, MD
Alan D. Weinberg, MS
Windsor Ting, MD

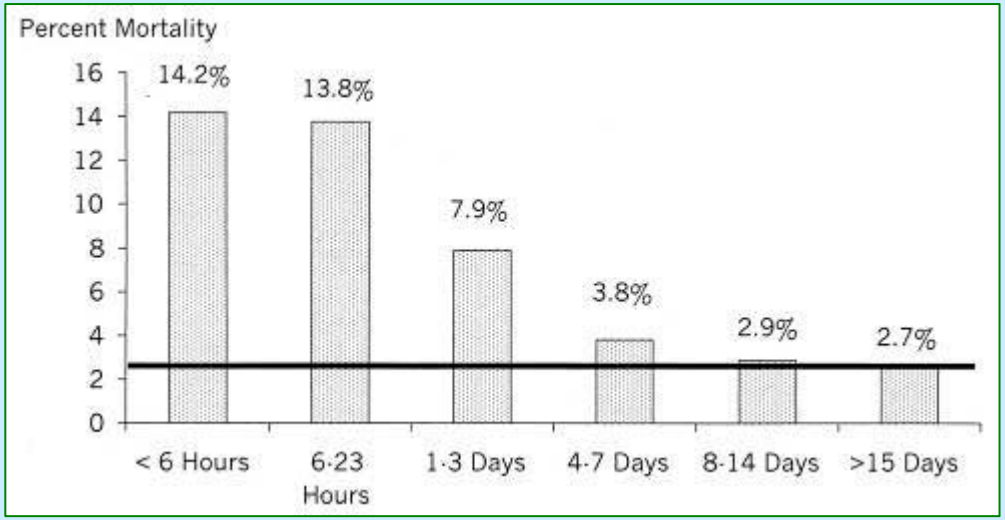
Objective: Recommended timing of coronary revascularization after transmural acute myocardial infarction ranges from immediate surgical intervention to repair 4 weeks after infarction. Such wide variation has created a dilemma in the management of these patients. The objective of this study was to delineate the optimal timing of revascularization after transmural acute myocardial infarction in a large and contemporary patient population.

Methods: We performed a retrospective multicenter analysis of 32,099 patients who underwent coronary artery bypass grafting as the sole procedure after transmural myocardial infarction between 1991 and 1996 by 179 surgeons at 33 hospitals in New York State.

Results: Overall hospital mortality for all patients who underwent coronary revascularization with a history of transmural myocardial infarction was 3.3%. Hospital mortality decreased with increasing time interval between revascularization and transmural acute myocardial infarction: 14.2%, 13.8%, 7.9%, 3.8%, 2.9%, and 2.7% for less than 6 hours, 6 hours to 1 day, 1 to 3 days, 4 to 7 days, 7 to 14 days, and greater than 15 days, respectively. Multivariate analyses of 43 potential risk factors suggests that revascularization within 3 days of transmural acute myocardial infarction is independently associated with mortality.

Conclusions: Coronary revascularization within 3 days of a transmural acute myocardial infarction might be an added risk for mortality. In the absence of absolute indications for emergency surgical intervention, such as structural complications and ongoing ischemia, a 3-day waiting period before surgical revascularization should be considered.

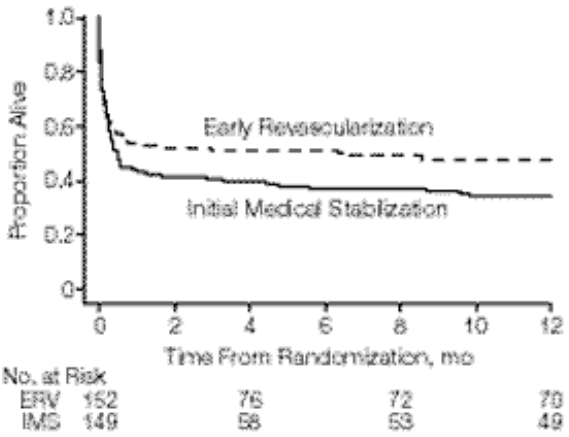
J Thorac Cardiovasc Surg 2003;125:115-120



One-Year Survival Following Early Revascularization for Cardiogenic Shock

Judith S. Hochman, MD
Lynn A. Sleeper, ScD
Harvey D. White, DSc
Vladimir Dzavik, MD
S. Chiu Wong, MD
Venu Menon, MD
John G. Webb, MD
Richard Steingart, MD
Michael H. Picard, MD
Mark A. Menegus, MD
Jean Boland, MD
Timothy Sanborn, MD
Christopher E. Buller, MD
Sharada Modur, MS
Robert Forman, MD
Patrice Desvigne-Nickens, MD
Alice K. Jacobs, MD
James N. Slater, MD
Thierry H. LeJemtel, MD
for the SHOCK Investigators

Figure. Kaplan-Meier Survival Curve 1-Year Postrandomization



Survival estimates for early revascularization (n = 152) and initial medical stabilization (n = 149) groups. Log-rank test $P = .04$. ERV indicates early revascularization group; IMS, initial medical stabilization group.

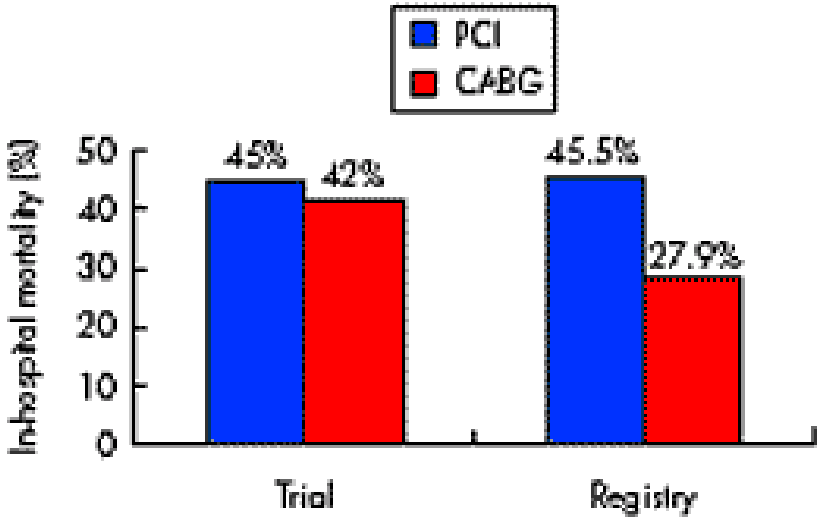


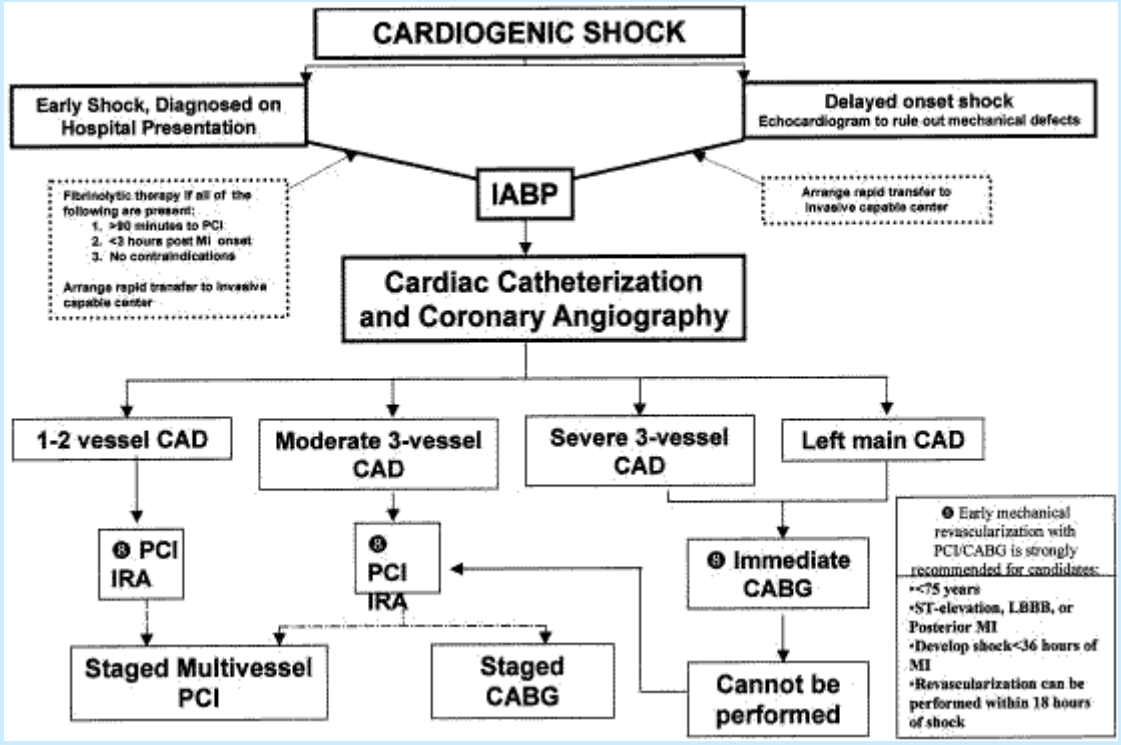
Figure 4 In-hospital mortality with percutaneous coronary intervention (PCI) and coronary artery bypass graft surgery (CABG) in the early revascularisation arm of the randomised SHOCK trial compared to the non-randomised larger SHOCK registry.

ACC/AHA PRACTICE GUIDELINES—FULL TEXT

ACC/AHA Guidelines for the Management of Patients With ST-Elevation Myocardial Infarction

A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee to Revise the 1999 Guidelines for the Management of Patients With Acute Myocardial Infarction)

Developed in Collaboration With the Canadian Cardiovascular Society



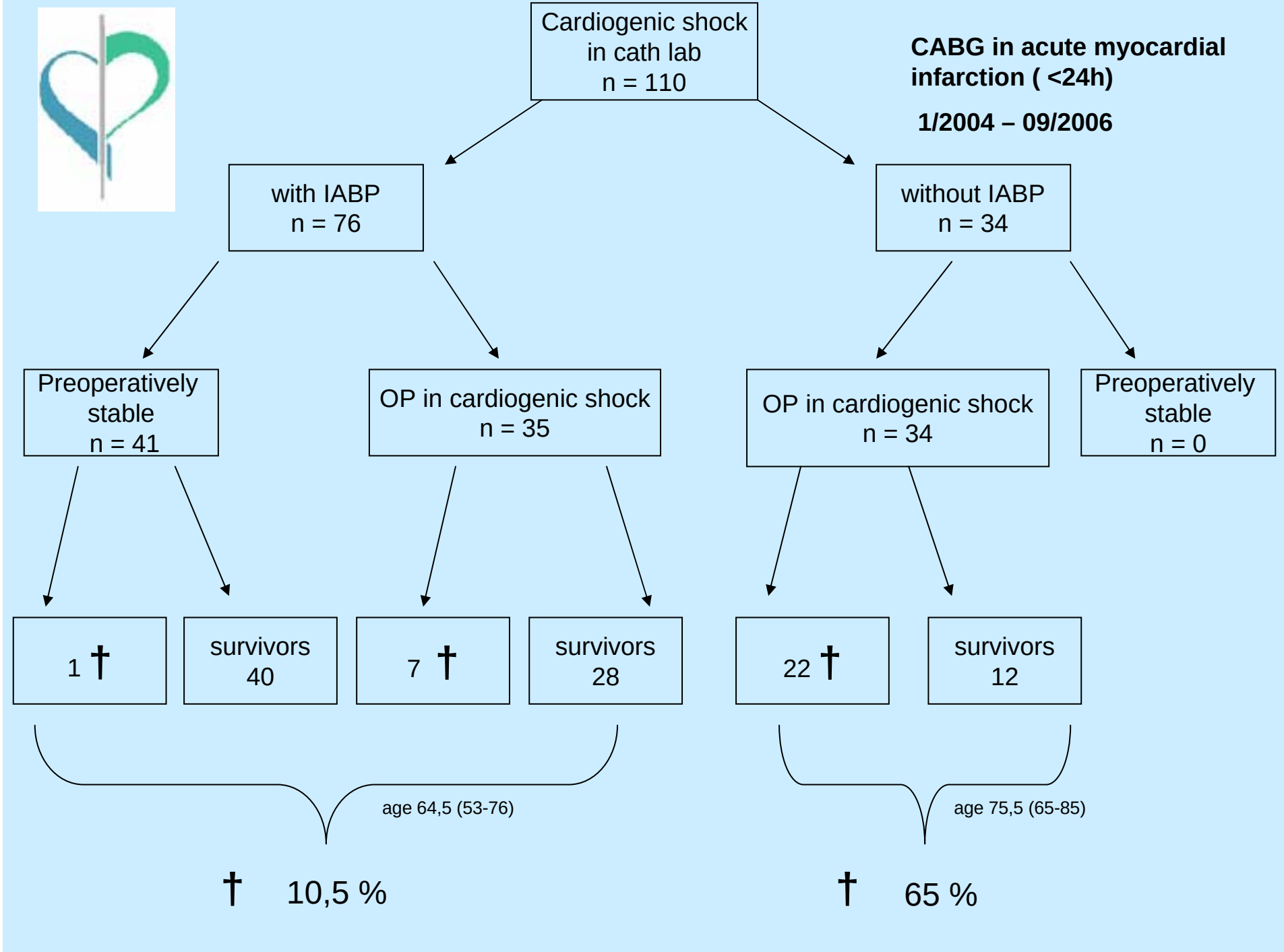
Schüchtermann-Klinik

CABG in acute myocardial infarction (<24h)

1/2004 – 09/2006

n = 321 (30 day mortality 10 %)

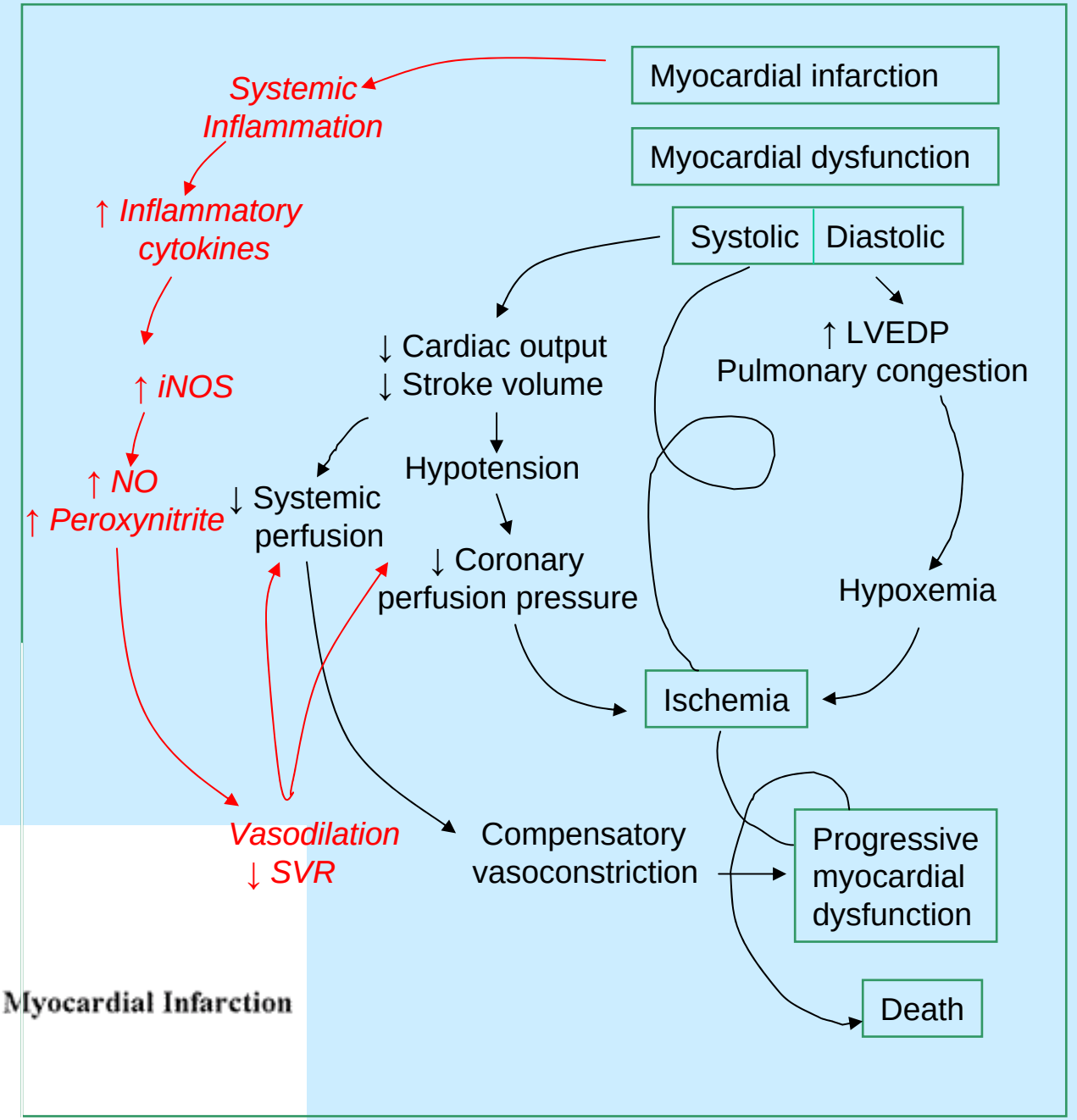
	without shock	Cardiogenic shock
n	211	110
30 day mortality	1,4% 95% CI 0-6	27% 95% CI 8-52 (p < 0,05)
age(years)	67,3 (38-94) n.s.	66,5 (33-85) n.s.
EF < 30%	14,2%	56,3% (p < 0,05)


Cardiogenic shock
in cath lab
n = 110
CABG in acute myocardial infarction (<24h)
1/2004 – 09/2006
with IABP
n = 76
without IABP
n = 34
Preoperatively stable
n = 41
OP in cardiogenic shock
n = 35
OP in cardiogenic shock
n = 34
Preoperatively stable
n = 0
1 †
survivors
40
7 †
survivors
28
22 †
survivors
12
age 64,5 (53-76)
age 75,5 (65-85)
† 10,5 %
† 65 %

Operative Revaskularisation im akuten Koronarsyndrom

- Patienten aus Bielefeld -

		2004	2005	2006
AMI	IABP +	1/0	6/1	9/2
	IABP -	11/3	15/4	13/1
instabile AP		15/1	10/2	12/1
Patienten gesamt		27	31	34



(Circulation. 2003;107:2998.)

Clinician Update

Cardiogenic Shock Complicating Acute Myocardial Infarction

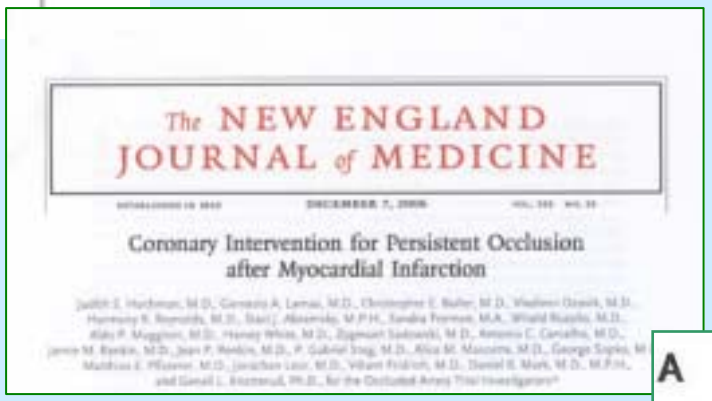
Expanding the Paradigm

Judith S. Hochman, MD

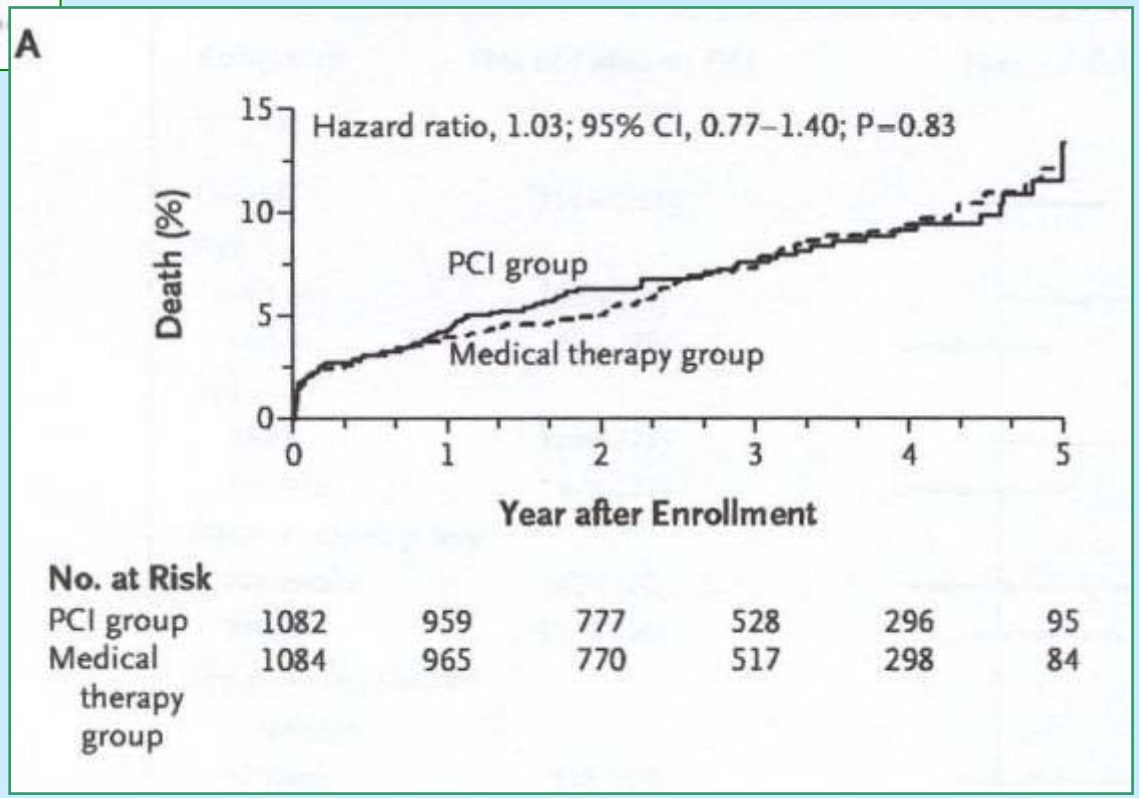
From the Division of Cardiology, New York University School of Medicine, New York.

OPEN ARTERY TRIAL

NEJM 355:2395,2006

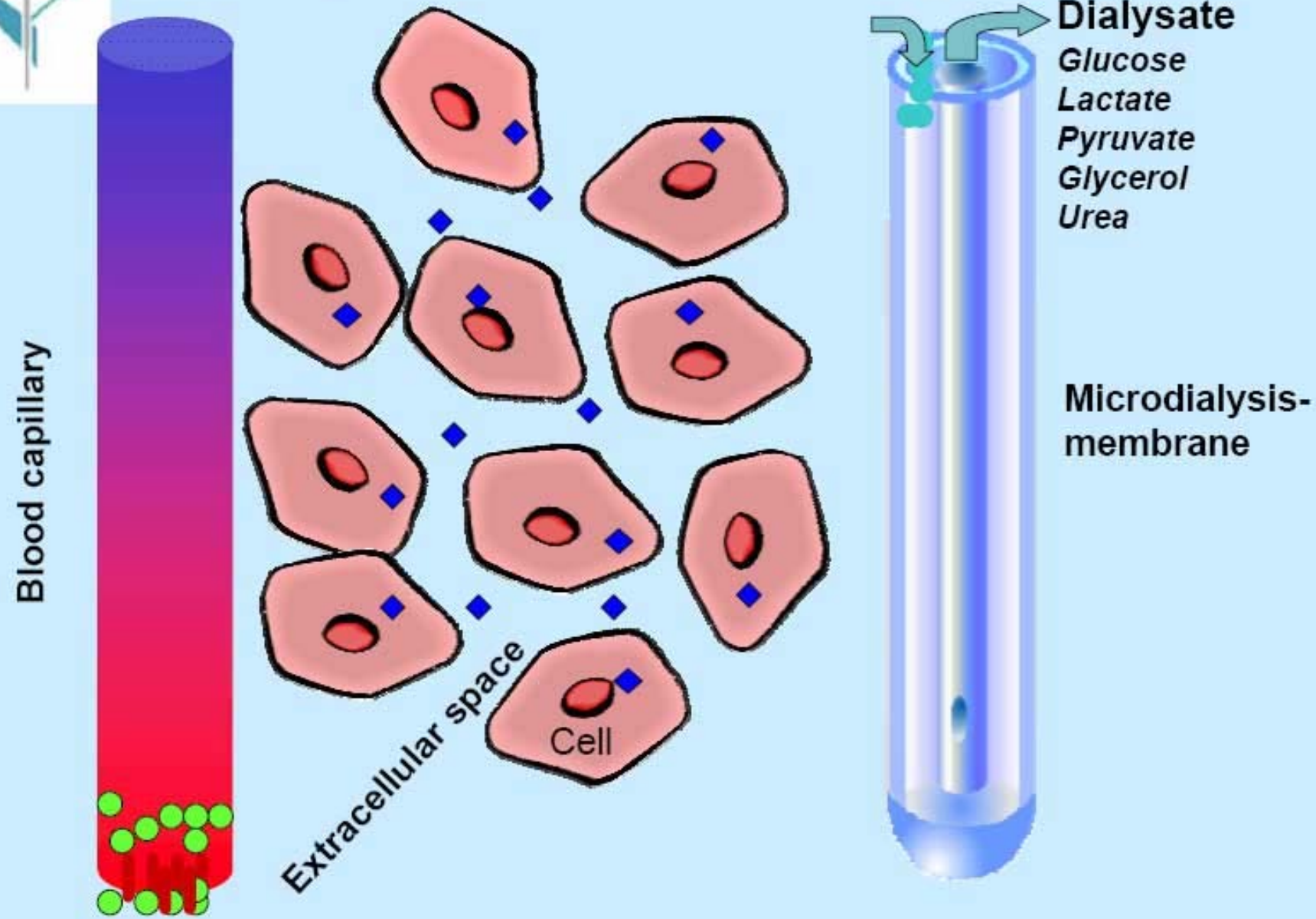

The NEW ENGLAND JOURNAL of MEDICINE

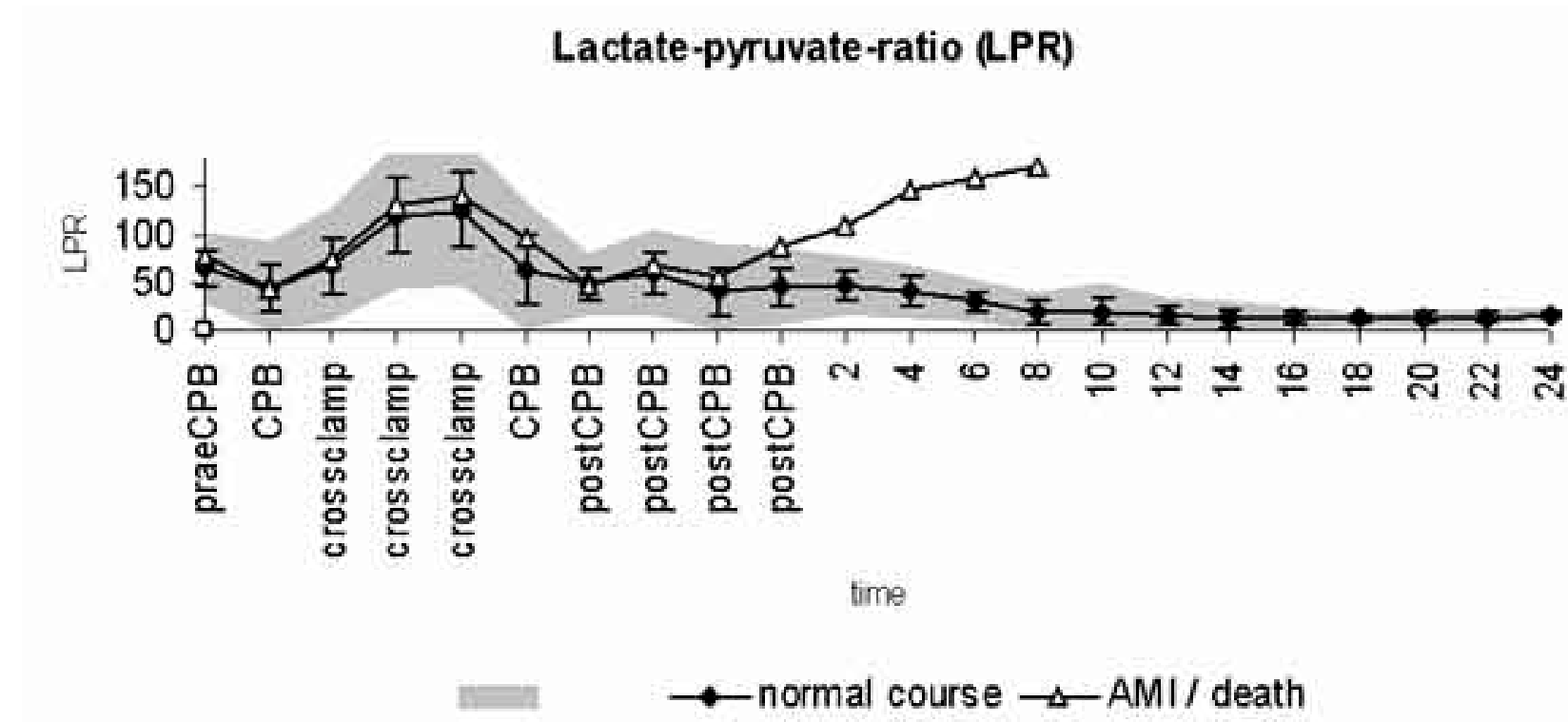
Coronary Intervention for Persistent Occlusion after Myocardial Infarction



No. at Risk						
PCI group	1082	959	777	528	296	95
Medical therapy group	1084	965	770	517	298	84

Myocardial microdialysis




Lactate-pyruvate-ratio (LPR)
LPR
150
100
50
0
praeCPB
CPB
crossclamp
crossclamp
crossclamp
CPB
postCPB
postCPB
postCPB
postCPB
2
4
6
8
10
12
14
16
18
20
22
24
time
normal course
AMI / death

Schlußfolgerungen

- Die sofortige ACVB-OP ist der Sofort-PTCA zumindest gleichwertig
- Die schlechte Prognose des kardiogenen Schocks kann verbessert werden durch
  - → sofortige IABP
  - → Sofort-Operation
- Es bleibt derzeit ungewiß, wie lange nach Infarkteintritt die Revaskularisation sinnvoll ist

Hypothesen und Faustregeln

→ Sofort oder gar nicht

→ IABP lieber zu früh als zu spät

→ Eine offene Arterie ist besser als eine verschlossene

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