

# Perindopril Stalls Post-MI Ventricular Remodeling

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STOCKHOLM — Treatment with the ACE inhibitor perindopril cut the incidence of left ventricular remodeling following myocardial infarction in a study with more than 1,200 elderly patients with preserved left ventricular function.

Perindopril, at a dosage of 8 mg/day, “may be suggested as standard treatment in this clinical setting,” Roberto Ferrari, M.D., said at the annual congress of the European Society of Cardiology.

Based on the results of the Perindopril Remodeling in Elderly with Acute Myocardial Infarction (PREAMI) study and those of seven previous studies, “we now have convincing evidence that all patients with coronary artery disease should get treated with an ACE inhibitor,” commented Nicolas Danchin, M.D., a professor of medicine at the European Hospital Georges Pompidou in Paris.

The PREAMI study enrolled 1,252 patients, average age 72 years, at 109 centers in five European countries. All had a left ventricular ejection fraction of at least 40%; the average ejection fraction was 59%. About 80% of patients had New York Heart Association class I heart failure.

Patients were enrolled 7-20 days (a mean

of 11 days) after their MI. Patients who had already begun treatment with an ACE inhibitor were withdrawn from the drug for at least 24 hours before entering the study. Three-quarters were on a  $\beta$ -blocker, which they continued to take.

Patients were randomized to treatment with either 4-mg perindopril daily or placebo for the first month of the study, after which the drug dosage was raised to 8 mg daily. Patients were followed for a total of 12 months. The study’s primary end point was

the combined incidence of death, hospitalization for heart failure, or left ventricular remodeling. Remodeling was defined as a rise of at least 8% in left ventricular and diastolic volumes. Echocardiographs were available a year after treatment started for 455 perindopril and 441 placebo patients.

The incidence of the primary end point was cut by 38% in patients on perindopril, compared with those on placebo, a statistically significant difference, reported Dr. Ferrari, head of cardiology at the Univer-

sity of Ferrara (Italy). But the result was driven entirely by a 46% relative drop in the rate of ventricular remodeling in the perindopril-treated patients (28%), compared with the controls (51%). There was no difference in the mortality rate.

The study was sponsored by Servier, marketer of perindopril (Coversyl) in Europe and elsewhere. In the United States, perindopril is marketed as Aceon by a partnership of Solvay Pharmaceuticals Inc. and CV Therapeutics Inc. ■

## Hypothermia Linked to Heart Failure Death

STOCKHOLM — Body temperature gauged prognosis in a retrospective analysis of patients hospitalized for heart failure.

Patients hospitalized for heart failure with hypothermia (a body temperature of 96.5°F or less) at admission were fourfold more likely to die during follow-up as were normothermic patients, Mihai Gheorghide, M.D., said at the annual congress of the European Society of Cardiology.

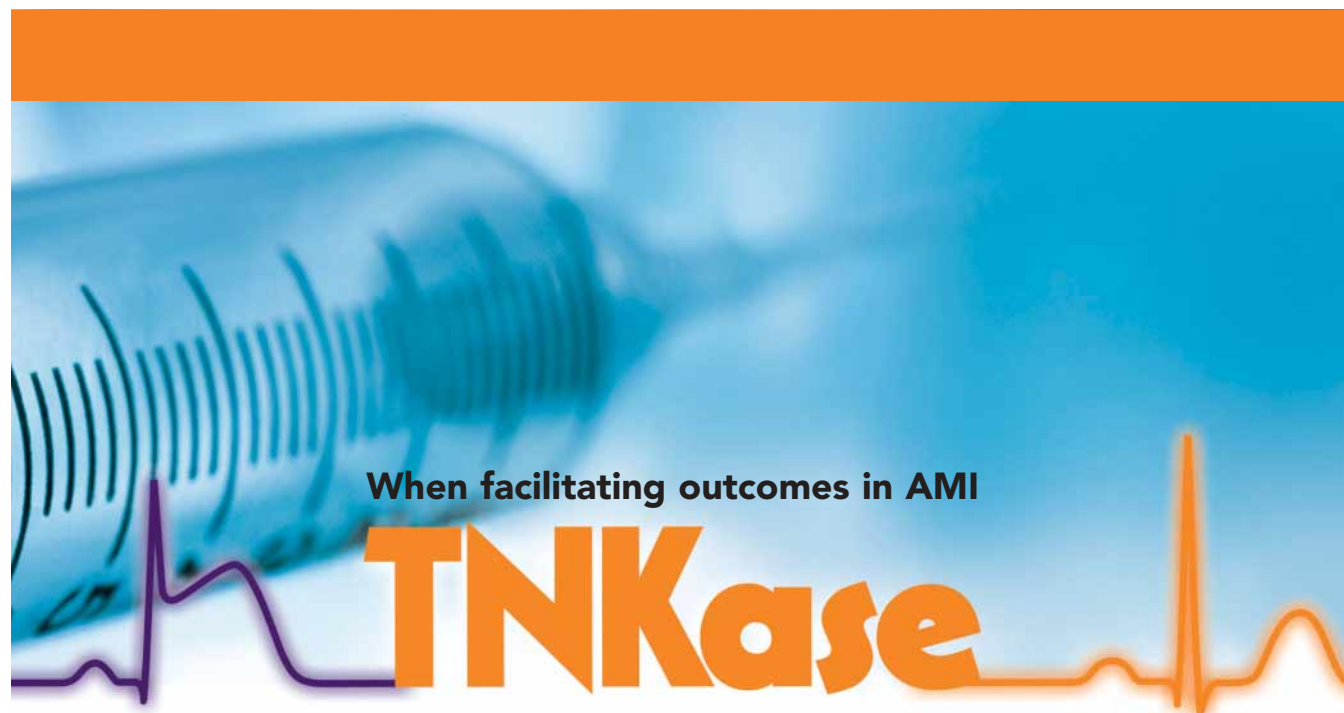
“This is the first report [of the link with hypothermia], so it needs validation before making any conclusion that temperature is a prognostic factor,” said Dr. Gheorghide, professor of medicine at Northwestern University, Chicago.

The correlation was made by reviewing data collected in a study designed to test the safety and efficacy of tolvaptan, an oral vasopressin receptor antagonist, in patients with systolic dysfunction who were hospitalized for worsening heart failure. Of 319 patients enrolled, body temperature readings on admission were available for 315.

Of those patients, 32 had hypothermia. At 60 days, mortality was 9.4% in patients with hypothermia and 5.9% in those with normothermia. After adjustment for baseline differences in blood urea nitrogen, age, and tolvaptan treatment, the patients with hypothermia were 3.9 times more likely to die.

In clinical trials, body temperature should be measured at admission and daily to correlate temperature and heart failure status, Dr. Gheorghide said.

—Mitchel L. Zoler



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Reference 1. Antman EM, et al. ACC/AHA guidelines for the management of patients with ST-elevation myocardial infarction. 2004. Available at <http://www.acc.org/clinical/guidelines/stemi/index.pdf>.

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