Unseen Ischemic Symptoms Result in Poor Care

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WASHINGTON — Myocardial infarction patients who lacked documented ischemic symptoms upon hospital admission received lower quality care, were issued fewer established therapies, and had significantly higher risk-adjusted, in-hospital mortality than those with symptoms, Erik Schelbert, M.D., reported at a meeting sponsored by the American Heart Association.

There was significantly less use of aspirin, β-blockers, and reperfusion therapy in those without ischemic symptoms, who were also more likely to be women, nonwhite, and older than the symptomatic patients.

"Curiously, these trends continued until discharge," said Dr. Schelbert of the University of Iowa, Iowa City.

He presented data from the Prospective Registry Evaluating Outcomes After Myocardial Infarction: Events and Recovery (PREMIER) study, which enrolled 3,960 MI patients in 19 centers during January 2003 through June 2004.

This is the first study to include patient interviews in order to link symptoms with outcomes; 'there is evidence of a significant breakdown in communication.'

Dr. Schelbert and his coinvestigators reviewed the charts of 3,825 patients, comparing Centers for Medicare and Medicaid Services performance measures and in-hospital death data to learn whether ischemic symptoms were documented.

Trauma patients and those with acute GI bleeds, strokes, and hip fractures were excluded.

A subgroup of 2,480 patients was interviewed within 2 days of admission to get their point of view of what brought them to the hospital.

While data from other studies have shown that women, minorities, and older patients often don't show traditional symptoms for MI, this is the first study to include patient interviews in order to link symptoms with outcomes.

Overall, 6.2% of the 3,825 patients had no ischemic symptoms documented in their charts upon admission, but of those who were interviewed, 72% had at least one symptom that would be considered ischemic by current American Heart Association/American College of Cardiology guidelines.

The undocumented symptoms included shortness of breath (50%), chest pain (40%), and nausea (31%).

Although troponin assays confirmed myocardial damage in all patients, the disparities in care were found to persist through discharge.

"Because the lack of documented symptoms of MI and the following lesser-quality care were linked, we inferred that patients' symptoms were not recognized. Clearly, most patients actually did have symptoms, as the interviews then showed," said Dr. Schelbert. It's possible that these patients had comorbidities that made a diagnosis of MI more difficult, he added.

Of those asymptomatic patients eligible during hospital admission, 85% received aspirin vs. 96% of those with symptoms, 64% received β-blockers within 24 hours vs. 85% of patients with symptoms, and 18% received reperfusion therapy vs. 71% of patients with symptoms, all significant differences.

At hospital discharge, patients without ischemic symptoms were less likely than patients with ischemic symptoms to receive aspirin (86% vs. 94%), β-blockers (80% vs. 89%), or ACE inhibitors (58% vs. 69%).

Asymptomatic patients also were less likely to receive statin therapy for secondary MI prevention at LDL cholesterol thresholds of 100 mg/dL (70% vs. 87%) or 70 mg/dL (61% vs. 84%). Unadjusted in-hospital mortality rates were also higher in patients without ischemic symptoms (15% vs. 3%).

"There is evidence of a significant breakdown in communication, and patient symptoms are being missed. The cause of this needs further investigation," said Dr. Schelbert.

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