icantly different at any time point: 96.4% for CABG and 96.5% for PCI at 1 year; 90.7% and 89.7%, respectively, at 5 years.

Angina relief was superior for CABG. At 1 year, 84% of CABG patients, compared with 75% of PCI patients, were free of angina. At 5 years, the proportions were 84% and 79%, respectively.

PCI patients were 24% more likely to require repeat revascularization (26% at 1 year and 40% at 5 years), compared with CABG patients (4% at 1 year and 10% at 5 years).

The review's finding of similar long-term survival for CABG and PCI differ from reports based on clinical registries, which show improved survival after CABG, the investigators noted. "These observations suggest that the seemingly disparate results of randomized trials and clinical registries can be reconciled by taking into account that the overall outcomes in clinical registries are heavily weighted by the large number of events in the higher-risk patients with the most extensive disease, who appear to have better outcomes after CABG than after PCI." By contrast, overall outcomes in the randomized trials "were assessed in intermediate-risk patients, in whom CABG and PCI outcomes were also similar in clinical registries," they explained. ■

Anemia Tied to Worse Acute Coronary Syndrome Outcomes

BY MITCHEL L. ZOLER
Philadelphia Bureau

VIENNA — Anemia was a significant risk factor for worse outcomes in patients with acute coronary syndrome in a post hoc analysis of almost 14,000 patients enrolled in a recent trial.

Despite this evidence of anemia's risk, it's premature to conclude that treating anemia—either with blood transfusions or with erythropoietin—is the best way to reduce the risk, Dr. Roxana Mehran said at the annual congress of the European Society of Cardiology.

"We believe that anemia is another risk factor, like age or diabetes, but there may be confounders when you find anemia in ACS [acute coronary syndrome] patients, so it's hard to tease out," said Dr. Mehran, director of outcomes research at the center for interventional vascular therapy at Columbia University, New York.

The effects of anemia in ACS were studied using data collected on 13,819 patients with either unstable angina or non-ST elevation myocardial infarction enrolled in the ACUITY (Acute Catheterization and Urgent Intervention Triage Strategy) trial. The primary end point of the study showed that benefit and risk from treatment with the antithrombotic drug bivalirudin (Angiomax) alone was similar to standard treatment with a heparin (either unfractionated heparin or low-molecular-weight heparin) plus a glycoprotein IIb/IIIa inhibitor, or to treatment with bivalirudin plus a GP IIb/IIIa inhibitor (N. Engl. J. Med. 2006;355:2203-16).

The trial was sponsored by the Medicines Co., which markets Angiomax. Dr. Mehran is a speaker for and had received honoraria from the Medicines Co.

Anemia information at baseline was available for about 94% of patients, including 10,839 without anemia and 2,200 with anemia. The primary end point in the ACUITY trial was a composite risk and benefit measure for the first 30 days after treatment that added the total number of deaths, myocardial infarctions, unplanned revascularization procedures, and major bleeding events. For the patients with anemia, the rate was 16.2%, compared with a 10.2% rate in the nonanemic patients, a statistically significant difference, said Dr. Mehran. Anemia was linked with significantly worse outcomes for each of these outcome measures, except for the rate of unplanned revascularization. (See box.) The worse outcomes of patients with anemia were also seen uniformly regardless of how the ACS patients were managed. ■