Atherothrombosis Linked to Major CV Events

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ATLANTA — Stable outpatients with atherothrombosis who receive contemporary therapy have a "staggeringly high" one in eight risk of a major adverse cardiovascular event within 1 year, Dr. P. Gabriel Steg reported at the annual meeting of the American College of Cardiology.

A key finding of his initial report from the 68,000-patient Reduction of Atherothrombosis for Continued Health (REACH) registry was that this event risk increased in stepwise fashion with the number of symptomatic vascular beds.

"The overlap between symptomatic vascular beds is what really drives the event rates and takes them very high," observed Dr. Steg, professor of cardiology at the University of Paris and director of the coronary care unit at Bichat-Claude Bernard Hospital.

The clinical implication for physicians is that they need to avoid interpreting atherothrombosis solely from the perspective of their particular specialty, be it cardiology, neurology, or vascular medicine. "We have to stop viewing our patients with atherothrombosis as being affected with one disease. Instead, we have to view the disease as a global disease affecting all vascular beds, and we have to seek, identify, and treat the other vascular locations," he stressed.

REACH is an ongoing real-world registry of patients in 44 countries, including 28,000 patients from North America and 18,000 from Europe. It was designed to characterize the burden of atherothrombosis in stable outpatients who were managed mainly in primary care settings. Indeed, 70% of the participants were recruited by family physicians and internists, who were encouraged to enroll patients consecutively. There is a paucity of data on such patients—most large studies of atherothrombosis have been confined to patients during or shortly after hospitalization for MI or stroke.

Participants in REACH had to have a history of symptomatic coronary artery, cerebrovascular, or peripheral vascular disease, or at least three risk factors. Two-thirds had symptomatic disease in one arterial bed, 16% had polyvascular disease, and 18% had risk factors alone.

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Dr. Steg characterized the medical management of REACH participants as "pretty good," with three-quarters on a statin, half on a β-blocker, half on an ACE inhibitor, one-quarter on an angiotensin receptor blocker, and three-quarters on antiplatelet therapy, mainly aspirin alone.

The 1-year composite rate of cardiovascular death, nonfatal MI or stroke, or hospitalization for an ischemic event was 5% in patients with multiple risk factors only, and two- to threefold greater in patients with symptomatic disease in one vascular bed. One in four patients with symptomatic polyvascular disease experienced the composite end point in the first year.

Restricting the analysis to "hard" cardiovascular events—death, MI, or stroke—the 1-year incidence was 1.5% in patients with risk factors only, 3.4% in those with symptomatic disease in either the coronary, cerebral, or peripheral arteries, 5.7% in patients with symptomatic disease in two vascular beds, and 7.1% in those with documented disease in three arterial beds.

Five percent of patients with documented coronary artery disease underwent coronary revascularization within 1 year. In patients with cerebrovascular disease, 1.1% had carotid stenting or surgery. And more than 11% of patients with baseline documented peripheral arterial disease required peripheral angioplasty, stenting, vascular surgery, or amputation of a lower limb. "The 1-year 1.3% amputation rate came as a surprise," Dr. Steg said.

The event rates varied markedly by geography, with Eastern Europeans and Middle Easterners consistently having the highest rates.

REACH, sponsored by Sanofi-Aventis and Bristol-Myers Squibb, will continue for 4 years of follow-up and will include intervention phases. Dr. Steg is a consultant to the sponsors. ■

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