

Attacking the attack

In the hospital, if a heart attack seems to be occurring after the appropriate studies (electrocardiogram, cardiac enzymes, troponin and, in some facilities, a coronary angiography), it is determined whether or not there is an ongoing heart attack and, if so, immediate interventions are initiated.



DRUG BLOCK

ALL THINGS MEDICAL

These include the use of clot stabilizers like heparin, intravenous infusion of thrombolytic, then, if need be, an invasive procedure such as coronary angioplasty. In many of these patients, a stent or a reinforcing tube is placed within the vessels to prevent its collapse.

For the last several months, I have been recommending Plavix (clopidogrel). This works very much like the clot-

buster that is given in the IV at the hospital to "dissolve" clots. As early as 1996, F. Bachman published information in the "European Heart Journal" that a high dose of Plavix will thwart the thrombotic process. There are now ongoing double-blind control studies which will be available in the next three years, detailing the effectiveness of this therapy. Why wait until the literature becomes black and white? It is clear enough for me to see now that this is going to be paramount in the treatment of acute heart attack prevention. Therefore, I give my potential heart attack patients a loading dose of 300-450 mg of Plavix to keep with them at all times, to chew and swallow immediately after calling 911 on the first symptom of heart attack, for example, sustained chest pressure. By the time the ambulance arrives there is a fair chance the heart attack will be aborted.

An important step in the prevention of heart attacks is to identify who needs to carry the Plavix and be ready to attack the heart attack. It is a given

that, if a patient has already had an acute coronary event, he/she is 50 times more vulnerable to have a heart attack than a person who has not.

But what about the folks who have never had a heart attack? In our office, we monitor patients by a variety of ways. The most important is the history of risk factors, such as smoking, previous stroke, high blood pressure, blood studies, lipid profile, homocysteine, fibrinogen, microalbumin, and High-sensitivity C-Reactive Protein (HsCRP). Other tests include treadmill stress tests sometimes done with thallium, EKGs, ultrasound of the carotids (looking for plaque), and finally a coronary angiogram. HsCRP is something so important that people should know this number more than any other test. This has been shown to predict an acute cardiovascular event in the near future better than all the other studies as indicated in US News and World Report of Nov. 22, 2002.

Next week, how to treat a vulnerable patient.