Arq Bras Cardiol
2002; 78: 439-40.

Dear Dr. Kursaklioglu and colleagues,

Thank you for comments regarding the paper from our authorship. In order to answer your questions:

1) These data were taken from American Heart Association report on elderly population. Off course, the data is underestimated and always will be surpassed by the delay in presenting it. However, we lack from similar data regarding the whole world population. And even having that, there will be always a great chance that it will never be so accurate, for many geographic and temporal reasons. In Brazil [1], for example, the last annual demographic census had demonstrated that the Brazilians had a progressively higher expectancy of life. In 1999, the Brazilians with age higher than 60 years already constitutes 10% of the whole population, an elevation of 14.5%, compared to the data from 1995. We could understand your expectations, but the message is clear, that the population is getting older with all the implications related to that fact.

2) We were not aware that any emergency room waits for the arrival of serum cardiac markers in order to start coronary reperfusion, either by using thrombolytics or mechanical method, after the clinical diagnosis of acute myocardiol infarction (AMI) is done (pain and EKG changes). For your information, all patients submitted to primary PCI in our Institution underwent serum cardiac marker (CKMB) analysis. In the first 48 hours after AMI, four times, and after that, twice a day, until it gets in the normal range. In these patients, the highest mean peak of CKMB was 79,43±44,85 IU. In our opinion, in patients with acute coronary syndrome and ST segment elevation, cardiac enzymes can clarify the final extension of myocardial infarction, with its prognostic implications, but were not helpful as a tool to confirm the diagnosis of myocardial infarction, that still is purely clinical.

3) We had been practicing primary PTCA since 1983, with nearly 2,000 patients treated until now [2,3]. We always perform left ventriculogram in these patients without any major complications. First, it is safe, if you take care of not performing excessive LV manipulation, avoiding the creation of ectopic beats. Second, you can perform a good LV angiogram with at least 10 cc of dye, a similar quantity of contrast used for a coronary injection. Third, it provides so much amount of information, for the patient and operator, in an acutely fashion, regarding the patient status, risk and prognosis. Sometimes, poor experienced PTCA operators spend more contrast during the performance of a PTCA, than performing a LV angiogram. In the past, we presented our experience with that, demonstrating how safe and valuable is the information provided by it[4-6]. We also participate in two major international randomized trials regarding primary PCI in AMI (STENT PAMI and CADILLAC), and its performance was not a contraindication[7]. In the SENIOR PAMI trial, LV angiogram is not encouraged, not related to any additional hemodynamic risks, but in order to avoid a potential renal failure, in elderly patients who were not aware of their plasma creatinine levels. Off course, we did not perform it in patients in a very poor hemodynamic status. In order to clarify you, the mean value of left ventricular ejection fraction reported in the present analysis was related to the ones that perform it. In the elderly population (≥70 years), 6 (6,4%) patients did not perform that, for the reasons explained above.

4) For this analysis, we did not measure the time spent from cath lab arrival and first balloon inflation. Thus you were aware that primary PTCA delay is a controversial theme, regarding the apparent lack of relationship between delay and primary PTCA success[8,9].

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