Ten Points to Remember from the 2007 STEMI Guideline Update

Based on the 2007 Focused Update of the 2004 Guidelines for the Management of Patients With ST-Elevation Myocardial Infarction: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines

Antman EM, Hand M, Armstrong PW, et al., for the 2007 Writing Group to Review New Evidence and Update the ACC/AHA 2004 Guidelines for the Management of Patients With ST-Elevation Myocardial Infarction, Writing on Behalf of the 2004 Writing Committee.

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1. Patients routinely taking NSAIDs (except for aspirin), both nonselective as well as COX-2 selective agents, before STEMI should have those agents discontinued at the time of presentation with STEMI because of the increased risk of mortality, reinfarction, hypertension, heart failure, and myocardial rupture associated with their use.

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2. Oral beta-blocker therapy should be initiated in the first 24 hours for patients who do not have any of the following:
   - a) Signs of heart failure
   - b) Evidence of a low output state
   - c) Increased risk for cardiogenic shock
   - d) Other relative contraindications to beta blockade
     - PR interval > 0.24 seconds
     - Second- or third-degree heart block
     - Active asthma or reactive airway disease

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3. STEMI patients presenting to a hospital with PCI capability should be treated with primary PCI within 90 minutes of first medical contact as a systems goal.
4. STEMI patients presenting to a hospital without PCI capability and who cannot be transferred to a PCI center and undergo PCI within 90 minutes of first medical contact should be treated with fibrinolytic therapy within 30 minutes of hospital presentation as a systems goal unless fibrinolytic therapy is contraindicated.

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5. A strategy of coronary angiography with intent to perform PCI (or emergency CABG) is recommended for patients who have received fibrinolytic therapy and have any of the following:
   - Cardiogenic shock in patients <75 years who are suitable candidates for revascularization,
   - Severe congestive heart failure and/or pulmonary edema (Killip class III), or
   - Hemodynamically compromising ventricular arrhythmias

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6. Patients undergoing reperfusion with fibrinolytics should receive anticoagulant therapy for a minimum of 48 hours and preferably for the duration of the index hospitalization, up to 8 days (regimens other than unfractionated heparin [UFH] are recommended if anticoagulant therapy is given for more than 48 hours because of the risk of heparin- induced thrombocytopenia with prolonged UFH treatment).

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7. Clopidogrel 75 mg per day orally should be added to aspirin in patients with STEMI regardless of whether they undergo reperfusion with fibrinolytic therapy or do not receive reperfusion therapy. Treatment with clopidogrel should continue for at least 14 days.
8. Every tobacco user and family members who smoke should be advised to quit at every visit.

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9. For all post-PCI STEMI stented patients without aspirin resistance, allergy, or increased risk of bleeding, aspirin at a dose of 162-325 mg daily should be given for at least 1 month after bare-metal stent (BMS) implantation, 3 months after sirolimus-eluting stent implantation, and 6 months after paclitaxel-eluting stent implantation, after which long-term aspirin use should be continued indefinitely at a dose of 75-162 mg daily.

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10. For all post-PCI patients who receive a drug-eluting stent, clopidogrel 75 mg daily should be given for at least 12 months if patients are not at high risk of bleeding. For post-PCI patients receiving a BMS, clopidogrel should be given for a minimum of 1 month and ideally up to 12 months (unless the patient is at increased risk of bleeding; then it should be given for a minimum of 2 weeks).