

Occurrence and predictors of left ventricular systolic dysfunction at hospital discharge and in long-term follow-up after acute myocardial infarction treated with primary percutaneous coronary intervention

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Abstract

Background: Post-ST-segment elevation myocardial infarction (STEMI) left ventricular systolic dysfunction (LVSD) has been identified as an important marker of poor prognosis.

Aim: To assess the prevalence and course of LVSD at hospital discharge and in long-term follow-up in STEMI patients treated with primary percutaneous coronary intervention (pPCI).

Methods: We enrolled 205 patients (157 male, 48 female) with a first STEMI. Echocardiography was performed before hospital discharge and 12 months after STEMI. Left ventricular systolic function (LVSF) parameters were assessed: left ventricular ejection fraction (LVEF), wall motion score index (WMSI), and average peak systolic mitral annular velocity (S') by tissue Doppler echocardiography (TDE). B-type natriuretic peptide plasma concentration was measured at admission ($\text{BNP}_{\text{admission}}$) and at discharge ($\text{BNP}_{\text{discharge}}$).

Results: We found moderate LVSD, both at hospital discharge and after 12 months. Significant global LVSD ($\text{LVEF} \leq 40\%$) was observed in 34% of patients at discharge, and 21% after 12 months ($p < 0.001$). Significant regional LVSD ($\text{WMSI} \geq 1.7$) after 12 months was less frequent than at discharge (21% vs 33%; $p < 0.001$). More patients had significant longitudinal LVSD ($S' \leq 6.0 \text{ cm/s}$) after 12 months compared to discharge (28% vs 23%; $p < 0.001$). Severe global LVSD ($\text{LVEF} \leq 30\%$) was rare. Univariate logistic regression analysis revealed the predictors of significant global LVSD at 12 months after STEMI to be: anterior location of STEMI; pre-discharge echocardiographic parameters of LVSF and left ventricle size and mass; pre-pPCI angiographic indices; ratio of the difference of $\text{BNP}_{\text{discharge}}$ and $\text{BNP}_{\text{admission}}$ to $\text{BNP}_{\text{admission}}$ expressed as % ($\text{BNP}_{\text{delta}}\%$); time from onset of pain to balloon, and the use of abciximab. Multivariate logistic regression analysis found independent predictors of significant global LVSD at 12 months to be: $\text{BNP}_{\text{delta}}\%$ and LVEF at discharge with optimal cut-off values of 728.2% for $\text{BNP}_{\text{delta}}\%$ and 37% for LVEF.

Conclusions: Patients with a first STEMI treated with pPCI present moderate LVSD, both at hospital discharge and after 12 months. In long-term follow-up, we found an improvement in global LVSF, and, albeit a smaller, improvement in regional LVSF. No improvement in longitudinal LVSF was observed. The increase of BNP during hospitalisation, and LVEF at discharge, are independent predictors of significant global LVSD at 12 months after a first STEMI treated with pPCI. Pre-discharge peak systolic mitral annular velocity obtained by TDE may be useful in predicting LVEF in long-term follow-up in this group of patients.

Key words: acute myocardial infarction, primary percutaneous coronary intervention, left ventricular systolic function, two-dimensional echocardiography, tissue Doppler echocardiography

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INTRODUCTION

Mortality reduction in acute ST-segment elevation myocardial infarction (STEMI) due to the use of primary percutaneous coronary intervention (pPCI) has resulted in greater survival of STEMI patients endangered by the development of left ventricular systolic dysfunction (LVSD) [1–3]. The lack of a common and routine pre- and post-discharge assessment of left ventricular systolic function (LVSF), as well as methodological difficulties, mean that data is sparse concerning the long-term prevalence and course of LVSD following STEMI treated with pPCI [2–5]. Methods of detection and monitoring of LVSD in STEMI patients should be simple, objective, non-invasive and feasible for common implementation. Two-dimensional transthoracic echocardiography (TTE) enables the assessment of global and regional LVSF [6]. Left ventricular ejection fraction (LVEF) is a well-recognised marker of LVSF and an independent prognostic factor [6, 7]. The Simpson method commonly applied for the calculation of LVEF requires, however, good visualisation of the endocardial border line as well as an experienced echocardiographer. Tissue Doppler echocardiography (TDE) is a highly promising diagnostic tool offering advantages such as quantitative assessment of myocardial function, good time resolution, and considerable independence from echocardiographic views, thus providing new possibilities of diagnosis and monitoring of LVSD [8, 9]. Average peak systolic mitral annular velocity (S') of > 4 cm/s has been identified in the literature as the cut-off point for the prediction of cardiac events after STEMI, and average peak systolic mitral annular velocity (S') of < 7.5 cm/s has been reported as being evidence of subendocardial damage due to myocardial infarction (MI), and a cut-off point in predicting a preserved global LVSF after a first MI [10, 11].

The evaluation of B-type natriuretic peptide plasma concentration (BNP) is a useful tool for detecting left ventricular (LV) dysfunction and a risk marker for adverse clinical outcome after STEMI [12–14].

The aim of this study was to assess the prevalence and course of LVSD at hospital discharge and in a long-term follow-up in STEMI patients treated with pPCI, using TTE and TDE.

METHODS

Study design and patient characteristics

We enrolled 205 patients (157 male, 48 female) with a first STEMI, admitted for pPCI between 25 November 2005 and 27 November 2008. The inclusion criteria were: (i) typical stenocardial chest pain of at least 30 min' duration, (ii) onset of symptoms < 12 h before hospital admission, and (iii) features of acute STEMI in ECG (ST-segment elevation ≥ 0.1 mV in at least two limb leads or ≥ 0.2 mV in at least two precordial leads). The exclusion criteria were: (i) prior coronary revascularisation, (ii) cardiogenic shock on admission, (iii) heart failure NYHA $\geq$ III, (iv) bundle branch block, (v) permanent

atrial fibrillation, (vi) haemodynamically severe valvular heart disease, (vii) primary cardiomyopathies, (viii) severe arterial hypertension, and (ix) creatinine concentration > 176.8 mmol/L. The BNP was measured with a chemiluminescent microparticle immunoassay (analyser: Architect ci 8200, Abbott) at admission ($\text{BNP}_{\text{admission}}$) and at discharge ($\text{BNP}_{\text{discharge}}$). Total major clinical adverse events (MACEs) were defined as: death, non-fatal reinfarction, revascularisation, stroke and hospitalisation for heart failure during the 12 month follow-up. Restenosis was defined as the decrease of infarct-related artery (IRA) flow caused by $\geq 50\%$ diameter stenosis in the post-pPCI segment, present in coronarography performed during follow-up. We obtained approval from the Local Bioethics Committee. All patients gave written, voluntary, informed consent for participation in the study.

Coronarography and percutaneous coronary intervention

Coronarography (at admission and after six months) and pPCI were performed using a standard artery approach. The use of abciximab was left to the operator's discretion. Intracoronary stents were routinely implanted. The coronary artery luminal stenosis was measured with quantitative coronary angiography (QCA). Epicardial coronary flow was assessed according to the TIMI (Thrombolysis in Myocardial Infarction) score and TFC (TIMI frame count), and myocardial perfusion according to the TMPG (TIMI Myocardial Perfusion Grade).

Echocardiography

The TTE recordings employing the Doppler technique were acquired before discharge (d) and 12 months after discharge (fu) using a Philips Sonos 7500 Ultrasound System, according to the protocol recommended by American Society of Echocardiography [15]. We assessed the sizes of the heart chambers, myocardium wall thickness, and the following LVSF parameters: (i) LVEF (measured with the biplane method of discs in four- and two-chamber views) and (ii) wall motion score index (WMSI), derived as the sum of all scores divided by the number of segments visualised, implementing the 16-segment model of LV segmentation and assigning a score of 1, 2, 3, and 4 points for normokinesia, hypokinesia, akinesia, and dyskinesia, respectively [15, 16]. Left ventricular mass index (LVMI) was calculated according to the Devereux formula [17]. Measurements of peak systolic mitral annular velocities were obtained for four basal segments of LV (septal, lateral, inferior and anterior) using pulsed TDE with the Doppler gate targeted at the junction of LV walls with mitral annulus in four- and two-chamber views.

Average peak systolic mitral annular velocity (S') and average septal and lateral peak systolic mitral annular velocity (S'') were obtained [8]. The LVSF was classified: (i) global according to the value of LVEF: $> 50\%$ — as preserved; $\leq 50\%$ and $> 40\%$ — as moderate LVSD; $\leq 40\%$ — as significant

LVSD; $\leq 30\%$ — as severe LVSD; (ii) regional according to the value of WMSI: < 1.3 — as preserved; ≥ 1.3 and < 1.7 — as moderate LVSD; ≥ 1.7 — as significant LVSD; and (iii) longitudinal according to the value of S' : > 7.5 cm/s — as preserved; ≤ 7.5 cm/s and > 6.0 cm/s — as moderate LVSD; ≤ 6.0 cm/s — as significant LVSD [6, 8, 10, 11]. For the next stage of analysis, according to the values of LVEF at discharge, patients were divided into groups as follows: with significant global LVSD (the group EF $\leq 40\%$), and without significant global LVSD (the group EF $> 40\%$).

Statistical analysis

Statistical analysis was carried out using the Statistica 8.0 package. Due to the fact that data distribution was different from normal, based on the Shapiro-Wilk W-test and the Kolmogorov-Smirnov test, the results are presented as the median value and IQ range for quantitative parameters and as a percentage of the population for qualitative parameters. Analysis of the differences between subgroups was performed using a non-parametric test (the Mann-Whitney U-test or the Kruskal-Wallis ANOVA). Wilcoxon's signed rank test was used to evaluate dependent samples. The χ^2 test (with the Yates correction if needed) was used for qualitative variables. The correlation between two variables was studied with Pearson's test or Spearman's log-rank correlation test, depending on whether the variables were normally distributed or not. A univariate and multivariate logistic regression model was used to identify risk factors for the incidence of LVSD. The optimum cut-off points were determined using receiver operator characteristics (ROC) curve analysis. A two-sided difference was considered significant at $p < 0.05$.

RESULTS

The clinical characteristics of the patients are shown in Table 1. Post-pPCI IRA flow assessment compared to pre-pPCI values showed a reduction in luminal stenosis ($11.2\% \pm 7.8\%$ vs $93.7\% \pm 10.3\%$; $p < 0.001$), an increase in TIMI grading (grade 3 in 92.7% vs 27.3% of patients; $p < 0.001$), and a decrease of TFC (26.1 ± 17.2 vs 75.8 ± 33.4 frames; $p < 0.001$). Coronary microcirculation perfusion in the infarcted area after pPCI was estimated for TMPG grade 3 in 46.7% of patients. Intracoronary stent placement during pPCI was performed in 98.5% of cases (98% — a bare metal stent). Infusion of abciximab was implemented in 24% of patients. The BNP increased during hospitalisation ($p < 0.001$). Both BNP_{admission} and BNP_{discharge} and the ratio of the difference of BNP_{discharge} and BNP_{admission} to BNP_{admission} expressed as % (BNP_{delta} %) were higher in the group EF $\leq 40\%$ compared to the group EF $> 40\%$ (62.3 vs 45.8 pg/mL; $p = 0.004$; 252.8 vs 91.4 pg/mL; $p < 0.001$ and 538.7% vs 194.1% ; $p = 0.004$ respectively).

The echocardiographic characteristics of the studied group at hospital discharge, and 12 months after STEMI, are summarised in Table 2. At 12 month follow-up, we observed an

Table 1. Demographic and clinical characteristics of the study population

Analysed feature	Value
Age [years]	56.0 (33.0–79.0)
Gender [male/female]	157/48 (76.6/23.4%)
Anterior location of myocardial infarction	98 (47.8%)
Time from onset of pain to balloon [min]	208.0 (50.0–720.0)
Multivessel coronary disease	128 (62.4%)
CK-MB [U/L]	26.0 (6.0–452.0)
CK-MB24 [U/L]	94.0 (12.0–543.0)
TnI [ng/mL]	0.3 (0.0–37.9)
TnI max [ng/mL]	47.0 (0.31–50.0)
Admission glycaemia [mmol/L]	7.6 (4.6–28.7)
HbA1c [%]	6.1 (4.8–11.7)
Body mass index [kg/m ²]	26.8 (17.3–44.3)
BNP _{admission} [pg/mL]	51.2 (10.0–1,591.0)
BNP _{discharge} [pg/mL]	124.1 (10.0–1,716.0)
BNP _{delta} %	313.5% (237.7–389.3%)
Abdominal circumflex [cm]	99.0 (65.0–130.0)
Arterial hypertension	89 (43.4%)
Diabetes mellitus	44 (21.5%)
Current smoker/history of smoking	109 (53.2%)/23 (11.2%)
Positive cardiovascular family history	45.0 (22%)
LDL/HDL/TG [mmol/L]	$3.7 \pm 1.2/1.3 \pm 0.3/1.0 \pm 0.9$
Angina prior to myocardial infarction	75 (36.6%)
Heart failure (NYHA I/II) prior to MI	6 (2.9%)
Medication at discharge:	
Aspirin	100%
Clopidogrel/ticlopidine	76.1%/23.4%
Statins	100%
ACE inhibitors	98%
Beta-blockers	99%

Results are presented as the median value and IQ range or as number (percentage) of the study population; CK-MB — activity of CK-MB in the blood on admission; CK-MB24 — activity of CK-MB in the blood 24 h after admission; TnI — concentration of troponin I in the blood on admission; TnI max — peak concentration of troponin I in the blood; HbA1c — level of glycated haemoglobin on admission; BNP — B-type natriuretic peptide plasma concentration; BNP_{delta} % — ratio of the difference of BNP between discharge and admission to BNP at admission expressed as %; MI — myocardial infarction; LDL — LDL-cholesterol; HDL — HDL-cholesterol; TG — triglycerides

increase in left chamber size, LVMI and LVEF, a decrease in WMSI, with no significant changes in S' . The prevalence of preserved global and regional LVSD at discharge vs after 12 months differed significantly (18% vs 34% ; $p < 0.001$; 4% vs 18% ; $p < 0.001$, respectively) (Fig. 1A, B). Significant global LVSD was found in 34% of patients at discharge and 21% after 12 months ($p < 0.001$) (Fig. 1A). Significant regional LVSD after 12 months was less frequent (21% vs 33% ;

Table 2. Echocardiographic characteristics of the study population: indices obtained by two-dimensional and tissue Doppler echocardiography at discharge from hospital and after 12 months

Index	Hospital discharge	12 months post-discharge	P
LA [mm]	39.0 (30.0–59.0)	41 (31.0–58.0)	< 0.001
LVEDD [mm]	49.0 (35.0–63.0)	50.0 (38.0–67.0)	< 0.001
LVESD [mm]	33.0 (22.0–50.0)	34.0 (25.0–52.0)	0.001
LVMI [g/m ²]	113.0 (50.7–199.9)	117.2 (66.8–184.9)	0.047
LVEDVI [mL/m ²]	48.4 (24.4–103.8)	55.4 (30.9–103.8)	< 0.001
LVESVI [mL/m ²]	26.8 (14.0–72.2)	28.3 (13.8–72.3)	< 0.001
LVEF [%]	44.1 (22.0–62.0)	47.8 (28.0–69.0)	< 0.001
WMSI [pts]	1.56 (1.13–2.38)	1.44 (1.06–2.0)	< 0.001
S' [cm/s]	7.0 (3.7–11.4)	6.8 (3.1–11.0)	NS
S'' [cm/s]	7.0 (3.9–12.5)	6.8 (3.5–11.7)	NS

LA — left atrium; LVEDD — left ventricular end-diastolic diameter; LVESD — left ventricular end-systolic diameter; LVMI — left ventricular mass index; LVEDVI — left ventricular end-diastolic volume index; LVESVI — left ventricular end-systolic volume index; LVEF — left ventricular ejection fraction; WMSI — wall motion score index; S' — average peak systolic mitral annular velocity; S'' — average septal and lateral peak systolic mitral annular velocity

$p < 0.001$) (Fig. 1B). More patients had significant longitudinal LVSD after 12 months compared to discharge (28% vs 23%; $p < 0.001$) (Fig. 1B). Severe global LVSD was rare, both at discharge and after 12 months (Fig. 1A). When compared to the group EF > 40%, not only had the patients in the group EF ≤ 40% a higher prevalence of anterior STEMI (63.3% vs 36.7%; $p < 0.001$) and arterial hypertension (57.3% vs 42.7%; $p = 0.034$), but also higher levels of CK-MB 24 h after admission (CK-MB24) ($p < 0.001$), peak concentration of troponin I (TnI max) ($p < 0.001$) and admission glycaemia ($p = 0.003$), as well as more frequent pre-pPCI TIMI 0–1 IRA flow (73.2% vs 56.0%; $p = 0.017$), less frequent pre-pPCI TIMI 3 IRA flow (12.7% vs 35.1%; $p < 0.001$), and a higher administration rate of abciximab (37.1% vs 17.4%; $p = 0.002$). At discharge, the group EF ≤ 40% showed significant regional LVSD and more pronounced longitudinal LVSD compared to the group EF > 40% (Table 3). After 12 months in both groups, we found an improvement in regional and global LVSF, but no longitudinal LVSF (Table 3, Fig. 2). Only in the group EF ≤ 40% we observed significant longitudinal LVSD at 12 month follow-up (Table 3).

We found correlations between LVEF after 12 months and several echocardiographic parameters at discharge (Table 4; Figs. 3A, B). There were also correlations between LVEF at follow-up and: higher levels of glycaemia at admission ($r = -0.244009$; $p = 0.001$), diabetes mellitus in anamnesis ($r = -0.168072$; $p < 0.05$), and glycated haemoglobin at admission ($r = -0.158679$; $p = 0.0329$); as well as anterior location of STEMI ($r = 0.500847$; $p < 0.05$), CK-MB24 ($r = -0.370769$; $p < 0.001$) and pre-pPCI angiographic parameters: TIMI ($r = 0.248202$; $p < 0.05$), TFC ($r = -0.224386$; $p < 0.05$) and QCA ($r = -0.206226$; $p < 0.05$). Univariate logistic regression analysis revealed the following predictors of significant global LVSD at 12 months after STEMI: anterior

location of STEMI; the echocardiographic indices at discharge: S', S'', LVEF, LVMI, LV volume and diameter, and WMSI; pre-pPCI angiographic indices: TIMI, TFC and QCA; BNP_{delta} %; time from onset of pain to balloon, and the use of abciximab (Table 5). In this model, diabetes mellitus in anamnesis, arterial hypertension, and the occurrence of IRA restenosis during follow-up were not associated with LVEF ≤ 40% at 12 months. The final model of multivariate logistic regression analysis found the independent predictors of significant global LVSD at 12 months to be: BNP_{delta} % and LVEF at discharge (Table 5). ROC curves analysis to assess the diagnostic accuracy for the prediction of LVEF ≤ 40% at 12 months after STEMI revealed an optimal cut-off value of 728.2% for BNP_{delta} % and 37% for LVEFd (Fig. 4).

During the 12 month follow-up, there were 63 MACEs and 55 IRA restenosis in the whole studied group; non-significantly more in the group EF ≤ 40% compared to the group EF > 40% (Table 6). Fewer patients had the symptoms of heart failure (NYHA ≥ II) after 12 months than at discharge (9% vs 12%; $p < 0.001$). Heart failure was diagnosed more frequently in the group EF ≤ 40% compared to the group EF > 40% both at discharge and at 12 months (respectively: 25% vs 4%; $p < 0.001$; 13% vs 7%; $p < 0.001$).

DISCUSSION

The prevalence of LVSD in post MI patients has been estimated at 27%–60%, depending on the applied diagnostic criteria (most commonly LVEF assessed with TTE), therapeutic approach (including reperfusion therapy) and time point of assessment [3, 4, 18, 19].

Yet, to the best of our knowledge, there is little information as to the long-term course of LVSD assessed with TTE or/and TDE after pPCI-treated STEMI available in the literature [20–23].



Figure 1. A. Incidence of preserved global left ventricular systolic function and left ventricular systolic dysfunction at hospital discharge (d) and 12 months post-discharge (fu) in ST-segment elevation myocardial infarction patients treated invasively; **B.** Left ventricular regional and longitudinal dysfunction at hospital discharge and 12 months post-discharge after ST-segment elevation myocardial infarction treated invasively: percentage of patients with WMSI ≥ 1.7; WMSI < 1.3; S' and S'' ≤ 6 cm/s; abbreviations as in Table 2

In our study including patients with a first STEMI treated invasively, we observed the features of moderate LVSD, both at hospital discharge and after 12 months. Based on our findings, it may be concluded that, one year after STEMI, an improvement in global and regional LVSF has occurred, with no accompanying changes in longitudinal LVSF. After 12 months, both global and, less so, regional LVSF were preserved more commonly than at discharge. A pattern can be noticed whereby anticipated improvement in regional LVSF does not follow the ongoing recovery of global LVSF.

It is worth noting that both significant global and regional LVSD were less common at long-term follow-up compared to hospital discharge. This presumably resulted from a conspicuous improvement in LVSF in the group of patients with at pre-discharge a more depressed LVSF. The significant longitudinal LVSD was more common at 12 months after STEMI compared to discharge and it was found only in the group of patients with pre-discharge LVEF ≤ 40%. We found LVEF at discharge lower than 37% to be an independent predictor of significant global LVSD at 12 months after STEMI. In our stu-

Table 3. Echocardiographic characteristics of the groups with significant ($EF \leq 40\%$), and without significant ($EF > 40\%$), left ventricular systolic dysfunction, according to left ventricular ejection fraction assessment at hospital discharge. Indices obtained with two-dimensional and tissue Doppler echocardiography at hospital discharge and 12 months post-discharge

Index	Group $EF \leq 40\%$ (n = 71)	P (discharge vs follow up)	Group $EF > 40\%$ (n = 134)	P (discharge vs follow up)	p ($EF > 40\%$ vs $EF \leq 40\%$)
LA discharge [mm]	40.0 (30.0–59.0)		39.0 (30.0–54.0)		NS
LA follow up [mm]	42.0 (33.0–54.0)	0.001	40.5 (31.0–58.0)	0.000	0.005
LVEDD discharge [mm]	50.0 (38.0–63.0)		48.0 (35.0–61.0)		< 0.001
LVEDD follow up [mm]	54.0 (43.0–64.0)	< 0.001	49.0 (38.0–67.0)	0.008	< 0.001
LVESD discharge [mm]	34.0 (25.0–50.0)		32.0 (22.0–47.0)		< 0.001
LVESD follow up [mm]	35.5 (26.0–52.0)	0.044	32.5 (25.0–52.0)	NS	< 0.001
LVMI discharge [g/m ²]	128.9 (75.6–199.8)		106.6 (50.7–200.0)		< 0.001
LVMI follow up [g/m ²]	131.4 (87.3–184.9)	NS	111.5 (66.8–181.2)	NS	< 0.001
LVEDVI discharge [mL/m ²]	54.7 (33.1–103.8)		46.4 (24.4–89.3)		< 0.001
LVEDVI follow up [mL/m ²]	68.5 (30.9–103.8)	< 0.001	51.1 (36.0–92.1)	< 0.001	< 0.001
LVESVI discharge [mL/m ²]	34.8 (20.8–72.2)		23.6 (14.0–53.1)		< 0.001
LVESVI follow up [mL/m ²]	40.5 (15.0–72.3)	0.021	25.3 (13.8–58.7)	0.008	< 0.001
LVEF discharge [%]	37.2 (22.0–40.0)		47.4 (40.4–62.0)		< 0.001
LVEF follow up [%]	42.0 (28.0–69.0)	< 0.001	50.0 (36.0–66.0)	< 0.001	< 0.001
WMSI discharge [pts]	1.75 (1.38–2.38)		1.44 (1.13–2.25)		< 0.001
WMSI follow up [pts]	1.69 (1.13–2.0)	< 0.001	1.38 (1.06–1.94)	< 0.001	< 0.001
S' discharge [cm/s]	6.2 (3.7–8.4)		7.4 (4.6–11.4)		< 0.001
S' follow up [cm/s]	5.9 (3.1–10.6)	NS	7.1 (4.5–11.0)	0.006	< 0.001
S'' discharge [cm/s]	6.1 (3.9–9.2)		7.4 (4.2–12.5)		< 0.001
S'' follow up [cm/s]	6.1 (3.5–11.7)	NS	7.0 (4.6–11.7)	0.003	< 0.001

Abbreviations as in Table 2

dy, decreased S' and S'' at discharge were strongly associated with $LVEF \leq 40\%$ after 12 months.

It is worth noting the usefulness of relatively simple to obtain TDE parameters (especially S'') in predicting global LVSF in long-term follow-up after STEMI [8–11]. An increase of BNP during hospitalisation greater than 7.3 times was found in our study to be the strongest independent predictor of $LVEF \leq 40\%$ in long-term follow-up, more useful than BNP_{admission} or BNP_{discharge}. The abnormal increase of BNP on the 5th–7th day of STEMI (so-called biphasic release) reflects the extent of MI area and may better predict the development of LVSD [12, 13]. Higher BNP, which we observed during hospitalisation in the group $EF \leq 40\%$, has been identified in the literature as an important factor associated with early LV dysfunction in patients with STEMI [12, 13]. Richards found the combined measurement of BNP and LVEF 1–4 days from the onset of STEMI to be complementary independent predictors of major adverse events during a three-year follow-up, providing better risk stratification than either measurement alone [14].

According to our observations, significant global LVSD at discharge was 1.7-fold more common in anterior STEMI, potentially associated with a larger area of myocardial necrosis [24]. The presence of significant regional LVSD at discharge in the group $EF \leq 40\%$ proves the existence of extensive

regional contractility abnormalities in the early phase of MI in this group of patients. Anterior location of STEMI and high pre-discharge WMSI were also important predictors of significant global LVSD at 12 months after STEMI. This assumption seems to be supported by considerable association of high CK-MB24 and TnI max with depressed LVEF at discharge and after 12 months. Data from the registries proves the extent of myocardial necrosis, expressed by the highest CK-MB in the acute phase of MI, to be an important determinant of heart failure occurrence after MI across 6.6 years of follow-up [2].

The extent of improvement in LVSF after STEMI depends to a great degree on the presence of myocardial stunning and expansion of an adequately perfused area of myocardium, particularly in individuals with anterior STEMI [25, 26]. The increase in LVEF at five months after STEMI was related to the extent of necrosis and disturbed myocardial perfusion assessed on day 5 using magnetic resonance imaging [26]. As highlighted in the literature, the more extensive area of necrosis in our patients with significant LVSD at discharge compared to those without it, may result from less frequent pre-pPCI TIMI 3 IRA flow as well as a high incidence of multivessel coronary disease in the studied group [24, 27]. We observed that pre-pPCI, but not post-pPCI, angiographic indices of IRA flow and stenosis also influences global LVSF in long-term follow-up after

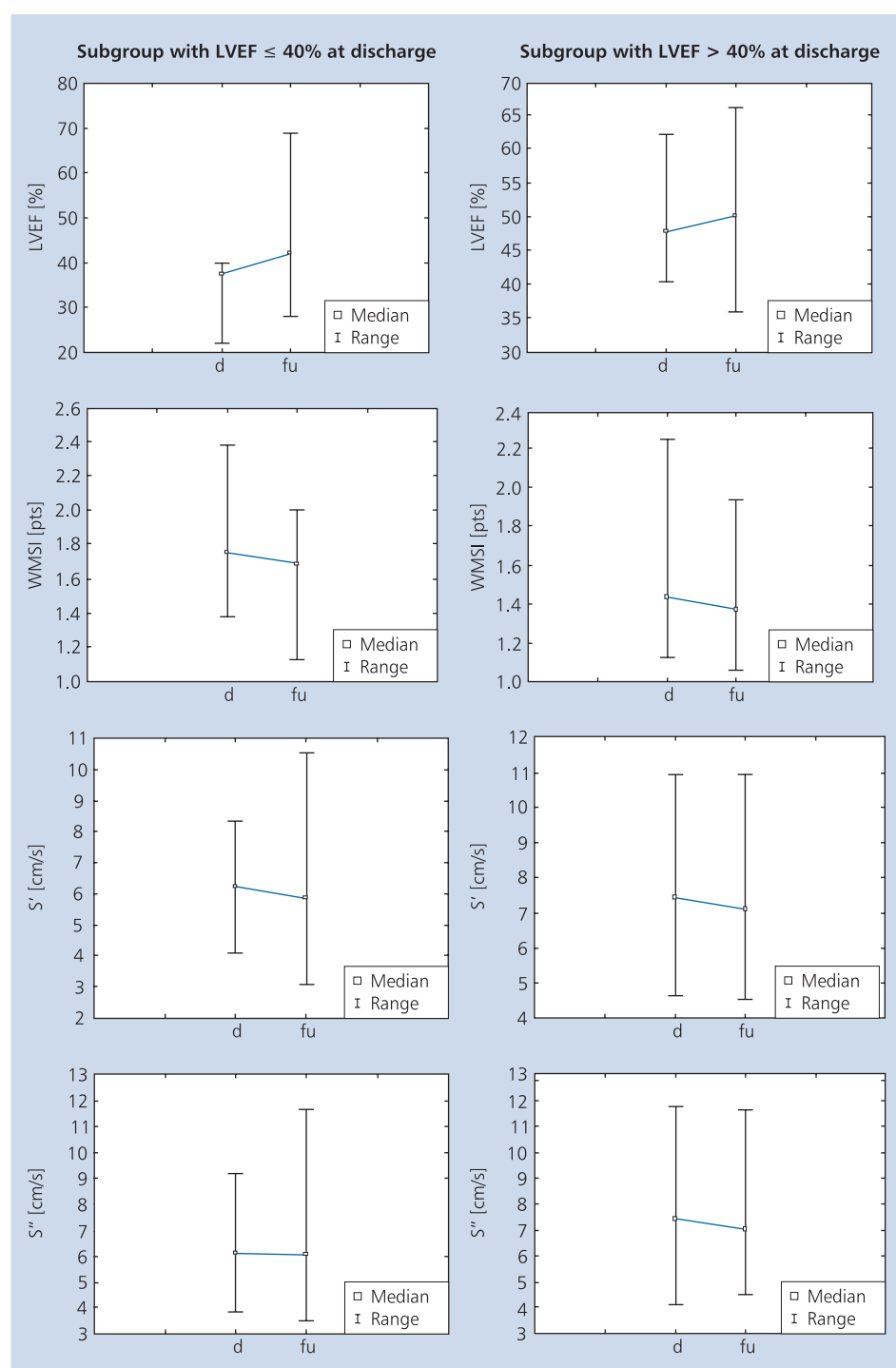


Figure 2. Changes in values of left ventricular systolic function indices after 12 months in ST-segment elevation myocardial infarction patients treated invasively and with significant left ventricular systolic dysfunction at discharge from hospital. Abbreviations as in Table 2

STEMI. Particular attention should be paid to the delay from the onset of pain to pPCI, as its reduction below 3 h results in significantly higher LVEF [28, 29]. Time to reperfusion determines the extent of the area of stunned and necrotic myocardium, and is responsible for the maintenance of microcirculatory integrity [30]. Normal microcirculatory perfusion after pPCI was

obtained in less than half of our patients with near normal post-pPCI IRA flow. This finding, in addition to the high rate of anterior STEMI, might explain the merely moderate improvement in LVSF after 12 months in the studied population.

It has also been shown that the degree of LVSF improvement, particularly in the regional aspect, depends on the cross-

Table 4. Correlations between left ventricular ejection fraction after 12 months and echocardiographic parameters at discharge; $p < 0.001$

Index at discharge	r	r ²
LVEF	0.698992	0.488589
WMSI	−0.643378	0.413935
LVESVI	−0.546948	0.299152
S'	0.414890	0.172133
S''	0.398091	0.158477
LVMI	−0.372835	0.139006
LVEDVI	−0.343373	0.117905

Abbreviations as in Table 2

wall LV involvement of disturbed myocardial perfusion [26, 31]. Only 5–29% of patients with perfusion disturbances involving > 75% of LV wall thickness show an improvement, albeit incomplete, in LVSF in long-term follow-up [31].

Other risk factors present in our patients with significant pre-discharge global LVSD included a higher prevalence of

arterial hypertension, and an increased level of glycaemia. Arterial hypertension may precipitate LVSD through hypertrophy and fibrosis of LV muscle and subendocardial ischemia. There have been reports of higher levels of myocardial necrosis markers, lower LVEF, and more frequent no-reflow in MI patients with an increased level of glycaemia [32, 33]. Hyperglycaemia on admission has also been shown to confer increased mortality in STEMI patients [34, 35]. We found a significant association between long-term LVEF and glycaemic parameters at discharge: level of glycaemia, HbA1c and diabetes mellitus in anamnesis. Based on our findings, the other predictors of $\text{LVEF} \leq 40\%$ after 12 months were: pre-discharge LVMI and LV diameter and volume indices. The considerable increase in LVMI and LV volume parameters observed in our patients at 12 months after STEMI may express the compensatory LV hypertrophy in areas unaffected by MI in progress of STEMI-related LV remodelling [26]. White has confirmed LV end-systolic volume (LVESV) as the surrogate for mortality following MI, rather than LVEF [36]. Similar findings were observed in the GUSTO-I trial, where the incidence of heart failure and death was closely linked to the progressive

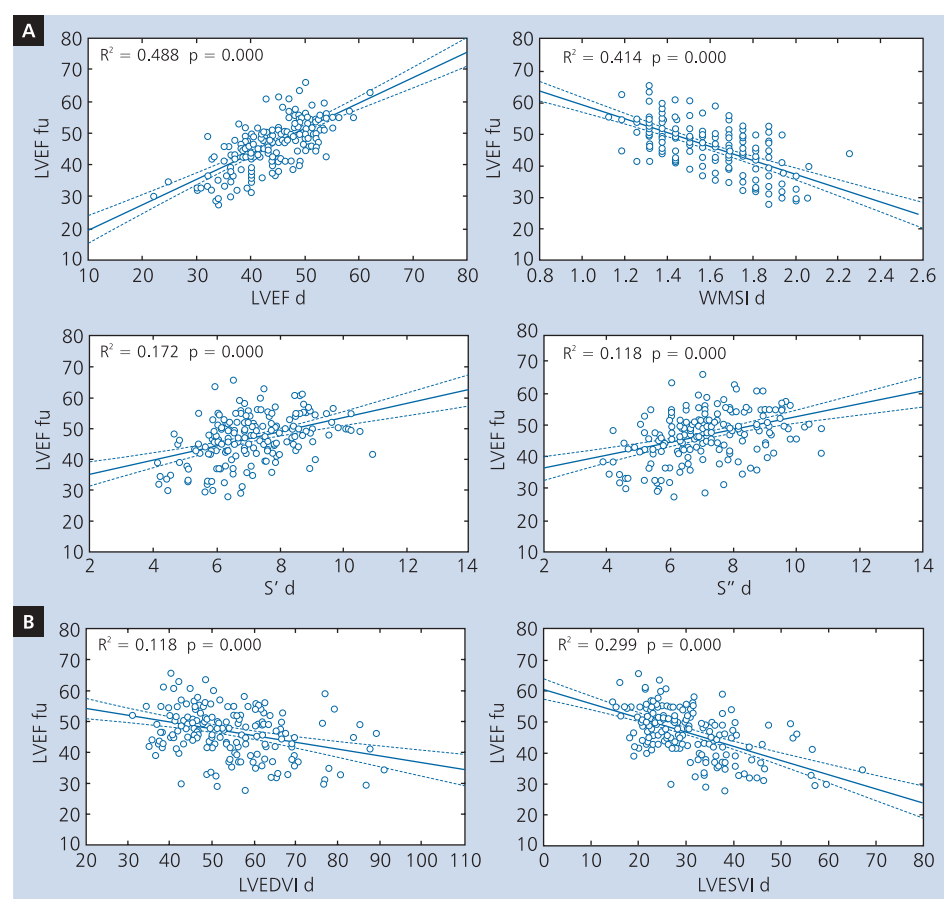
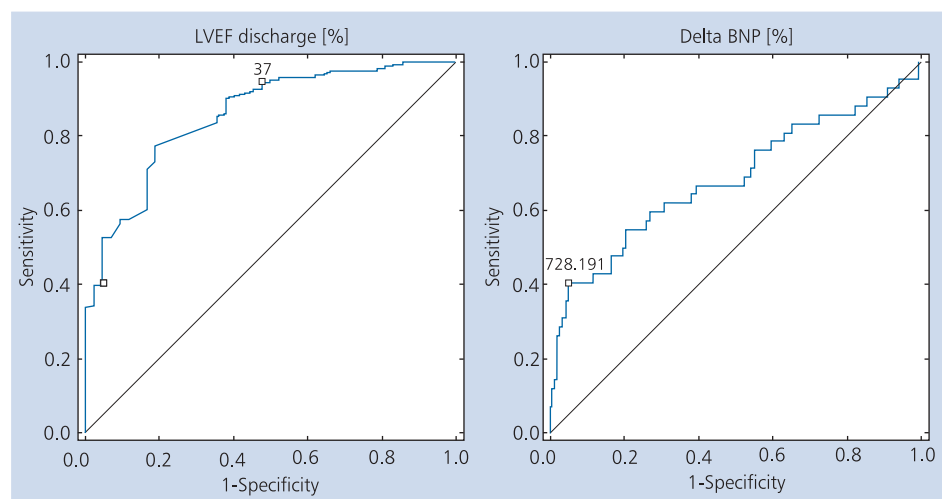


Figure 3. Correlations between left ventricular ejection fraction after 12 months and echocardiographic parameters describing left ventricular systolic function (A) and left ventricular volumes (B) at hospital discharge in ST-segment elevation myocardial infarction patients treated invasively. Abbreviations as in Table 2

Table 5. Univariate and multivariate logistic regression analysis for prediction of significant left ventricular systolic dysfunction at 12 months after hospital discharge in patients with acute ST-segment elevation myocardial infarction

Univariate logistic regression	OR	–95% CL	95% CL	P
Anterior STEMI	3.412	0.679	1.775	< 0.001
S'discharge	2.201	0.448	1.129	< 0.001
S''discharge	1.841	0.321	0.899	< 0.001
Pre-pPCI TIMI	1.374	0.028	0.607	0.031
LVEF discharge	1.306	0.179	0.354	< 0.001
BNP _{delta} %	1.002	1.001	1.003	< 0.001
Time from onset of pain to balloon	1.002	0.000	0.005	0.034
Pre-pPCI TFC	0.987	–0.024	–0.000	0.034
LVMI discharge	0.958	–0.058	–0.025	< 0.001
Pre-pPCI QCA	0.947	–0.104	–0.003	0.037
LVEDVI discharge	0.943	–0.087	–0.028	< 0.001
LVEDD discharge	0.897	–0.176	–0.038	0.002
LVESVI discharge	0.881	–0.172	–0.078	< 0.001
LVESD discharge	0.878	–0.203	–0.056	< 0.001
Use of abciximab	0.340	–1.810	–0.342	0.004
WMSI discharge	0.001	–9.236	–4.518	< 0.001
Multivariate logistic regression	OR	–95% –CL	95% +CL	P
BNP _{delta} %	1.001	1.000	1.002	0.023
LVEF discharge	0.791	0.724	0.864	< 0.001

Abbreviations as in Tables 1 and 2

**Figure 4.** Receiver operated curves for left ventricular ejection fraction at discharge and the ratio of the difference of B-type natriuretic peptide (BNP) plasma concentration at discharge and at admission to B-type natriuretic peptide plasma concentration at admission for prediction of left ventricular ejection fraction (LVEF) $\leq 40\%$ after 12 months in ST-segment elevation myocardial infarction patients treated invasively

rise in LVESV index beyond 40 mL/m^2 following successful reperfusion by thrombolysis [37]. Their findings imply that monitoring LV volumes may provide a useful tool to correlate the patient's risk for worsening heart failure symptoms that contribute towards increased mortality. In our study, LV vo-

lume indices at discharge were strongly associated with LVEF after 12 months. However only in the group $\text{EF} \leq 40\%$ we observed at 12 months after STEMI an increase in LVESV index $> 40 \text{ mL/m}^2$, indicating a high risk of the development of heart failure [37].

Table 6. Prevalence of major adverse cardiac events and restenosis of infarct-related artery during 12 months after ST-segment elevation myocardial infarction treated invasively in groups of patients with (group EF $\leq$ 40%), and without (group EF $>$ 40%), significant left ventricular systolic dysfunction at discharge

	Group EF $\leq$ 40% (n = 71)	Group EF $>$ 40% (n = 134)	P
MACE (hospitalisation for heart failure)	38% (9%)	27% (2%)	0.099 (0.087)
Restenosis	31%	25%	0.328

MACE — major adverse cardiac events: death, non-fatal reinfarction, stroke, revascularisation, hospitalisation for heart failure; Restenosis — decrease of infarct-related artery flow caused by $\geq$ 50% diameter stenosis in the post-primary percutaneous coronary intervention segment present in coronarography performed during follow-up

The more frequent occurrence (43%) of significant LVSD before discharge reported in the EMIAT trial compared to our study may be secondary to the history of prior MI in 29% of its participants [38]. The lower incidence (27–28%) of significant LVSD in pre-discharge assessment according to other registries and studies may be associated with the smaller percentage of STEMI patients in these studies (merely 49–56%) and lower incidence of anterior STEMI (e.g. 33% in VALLIANT Registry vs 47.8% in our study) [3, 4, 19]. Based on data from the literature, the prevalence of LVEF $<$ 40% in STEMI population measured 4–6 months after discharge is estimated at 22–30%, more frequent than in the long-term follow-up in our study [20, 39]. Post-MI LVSD has been identified as an important marker of poor prognosis, associated with a severely increased risk of cardiac death, reinfarction and re-hospitalisation in long-term follow-up [5, 40–42]. As many as 50% of the patients with early post-MI LVSD go on to develop heart failure [38]. Our findings confirm these observations, as the symptoms of heart failure were more frequent at 12 months in the group EF $\leq$ 40%. Also, hospitalisation for heart failure and total MACEs during the 12 month follow-up seemed to be more common in this group of patients. Data available in the literature emphasises the usefulness of serial measurements of LVEF in heart failure patients [7, 25, 41]. Repeated echocardiographic monitoring at multiple time points is prognostically superior to single-time-point LVEF assessment [7, 41]. The V-HeFT II trial identified a change in LVEF after 12 months exceeding 5% in relation to the initial values to be the strongest predictor of mortality, independent of mode of treatment or initial LVEF [7]. Several authors have reported a discernible improvement in LVSF 3–6 months after STEMI, specifically quantified for 6% rise in LVEF in a paper from van Melle et al. [20–23]. Parodi et al. [22] observed an increase in LVEF $\geq$ 10% in 58% of patients at six months after MI. In a paper by Antoni et al. [25], improvement in LVSF, defined as a $\geq$ 10% increase in systolic longitudinal strain rate of myocardium, was present in 72% of patients in a one-year follow-up. Given these findings, the noticeable increase in LVEF observed in our population at 12 months after STEMI,

although significant, appears to be insufficient to assess its correlation with mortality.

Limitations of the study

The study population, relatively small, only with a first STEMI, received early reperfusion treatment, resulting in a relatively well preserved LVEF and low one-year event rate. The use of bare metal stents in 98% of cases and ticlopidine in 24% of patients could influence the angiographic effect of pPCI in our study. The assessment of LVSF by TTE is dependent on the examiner's experience and has limitations in patients with a poor acoustic window. We did not assess the torsion of LV, which would be worth measuring using speckle tracking echocardiography, a new method of LVSF quantitative analysis. Finally, not all variables involved in determining dynamic changes in LVSF after STEMI were considered in this study; in particular: LV diastolic dysfunction and neurohormonal activation.

CONCLUSIONS

Patients with a first STEMI treated with pPCI intervention present moderate LVSD, both at hospital discharge and after 12 months. In the long-term follow-up, an improvement in global, and, although less so, in regional, LVSF was seen. No improvement in longitudinal systolic function was observed. The increase of BNP concentration during hospitalisation, and LVEF at discharge, are independent predictors of significant global LVSD at 12 months after a first STEMI treated with pPCI. Pre-discharge peak systolic mitral annular velocity obtained by TDE may be a useful tool in predicting LVEF in long-term follow-up in this group of patients.

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Występowanie i czynniki prognostyczne dysfunkcji skurczowej lewej komory przy wypisie ze szpitala i w obserwacji odległej po ostrym zawale serca leczonym pierwotną przezskórną interwencją wieńcową

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Streszczenie

Wstęp: Wystąpienie dysfunkcji skurczowej lewej komory (LVSD) w przebiegu ostrego zawału serca z uniesieniem odcinka ST (STEMI) wiąże się z gorszym rokowaniem.

Cel: Celem niniejszego badania, przeprowadzonego w grupie pacjentów z STEMI leczonych pierwotną przezskórną interwencją wieńcową (pPCI), była ocena występowania i przebiegu LVSD przy wypisie ze szpitala oraz w obserwacji odległej.

Metody: Obserwacji poddano 205 chorych (157 mężczyzn, 48 kobiet) przyjętych z rozpoznaniem pierwszego w życiu STEMI. Badanie echokardiograficzne wykonywano przed wypisem ze szpitala i po 12 miesiącach. Oceniano następujące parametry funkcji skurczowej lewej komory (LVSF): frakcję wyrzutową lewej komory (LVEF) wyznaczaną metodą sumowania dysków z dwóch płaszczyzn; wskaźnik kurczliwości lewej komory (WMSI) i średnią maksymalną prędkość skurczową segmentów podstawnych lewej komory (S'), przy użyciu tkankowej echokardiografii dopplerowskiej (TDE).

Wyniki: Zarówno przy wypisie ze szpitala, jak i w obserwacji odległej stwierdzono umiarkowaną LVSD. Istotna globalna LVSD (LVEF $\leq$ 40%) występowała u 34% pacjentów przy wypisie ze szpitala i w 21% przypadków po 12 miesiącach ($p < 0,001$). Istotną regionalną LVSD (WMSI $\geq 1,7$) stwierdzono przy wypisie u 33%, a po 12 miesiącach u 21% pacjentów ($p < 0,001$). Istotna podłużna LVSD ($S' \leq 6,0$ cm/s) występowała po 12 miesiącach od STEMI częściej niż przy wypisie ze szpitala (28% v. 23%; $p < 0,001$). Ciężka globalna LVSD (LVEF $\leq$ 30%) w badanej grupie chorych występowała rzadko. W analizie regresji jednoczynnikowej predyktorami istotnej globalnej LVSD po 12 miesiącach po STEMI były: przednia lokalizacja STEMI; echokardiograficzne wskaźniki LVSF oraz wielkość i masa lewej komory (LV) przy wypisie ze szpitala; wskaźniki angiograficzne przed pPCI; procentowa zmiana stężeń peptydu natriuretycznego typu B między przyjęciem i wypisem ze szpitala w stosunku do wartości przy przyjęciu (BNP_{delta} %); czas bólu zawałowego do wykonania pPCI oraz użycie abcximabu. W analizie regresji wieloczynnikowej niezależnymi predyktorami istotnej globalnej LVSD po 12 miesiącach po STEMI były: BNP_{delta} % (punkt odcięcia 728,2%) oraz LVEF przy wypisie ze szpitala (punkt odcięcia 37%).

Wnioski: W grupie pacjentów z pierwszym w życiu STEMI leczonym przy użyciu pPCI stwierdzono występowanie umiarkowanej LVSD, zarówno przy wypisie ze szpitala, jak i po 12 miesiącach po zawale. W obserwacji długoterminowej następowała poprawa globalnej i, w mniejszym stopniu, regionalnej LVSF. W obserwacji długoterminowej nie stwierdzono poprawy funkcji skurczowej podłużnej LV. Wzrost stężenia BNP w czasie hospitalizacji i LVEF przy wypisie ze szpitala są niezależnymi predyktorami pozwalającymi przewidzieć wystąpienie istotnej LVSD po 12 miesiącach od wypisu ze szpitala u pacjentów ze STEMI leczonym za pomocą pPCI. Pomiar średniej maksymalnej prędkości skurczowej segmentów podstawnych LV przy użyciu TDE może być przydatny w przewidywaniu obniżenia LVEF w obserwacji długoterminowej w tej grupie chorych.

Słowa kluczowe: ostry zawał serca, pierwotna przezskórna interwencja wieńcowa, funkcja skurczowa lewej komory, echokardiografia dwuwymiarowa, tkankowa echokardiografia dopplerowska

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