Reperfusion Strategies in Hospitals Without Primary Percutaneous Coronary Intervention. Response

Estrategias de reperfusión en hospitales sin intervención coronaria percutánea primaria. Respuesta

To the Editor,

We appreciate the comments by Rosell-Ortiz et al. Indeed, half the patients in our study required transfer between centers for primary angioplasty with the associated delay that this entails.[1] Although some randomized studies have shown noninferiority of fibrinolysis therapy in the first few hours after ST-elevation myocardial infarction compared with primary angioplasty,[2] in general, primary angioplasty is superior, given its greater reperfusion efficacy and lower frequency of complications and bleeding complications in particular.[3] Another recent analysis of patients treated according to the *Codi Infart* protocol within 2 hours of infarction also reported that primary angioplasty was superior to fibrinolysis, except when the delay from first medical contact to reperfusion exceeded 140 minutes.[4]

The *Codi Infart* protocol includes administration of fibrinolysis when the delay between first medical contact and reperfusion is expected to be longer than 120 minutes on the basis of availability of a catheterization laboratory, number of ambulances, and traffic in the area. This strategy is also used in other consolidated care systems such as that in Asturias, with a different orography to that in Catolonia, although also with excellent results.[5] The geography of Catalonia is not complex, which usually allows primary angioplasty within the recommended timeframe. Fibrinolysis (and subsequent transfer to a referral hospital with a catheterization laboratory) is reserved for situations when the timeframe is truly unrealistic (that is, centers a very long way from the referral hospital). This suggests that most delays could be shortened by much earlier diagnosis and drainage after first contact.

Acknowledgments

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