

The Reply



We thank the authors for their interest in our publication, “Diagnosis of unstable angina pectoris has declined markedly with the advent of more sensitive troponin assays.”¹

Our publication addressed patients with acute coronary syndromes. An additional 1089 patients with troponin elevations above the 99th percentile of the upper reference limit were excluded. Thus, these patients did not fulfill the acute myocardial infarction criteria, as defined by the 2007 universal definition. Indeed, the patients did not exhibit a rise/fall pattern of troponin values and they did not have evidence of myocardial ischemia defined as at least 1 of the following: symptoms of ischemia; electrocardiogram (ECG) changes indicative of new ischemia; development of pathologic Q waves in the ECG; imaging evidence of new loss of viable myocardium or new regional wall motion abnormality).² A manuscript specifying the associated different clinical conditions in the 1089 myocardial injury patients together with long-term mortality data has been submitted for publication.

As proposed by the universal definition, acute myocardial infarction, for the sake of immediate treatment strategies, can be classified according to ECG abnormalities as an ST-elevation myocardial infarction (STEMI) or as a non-ST elevation myocardial infarction (NSTEMI).² We used this classification in the present publication, with 133 patients being categorized as having STEMI, whereas 346 were designated as having NSTEMI.¹

According to the universal definition, however, myocardial infarction may also be classified into various types according to pathologic and clinical differences.² Using this classification we recently reported that 360 of

the 479 patients had type 1 myocardial infarction, whereas 119 were categorized as having type 2 myocardial infarction.³ Thus, the “inclusion of 115 type 2 myocardial infarction patients in the NSTEMI group” of our acute coronary syndrome publication simply reflects that the large majority of patients with type 2 myocardial infarction (115 of 119) fulfill the NSTEMI criteria.¹ On the other hand, our data also demonstrate that type 2 myocardial infarction is rarely present (4 of 133) in patients with STEMI.¹

Our acute coronary syndrome study is an all-comers study also addressing NSTEMI patients at highest risk, including those in whom early coronary angiography was considered inappropriate. So far, the optimal treatment strategy for these patients has not been defined. When it comes to NSTEMI patients considered suitable for either routine invasive or selective invasive strategies, it seems that the 2 treatment choices are similar when it comes to long-term mortality.⁴

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References

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