

Editorial

Minimum Workup After Myocardial Infarction

Of all the disasters that can beset the heart, there is none so catastrophic, so common and so lethal as acute myocardial infarction. Almost 40% of all heart attack victims die. The lucky 60% survivors have shaken hands with death and have been luckily let go but have identified themselves as individuals more prone than any other group to the risk of another heart attack. What then should be our strategy regarding future management of this large group of patients? This is the subject of intense ongoing research and debate.

It has been known for long that patients who after an infarction are free of heart failure, recurrent angina and arrhythmias, do very well and have a good long term prognosis. The present day correlates of these three powerful markers are the extent of myocardial damage and state of overall myocardial pump function, the extent of disease on coronary angiography with objective documentation of myocardial ischemia and the presence of clinical arrhythmias with evidence of delayed myocardial potentials and inducible sustained ventricular arrhythmias. Does it therefore mean that survivors of a myocardial infarction should have an Echocardiogram, an ETT, a Holter recording, signal averaged ECG for delayed potentials, Thallium Scan, Radionuclide Angiogram, SPECT scan, PET scan, Coronary Angiography with left ventriculography and PES study, followed by PTCA, Coronary Bypass Surgery, Aneurysmectomy, arrhythmogenic myocardium resection/ablation or implantation of an AICD (automatic implantable cardioverter/defibrillator/ pacing) device? Obviously some sort of risk stratification strategy and regularly updated indications will have to be evolved for a rational and cost-effective approach by the richest of societies anywhere in the world. Such strategies exist and are constantly evolving for the populations of the advanced countries.

What are the options for a poor country like Pakistan where resources are very scarce but myocardial infarction is a common occurrence? Should we be content with just the clinical indicators like angina, heart failure and clinical arrhythmias or should every patient be screened by at least an ETT and Echocardiogram? As a large number of patients may be identified as abnormal by ETT/Echo, what should be the strategy for further workup and interventions? We shall have to see what is the maximum possible we can deliver to our patient population and we shall have to devise our strategy in light of such reality. Our scarce resources must not be wasted on the alter of whims and fancies and a sketchy notion of what is considered the "in thing" in the rich advanced countries.

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