SUMMARY AND CONCLUSION

Myocardial infarction has become one of the most important diseases in technically advanced countries. Anticoagulants have been used for more than thirty-fou years in the management of the acute phase of the dise se but whether routine anticoagulation should be adopted r not is still not settled. This is why we planned our tudy in a trial to re-evaluate the possible benefits and ha ards of such therapy.

Twenty patients admitted to Tanta Coronary Care nit, suffering from acute myocardial infarction have been s udied. Ten of them were on anticoagulation therapy and ten we e not, thus serving as controls.

The patients were studied as regards the relevant risk and prognostic factors available in their files: ge and sex, site and size of the infarct, presence or abs nce of previous infarction, heart failure, hyperglycaemia, hypercholesterolaemia, hypertension, arrhythmias and h em-atocrit value, systolic time Interval, The control and anticoagulated groups were evaluated statistically an they proved to be comparable.

Both groups were studied to find statistically i any correlation existed between any complications and the individual risk and prognostic factors mentioned abov .

In conclusion, by using anticoagulants in the man gement of acute myocardial infarction, life long serious dis bility may be decreased or abolished through a beneficial inf uence on the incidence of arterial thromboemboli. This is a comp-lished without singificantly altering the mortality r te in either direction.

In other words, by using anticoagulants, we are t ying to add "Life to the years, if not years to the life o our patients".

CONCLUSION :

1. Anticoagulation should be the therapy of choice or acute myocardial infarchen. Preventing or imped ng the progression of coronary thromboisis could p event infarction or limit infarct size, and prevent re nfarc-tion. Furthermore, anticoagulation should reduc the incidence of two major complications of myocardi l infarction systemic embolism and pulmonary embol sm.

2. Mortality from myocardial infarction has markedl diminished after the advent of the era of corona y care units.

3. The incidence of thromboembolism is diminshed by early mobilization.

4. The incidence of thromboembolism is higher in the "high risk" groups, in patients with diseased blood ves els, and in those conifned to bed for long periods.

5. There is no definite proof that anticoagulant alt r today the overall mortality or the extension of a thrombus in the coronary tree, in the acute phase of myocardial infarction.

6. Anticoagulants do decrease the rate of thromboemb lism to a more significant level in the patients with higher incidence of this complication.

7. The incidence of thromboembolism, especially arte ial, is markedly diminished by anticoagulation. Becau e of this fact, properly controlled anticoagulant t erapy is justified in the acute phase of myocardial inf rction to avoid potentially serious disability that migh be permanent.

Given our interpretation of the data available on the efficacy of anticoagulation in acute myocardial infarc ion we have adopted the following recommendations in our coronary care unit. On admission, low-dose heparin is begun if the suspect myocardial infarction is ruled ou , heparin is discontinued; if the diagnosis of definite myocardial infarction is established, low-dose heparir is

continued until the patient is ambulatory. We belive that low-dose heparin, given its low morbidity, is appropriate to further decrease the low incidence of pulmonary embolism. We reserve the use of full-dose heparinization to those patients at increased risk of plumonary embolism. We reserve the use of ful-dose heparinization to those patients at increased risk of pulmonary embolism. Increased risk of symtemic embolism because of past history of systemic embolism or the presence of atrial fibrillation.