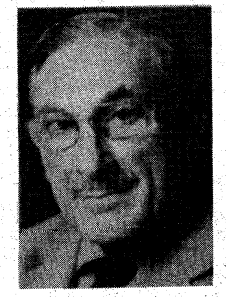
Minor Infarctions:



Dr. Sampson is Clinical Professor of Medicine, University of California, San Francisco; and past president of the American Heart Association

The intermediate syndrome of acute coronary insufficiency has been described in ill-defined, imprecise terms. It encompasses a broad spectrum of signs and symptoms, with wide variations in prognosis. Distinction between the benign and more serious forms of this syndrome is important in charting the course of therapy.

Almost 40 years ago, two papers (one by Feil and the other by Eliaser and myself) were published describing the clinical patterns of patients who had experienced recurrences of angina pectoris that deviated from prior attacks. Importance was attached to these new episodes because about half of the patients developed typical myocardial infarction within a half-day to a month, despite restriction of their physical activity. At that time, it had already been well established that a number of anginal attacks may precede myocardial infarction.

Many of the patients recovered spontaneously without ill effects, while others developed serious myocardial infarctions with a relatively high fatality rate. Still, the tendency has been to label all such patients with one diagnosis: intermediate coronary insufficiency syndrome.

Since myocardial revascularization, largely by aorto-coronary bypass, has come into widespread use, the challenge to the physician is to distinguish between the benign and the more serious forms of such deviant anginal attacks. This distinction may indicate which patients might best benefit from surgical revascularization, and which run the highest operative risks.

Criteria Are Limited

Unfortunately, prognostic criteria are few and diagnostic criteria are inadequately defined. Various degrees of coronary occlusion can develop asymptomatically. Even severe narrowing of all three coronary vessels may give no warning or may produce only minor, stable angina until a serious myocardial infarction suddenly occurs. Conversely, coronary angiography may reveal relatively minor occlusive disease or no evident arterial narrowing in patients who have repeatedly required protective hospital admissions for severe "crescendo" spontaneous angina or angina of effort. Patients with Prinzmetal's variant of angina often present such deviations from the expected occlusive disease, and this type of attack has been attributed to coronary arterial spasm.

Different authors have offered different diagnostic criteria. To a large extent, these criteria depend on what statistical plan is to be used for analysis of a specific collection of cases. Another factor that influences the specified diagnostic criteria is the physician's sphere of interest. For example, a cardiologist who is interested in the natural history of the disease, in noninvasive diagnostic study, and in "medical" care (i.e., rest during a presumptive criti-