Paradoxically, the stroke rate was lower in smokers, probably related to younger age and less CRFs.

Conclusions: Intensive cholesterol lowering with atorvastatin over 16 weeks in patients with acute coronary syndromes reduced stroke rate by about 50%.

Perspective: The impressive results may be related to the relatively high stroke rate on placebo but nevertheless lend support to the routine use of statins at the time of acute coronary events. To what degree the reduced hospitalization for ischemic events and stroke in MIRACL is attributable to the high dose of atorvastatin or the degree of lipid lowering remains to be determined. The relatively high early recurrence and stroke rate in this and other studies of ACS is consistent with the concept of the vulnerable patient rather than a specific vulnerable plaque. MR

Effects of End-of-Month Admission on Length of Stay and Quality of Care Among Inpatients With Myocardial Infarction

Smith JP, Mehta RH, Das SK, et al. Am J Med 2002;113:288–93.

Study Question: Does the transfer of care when house staff and faculty switch services affect length of stay or quality of care among hospitalized patients?

Methods: Consecutive patients admitted with acute myocardial infarction from 1995 to 1998 were analyzed to evaluate the impact of transfer of care when faculty and house staff changed service. Patients who were admitted within 3 days of change in staff (denoted end-of-month patients) were compared to those admitted at other times to evaluate the differences in the length of stay and quality of care between these two cohort.

Results: Ninety-two patients (12%) were admitted at the end of the month and the remaining 690 (88%) were admitted at other times of the month. The median length of stay was longer for patients admitted at the end of the month compared to those admitted at other time periods (8 vs. 7 days, $p=0.06$), with end of month an independent predictor of length of stay in multivariate models. The utilization of key quality-of-care indicators (aspirin, beta-blockers, angiotensin-converting enzyme inhibitors or lipid-lowering agents at discharge between midmonth and end-of-month patients. Mortality and in-hospital adverse events did not differ between the two groups.

Conclusions: Admission during the last 3 days of the month is associated with increased length of stay without influencing the quality of care among patients with myocardial infarction.

Perspective: The increase in length of stay for patients admitted at the end of month when the switch of their care occurs may be related to the time that the house staff and the attending takes to get familiar with their patients. The better familiarity of their patient's condition in return allows them to provide excellent quality of care to these patients similar to that received by patients admitted at other time period of the month. Staggering the time of switch for house staff and faculty may allow the delivery of excellent quality of service without an increase in length of stay. RM/DM

Medical Treatment of Myocardial Ischemia in Coronary Artery Disease: Effect of Drug Regime and Irregular Dosing in the CAPE II Trial

Deanfield JE, Detry JM, Sellier P, et al., for the CAPE II Trial Investigators. J Am Coll Cardiol 2002;40:917–25.

Study Question: What is the efficacy of amlodipine and diltiazem compared to the combination of amlodipine/atenolol and diltiazem/isosorbide 5-mononitrate on exercise and ambulatory myocardial ischemia during regular therapy and after omission of medication?

Methods: Patients with ≥4 ischemic episodes or ≥20 min of ST-segment depression on 72-h electrocardiogram were assigned to receive amlodipine (10 mg QD) or diltiazem (300 QD) for 14 weeks in a double-blind randomized fashion. Following this period, atenolol (100 mg QD) was added to amlodipine and isosorbide 5-mononitrate (100 mg QD) was added to diltiazem. Ischemia was assessed by 72-hour ambulatory electrocardiogram as well as by exercise testing performed after both phases, on treatment and after a 24-h drug-free interval (after these therapies were stopped for 24 hours).

Results: Monotherapy with amlodipine and diltiazem had similar efficacy on ischemic symptoms and ambulatory and exercise ischemia. Additional reductions of ischemic episodes were seen with combination therapy, with amlodipine/atenolol being superior to diltiazem/isosorbide 5-mononitrate. Further, the combination of amlodipine/atenolol had greater efficacy during the drug-free interval with maintenance of ischemia reduction than with diltiazem/isosorbide 5-mononitrate.

Conclusions: Amlodipine alone or in combination with beta-blocker is likely to produce greater reduction in ischemia in clinical practice when patients frequently forget to take medication or take their drugs irregularly.

Perspective: Beta-blockers are currently considered to be the first line of treatment for improving ischemic symptoms. Therefore, the only relevant information in this trial is that either amlodipine or diltiazem are reasonable choices for a patient with an absolute contraindication to taking a beta-blocker. RM/KE

Effect of Treatment With Low Doses of Hydrocortisone and Fludrocortisone on Mortality in Patients With Septic Shock

Annane D, Sebille V, Charpentier C, et al. JAMA 2002;288:862–71.

Study Question: Do low doses of steroids improve 28-day survival in patients with septic shock and relative adrenal insufficiency?