


# Fibrinolytic Therapy For Stemi

Common thrombolytics regimens for STEMI <sup>1</sup>			
	Initial treatment	Co-therapy	Contraindications
Streptokinase (SK)	1.5 million U in 100 mL D5W or NS over 30–60 min	None or iv heparin x 24–48 hrs	Prior SK or anistreplase
Alteplase (tPA)	15 mg iv bolus, then 0.75 mg/kg over 30 min, then 0.5 mg/kg iv over 60 min Total dose not over 100 mg	iv heparin x 24–48 hrs	
Reteplase (r-PA)	10 U + 10 U iv bolus given 30 min apart	iv heparin x 24–48 hrs	
Tenecteplase (TNK-tPA)	Single iv bolus 30 mg if <60 kg 35 mg if 60 kg to <70 kg 40 mg if 70 kg to <80 kg 45 mg if 80 kg to <90 kg 50 mg if ≥90 kg	iv heparin x 24–48 hrs	
Note: ASA should be given to all patients without contraindications			

 1. Van de Werf F et al. Eur Heart J 2003; 24: 28–66.

**Fibrinolytic therapy for STEMI** is a critical intervention in the management of ST-Elevation Myocardial Infarction (STEMI), a severe type of heart attack characterized by the complete blockage of a coronary artery. This blockage prevents blood from reaching a portion of the heart muscle, resulting in tissue damage and potentially life-threatening complications. Fibrinolytic therapy aims to dissolve the thrombus (blood clot) that obstructs the coronary artery, restoring blood flow and minimizing myocardial damage. This article explores the mechanisms, indications, contraindications, administration protocols, and outcomes of fibrinolytic therapy in STEMI patients.

## Understanding STEMI

STEMI is a medical emergency that requires rapid intervention to salvage heart muscle and improve patient outcomes. It is differentiated from Non-ST Elevation Myocardial Infarction (NSTEMI) by the presence of specific changes on an electrocardiogram (ECG), namely ST-segment elevation.

## Pathophysiology of STEMI

The pathophysiology of STEMI involves:

1. Atherosclerosis: The buildup of plaques (fatty deposits) in the coronary

arteries, leading to narrowing and potential rupture.

2. Thrombus Formation: Upon rupture of a plaque, platelets aggregate, and a thrombus forms, causing acute blockage of blood flow.

3. Myocardial Ischemia: The deprived muscle experiences ischemia, leading to cell death if blood flow is not restored.

## **Fibrinolytic Therapy: Mechanism of Action**

Fibrinolytic therapy utilizes medications to break down the clot obstructing the coronary artery. The primary agents used include:

- Tissue Plasminogen Activator (tPA): Converts plasminogen to plasmin, leading to the breakdown of fibrin in clots.
- Streptokinase: Activates plasminogen but is less specific and can elicit immune responses.
- Urokinase: Directly converts plasminogen to plasmin, similar to tPA but with different pharmacokinetics.

## **Indications for Fibrinolytic Therapy**

Fibrinolytic therapy is indicated for patients with STEMI when:

1. Symptoms: Patients present with chest pain or discomfort lasting more than 20 minutes.
2. ECG Findings: ST-segment elevation of at least 1 mm in two contiguous leads.
3. Time Frame: Treatment is most effective when administered within 12 hours of symptom onset, preferably within the first 3-4 hours.

## **Patient Selection Criteria**

Ideal candidates for fibrinolytic therapy typically include:

- Adult patients aged 18-75 years.
- Those without contraindications.
- Patients presenting within the specified time frame.

## **Contraindications for Fibrinolytic Therapy**

While fibrinolytic therapy can be life-saving, it is not suitable for everyone. Absolute contraindications include:

1. History of Intracranial Hemorrhage: Any prior bleeding into the brain.

2. Known Structural Cerebral Vascular Lesions: Such as arteriovenous malformations.
3. Recent Stroke: Particularly within the last three months.
4. Active Bleeding: Any significant bleeding disorder or trauma within the past two months.
5. Severe Uncontrolled Hypertension: Blood pressure exceeding 180/110 mmHg.

Relative contraindications may include:

- Older age (over 75).
- Pregnancy or recent childbirth.
- Non-compressible vascular punctures.
- Certain surgical procedures performed recently.

## **Administration of Fibrinolytic Therapy**

The administration of fibrinolytic therapy involves careful monitoring and adherence to protocols to maximize efficacy and minimize complications.

### **Protocol for Administration**

1. Patient Assessment: Evaluate the patient's history, perform a physical examination, and obtain an ECG.
2. Obtain IV Access: Establish intravenous access for medication delivery and administration of adjunctive therapies.
3. Medication Dosage: Administer the fibrinolytic agent based on weight and type of drug. For example:
  - For tPA: A common regimen is a bolus followed by an infusion over a specific duration.
  - For streptokinase: A fixed-dose infusion is often used.
4. Monitor Vital Signs: Continuously monitor blood pressure, heart rate, and any signs of bleeding.
5. Post-Administration Care: After therapy, observe the patient for signs of reperfusion and complications, such as bleeding or allergic reactions.

### **Adjunctive Therapy**

In addition to fibrinolytics, patients often receive adjunctive therapies, including:

- Antiplatelet Agents: Such as aspirin and clopidogrel to prevent further clotting.
- Anticoagulants: Heparin is often administered to enhance the effects of fibrinolytics and prevent re-occlusion.
- Beta-Blockers and ACE Inhibitors: To reduce myocardial oxygen demand and

improve cardiovascular outcomes.

## Outcomes and Complications

Fibrinolytic therapy can significantly improve outcomes in STEMI patients when administered timely and appropriately. The potential benefits include:

- Restoration of Blood Flow: Prompt opening of the blocked artery can save heart muscle and preserve function.
- Reduced Mortality: Studies show a decrease in mortality rates when fibrinolytics are used within the optimal time frame.

However, the therapy is not without risks. Complications may include:

1. Bleeding: The most significant risk, particularly intracranial hemorrhage.
2. Reperfusion Arrhythmias: Abnormal heart rhythms that can occur as blood flow is restored.
3. Reocclusion: The possibility of the artery becoming blocked again after initial reopening.

## Conclusion

Fibrinolytic therapy is an essential component in the management of STEMI. Its ability to dissolve clots and restore blood flow can significantly improve patient outcomes when used appropriately. Despite its advantages, careful patient selection and monitoring are vital to minimize risks and complications. As advancements in medical technology and pharmacology continue, the role of fibrinolytics may evolve, but their importance in acute cardiac care will remain significant. Ongoing research and clinical trials will further elucidate their optimal use and integration into broader STEMI management protocols.

## Frequently Asked Questions

### What is fibrinolytic therapy and how does it work in STEMI treatment?

Fibrinolytic therapy involves the administration of drugs that dissolve blood clots obstructing coronary arteries during a ST-Elevation Myocardial Infarction (STEMI). These medications activate the fibrinolytic system, breaking down fibrin and allowing blood flow to be restored to the heart muscle.

## **What are the primary fibrinolytic agents used in STEMI management?**

The primary fibrinolytic agents include alteplase, reteplase, and tenecteplase. Each of these drugs functions by targeting and breaking down the fibrin in blood clots.

## **What are the timing considerations for administering fibrinolytic therapy in STEMI?**

Fibrinolytic therapy is most effective when administered within the first 12 hours of symptom onset, with the best outcomes typically seen when given within the first 3 to 4 hours.

## **What are the contraindications for fibrinolytic therapy in STEMI patients?**

Contraindications include active bleeding, recent surgery or trauma, history of hemorrhagic stroke, uncontrolled hypertension, and known bleeding disorders. Each patient's risk factors should be carefully assessed.

## **How does fibrinolytic therapy compare to percutaneous coronary intervention (PCI) for STEMI?**

While fibrinolytic therapy is effective for restoring blood flow, PCI is often preferred when available, especially within the first 120 minutes of symptom onset, as it has a lower risk of recurrent ischemia and bleeding complications.

## **What are the common side effects associated with fibrinolytic therapy?**

Common side effects include bleeding complications, allergic reactions, and hypotension. Close monitoring is necessary to manage these potential risks.

## **What role does aspirin play in conjunction with fibrinolytic therapy for STEMI?**

Aspirin is administered alongside fibrinolytic therapy to inhibit platelet activation and aggregation, which helps to prevent further clot formation and improves overall outcomes in STEMI patients.

## **How is the success of fibrinolytic therapy evaluated in STEMI patients?**

Success is typically evaluated through clinical signs of reperfusion, such as relief of chest pain, resolution of ST-segment elevation on ECG, and improvement in hemodynamic stability.

# What advancements are being made in fibrinolytic therapy for STEMI treatment?

Recent advancements include the development of more targeted fibrinolytic agents, studies on optimal dosing strategies, and the combination of fibrinolytics with adjunctive therapies to enhance efficacy and safety.

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