



# Incidence and Significance of Spontaneous ST Segment Re-elevation After Reperfused Anterior Acute Myocardial Infarction

## — Relationship With Infarct Size, Adverse Remodeling, and Events at 1 Year —

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**Background:** Up to 25% of patients with ST elevation myocardial infarction (STEMI) have ST segment re-elevation after initial regression post-reperfusion and there are few data regarding its prognostic significance.

**Methods and Results:** A standard 12-lead electrocardiogram (ECG) was recorded in 662 patients with anterior STEMI referred for primary percutaneous coronary intervention (PPCI). ECGs were recorded 60–90 min after PPCI and at discharge. ST segment re-elevation was defined as a  $\geq 0.1$ -mV increase in ST<sub>Max</sub> between the post-PPCI and discharge ECGs. Infarct size (assessed as creatine kinase [CK] peak), echocardiography at baseline and follow-up, and all-cause death and heart failure events at 1 year were assessed. In all, 128 patients (19%) had ST segment re-elevation. There was no difference between patients with and without re-elevation in infarct size (CK peak [mean  $\pm$  SD] 4,231 $\pm$ 2,656 vs. 3,993 $\pm$ 2,819 IU/L;  $P=0.402$ ), left ventricular (LV) ejection fraction (50.7 $\pm$ 11.6% vs. 52.2 $\pm$ 10.8%;  $P=0.186$ ), LV adverse remodeling (20.1 $\pm$ 38.9% vs. 18.3 $\pm$ 30.9%;  $P=0.631$ ), or all-cause mortality and heart failure events (22 [19.8%] vs. 106 [19.2%];  $P=0.887$ ) at 1 year.

**Conclusions:** Among anterior STEMI patients treated by PPCI, ST segment re-elevation was present in 19% and was not associated with increased infarct size or major adverse events at 1 year.

**Key Words:** Reperfusion syndrome; ST segment elevation myocardial infarction; ST segment re-elevation; ST segment regression

The electrocardiogram (ECG) is the first-line diagnostic tool in ST elevation myocardial infarction (STEMI). The ECG is a simple and easily reproducible test, with a non-ambiguous diagnostic ability.

ST segment resolution is commonly used as a marker of successful reperfusion. It is an independent prognostic parameter of subsequent adverse events in STEMI patients. In many studies, the absence of ST segment resolution has

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been associated with the extent of myocardial damage, re-infarction, left ventricular (LV) remodeling, and mortality.<sup>1-5</sup>

Regression of ST segment elevation has been used in several studies to assess the quality of reperfusion.<sup>6-9</sup>

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Approximately one-quarter of patients with STEMI have ST segment re-elevation after initial regression following primary percutaneous coronary intervention (PPCI). There are few data regarding the significance of ST segment re-elevation after reperfusion, with most data coming from small clinical studies that were performed before the PPCI reperfusion era.<sup>10–14</sup>

In these small studies, the results are discordant, suggesting either increased severity in myocardial injury,<sup>10</sup> increased infarct size and poorer LV functional outcomes,<sup>11,12</sup> subclinical pericarditis,<sup>13</sup> or no significant effect on LV functional outcomes.<sup>14</sup> Moreover, there have been no studies examining the relationship between ST segment re-elevation and clinical outcomes.

The primary aim of the study, a substudy of the CIRCUS (Cyclosporine to Improve Clinical Outcome in ST-elevation myocardial infarction patients) trial, was to assess the frequency of ST segment re-elevation and its association with infarct size, LV functional parameters, as evaluated by echocardiography, and all-cause death and heart failure events at 1 year in a patient population with anterior STEMI treated with PPCI.

## Methods

### CIRCUS Trial

The subjects in the present study were recruited from the CIRCUS trial database.<sup>9</sup> Briefly, the CIRCUS trial was an international prospective multicenter randomized double-blind placebo-controlled clinical trial conducted between April 2011 and February 2014 that evaluated the efficacy of cyclosporine to prevent reperfusion injury in an anterior STEMI population. The CIRCUS trial did not show any significant effect of cyclosporine on clinical outcomes.<sup>9</sup> Approval for the present study was obtained from ethics committees in the relevant countries and all patients provided written informed consent prior to inclusion in the CIRCUS trial.

To be eligible for enrollment in the present study, patients had to be  $\geq 18$  years of age, to have presented within 12 h after the onset of acute coronary syndrome symptoms, to have ST segment elevation  $\geq 2$  mm in at least 2 anterior leads, and referred for PPCI. The culprit coronary artery was the left anterior descending coronary artery, with a Thrombolysis in Myocardial Infarction (TIMI) flow grade of 0 or 1 at the time of coronary angiography. Complete inclusion and exclusion criteria, study design, and the primary results already been reported elsewhere.<sup>9,15</sup>

Patients underwent percutaneous coronary intervention (PCI) according to standard guidelines. The use of thrombus aspiration, bare metal or drug-eluting stents, and glycoprotein IIb/IIIa inhibitor was left to the discretion of the treating physician.

### Acquisition and Analysis of ECG Recordings

Standard 12-lead ECGs were recorded upon admission (ECG-1), 60–90 min after PCI (ECG-2), and at discharge from hospital (ECG-3). All ECGs were standardized (0.1 mV/mm, 25 mm/s) and performed carefully. All ECGs were recorded, anonymized, and sent to a core laboratory for centralized reading. All ECGs were read by 2 experienced observers, blinded to all other study characteristics and outcomes, and independently of previous ECG recordings. ST segment elevation was measured manually by each observer. ST segment elevation was measured as

“STmax”, whereby only the lead with the greatest ST segment elevation (from V1 to V4) on each ECG was considered.

In assessing the reproducibility of ST segment analysis, the intrareader correlation coefficient was found to be 0.9725, with a mean ( $\pm$ SD) difference of  $0.05 \pm 0.7$  mm, and the inter-reader correlation coefficient was found to be 0.9659, with an average difference of  $0.35 \pm 0.81$  mm. Patients were excluded from analysis there was at least 1 ECG missing or if there was a left branch bundle block or paced heart rhythm. Patients who died before discharge were also excluded from analyses. The “ST segment re-elevation” group (ReST+) was defined as those patients exhibiting an increase of  $\geq 0.1$  mV ( $\geq 1$  mm) on ECG-3 compared with ECG-2. Patients with no re-elevation of the ST segment were classified as belonging to the “no ST segment re-elevation” group (ReST-).

### Study Endpoints

Infarct size was estimated by peak creatine kinase (CK) release. CK concentrations were measured locally at admission, and then again 4, 12, and 24 h after reperfusion. The CK peak was defined as the highest concentration measured during the 24 h following PPCI.

All patients underwent echocardiography during the initial hospitalization and again after 1 year. The LV ejection fraction (EF) was estimated by the Simpson method, as were LV end-diastolic volume (LVEDV) and LV end-systolic volume (LVESV). Absolute remodeling was defined as the relative increase in LVEDV between baseline and 1 year. Adverse LV remodeling was defined as a  $\geq 15\%$  increase in LVEDV (i.e.,  $[\text{LVEDV at 1 year} - \text{initial LVEDV}] / \text{initial LVEDV} > 15\%$ ).

Clinical outcomes were recorded prospectively at 1 year and were a composite of all-cause death and heart failure worsening during initial hospitalization or rehospitalization for heart failure. In addition, we assessed the incidence of pericarditis and stent thrombosis during the initial hospitalization. These are known adverse events possibly responsible for re-elevation of the ST segment. All clinical events were adjudicated by an events validation committee whose members were unaware of study group assignment.

### Statistical Analysis

All statistical analyses were post hoc analyses and were not prespecified in the original CIRCUS statistical analysis plan. Continuous variables with a normal distribution are expressed as the mean  $\pm$  SD, whereas those that were not normally distributed are expressed as the median and interquartile range (IQR). Normality was tested using the Shapiro-Wilk test. Discrete variables are expressed as percentages.

Comparisons of baseline characteristics or outcomes were performed using the  $\chi^2$  test or Fischer’s exact test, as appropriate, for categorical variables. Student’s t-test or the Wilcoxon test were used for continuous variables according to variable distribution.

Unadjusted event-free survival was evaluated by Kaplan-Meier estimates and statistical significance was assessed by the log-rank test. Adjusted risk estimates were obtained using Cox proportional hazard models, including variables found to differ significantly between groups on univariate analysis or deemed to be clinically relevant.

The same analyses were performed after exclusion of all patients with pericarditis and/or stent thrombosis to assess

the effect of ST segment re-elevation from “unknown causes”.

For all comparisons,  $P < 0.05$  was considered significant. All statistical analyses were conducted using STATA version SE 14.2 (StataCorp, College Station, TX, USA).

## Results

### ECG Characteristics

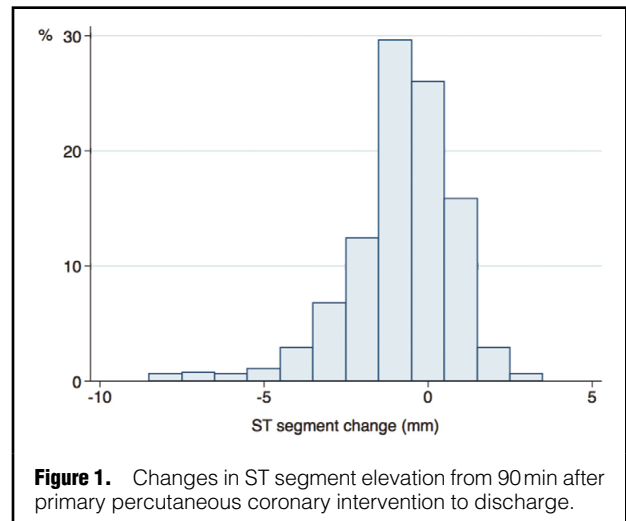
Complete ECG datasets were available for 662 patients from the CIRCUS trial and these patients were included in the present study. Of the original 969 patients enrolled in the CIRCUS trial, 307 were excluded from analyses because of left branch bundle block, paced heart rhythm, missing or non-analyzable ECG, or death before discharge (16 [1.7%] patients died before discharge).

Initial ST segment regression between ECG-1 and ECG-2 was compared and 3 groups were subsequently created: (1) complete ST segment regression ( $>70\%$ ); (2) partial regression (30–70%); and (3) no ST segment regression ( $<30\%$ ). No regression, or even partial regression, was strongly correlated with 1-year all-cause mortality ( $P=0.009$ ).

The median (IQR) time to recording of ECG-3 (at discharge) was 5 days (4, 7 days). In all, there were 128 patients (19%) in the ReST+ group. The median (IQR) change in ST segment elevation in the entire population between post-reperfusion and discharge was  $-1$  mm ( $-2, 0$  mm). The distribution of ST segment changes is shown in **Figure 1**.

ST re-elevation occurred significantly more frequently in patients with complete initial ST regression (70 patients; 54.7% of the ReST+ group) than in patients with partial (44 patients; 34.4%) or absent (14 patients; 10.9%) ST regression ( $P < 0.001$ ; **Table 1**).

Residual ST segment elevation was assessed on 1-year ECG recordings: 395 patients (59.7%) still had ST segment elevation of at least 1 mm, and 267 (40.3%) had complete ST segment resolution. In the ReST+ group, 89 patients (69.5%) still had ST segment elevation  $\geq 1$  mm at 1 year, whereas in the ReST– group 306 patients (57.3%) had ST segment elevation  $\geq 1$  mm at 1 year ( $P=0.011$ ).



**Figure 1.** Changes in ST segment elevation from 90 min after primary percutaneous coronary intervention to discharge.

### Procedural Characteristics and Hospital Course

Baseline characteristics for all patients are reported in **Table 1**. There was no difference in ST re-elevation between the cyclosporine-treated and control groups ( $P=0.852$ ). There were no significant differences between the ReST+ and ReST– groups, with a similar proportion of patients in both groups having diabetes, hypertension, dyslipidemia, or current smoker status. In addition, there were no significant differences in the glycemia or creatinine clearance at admission. Although total ischemic time was the same in the 2 groups, the door-to-balloon time was significantly greater in the ReST+ group ( $141 \pm 91$  vs.  $124 \pm 81$  min;  $P=0.048$ ), with a mean difference of 17 min.

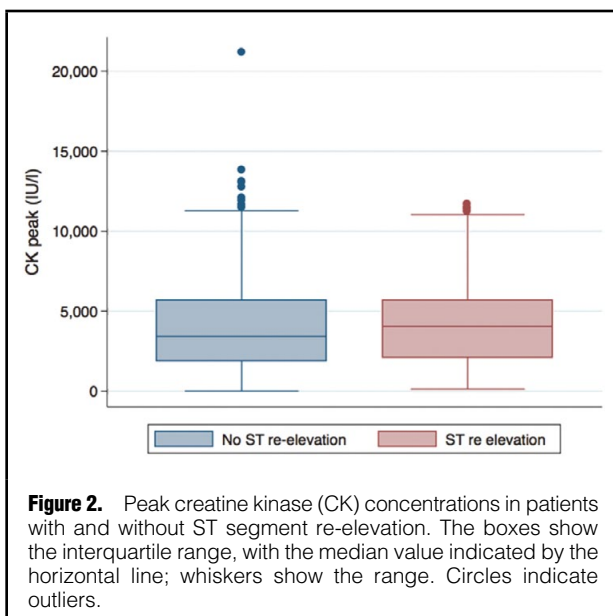
Procedural characteristics were similar between the ReST+ and ReST– groups, with the same initial and final coronary TIMI flow and proportion of multivessel disease and stenting (**Table 2**). There was no significant difference in medical prescriptions at discharge between the 2 groups.

<b>Table 1. Baseline Characteristics in Patients With and Without ST Segment Re-elevation</b>			
	No ST re-elevation (n=534)	ST re-elevation (n=128)	P value
Male	445 (83.5)	103 (80.5)	0.441
Age (years)	59±13	60±13	0.189
BMI (kg/m <sup>2</sup> )	27±4	26±4	0.227
Current smoker	245 (45.9)	47 (36.7)	0.061
Dyslipidemia	222 (41.6)	47 (36.7)	0.315
Hypertension	206 (38.6)	45 (35.2)	0.474
Diabetes mellitus	64 (12.0)	13 (10.2)	0.562
Previous MI	28 (5.2)	5 (3.9)	0.655
Peripheral ischemic disease	13 (2.4)	1 (0.8)	0.490
MDRD (mL/min)	92±26	89±22	0.365
Glycemia (mmol/L)	6.5±2.2	6.4±2.1	0.908
Initial ST segment resolution (%)			<0.001
<30	140 (26.2)	14 (10.9)	
30–70	276 (51.7)	44 (34.4)	
>70	118 (22.1)	70 (54.7)	

Data are given as the mean  $\pm$  SD or as n (%). BMI, body mass index; MDRD, creatinine clearance determined by the Modification of Diet in Renal Disease equation; MI, myocardial infarction.

<b>Table 2. Procedural Characteristics and Discharge Treatment in Patients With and Without ST Segment Re-elevation</b>			
	<b>No ST re-elevation (n=534)</b>	<b>ST re-elevation (n=128)</b>	<b>P value</b>
<b>Procedural characteristics</b>			
Ischemic time (min)	255±162	279±153	0.156
Door to balloon (min)	124±81	141±91	0.048
P2Y <sub>12</sub> receptor inhibitor	482 (90.3)	109 (85.2)	0.094
Thrombolysis	21 (3.9)	7 (5.5)	0.438
Thrombus aspiration	404 (75.7)	104 (81.3)	0.178
Stenting	475 (89.0)	113 (88.3)	0.829
Angiographic no reflow	25 (4.7)	5 (3.9)	0.817
<b>TIMI flow grade</b>			
Initial			0.578
0	410 (80.6)	100 (80.7)	
1	61 (12.0)	17 (13.7)	
2	30 (5.9)	4 (3.2)	
3	8 (1.6)	3 (2.4)	
Final			0.328
0	5 (1.0)	3 (2.4)	
1	4 (0.8)	1 (0.8)	
2	26 (5.0)	10 (7.9)	
3	490 (93.3)	113 (89.0)	
Multivessel disease	211 (39.5)	41 (32.0)	0.117
Cyclosporine	217 (40.6)	51 (39.8)	0.852
<b>Discharge treatment</b>			
P2Y <sub>12</sub> receptor inhibitor	509 (95.5)	123 (96.8)	0.497
Aspirin	528 (99.1)	128 (100)	0.273
ACE inhibitor	475 (89.1)	117 (92.1)	0.316
β-blocker	507 (95.1)	120 (94.5)	0.768
Statin	517 (97.0)	123 (96.9)	0.930
Aldosterone antagonist	140 (26.3)	27 (21.3)	0.244

Data are given as the mean±SD or as n (%). ACE, angiotensin-converting enzyme; TIMI, Thrombolysis in Myocardial Infarction.



**Figure 2.** Peak creatine kinase (CK) concentrations in patients with and without ST segment re-elevation. The boxes show the interquartile range, with the median value indicated by the horizontal line; whiskers show the range. Circles indicate outliers.

### Infarct Size and Echocardiography Endpoints

Infarct size did not differ between the ReST+ and ReST- groups, peak CK concentrations of 4,231±2,656 and 3,993±2,820 IU/L, respectively (P=0.402; **Figure 2**). In addition, LVEF, LVEDV, and LVESV were similar on initial echocardiography in both groups (**Table 3**). At 1 year, there was no difference in LVEF between the ReST- and ReST+ groups (52.2±10.8% vs. 50.7±11.6% respectively; P=0.186) and the proportion of patients exhibiting adverse LV remodeling at 1 year was similar in the 2 groups (317 [59.4%] vs. 75 [58.6%], respectively; P=0.874). Mean remodeling in the ReST- group was 18.3±30.9%, compared with 20.1±38.9% in the ReST+ group (P=0.631; **Figure 3**).

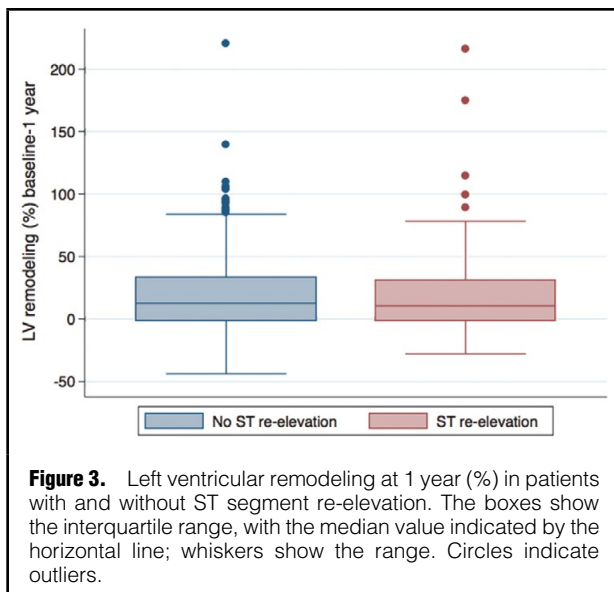
### Adverse Events

There was no significant difference in the incidence of pericarditis and stent thrombosis between the ReST- and ReST+ groups. The incidence of in-hospital pericarditis was 47 (8.8%) in the ReST- group and 12 (9.4%) in the ReST+ group (P=0.863), whereas stent thrombosis occurred in 7 patients (1.3%) in the ReST- group and in 1 patient (0.8%) in the ReST+ group (P=1.0).

There was no significant difference in all-cause death between the 2 groups (19 [3.6%] vs. 3 [2.3%] in the ReST- and ReST+ groups, respectively; P=0.783). Similarly, there

Table 3. Outcomes in Patients With and Without ST Segment Re-elevation			
	No ST re-elevation (n=534)	ST re-elevation (n=128)	P value
<b>Infarct size</b>			
Peak CK concentration (IU/L)	3,993±2,820	4,231±2,656	0.402
<b>Echocardiographic outcomes</b>			
At baseline			
LVEF (%)	47.4±10.1	47.7±10.0	0.745
LVEDV (mL/m <sup>2</sup> )	55±15	54±11	0.521
LVESV (mL/m <sup>2</sup> )	29±13	29±9	0.772
At 1 year			
LVEF (%)	52.2±10.8	50.7±11.6	0.186
LVEDV (mL/m <sup>2</sup> )	63±20	65±21	0.516
LVESV (mL/m <sup>2</sup> )	32±16	34±19	0.269
Adverse LV remodeling	317 (59.4)	75 (58.6)	0.874
% LV remodeling	18.3±30.9	20.1±38.9	0.631
<b>In-hospital adverse events</b>			
Pericarditis	47 (8.8)	12 (9.4)	0.863
Stent thrombosis	7 (1.3)	1 (0.8)	1.000
<b>Clinical outcomes</b>			
All-cause death/heart failure events	106 (19.2)	22 (19.8)	0.887
All-cause death	19 (3.6)	3 (2.3)	0.783
Heart failure	83 (15.5)	22 (19.8)	0.647

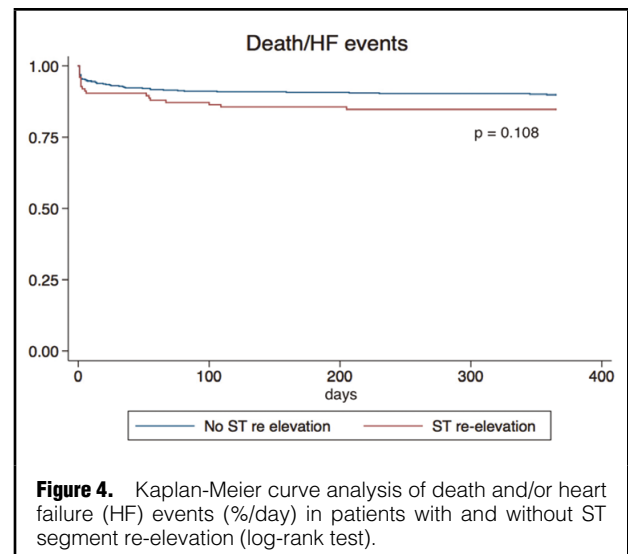
Data are given as the mean±SD or as n (%). CK, creatine kinase; LV, left ventricle; LVEDV, LV end diastolic volume; LVEF, LV ejection fraction (Simpson method); LVESV, LV end systolic volume.



was no significant difference in the incidence of heart failure events between the ReST<sup>-</sup> and ReST<sup>+</sup> groups (83 [15.5%] vs. 22 [19.8%], respectively; P=0.647).

There was no difference in the frequency of the composite outcome (all-cause death and heart failure) at 1 year, with 106 events (19.2%) in the ReST<sup>-</sup> group and 22 events (19.8%) in the ReST<sup>+</sup> group (P=0.887). However, on the Kaplan-Meier survival curves, there was a non-significant trend towards an increased incidence of events in the ReST<sup>+</sup> group (P=0.108; **Figure 4**).

Overall, the results were similar after exclusion of all



patients presenting with potential confounding clinical characteristics, such as pericarditis and stent thrombosis.

## Discussion

In the present study we found that ST segment re-elevation after reperfusion is present in 19% of patients with anterior STEMI, but does not have any significant relationship with infarct size, LVEF, adverse remodeling, or the composite endpoint of all-cause mortality and heart failure at 1 year.

The present study is the first to analyze the relationship between ST segment re-elevation and several important endpoints in a large and homogeneous group of patients with anterior STEMI followed up for 1 year. The incidence of ST segment re-elevation in STEMI patients in the present study was similar to that reported in previous studies, which ranged between 23% and 29%.<sup>10,12,14</sup> The absence of a significant relationship with any clinical endpoint is consistent with the findings of Matano et al.<sup>14</sup> In that study on patients with anterior STEMI, the authors did not find any difference in LVEF or LVEDV between patients with or without ST-segment re-elevation, and the study did not have sufficient power to assess clinical outcomes. The present study in a larger (and more homogeneous) population of patients with anterior STEMI is more powerful, and takes the findings of Matano et al.<sup>14</sup> further by showing the absence of any correlation between ST segment re-elevation and clinical outcomes.

In contrast, the results are not consistent with those reported by Okuda et al,<sup>12</sup> who found ST segment re-elevation was associated with larger infarct size and poorer LVEF at 6 months. Okuda et al<sup>12</sup> even showed that ST segment re-elevation (after initial ST resolution) was worse than the absence of initial ST segment resolution. However, the study population of patients with anterior STEMI in the study of Okuda et al<sup>12</sup> differs significantly from the present study population because, in their study, 31% of patients underwent thrombolysis alone, and the proportion of patients undergoing PCI differed significantly between groups with and without ST segment re-elevation. Furthermore Okuda et al<sup>12</sup> did not confirm their results in terms of clinical outcomes.

In a small observation cardiovascular magnetic resonance (CMR) study, Weaver et al<sup>10</sup> found a significant correlation between ST segment re-elevation and the extent and severity of myocardial injuries as assessed by contrast-enhanced CMR. The apparent discrepancy with the results of the present study could be explained by differences in study populations and the significantly smaller sample size in the study of Weaver et al,<sup>10</sup> with potential selection bias limitations. The population in the present study was more homogeneous because we only enrolled patients with anterior STEMI. In addition, Weaver et al<sup>10</sup> compared sumST (i.e., the sum of ST elevation on all ECG leads affected by the infarction) using a very low border of 0.1 mV and mixing anterior and inferior STEMI, which may have affected their results.

Persistence of ST elevation after reperfusion has been evaluated in many studies. In most of these studies, it has been associated with echographic, biological, and clinically poor prognosis,<sup>2,16,17,20–28</sup> even if some recent studies show only a weak or absent relationship.<sup>19,29–31</sup> Patients with persistent ST elevation are older, have more diabetes, a longer ischemic time, and a predominance of anterior STEMI.<sup>2,16–22</sup> Of note, there was no significant difference in these factors between the 2 groups in the present study population. Infarct size as assessed by peak CK or contrast-enhanced CMR is bigger if ST elevation persists,<sup>2,16,17,19,21,23–25</sup> and is associated with degraded LV parameters on echography or angiography in both the short and long term after discharge.<sup>3,17,22,26</sup> In most studies, persistent ST elevation was strongly associated with clinical outcomes, including 1-year mortality, heart failure, and major adverse cardiac events.<sup>2,3,16,17,20,21,23,27,28</sup> However, some recent studies do not confirm the relationship between ST recovery and LV

functional parameters.<sup>29–31</sup> Sejersten et al<sup>19</sup> showed a correlation between absence of ST recovery and long-term mortality only after thrombolysis, but not after PPCI.

ST segment resolution appears as a indication of epicardial reperfusion and is associated with a better final TIMI flow grade on the coronary angiogram.<sup>17,20</sup> Despite a final TIMI flow of Grade 3, some patients still have ST segment elevation and a poorer prognosis. It has been suggested that ST segment elevation may also reflect microvascular obstruction (i.e., myocardial reperfusion). Indeed, ST segment recovery is associated with an improved myocardial blush grade<sup>32</sup> on the coronary angiogram. Conversely, persistence of ST segment elevation is associated with no-reflow on myocardial contrast echocardiography<sup>33</sup> and microvascular obstruction on contrast-enhanced CMR.<sup>10,25,34</sup> This was well established in the thrombolysis era,<sup>1</sup> and ST resolution is still used to assess the efficacy of thrombolysis.

Recent studies evaluating ST segment and tissue perfusion after PPCI show discordant results. For example, Galiuto et al<sup>31</sup> did not confirm a relationship between ST recovery and echocardiographic no-reflow.

In the present study, the absence of initial ST segment resolution was a strong predictor of poor prognosis. In addition, we found that initial ST resolution had a significant effect on the incidence of ST re-elevation: the greater the initial resolution, the higher the probability of re-elevation. Initial complete ST resolution in the present study remained a very powerful predictive factor of a positive outcome, but was associated with an increased risk of ST segment re-elevation at discharge. This interaction could explain, in part, the absence of an effect of ST segment re-elevation on clinical outcomes at 1 year.

Non-painful and spontaneous ST segment re-elevation is an incompletely understood phenomenon. Several clinical situations have been associated with ST segment re-elevation, including subclinical pericarditis,<sup>13</sup> reinfarction or stent thrombosis, infarct expansion,<sup>35</sup> reperfusion injury, or an intense inflammatory response.<sup>12</sup> Zmyslinski et al<sup>13</sup> described ST segment re-elevation by ECG mapping in large groups of STEMI patients and found that its incidence was higher in case of pericarditis. The incidence of manifest pericarditis and stent thrombosis during the initial hospitalization did not differ between the 2 groups in the present study. So, we can suppose that these 2 adverse events, well known as being responsible for ST segment elevation, did not have any effect on the ST segment re-elevation we noted. This is backed up by the absence of any change in the results after these patients were excluded from the analyses.

Okuda et al<sup>12</sup> reported that C-reactive protein concentrations at 3 days in STEMI patients were higher in cases of ST segment re-elevation. This suggests that a more intense inflammatory response could be associated not only with a larger infarct size, but also with the healing process of the infarct and the pathophysiology of secondary reperfusion injuries.<sup>36</sup> The dynamic changes to myocardial tissue after reperfusion have recently been emphasized in an experimental model of pig infarction, in which Fernández-Jiménez et al<sup>37</sup> showed that there were 2 waves of edema seen on CMR after reperfusion. The 2nd wave and its intensity could play a role in the incidence of ST segment re-elevation.

In the present study, the door-to-balloon time was greater in the ReST+ group, although total ischemic time did not differ between the 2 groups. Even if we can assume that ST segment re-elevation is linked to a longer ischemic time,

the mean difference of 17 min between the 2 groups is low and its clinical significance seems weak. Somitsu et al<sup>38</sup> found that the history of angina predicted absence of ST segment re-elevation and they speculated that ischemic preconditioning and the development of good collaterals could be another explanation for this phenomenon.

Efficient reperfusion with PPCI has considerably improved the prognosis for patients with STEMI. With efficient reperfusion, ST segment dynamics have changed significantly. The clinical significance of ST segment modification (complete, partial, or absence of regression, and re-elevation) is probably different from prior reports in the era of absence of reperfusion or thrombolysis. However, ST segment regression is still currently used as a principal clinical endpoint in therapeutic studies on reperfusion.<sup>8,9</sup> The present study shows significant modification in the ST segment in a large and homogeneous population of patients with anterior STEMI. We did not find any clinical significance of ST segment re-elevation, which occurs in approximately one-fifth of patients. Further studies reassessing the day-by-day dynamics of the ST segment are needed in broader groups of STEMI patients to better understand the pathophysiology of ST segment re-elevation following reperfusion.

### Study Limitations

The principal limitation of the present study is the lack of a significant number of ECGs. The exclusion because of death before discharge could have been a bias, but it only concerned 16 patients. However, the power of the present study is much higher power than that of previously published studies.

The second limitation of the study is the time of ECG recording. ECG mapping studies<sup>13,35</sup> show that ST levels fluctuate, especially during the first days after STEMI. The moment of ECG recording in the present study was variable, and depended on the time of hospital discharge; this may have affected the level of ST elevation recorded.

In all ECG studies, 100% reproducibility in ECG realization is impossible because of potential variation in the exact position of the electrodes (especially precordial leads). This could have affected the results of the present study, but is real-life practice and we have no technical way to control this variability. We tried to minimize this phenomenon by using the STmax method. ST segment elevation measurements using the STmax method are solid and reproducible. There are several methods for measuring ST segment elevation in the literature, but the STmax method is one of the most frequently used and the simplest.<sup>2,17,18,23,27</sup> We did not study ST reciprocal deviation because this would have made the measures more complex and variable.

The 0.1 mV (1 mm) threshold was chosen because this is the minimum change that can be unequivocally detected visually by an expert reader. We did not choose a more elevated threshold because the proportion of patients with ST segment re-elevation would have been too small to enable any conclusions to be made (using a 0.2 mV [2 mm] threshold, the proportion of patients with ST segment re-elevation would have been 3%). The proportion of patients with ST segment re-elevation in the present was 19%, which is comparable with other published data.<sup>10,14</sup>

### Conclusions

In conclusion, in a group of patients with anterior STEMI,

ST segment re-elevation after revascularization by PPCI occurred in one-fifth of patients and was not predictive of increased infarct size, worse LV functional parameters, or major clinical adverse events. Further studies are needed to determine the significance of ST segment re-elevation.

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