In-Hospital Outcomes Associated With Fibrinolytic and Thienopyridine Use in Patients With ST-Segment Elevation Acute Myocardial Infarction. The Global Registry of Acute Coronary Events

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Introduction and objectives. To investigate how thienopyridine treatment, with or without associated fibrinolysis, affects the rates of major bleeding and in-hospital death in patients with ST-elevation myocardial infarction (STEMI).

Methods. The rates of major bleeding and in-hospital death were studied in 14 259 consecutive patients with STEMI. During hospitalization, 5340 (38%) received thienopyridines, 3007 (21%) received fibrinolytic drugs, and 2044 (14%) received both.

Results. Major bleeding occurred more frequently in patients who received thienopyridines with or without fibrinolitics, in 4.6% and 4.1%, respectively, compared with 2.3% in those who received fibrinolitics alone and 2.8% in those who received neither (P<.001). Multivariate analysis, which included adjustments for risk factors for bleeding, percutaneous coronary intervention, and cardiac catheterization, showed that thienopyridine treatment was an independent risk factor for bleeding (odds ratio =1.68; 95% confidence interval, 1.23–2.31). In-hospital mortality was lower in patients who received a thienopyridine, and such treatment was an independent predictor of lower mortality (odds ratio =0.50; 95% confidence interval, 0.39-0.60).

Conclusions. Thienopyridine treatment was associated with an increased risk of major bleeding but also with a better in-hospital prognosis. These findings in unselected patients with STEMI, who are representative of those seen in daily clinical practice, complement, but do not replace, the data obtained in randomized clinical trials of selected patients.

Key words: Acute coronary syndromes. Thienopyridines. Anticoagulants. Fibrinolytics. ST-elevation myocardial infarction.

Evolución hospitalaria asociada al empleo de fibrinolíticos y tienopiridinas en pacientes con infarto agudo de miocardio y elevación del segmento ST. The Global Registry of Acute Coronary Events

Introducción y objetivos. Investigar la incidencia de hemorragias graves y la mortalidad hospitalaria en pacientes con infarto de miocardio y elevación del segmento ST (IAMCEST) en relación con la administración de tienopiridinas con o sin tratamiento trombolítico asociado.

Métodos. Se estudió la incidencia de hemorragias graves y mortalidad hospitalaria en 14 259 pacientes...
consecutivos con IAMCEST. Un total de 5.340 pacientes (38%) recibieron tratamiento con tiropiridinas, 3.007 (21%) recibieron fármacos trombolíticos y 2.044 (14%) ambos tipos de fármacos durante el periodo de hospi
talización.

Resultados. Las hemorragias graves fueron más frecuentes en los pacientes que recibieron tiropiridinas con o sin fármacos trombolíticos asociados (el 4,6% y el 4,1%, respectivamente), que en los pacientes que solo reci-
cieron fibrinolíticos (2,3%) o ninguno de los dos tipos de fármacos (2,8%) (p < 0,001). En el análisis multivariante, ajustado para los factores de riesgo hemorrágico y cate-
terismo cardiaco o intervención coronaria percutánea, el tratamiento con tiropiridinas se identificó como un fac-
tor independiente de hemorragia (odds ratio [OR] = 1,68; intervalo de confianza [IC] del 95%, 1,23–2,31). La mortal-
talidad intrahospitalaria fue menor en los pacientes que recibieron tiropiridinas, lo que se identificó como fac-
tor independiente relacionado con menor mortalidad (OR =0,50; IC del 95%, 0,39–0,60).

Conclusiones. El tratamiento con tiropiridinas se asoció con un aumento del riesgo de hemorragias, pero con mejor pronóstico intrahospitalario. Estos resultados, en pacientes no seleccionados con diagnóstico de IAM-
CEST y representativos de la práctica clínica diaria com-
plementan, pero no reemplazan, la información derivada de ensayos clínicos en enfermos seleccionados y con dis-
tribución aleatoria del tratamiento.

Palabras clave: Síndromes coronarios agudos. Tienopiri-
dinas. Anticoagulantes. Fibrinolíticos. Infarto agudo de miocardio con elevación de ST.

ABBREVIATIONS
ACS: acute coronary syndrome
GRACE: Global Registry of Acute Coronary
Events
PCI: percutaneous coronary intervention
STEMI: ST-elevation myocardial infarction

INTRODUCTION
Platelet aggregation and thrombosis play a major role in the development of acute coronary
syndromes (ACS). Treatment with aspirin and heparin is recommended in all patients with acute
myocardial infarction and unstable angina, while fibrinolysis remains the most frequently used method
of reperfusion therapy in patients with acute ST-segment elevation myocardial infarction (STEMI),
and glycoprotein IIb/IIIa inhibitors are frequently
used in conjunction with percutaneous coronary
intervention (PCI). As a result, an increasing
number of patients receive several antithrombotic
drugs simultaneously during the first few days
after developing unstable angina or suffering a
myocardial infarction. The potential increase in
bleeding risk associated with combination therapy
has not been fully investigated in clinical practice.
The use of tiropiridinas, in particular clopidogrel,
in ACS has been associated with an improvement in
outcome. However, little information is available
about the use of tiropiridinas outside the context
of clinical trials. The outcome in regular patients
is unknown and concern exists regarding the potential
increase in bleeding risk.

The aim of this study was to analyze the rates of
major bleeding and in-hospital death in patients
with STEMI who were treated with tiropiridinas,
with or without fibrinolytic drugs, in an unselected
population of patients enrolled in the Global
Registry of Acute Coronary Events (GRACE).

METHODS
Study Population
The GRACE study is a large, prospective,
multinational, observational study designed to
reflect an unbiased population of patients with
the spectrum of ACS. A total of 106 hospitals
in 14 countries have contributed data to the
study. Patients entered in the registry had to be at
least 18 years old and alive at the time of hospital
presentation, be admitted for ACS as a presumptive
diagnosis (ie, to have symptoms consistent with acute
ischaemia) and have at least one of the following:
electrocardiographic changes consistent with ACS,
serial increases in serum biochemical markers of
cardiac necrosis, and/or documentation of coronary
tree disease. The qualifying ACS must not have
been precipitated by significant non-cardiovascular
comorbidity such as trauma or surgery.

To ensure the enrolment of an unbiased population,
the first 10-20 consecutive patients were recruited
from each study site on an ongoing monthly basis.
Data were collected by trained coordinators using
a standardized case report form. Demographic
characteristics, medical history, symptoms at
presentation, biochemical and electrocardiographic
findings, treatment practices, and a variety of
hospital outcome data were collected. In-hospital
management of the patients was left to the discretion
of the investigating physicians. Standardized
definitions for all patient-related variables and
clinical diagnoses were used. STEMI was defined
by the presence of new ST-segment elevation >0.1 mV in 2 contiguous leads in the index or qualifying electrocardiogram, and serum biochemical markers indicative of myocardial necrosis within each hospital laboratory’s normal range. Patients originally admitted for unstable angina but in whom STEMI occurred during the hospital stay were classified as having STEMI. Patients with STEMI who were transferred from hospitals not involved in the GRACE registry were excluded.

Patients were divided into 4 groups according to the treatment they received during the first 24 h of admission or at any time during the index hospitalization: a) thienopyridines (clopidogrel or ticlopidine) without fibrinolytic drugs; b) fibrinolytic drugs without thienopyridines; c) both thienopyridines and fibrinolytic drugs; and d) neither thienopyridines nor fibrinolytic drugs.

Clinical Endpoints

The principal endpoints of this study were in-hospital major bleeding and all-cause mortality. Major bleeding was defined as life-threatening bleeding with at least 1 of the following present: a bleed requiring a transfusion of 2 or more units of packed red cells, or a bleed resulting in an absolute reduction in hematocrit of ≥10%. Major bleeding also included intracranial bleeding or bleeding that resulted in death. Bleeding episodes that occurred secondary to coronary artery bypass surgery were excluded. Although the full spectrum of renal dysfunction is related to a higher risk for bleeding and outcome, for this study severe renal dysfunction was arbitrarily defined as a creatinine clearance of <30 mL/min.

Statistical Analysis

Comparisons between groups were made using the 2-tailed Kruskal-Wallis test for continuous variables and the χ² or Fisher’s exact test for categorical variables. Multivariable logistic regression analysis was carried out to identify factors associated with the hospital use of thienopyridine, adjusting for a variety of demographic and clinical factors.

The study population was divided into 2 groups according to whether or not they received a fibrinolytic drug. The relationship between thienopyridine use and major bleeding episodes was examined in both groups after adjusting for cardiac catheterization and PCI a) at any time during hospitalization; b) during the first 24 h; and c) after the first 24 h, and for the variables included in the GRACE in-hospital mortality model (age, Killip class, systolic blood pressure, ST-segment deviation, cardiac arrest during presentation, serum creatinine level, positive initial cardiac enzyme findings, and heart rate).

All tests were 2 sided; significance was set at α = 0.05. Because of the multiple comparisons and the exploratory nature of these analyses, results of borderline statistical significance (α = .01-.05) were considered as hypothesis-generating and not definitive.

RESULTS

Thienopyridine Use in Patients With STEMI

A total of 14259 patients with STEMI at admission were included in this analysis. These patients were admitted to GRACE hospitals between April 1999 and December 2005. Overall, 70% of the study population were men. The median age of the patients was 65 years. Some 7384 patients (52%) received thienopyridines at some time (5239 during the first 24 h) and 5051 (35%) received fibrinolytic drugs (1093 [21%] with thienopyridines within the first 24 h and 2044 [41%] with thienopyridines at some time during hospitalization). Over the study period the use of thienopyridines increased markedly, from 32% in 1999 (clopidogrel 19%; ticlopidine 15%) to 70% (clopidogrel 69%; ticlopidine 4.4%) in 2005. The most commonly used fibrinolytic drug was alteplase (57%), followed by streptokinase (33%), tenecteplase (8.5%), and other fibrinolytic drugs (1.5%).

Patient Characteristics (Table 1)

Patients who received thienopyridines alone presented with a similar clinical history and admission profile to patients receiving fibrinolytic drugs alone or in combination with thienopyridines. Treatment during hospitalization was similar in these groups, with the exception of the use of glycoprotein IIb/IIIa inhibitors, statins, and PCI, each of which was more commonly used in patients receiving thienopyridines. Patients who did not receive fibrinolytic drugs or thienopyridines had a higher risk profile both in terms of the risk of bleeding and death during hospitalization. These patients were characterized as being older and included a greater
In-Hospital Major Bleeding

Major bleeding rates during hospitalization were lowest in patients who received fibrinolytic drugs only, and were highest in patients who received both fibrinolytic drugs and thienopyridines (2.3% vs 4.6%, respectively; \( P < .001 \)) (Table 2). After adjusting for the GRACE variables for bleeding risk and PCI, the risk of major bleeding was higher in patients who received thienopyridines at some time during hospitalization.

### TABLE 1. Patient Characteristics According to Treatment During Hospitalization

<table>
<thead>
<tr>
<th></th>
<th>Treatment With a Fibrinolytic Drug (35%)</th>
<th>No Treatment With a Fibrinolytic Drug (65%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Thienopyridine</td>
<td>No Thienopyridine</td>
</tr>
<tr>
<td>Patients, n</td>
<td>2044</td>
<td>3007</td>
</tr>
<tr>
<td>Age, median (interval), y</td>
<td>60 (51-69)</td>
<td>63 (54-73)</td>
</tr>
<tr>
<td>Male, %</td>
<td>78</td>
<td>72</td>
</tr>
<tr>
<td>History, %</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Angina</td>
<td>33</td>
<td>38</td>
</tr>
<tr>
<td>MI</td>
<td>15</td>
<td>14</td>
</tr>
<tr>
<td>Hypertension</td>
<td>46</td>
<td>46</td>
</tr>
<tr>
<td>Diabetes</td>
<td>16</td>
<td>17</td>
</tr>
<tr>
<td>Hyperlipidemia</td>
<td>41</td>
<td>32</td>
</tr>
<tr>
<td>Renal dysfunction</td>
<td>3.4</td>
<td>3.4</td>
</tr>
<tr>
<td>Congestive heart failure</td>
<td>2.4</td>
<td>3.5</td>
</tr>
<tr>
<td>Peripheral vascular disease</td>
<td>4.8</td>
<td>5.8</td>
</tr>
<tr>
<td>Atrial fibrillation</td>
<td>2.1</td>
<td>3.2</td>
</tr>
<tr>
<td>Stroke</td>
<td>3.1</td>
<td>4.5</td>
</tr>
<tr>
<td>Major bleeding</td>
<td>0.5</td>
<td>0.8</td>
</tr>
<tr>
<td>PCI</td>
<td>8.6</td>
<td>4.0</td>
</tr>
<tr>
<td>CABG</td>
<td>3.0</td>
<td>2.7</td>
</tr>
<tr>
<td>Presentation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-hospital delay, median (range), h</td>
<td>7 (5-11)</td>
<td>7 (4-11)</td>
</tr>
<tr>
<td>Killip class I, %</td>
<td>89</td>
<td>83</td>
</tr>
<tr>
<td>Killip class II, %</td>
<td>9.0</td>
<td>13</td>
</tr>
<tr>
<td>Killip class III, %</td>
<td>1.0</td>
<td>2.4</td>
</tr>
<tr>
<td>Killip class IV, %</td>
<td>0.8</td>
<td>1.6</td>
</tr>
<tr>
<td>Cardiac arrest, %</td>
<td>2.3</td>
<td>3.4</td>
</tr>
<tr>
<td>Systolic BP, mm Hg</td>
<td>135 (118-151)</td>
<td>139 (120-157)</td>
</tr>
<tr>
<td>Heart rate, beats/min</td>
<td>74 (62-86)</td>
<td>75 (63-89)</td>
</tr>
<tr>
<td>Treatment during hospitalization, %</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aspirin</td>
<td>96</td>
<td>97</td>
</tr>
<tr>
<td>ACE inhibitors</td>
<td>77</td>
<td>66</td>
</tr>
<tr>
<td>Beta-blockers</td>
<td>91</td>
<td>85</td>
</tr>
<tr>
<td>GP IIb/IIIa inhibitors</td>
<td>33</td>
<td>4.9</td>
</tr>
<tr>
<td>UFH</td>
<td>65</td>
<td>59</td>
</tr>
<tr>
<td>LMWH</td>
<td>57</td>
<td>43</td>
</tr>
<tr>
<td>Statins</td>
<td>77</td>
<td>57</td>
</tr>
<tr>
<td>PCI within first 24 h</td>
<td>38</td>
<td>2.3</td>
</tr>
<tr>
<td>PCI at any time</td>
<td>70</td>
<td>6.5</td>
</tr>
</tbody>
</table>

ACE indicates angiotensin-converting enzyme; BP, blood pressure; CABG, coronary artery bypass grafting; GP, glycoprotein; LMWH, low molecular weight heparin; MI, myocardial infarction; PCI, percutaneous coronary intervention; UFH, unfractionated heparin.

The proportion of those with previous angina and myocardial infarction, diabetes, renal dysfunction, chronic heart failure and stroke, and a poorer Killip class at admission. In addition, patients who did not receive either thienopyridines or fibrinolytic drugs were less likely to receive evidence-based cardiac therapies during hospitalization including, aspirin, beta-blocker, and statin therapies.

After multivariable analysis, the use of thienopyridines was associated with a medical history of coronary artery disease, cardiac catheterization, the in-hospital use of angiotensin-converting enzyme inhibitors, statins, low molecular weight heparin and glycoprotein IIb/IIIa inhibitors, and especially with PCI (Figure).
who received either fibrinolytic drugs alone or neither therapy. While treatment with a thienopyridine was independently associated with an increased risk of

\[
\text{OR} = 1.68; \quad 95\% \text{ CI}, 1.23-2.31
\]

(Table 3).

In-hospital Mortality

Hospital death rates were lowest in patients receiving both fibrinolytic drugs and thienopyridines and highest in patients receiving neither fibrinolytic drugs nor thienopyridines (3.0\% vs 15\%, respectively) (Table 2). After adjusting for the potentially confounding variables included in the GRACE risk model for hospital mortality\textsuperscript{15} and PCI, the use of thienopyridines, both during the first 24 h and at any time during hospitalization, was associated with a significantly lower death rate (OR =0.50; 95\% CI, 0.39-0.60) (Table 3).

**DISCUSSION**

The results of this large observational study in patients with STEMI showed that bleeding was more common in patients who received thienopyridines with or without fibrinolytic drugs than in patients who received either fibrinolytic drugs alone or neither therapy. While treatment with a thienopyridine was independently associated with an increased risk of

\[
\text{OR} = 1.68; \quad 95\% \text{ CI}, 1.23-2.31
\]
bleeding, it was also associated with a lower risk of in-hospital death.

**Increasing Use of Thienopyridines in STEMI**

These data from the large, multinational GRACE study show a progressive increase in the use of thienopyridines in patients with STEMI, similar to that observed in other contemporary registries. The administration of thienopyridines, in particular clopidogrel, in association with aspirin appears to be effective in reducing the risk of ischaemic events in patients with non-ST elevation ACS, and in preventing the thrombotic occlusion of coronary arteries after PCI and stent implantation. Moreover, the early use of clopidogrel in patients with STEMI who receive fibrinolytic therapy is associated with a better outcome, as demonstrated in the Clopidogrel as an Adjunctive Reperfusion Therapy (CLARITY) and the Clopidogrel and Metoprolol in Myocardial Infarction (COMMIT) randomized clinical trials.

The use of thienopyridines was more common in patients undergoing PCI (Table 1, Figure), but a significant number of patients who did not undergo invasive treatment received thienopyridines along with aspirin, unfractionated heparin, or low molecular weight heparin. Before the publication of the CLARITY and COMMIT results in March 2005, no clinical data were available to support the use of clopidogrel or ticlopidine in patients with STEMI; therefore the increase in use could be attributed to a perception of benefit not supported by the available clinical evidence at that time. In addition, patients receiving thienopyridines were more likely to receive glycoprotein IIb/IIIa inhibitors, statins, low molecular weight heparins, and angiotensin-converting enzyme inhibitors.

**Bleeding Complications**

Major bleeding was more common than that observed in randomized clinical trials, probably reflecting a more liberal use of antithrombotics without the protective inclusion and exclusion criteria and the more rigid control enforced in clinical trials. Treatment with thienopyridines was associated with an increased risk of major bleeding in both patients who received and who did not receive treatment with fibrinolytic drugs. The use of thienopyridines was also an independent predictor for major bleeding after correction for other factors related to an increase in bleeding complications in patients with STEMI. Because the mechanisms of action of aspirin, thienopyridines, glycoprotein IIb/IIIa inhibitors, fibrinolytic drugs, and heparins are different, their combined use may exert an additive antithrombotic effect but may also increase the potential risk of bleeding. An increase in bleeding complications has been reported with the combination of aspirin and clopidogrel, and a small and statistically inconclusive excess bleeding risk has been reported in patients referred for urgent surgery. However, the risk of bleeding complications does not appear to be increased significantly with triple antiaggregant therapy using aspirin, thienopyridines, and glycoprotein IIb/IIIa inhibitors, or with high clopidogrel doses associated with percutaneous coronary revascularization. No significant risk of bleeding was observed with the combined use of clopidogrel and fibrinolytics in the well selected groups of STEMI patients with low bleeding risk included in the CLARITY and COMMIT trials. The increase in bleeding risk in the present study could be explained by a more liberal use of antithrombotic drugs, without the careful clinical selection of patients with low bleeding risk observed in clinical trials.

**Outcome**

All-cause in-hospital mortality was lower in patients with STEMI who were treated with thienopyridines, especially in association with fibrinolytic therapy. In addition, the use of thienopyridines was associated with lower in-hospital mortality after adjusting for a variety of factors previously shown to be associated with short-term mortality after an ACS. The lower mortality rate associated with thienopyridine use may reflect a beneficial effect of treatment but many confounding factors may also influence this association. The clinical effects of thienopyridines have been reported in patients with non-ST elevation ACS and in patients undergoing PCI, but the clinical benefit was only significant for combined end points and no direct benefit was reported in relation to mortality. In the CLARITY study, the addition of clopidogrel and aspirin to fibrinolytic therapy improved clinical outcome, but no difference in mortality was observed in patients who received clopidogrel or placebo. In the COMMIT trial, a modest but significant reduction in mortality was observed in patients receiving clopidogrel compared to placebo. It is difficult to explain the significant reduction in mortality found in the present study. It might be attributed to mechanisms that are difficult to ascertain in a non-randomized observational study or to an effect apparent only in higher-risk groups. Patients treated with thienopyridines were in general better treated, more frequently receiving medications that are highly recommended in practice guidelines (Table 1). It is interesting to
note that patients included in the GRACE registry were at substantially higher risk than those enrolled in the CLARITY and COMMIT trials. In the GRACE registry, hospital mortality in patients who were not treated with thienopyridines or fibrinolytics was 15%, whereas 28-day mortality in patients who received neither drug was 10% in the COMMIT trial. Cardiovascular death at 30 days was only 4.5% in the placebo group of the CLARITY trial.

Limitations and Strengths of the Study

While registry studies are always subject to potential biases, they are valuable for studying real-world practice patterns and detecting rare side-effects of drugs and drug interactions. The nature of GRACE, as well as any other registry with treatments not randomized in selected groups of patients, prevents clear conclusions being drawn regarding the benefit and potential risk of treatments. The findings may be an overestimation in view of the fact that it is impossible to control for all of the differences in baseline variables. Unmeasured variables may have led to clinicians deciding not to use thienopyridines, or indeed other pharmacological and interventional therapies in some high risk patients with complex comorbidity. Besides, the GRACE registry does not collect information on specific thienopyridine drugs, dosing and adherence to the treatment throughout the study period, preventing a more detailed analysis of the data. Furthermore, the 2 populations differ in terms of their baseline characteristics, with patients treated with a thienopyridine and no fibrinolytic having more important risk characteristics than those who received a fibrinolytic alone. Another important limitation is the lack of a standard definition of bleeding. The definition used in the GRACE study is similar to those used in other studies, but the rates of bleeding are not truly comparable with those associated with other definitions. Finally, it is impossible to assess a causal relationship between an endpoint and treatments from registry data. On the other hand, GRACE is a multicentre, prospective registry including unselected patients with ACS, and thus provides unbiased information on treatments and outcomes in clinical practice which may differ from those expected on the basis of results from randomized clinical trials involving selected populations of patients with well-defined inclusion and exclusion criteria. Thus, information obtained from large registries complements the information obtained in clinical trials, and is particularly relevant for exploring secondary effects in populations that are not protected by the rigid exclusion criteria of clinical trials. However, reliable conclusions cannot be established with respect to contradictions with the results of clinical trials, in particular in regard to the benefit of treatments.

CONCLUSIONS

The proportion of patients with STEMI who received thienopyridines has been progressively increasing, and over 70% of patients with STEMI now receive thienopyridines. Major bleeding was more common than in clinical trials, suggesting that less attention was given to the appropriate use of antithrombotics. Major bleeding was more common in patients who received thienopyridines, although the use of thienopyridines during the first 24 h post-STEMI was not found to be an independent risk factor for bleeding. A significantly lower death rate was also observed, suggesting that, overall, the use of thienopyridines may improve outcome in patients with STEMI.

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