returning to their referring hospital or if they were transferred directly from the catheterization laboratory, and whether or not these details could have had any influence when calculating the hospital stay times and intensive care stay times.

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Does Implementation of the Infarction Code Lead to Changes in the Treatment and Prognosis of Patients With Non-ST Elevation Acute Coronary Syndrome? Response

¿La implantación del código infarto implica cambios en el tratamiento y el pronóstico de los pacientes con síndrome coronario agudo sin elevación del ST? Respuesta

To the Editor,

We appreciate the compliments and comments from the team at the Catheterization Unit of the *Hospital de Cuidad Real*. We agree that the results observed in patients with non—ST-elevation acute coronary syndrome (NSTEACS) in our study[1] are difficult to explain, given that the infarction code centers around ST-elevation acute coronary syndrome. Regarding their first question, the percentage of patients with NSTEACS classified as high risk increased from 3.9% to 12.6% ($P = .01$) after implementation of the infarction code. In this high-risk NSTEACS subgroup, the total revascularization rate increased from 62.5% to 87.5% ($P = .04$), but the rate of revascularization in the first 24 hours did not increased (69.6% vs 62.5%; $P = .89$).

In response to their second question, in NSTEACS patients, the biggest change in drug treatment between the 2 periods was the use of the new antiplatelet agents, which increased from 1.4% to 32.6% ($P < .01$): ticagrelor, from 0% to 26.3%; and prasugrel, from 1.4% to 6.3% ($P < .01$ for both). This coincided with the dissemination of the antiplatelet therapy protocol in the infarction code, and is in line with the recommendations in clinical practice guidelines.[2] The increased rate of revascularization, the increased use of new antiplatelet agents, and the general reorganization of the services involved in the infarction code could explain the benefits observed in NSTEACS patients.

With the exception of 1 privately-managed hospital that continued to use thrombolysis, primary angioplasty became practically the only reperfusion strategy in our area. Unless clinically contraindicated, all patients were transferred directly from the catheterization lab to the intensive care unit of their referring hospital. The organization of the infarction code in Alicante with 2 out of hours care areas means that the province's resources are concentrated in a rational and coherent way. This, combined with the endeavor of the professionals involved, has allowed primary angioplasty to enter into routine use, with the consequent benefits to the population.

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