

For patients diagnosed with acute coronary syndrome*

Clinical criteria for use of AGGRASTAT¹

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- 1 **Positive history**
 - Prolonged (≥ 10 minutes) anginal pain or repetitive episodes of angina at rest or during minimal exercise

and

 - 2 **Positive ECG**
 - ST-segment depression ≥ 1.0 mm
 - Transient ST-segment elevation ≥ 1.0 mm (lasting less than 20 minutes)
 - T-wave inversion in at least two contiguous leads

or

 - 3 **Positive cardiac enzymes**

Contraindications: • Known hypersensitivity to any component of the product • Active internal bleeding or history of bleeding diathesis within the previous 30 days • History of intracranial hemorrhage, intracranial neoplasm, arteriovenous malformation, or aneurysm • History of thrombocytopenia following prior exposure to AGGRASTAT • History of stroke within 30 days or any history of hemorrhagic stroke • Major surgical procedure or severe physical trauma within the previous month • History, symptoms, or findings suggestive of aortic dissection • Severe hypertension (systolic blood pressure >180 mmHg and/or diastolic blood pressure >110 mmHg) • Concomitant use of another parenteral GP IIb/IIIa inhibitor • Acute pericarditis

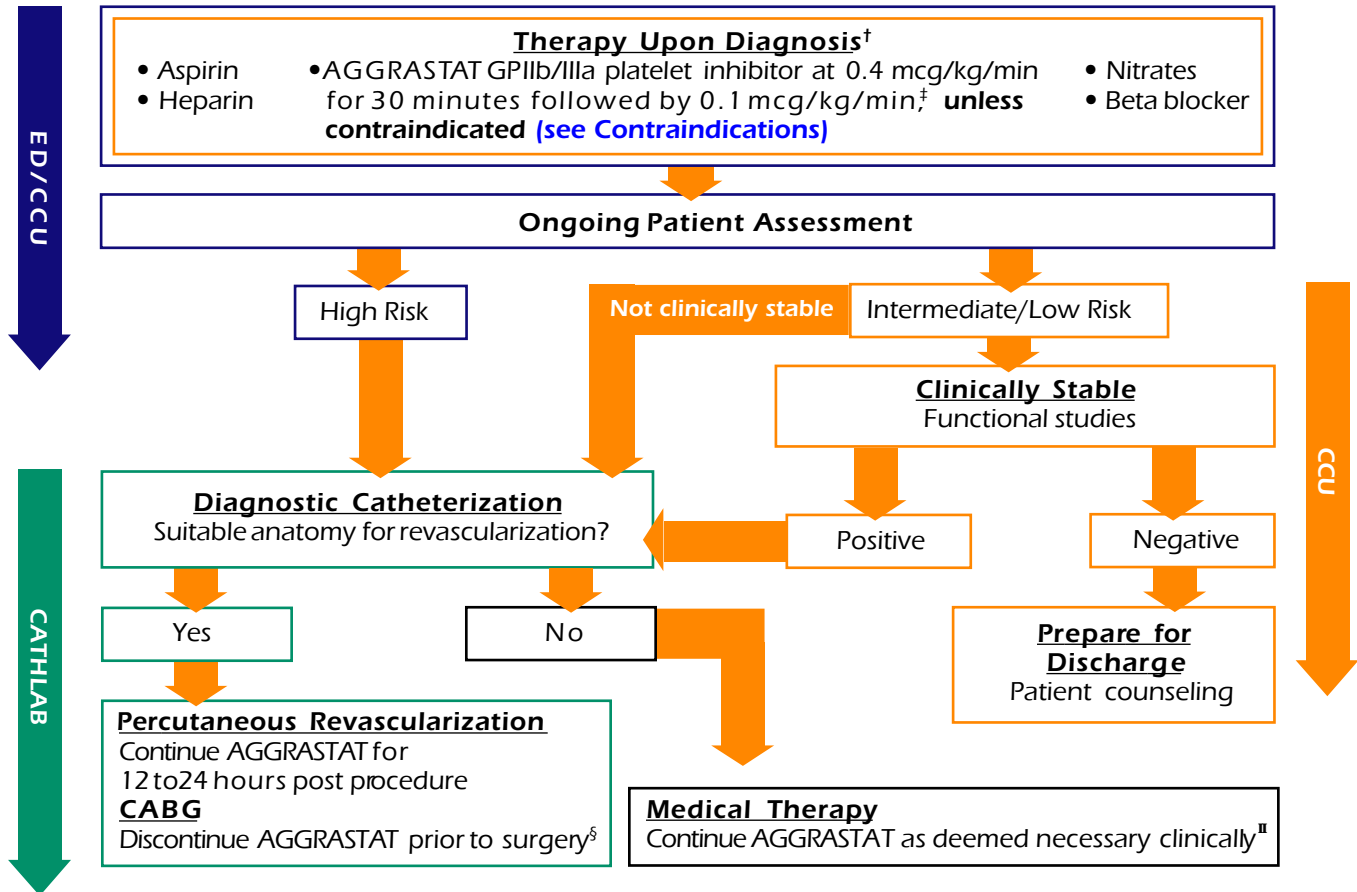
* Acute coronary syndrome includes unstable angina and non-Q-wave MI and excludes Q-wave or nontransient ST-elevation MI.

REFERENCE: 1. The Platelet Receptor Inhibition in Ischemic Syndrome Management in Patients Limited by Unstable Signs and Symptoms (PRISM-PLUS) Study Investigators. Inhibition of the platelet glycoprotein IIb/IIIa receptor with tirofiban in unstable angina and non-Q-wave myocardial infarction. *N Engl J Med.* 1998;338:1488–1497.

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Start AGGRASTAT with heparin upon diagnosis of acute coronary syndrome*



Selected Bleeding Precautions: Bleeding is the most common complication encountered during therapy with AGGRASTAT. Most major bleeding occurs at the arterial access site for cardiac catheterization. When bleeding cannot be controlled with pressure, infusion of AGGRASTAT and heparin should be discontinued. Administer cautiously with drugs that affect hemostasis (e.g., warfarin).

Before prescribing AGGRASTAT, please read the full Prescribing Information.

* Acute coronary syndrome includes unstable angina and non-Q-wave MI and excludes Q-wave or nontransient ST-elevation MI.

[†] unless contraindicated.

[‡] The dosage of AGGRASTAT should be decreased by 50% in patients with severe renal insufficiency (creatinine clearance <30 mL/min).

[§] Following discontinuation of an infusion of AGGRASTAT 0.10 mcg/kg/min, ex vivo platelet aggregation returns to near baseline in approximately 90% of patients with coronary artery disease in 4 to 8 hours.

^{||} PRISM-PLUS, AGGRASTAT was administered in combination with heparin for 48 to 108 hours.



Short-Term Risk of Death or Nonfatal Myocardial Infarction in Patients With Symptoms Suggesting Unstable Angina

High risk	Intermediate risk	Low risk
At least one of the following features must be present:	No high-risk feature, but must have any of the following:	No high- or intermediate-risk feature, but may have any of the following:
Prolonged ongoing (>20 mins) rest pain	Rest angina now resolved but not low likelihood of CAD	Increased angina frequency, severity, or duration
Pulmonary edema	Rest angina (>20 mins or relieved with rest or nitroglycerin)	Angina provoked at a lower threshold
Angina with new or worsening mitral regurgitation murmurs	Angina with dynamic T-wave changes	New onset angina within 2 weeks to 2 months
Rest angina with dynamic ST changes ≥ 1 mm	Nocturnal angina	Normal or unchanged ECG
Angina with S3 or rales	New onset CCSC III or IV angina in past 2 weeks but not low likelihood of CAD	
Angina with hypotension	Q-waves or ST depression ≥ 1 mm in multiple leads	
	Age >65 years	

Reprinted from: Braunwald E, Mark DB, Jones RH, et al. Diagnosing and Managing Unstable Angina. Quick Reference Guide for Clinicians, Number 10 (amended) AHCPR Publication No. 94-0603. Rockville, MD, U.S. Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research and National Heart, Lung, and Blood Institute. May 1994.

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