

Beta-blockers and Cocaine-associated ST-segment Elevation Myocardial Infarction in an Inner-city Community

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in an Inner-city Community**

To the Editor:

I appreciated the comprehensive study on cocaine-associated ST-segment elevation myocardial infarction in an inner-city community by Shitole and associates.¹ I found the differences observed between cocaine-positive and negative patients receiving β -blockers at discharge of interest and worthy of comment. As shown in Figure 2, There was a statistically significant difference in the proportion between these two groups, approximately 74% versus 94% by my estimation. The authors' interpretation of this difference is "For β -blockers, given that professional recommendations to prescribe these agents at discharge in this context are based on retrospective observational studies and expert opinion, these findings may reflect discomfort with the benefit-risk ratio of these medications in real-world situations in disadvantaged communities." The authors cite a 2008 American Heart Association scientific statement (not guideline) that is greatly in need of updating and revision with regard to β -blockers.²

There have been many studies and case series published in the past 9 years highlighting the widespread and safe use of β -blockers for patients with cocaine-induced chest pain, two of which are cited by the authors in their aforementioned sentence.³⁻⁹ The long-standing dogma of "unopposed α -stimulation," in which β -blockers in theory may exacerbate cocaine-associated coronary vasoconstriction and/or lead to increased blood pressure, continues to appear in medical literature despite extremely limited evidence. Based on a comprehensive systematic review on the treatment of cardiovascular toxicity from cocaine, β -blockers were a safe and effective

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