adolescent overweight might have on the future prevalence of CHD in US adults.

The proportion of overweight adolescents (weight above the 95th percentile for their age) who would become obese adults (BMI ≥30 kg/m^2) was estimated from US National Health and Nutrition Examination survey data. Current US data reveal that, at age 35 years, 25% of men and 32% of women are obese. The authors calculated that in 2020, 30–37% of 35-year-old men and 34–44% of 35-year-old women would be obese. The prevalence of CHD risk factors and the number of CHD events in young adults, a population normally considered at low risk for CHD, were predicted to rise as a consequence of this increase in obesity. The authors' model predicted that the prevalence of CHD would rise by 5–16% by 2035, which corresponds to more than 100,000 additional cases of CHD.

The authors point out that long-term projections must be interpreted with caution. For example, major changes in the treatment or prevention of obesity-related illness and CHD could change these estimates. They suggest, however, that such new treatments would need to be initiated in early adulthood to have a substantial effect on these projections.

Original article Bibbins-Domingo K *et al.* (2007) Adolescent overweight and future adult coronary heart disease. *N Engl J Med* **357:** 2371–2379

Low initial dose of aspirin is superior to a high dose after acute STEMI

Immediate administration of aspirin after ST-segment-elevation myocardial infarction (STEMI) reduces the risk of vascular events, but the optimum dose in this setting is unknown. Berger *et al.* retrospectively analyzed data from two trials of fibrinolytic therapy in STEMI to determine the effect of high-dose versus low-dose aspirin on cardiovascular outcome and bleeding events.

From 1990 to 1997, the GUSTO I and GUSTO III trials enrolled patients with STEMI <6 h after symptom onset. Patients were treated in the acute setting with a single dose of aspirin in the range 126–162 mg or 163–330 mg ('162 mg group' and '325 mg group', respectively) at the discretion of the treating physician.

This analysis included a total of 48,422 patients, of whom 11,828 (24.4%) were in the 325 mg group and 36,594 (75.6%) were in the 162 mg group. After adjustment for baseline, treatment and procedural characteristics, there were no significant differences between the 325 mg and the 162 mg groups in the composite end point of mortality, myocardial infarction or stroke at 24 h (odds ratio [OR] 1.05, 95% CI 0.91–1.21) or at 7 days (OR 1.00, 95% CI 0.91–1.10), or in mortality at 30 days (OR 0.99, 95% CI 0.87–1.12). The 325 mg dose was independently associated with a significantly increased risk of in-hospital major or moderate bleeding compared with the 162 mg dose (OR 1.14, 95% CI 1.05–1.24; P <0.003).

The authors conclude that an initial aspirin dose of 162 mg may be as effective as, and possibly safer than, a 325 mg dose in patients with STEMI.

Original article Berger JS *et al.* (2008) Initial aspirin dose and outcome among ST-elevation myocardial infarction patients treated with fibrinolytic therapy. *Circulation* **117:** 192–199

Implantable device enables left atrial pressure monitoring in ambulatory patients with HF

An increase in left atrial pressure (LAP) usually precedes symptom onset in patients with heart failure (HF). Accurate monitoring of LAP could, therefore, facilitate the early identification of incipient decompensation. In a recent paper, researchers have reported their initial experience with a new permanent implantable device that enables LAP to be monitored in ambulatory patients with HF.

Eight male patients with established HF underwent successful device implantation with no procedural complications. The mean device implantation time was 153 min. Following implantation, all patients received at least 150 mg aspirin daily and, for a minimum of 6 months, 75 mg clopidogrel daily. Device-derived and catheter-derived left atrial waveforms showed excellent concordance at baseline. At right heart catheterization 3 months later, 87% of device-derived LAP measurements were within 5 mmHg of pulmonary capillary wedge pressure measurements, and 96% were within 10 mmHg. The mean net device