

The impact of COVID-19 on percutaneous coronary intervention for ST-elevation myocardial infarction

Running title: COVID-19 and primary PCI for STEMI in England

Chun Shing Kwok MBBS MSc BSc,^{1,2} Chris P Gale MBBS PhD,^{3,4} Tim Kinnaird MD,⁵
Nick Curzen MD,⁶ Peter Ludman MD,⁷ Evangelos Kontopantelis PhD,⁹ Jianhua Wu PhD,⁴
Tom Denwood,¹⁰ Nadeem Fazal,⁸ John Deanfield BChir MB,⁸ Mark A. de Belder MD,⁸
Mamas A Mamas BM BCh DPhil^{1,2}

1. Keele Cardiovascular Research Group, Centre for Prognosis Research, Institute for Primary Care and Health Sciences, Keele University, Stoke-on-Trent, UK
2. Department of Cardiology, Royal Stoke University Hospital, Stoke-on-Trent, UK
3. Leeds Institute of Cardiovascular and Metabolic Medicine, University of Leeds, UK
4. Leeds Institute for Data Analytics, University of Leeds, UK
5. Department of Cardiology, University Hospital of Wales, Cardiff, United Kingdom.
6. Wessex Cardiothoracic Unit, Southampton University Hospital Southampton & Faculty of Medicine University of Southampton, UK
7. Institute of Cardiovascular Sciences, University of Birmingham, Birmingham, UK
8. National Institute for Cardiovascular Outcomes Research, Barts Health NHS Trust, London, UK
9. Division of Informatics, Imaging and Data Sciences, School of Health Sciences, Faculty of Biology, Medicine and Health, The University of Manchester, Manchester, UK
10. NHS Digital, Leeds, UK

Corresponding author

Chun Shing Kwok

Keele Cardiovascular Research Group

Keele University, Stoke-on-Trent, UK

Email: shingkwok@doctors.org.uk

Tel: +44 1782 671654

Fax: +44 1782 674467

Keywords: percutaneous coronary intervention; COVID-19; STEMI; National Institute for Cardiovascular Outcomes Research (NICOR)

Word count: 2,997

The Corresponding Author has the right to grant on behalf of all authors and does grant on behalf of all authors, an exclusive licence (or non exclusive for government employees) on a worldwide basis to the BMJ Publishing Group Ltd and its Licensees to permit this article (if accepted) to be published in HEART editions and any other BMJPGL products to exploit all subsidiary rights

Abstract

Background: The objective of the study was to identify any changes in primary PCI for ST-elevation myocardial infarction (STEMI) in England by analyzing procedural numbers, clinical characteristics and patient outcomes during the COVID-19 pandemic.

Methods: We conducted a retrospective cohort study of patients who underwent PCI in England between January 2017 and April 2020 in the British Cardiovascular Intervention Society (BCIS)-National Institute of Cardiovascular Outcomes Research (NICOR) database. Analysis was restricted to forty-four hospitals that reported contemporaneous activity on PCI. Only patients with primary PCI for STEMI were included in the analysis.

Results: A total of 34,127 patients with STEMI (primary PCI 33,938, facilitated PCI 108, rescue PCI 81) were included in the study. There was a decline in the number of procedures by 43% (n=497) in April 2020 compared to the average monthly procedures between 2017 and 2019 (n=865). For all patients, the median time from symptom-to-hospital showed increased after the lockdown (150[99-270] vs 135[89-250] min, $p=0.004$) and a longer door-to-balloon time after the lockdown (48[21-112] vs 37[16-94] min, $p<0.001$). The in-hospital mortality rate was 4.8% before the lockdown and 3.5% after the lockdown ($p=0.12$). Following adjustment for baseline characteristics, no differences were observed for in-hospital death (OR 0.87 95%CI 0.45-1.68, $p=0.67$) and MACE (OR 0.71 95%CI 0.39-1.32, $p=0.28$).

Conclusions: Following the lockdown in England, we observed a decline in primary PCI procedures for STEMI and increases in overall symptom-to-hospital and door-to-balloon time for patients with STEMI. Restructuring health services during COVID-19 has not adversely influenced in-hospital outcomes.

Key Questions:

What is already known about the subject?

- Little is known about the impact of the COVID-19 pandemic on STEMI rates and outcomes on a national level.

What does the study add?

- Our analysis of 34,127 patients with STEMI showed a decline in STEMI procedures by 43% in April 2020 compared to the average between 2017 and 2019.
- After the March 23rd lockdown, both the median time from symptom-to-hospital (+15 min, $p=0.004$) and door-to-balloon time (+11 min, $p<0.001$) increased.
- The in-hospital mortality rate was 4.8% before and 3.5% after the lockdown but after adjustments no differences were observed for in-hospital death.

How might this impact on clinical practice?

- Restructuring of health services during COVID-19 has not adversely influenced in-hospital outcomes.

Introduction

In response to the coronavirus disease 2019 (COVID-19) pandemic, routine hospital services including cardiac catheterization have been restructured in order to increase hospital capacity for patients infected with COVID-19 and reduce the risk of cross-infection. This has led to the cancellation of some elective procedures, and reduced access to care for patients without COVID-19 related disorders. Many countries have imposed social containment mandates, known as ‘lockdown’ in order to reduce the spread of the virus, which may have contributed to patient delays in seeking emergency care, because of fear of contracting COVID-19 at hospitals and this has resulted in a reduction in cardiovascular admissions.[1-3] This would inevitably have important consequences especially in conditions such as ST-elevation myocardial infarction (STEMI) in which timely coronary revascularization is proven to reduce mortality and complications.[4]

While there are isolated local and regional level reports that the COVID-19 pandemic is associated with a reduction in both presentations with acute myocardial infarction and percutaneous coronary intervention (PCI) procedures,[5-9] there have been no previous data regarding its impact on national primary PCI rates and practices, and whether there have been changes in either procedural or clinical characteristics of patients or their clinical outcomes.

Following dialogue with the Chief Scientific Advisor to the Government of the United Kingdom, a series of analyses by the National Institute for Cardiovascular Outcomes Research (NICOR) were endorsed to help inform government decision making. The objective of this current analysis is to identify the changes in primary PCI activity during the COVID-19 pandemic from a national perspective, including any changes in the clinical presentation and characteristics of patients and their clinical outcomes.

Methods

The reporting of this cohort is in accordance with the recommendations of the STrengthening the Reporting of Observational studies in Epidemiology (STROBE) statement.[10]

The British Cardiovascular Intervention Society (BCIS) registry contains data from all consecutive adults undergoing all PCI in the United Kingdom (UK) in the National Health Service Hospitals in England. The dataset has around 120 variables covering demographic characteristics, clinical information, periprocedural and outcome variables, as previously described.[11-13] BCIS has made it their mandate that all operators record information for all PCI procedures undertaken and data collection is overseen by NICOR.[14]

Study design, population and outcomes

We conducted a retrospective cohort study of all patients who underwent PCI for STEMI in England between 1st January 2017 and 30th April 2020 in the BCIS database. Hospitals either enter data directly into a web-based interface provided by NICOR or upload data from their local database. Hospitals were encouraged to upload their data more frequently than usual to facilitate more contemporaneous analysis. To this end they received special communications from both the British Cardiovascular Society and the BCIS to their members. In addition, staff at NICOR made direct contact with each hospital's cardiovascular audit team. This project only included data from hospitals that successfully uploaded data on PCI procedures in each month of the current year until the end of April 2020 (by May 7th). This was necessary to ensure only those centers in whom all procedures had been reported and uploaded until the end of April were included, in order to minimize the risk that we included data from centers that had failed to upload their most recent PCI activity. Patients not allocated by gender were excluded as were those who did not have PCI or those admitted to private hospitals, who represent less than 5% of PCI activity in the UK and virtually no primary PCI.

The primary outcome of interest was the number of primary PCI procedures for STEMI undertaken before and after the COVID-19 pandemic lockdown on 23 March 2020 and the secondary outcomes were the in-hospital mortality and major adverse cardiovascular events (MACE, a composite of death, reinfarction and unplanned re-PCI) for these procedures over the same period. Other in-hospital outcomes were receipt of transfusion (blood or platelet), major bleeding, embolic stroke, coronary perforation, retroperitoneal bleed, renal failure/dialysis and re-PCI. Patients who were admitted with STEMI but remained in hospital beyond 30th April 2020 were classified according to whether they had in-hospital mortality at the time of latest follow up (7th May 2020). Those that remained in hospital and were not discharge were classed as being alive.

Covariates

Data were collected on patient demographics, comorbidities and treatments received (described in Supplemental Data 1).

Statistical analysis

Statistical analyses were performed on Stata/MP version 16.0 (Stata Corp, College Station, TX). We included patients with primary PCI for STEMI, facilitated PCI for STEMI and rescue PCI for STEMI in the cohort but only those with primary PCI for STEMI were included in the analysis. The cohort was divided into patients who underwent primary PCI for STEMI in 2017-2019 and those who had a primary PCI procedure performed from 1st January to 30th April 2020. For the analysis of trend, the monthly average PCI procedures for the years 2017, 2018 and 2019 were determined and these averages were compared against the number of procedures in each month in 2020. The date of the UK lockdown was 23 March 2020 and was marked in the figures between the months March and April 2020. Descriptive statistics are presented by whether primary PCI took place before or after the lockdown. Median values and interquartile ranges for continuous variables and the number and percentages for categorical

variables were reported. Using all patients admitted in 2017-2019 as a reference group, the Mann-Whitney test for continuous variables and Chi² test for categorical variables were used to determine if there was any statistical difference in patient characteristics, procedural variables and in-hospital outcomes after and before the lockdown. Figures were used to show timing from symptom-to-hospital and door-to-balloon as well as in-hospital death and MACE before and after the lockdown. This was done for the overall primary PCI cohort for STEMI as well as the subgroups that were admitted to the PCI center directly from the community and those that were transferred to the PCI center from another hospital. Multiple logistic regression models were used to evaluate the independent odds of in-hospital mortality and MACE. This model was adjusted for all covariates previously mentioned, except for left ventricular function, smoking status and ethnicity because of the extent of missing data for these variables. Additional analyses were performed where the *mi impute chained* function was used to generate 10 complete datasets to account for missing data. Multiple logistic regressions were then conducted to evaluate the independent odds of in-hospital mortality and MACE were performed with adjustments all variables including left ventricular function, smoking status and ethnicity. Finally, the descriptive statistics were also presented in tables stratified by indication for PCI. A sensitivity analysis was performed restricting the control group to the same months of January to April in the calendar years 2017, 2018 and 2019 in order to avoid any potential issues related to seasonal differences in the numbers of procedures.

Results

A total of 34,127 patients undergoing PCI with STEMI were included in the analysis (Figure 1). The list of hospitals included in the analysis is shown in the Supplemental Data 2. This includes STEMI patients undergoing primary PCI (n=33,938), facilitated PCI (n=108) and

rescue PCI (n=81). The missing data for the cohort of patients with STEMI who underwent primary PCI is shown in Supplementary Table 1.

The numbers of primary PCI for STEMI over time is illustrated in Figure 2. A 43% decline in monthly average procedures was recorded between 2017-2019 (865) to 497 in April 2020. The changes in rescue and facilitated PCI for STEMI is shown in Supplementary Figure 1 and there were no clinically significant increases.

The characteristics according to month are shown in Supplementary Table 2. Compared with 2017-2019, patients admitted with primary PCI for STEMI in the month of April 2020 were more likely to have radial access (89.1% vs 83.9%, $p=0.002$), multivessel PCI (16.9% vs 12.8%, $p=0.007$) and have longer time from symptom-to-hospital (median 135 min vs 153 min, $p=0.004$) and door-to-balloon time (median 37 min vs 48 min, $p<0.001$).

The percentage difference comparing the number of procedures after and before the lockdown was not consistent across all primary PCI volume centres as there was a decline of 20.4%, 25.9%, 11.1% and 56.8% across the quartiles 1, 2, 3 and 4 based on volume of primary PCI. It appears that the largest decline was observed in highest volume centres. The patient characteristics for primary PCI pre- and post-lockdown are shown in Table 1. Patients post-lockdown had a greater proportion of multivessel intervention (16.0% vs 12.7%, $p=0.012$) with an increased use of prasugrel (12.9% vs 6.4%, $p<0.001$), with a decline in clopidogrel (11.0% vs 21.5%, $p<0.001$), ticagrelor (41.0% vs 48.6%, $p<0.001$), glycoprotein IIb/IIIa inhibitor (22.6% vs 27.7%, $p=0.003$) use.

The characteristics of patients according to direct admission from community compared to transfer from another hospital are shown in Supplementary Table 3 and transferred patients were younger (62 vs 64 years, $p<0.001$) and a greater proportion were male (76.6% vs 74.3%, $p<0.001$), of non-Caucasian ethnicity (19.3% vs 13.4%, $p<0.001$) and had out-of-hours PCI (57.9% vs 53.3%, $p<0.001$).

The time from symptom-to-hospital and from door-to-balloon before and after lockdown are shown in Figure 3. For all patients, the time from symptom to hospital was greater after the lockdown (median 150 min vs 135 min, $p=0.004$) and the door-to-balloon time was also greater after the lockdown (median 48 min vs 37 min, $p<0.001$). The increase in time from symptom to hospital was observed after lockdown for the subgroup of patients admitted directly from community (median 145 min vs 135 min, $p=0.020$) as well as those that were transferred between hospitals (median 239 min vs 235 min, $p=0.045$). The door-to-balloon time was also greater after the lockdown for patients admitted directly from the community (median 41 min vs 28 min, $p<0.001$) but not statistically different for those with hospital transfer (median 185 min vs 143 min, $p=0.13$).

Crude in-hospital patient outcomes pre-and post-lockdown are shown in Table 2 and Figure 4. No significant differences in mortality were observed overall (3.5% vs 4.8%, $p=0.12$), but in hospital MACE was significantly reduced post-lockdown (3.5% vs 5.5%, $p=0.022$) and there was a shorter median length of stay post lockdown (2 vs 3 days, $p<0.001$). Similar patterns were observed for patients who were admitted directly from the community (2.6% vs 4.7%, 2.6% vs 5.5%, respectively). For patients who were transferred from another hospital there was an increase in both in-hospital death (7.5% vs 4.5%) and MACE (7.3% vs 5.1%).

The adjusted odds of in-hospital death and MACE are shown in Table 3. No differences were observed for both outcomes overall (OR 0.87 95%CI 0.45-1.68, $p=0.67$ and OR 0.71 95%CI 0.39-1.32, $p=0.28$, respectively) or in the subgroups according to direct or inter-hospital admission. After imputations for missing data, the analysis adjusted additionally for left ventricular function, ethnicity and smoking status and similarly showed no significant differences in in-hospital outcomes.

The sensitivity analysis only including the months of January to April for the calendar years 2017 to 2019 are shown in Supplementary Figure 1 and Supplementary Table 4. The results are largely similar to those reported in the overall analysis.

Discussion

Our evaluation to describe national cases of primary PCI activity for STEMI during the COVID-19 pandemic has several key findings. First, the decline in number of cases of primary PCI for STEMI started before the lockdown on the 23 March 2020 and there was a 43% decrease by the end of April 2020. Secondly, the lockdown was associated with increases in symptom-to-hospital time and door-to-balloon time. Third, after the lockdown the difference in time from symptom-to-hospital and door-to-balloon was greatest for patients that underwent hospital transfer. Finally, once differences in baseline characteristics were adjusted for, there were no differences in clinical outcomes (mortality and MACE) before and after lockdown. These findings suggest that primary PCI for STEMI has declined after the national lockdown in England but restructuring of hospital services during the COVID-19 pandemic has not adversely compromised in-hospital outcomes for patients having these procedures.

Our results support the decline in primary PCI procedures for STEMI reported in other studies but we add some additional value to such observations by describing clinical and procedural characteristics and clinical outcomes after the COVID lockdown using previous years as a reference. During the early phase of COVID pandemic there was an estimated 38% reduction in US cardiac catheterization laboratory STEMI activations from 9 high-volume centers.[8] Another survey of 73 centers in Spain reported a 40% reduction in procedures performed in the STEMI settings.⁹ We report a 43% reduction in all STEMI-related PCI procedures (including primary, rescue and facilitated) in England in the month after the lockdown. Importantly, our paper shows that patients undergoing primary PCI were not at

increased odds of in-hospital death and MACE compared to patients before the lockdown period.

There are several explanations why there may be a decrease in primary PCI for STEMI during the COVID-19 pandemic. One possibility is that there was a lower incidence of STEMI during the outbreak but this is unlikely. A more convincing explanation is that lower rates of STEMI relate to multiple factors including avoidance of medical care or concerns over contracting COVID-19 in hospital, misdiagnosis and increased use of pharmacological reperfusion due to COVID-19.[8] In England there were clear government recommendations to “stay at home and protect the National Health Service (NHS)” which may have created an atmosphere of fear of contracting COVID-19 by leaving the home and going to hospital. The consequences of not seeking medical care following a STEMI may be significant, for example a 58% increase in out-of-hospital cardiac arrests was observed between February and March 2020 compared to 2019 in the Lombardia Cardiac Arrest Registry.[15] In addition, a reduction in primary PCI activity may be related to reduced catheter laboratory capacity due to staff sickness and redeployments as well as the need for deep cleaning between cases as these were important factors highlighted in a survey of 43 UK primary PCI centres.[16]

Whilst our findings suggest that there are fewer patients receiving primary PCI, we have shown that the COVID pandemic does not appear to have compromised overall in-hospital clinical outcomes. Our study provides further insight regarding delays to PCI during the COVID-19 pandemic. Specifically, we found evidence of prolonged symptom-to-hospital time after the COVID-19 lockdown in England. This is consistent with the findings from a study of the management of STEMI in Hong Kong reporting a median of 318 min from symptom onset to first medical contact for 7 patients since January 2020 compared to 82 min during office hours in 2018-2019 for 48 patients and a prolonged door to device time of 110 min compared to 84 min, respectively.[4] We have furthered what is known by identifying that

the delays were greatest for patients who required inter-hospital transfer which may relate to hospital COVID policies that delay transfers between hospitals. It is possible that ambulance services have been busier and occupied with the burden of patients with suspected COVID-19 which further contributed to this delay. We also report an increase in delay from door-to-balloon after the lockdown which is likely multi-factorial. During the COVID pandemic, UK government recommended cancellation of elective procedures,[17] allowing hospital services to be restructured to divert more hospital staff and infrastructure to increase capacity for the treatment of COVID-19, reduce the exposure of individual patients and their relatives to the hospital environment and reduce the exposure of healthcare workers to asymptomatic COVID-19 patients. Furthermore, catheter laboratory staff were redeployed to other intensive care environments, and that consequently may have decreased catheter lab capacity, introducing delays particularly if more than one STEMI call is activated. Further, new and more intensive evaluation prior to the angiogram procedure due to activities such as chest X-ray and other assessments to ascertain the potential risk of COVID-19 infection, as well as the additional time required to ensure that staff to 'don' personal protective equipment, may have further contributed to delays.

A few other observations can be made about the population receiving PCI before and after the COVID-19 lockdown. We observed that patients presenting after the lockdown were more likely to receive multivessel PCI. This may reflect recent data from the Complete Revascularization with Multivessel PCI for Myocardial Infarction (COMPLETE) trial that patients with STEMI and multivessel coronary artery disease had lower rates of cardiovascular death and myocardial infarction with complete compared to culprit only revascularization.[18] However, it may also relate to the operator awareness that since elective activity stopped during peak the COVID-19 outbreak, patients with bystander disease discharged with culprit only PCI

may be put at a disadvantage in terms of elective access for staged complete revascularization within 45 days, as used in COMPLETE.

An important consideration around primary PCI services for STEMI during the COVID-19 pandemic is how changes in patient's health seeking behaviour, health service delivery and government strategies in mitigating the impact of the pandemic may impact the characteristics of patients that receive treatment and their associated clinical outcomes. Fear of contracting COVID-19 and messages from government about self-isolation and avoiding hospitals unless absolutely necessary may result in patients not seeking or delay seeking medical attention. In the context of STEMI, this could manifest itself as increase in number of out-of-hospital cardiac arrest which has been observed in Italy and France.[19,20] It is important to recognize that the patients evaluated in the current study are those that underwent primary PCI, but there may be patients who had STEMI who did not undergo PCI such as those who had an out-of-hospital cardiac arrest and died, or those that chose not seek medical attention, or those that presented late where the infarct was completed and there would be little benefit to PCI. We observed an increase in the use of prasugrel and a decrease in use of ticagrelor and clopidogrel after the lockdown. This is likely because of the changes in practice in response to the Intracoronary Stenting and Antithrombotic Regimen: Rapid Early Action for Coronary Treatment (ISAR-REACT) 5 trial [21] which found that death, myocardial infarction and stroke was lower among patients with prasugrel compared to ticagrelor. While not statistically significant, there were a greater proportion of patients with previous stroke in the group before compared to after the lockdown. Prasugrel is contraindicated in patients with previous stroke and this may partly explain why there may be an increase use of prasugrel post lockdown.

Our study has several limitations. First, not all hospitals in England were included in the analysis because they did not report their PCI activity in either March or April 2020. It was

important to exclude these hospitals that had so far not submitted, because the decline in PCI activity could be incorrectly attributed to failure of timely data submission rather than fewer cases. Secondly, in-hospital outcomes are self-reported and together with early discharge may have result in under-reporting of adverse outcomes. There is no post discharge follow up data and there were missing data particularly regarding left ventricular ejection fraction and smoking status which may confound multivariate adjustment. Nevertheless, the data are subject to logical checks and assessments of internal validity at upload to NICOR. Additionally, the decline in PCI activity that we have observed is in line with that reported in Spain and the United States of America.[8,9] Finally, there is no understanding of how local policies at each hospital may have changed as a result of the COVID-19 crisis which may be driving the decline in procedures.

In conclusion, our national evaluation demonstrates a 43% decrease in PCI activity following the COVID-19 response lockdown. Although symptom-to-hospital and door-to-balloon times were increased after the lockdown, we did not demonstrate any differences in adverse in-hospital patient outcomes after the lockdown.

Contributorship

MAM was responsible for the study design and concept. CSK performed the data cleaning and analysis. CSK and MAM wrote the first draft of the manuscript, and all authors contributed to the writing of the paper.

Transparency declaration

CSK affirms that the manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned have been explained.

Ethical committee approval

In the efforts to understand the impact of the COVID-19 pandemic on cardiology services, extraordinary government permission was obtained to evaluate anonymized records from this database through an agreement with NHS Digital. This work was endorsed by (a) Scientific Advisory Group for Emergencies (SAGE), (a body responsible for ensuring timely and coordinated scientific advice is made available to decision makers to support UK cross-government decisions in the Cabinet Office Briefing Room (COBR)), (b) NHS England, a public body of the Department of Health and Social Care, and (c) NHS Improvement - responsible for overseeing NHS trusts. NICOR, which houses the BCIS registry, has support under section 251 of the NHS Act 2006 to use patient information for approved medical research without informed consent. For this rapid NHS evaluation, health data analysis was enabled under Section 254 of the Health and Social Care Act 2012.

Acknowledgments

We are grateful for the UK government for the opportunity to analyse this data and to NICOR and the NHS digital team for helping with processing and access of data and facilitating the data analysis on their servers. This work uses data provided by patients and collected by the NHS as part of their care and support.

Funding

None.

Competing Interest and Disclosures

None.

Figure 1: Flow diagram of patient inclusion

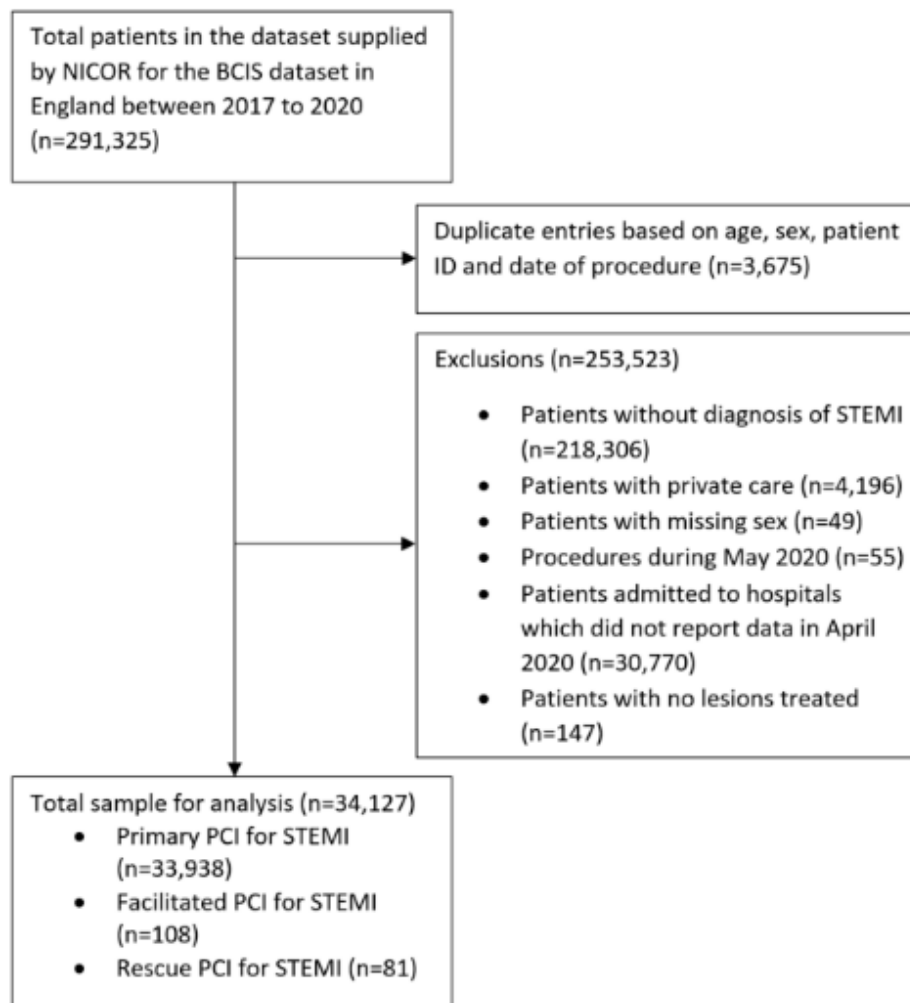


Figure 2: Rate of primary percutaneous coronary intervention for ST-elevation myocardial infarction over time

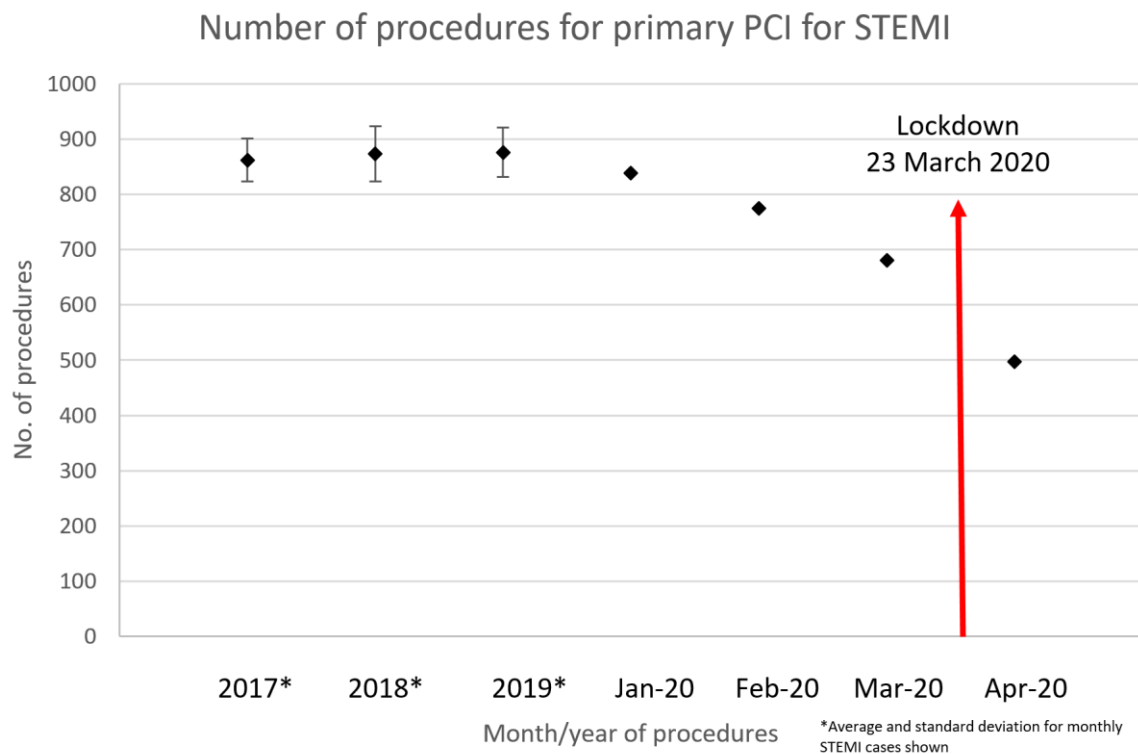


Figure 3: Median time to from symptom-to-hospital and door-to-balloon time percutaneous coronary intervention pre and post lockdown

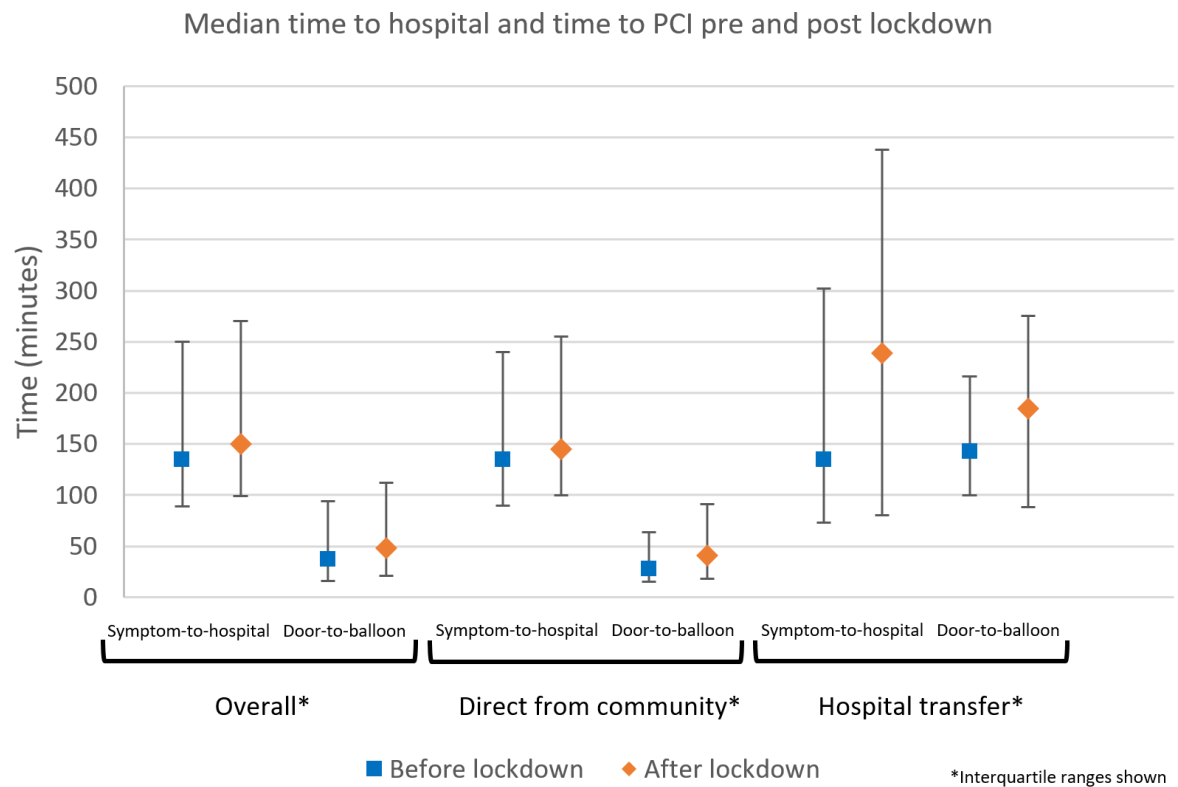


Figure 4: In-hospital mortality and major adverse cardiovascular events pre and post lockdown

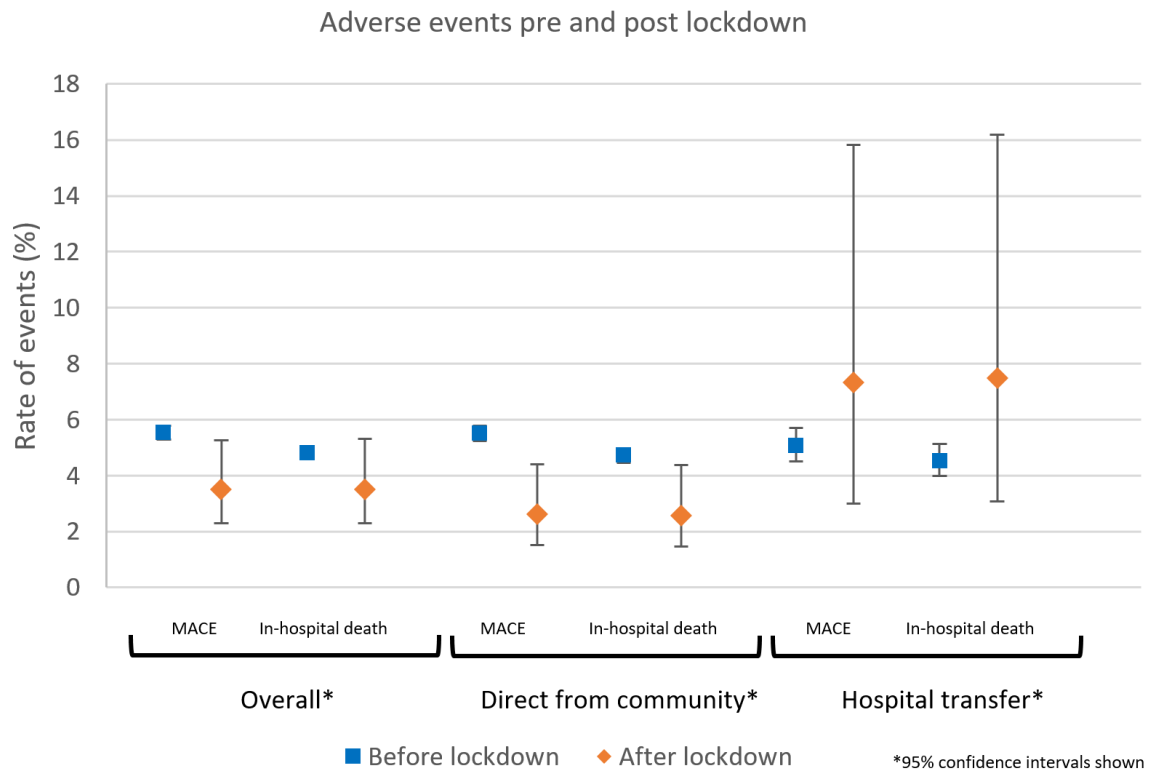


Table 1: Patient characteristics for patients who underwent primary percutaneous coronary intervention for ST-elevation myocardial infarction according to those who are admitted pre and post lockdown

Variable	Pre-lockdown (n=33,255)	Post-lockdown (n=683)	p-value*
Median age [IQR]	63 [55-73]	64 [55-72]	0.45
Male	24,829 (74.7%)	498 (72.9%)	0.30
Ethnicity			0.30
Caucasian	23,893 (85.8%)	482 (84.3%)	
Black, Asian or other	3,952 (14.2%)	90 (15.7%)	
Smoker	7,869 (40.9%)	148 (38.1%)	0.26
Hypertension	13,826 (43.2%)	234 (39.4%)	0.067
Hypercholesterolaemia	11,186 (34.9%)	195 (32.8%)	0.29
Diabetes mellitus	6,006 (18.5%)	107 (16.4%)	0.16
Left ventricular function			0.95
Good	4,289 (44.0%)	79 (45.1%)	
Fair/Moderate	4,350 (44.6%)	76 (43.4%)	
Poor	1,109 (11.4%)	20 (11.4%)	
Renal failure			0.42
None	30,192 (98.1%)	579 (98.0%)	
Acute renal failure	439 (1.4%)	11 (1.9%)	
Chronic renal failure	136 (0.4%)	1 (0.2%)	
Previous MI	4,046 (12.4%)	72 (11.4%)	0.43
Previous stroke	1,220 (3.8%)	16 (2.7%)	0.16
Previous PCI	4,081 (12.5%)	75 (11.8%)	0.60
Previous CABG	787 (2.4%)	15 (2.3%)	0.92
Peripheral vascular disease	898 (2.8%)	10 (1.7%)	0.10
Valvular heart disease	62 (2.0%)	4 (0.7%)	0.024
Radial access	27,917 (84.0%)	611 (89.5%)	<0.001
Multivessel intervention	4,229 (12.7%)	109 (16.0%)	0.012
Vessel of intervention			
Left main	917 (2.8%)	17 (2.5%)	0.67
RCA	13,982 (42.0%)	282 (41.3%)	0.69
LAD	14,683 (44.2%)	308 (45.1%)	0.62
LCx	5,881 (17.7%)	143 (20.9%)	0.028
Graft	348 (1.1%)	8 (1.2%)	0.75
Medications			
Clopidogrel	7,160 (21.5%)	75 (11.0%)	<0.001
Ticagrelor	16,165 (48.6%)	280 (41.0%)	<0.001
Prasugrel	2,130 (6.4%)	88 (12.9%)	<0.001
Glycoprotein IIb/IIIa inhibitor	9,195 (27.7%)	154 (22.6%)	0.003
Imaging (OCT/IVUS)	2,348 (7.1%)	52 (7.6%)	0.58
Rotational atherectomy	71 (0.2%)	1 (0.2%)	0.71
IABP	625 (1.9%)	2 (0.3%)	0.002
ECMO/Impella	19 (0.06%)	1 (0.2%)	0.34
Cardiogenic shock	2,474 (7.4%)	42 (6.2%)	0.20
Inotropes	1,333 (4.0%)	19 (2.8%)	0.11
Thrombectomy device use	5,142 (15.5%)	84 (12.3%)	0.023
Number of stents			0.38

0	3,460 (10.4%)	61 (8.9%)	
1	18,950 (57.0%)	405 (59.3%)	
2	7,568 (22.8%)	158 (23.1%)	
3+	3,277 (9.9%)	59 (8.6%)	
TIMI 3 flow post procedure	26,598 (84.6%)	559 (89.6%)	0.001
Route			0.010
Direct from community	27,014 (81.2%)	579 (84.8%)	
Hospital transfer	5,375 (16.2%)	82 (12.0%)	
Already in hospital	866 (2.6%)	22 (3.2%)	
Median time from symptom-to-hospital [IQR]	135 [89-250]	150 [99-270]	0.004
Median time from door-to-balloon [IQR]	37 [16-94]	48 [21-112]	<0.001
Out-of-hours symptom onset	19,744 (60.9%)	372 (60.7%)	0.92
Out-of-hours PCI	17,949 (54.0%)	367 (54.7%)	0.90

*Mann-Whitney test for continuous variables, Chi² test for categorical variables

Abbreviations: IQR = intraquartile range, MI = myocardial infarction, PCI = percutaneous coronary intervention, CABG = coronary artery bypass graft, RCA = right coronary artery, LAD = left anterior descending, LCx = left circumflex, OCT = optical coherence tomography, IVUS = intravascular ultrasound, IABP = intra-aortic balloon pump, ECMO = extracorporeal membrane oxygenation, TIMI = thrombolysis in myocardial infarction

Table 2: Patient outcomes for patients who underwent primary percutaneous coronary intervention for ST-elevation myocardial infarction according to those who are admitted pre and post lockdown

Variable	Pre-lockdown (n=33,255)	Post-lockdown (n=683)	p-value*
Transfusion	75 (0.2%)	2 (0.3%)	0.71
Major bleeding	69 (0.2%)	3 (0.4%)	0.19
Death	1,590 (4.8%)	23 (3.5%)	0.12
MACE (death, reinfarction, PCI)	1,841 (5.5%)	24 (3.5%)	0.022
Embolic stroke	53 (0.2%)	0 (0%)	0.30
Coronary perforation	78 (0.2%)	2 (0.3%)	0.76
Retroperitoneal bleed	10 (0.03%)	2 (0.30%)	<0.001
Renal failure/dialysis	78 (0.2%)	1 (0.2%)	0.64
Re-PCI	236 (0.7%)	1 (0.2%)	0.080
Median length of stay [IQR]	3 [2-4]	2 [1-3]	<0.001

Abbreviations: PCI = percutaneous coronary intervention, IQR = interquartile range

Table 3: Multivariable odds of major adverse cardiovascular events and in-hospital death for patients pre and post lockdown who underwent primary percutaneous coronary intervention for ST-elevation myocardial infarction

Group	Comparison of post vs pre lockdown			
	No imputations		Imputed dataset	
	Adjusted OR (95%CI)*	p-value	Adjusted OR (95%CI)†	p-value
Overall				
MACE	0.71 (0.39-1.32)	0.28	0.78 (0.50-1.24)	0.29
In-hospital death	0.87 (0.45-1.68)	0.67	0.94 (0.58-1.52)	0.80
Direct from community				
MACE	0.66 (0.33-1.30)	0.23	0.63 (0.36-1.10)	0.10
In-hospital death	0.77 (0.37-1.63)	0.50	0.74 (0.41-1.33)	0.31
Transfer				
MACE	0.88 (0.16-5.02)	0.89	1.39 (0.50-3.86)	0.52
In-hospital death	1.18 (0.20-7.10)	0.86	1.86 (0.66-5.28)	0.24

*Adjusted for age, sex, hypertension, hypercholesterolaemia, diabetes mellitus, renal disease, previous myocardial infarction, previous stroke, previous percutaneous coronary intervention, previous coronary artery bypass graft, peripheral vascular disease, valvular heart disease, radial access, multivessel disease, vessel of intervention, medications, glycoprotein IIb/IIIa inhibitor use, imaging, rotational atherectomy, intra-aortic balloon pump, extracorporeal membrane oxygenation/Impella, cardiogenic shock, inotropes, number of stents, flow, thrombectomy, symptom-to-hospital time, door-to-balloon time, out-of-hours symptoms and out-of-hours percutaneous coronary intervention.

†Adjusted for all variables in * and left ventricular function, ethnicity and smokers.

Abbreviations: OR = odds ratio, 95%CI = 95% confidence interval, MACE = major adverse cardiovascular events

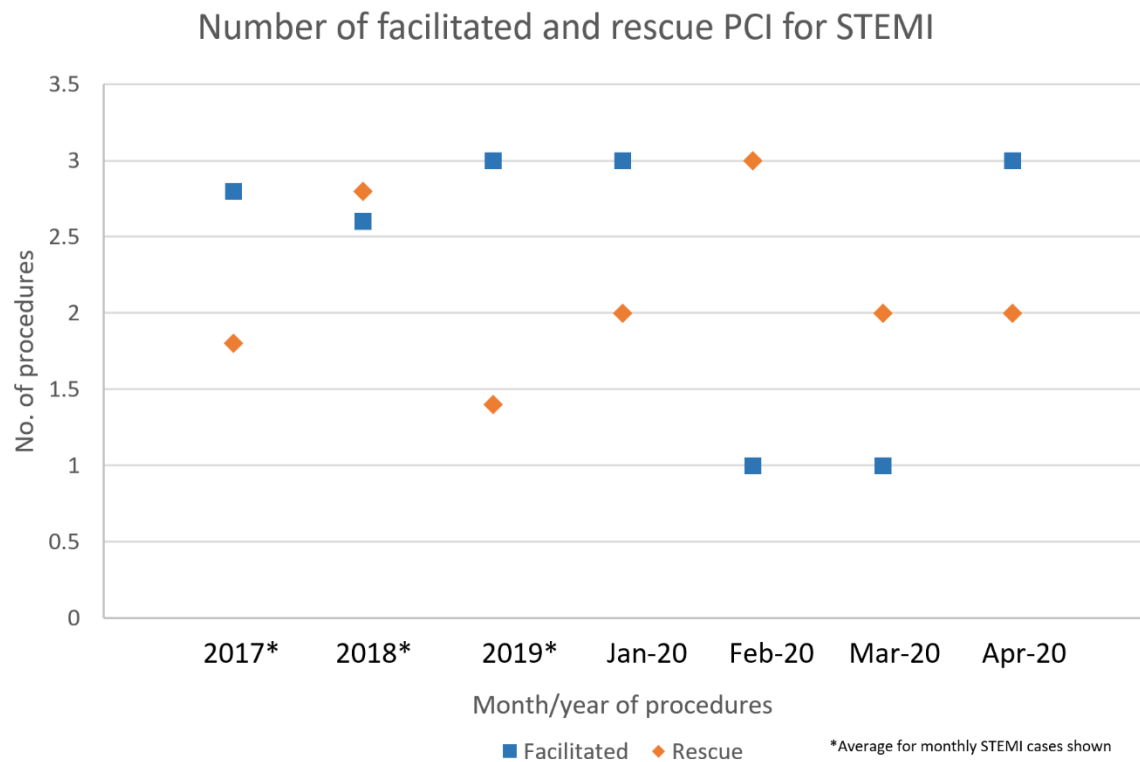
Reference

1. De Filippo O, D'Ascenzo F, Angelini F, Brocchino PP, Conrotto F, Saglietto A, Secco GG, Campo G, Gallone G, Verardi R, Gaido L, Iannaccone M, Galvani M, Ugo F, VBarbero U, Infantino V, Olivotti L, Mennuni M, Gili S, Infusion F, Vercellino M, Zucchinetti O, Casella G, Giammaria M, Boccuzzi G, Tolomeo P, Doronzo B, Senatore G, Marra WG, Rognoni A, Trabattoni D, Franchin L, Borin A, Bruno F, Galluzzo A, Gambino A, Nicolino A, Giachet AT, Sardella G, Fedele F, Monticone S, Montefusco A, Omede P, Pennone M, Patti G, Mancone M, de Ferrari GM. Reduced rate of hospital admissions for ACS during COVID-19 outbreak in Northern Italy. *N Engl J Med* 2020. doi: 10.1056/NEJMc2009166.
2. Markus HS, Brainin M. COVID-19 and stroke – A global World Stroke Organization perspective. *Int J Stroke* 2020;15:361-364.
3. Bromage DI, Cannata A, Rind IA, Gregorio C, Piper S, Shah AM, McDonagh TA. The impact of COVID-19 on heart failure hospitalization and management: report from a Heart Failure Unit in London during the peak of the pandemic. *Eur J Heart Fail* 2020. doi: 10.1002/ehfj/1925.
4. Tam CF, Cheung KS, Lam S, Wong A, Yung A, Sze M, Lam YM, Chan C, Tsang TC, Tsui M, Tse HF, Siu CW. Impact of coronavirus disease 2019 (COVID-19) outbreak on ST-segment-elevation myocardial infarction care in Hong Kong, China. *Circ Cardiovasc Qual Outcomes*. 2020;13:e006631.
5. Metzler B, Siostrzonek P, Binder RK, Bauer A, Reinstadler SJ. Decline of acute coronary syndrome admission in Austria since the outbreak of COVID-19: the pandemic response causes cardiac collateral damage. *Eur Heart J* 2020;41:1852-1853.
6. Solomon MD, McNulty EJ, Rana JS, Leong TK, Lee C, Sung SH, Ambrosy AP, Sidney S, Go AS. The Covid-19 pandemic and the incidence of acute myocardial infarction. *N Engl J Med* 2020. doi: 10.1056/NEJMc2015630.
7. De Rosa S, Spaccarotella C, Basso C, Calabro MP, Curcio A, Filardi PP, Mancone M, Mercuro G, Muscoli S, Nodari S, Pedrinelli, Gianofranco S, Indolfi C. Reduction of hospitalizations for myocardial infarction in Italy in the COVID-19 era. *Eur Heart J* 2020. doi 10.1093/eurheartj/ehaa409.
8. Garcia S, Albaghdadi MS, Meraj PM, Schmidt C, Garberich R, Jaffer FA, Dixon S, Rade JJ, Tannenbaum, Chambers J, Huang PP, Henry TD. Reduction in ST-segment elevation cardiac catheterization laboratory activations in the United States during the COVID-19 pandemic. *JACC* 2020;75:2871-2872.
9. Rodriguez-Leor O, Cid-Alvarez B, Ojeda S, Marin-Moreiras J, Rumoroso JR, Lopez-Paloo R, Serrador A, Cequier A, Romaguera R, Cruz I, Perez de Prado A, Merono R. Impact of the COVID-19 pandemic on interventional cardiology activity in Spain. *REC Interv Cardiol* 2020;2:82-89.
10. Von Elm E, Altman DG, Egger M, Pocock SJ, Gotsche PC, Vandenbroucke JP. The strengthening the reporting of observational studies in epidemiology (STROBE) statement: guidelines for the reporting observational studies. *Lancet* 2007;370:1453-1457.
11. Rashid M, Ludman PF, Mamas MA. British Cardiovascular Intervention Society registry framework: a quality improvement initiative on behalf of the National Institute of Cardiovascular Outcomes Research (NICOR). *Eur Heart J Qual Care Clin Outcomes*. 2019;5:292-297.
12. Kinnaird T, Johnson T, Anderson R, Gallagher S, Sirker A, Ludman P, de Belder MA, Copt S, Oldroyd K, Banning A, Mamas M, Curzen N. Intravascular Imaging and 12-Month Mortality After Unprotected Left Main Stem PCI: An Analysis From the

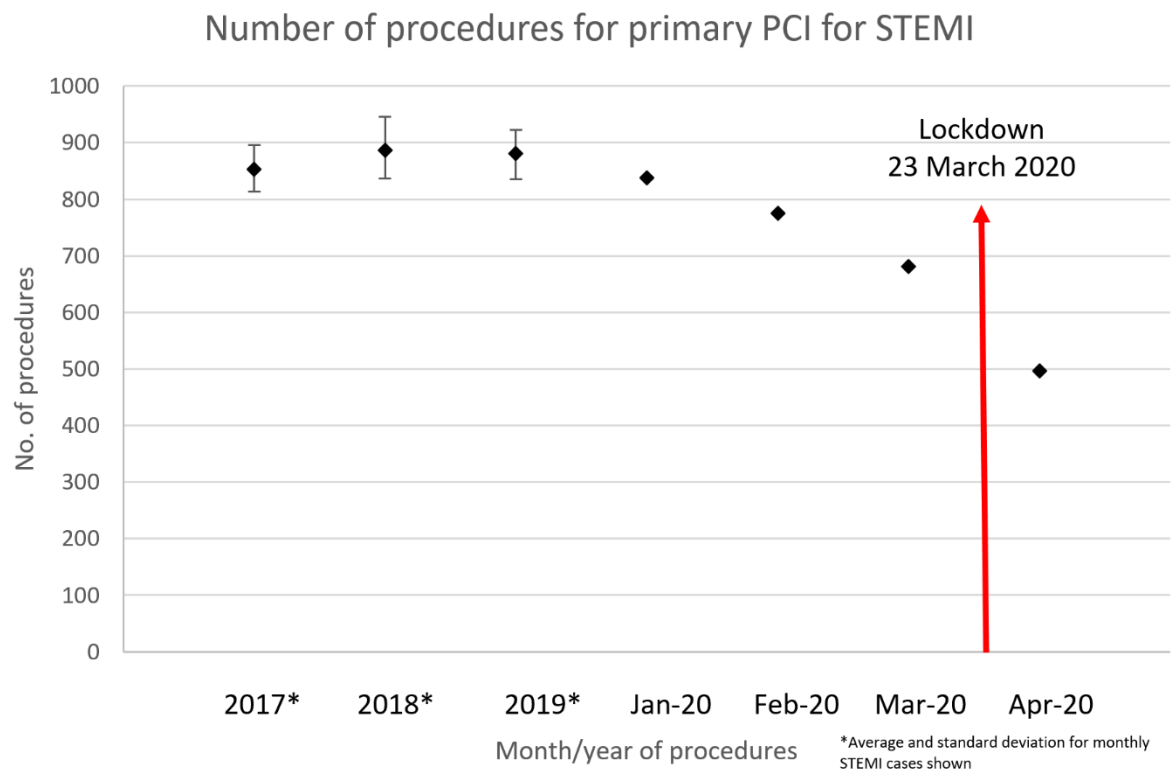
British Cardiovascular Intervention Society Database. JACC Cardiovasc Interv 2020;13:346-357.

13. Shoaib A, Kinnaird T, Curzen N, Ludman P, Smith D, Khoo CS, Kontopantelis E, Rashid M, Mohamed M, Nolan J, Zaman A, Mamas MA. Outcomes Following Percutaneous Coronary Intervention in Saphenous Vein Grafts With and Without Embolic Protection Devices. JACC Cardiovasc Interv 2019;12:2286-2295.
14. National Institute of Cardiovascular Outcomes Research. Available at: <https://www.nicor.org.uk/>
15. Baldi E, Sechi GM, Mare C, Canevari F, Brancaglione A, Primi R, Klersy C, Palo A, Contri E, Ronchi V, Beretta G, Reali F, Parogni P, Facchin F, Bua D, Rizzi U, Bussi D, Ruggeri S, Visconti LO, Savastrano S. Out-of-hospital cardiac arrests during the COVID-19 outbreak in Italy. N Engl J Med 2020. doi: 10.1056/NEJMc2010418.
16. Adlan AM, Lim VG, Dhillon G, Kurdi H, Doolub G, Elamin N, Aziz A, Sastry S, Davis G. Impact of COVID-19 on primary percutaneous coronary intervention centres in the UK: a survey. Br J Cardiol 2020;27:51-54.
17. NHS England and NHS Improvement. Important and urgent – next steps on NHS response to COVID-19. Available at: <https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/urgent-next-steps-on-nhs-response-to-covid-19-letter-simon-stevens.pdf>
18. Mehta SR, Wood DA, Storey RF, Mehran R, Bainey KR, Nguyen H, Meeks B, Di Pasquale G, Lopez-Sendon J, Faxon DP, Mauri L, Rao SV, Feldman L, Steg PG, Avezum A, Sheth T, Pinilla-Echeverri N, Morena R, Campo G, Wrigley B, Kedev S, Sutton A, Oliver R, Rodes-Cabau J, Stankovic G, Welsh R, Lavi S, Cantor WJ, Wang J, Nakamya J, Bangdiwala I, Cairns JA. Complete revascularization with multivessel PCI for myocardial infarction. N Engl J Med 2019;381:1411-1421.
19. Marijon E, Karam N, Jost D, Perrot D, Frattini B, Derkenne C, Sharifzadehgan A, Waldmann V, Beganton F, Narayanan K, Lafont A, Bougouin W, Jouven X. Out-of-hospital cardiac arrest during the COVID-19 pandemic in Paris, France: a population-based, observational study. Lancet Public Health 2020; doi: 10.1016/S2468-2667(20)30117-1.
20. Baldi E, Sechi GM, Mare C, Canevari F, Brancaglione A, Primi R, Klersy C, Palo A, Contri E, Ronchi V, Beretta G, REali F, Parogni P, Fachin F, Bua D, Rizzi U, Bussi D, Ruggeri S, Visconti LO, Savastrano S. Out-of-Hospital Cardiac Arrest during the Covid-19 Outbreak in Italy. N Engl J Med. 2020; 10.1056/NEJMc2010418.
21. Schüpke S, Neumann FJ, Menichelli M, Mayer K, Bernlochner I, Wöhrle J, Richardt G, Liebetrau C, Witzenbichler B, Antoniucci D, Akin I, Bott-Flügel L, Fischer M, Landmesser U, Katus HA, Sibbing D, Seyfarth M, Janisch M, Boncompagni D, Hilz R, Rottbauer W, Okrojek R, Möllmann H, Hochholzer W, Migliorini A, Cassese S, Mollo P, Xhepa E, Kufner S, Strehle A, Leggewie S, Allali S, Ndrepepa G, Schühlen H, Angiolillo DJ, Hamm CW, Hapfelmeier A, Tölg R, Trenk D, Schunkert H, Laugwitz KL, Kastrati A. Ticagrelor or prasugrel in patients with acute coronary syndromes. N Eng J Med 2019;381:1524-1534.

Supplementary Figure 1: Trends in procedures for facilitated and rescue percutaneous coronary intervention for ST-elevation myocardial infarction



Supplementary Figure 2: Sensitivity analysis only considering months January to April for each year



Supplementary Table 1: Missing data for patients with primary percutaneous coronary intervention for ST-elevation myocardial infarction in the dataset

Variable	Data available	% missing data
Age	33,938	0%
Male	33,938	0%
Ethnicity	28,417	16.3%
Smoker	19,632	42.1%
Hypertension	32,631	3.9%
Hypercholesterolaemia	32,631	3.9%
Diabetes mellitus	33,058	2.6%
Left ventricular function	9,923	70.8%
Renal failure	31,358	7.6%
Previous MI	33,255	2.0%
Previous stroke	32,631	3.9%
Previous PCI	33,294	1.9%
Previous CABG	33,431	1.5%
Peripheral vascular disease	32,631	3.9%
Valvular heart disease	32,631	3.9%
Radial access	33,938	0%
Multivessel intervention	33,938	0%
Vessel of intervention	33,938	0%
Medications		
Clopidogrel	33,938	0%
Ticagrelor	33,938	0%
Prasugrel	33,938	0%
Glycoprotein IIb/IIIa inhibitor	33,938	0%
Imaging (OCT/IVUS)	33,938	0%
Rotational atherectomy	33,938	0%
IABP	33,938	0%
ECMO/Impella	33,938	0%
Cardiogenic shock	33,938	0%
Inotropes	33,938	0%
Thrombectomy device use	33,938	0%
Number of stents	33,938	0%
TIMI 3 flow post procedure	32,052	5.6%
Route	33,938	0%
Time from symptom-to-hospital	31,658	6.7%
Time from door-to-balloon	30,855	9.1%
Out-of-hours symptom onset	33,046	2.6%
Out-of-hours PCI	33,938	0%
Transfusion	33,938	0%
Major bleeding	33,938	0%
Death	33,676	0.8%
MACE (death, reinfarction, PCI)	33,938	0%
Embolic stroke	33,938	0%
Coronary perforation	33,938	0%
Retroperitoneal bleed	33,938	0%

Renal failure/dialysis	33,938	0%
Re-PCI	33,938	0%
Median length of stay	32,125	5.3%

Abbreviations: MI = myocardial infarction, PCI = percutaneous coronary intervention, CABG = coronary artery bypass graft, OCT = optical coherence tomography, IVUS = intravascular ultrasound, IABP = intra-aortic balloon pump, ECMO = extracorporeal membrane oxygenation, TIMI = thrombolysis in myocardial infarction

Left main	873 (2.8%)	17 (2.0%)	0.18	18 (2.3%)	0.42	12 (1.8%)	0.10	14 (2.8%)	0.99
RCA	13,085 (42.0%)	367 (43.8%)	0.30	320 (41.3%)	0.69	282 (41.4%)	0.75	210 (42.3%)	0.91
LAD	13,766 (44.2%)	340 (40.6%)	0.037	353 (45.6%)	0.45	312 (45.8%)	0.40	220 (44.3%)	0.98
LCx	5,529 (17.8%)	155 (18.5%)	0.58	122 (15.7%)	0.15	113 (16.6%)	0.43	105 (21.1%)	0.051
Graft	326 (1.1%)	5 (0.6%)	0.20	9 (1.2%)	0.76	12 (1.8%)	0.072	4 (0.8%)	0.60
Medications									
Clopidogrel	6,845 (22.0%)	117 (14.0%)	<0.001	119 (15.4%)	<0.001	110 (16.2%)	<0.001	44 (8.9%)	<0.001
Ticagrelor	15,333 (49.2%)	360 (43.0%)	<0.001	265 (34.2%)	<0.001	270 (39.7%)	<0.001	217 (43.7%)	0.014
Prasugrel	1,957 (6.3%)	62 (7.4%)	0.19	70 (9.0%)	0.002	65 (9.5%)	0.001	64 (12.9%)	<0.001
Glycoprotein IIb/IIIa inhibitor	8,648 (27.8%)	225 (26.9%)	0.56	189 (24.4%)	0.038	171 (25.1%)	0.13	116 (23.3%)	0.029
Imaging (OCT/IVUS)	2,144 (6.9%)	83 (9.9%)	0.001	74 (9.6%)	0.004	61 (9.0%)	0.035	38 (7.7%)	0.51
Rotational atherectomy	69 (0.2%)	0 (0%)	0.17	1 (0.1%)	0.59	1 (0.2%)	0.68	1 (0.2%)	0.92
IABP	603 (1.9%)	8 (1.0%)	0.041	9 (1.2%)	0.12	7 (1.0%)	0.087	0 (0%)	0.002
ECMO/Impella	18 (0.06%)	1 (0.12%)	0.47	0 (0%)	0.50	1 (0.2%)	0.35	0 (0%)	0.59
Cardiogenic shock	2,344 (7.5%)	56 (6.7%)	0.36	40 (5.2%)	0.013	48 (7.1%)	0.64	28 (5.6%)	0.11
Inotropes	1,263 (4.1%)	37 (4.4%)	0.60	16 (2.1%)	0.005	24 (3.5%)	0.49	12 (2.4%)	0.065
Thrombectomy device use	4,920 (15.8%)	91 (10.9%)	<0.001	75 (9.7%)	<0.001	75 (11.0%)	0.001	65 (13.1%)	0.099
Number of stents			0.42		<0.001		0.48		0.51
0	3,207 (10.3%)	91 (10.9%)		110 (14.2%)		71 (10.4%)		42 (8.5%)	
1	17,720 (56.9%)	477 (56.9%)		463 (59.7%)		404 (59.3%)		291 (58.6%)	
2	7,111 (22.8%)	200 (23.9%)		149 (19.2%)		148 (21.7%)		118 (23.7%)	
3+	3,109 (10.0%)	70 (8.4%)		53 (6.8%)		58 (8.5%)		46 (9.3%)	
TIMI 3 flow post procedure	24,859 (84.4%)	698 (87.4%)	0.022	637 (88.7%)	0.002	556 (89.0%)	0.002	407 (90.0%)	0.001
Route			0.76		0.63		0.41		0.015
Direct from community	24,980 (81.0%)	660 (80.5%)		614 (80.5%)		556 (82.7%)		418 (85.7%)	
Hospital transfer	5,037 (16.3%)	135 (16.5%)		132 (17.3%)		97 (14.4%)		56 (11.5%)	
Already in hospital	813 (2.6%)	25 (3.1%)		17 (2.2%)		19 (2.8%)		14 (2.9%)	
Median time from symptom-to-hospital [IQR]	135 [89-250]	136 [91-240]	0.78	130 [89-247]	0.93	143 [90-257]	0.31	153 [100-270]	0.004

Median time from door-to-balloon [IQR]	37 [16-93]	35 [15-94]	0.42	43 [16-105]	0.076	43 [17-106]	0.054	48 [21-113]	<0.001
Out-of-hours symptom onset	18,493 (60.8%)	497 (61.0%)	0.91	454 (62.5%)	0.36	393 (62.0%)	0.54	279 (62.6%)	0.45
Out-of-hours PCI	16,866 (54.2%)	444 (53.0%)	0.50	382 (49.3%)	0.007	347 (51.0%)	0.098	277 (55.7%)	0.48

*Mann-Whitney test for continuous variables, Chi² test for categorical variables

Abbreviations: IQR = intraquartile range, MI = myocardial infarction, PCI = percutaneous coronary intervention, CABG = coronary artery bypass graft, RCA = right coronary artery, LAD = left anterior descending, LCx = left circumflex, OCT = optical coherence tomography, IVUS = intravascular ultrasound, IABP = intra-aortic balloon pump, ECMO = extracorporeal membrane oxygenation, TIMI = thrombolysis in myocardial infarction

Supplementary Table 3: Patient characteristics according to direct from community vs transfer

Variable	Direct from community (n=27,228)	Transfer (n=5,457)	p-value*
Median age [IQR]	64 [55-73]	62 [53-71]	<0.001
Male	20,233 (74.3%)	4,118 (76.6%)	<0.001
Ethnicity			<0.001
Caucasian	19,990 (86.6%)	3,436 (80.7%)	
Black, Asian or other	3,091 (13.4%)	824 (19.3%)	
Smoker	6,496 (41.4%)	1,200 (36.8%)	<0.001
Hypertension	11,274 (43.0%)	2,202 (42.0%)	0.18
Hypercholesterolaemia	9,065 (34.6%)	1,859 (35.4%)	0.23
Diabetes mellitus	4,775 (18.0%)	1,058 (20.0%)	0.001
Left ventricular function			<0.001
Good	3,607 (45.1%)	560 (37.9%)	
Fair/Moderate	3,536 (44.2%)	714 (48.3%)	
Poor	853 (10.7%)	204 (13.8%)	
Renal failure			0.10
None	24,833 (98.3%)	4,897 (97.9%)	
Acute renal failure	334 (1.3%)	85 (1.7%)	
Chronic renal failure	95 (0.4%)	21 (0.4%)	
Previous MI	3,251 (12.2%)	612 (11.5%)	0.15
Previous stroke	987 (3.8%)	180 (3.4%)	0.25
Previous PCI	3,320 (12.4%)	606 (11.3%)	0.030
Previous CABG	624 (2.3%)	115 (2.2%)	0.43
Peripheral vascular disease	715 (2.7%)	129 (2.5%)	0.27
Valvular heart disease	457 (1.7%)	148 (2.8%)	<0.001
Radial access	22,897 (84.1%)	4,654 (85.3%)	0.027
Multivessel intervention	3,409 (12.5%)	726 (13.3%)	0.11
Vessel of intervention			
Left main	722 (2.7%)	157 (2.9%)	0.35
RCA	11,757 (43.2%)	2,053 (37.6%)	<0.001
LAD	11,912 (43.8%)	2,508 (46.0%)	0.003
LCx	4,630 (17.0%)	1,141 (20.9%)	<0.001
Graft	266 (1.0%)	60 (1.1%)	0.41
Medications			
Clopidogrel	5,723 (21.0%)	1,169 (21.4%)	0.51
Ticagrelor	12,839 (47.2%)	3,007 (55.1%)	<0.001
Prasugrel	1,915 (7.0%)	236 (4.3%)	<0.001
Glycoprotein IIb/IIIa inhibitor	7,709 (28.3%)	1,294 (23.7%)	<0.001
Imaging (OCT/IVUS)	1,855 (6.8%)	427 (7.8%)	0.007
Rotational atherectomy	57 (0.2%)	11 (0.2%)	0.91
IABP	498 (1.8%)	84 (1.5%)	0.14
ECMO/Impella	19 (0.07%)	0 (0%)	0.051
Cardiogenic shock	1,951 (7.2%)	412 (7.6%)	0.32
Inotropes	1,062 (3.9%)	216 (4.0%)	0.84
Thrombectomy device use	4,197 (15.4%)	828 (15.2%)	0.65
Number of stents			0.006
0	2,767 (10.2%)	596 (10.9%)	
1	15,522 (57.0%)	3,196 (58.6%)	

2	6,264 (23.0%)	1,181 (21.6%)	
3+	2,675 (9.8%)	484 (8.9%)	
TIMI 3 flow post procedure	21,891 (85.0%)	4,239 (83.1%)	0.001
Median time from symptom-to-hospital [IQR]	135 [90-240]	136 [73-306]	0.014
Median time from door-to-balloon [IQR]	28 [15-64]	143 [100-216]	<0.001
Out-of-hours symptom onset	16,129 (60.7%)	3,321 (62.1%)	0.058
Out-of-hours PCI	14,513 (53.3%)	3,161 (57.9%)	<0.001

*Mann-Whitney test for continuous variables, Chi² test for categorical variables

Abbreviations: IQR = intraquartile range, MI = myocardial infarction, PCI = percutaneous coronary intervention, CABG = coronary artery bypass graft, RCA = right coronary artery, LAD = left anterior descending, LCx = left circumflex, OCT = optical coherence tomography, IVUS = intravascular ultrasound, IABP = intra-aortic balloon pump, ECMO = extracorporeal membrane oxygenation, TIMI = thrombolysis in myocardial infarction

Supplementary Table 4: Sensitivity analysis of patient characteristics according to pre and post lockdown only considering months January to April for each year

Variable	Pre-lockdown (n=12,587)	Post-lockdown (n=683)	p-value*
Median age [IQR]	63 [55-73]	64 [55-72]	0.46
Male	9,401 (74.7%)	498 (72.9%)	0.30
Ethnicity			0.34
Caucasian	9,149 (85.7%)	482 (84.3%)	
Black, Asian or other	1,526 (14.3%)	90 (15.7%)	
Smoker	2,962 (40.6%)	148 (38.1%)	0.32
Hypertension	5,196 (43.1%)	234 (39.4%)	0.075
Hypercholesterolaemia	4,303 (35.7%)	195 (32.8%)	0.16
Diabetes mellitus	2,259 (18.4%)	107 (16.4%)	0.19
Left ventricular function			0.95
Good	1,659 (44.4%)	79 (45.1%)	
Fair/Moderate	1,669 (44.6%)	76 (43.4%)	
Poor	412 (11.0%)	20 (11.4%)	
Renal failure			0.41
None	11,426 (98.1%)	579 (98.0%)	
Acute renal failure	165 (1.4%)	11 (1.9%)	
Chronic renal failure	52 (0.5%)	1 (0.2%)	
Previous MI	1,523 (12.3%)	72 (11.4%)	0.46
Previous stroke	479 (4.0%)	16 (2.7%)	0.12
Previous PCI	1,615 (13.1%)	75 (11.8%)	0.35
Previous CABG	265 (2.1%)	15 (2.3%)	0.73
Peripheral vascular disease	343 (2.8%)	10 (1.7%)	0.093
Valvular heart disease	253 (2.1%)	4 (0.7%)	0.016
Radial access	10,599 (84.2%)	611 (89.5%)	<0.001
Multivessel intervention	1,507 (12.0%)	109 (16.0%)	0.002
Vessel of intervention			
Left main	332 (2.6%)	17 (2.5%)	0.81
RCA	5,345 (42.5%)	282 (41.3%)	0.55
LAD	5,543 (44.0%)	308 (45.1%)	0.59
LCx	2,182 (17.3%)	143 (20.9%)	0.016
Graft	125 (1.0%)	8 (1.2%)	0.65
Medications			
Clopidogrel	2,758 (21.9%)	75 (11.0%)	<0.001
Ticagrelor	6,168 (49.0%)	280 (41.0%)	<0.001
Prasugrel	835 (6.6%)	88 (12.9%)	<0.001
Glycoprotein IIb/IIIa inhibitor	3,517 (27.9%)	154 (22.6%)	0.002
Imaging (OCT/IVUS)	883 (7.0%)	52 (7.6%)	0.55
Rotational atherectomy	19 (0.2%)	1 (0.2%)	0.98
IABP	23 (1.9%)	2 (0.3%)	0.002
ECMO/Impella	9 (0.1%)	1 (0.2%)	0.49
Cardiogenic shock	925 (7.4%)	42 (6.2%)	0.24
Inotropes	502 (4.0%)	19 (2.8%)	0.11
Thrombectomy device use	1,943 (15.4%)	84 (12.3%)	0.026
Number of stents			0.47
0	1,293 (10.3%)	61 (8.9%)	

1	7,185 (57.1%)	405 (59.3%)	
2	2,882 (22.9%)	158 (23.1%)	
3+	1,227 (9.8)	59 (8.6%)	
TIMI 3 flow post procedure	9,993 (84.0%)	559 (89.6%)	<0.001
Route			0.015
Direct from community	10,242 (81.4%)	579 (84.8%)	
Hospital transfer	2,016 (16.0%)	82 (12.0%)	
Already in hospital	329 (2.6%)	22 (3.2%)	
Median time from symptom-to-hospital [IQR]	134 [89-246]	150 [99-270]	0.003
Median time from door-to-balloon [IQR]	38 [16-94]	48 [21-112]	<0.001
Out-of-hours symptom onset	7,387 (60.4%)	372 (60.7%)	0.90
Out-of-hours PCI	6,692 (53.2%)	367 (54.7%)	0.77
Transfusion	24 (0.2%)	2 (0.3%)	0.56
Major bleeding	20 (0.2%)	3 (0.4%)	0.086
Death	600 (4.8%)	23 (3.5%)	0.13
MACE (death, reinfarction, PCI)	702 (5.6%)	24 (3.5%)	0.021
Embolic stroke	19 (0.2%)	0 (0%)	0.31
Coronary perforation	35 (0.3%)	2 (0.3%)	0.94
Retroperitoneal bleed	2 (0.02%)	2 (0.30%)	<0.001
Renal failure/dialysis	27 (0.2%)	1 (0.2%)	0.71
Re-PCI	93 (0.7%)	1 (0.2%)	0.072
Median length of stay [IQR]	3 [2-4]	2 [1-3]	<0.001

*Mann-Whitney test for continuous variables, Chi² test for categorical variables

Abbreviations: IQR = intraquartile range, MI = myocardial infarction, PCI = percutaneous coronary intervention, CABG = coronary artery bypass graft, RCA = right coronary artery, LAD = left anterior descending, LCx = left circumflex, OCT = optical coherence tomography, IVUS = intravascular ultrasound, IABP = intra-aortic balloon pump, ECMO = extracorporeal membrane oxygenation, TIMI = thrombolysis in myocardial infarction

Supplementary Data 1: Description of included variables

Covariates

Data were collected on patient demographics, comorbidities and treatments received. Specifically, data were collected on age, sex, ethnicity, smoking status, comorbidities (diabetes mellitus, hypertension, hypercholesterolaemia, renal failure, previous myocardial infarction, previous stroke, peripheral vascular disease, valvular heart disease), previous PCI, previous coronary artery bypass graft (CABG), indication for PCI, PCI access site, multivessel coronary disease, target vessel(s) for PCI, antiplatelet medications (clopidogrel, ticagrelor, prasugrel), use of glycoprotein IIb/IIIa inhibitors, imaging (optical coherence tomography/intravascular ultrasound), rotational atherectomy, intra-aortic balloon pump, extracorporeal membrane oxygenation/Impella device, cardiogenic shock, use of inotropes, use of thrombectomy device, number of stents and TIMI 3 flow post procedure. Additional data were collected on the access route to hospital (direct from community, hospital transfer, already in hospital), time from symptom onset to hospital, door-to-balloon time, out-of-hours symptoms onset and out-of-hours PCI.

Supplemental Data 2: Hospitals included in the analysis

1. AEI – Royal Albert Edward Infirmary
2. AMG – Wycombe Hospital
3. BAL – Barts and The London Hospital
4. BHL – Liverpool Cardiothoracic Centre
5. BOU – Royal Bournemouth Hospital
6. BRD – Bradford Royal Infirmary
7. BRI – Bristol Royal Infirmary
8. BRY – Acute Pennine Trust Fairfield
9. BSM – Southmead Hospital Bristol
10. CMI – Cumberland Infirmary
11. DUD – Birmingham City Hospital
12. EBH – Birmingham Heartlands Hospital
13. GRL – Glenfield Hospital
14. HAM – Hammersmith Hospital
15. KMH – Kings Mill Hospital
16. LGI – Yorkshire Heart Centre
17. LIS – Lister Hospital
18. MAY – Croydon University Hospital
19. MPH – Musgrove Park Hospital
20. NCR – New Cross Hospital
21. NOR – Norfolk and Norwich University Hospital
22. NPH – Norwick Park Hospital
23. QAP – Queen Alexandra Hospital
24. QEB – Queen Elizabeth Hospital, Birmingham
25. RCH – Royal Cornwall Hospital
26. RDE – Royal Devon & Exeter Hospital
27. RSC – Royal Sussex County Hospital
28. SAL – Salisbury District Hospital
29. SCM – James Cook University Hospital
30. SCU – Scunthorpe General Hospital
31. SGH – Southampton General Hospital
32. STO – University Hospitals of North Midlands
33. SUN – Sunderland Royal Hospital
34. TOR – Torbay Hospital
35. VIC – Blackpool Victoria Hospital
36. WAL – University Hospital of Coventry
37. WDH – Dorset County Hospital
38. WRC – Worchester Royal Hospital
39. WRG – Worthing Hospital