who present with factors that are clearly recognized in the medical literature to be predictive of CAVB after transcatheter aortic valve implantation, such as right bundle branch block and the depth of valve implantation, will require close follow-up.

CONFLICTS OF INTEREST

C. Morís is a proctor for the CoreValve system and a member of Medtronic's Latin American Advisory Board.

Alfredo Renilla,* José M. Rubín, and César Morís

Servicio de Cardiología, Hospital Universitario Central de Asturias, Oviedo, Asturias, Spain

* Corresponding author:
E-mail address: dr.renilla@gmail.com (A. Renilla).

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Time of Pacemaker Implantation After Percutaneous Aortic Valve Replacement. Response

Momento del implante de un marcapasos tras el recambio valvular aórtico percutáneo. Respuesta

To the Editor,

We appreciate the publication of the letter from Renilla et al concerning our article about the changes in cardiac conduction following implantation of a CoreValve prosthesis.[1] After reading the letter carefully, we would like to make a few comments on their reflections.

It is true that this prosthesis has frequently been associated with the need for a pacemaker, especially when this percutaneous technique was starting to be introduced. One of the reasons is probably that pointed out by the authors: the lack of data on the time course of complete atrioventricular block secondary to valve implantation. During the early years of the technique, many of the indications for pacemaker insertion were due to the development of new conduction disturbances, other than complete atrioventricular block, with unknown natural courses. Although controversy remains to this day,[2,3] in our experience, patients with new onset left bundle branch block after valve implantation are no more likely to need a pacemaker because of this acquired conduction disturbance than patients without this disorder. The course of patients who develop right bundle branch block after transcatheter aortic valve implantation appears to be different; in our series, this subgroup of patients seems to exhibit an early increase in the probability of needing a pacemaker.

As to setting an exact time limit to the causal relationship between implantation of the valved stent and the need for a permanent pacemaker, we agree with Renilla et al in that it is complicated. Although some authors establish a limit of 30 days, according to the latest European Society of Cardiology guidelines,[4] if bradycardia is significant and does not resolve within an adequate period of observation after prosthesis implantation (established as 1 week), insertion of a permanent pacemaker is unavoidable. Regardless of this consideration, we cannot lose sight of the fact that these patients are very elderly and have a disease that affects the conduction tissue and impulse generation. Proof of this are the 2 patients (1.1%) who had recurrent syncopal episodes for whom we requested pacemaker implantation, although their atrioventricular conduction was intact, because late electrophysiological studies revealed sinus node dysfunction after 1 month and 20 months of follow-up, respectively.[1]

José López-Aguilera,* José M. Segura, and José Suárez de Lezo

Servicio de Cardiología, Hospital Universitario Reina Sofía, Córdoba, Spain

* Corresponding author:
E-mail address: mircardjla@gmail.com (J. López-Aguilera).

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Professional Competence and Teamwork in the Treatment of Patients With Acute and Critical Heart Disease

Competencias profesionales y trabajo en equipo en pacientes con enfermedades cardiacas agudas y críticas

To the Editor,

We have read the editorial by Worner et al,[1] describing the position of the Spanish Society of Cardiology concerning the care of patients with acute and critical heart disease. We would like to convey our perplexity with regard to certain aspects of the editorial and express a few considerations.

We agree with the authors that the care of critically ill cardiac patients is increasingly complex and poses a major challenge. However, it does not seem logical, as the authors propose, that the treatment of the entire disease process by a single department during the patient's hospital stay would guarantee better continuity of care and be safer and more efficient. On the contrary, process management shifts from the classical vertical management, with a specialized, compartmental, service-oriented organization, to horizontal, integral and multidisciplinary management, focused on the patient, rather than the interests of certain specialties or their professionals.

We also share the view that ensuring excellent care of acutely ill cardiac patients during the critical phase is essential and has a strong impact on the final outcome. To achieve this, it is indispensable that the patients, particularly those with other organ dysfunctions in addition to their cardiac condition, be attended by professionals with specific, well-defined competence and the necessary training. The authors themselves admit that these aptitudes are not acquired during specialized cardiology training. Intensivists, in contrast, do have the specific training to assume these responsibilities, as recognized in the intensive care training program and demonstrated by the long experience of the departments of intensive care medicine in Spain.

Competence can be gained through training,[2,3] but we must be aware of the time and resources necessary to achieve it without risking patient safety or the sustainability of the health system. For this reason, the proposal concerning the accreditation of all cardiologists in the treatment of critically ill patients does not appear to be appropriate. The model in which the care of these patients is carried out by intensivists, with the collaboration of many other specialties, has been shown to be effective, safe, and efficient.[4]

The authors cite data from a study[5] that attempts to relate organizational aspects of coronary care units under the responsibility of cardiology departments with a lower risk-adjusted mortality in acute myocardial infarction. This study has substantial biases and clear methodological errors. The conditions of patients attended exclusively by members of cardiology departments were less serious and complex, and the overall mortality rate was lower. To make them comparable, adjustment variables were utilized with data from the 1990s and based on the minimum data set. Both approaches are questionable, one because it is old-fashioned and the other because of its imprecision, as the minimum data is not appropriate for the activity of intensive care departments.

Seeking collaboration with intensive care and other specialties only to achieve the strategic objectives of a single specialty neither strengthens nor favors trust and collaboration among specialties that should always work as a team to provide the best possible health care to each patient. Teamwork encompasses complementary competencies, all of them indispensable, and all the members of the team contribute equally to the process, which should be headed by the member or members who can provide the care most needed by a patient at any given time. The idea that the care of complex critically ill patients can be carried out without specialists in intensive care medicine, when technology and scientific evidence demand extraordinary professional training, is rash, to put it mildly, no matter how great the impetus of the heads of some departments or however favorable the situations that make it possible.

Meticulous clinical investigation of critically ill cardiac patients should indicate which organizational models are optimal, most efficient, and of the highest quality. The professionals, specialties, and scientific societies should be at the service of these aims, putting aside other interests, and pursuing the best health care that scientific evidence and the available resources can offer at all times.

María Cruz Martín Delgado,[a,*] José Luis García Garmendia,[b] María Paz Fuset Cabanes,[c] and Enrique Fernández-Mondéjar[d]

[a]*Servicio de Medicina Intensiva, Hospital Universitario de Torrejón, Torrejón de Ardoz, Madrid, Spain*
[b]*Servicio de Cuidados Críticos y Urgencias, Hospital San Juan de Dios del Aljarafe, Sevilla, Spain*
[c]*Servicio de Medicina Intensiva, Hospital Universitari i Politècnic La Fe, Valencia, Spain*
[d]*Servicio de Medicina Intensiva, Complejo Hospitalario Universitario de Granada, Granada, Spain*

* Corresponding author:
E-mail address: mcmartindelgado@gmail.com (M.C. Martín Delgado).

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