Antithrombotic Therapy and Surgery: From Consensus to Clinical Practice. Response to Related Letters

Antitrombóticos y cirugía: del consenso a la práctica clínica. Respuesta a cartas relacionadas

To the Editor,

First of all, we would like to thank Santiago de Dios and Martín-Rioboó et al. for their interest in the consensus document on the perioperative and periprocedural management of antithrombotic therapy.[1] We would like to clarify the following regarding the comments received:

The situation of patients on anticoagulants and antiplatelet agents is complex and in our opinion the decision to stop one of these drugs (and when to do so) must be individualized in each patient. Regarding patients with low ischemic risk (essentially after 1 year) who are taking anticoagulation alone, there is no evidence to generate a recommendation in this consensus for the use of antiplatelet agents as a "bridge" therapy in the perioperative period.[2]

The consensus document recommends limiting bridge therapy and reserving it only, according to the available evidence, for patients with of high thromboembolic risk.[3] The recommended dose of low-molecular weight heparin refers to a full anticoagulation dose, which is restarted after the procedure depending on the bleeding risk and is later stopped once the adequate international normalized ratio is reached with oral anticoagulation.[4] In patients receiving prophylactic doses of parenteral anticoagulation prior to intervention, it is recommended that the last dose be taken 12 hours previously; if the parenteral anticoagulation is used at a therapeutic dose, the recommendation is to stop it 24 hours previously.

As to the classification of operations and procedures according to bleeding risk, these have been stratified by all the participating societies according to their criteria and evidence.[1] Given that there may be some disagreement for certain procedures, and to facilitate the application of the recommendations, the consensus document leaves open the possibility of not stopping anticoagulation in such cases, as is explained in the text and in the footer of Table 1 in the supplementary material.

In conclusion, we hope that the consensus document will be a useful, practical, easy-to-use tool and that it will help implement local multidisciplinary protocols to avoid the adverse consequences of variability in clinical practice.

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Cancer and Acute Coronary Syndrome. A Close but Complicated Relationship

Cáncer y síndrome coronario agudo. Una estrecha pero complicada relación

To the Editor,

I have carefully read the article by Cordero et al.[1] on the postdischarge prevalence and incidence of malignant tumors in patients with acute coronary syndrome (ACS), and I would like to congratulate the authors for addressing a subject that has been little studied to date, but is of great interest to cardio-oncology departments.

The first finding of note in this study was that the on-admission prevalence of cancer in patients admitted for an ACS was 3.4% and that the postdischarge incidence of cancer was 3.1% (median follow-up of 33 months). In summary, 6.5% of patients admitted for an ACS have had or will have cancer. However, it is expected that the prevalence of cancer in patients with ACS will increase in the coming years. In fact, cardiovascular disease is currently an important cause of morbidity and mortality in cancer patients,[2,3] for which there are main 2 reasons: the increased survival of cancer patients, because of early detection programs and advances in antitumor treatments[4]; and because cancer and cardiovascular disease have numerous risk factors in common.[5] In fact, the present study found no differences between the percentage of patients with or without cancer with a history of smoking, hypertension, dyslipidemia, or diabetes.

The second truly striking and novel finding of the present study was the increase in mortality observed in patients with prevalent and incident malignant tumors. In patients with de novo tumors, the increase in mortality was mainly due to an increase in noncardiovascular mortality (subhazard ratio [sHR], 33.03; 95% confidence interval [95%CI] 20.32-53.67).

Although this finding could suggest that the role of cardiologists would be minimal in this patient subgroup, analysis of these results should be deepened. It is unclear from the present study whether the noncardiovascular mortality rate of patients with de