

Factors Contributing to the Low Rate of Surgical Revascularization in Spain



Factores que contribuyen a la reducida indicación de revascularización quirúrgica en España

To the Editor,

We read with interest the article by Vázquez Ruiz de Castroviejo et al¹ and we would like to congratulate the authors for this undoubtedly important contribution. In our opinion, the differences in the percentage of surgical revascularization between Spain and other countries could be due in part to the specifics of the different health care systems. Firstly, in Spain in general, patients must present to a specific referral center, and the physician's salary is independent of the number of patients seen. This situation differs from that in other countries where patients can choose their center, and even their physician, based on publicly reported outcomes, and where the physician is paid according to the number of patients seen. The Spanish system could cause a certain depersonalization of the process, with less physician influence in the decision to perform revascularizations and more freedom for the interventionalist, which could increase the number of percutaneous revascularizations. Secondly, the long surgical waiting lists could also have a significant influence. Type 1 indications are based on randomized studies, while daily practice in certain regions is quite distinct. In the year 2000, the criteria for temporary management of cardiac surgery were published;² a call was made for a thorough remodeling of public hospitals and increased resources, while warnings were issued that it would be very difficult to achieve the recommended target times within 2 years. Fifteen years later there are still substantial delays in certain regions, despite interventional cardiologists, in theory, performing procedures that, according to the guidelines, should be surgical. The Royal Decree 605/2003³ aimed to standardize public waiting lists and underlines the role of the Interterritorial Council in guaranteeing conditions of effective equality. It defines the "Register of patients awaiting scheduled surgical intervention" as a "register that includes all patients with nonurgent indication for a diagnostic or therapeutic procedure, as established by a surgical specialist, after completion of diagnostic investigation, accepted by the patient, and which the hospital expects to be performed in an operating room". "Date of entry to the register" is defined as the date of the decision to operate by a surgical specialist, and patients are classified into 3 groups: a) structural awaiting intervention, those who are ready to undergo surgery and whose wait is attributable to the organization and resources available; b) awaiting intervention after declining intervention in a different center, and c) temporarily unable to be scheduled because of clinical contraindications, or because the intervention is temporarily not recommended, or because postponement is requested for personal or work reasons. In our opinion, it is very important to standardize the criteria, since, in some centers,

patients are put on the register as soon as they are accepted in a medical-surgical meeting, whilst in others, this is done at a subsequent consultation with the surgeon, sometimes months later, with the consequent absence of a considerable number of patients on the list, although they have already been accepted by the surgeon at the meeting. Furthermore, occasionally, the alternative center offered is located so far away that the family must stay in a hotel in a different city or even another region of Spain, with the consequent disruption, which is why many decline this solution and are allocated to the group that declined intervention in a different center. All this affects the list and, far from solving the problem, makes it worse by camouflaging it, as the number of patients accepted at the meeting and awaiting surgery does not change. Finally, one last natural restructuring can complicate the problem even more, namely, the frequent destabilization of coronary patients means that they overtake the valvular patients on the list, who then suffer more serious consequences, as they tend to have a silent clinical onset whilst waiting, until their clinical deterioration, when the situation is then much more unfavorable. The incidence of aortic stenosis is progressively increasing and, under current restrictions, percutaneous valve replacement has facilitated treatment of inoperable patents while hardly reducing the surgical waiting list. Consequently, we believe that, catheterization departments have an obligation to reduce these delays—which can have fatal consequences—by decreasing referrals of coronary patients.

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