

Optimal Medical Treatment: Is It the Worst Option in Multivessel Coronary Disease? Response



Tratamiento médico óptimo: ¿es la peor opción en la enfermedad coronaria multivaso? Respuesta

To the Editor,

We would like to thank Dr. Morales Salinas for his comments regarding our article on decision making between percutaneous coronary intervention or bypass surgery in multi-vessel coronary disease, which was recently published in *Revista Española de Cardiología*.¹ The author reflects on the option of optimal medical treatment (OMT) for the treatment of multivessel coronary artery disease, compared with accepted revascularization strategies in the form of coronary artery bypass grafting and percutaneous coronary intervention.

We agree with the author that OMT does play a role in the treatment of the patient with coronary artery disease, but we must not overlook the vital role of revascularization. Indeed, with reference to the European Guidelines on Stable Coronary Artery Disease quoted by the author, the same guidelines state that “OMT should not be considered an alternative but a synergistic approach to revascularization”.²

It is accepted that OMT alone may be appropriate in the presence of a low ischemic burden; however, we must emphasize that revascularization in higher risk subgroups by either strategy has been demonstrated to have a mortality benefit. Notably, the MASS II trial demonstrated significantly reduced rates of myocardial infarction out to 10 years, with a trend to lower mortality with revascularization vs OMT.³ Other contemporary studies demonstrated similar favorable outcomes in patients with a significant ischemic burden (SWISSI⁴ and ACIP⁵ trials). More recently, the FAME-2 study confirmed significantly improved clinical outcomes with percutaneous coronary intervention plus OMT, compared with OMT alone.⁶

We accept that the proportion of arterial grafts may be higher in such studies than in the real world, as the author suggests; however, counterbalancing this, the difficulty of implementing OMT in daily practice has to be taken into consideration. Indeed, the guidelines state: “It takes enormous effort, dedication, cultural change, and commitment to expect the benefits observed in the randomized trials to manifest in “real” practice”.² Patients may not be fully compliant with daily therapy and hence not derive the full benefit as demonstrated in clinical studies.

Furthermore, as discussed by the author, pharmacological therapy for the treatment of coronary artery disease has developed significantly; importantly, however, so too have revascularization technologies. Hence, in conclusion, we do agree on the importance of OMT in the patient with coronary artery disease; however, this must be in conjunction with consideration of revascularization if deemed appropriate by the treating physician. Future studies may provide a greater insight to this debate. For example, the ISCHEMIA trial is currently randomizing 8000 patients with moderate ischemia to revascularization plus OMT vs OMT alone, reserving revascularization for those who fail, with a primary endpoint of time to cardiovascular death or nonfatal myocardial infarction.

Gill Louise Buchanan,^a Gennaro Giustino,^b and Alaide Chieffo^{b,*}

^aDepartment of Cardiology, North Cumbria University NHS Trust, Carlisle, United Kingdom

^bInterventional Cardiology Unit, San Raffaele Scientific Hospital, Milan, Italy

*Corresponding author:

E-mail address: chieffo.alaide@hsr.it (A. Chieffo).

Available online 7 November 2014

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