

2. Bonde AN, Lip GYH, Kamper AL, et al. Renal Function Time in Therapeutic Range and Outcomes in Warfarin-Treated Atrial Fibrillation Patients: A Retrospective Analysis of Nationwide Registries. *Thromb Haemost.* 2017;117:2291–2299.
3. Chao TF, Liu CJ, Wang KL, et al. Incidence and prediction of ischemic stroke among atrial fibrillation patients with end-stage renal disease requiring dialysis. *Heart Rhythm.* 2014;11:1752–1759.
4. Dahal K, Kunwar S, Rijal J, Schulman P, Lee J. Stroke, major bleeding, and mortality outcomes in warfarin users with atrial fibrillation and chronic kidney disease: a meta-analysis of observational studies. *Chest.* 2016;149:951–959.
5. Lip G, Freedman B, De Caterina R, Potpara TS. Stroke prevention in atrial fibrillation: Past, present and future. Comparing the guidelines and practical decision-making. *Thromb Haemost.* 2017;117:1230–1239.

6. Potpara TS, Ferro CJ, Lip GYH. Use of oral anticoagulants in patients with atrial fibrillation and renal dysfunction. *Nat Rev Nephrol.* 2018;14:337–351.

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Use of High-potency Statins After Percutaneous Revascularization



Uso de estatinas de alta potencia tras revascularización percutánea

To the Editor,

We have read with interest the editorial by Parikh and Kirtane¹ on the indication for higher-intensity lipid-lowering therapy after drug-eluting stent implantation. Statins reduce the risk of atherosclerotic cardiovascular disease and improve prognosis after acute coronary syndrome. The effectiveness of the therapy has been linked to the magnitude of the drug-induced reduction in low-density lipoproteins. Thus, high-potency statins provide an even greater benefit than lower-potency statins.²

Our group recently compared the percutaneous revascularization strategy for severe lesions in secondary coronary branches (diameter ≥ 2 mm) of major epicardial arteries vs conservative treatment in 589 patients.³ After a mean follow-up of 24 months, there were no significant differences in the occurrence of cardiovascular events between percutaneous treatment (376 patients, 63.8%) and conservative treatment (213 patients, 36.2%).

We also analyzed whether the use of high-potency statins (atorvastatin, rosuvastatin, pitavastatin, and simvastatin 80 mg) vs low-potency statins differed according to the revascularization strategy adopted. None of the patients—neither overall nor when stratified according to the treatment received—showed differences in cardiovascular events during follow-up according to whether they received percutaneous revascularization or optimal medical therapy.

We believe that 2 important aspects should be considered by researchers evaluating the benefit of the use of high-potency statins after percutaneous revascularization. The first is the possible prescription bias that leads physicians to prescribe more intensive treatments after stenting vs optimal medical treatment.⁴ The second aspect is the greater adherence to lipid-lowering therapy in patients receiving percutaneous treatment vs those who do not.⁵

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REFERENCES

1. Parikh KH, Kirtane AJ. Should we up the intensity of statin therapy after placing a drug-eluting stent? *Rev Esp Cardiol.* 2018;71:416–417.
2. Jiménez Navarro MF. Comments on the 2016 ESC Guidelines on cardiovascular disease prevention in clinical practice. *Rev Esp Cardiol.* 2016;69:894–899.
3. Cano-García M, Millán-Gómez M, Sánchez-González C, et al. Impact of percutaneous coronary revascularization of severe coronary lesions on secondary branches. *Rev Esp Cardiol.* 2018. <http://dx.doi.org/10.1016/j.rec.2018.04.011>.
4. Bagnall AJ, Yan AT, Yan RT, et al. Optimal medical therapy for non-ST-segment-elevation acute coronary syndromes: exploring why physicians do not prescribe evidence-based treatment and why patients discontinue medications after discharge. *Circ Cardiovasc Qual Outcomes.* 2010;3:530–537.
5. Kocas C, Abaci O, Oktay V, et al. Percutaneous coronary intervention vs. optimal medical therapy—the other side of the coin: medication adherence. *J Clin Pharm Ther.* 2013;38:476–479.

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<https://doi.org/10.1016/j.rec.2018.08.006>

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