

perforation of the vessel, embolization with metallic material, slow-flow, and periprocedure infarction.² Furthermore, it is a technique that requires adequate training and a learning curve. Coronary lithoplasty is a novel, simple technique, with little reported experience as yet, but holds great promise. The available case series guided by optical coherence tomography have described its effects on calcified plaque and have reported a small percentage of complications.³ These studies have shown that the energy emitted with this technique interacts with atherosclerotic plaque and causes vibrations that fracture the calcium present in both the superficial and deep layers of the vessel wall.⁴ We believe that the effect of coronary lithoplasty on deep calcium may be its greatest advantage over other ablative techniques. In this line, we would like to underscore the importance of using optical coherence tomography to evaluate the extent of calcium and its depth and enable individualized treatment for each case. However, additional studies are needed to define the clinical effects of coronary lithoplasty and its impact on the stent structure.

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Scientific evidence and expert opinion. Why is TAVI different?



Evidencia científica y opinión de expertos. ¿Por qué el TAVI es diferente?

To the Editor,

We read the article by Jiménez Quevedo et al.¹ on the disparity between scientific evidence and expert opinion regarding the need for on-site cardiac surgery in centers performing transcatheter aortic valve implantation (TAVI), and we would like to thank the working group for underscoring the importance of scientific data in this debate.

The situation in Spain is worthy of analysis, not only for the strikingly diverse initial interpretations of the need for cardiac surgery in these centers, but also for the continuous inconsistencies in relation to this issue. Some examples include ceasing the activity in Andalusia, Catalonia, and Castile and León without having analyzed the outcomes, which in the end, turned out to be very good,² maintaining the activity in Castile-La Mancha and Madrid, and later, resuming the activity in Andalusia. To further complicate things, the future suppression of a cardiac surgery service in Basque Country in a center where TAVI is performed will make this situation even more convoluted. Although a part of this haphazardness can be due to fragmentation of the health system, there are other origins.

Up to now, the reasons given have been the potential to resolve complications by having on-site cardiac surgery, and in the recent refusal to reopen 2 centers in Catalonia, not the protection afforded

by surgery, but the argument that treatment decisions should be made by a cardiology team.

If there is one specialty that can boast of scientific evidence, it is cardiology. We have very robust data in this line from the AQUA registry of 17 979 patients,³ which shows no significant differences in mortality rates between centers with and without on-site surgery. These results were confirmed in 1822 cases in Austria and 384 procedures in Spain.² Furthermore, in one registry in Europe⁴ with 27 760 patients and another in the United States⁵ with 47 546 patients, urgent conversion to surgery was required in 0.76% and 1.17% of the total, respectively, with decreasing values over the years. Moreover, many of these procedures were carried out using outmoded techniques, and in both registries half of the small number of patients who required surgery did not survive hospitalization.

The argument about the desirability of decision-making by the cardiology team is very appropriate, but medical-surgical sessions have been conducted in centers without on-site surgery for years, either face-to-face or using one of the many currently available options that do not require personal contact. That said, the recommendation should also be for ischemic heart disease, and therefore, should be implemented in centers where it is not being done.⁶

We would like to point out the importance of the consequences of the present situation. First, it limits patients' access to treatment, with the subsequent increase in mortality.⁷ Second, the Spanish Society of Cardiology should be aware that the professional development of many interventional cardiologists and that of our cardiology services is limited. Advanced imaging is not progressing, and private funding for computed tomography facilities is decreasing, which is crucial given the limited access of cardiology patients to this resource. This has led to the flight of solidly trained professionals to other centers. Third, the Spanish Society of Cardiology should determine whether it is realistic to face the huge demand only with cardiac surgery in the

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centers, and if this is not possible, it should foresee what scenario will cover this demand, because ultimately, it may not have to completely depend on cardiology.

There is a strong, traditional link between cardiology decisions and clinical evidence, which in this case, endorses TAVI in centers without on-site surgery. Hence, as the working group indicates,¹ these procedures should be allowed in nonsurgical centers that have experienced interventional cardiology and vascular teams using repositionable self-expanding valves in high-risk patients.

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