Management of Stable Coronary Disease: Primum Nil Nocere

To the Editor:

In a recent study, Hambrecht et al1 compared percutaneous coronary interventions (PCI) with exercise training in low-risk patients with stable coronary disease (CAD) and significant stenosis at coronary angiography. Exercise training was associated with increased exercise tolerance, decreased total progression of CAD, and a higher event-free survival rate. These benefits were combined with significantly reduced costs. However, in their discussion, the authors conclude that in the majority of patients, PCI will remain the therapy of choice. I disagree. Several other studies have shown increased event rates2,3 and higher costs4 with PCI in low-risk patients with stable CAD. Therefore, as long as clear benefit of PCI in terms of hard end points has not been shown, the use of PCI should be confined to high-risk patients and to patients whose symptoms cannot be controlled with a conservative strategy. To differentiate true benefits of exercise training and risks of an invasive approach, the proposed multicenter trial should include a control group receiving modern pharmacological therapy only. Nevertheless, in clinical practice, the importance of physical exercise has to be emphasized.

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Response

We cordially welcome Dr Wolber’s comments on the conclusions to be drawn from our recent article1 comparing percutaneous coronary angioplasty and exercise training in patients with stable coronary artery disease.

In an ideal world, we would agree to his proposed strategy to confine interventional therapy to high-risk patients and to those in whom symptoms cannot be controlled by conservative treatment. However, in the course of conducting the PCI versus Exercise Training (PET) pilot study we met the several obstacles in the real world, both patient- and physician-related: Only a minority of patients screened for study enrollment (101/380) was willing to change their sedentary lifestyle and to participate in a long-term training program. In addition, some patients view a strategy avoiding/delaying interventional treatment until clearly indicated as receiving suboptimal therapy. In a technology-oriented world, a sophisticated drug-eluting stent system seems to be a more attractive option than a “low-tech” exercise training program, a position also shared by protagonists of interventional cardiology. Because the success of exercise training programs depends on the long-term motivation of both patients and physicians, the aspects mentioned above clearly limit the widespread use of training interventions. We would welcome all attempts to influence these factors in ways that facilitate the use of exercise training as the therapy of first choice in stable coronary artery disease (CAD).

Regarding his comments on the study design of the PET multicenter study, we considered including a conservative-only group as a third arm; however, the limited resources did not permit the realization of such a control group. Dr Wolber is correct that even a conservative strategy with statins can be superior to an interventional approach as evidenced by the Atorvastatin Versus Revascularization Treatment (AVERT) study.2,3 However, exercise training on top of optimal medical treatment seems to be superior to purely pharmacological therapy in patients with stable coronary artery disease. It also has well-documented positive effects on coronary flow reserve and myocardial perfusion not seen in a conservative-only group.4,5

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