Optimal Timing of Noncardiac Surgery After Stents

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The planning of noncardiac surgery in patients with a history of coronary artery disease and previous percutaneous coronary intervention with stent implantation is a topic that elicits clinical concern and discussion. These patients face risks related to their underlying coronary heart disease, as well as potential problems related to the coronary stent or associated antiplatelet medications. Some surgical procedures that confer a significant risk of surgical bleeding may require consideration of interrupting dual antiplatelet therapy. This is particularly challenging within the first year after coronary stenting, for which there are only limited data to guide practice.1–5

In-stent restenosis, leading to recurrent coronary ischemia, is pathophysiologically distinct from stent thrombosis, and recommend that surgery be delayed. The conditions of patients were diverse in this study, and perhaps not entirely controlled for in the comparisons made. Many of the surgeries performed in the study, although not emergency surgeries, are indicated for life-threatening time-sensitive conditions such as cancer or severe vascular conditions, and are associated with highly variable risks of bleeding. Likewise, the coronary substrate may have varied from a single large vessel stent compared with a complex bifurcation stent, indicating different stent thrombosis risks. This degree of detail was not available for adjustment in the study.

Nonetheless, this is the largest published observational cohort to examine the optimal time for surgery after stents. Its chief strength is the breadth of the study population. Randomized trials focused on the question of timing of surgery are unlikely to be performed, so it is likely that clinical decisions will continue to rely entirely on observational data such as these. The authors report their findings in the context of current recommendations from the American College of Cardiology/American Heart Association/Society of Cardiac Angiography and Intervention Guidelines that recommend, if possible, at least 30 days after BMS and at least 365 days after DES implantation.7,8

Given the limited number of available analysis, the authors have combined events of different pathophysiologic cause—myocardial infarction (the minority of which is likely to be related to the stent itself) and repeat revascularization. To define the optimal time for elective surgical procedures one must consider the potential hazards separately, how these vary over time, and the safety of stopping dual antiplatelet therapy if required. Although the current study offers new information regarding the hazard of certain events after surgery, there is also considerable preexisting information about the expected time course of recovery and risk after coronary stenting. In particular, clinical events that are directly related to the stent procedure—stent thrombosis and stent restenosis—follow a predictable time course (Figure).9–19

For BMS and DES it is clearly established that the thrombosis rates are highest periprocedure, decline over the first 2 weeks, and then continue to decline.9,20 Studies of BMS21 and clinical practice guidelines7,8 have indicated 30 days of antiplatelet therapy are warranted to minimize stent thrombosis risk, and studies of noncardiac surgery after BMS describe a diminution in risk of in-hospital complications after this period. When surgery is required within 30 days of revascularization and when dual antiplatelet therapy is not feasible periopeatively, balloon angioplasty alone may be a reasonable strategy if a good acute result is expected because aspirin rather than dual antiplatelet may be sufficient.22

The opinions expressed in this article are not necessarily those of the editors or of the American Heart Association.

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usually develops gradually. The hazard for BMS restenosis peaks at 4 to 9 months after stent placement, with a few additional events presenting later in the first year, and an overall risk of about 14% over the first year. The raison d’être for DES is prevention of restenosis; DES are associated with a risk of 3% to 4% over the first year, a relative risk reduction of approximately 75% compared with BMS. Based on the mechanism of delayed endothelialization, a longer duration of antiplatelet therapy has been presumed to be necessary in clinical use of DES. It is clear that for current DES, discontinuation before 6 months is associated with a higher risk of stent thrombosis than continuation. Although the incremental risks are low beyond 6 months, as measured in several randomized studies not powered to detect stent thrombosis, the optimal duration of antiplatelet therapy is under ongoing investigation in larger randomized trials.

We must congratulate the authors for their efforts to bring more evidence to the question of surgical timing faced commonly in clinical practice. What is reassuring from this report is that clinicians do fairly well choosing the timing of surgery with a low rate of adverse cardiac events. It is also clear from this report that whether a BMS or DES was recently implanted, undergoing noncardiac surgery in the initial 45 days after percutaneous coronary intervention is associated with an increased risk of adverse events. In a perfect world, the delay between percutaneous coronary intervention, especially with DES use, and surgery would be a minimum of 1 year. For BMS, the optimal duration falls after the stent thrombosis risk of the first 30 to 45 days has been passed, and before restenosis becomes likely (at 6 months). For DES, larger datasets with more detail around cardiac and anatomic risk and on more refined cardiac outcomes will be helpful to navigate cardiac and surgical risk more clearly in the future.

The finding that most DES patients who are operated on beyond 6 months after stenting do well is consistent with a large body of knowledge from the initial trials of DES, where the standard duration of antiplatelet therapy was 3 to 6 months. However, these trials were conducted primarily in subjects without acute coronary syndromes and with noncomplex single vessel stent treatment. Although surgery after 6 months may be reasonable in some simple lesions with good acute results, data such as those from the study by Wijeyasuryera and colleagues do not have sufficient size and scope to change the current guidelines to cover the scope of broad practice and recommend earlier surgery after DES, when there remain concerns regarding the residual risk of stent thrombosis within the first year. Ongoing randomized studies to examine whether it is reasonable to stop antiplatelet therapy earlier than 1 year across the range of patients treated, and identification of new stent technology to allow both low restenosis and low stent thrombosis risk, are directions that may allow greater certainty of safety for patients with coronary disease requiring noncardiac surgery in the future. Ultimately the decision of timing is quite individual, balancing the well-understood risks of restenosis with less certain risks of stent thrombosis, as well as patient anatomy, perioperative bleeding risks, and risks of delaying surgical procedures. It is important to remember that these complex decisions will not be answered by simple rules, because the interplay of surgical risk anatomic complexity of the coronary stent procedures and the urgency of surgery will vary between patients.

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References


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