
To the Editor:

In the Acute Catheterization and Urgent Intervention Triage Strategy (ACUITY) trial, Rosner and colleagues1 evaluate the impact of the presence and extent of incomplete angiographic revascularization after percutaneous coronary intervention in acute coronary syndromes. They should be commended for their attempts to answer a pertinent debate on the clinical importance of incomplete coronary revascularization (ICR) after percutaneous coronary intervention. However, a few interesting points arise from the analysis, and several caveats have to be considered before a final conclusion is reached.

First, it would be interesting to know whether the authors have data on baseline and postrevascularization left ventricle ejection fraction (which is an established predictor of major acute coronary events) and distribution of medical conditions like congestive heart failure, cardiogenic shock, and peripheral artery disease in the ICR and complete coronary revascularization groups that could act as confounder factors in the calculation of major acute coronary events. Second, in the ICR group, the percentage of patients with triple-vessel disease was more than double that of the complete revascularization group; thus, it seems that patients in the ICR group had more severe/generalized atherosclerotic disease, which could explain the subsequent higher rate of major acute coronary events in this group.

Furthermore, what is the impact of this study on patient management? Even if ICR is associated with higher major acute coronary events, what should be the next step? Should patients undergo repeat revascularization? Or should complete revascularization be performed as an index procedure in every patient? What would be the cost-effectiveness of such approach? These questions should be considered in light of previous trials that have shown no long-term benefits of complete revascularization compared with ICR.2,3 We believe that revascularization should be ischemia guided and should not be based solely on angiographically detected degree of stenosis because only 35% of angiographically diagnosed lesions are functionally ischemic.4

We thank the authors again for an elaborate and illuminating paper.

Disclosures

None.

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References

Letter by Sharma et al Regarding Article, "Impact of the Presence and Extent of Incomplete Angiographic Revascularization After Percutaneous Coronary Intervention in Acute Coronary Syndromes: The Acute Catheterization and Urgent Intervention Triage Strategy (ACUITY) Trial"
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