
We appreciate the comments and suggestions made by Bouguin et al. As they point out, there are several important limitations of our analysis, including the lack of cause-specific mortality in long-term follow-up.1 Although the Early Glycoprotein IIb/IIIa Inhibition in NSTE ACS (EARLY ACS) trial captured cause of death at 30 days, these data were unavailable at 1 year. However, our suggested recommendations are well supported by the data. A key finding in our analysis was that ventricular tachycardia/ventricular fibrillation is just as likely to occur ≥48 hours after a non–ST-segment elevation acute coronary syndrome as within the immediate post–acute coronary syndrome period (0–48 hours). Thus, aggressive in-hospital monitoring through discharge seems warranted. We agree with Bouguin et al that management of arrhythmic risk after discharge in patients who develop ventricular tachycardia/ventricular fibrillation in the setting of an acute coronary syndrome is more difficult. Current guidelines advocate revascularization as the primary therapy. As we suggested in our discussion, given the competing risks of heart failure death and arrhythmic death, interventions to decrease arrhythmic risk after discharge require further study in randomized clinical trials. These interventions could include wearable cardioverter-defibrillators, pharmacological therapies, and novel risk stratification techniques that might help to clarify which patients are at risk for recurrent ventricular tachycardia/ventricular fibrillation despite revascularization.

Disclosures

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