Response to Letter Regarding Article, “Surgical Ineligibility and Mortality Among Patients With Unprotected Left Main or Multivessel Coronary Artery Disease Undergoing Percutaneous Coronary Intervention”

We thank our colleagues for reading and commenting on our recently published article.1 Our results suggested that documentation of surgical ineligibility was common (22%) among patients undergoing percutaneous revascularization for multivessel coronary artery disease. Furthermore, documentation of surgical ineligibility was associated with an increased risk of mortality.

As detailed in their letter, Gasparovic and colleagues emphasized the importance of a heart team approach for the treatment of complex coronary artery disease. The published analysis demonstrated that documentation of surgical ineligibility was derived from myriad sources, although formal documentation from a cardiac surgeon occurred in a minority of cases (20%). As detailed in the text, documentation of surgical ineligibility was also ascertained from cardiology consultation notes (37%) and cardiac catheterization reports (21%). It is important to note that these other documents often referenced conversations with a cardiothoracic surgeon, emblematic of the heart team approach. The documentation of these collaborative decisions continues to evolve, however, and does not always include a formal note written by a cardiothoracic surgeon.

Gasparovic and colleagues also raised a concern with the definition of renal insufficiency. As described in the original text, a measurable proportion of patients (16%) were deemed ineligible for surgical revascularization because of renal insufficiency. Because patients with renal insufficiency represented only a modest fraction of those deemed to be ineligible, this had only a mild impact on the mean glomerular filtration rate of the ineligible patients as a whole. In fact, the median glomerular filtration rate (32 mL·min⁻¹·1.73 m², interquartile range, 19–45 mL·min⁻¹·1.73 m²) among those deemed surgically ineligible because of renal insufficiency was most consistent with moderate (stage 3) kidney disease. Although we agree that renal failure is not a contraindication to surgical revascularization, data strongly suggest that it increases the perioperative risks and mortality of patients undergoing this procedure.2,3 The surgeons treating patients included in our study documented that the increased risk for those patients, considered in combination with their other comorbidities, was prohibitive and deemed the patients ineligible for surgical revascularization. It would not be feasible to radjudicate whether the patients included were truly ineligible for cardiac surgery using retrospective data because these assessments necessarily require face-to-face evaluations of patients. We do agree, however, that potential risk aversion based on mortality reporting may lead to the avoidance of high-risk procedures in the care of cardiac patients, as we have recently demonstrated.4

We believe that our analysis represents a contemporary evaluation of clinical practice, demonstrating that patients documented as surgically ineligible by the treating clinicians have an increased risk of mortality after percutaneous coronary intervention. Although we acknowledge the important perspective of the surgeons, we believe the implications of our findings extend beyond the interests of subspecialty groups and have broader implications for all physicians, healthcare systems, and most important, our patients.

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References

Disclosures
None.

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