Angioplasty After Thrombolysis

To the Editor:

The article by Meyer et al.1 (Circulation 66: 905, 1982) presents exciting, well-documented treatment of patients with successful thrombolysis followed by immediate angioplasty. The average area stenosis of the reported successes was reduced from 90.2 ± 7.3% to 58.6 ± 19%. These results parallel our own in routine angioplasty and selected post-thrombolysis patients.

How disappointing, then, to read Dr. Swan's following editorial where he recommends that lesions of 75% cross-sectional narrowing (area) are suitable for angioplasty, whereas lesions greater than 90% should be managed surgically. This appears quite contradictory. Putting aside the confusion produced by diameter reduction methods vs area methods, it is simply not true that the severity of stenosis limits angioplasty improvement in Meyer's article. Almost all of our current angioplasty candidates have at least 90% area stenosis (75% diameter reduction), and good results are usually seen. Unfortunately, we have already heard well-meaning cardiologists quote Dr. Swan's editorial and withhold angioplasty because the lesion appears to be "over 90%.

Perhaps Dr. Swan could clarify his editorial and provide some documentation for his statements.

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Reference

The author replies:

To the Editor:

A substantive body of information on the optimal method for treatment of coronary atherosclerosis after thrombolysis for acute evolving myocardial infarction remains to be gathered. Only then will comparisons of "optimal" intervention prove to be possible. Until that time, it seems incumbent to offer the patient a treatment form of proven efficacy and low complication rate. At the present time, the beneficial effects of coronary bypass surgery in multivessel, high-grade proximal disease are established. Excellent results are not confined to major academic centers, but have been reported from many community hospitals. On the contrary, even in the most skilled of hands, angioplasty in one-vessel disease is accompanied by a primary recurrence rate of 15–20% and its role in multivessel disease is only currently under serious study. Even in the management of moderate degrees of coronary stenosis, the primary success rate was 87% and restenosis remained at 25%. Indeed, Ischinger and Gruentzig1 concluded that PTCA should be performed only as an alternative to coronary bypass surgery. Therefore, until these particular issues are resolved, and appropriate comparisons published, it would seem that direct revascularization remains the optimal treatment for patients with severe multivessel disease.

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Reference
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_Circulation_. 1983;67:710
doi: 10.1161/01.CIR.67.3.710
_Circulation_ is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
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Print ISSN: 0009-7322. Online ISSN: 1524-4539

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