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INSIDE THIS ISSUE

CORONARY

Vascular Access Site and Outcomes Among 26,807 Chronic Total Coronary Occlusion Angioplasty Cases From the British Cardiovascular Interventions Society National Database

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Tim Kinnaird, Richard Anderson, Nick Ossei-Gerning, Sean Gallagher, Adrian Large, Julian Strange, Peter Ludman, Mark de Belder, James Nolan, David Hildick-Smith, Mamas Mamas

Using a national percutaneous coronary intervention (PCI) database, access-site choice and outcomes after chronic total occlusion (CTO) PCI were assessed in 26,807 elective CTO PCI procedures performed in England and Wales between 2006 and 2013. There was a significant decrease in femoral artery (FA) access from 84.6% in 2006 to 57.9% in 2013. Procedural factors associated with FA access included dual access, CrossBoss/Stingray, intravascular ultrasound, and microcatheter use. There was an association between FA access and the number of CTO devices used. Access-site complications, periprocedural myocardial infarction, major bleeding, transfusion, and 30-day death were more frequent in patients undergoing CTO PCI using FA access.

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Incidence, Patterns, and Associations Between Dual-Antiplatelet Therapy Cessation and Risk for Adverse Events Among Patients With and Without Diabetes Mellitus Receiving Drug-Eluting Stents: Results From the PARIS Registry

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Michela Faggioni, Usman Baber, Samantha Sartori, Gennaro Giustino, David J. Cohen, Timothy D. Henry, Serdar Farhan, Cono Ariti, George Dangas, Michael Gibson, Daniele Giacoppo, Mitchell W. Krucoff, Melissa Aquino, Jaya Chandrasekhar, David J. Moliterno, Antonio Colombo, Birgit Vogel, Alaide Chieffo, Annapoorna S. Kini, Bernhard Witzenbichler, Giora Weisz, Philippe Gabriel Steg, Stuart Pocock, Roxana Mehran

In patients treated with contemporary percutaneous coronary intervention and at least 1 drug-eluting stent, dual-antiplatelet therapy (DAPT) cessation because of physician-recommended discontinuation was less frequent in patients with diabetes mellitus compared with those without, while the rate of DAPT interruption or disruption was comparable between the groups through 2 years after percutaneous coronary intervention. Physician-recommended discontinuation and interruption did not increase the risk for clinical outcomes regardless of diabetic status. Conversely, DAPT disruption because of bleeding or poor compliance significantly increased the rate of cardiovascular outcomes. No interaction was found between diabetes mellitus and the risk for adverse events for any DAPT cessation pattern.

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EDITORIAL COMMENT

More Bad News for Patients With Diabetes and a Thin Silver Lining

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Sorin J. Brener



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Detecting Periprocedural Myocardial Infarction in Contemporary Percutaneous Coronary Intervention Trials

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Ernest Spitzer, Ton de Vries, Rafael Cavalcante, Marieke Tuinman, Tessa Rademaker-Havinga, Maaïke Alkema, Marie-Angele Morel, Osama I. Soliman, Yoshinobu Onuma, Gerrit-Anne van Es, Jan G.P. Tijssen, Eugene McFadden, Patrick W. Serruys

Periprocedural myocardial infarction (PMI) is a common component of primary endpoints in coronary device trials. Among others, 3 definitions are used in current randomized comparisons: World Health Organization extended definition, Third Universal definition, and Society for Cardiovascular Angiography and Interventions definition. Operationalization of PMI definitions for event triggering was accomplished through programmable algorithms. The authors observed that PMI definitions are not interchangeable. The results suggest that comparability of trial results may rely partially on the definitions of PMI used because the rate of events may differ considerably. Complete baseline information facilitates the accurate assessment of events during adjudication, and should be considered a metric of performance.

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■ EDITORIAL COMMENT

The Devil Is Always in the Details

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Karen A. Hicks, Robert J. Temple

Assessment of Operator Variability in Risk-Standardized Mortality Following Percutaneous Coronary Intervention: A Report From the NCDR

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Jacob A. Doll, Dadi Dai, Matthew T. Roe, John C. Messenger, Matthew W. Sherwood, Abhiram Prasad, Ehtisham Mahmud, John S. Rumsfeld, Tracy Y. Wang, Eric D. Peterson, Sunil V. Rao

This study of 3,760 operators performing 2,343,693 PCI procedures identified significant variability in operator-level in-hospital mortality after adjustment for demographic and clinical variables. This variability was not driven by differences in case mix; in fact, high RSMR operators treated patients with lower expected mortality risk. There were modest differences in the use of evidence-based treatments, such as radial access, fractional flow reserve, and drug-eluting stents. Operator RSMR was unstable year to year, thus limiting its utility as a sole performance measure for PCI.

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■ EDITORIAL COMMENT

In-Hospital Risk-Adjusted Mortality Poorly Reflects PCI Quality: So Why Is it Being Used?

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Michael McDaniel

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