

## HEART OF THE MATTER

## Just Say No

The schism that has opened between the Society for Cardiovascular Angiography and Interventions and the guideline committee of the American Heart Association and American College of Cardiology in regard to stand-alone percutaneous coronary intervention is reminiscent of the advice given to teenagers about alcohol. It is clear that they shouldn't drink, but if they do, we should tell them how to do it safely. On the other hand, some would suggest that they should just say "No."

The SCAI indicates that it is not "promoting" elective PCI without on-site surgical support. It is just providing "how-to" guidelines in case you are thinking about setting up a system to perform elective PCI in that setting. After all, PCI can be addicting. The fact that stand-alone PCI is being carried out in many communities in North America, not to mention most of the rest of the world, makes little difference to the AHA and ACC guideline committees. They are sticking to their previous statements that were supported by the SCAI, and just saying "No."

Where is all of this coming from? It is hard to believe that with almost a million elective PCIs performed in the United

States, there are patients going untreated because of a shortage of facilities or trained cardiologists. One could make a case that patients in remote areas of this country are not being well served if they need a PCI for the treatment of an acute MI, but thrombolysis is still a reasonable alternative with proven benefits.

There is a sense that although there is a concern about the patients in remote settings, much of the pressure for these changes is coming from urban areas. Many hospitals that are performing emergency primary PCI for acute MI in urban areas without on-site surgical backup use interventionalists who have elective PCI experience in other surgically supported laboratories. Expansion of elective PCI to these hospitals will not expand the availability of PCI to new populations, but will decrease the number of procedures performed at the established laboratories. If quality can be measured by quantity, these efforts will certainly not improve it. In addition, many of these established laboratories require a large volume of patients to train interventionalists.

Although it is quite possible that surgically supported interventional labora-

tories are in short supply in some places, such is not the case in the United States. In fact, there is an expansion of cardio-surgical programs, in part to support access to elective PCI. This is, of course, occurring largely as hospital marketing ventures in the paradoxical setting of a nationwide decrease in volume of coronary artery bypass surgeries. Cardiac surgery remains a profit center and often adds to the eminence of community hospitals.

It is clear that the SCAI statement represents a push to wider acceptance of stand-alone PCI throughout the country. The fact that complications and need for surgical intervention are rare in the centers now performing PCI has been used as an argument for its broader availability. Whether the same safety profile can be achieved when performed at smaller institutions with lower volumes remains to be seen.

The experience of transferring therapeutic interventions to the real world has not always been successful. In weighing the benefits of the expansion of PCI to this wider community, it may be that the appropriate response is just to say "No." ■

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## Correction



DR. MORTON J. KERN

In "On the Beat," an incorrect photo was published for Dr. Morton J. Kern of the University of California, Irvine (January 2007, p. 35). The photo was of Dr. William O'Neil of the University of Miami. CARDIOLOGY NEWS apologizes to both gentlemen for the error.

## LETTERS

Letters in response to articles in CARDIOLOGY NEWS and its supplements should include your name and address, affiliation, and conflicts of interest in regard to the topic discussed. Letters may be edited for space and clarity.

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