

HEART OF THE MATTER

How One Clinician Responds to COURAGE

Mr. Salvatore Armani is on my schedule today. I saw him about 4 weeks ago when he was referred because he was experiencing chest pressure climbing up a flight of stairs.

I had seen him almost 3 years ago when he was 65 and was referred to me for the treatment of his hypertension. In the interval, he had been followed by his internist until the development of his recent symptoms. His blood pressure was fairly well controlled on thiazide diuretics and a calcium entry blocker. His internist had started him on statin therapy.

Although it was clear that his symptoms represented angina, I ordered an exercise echocardiogram to define the ischemic region of his ventricle and to get a feeling about the severity of his symptoms. Last week, his stress echocardiogram came back indicating that he had significant ECG and echocardiographic evidence of ischemia in the pos-

terolateral region of the ventricle occurring in the second phase of his stress test when his heart rate reached 120 and his blood pressure was 170/80. He had experienced some chest pressure at that time.

Before the report of the COURAGE (Clinical Outcomes Utilizing Revascularization and Aggressive Drug Evaluation) trial (CARDIOLOGY NEWS, April 2007, p. 1) I would have automatically referred him to my interventional colleagues for angiography and almost certain angioplasty. Today, I paused and reflected on the message of the trial.

It was information that was not new to me. I knew for some time that angioplasty and, for that matter, coronary artery bypass graft, had little or no impact on mortality or morbidity of coronary artery disease. The Coronary Artery Surgery Study (Circulation 1983;68:939-50) more than 20 years ago had clearly shown that, with the exception of those pa-

tients with left ventricular dysfunction, there was no mortality benefit achieved by bypass surgery. Even in those patients with left ventricular dysfunction, the benefits were uncertain.

More recently, a meta-analysis of percutaneous coronary intervention over the past 10 years (Circulation 2005;111:2906-12) showed that there was no mortality benefit, but a marginal benefit in angina could be achieved with angioplasty in an era devoid of statin therapy and when β -blockade was less than optimal. This was information that was easily accessible to anyone reading the cardiology literature, and it was reinforced by American College of Cardiology/American Heart Association guidelines.

On numerous occasions, I had sat down with patients in an attempt to outline these facts, but my lecture routinely fell on deaf ears and my reluctance to arrange an angiogram was perceived by my patients. They thanked me for my advice and went "up the street" to get their angioplasty. I had even given the same lecture

to my close friends. They figured that I had not kept up with what was going on in cardiology and drove off to have their angioplasties performed by more "forward looking" cardiologists. Frankly, I had been beaten down and I found it easier to go along with the crowd.

The results of COURAGE may bring in a new era in our understanding of the benefits and risks of percutaneous coronary intervention and how we should apply it in the treatment of coronary artery disease. Today, I have not only medical science behind me, but the Wall

Street Journal, the New York Times, and even the Detroit Free Press. All of these papers and many more prided themselves in hyping up the miracles that could be achieved by stents and extolling the wonders performed by the cardiologists "up the street." Now they were suddenly on my side. They printed in bold headlines that pills were as good as a stent.

I guess I'll try it out again on Sal. ■

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BY SIDNEY GOLDSTEIN, M.D.

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