“Invasive or non-invasive?”, “Aggressive or conservative?”; “Open-chest or percutaneous?”; these questions are raised whenever we see patients suffering from serious cardiovascular diseases. Answers, of course, vary on a case by case basis, depending upon many constraining factors, such as the patient’s clinical characteristics (age, sex, comorbidity, etc) to social factors such as financial status and availability of appropriate transportation or medical treatment.

As Dr Desideri mentioned, dramatic progress has been made in the treatment modalities for ischemic heart disease, and that is also true for diagnostic modalities, including pharmacological stress tests (eg, dobutamine stress echo), use of novel biomarkers (eg, cardiac troponins, natriuretic peptides) and new imaging modalities such as coronary multislice CT (MSCT), coronary MRI, intravascular ultrasound (IVUS), optical coherence tomography and so on. In our guidelines for the management of patients with ST-elevation myocardial infarction, we tried our best to take these recent changes into account and formulated statements that were not only evidence-based but also capable of accommodating the variety of situations faced by each patient and attending doctor(s).

With regard to coronary interventions, we entirely agree with Dr Desideri that there seems to be an excessive push towards invasive treatment. Moreover, it appears that there is some divergence between what the guidelines recommend and what is being done in each facility (or by each interventionist); for instance, for some patients having a myocardial infarction, whether to “treat on-site” the non-infarct-related coronary lesion(s) concomitant with the infarct-related lesion can be controversial. The new imaging modalities, such as MSCT and IVUS, may facilitate the irresistible temptation called “oculostenotic reflex”, which can be attributed to more frequent and invasive treatment strategies in patients with acute coronary syndrome. Unfortunately, this seems to be occurring even though most cardiologists know that myocardial infarction evolves most frequently from plaques that are only mildly to moderately obstructive.

There is plenty of evidence to support the validity of an ischemia-guided strategy in patients with coronary artery disease. To go beyond this standard approach, more studies need to be undertaken, which will hopefully validate the thoughts and substantiate the current trend towards invasive strategies that is noticeably influenced by the luminologist’s instinct to treat every narrowed coronary artery. We do appreciate the opportunity Dr Desideri’s letter gave us to reconsider the issue of whether to treat ischemic patients invasively or not and to recall the importance of tailor-made medicine, which was a major goal of our guidelines.

Reference

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On behalf of the Task Force Members,
Guidelines for the management of patients with ST-elevation myocardial infarction (JCS 2008)
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