More about transport for primary PCI in AMI

Dear Editor

The issue arising from the correspondence between Drs. Casella and Pavesi and Dr. Widimsky,¹ ² that is, where to admit a patient transferred from a community hospital to a tertiary care centre following successful primary percutaneous intervention (PCI) for acute myocardial infarction (AMI), is still not addressed. While in fact, hospitalisation in the interventional centre would allow closer post-procedural monitoring and immediate re-intervention in case of need, exclusion of the non-interventional centre from the care of its patient would follow. Therefore, an integrated policy between the two types of centre is advisable, in order to immediately transfer back low-risk patients and admitting to the tertiary care hospital all the others.

In my view, the practical logistic problems inherent in such an organisation, might be overcome by providing both interventional and non-interventional centres with an on-call service, which should be formed by the interventionalists in the former and by staff cardiologists in the latter. Upon arrival of the patient at the community hospital, the cardiologist on duty, while arranging for patient’s transportation, would alert both the interventionalist team at the interventional centre and his (or her) on-call colleague. While replaced on the on-site duty by his (or her) colleague, the community hospital cardiologist would assist his (or her) patient during transportation to the tertiary care centre, cooperate with the interventionalist during PCI and again take care of his (or her) (low-risk) patient during the immediate trip back to the community hospital. Such an organisation would allow: (1) centralisation in a few centres of primary PCI procedures in AMI (which is needed to ensure optimal results); (2) involvement of community hospital cardiologists in the peri-procedural care of their patients (leading to continuous education, sharing of responsibilities and implementation of common diagnostic and therapeutic pathways); (3) continuity of care for patients (commonly preferring to be hospitalised in the hospital nearby where they live).

Cardiologists and health care administrators should consider the implementation of such an emergency territorial network, since it would allow to share out the high economic and logistic burden of the appropriate contemporary care of acute ischaemic heart disease, and to rationalise the use of resources by having also in community hospitals fully functioning Coronary Care Units, which otherwise, would have little justification.

References


Andrea Rubboli
Catheterization Laboratory
Division of Cardiology
S. Maria delle Croci Hospital
Ravenna, Italy
Tel.: +39-544285745
Fax: +39-544285395
E-mail address: andrearubboli@libero.it
(A. Rubboli)