Drug-eluting stent thrombosis in patients undergoing non-cardiac surgery

Editor—I read with interest the paper by Drs Godet and colleagues and they raise several important issues relating to drug-eluting stents (DES) perioperatively which seem to be getting more confusing and contradictory with each passing study. The cardiology community in the USA is divided as to how to interpret the latest data which seem to indicate that DES may not be as unsafe as labelled. However, a growing body of literature suggests that there is an increasing trend towards the implantation of bare-metal stents (BMS) in complicated patients (diabetes, acute coronary syndromes, renal failure, vein grafts, multiple and overlapping lesions) where the revascularization benefit with DES is arguably reduced, as also in patients who will need imminent non-cardiac surgery, those in whom dual antplatelet therapy with aspirin and a thienopyridine is either not possible or practical. The middle of the road approach seems to be the selective use of DES in patients who are at high risk for restenosis (<20% of patients) and bail out use in those who present with clinical restenosis after BMS use (<10–15% of patients). I would also argue that postoperative troponin release after vascular surgery is not uncommon and in no way should be a surrogate marker for stent thrombosis in the absence of clinical symptoms; angiographic endpoints should be the gold standard. Finally, in the absence of definitive data from randomized trials and conflicting studies that appear on a daily basis, it is of utmost importance to the anaesthetist to keep up to date with the rapidly evolving world of invasive cardiology and maintain an ongoing dialogue with our colleagues in the catheterization suite to ensure the safe anaesthetic care of these complex patients.

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Editor—We would like to thank Dr Ramakrishna for his interest in our article and the interesting points which he raises. DES obviously carry more risks than BMS. Because all experts recommend avoiding premature discontinuation of antiplatelet agents (AA) therapy if possible (the patients must remain on dual AA medication for a minimum of 6 or 12 months after insertion), and requires postponing elective surgery for 1 yr. In contrast, when an invasive procedure is required, the risk of intrastent thrombosis (IST) arises after stopping AA and a risk of bleeding if treatment is continued. The French cardiology community is not as divided as in the USA. Related to the ‘not so unsafe’ characteristics of DES, there is strong agreement for restricted use of them. The latter are indicated in the most severely ill patients, that is, patients with anatomically challenging lesions such as long, thin vessels, bifurcation lesions, and chronic total occlusions, patients with diabetes, and patients without the need for further non-cardiac surgery.

We agree that troponin elevation is not uncommon in severe CAD patients, and is unlikely to be related to IST. It is evident that the ECG remains the gold standard for diagnosis of IST. Finally, we agree with Dr Ramakrishna: anaesthetists must keep up to date with the rapidly evolving world of cardiology to ensure a safe anaesthetic care of these patients.

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