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

Editor—I read with great interest the recent article by Godet and colleagues1 on drug-eluting stent (DES) thrombosis. Recent literature indicates that barring neurosurgery, the risk of bleeding is small if the antiplatelet medication is continued, but the risk of acute coronary event due to stent thrombosis is high if the medication is discontinued. The risk of a cardiac event is greater in patients with recent stents.2,3 The results of Godet’s study suggest that the risk of specific thrombotic complications of DES is uncommon, despite discontinuing the antiplatelet medicines. However, analysis of the results reveals that the delay between DES and surgery was 14 months. The details of this delay are not provided, but the risk of acute coronary event due to DES may be decreased if the medication is continued.4 Recent data also indicate that clopidogrel should be continued for 1 yr after all types of DES, despite the increased risk of bleeding.5 This indirectly implies that clopidogrel may be discontinued for non-cardiac surgery after 1 yr of placement. Thus, if the interval between the DES implantation and the non-cardiac surgery is ≥12 months, Godet and colleagues are actually following the ACC/AHA guidelines and discontinuation of clopidogrel is permissible. In this scenario, the results would confirm the correctness of the guidelines. Therefore, the details of the interval between DES implantation and the non-cardiac surgery in this study become important and should be provided. Further, the results also confirm that the risk of bleeding is indeed low, because only three patients undergoing carotid endarterectomy developed moderate haematoma.

D. K. Tempe*
New Delhi, India
*E-mail: tempedeepak@hotmail.com

Editor—We would like to thank Dr Tempe for his interest in our paper.1 In our article, the mean delay between DES insertion and date for non-cardiac surgery is 14 months (see Table 1 in Godet and colleagues).1 However, both SD (11 months) and range (1 week–36 months) show that the ideal 1 yr duration for clopidogrel treatment was not always attained in our series of patients. In fact, clopidogrel was discontinued mainly because of the need for surgery which was unplanned at the time of coronary revascularization. In contrast to the more dogmatic AHA-ACC guidelines, a short discontinuation of clopidogrel was decided on by the anaesthetists and surgeons of our team, with the advice of a cardiologist, in relation to the relative risks for (i) in-stent thrombosis (IST) and (ii) increased bleeding. As a result, we did not observe an increased risk of bleeding in our patients (bleeding is a well-known factor for postoperative cardiac complication in such patients). Concerning our attitude for management of antiplatelet agents, the low incidence of IST in this series does not allow us to demonstrate a strong relation between IST, on the one hand, and both delay between DES insertion and surgery, or discontinuation of antiplatelet agents, on the other.

G. Godet* (on behalf of the authors)
Rennes, France
*E-mail: gilles.godet@chu-rennes.fr


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