Reply to Rubino et al.

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We thank Rubino et al. for their interest in our recently published paper [1, 2]. We agree with them that the correct timing for discontinuing double antiplatelet therapy is still controversial. The Society of Thoracic Surgeons guidelines recommend withholding clopidogrel at least 5 days prior to surgery in elective cases and a few days in acute coronary syndromes, while maintaining aspirin up to surgery in both scenarios [3]. On the contrary, previous European guidelines suggest discontinuing clopidogrel 5–7 days before surgery even in patients who need urgent cardiac surgery. Aspirin should be stopped 2–10 days before surgery in elective patients but continued up to the day of surgery in patients with acute coronary syndrome [4]. Furthermore, the timing of discontinuing double antiplatelet treatment might be different in patients with previous stent implantation in less than one year.

We strongly believe that the choice of withholding the double antiplatelet therapy should be tailored to the individual patient according to the risk of bleeding and thrombosis and possibly guided by a point-of-care testing. Currently, in the setting of an acute coronary syndrome, our policy is to continue aspirin and discontinue clopidogrel at least 2–3 days before surgery. In the presence of severe critical lesions, we prefer to administer an intravenous short acting glycoprotein IIb/IIIa inhibitor.

Our study confirms that patients receiving clopidogrel in combination with aspirin up to the time of surgery are at risk of increased blood loss, reoperation for bleeding and transfusions. Interestingly, these patients also had higher incidence of postoperative myocardial infarction, something previously reported in the literature and discussed in our paper. We recognize that in our study the three groups examined had a different risk profile and probably more complex coronary artery lesions; however, we reduced potential confounding factors using a multivariate analysis. The use of SYNTAX score might have been helpful in the risk stratification, but the SYNTAX trial data became available only in March 2009. Finally, we did not consider patients referred to surgery after failed PCI as our database did not account for this preoperative variable [5].

We agree that an accurate point-of-care test of platelet function in association with other clinical parameters may be better to identify high-risk patients for postoperative bleeding and reducing postoperative morbidity [6].

REFERENCES