Reply to Spiliopoulos et al.

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Received 24 August 2015; accepted 25 August 2015

Keywords: Acute myocardial infarction • Cardiogenic shock • Mechanical circulatory support

We appreciate the interest of Spiliopoulos et al. in reading our recent manuscript detailing our experience with mechanical circulatory support (MCS) for cardiogenic shock following acute myocardial infarction (AMI/CS) [1, 2]. We agree with their conclusion that reperfusion of end-organs should be prioritized similarly to, or at times even more importantly than, myocardial reperfusion, in cases of AMI/CS. In our programme, this strategy is called ‘early systemic flow restoration and myocardial revascularization’. This notion is further supported by multiple studies suggesting that early and aggressive therapy can improve outcomes, likely due to initiation of circulatory support prior to irreversible end-organ damage [3]. Amelioration (or prevention) of the multiorgan failure that is characteristic of this low-flow state might allow for earlier transition to long-term durable MCS devices—one feature common among studies with satisfactory outcomes [4]. While large randomized control trial data are lacking, we continue to believe that in the appropriate patient population, the risks and complications of MCS are outweighed by the potential survival benefit in what would be an otherwise uniformly fatal disease process. Again, we are gratified to reconfirm that there is internationally shared understanding of the unmet need to develop a better therapeutic algorithm for this disease entity. Now is the time to move forward with more aggressive application of MCS. Quantifying the effect of MCS on AMI/CS is not straightforward due to lack of a universal definition of cardiogenic shock, uncertainty of appropriate device selection and relative rarity of the condition. However, completion of the original SHOCK trial and SHOCK/IABP II trial proves that multicentre randomized trials in this cohort are feasible [5, 6].

REFERENCES

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doi:10.1093/ ejcts/ezv330
Advance Access publication 15 September 2015