Enfermedad coronaria multivaso: Intervencionismo percutáneo vs cirugía.

Obediencia a la evidencia, pero NO obediencia ciega.

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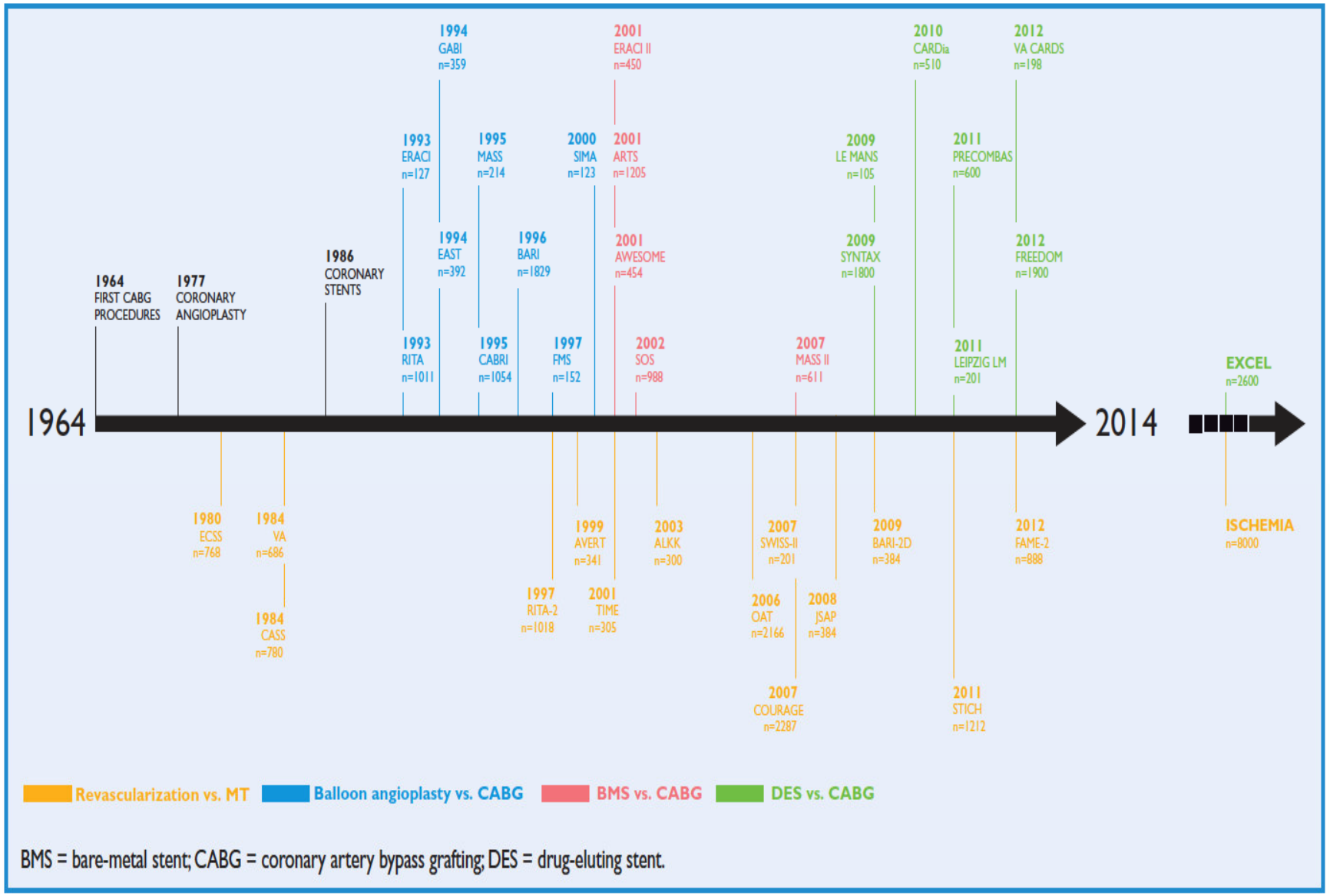


Figure 1 Randomized trials in myocardial revascularization therapy over the past five decades.

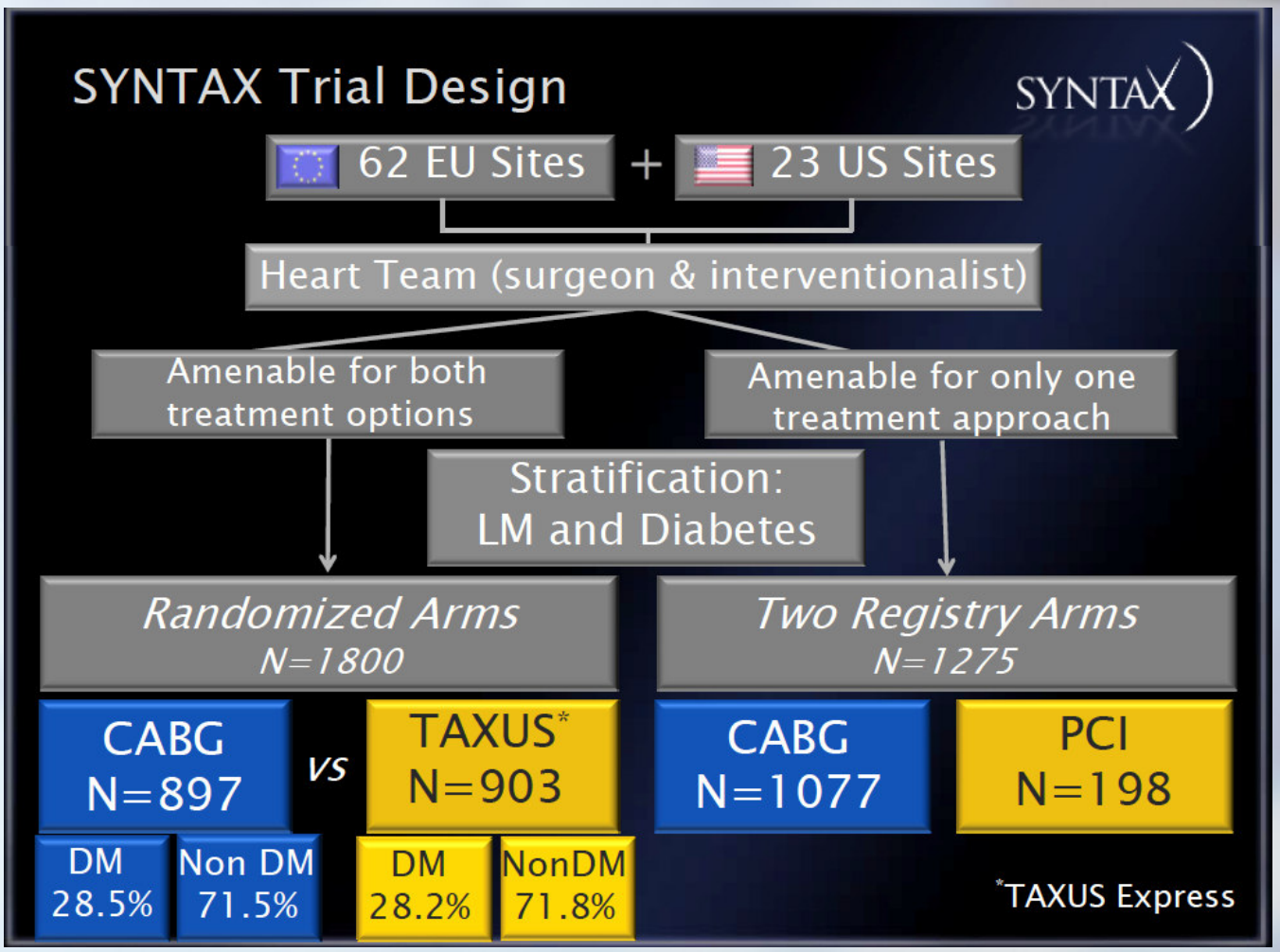
The NEW ENGLAND JOURNAL of MEDICINE

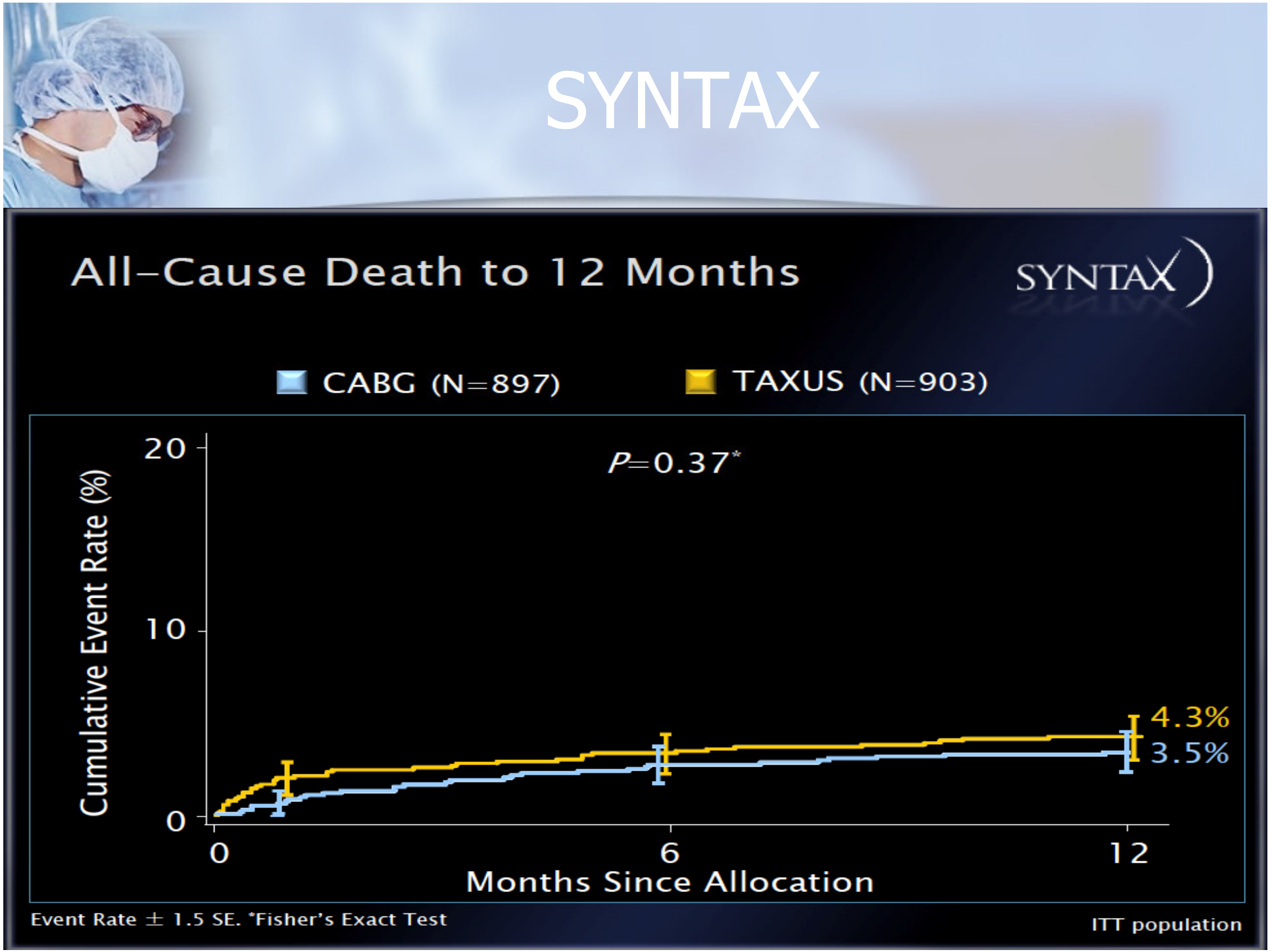
ESTABLISHED IN 1812 MARCH 5, 2009 VOL. 360 NO. 10

Percutaneous Coronary Intervention versus Coronary-Artery Bypass Grafting for Severe Coronary Artery Disease

Patrick W. Serruys, M.D., Ph.D., Marie-Claude Morice, M.D., A. Pieter Kappetein, M.D., Ph.D., Antonio Colombo, M.D., David R. Holmes, M.D., Michael J. Mack, M.D., Elisabeth Ståhle, M.D., Ted E. Feldman, M.D., Marcel van den Brand, M.D., Eric J. Bass, B.A., Nic Van Dyck, R.N., Katrin Leadley, M.D., Keith D. Dawkins, M.D., and Friedrich W. Mohr, M.D., Ph.D., for the SYNTAX Investigators*

SYNTAX

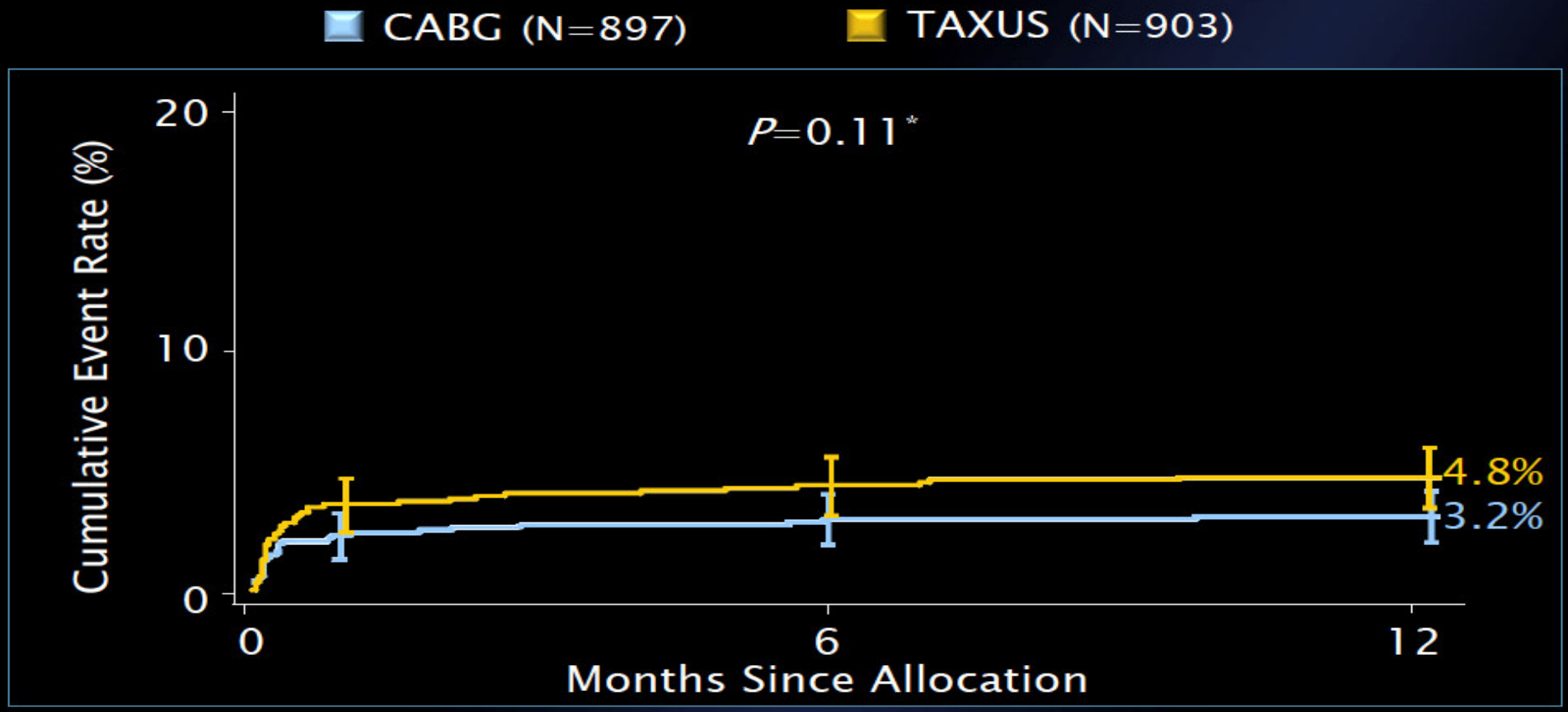

SYNTAX Trial Design
SYNTAX
62 EU Sites
+
23 US Sites
Heart Team (surgeon & interventionalist)
Amenable for both treatment options
Amenable for only one treatment approach
Stratification: LM and Diabetes
Randomized Arms N=1800
Two Registry Arms N=1275
CABG N=897
vs
TAXUS* N=903
CABG N=1077
PCI N=198
DM 28.5%
Non DM 71.5%
DM 28.2%
NonDM 71.8%
*TAXUS Express


SYNTAX
All-Cause Death to 12 Months
SYNTAX
CABG (N=897)
TAXUS (N=903)
P=0.37*
Cumulative Event Rate (%)
20
10
0
0
6
12
Months Since Allocation
4.3%
3.5%
Event Rate ± 1.5 SE. *Fisher's Exact Test
ITT population

SYNTAX

Myocardial Infarction to 12 Months

SYNTAX

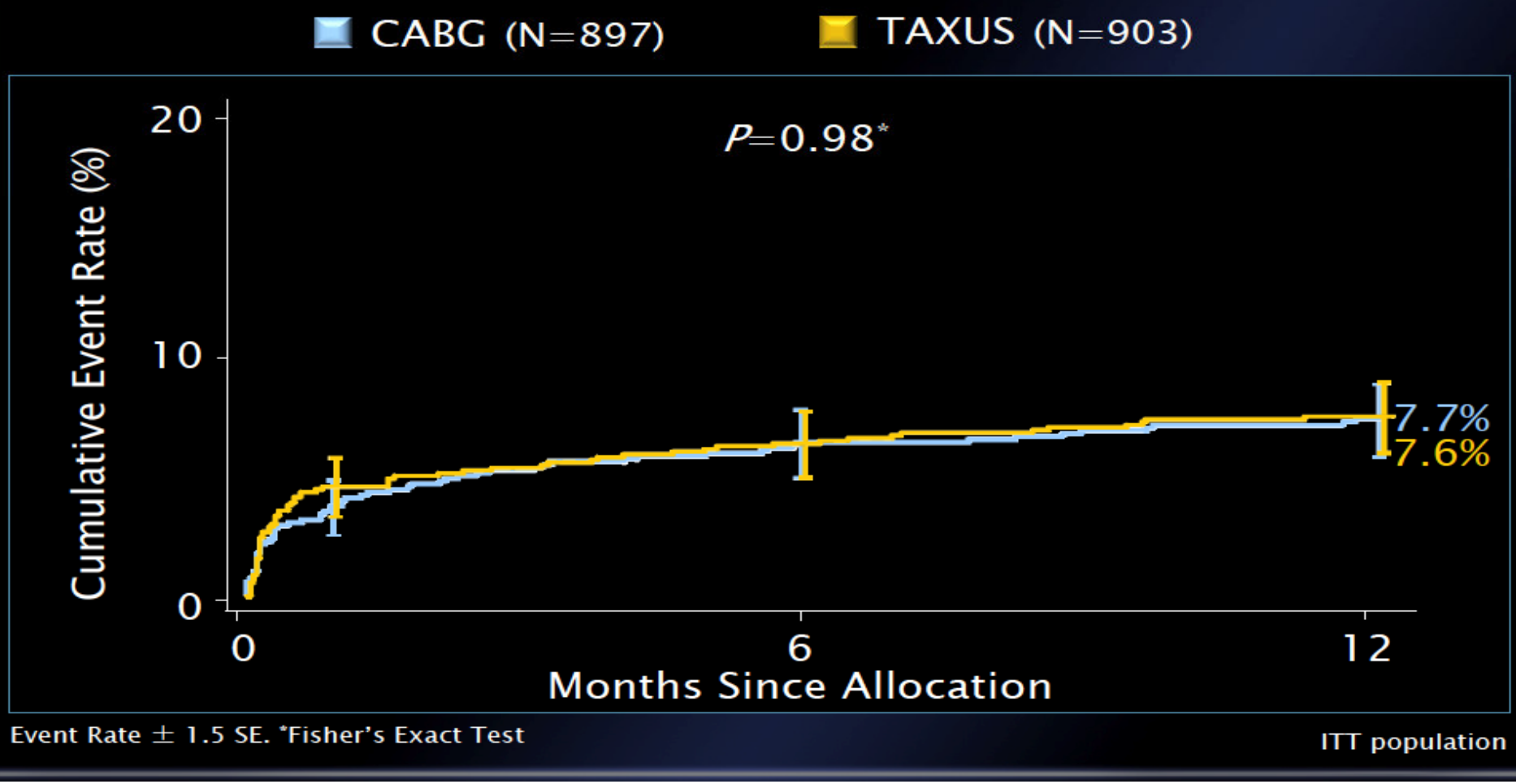


Event Rate ± 1.5 SE. *Fisher's Exact Test

ITT population

SYNTAX

All-Cause Death/CVA/MI to 12 Months

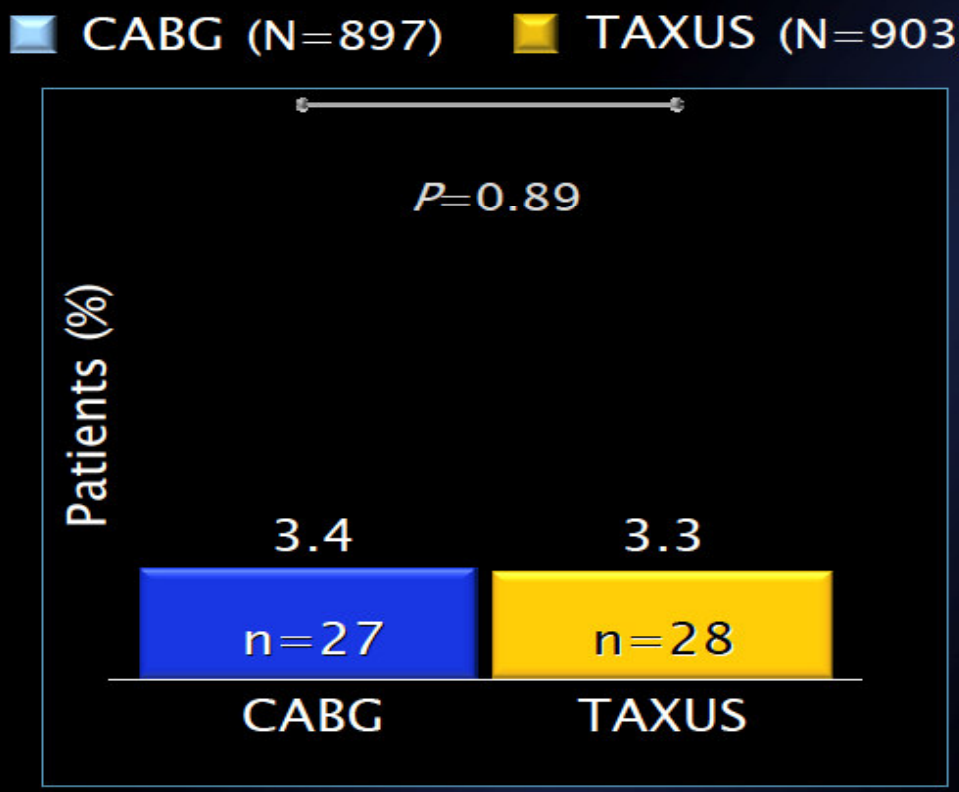


Event Rate ± 1.5 SE. *Fisher's Exact Test

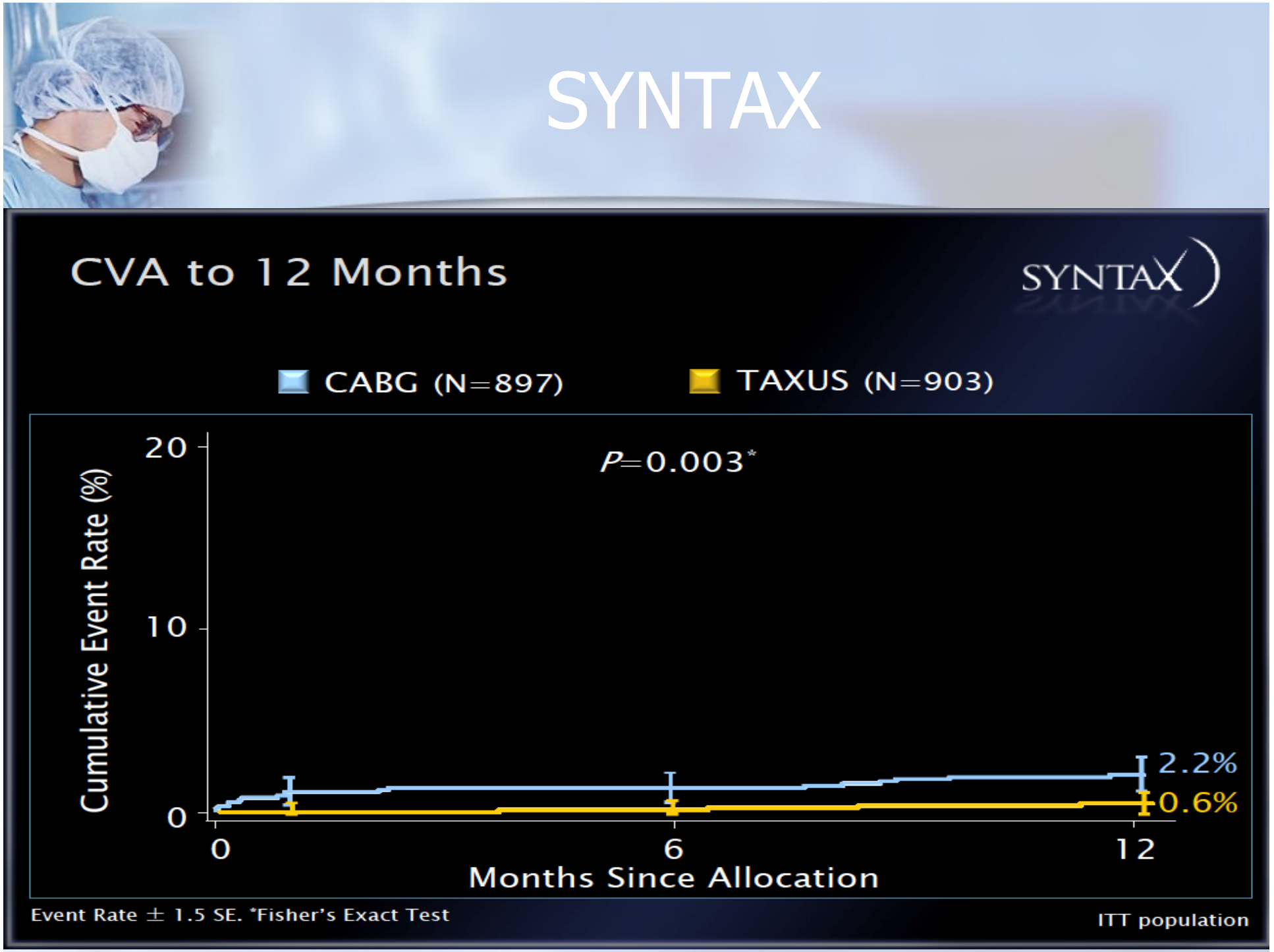
ITT population

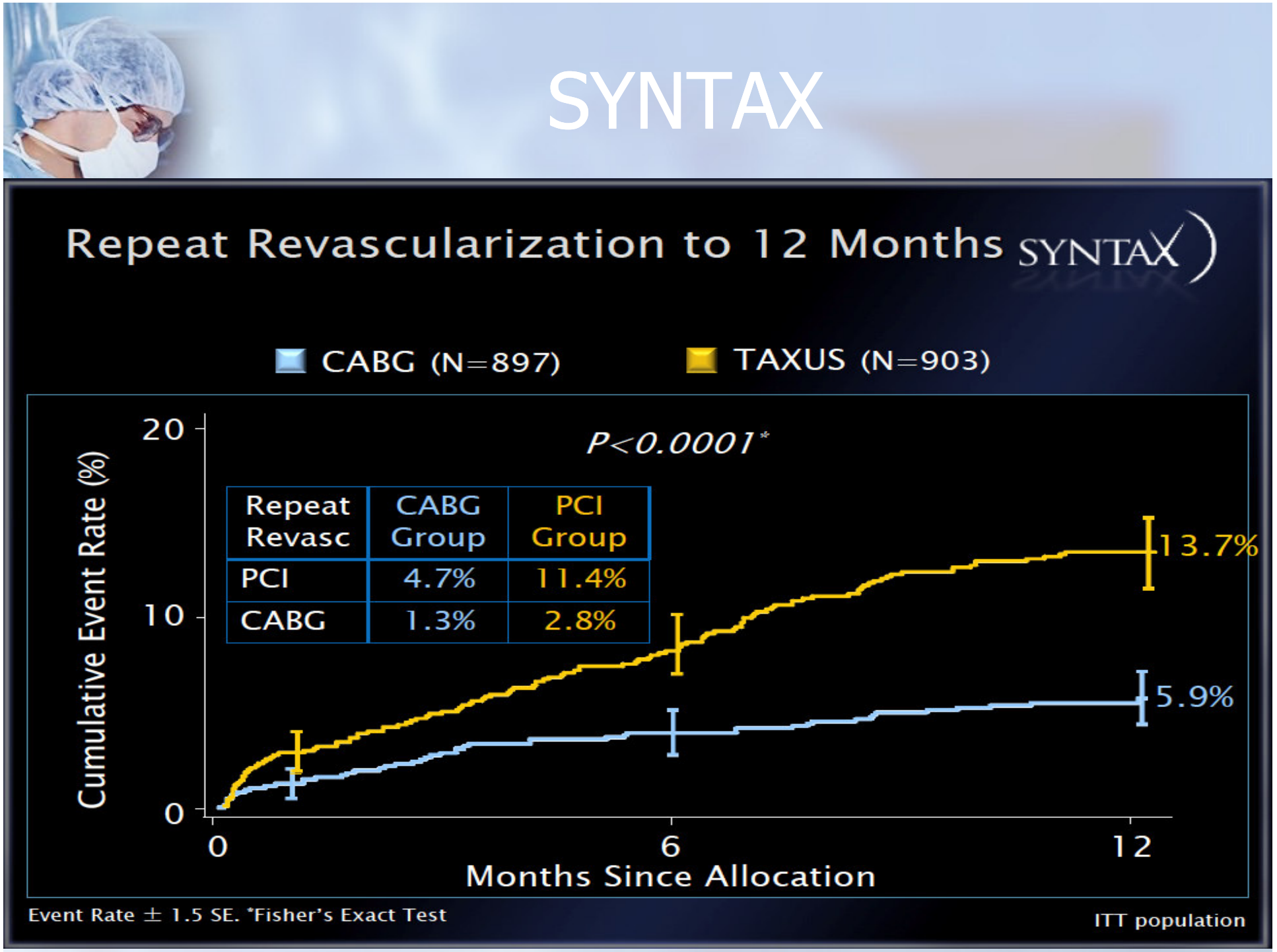
SYNTAX

Symptomatic Graft Occlusion & Stent Thrombosis to 12 Months



ITT population

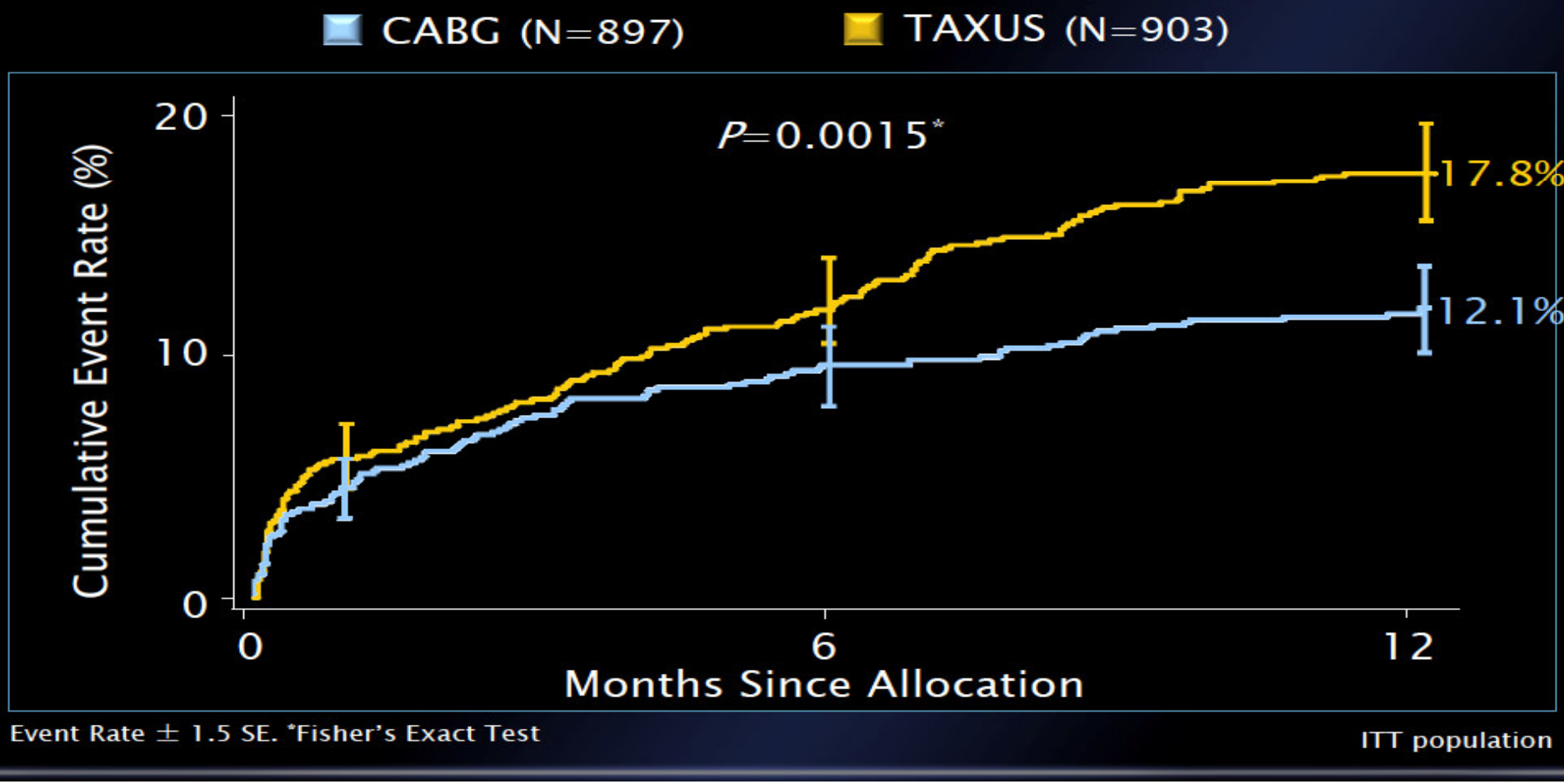

SYNTAX
CVA to 12 Months
SYNTAX
CABG (N=897)
TAXUS (N=903)
Cumulative Event Rate (%)
20
10
0
P=0.003*
2.2%
0.6%
0
6
12
Months Since Allocation
Event Rate ± 1.5 SE. *Fisher's Exact Test
ITT population


SYNTAX
Repeat Revascularization to 12 Months
SYNTAX
CABG (N=897)
TAXUS (N=903)
P<0.0001*
Repeat Revasc
CABG Group
PCI Group
PCI
4.7%
11.4%
CABG
1.3%
2.8%
13.7%
5.9%
Cumulative Event Rate (%)
20
10
0
0
6
12
Months Since Allocation
Event Rate ± 1.5 SE. *Fisher's Exact Test
ITT population

SYNTAX

MACCE to 12 Months

SYNTAX



Event Rate ± 1.5 SE. *Fisher's Exact Test

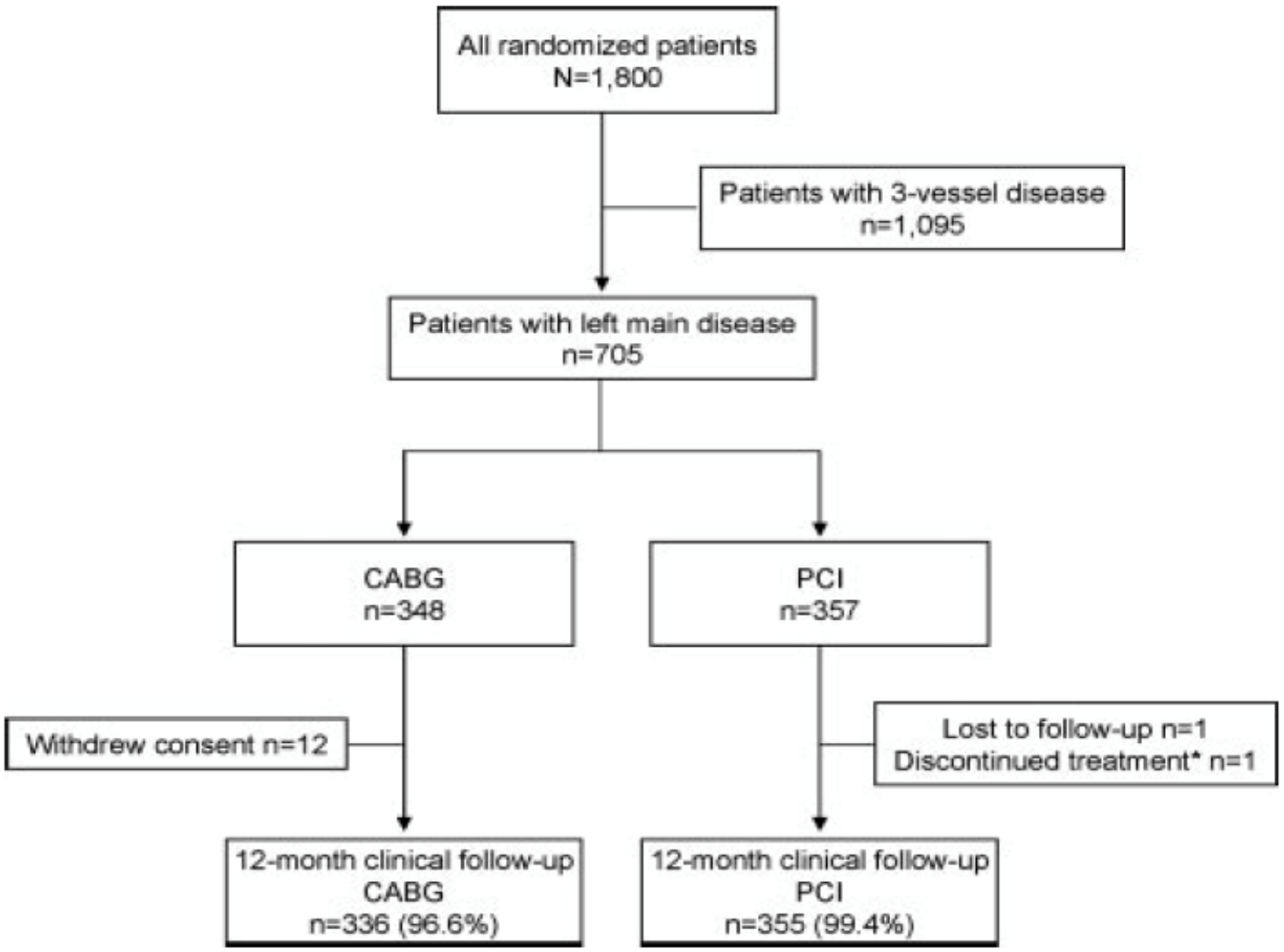
ITT population

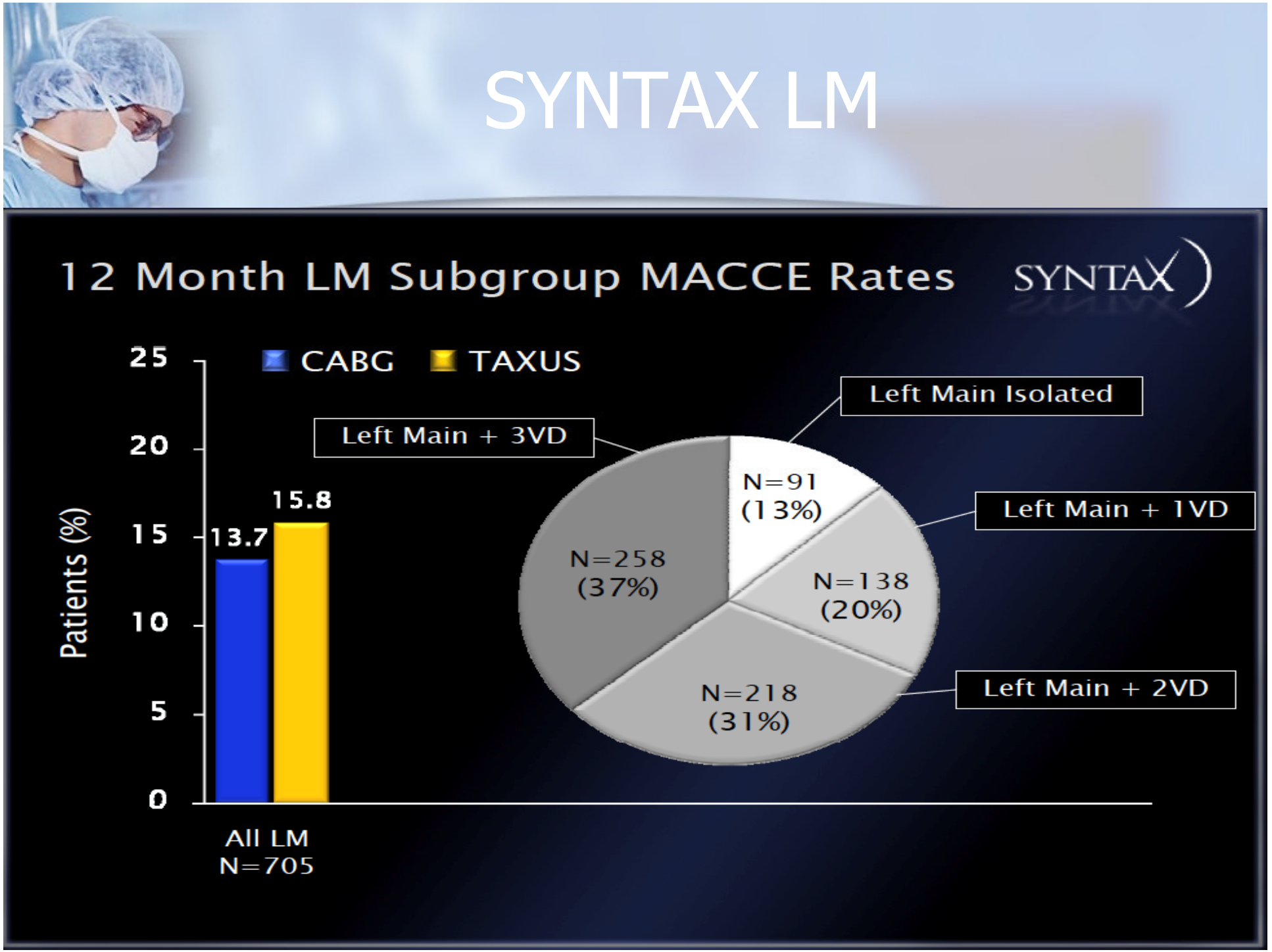
SYNTAX LM

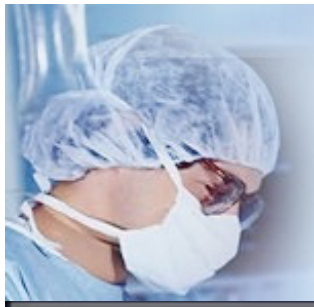
Outcomes in Patients With De Novo Left Main Disease Treated With Either Percutaneous Coronary Intervention Using Paclitaxel-Eluting Stents or Coronary Artery Bypass Graft Treatment in the Synergy Between Percutaneous Coronary Intervention With TAXUS and Cardiac Surgery (SYNTAX) Trial

Marie-Claude Morice, MD; Patrick W. Serruys, MD, PhD; A. Pieter Kappetein, MD, PhD; Ted E. Feldman, MD; Elisabeth Ståhle, MD; Antonio Colombo, MD; Michael J. Mack, MD; David R. Holmes, MD; Lucia Torracca, MD; Gerrit-Anne van Es, PhD; Katrin Leadley, MD; Keith D. Dawkins, MD; Friedrich Mohr, MD

(Circulation 2010;121:2645-2653.)


All randomized patients
N=1,800
Patients with 3-vessel disease
n=1,095
Patients with left main disease
n=705
CABG
n=348
PCI
n=357
Withdrew consent n=12
Lost to follow-up n=1
Discontinued treatment* n=1
12-month clinical follow-up
CABG
n=336 (96.6%)
12-month clinical follow-up
PCI
n=355 (99.4%)

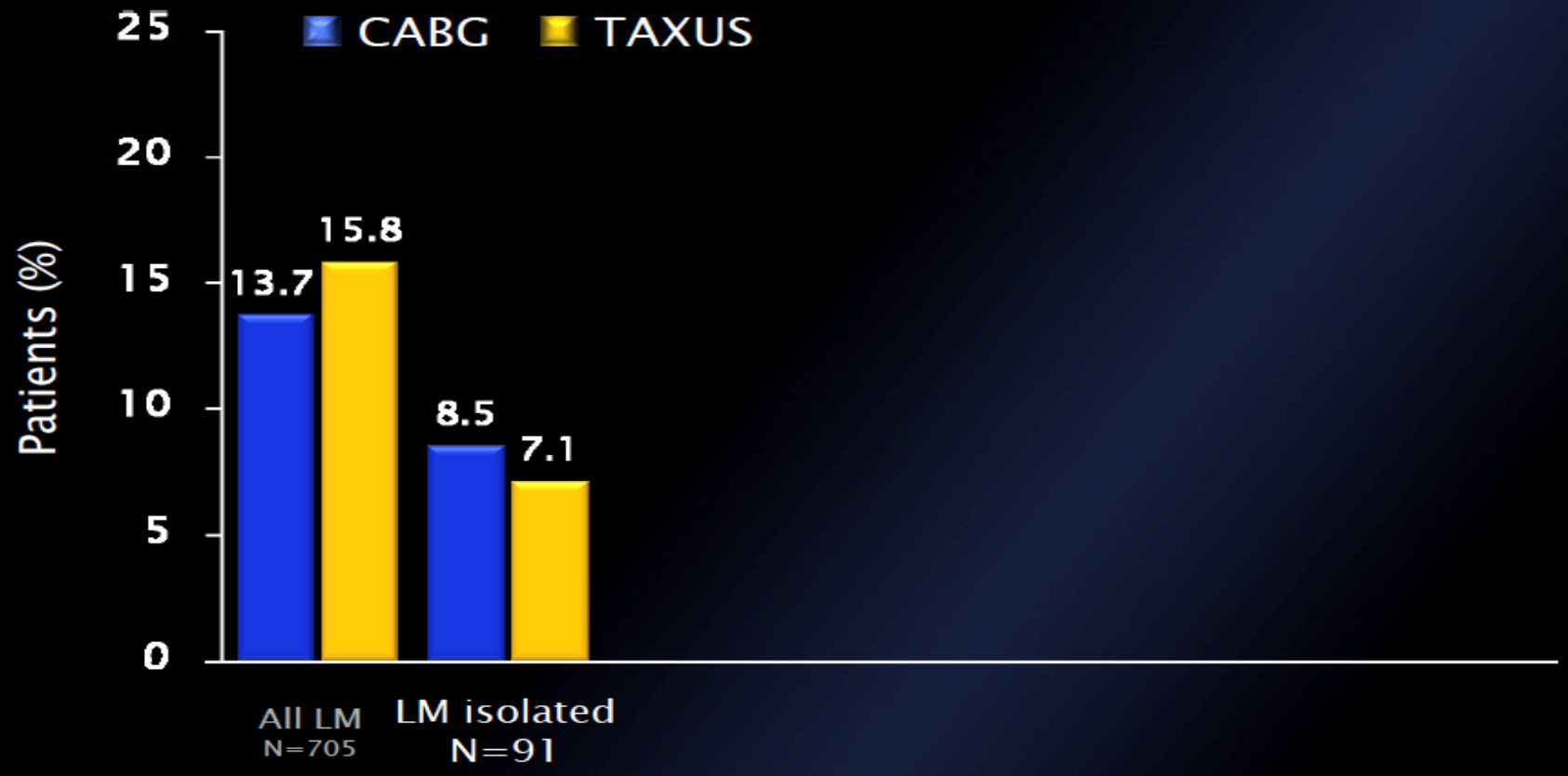

SYNTAX LM
12 Month LM Subgroup MACCE Rates
SYNTAX
CABG
TAXUS
Patients (%)
25
20
15
10
5
0
13.7
15.8
All LM
N=705
Left Main Isolated
Left Main + 3VD
Left Main + 1VD
Left Main + 2VD
N=91
(13%)
N=258
(37%)
N=138
(20%)
N=218
(31%)



SYNTAX LM

12 Month LM Subgroup MACCE Rates

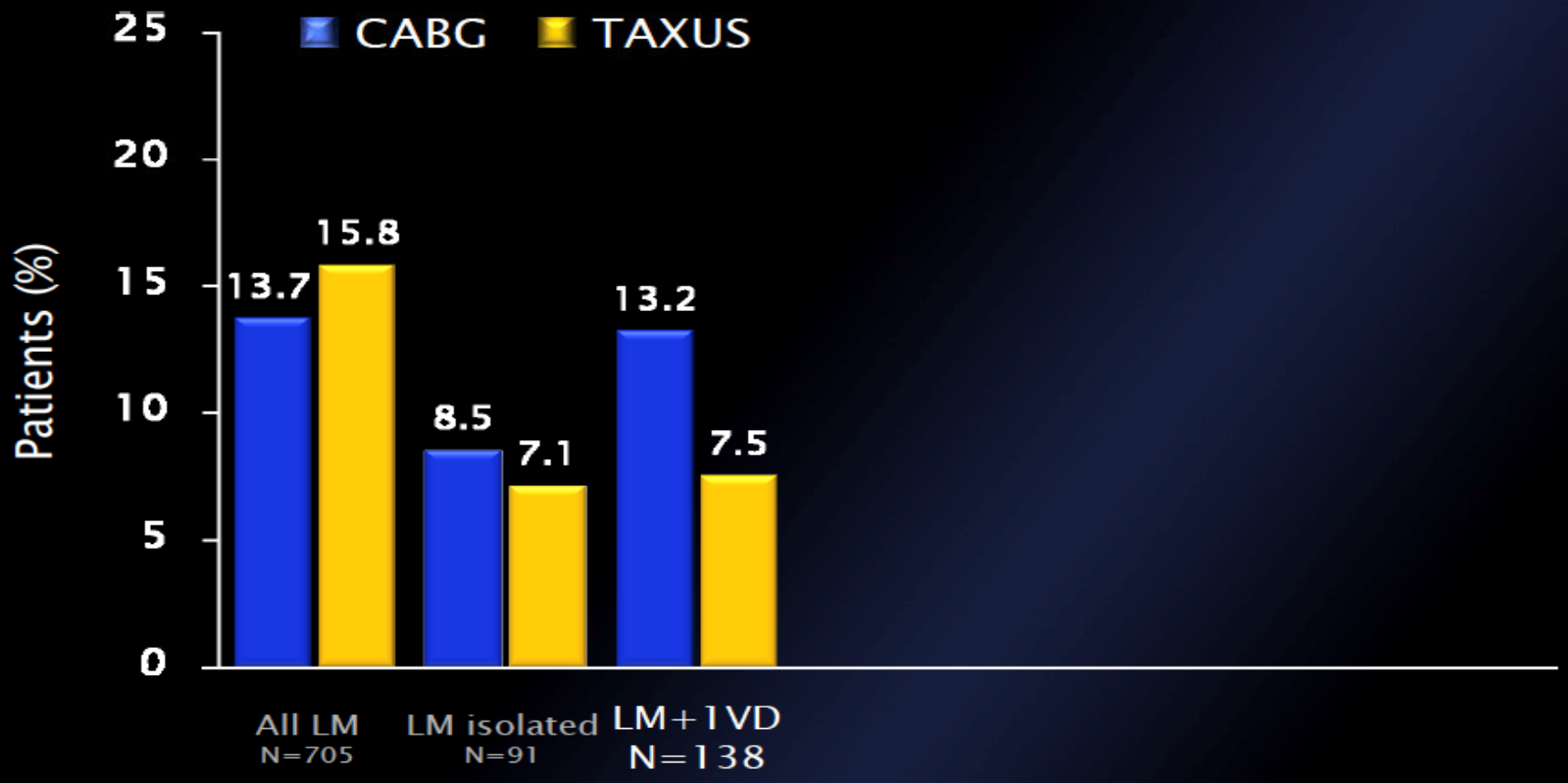
SYNTAX



SYNTAX LM

12 Month LM Subgroup MACCE Rates

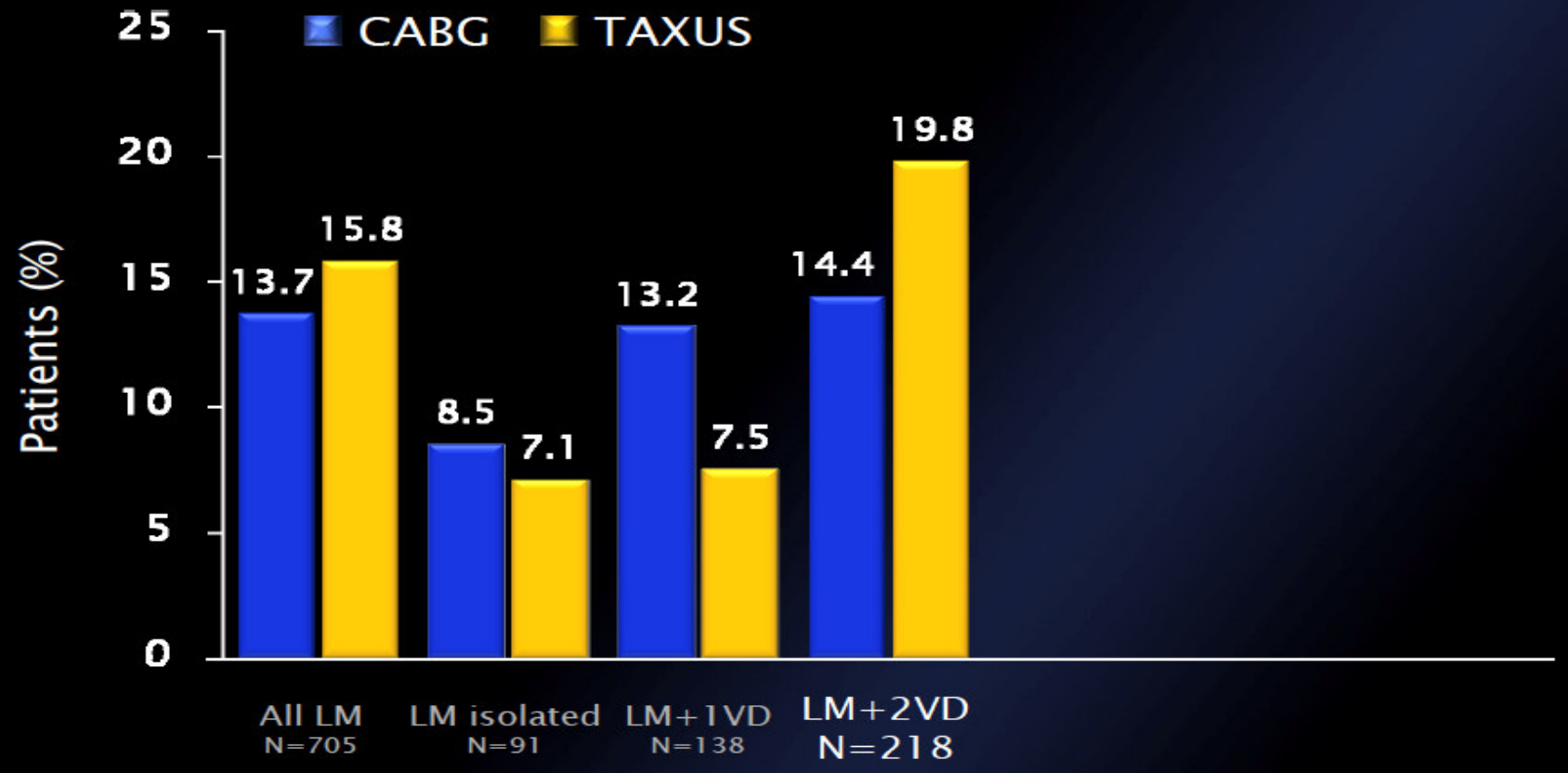
SYNTAX



SYNTAX LM

12 Month LM Subgroup MACCE Rates

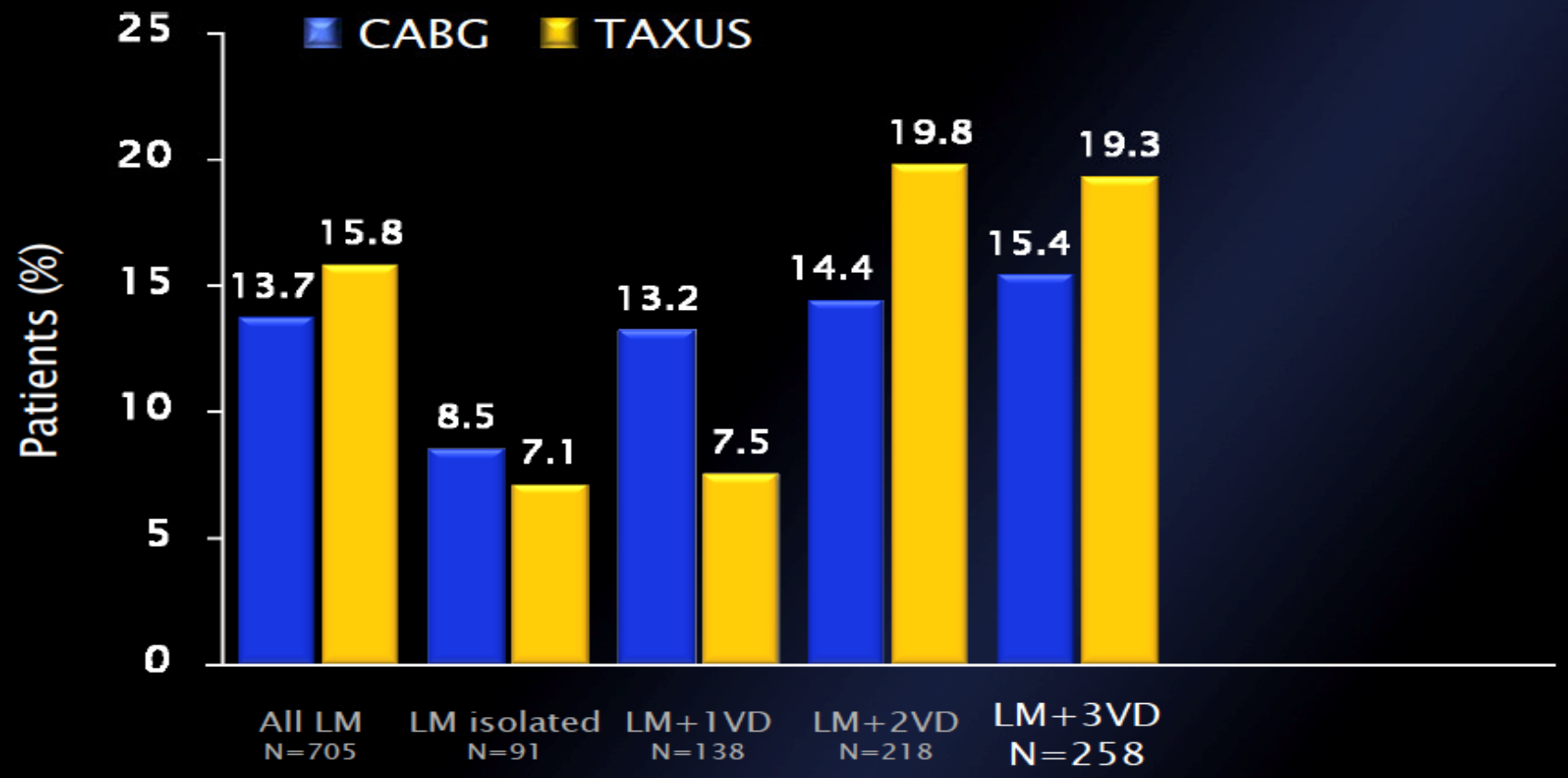
SYNTAX



SYNTAX LM

12 Month LM Subgroup MACCE Rates

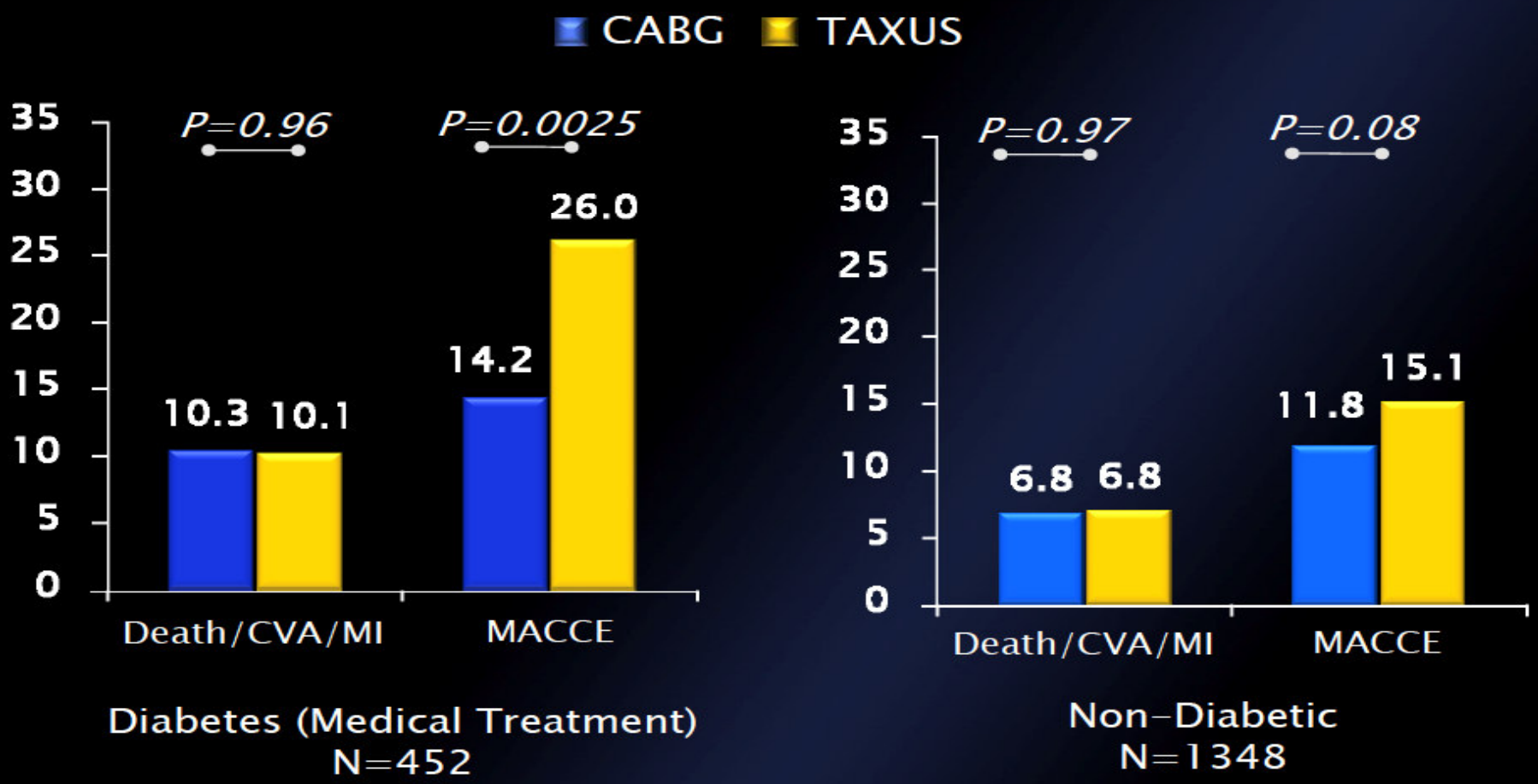
SYNTAX



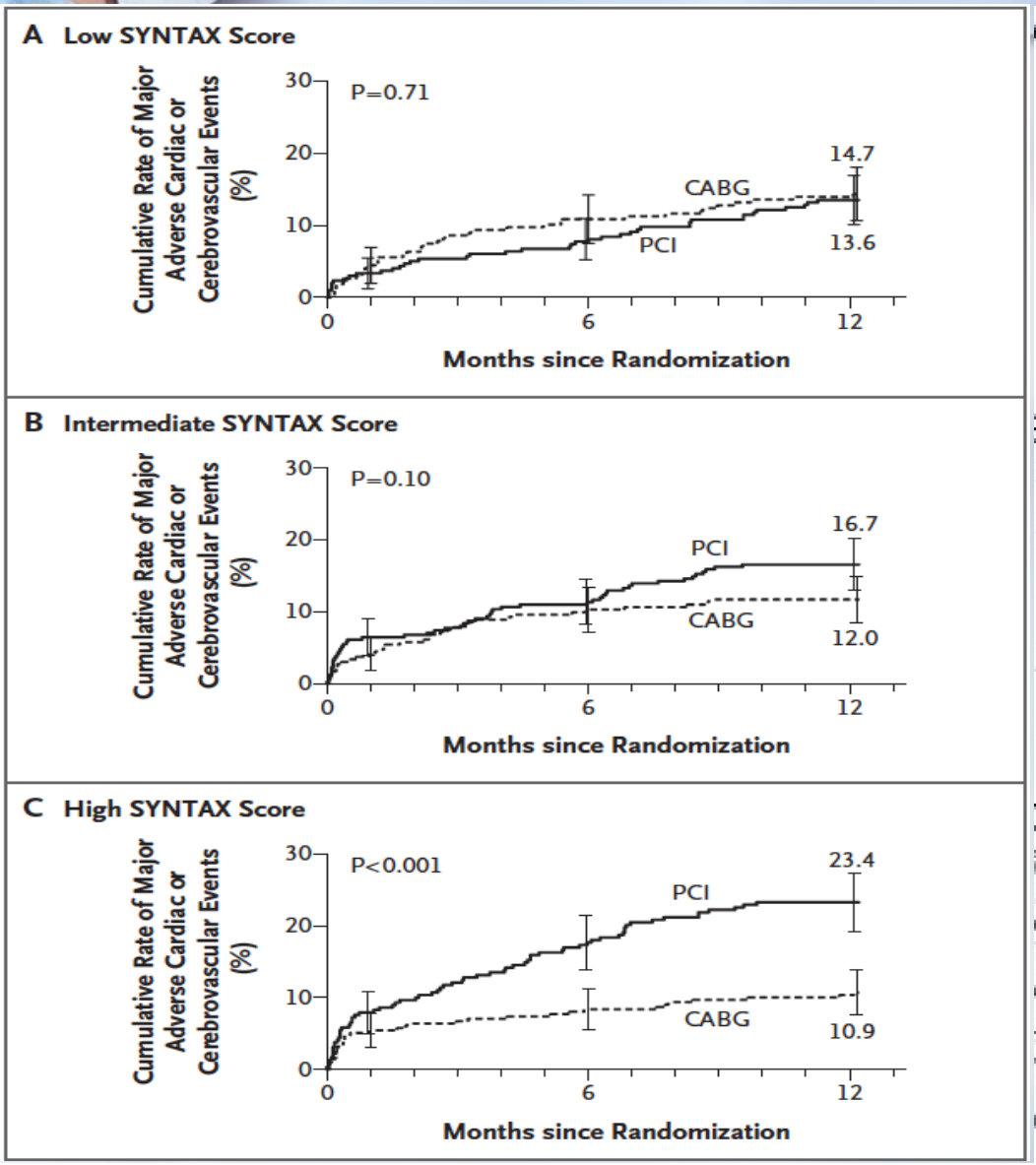
SYNTAX DM

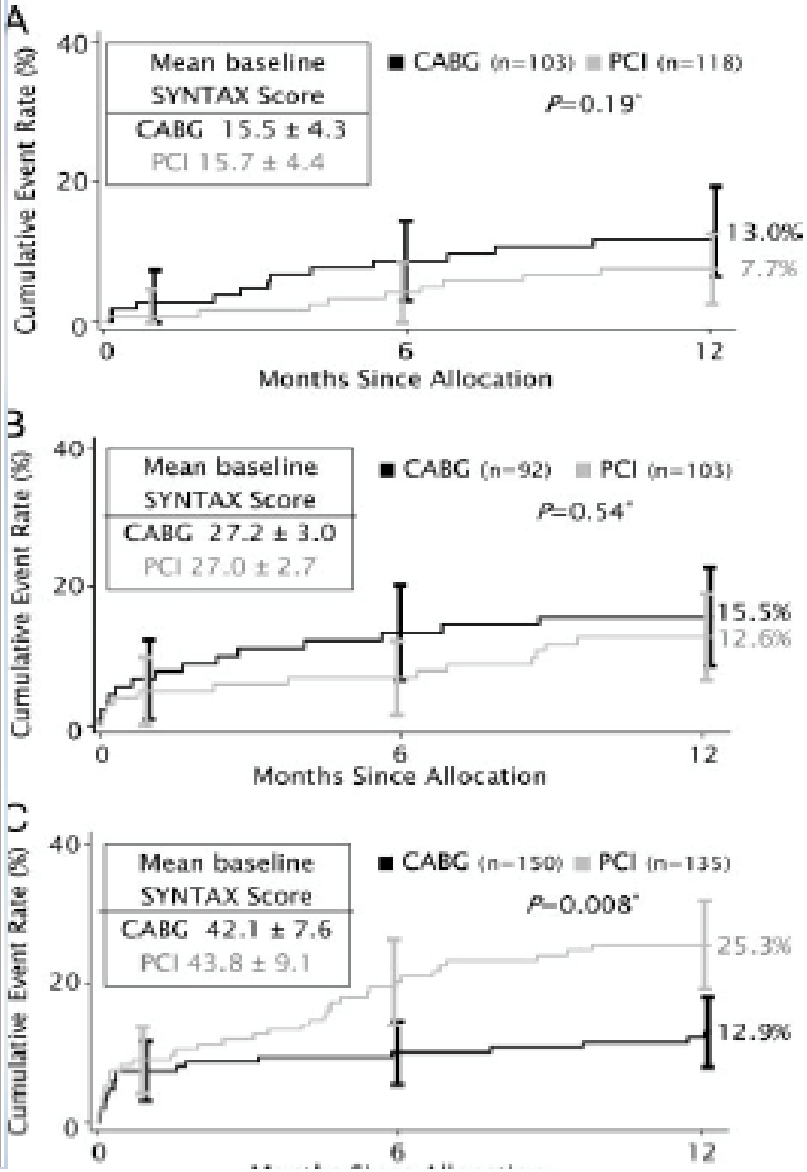
Outcome according to Diabetic Status

SYNTAX



SYNTAX


A Low SYNTAX Score
Cumulative Rate of Major Adverse Cardiac or Cerebrovascular Events (%)
P=0.71
CABG
PCI
14.7
13.6
Months since Randomization
B Intermediate SYNTAX Score
P=0.10
PCI
CABG
16.7
12.0
Months since Randomization
C High SYNTAX Score
P<0.001
PCI
CABG
23.4
10.9
Months since Randomization


Cumulative Event Rate (%)
Mean baseline SYNTAX Score
CABG 15.5 ± 4.3
PCI 15.7 ± 4.4
CABG (n=103) PCI (n=118)
P=0.19*
13.0%
7.7%
Months Since Allocation
Mean baseline SYNTAX Score
CABG 27.2 ± 3.0
PCI 27.0 ± 2.7
CABG (n=92) PCI (n=103)
P=0.54*
15.5%
12.6%
Months Since Allocation
Mean baseline SYNTAX Score
CABG 42.1 ± 7.6
PCI 43.8 ± 9.1
CABG (n=150) PCI (n=135)
P=0.008*
25.3%
12.9%

SYNTAX

Conclusions:

SYNTAX

- In the randomized SYNTAX cohort, there were comparable overall safety outcomes (Death, CVA, MI,) in CABG and PCI patients at 12 months (7.7 *vs.* 7.6 %).
- There was a significantly higher rate of revascularization in the PCI group (13.7 *vs.* 5.9 %), and a significantly higher rate of CVA in the CABG group (2.2 *vs.* 0.6 %).
- Overall MACCE in the PCI group was higher (17.8 *vs.*12.1 %) due to an excess of redo revascularization compared with CABG.
- Per protocol rates of symptomatic graft occlusion and stent thrombosis were similar.
- The SYNTAX score will help stratify patients for the appropriate revascularization option.

SYNTAX 5 AÑOS

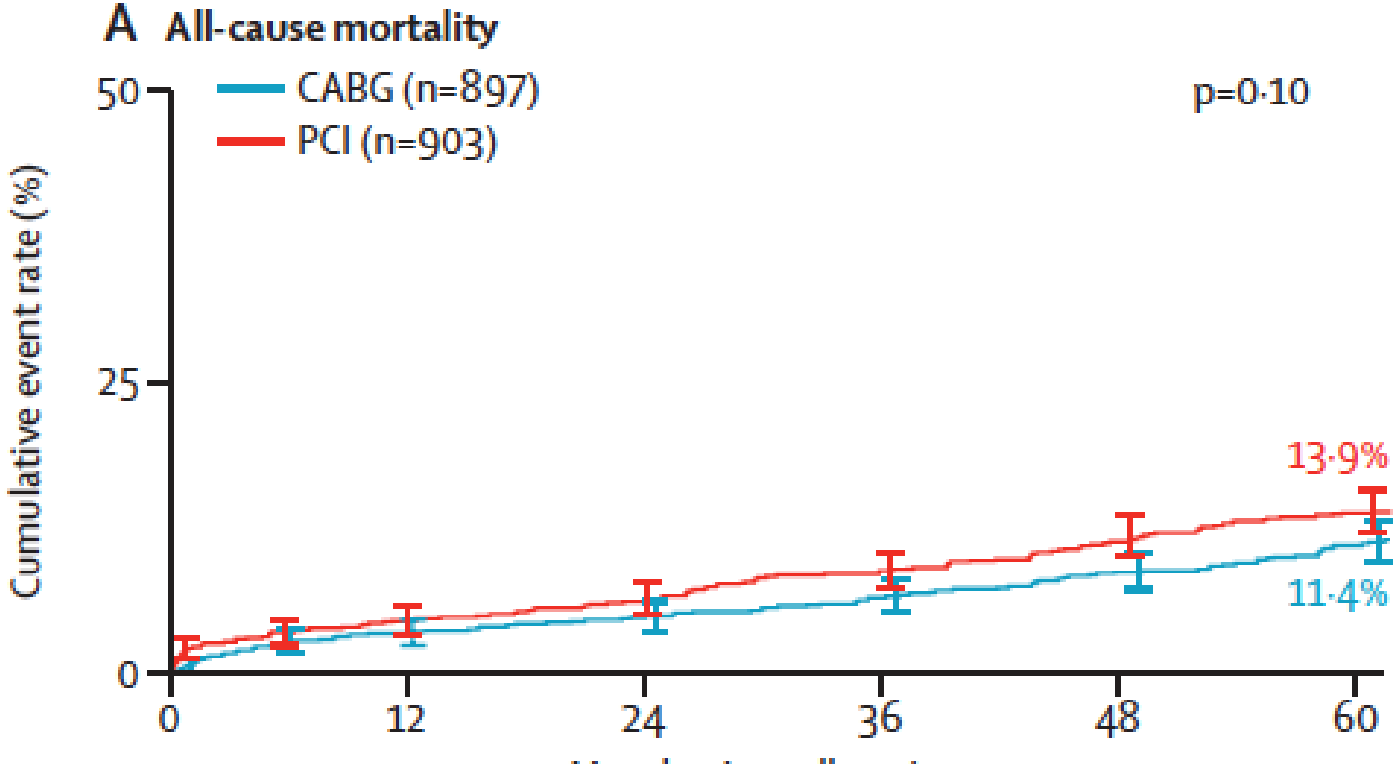
Coronary artery bypass graft surgery versus percutaneous coronary intervention in patients with three-vessel disease and left main coronary disease: 5-year follow-up of the randomised, clinical SYNTAX trial

Friedrich W Mohr, Marie-Claude Morice, A Pieter Kappetein, Ted E Feldman, Elisabeth Ståhle, Antonio Colombo, Michael J Mack, David R Holmes Jr, Marie-angèle Morel, Nic Van Dyck, Vicki M Houle, Keith D Dawkins, Patrick W Serruys

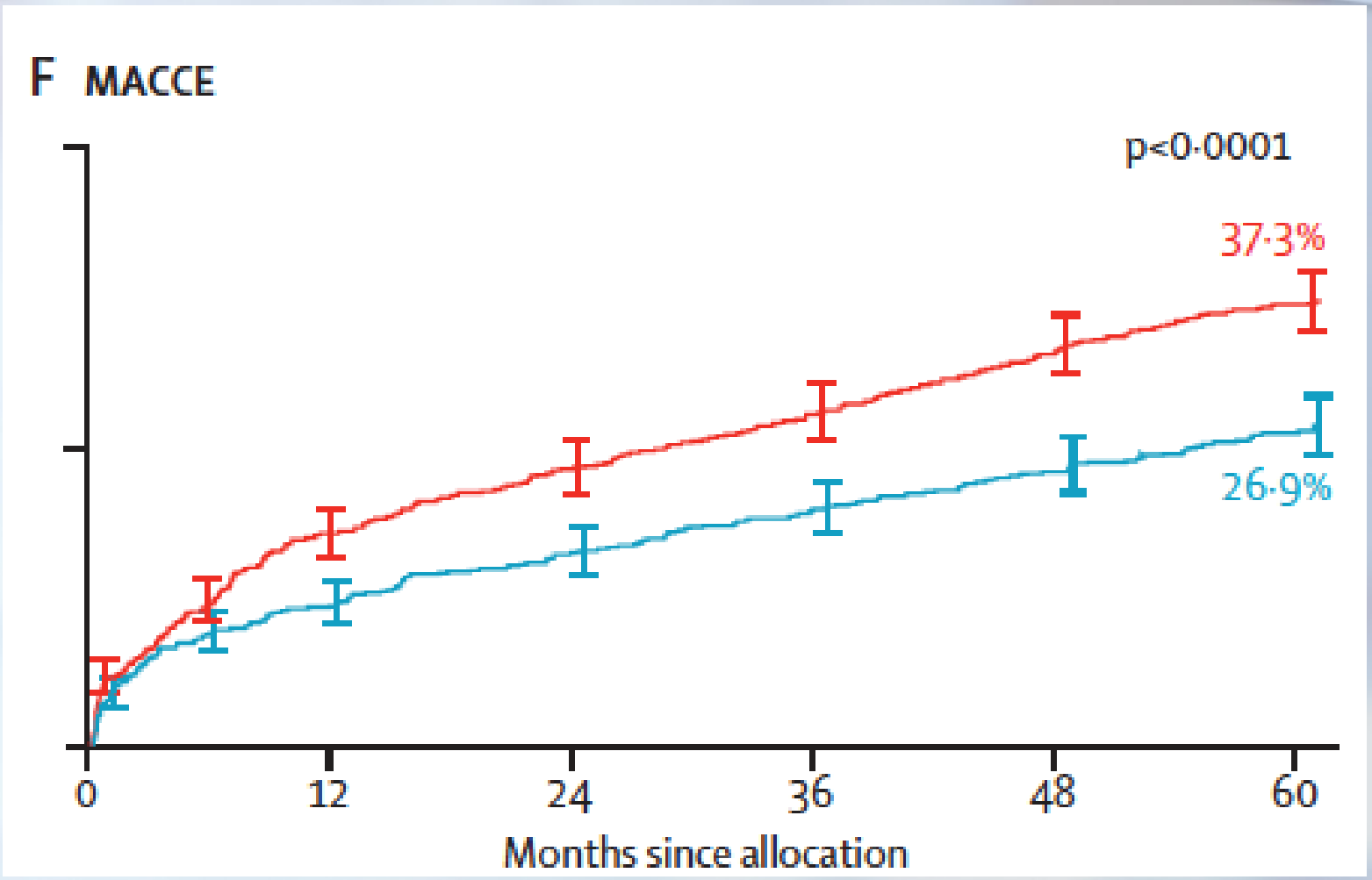
Summary

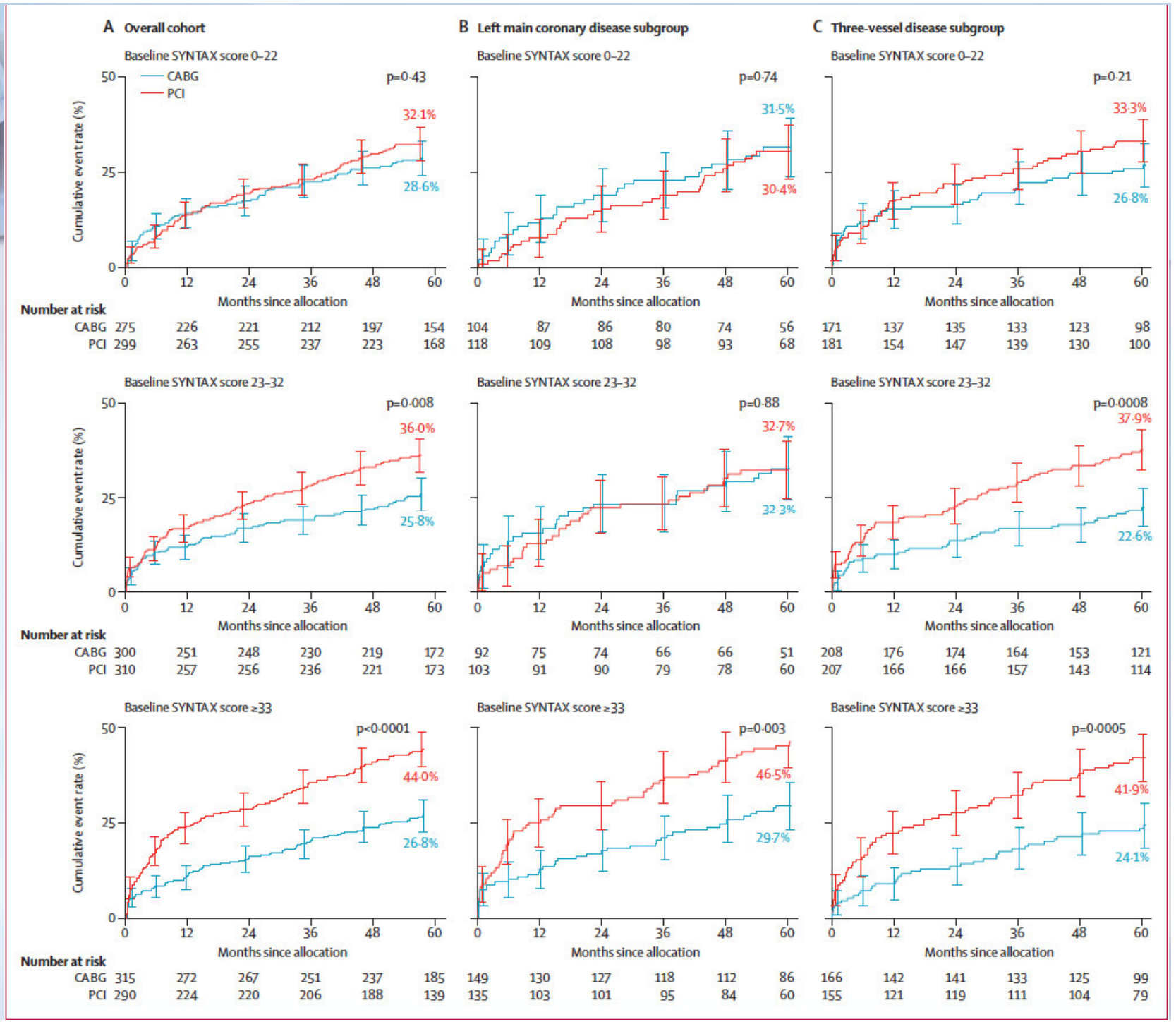
Background We report the 5-year results of the SYNTAX trial, which compared coronary artery bypass graft surgery

Lancet 2013; 381: 629–38



SYNTAX 5 AÑOS




A Overall cohort
B Left main coronary disease subgroup
C Three-vessel disease subgroup
Baseline SYNTAX score 0–22
Baseline SYNTAX score 23–32
Baseline SYNTAX score ≥33
CABG
PCI
p=0·43
p=0·74
p=0·21
p=0·008
p=0·88
p=0·0008
p<0·0001
p=0·003
p=0·0005
32·1%
28·6%
31·5%
30·4%
33·3%
26·8%
36·0%
25·8%
32·7%
32·3%
37·9%
22·6%
44·0%
26·8%
46·5%
29·7%
41·9%
24·1%
Cumulative event rate (%)
Months since allocation
Number at risk
CABG 275 226 221 212 197 154
PCI 299 263 255 237 223 168
CABG 104 87 86 80 74 56
PCI 118 109 108 98 93 68
CABG 171 137 135 133 123 98
PCI 181 154 147 139 130 100
CABG 300 251 248 230 219 172
PCI 310 257 256 236 221 173
CABG 92 75 74 66 66 51
PCI 103 91 90 79 78 60
CABG 208 176 174 164 153 121
PCI 207 166 166 157 143 114
CABG 315 272 267 251 237 185
PCI 290 224 220 206 188 139
CABG 149 130 127 118 112 86
PCI 135 103 101 95 84 60
CABG 166 142 141 133 125 99
PCI 155 121 119 111 104 79

J Am Coll Cardiol. 2010 Feb 2;55(5):432-40. doi: 10.1016/j.jacc.2009.10.014.

Randomized comparison of percutaneous coronary intervention with coronary artery bypass grafting in diabetic patients. 1-year results of the CARDia (Coronary Artery Revascularization in Diabetes) trial.

Kapur A[1], Hall RJ, Malik IS, Qureshi AC, Butts J, de Belder M, Baumbach A, Angelini G, de Belder A, Oldroyd KG, Flather M, Roughton M, Nihoyannopoulos P, Bagger JP, Morgan K, Beatt KJ.

⊕ Author information

Abstract

OBJECTIVES: The purpose of this study was to compare the safety and efficacy of percutaneous coronary intervention (PCI) with stenting against coronary artery bypass grafting (CABG) in patients with diabetes and symptomatic multivessel coronary artery disease.

BACKGROUND: CABG is the established method of revascularization in patients with diabetes and multivessel coronary disease, but with advances in PCI, there is uncertainty whether CABG remains the preferred method of revascularization.

METHODS: The primary outcome was a composite of all-cause mortality, myocardial infarction (MI), and stroke, and the main secondary outcome included the addition of repeat revascularization to the primary outcome events. A total of 510 diabetic patients with multivessel or complex single-vessel coronary disease from 24 centers were randomized to PCI plus stenting (and routine abciximab) or CABG. The primary comparison used a noninferiority method with the upper boundary of the 95% confidence interval (CI) not to exceed 1.3 to declare PCI noninferior. Bare-metal stents were used initially, but a switch to Cypher (sirolimus drug-eluting) stents (Cordis, Johnson & Johnson, Bridgewater, New Jersey) was made when these became available.

RESULTS: At 1 year of follow-up, the composite rate of death, MI, and stroke was 10.5% in the CABG group and 13.0% in the PCI group (hazard ratio [HR]: 1.25, 95% CI: 0.75 to 2.09; p=0.39), all-cause mortality rates were 3.2% and 3.2%, and the rates of death, MI, stroke, or repeat revascularization were 11.3% and 19.3% (HR: 1.77, 95% CI: 1.11 to 2.82; p=0.02), respectively. When the patients who underwent CABG were compared with the subset of patients who received drug-eluting stents (69% of patients), the primary outcome rates were 12.4% and 11.6% (HR: 0.93, 95% CI: 0.51 to 1.71; p=0.82), respectively.

CONCLUSIONS: The CARDia (Coronary Artery Revascularization in Diabetes) trial is the first randomized trial of coronary revascularization in diabetic patients, but the 1-year results did not show that PCI is noninferior to CABG. However, the CARDia trial did show that multivessel PCI is feasible in patients with diabetes, but longer-term follow-up and data from other trials will be needed to provide a more precise comparison of the efficacy of these 2 revascularization strategies. (The Coronary Artery Revascularisation in Diabetes trial; ISRCTN19872154).

PMID: 20117456 [PubMed - indexed for MEDLINE] Free full text

N Engl J Med. 2011 May 5;364(18):1718-27. doi: 10.1056/NEJMoa1100452. Epub 2011 Apr 4.

Randomized trial of stents versus bypass surgery for left main coronary artery disease.

Park SJ[1], Kim YH, Park DW, Yun SC, Ahn JM, Song HG, Lee JY, Kim WJ, Kang SJ, Lee SW, Lee CW, Park SW, Chung CH, Lee JW, Lim DS, Rha SW, Lee SG, Gwon HC, Kim HS, Chae IH, Jang Y, Jeong MH, Tahk SJ, Seung KB.

⊕ Author information

Abstract

BACKGROUND: Percutaneous coronary intervention (PCI) is increasingly used to treat unprotected left main coronary artery stenosis, although coronary-artery bypass grafting (CABG) has been considered to be the treatment of choice.

METHODS: We randomly assigned patients with unprotected left main coronary artery stenosis to undergo CABG (300 patients) or PCI with sirolimus-eluting stents (300 patients). Using a wide margin for noninferiority, we compared the groups with respect to the primary composite end point of major adverse cardiac or cerebrovascular events (death from any cause, myocardial infarction, stroke, or ischemia-driven target-vessel revascularization) at 1 year. Event rates at 2 years were also compared between the two groups.

RESULTS: The primary end point occurred in 26 patients assigned to PCI as compared with 20 patients assigned to CABG (cumulative event rate, 8.7% vs. 6.7%; absolute risk difference, 2.0 percentage points; 95% confidence interval [CI], -1.6 to 5.6; P=0.01 for noninferiority). By 2 years, the primary end point had occurred in 36 patients in the PCI group as compared with 24 in the CABG group (cumulative event rate, 12.2% vs. 8.1%; hazard ratio with PCI, 1.50; 95% CI, 0.90 to 2.52; P=0.12). The composite rate of death, myocardial infarction, or stroke at 2 years occurred in 13 and 14 patients in the two groups, respectively (cumulative event rate, 4.4% and 4.7%, respectively; hazard ratio, 0.92; 95% CI, 0.43 to 1.96; P=0.83). Ischemia-driven target-vessel revascularization occurred in 26 patients in the PCI group as compared with 12 patients in the CABG group (cumulative event rate, 9.0% vs. 4.2%; hazard ratio, 2.18; 95% CI, 1.10 to 4.32; P=0.02).

CONCLUSIONS: In this randomized trial involving patients with unprotected left main coronary artery stenosis, PCI with sirolimus-eluting stents was shown to be noninferior to CABG with respect to major adverse cardiac or cerebrovascular events. However, the noninferiority margin was wide, and the results cannot be considered clinically directive. (Funded by the Cardiovascular Research Foundation, Seoul, Korea, and others; PRECOMBAT ClinicalTrials.gov number, NCT00422968.).

J Am Coll Cardiol. 2015 May 26;65(20):2198-206. doi: 10.1016/j.jacc.2015.03.033. Epub 2015 Mar 15.

Randomized Trial of Stents Versus Bypass Surgery for Left Main Coronary Artery Disease: 5-Year Outcomes of the PRECOMBAT Study.

Ahn JM[1], Roh JH[1], Kim YH[1], Park DW[1], Yun SC[2], Lee PH[1], Chang M[1], Park HW[1], Lee SW[1], Lee CW[1], Park SW[1], Choo SJ[1], Chung C[1], Lee J[1], Lim DS[3], Rha SW[4], Lee SG[5], Gwon HC[6], Kim HS[7], Chae IH[8], Jang Y[9], Jeong MH[10], Tahk SJ[11], Seung KB[12], Park SJ[13].

⊕ **Author information**

Abstract

BACKGROUND: In a previous randomized trial, we found that percutaneous coronary intervention (PCI) was not inferior to coronary artery bypass grafting (CABG) for the treatment of unprotected left main coronary artery stenosis at 1 year.

OBJECTIVES: This study sought to determine the 5-year outcomes of PCI compared with CABG for the treatment of unprotected left main coronary artery stenosis.

METHODS: We randomly assigned 600 patients with unprotected left main coronary artery stenosis to undergo PCI with a sirolimus-eluting stent (n = 300) or CABG (n = 300). The primary endpoint was a major adverse cardiac or cerebrovascular event (MACCE: a composite of death from any cause, myocardial infarction, stroke, or ischemia-driven target vessel revascularization) and compared on an intention-to-treat basis.

RESULTS: At 5 years, MACCE occurred in 52 patients in the PCI group and 42 patients in the CABG group (cumulative event rates of 17.5% and 14.3%, respectively; hazard ratio [HR]: 1.27; 95% confidence interval [CI]: 0.84 to 1.90; p = 0.26). The 2 groups did not differ significantly in terms of death from any cause, myocardial infarction, or stroke as well as their composite (8.4% and 9.6%; HR, 0.89; 95% CI, 0.52 to 1.52; p = 0.66). Ischemia-driven target vessel revascularization occurred more frequently in the PCI group than in the CABG group (11.4% and 5.5%, respectively; HR: 2.11; 95% CI: 1.16 to 3.84; p = 0.012).

CONCLUSIONS: During 5 years of follow-up, our study did not show significant difference regarding the rate of MACCE between patients who underwent PCI with a sirolimus-eluting stent and those who underwent CABG. However, considering the limited power of our study, our results should be interpreted with caution. (Bypass Surgery Versus Angioplasty Using Sirolimus-Eluting Stent in Patients With Left Main Coronary Artery Disease [PRECOMBAT]; NCT00422968).

KEYWORDS: coronary artery bypass grafting; long-term outcome; percutaneous coronary intervention

Comment in

Coronary artery disease. Drug-eluting stents or CABG? [Nat Rev Cardiol. 2015]
Left main revascularization: surgical and interventional perspectives. [J Am Coll Cardiol. 2015]

FREEDOM

The NEW ENGLAND JOURNAL of MEDICINE

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Strategies for Multivessel Revascularization in Patients with Diabetes

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Table 2. Kaplan–Meier Estimates of Key Outcomes at 2 Years and 5 Years after Randomization.

Outcome	2 Years after Randomization		5 Years after Randomization		Patients with Event		P Value*
	PCI	CABG	PCI	CABG	PCI	CABG	
	number (percent)				*number*		
Primary composite†	121 (13.0)	108 (11.9)	200 (26.6)	146 (18.7)	205	147	0.005‡
Death from any cause	62 (6.7)	57 (6.3)	114 (16.3)	83 (10.9)	118	86	0.049
Myocardial infarction	62 (6.7)	42 (4.7)	98 (13.9)	48 (6.0)	99	48	<0.001
Stroke	14 (1.5)	24 (2.7)	20 (2.4)	37 (5.2)	22	37	0.03§
Cardiovascular death	9 (0.9)	12 (1.3)	73 (10.9)	52 (6.8)	75	55	0.12

* P values were calculated with the use of the log-rank test on the basis of all available follow-up data (i.e., more than 5 years).
† The primary composite outcome was the rate of death from any cause, myocardial infarction, or stroke.
‡ P=0.006 in the as-treated (non–intention-to-treat) analysis.
§ P=0.16 by the Wald test of the Cox regression estimate for study-group assignment in 1712 patients after adjustment for the average glucose level after the procedure.

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Recommendations on revascularizations in patients with chronic heart failure and systolic LV dysfunction (ejection fraction ≤35%)

Recommendations	Class[a]	Level[b]	Ref[c]
CABG is recommended for patients with significant LM stenosis and LM equivalent with proximal stenosis of both LAD and LCx arteries.	I	C	-
CABG is recommended for patients with significant LAD artery stenosis and multivessel disease to reduce death and hospitalization for cardiovascular causes.	I	B	112,288
LV aneurysmectomy during CABG should be considered in patients with a large LV aneurysm, if there is a risk of rupture, large thrombus formation or the aneurysm is the origin of arrhythmias.	IIa	C	
Myocardial revascularization should be considered in the presence of viable myocardium.	IIa	B	55
CABG with surgical ventricular restoration may be considered in patients with scarred LAD territory, especially if a post-operative LVESV index < 70 mL/m² can be predictably achieved.	IIb	B	291–295
PCI may be considered if anatomy is suitable, in the presence of viable myocardium, and surgery is not indicated.	IIb	C	

[a]Class of recommendation.
[b]Level of evidence.
[c]References.
CABG = coronary artery bypass grafting; LAD = left anterior descending; LCx = left circumflex; LM = left main; LVESV = left ventricular end-systolic volume; PCI = percutaneous coronary intervention; SVR = surgical ventricular reconstruction.

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Specific recommendations for revascularization in patients with diabetes

Recommendations	Class[a]	Level[b]	Ref[c]
In patients presenting with STEMI, primary PCI is recommended over fibrinolysis if it can be performed within recommended time limits.	I	A	363
In patients with NSTE-ACS, an early invasive strategy is recommended over non-invasive management.	I	A	180,338, 364–366
In stable patients with multivessel CAD and/or evidence of ischaemia, revascularization is indicated in order to reduce cardiac adverse events.	I	B	93,367
In patients with stable multivessel CAD and an acceptable surgical risk, CABG is recommended over PCI.	I	A	106, 175,349
In patients with stable multivessel CAD and SYNTAX score ≤ 22, PCI should be considered as alternative to CABG.	IIa	B	346,350
New-generation DES are recommended over BMS.	I	A	351,352
Bilateral mammary artery grafting should be considered.	IIa	B	368
In patients on metformin, renal function should be carefully monitored for 2 to 3 days after coronary angiography/PCI.	I	C	

[a]Class of recommendation.
[b]Level of evidence.
[c]References.
BMS = bare-metal stent; CABG = coronary artery bypass grafting; CAD = coronary artery disease; DES = drug-eluting stent; NSTE-ACS = non-ST-segment elevation acute coronary syndrome; PCI = percutaneous coronary intervention; STEMI = ST-segment elevation myocardial infarction.

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Specific recommendations for patients with moderate or severe CKD

Recommendations	Class[a]	Level[b]	Ref[c]
CABG should be considered over PCI in patients with multivessel CAD and symptoms/ischaemia whose surgical risk profile is acceptable and life expectancy is beyond 1 year.	IIa	B	25,382,390–392
PCI should be considered over CABG in patients with multivessel CAD and symptoms/ischaemia whose surgical risk profile is high or life expectancy is less than 1 year.	IIa	B	390,391
It should be considered to delay CABG after coronary angiography until the effect of contrast media on renal function has subsided.	IIa	B	393–395
Off-pump CABG may be considered rather than on-pump CABG.	IIb	B	396
New-generation DES are recommended over BMS.	I	B	375,376

[a]Class of recommendation.
[b]Level of evidence.
[c]References.
BMS = bare-metal stent; CABG = coronary artery bypass grafting; CAD = coronary artery disease; CKD = chronic kidney disease; DES = drug-eluting stent; PCI = percutaneous coronary intervention.

TABLA 9. Indicaciones para la cirugía de revascularización coronaria frente a la intervención coronaria percutánea en pacientes estables con lesiones adecuadas para ambas intervenciones y con un riesgo quirúrgico estimado bajo

Subgrupos de enfermedad coronaria según la anatomía	A favor de CABG	A favor de ICP	Ref.
Enfermedad de 1 o 2 vasos: DAI no proximal	IIb C	I C	
Enfermedad de 1 o 2 vasos: DAI proximal	I A	IIa B	30,31,50,51
Enfermedad de 3 vasos con lesiones simples, revascularización funcional completa con ICP, escala SYNTAX ≤ 22	I A	IIa B	4,30-37,53
Enfermedad de 3 vasos con lesiones complejas, revascularización funcional incompleta con ICP, escala SYNTAX > 22	I A	III A	4,30-37,53
Tronco común izquierdo (aislado o enfermedad de 1 vaso, *ostium*/tronco medio)	I A	IIa B	4,54
Tronco común izquierdo (aislado o enfermedad de 1 vaso, bifurcación distal)	I A	IIb B	4,54
Tronco común izquierdo + enfermedad de 2 o 3 vasos, escala SYNTAX ≤ 32	I A	IIb B	4,54
Tronco común izquierdo + enfermedad de 2 o 3 vasos, escala SYNTAX ≥ 33	I A	III B	4,54

CABG: cirugía de revascularización coronaria; DAI: arteria descendente anterior izquierda; ICP: intervención coronaria percutánea; Ref.: referencias.

ients with **SCAD** with suitable coronary anatomy for both procedures and low predicted surgical mortality

Recommendations according to extent of CAD	CABG		PCI		
	Class[a]	Level[b]	Class[a]	Level[b]	Ref[c]
One or two-vessel disease without proximal LAD stenosis.	IIb	C	I	C	
One-vessel disease with proximal LAD stenosis.	I	A	I	A	107,108,160, 161,178,179
Two-vessel disease with proximal LAD stenosis.	I	B	I	C	108,135,137
Left main disease with a SYNTAX score ≤ 22.	I	B	I	B	17,134,170
Left main disease with a SYNTAX score 23–32.	I	B	IIa	B	17
Left main disease with a SYNTAX score >32.	I	B	III	B	17
Three-vessel disease with a SYNTAX score ≤ 22.	I	A	I	B	17,157,175,176
Three-vessel disease with a SYNTAX score 23–32.	I	A	III	B	17,157,175,176
Three-vessel disease with a SYNTAX score >32.	I	A	III	B	17,157,175,176

CABG = coronary artery bypass grafting; LAD = left anterior descending coronary artery; PCI = percutaneous coronary intervention; SCAD = stable coronary artery disease.
[a]Class of recommendation.
[b]Level of evidence.
[c]References.

PREFERENCIAS DEL PACIENTE

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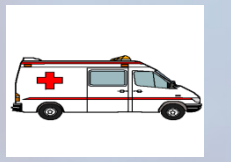
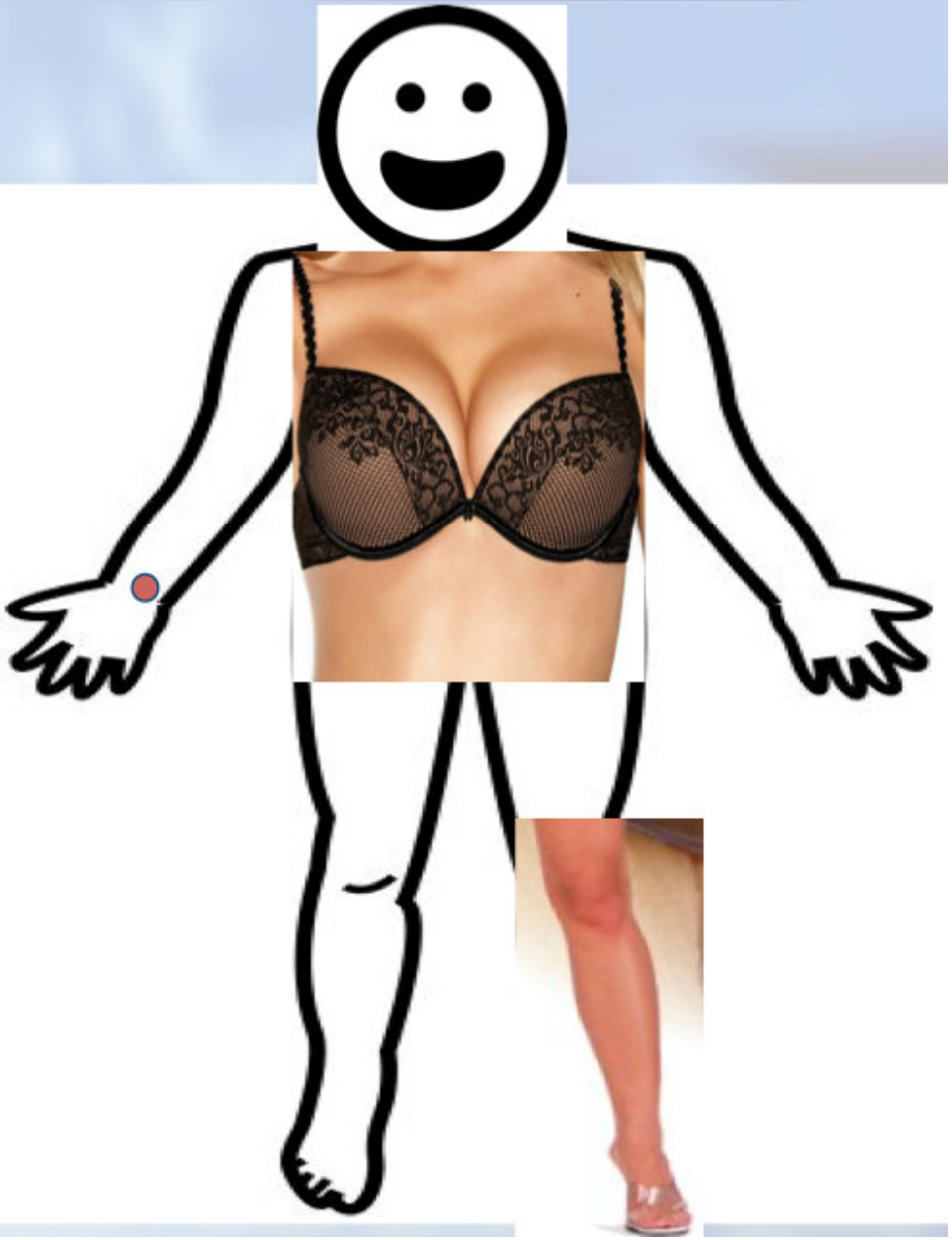



PREFERENCIAS DEL PACIENTE



RESULTADOS LOCALES

- Mortalidad hospitalaria.
- Mortalidad al año.
- Demora hasta la Intervención.
- Re-IAM al año.

¿El FUTURO?

BEST

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Trial of Everolimus-Eluting Stents or Bypass Surgery for Coronary Disease

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Table 3. Long-Term Clinical End Points after Randomization, According to Study Group.*

End Point	PCI (N=438)	CABG (N=442)	Hazard Ratio (95% CI)†	P Value‡
	number (percent)			
Primary end point: death, myocardial infarction, or target-vessel revascularization	67 (15.3)	47 (10.6)	1.47 (1.01–2.13)	0.04
Secondary end points				
Death				
Any cause	29 (6.6)	22 (5.0)	1.34 (0.77–2.34)	0.30
Cardiac cause	18 (4.1)	16 (3.6)	1.15 (0.58–2.25)	0.69
Noncardiac cause	11 (2.5)	6 (1.4)	1.87 (0.69–5.05)	0.21
Myocardial infarction				
Any	21 (4.8)	12 (2.7)	1.76 (0.87–3.58)	0.11
Fatal	4 (0.9)	0	NA	NA
Spontaneous	19 (4.3)	7 (1.6)	2.75 (1.16–6.54)	0.02
Spontaneous Q wave	4 (0.9)	2 (0.5)	2.03 (0.37–11.1)	0.40
Death or myocardial infarction	43 (9.8)	34 (7.7)	1.28 (0.82–2.01)	0.28
Stroke				
Any	11 (2.5)	13 (2.9)	0.86 (0.39–1.93)	0.72
Ischemic stroke	9 (2.1)	12 (2.7)	0.77 (0.32–1.82)	0.54
Hemorrhagic stroke	2 (0.5)	1 (0.2)	2.03 (0.18–22.4)	0.55
Death, myocardial infarction, or stroke	52 (11.9)	42 (9.5)	1.26 (0.84–1.89)	0.26
Death from cardiac cause, myocardial infarction, or stroke	42 (9.6)	37 (8.4)	1.16 (0.74–1.80)	0.52
Repeat revascularization				
Any	48 (11.0)	24 (5.4)	2.09 (1.28–3.41)	0.003
Target vessel	31 (7.1)	17 (3.8)	1·88 (1.04–3.40)	0.03
Target lesion	25 (5.7)	17 (3.8)	1.51 (0.82–2.80)	0.19
New lesion	24 (5.5)	10 (2.3)	2.47 (1.18–5.17)	0.01
Death, myocardial infarction, stroke, or any repeat revascularization	87 (19.9)	59 (13.3)	1.54 (1.11–2.14)	0.01
Death from cardiac cause, myocardial infarction, stroke, or any repeat revascularization	78 (17.8)	54 (12.2)	1.51 (1.06–2.13)	0.02
Bleeding				
TIMI major bleeding§	30 (6.8)	132 (29.9)	0.20 (0.14–0.30)	<0.001
Fatal bleeding	3 (0.7)	7 (1.6)	0.44 (0.11–1.68)	0.21

- Nuevas terapias antiagregantes.
- Nuevas terapias anticoagulantes.
- Vía radial, incluso en TCI.
- Evolución de los injertos de safena tras 5 años.
- Sobredimensión del objetivo "nueva revascularización"

SYNTAX II: En busca de mejores resultados