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Commentary: We can make better decisions regarding revascularization strategies for early coronary artery disease

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Using the Northern New England Cardiovascular Disease Study Group database, Robich and colleagues¹ retrospectively review outcomes of coronary artery bypass grafting (CABG) versus percutaneous coronary intervention (PCI) in younger patients (age <60 years). They take advantage of access to the National Death Master File and state vital statistics for the 3 participating states: Maine, New Hampshire, and Vermont. Within the limits of any retrospective review, these data are fairly compelling and the conclusion that CABG is underutilized in younger populations despite published appropriateness criteria^{2,3} is correct. In the current study, there were no risk-adjusted differences in short-term outcomes except the incidence of stroke. Patients younger than age 60 years with 2- or 3-vessel coronary artery disease were more likely to require repeat intervention if the initial treatment was PCI rather than CABG. Similarly, mortality risk was greater in this population if the initial treatment choice was PCI.

The greater lesson from these data is described by the very function of the Northern New England Cardiovascular Disease Study Group database and other quality initiatives such as the Michigan Society of Thoracic and Cardiovascular Surgeons⁴ and the Society of Thoracic Surgeons National Database. The Synergy between PCI with Taxus and Cardiac Surgery⁵ trial investigators emphasized the heart team multidisciplinary approach to patient care. There is great value in cooperative decision making that includes primary and interventional cardiologist, cardiovascular

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CENTRAL MESSAGE

A cooperative heart team approach to revascularization choices can improve the use of CABG in patients younger than age 60 years.

surgeon, and patient.⁶ Each member of the team brings a different perspective to the treatment decision. Too often decision is made to proceed to multivessel PCI at the time of diagnostic catheterization procedure without consideration of all these viewpoints. In that scenario, the patient, who should be ultimate decision maker, is denied the opportunity to participate in this important health care choice with complete informed consent.

It is undeniable that CABG is more stressful than PCI because it requires general anesthesia, multiday hospitalization, pain, and a recovery period measured in weeks to months. For younger patients, freedom from reintervention and greater long-term survival certainly warrants consideration in the initial treatment choice. CABG may not be the optimal choice for every younger patient, but approaching the decision to treat with a full armamentarium, cooperative team consideration, and a well-informed patient provides the best outcome for each individual and the health care system.

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