

Few important lessons should be taken away from this study: (1) many patients are receiving suboptimal medical therapy (at baseline), and we must do better both before and after CABG; (2) improving and maintaining drug compliance is hard work but can be done—patient education is key and pays dividends down the road; and (3) physicians and patients alike must understand that CAD and ICM are complex, multifactorial, chronic disease processes, and a band aid will not suffice. A stitch in time is part of the solution to improve survival, but it should be shined with sustained OMT.

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## Commentary: Just what the doctor ordered: The as-yet unrealized gains of optimal medical therapy for ischemic cardiomyopathy

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In their post hoc analysis of data obtained from the Surgical Treatment for Ischemic Heart Failure (STICH) trial, Farsky and colleagues<sup>1</sup> substantiate the benefit of optimal

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### CENTRAL MESSAGE

The long-term survival benefit conferred by optimal medical therapy in coronary bypass patients with ischemic cardiomyopathy emphasizes the importance of increasing medical compliance.

medical therapy (OMT) on long-term survival after surgical coronary revascularization in patients suffering from ischemic cardiomyopathy. This finding is particularly important given the surprisingly low adherence to OMT and attenuated long-term survival rates in these high-risk patients.

At face value, the authors' conclusion that OMT significantly improves long-term outcomes in these patients is intuitive, given that similar evidence-based medical regimens, including antiplatelet, beta-blocker, and lipid-lowering agents have long been shown to similarly benefit patients without heart failure undergoing coronary artery revascularization via surgical or percutaneous interventions. More importantly, the study shines a spotlight on the potentially greater overall impact of increasing adherence to OMT regimens, prompting better characterization of the multifactorial causes behind noncompliance and the development of effective remedial strategies.

Recent studies have investigated OMT noncompliance from different perspectives. Mathews and colleagues<sup>2</sup> reported that among patients hospitalized for acute myocardial infarction, commercial health insurance, prescription coverage insurance, and outpatient follow-up were associated with increased compliance, whereas increasing age, black race, and depression were negative markers of compliance. Diaz-Toro and colleagues<sup>3</sup> identified socioeconomic status as a powerful independent predictor of chronic heart failure and adverse outcomes, with inequities directly influencing the management and prognoses of these patients. Finally, Kurlansky and colleagues<sup>4</sup> astutely noted that even with the benefit of protocolized monitoring among clinical trial participants, suboptimal adherence to prescribed medical regimens (in the 43% to 78% range) has been reported among patients receiving treatment for chronic conditions (eg, heart failure).

Farsky and colleagues demonstrate a prevalence of OMT that was significantly higher than reported in other contemporary randomized and observational trials of

coronary artery bypass patients. Achieving 73.3% prevalence of OMT over the first 4 months of the trial resulted in more durable medical compliance among these chronic heart failure patients, at least for the first 5 years, translating into lower all-cause mortality over the study period irrespective of surgical treatment. This suggests that active medical optimization combined with regularly scheduled clinical assessments are effective measures in prolonging survival and improving quality of life in these patients.

Parenthetically, it is interesting to note higher baseline percentages of patients in the New York Heart Association (NYHA) heart failure class I/class II and CCS class I categories among OMT patients compared with non-OMT patients. Although this might be attributed to random chance, it might be postulated that NYHA class I and class II patients in the OMT group were less physically limited by heart failure symptoms and thus able to exert themselves more to the point of experiencing mild exertional angina.

Farsky and colleagues' findings set the stage for further investigation of the intermediate- and long-term consequences of OMT on patients suffering from ischemic cardiomyopathy. Additional questions could include characterizing the relative impact of the different components of OMT on outcomes and more robust definition of the impact of OMT on long-term survival within each of the NYHA and CCS functional categories.

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