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Letters

TO THE EDITOR

The Kaltenbach Bonzel Bare Wire

Not the Full Story

I read with interest the letter in the Research Correspondence from Martin Kaltenbach, entitled "40 Years of Percutaneous Coronary Intervention: A Historical Remark on the Development and Evolution of Guidewire Technology" (1). The late 70s and early 80s were an exciting time in interventional cardiology. Prof. Kaltenbach was not only an innovator, but his support and contribution to angioplasty needs to be emphasized. Not everyone was as supportive of this young East German immigrant usurping the surgical approach to coronary artery disease. Kaltenbach invited and welcomed Andreas Gruentzig to perform procedures at his hospital and supported Andreas at a time where not everyone was his friend. At the 40th anniversary of percutaneous coronary intervention, both Kaltenbach, Tassaio Bonzel, and others were part of that early team that need more recognition for their outstanding and selfless support of technology and treatment that many of us take for granted (2).

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Please note: Dr. Heuser has reported that he has no relationships relevant to the contents of this paper to disclose.

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RESEARCH CORRESPONDENCE

Costs of Transcatheter Aortic Valve Replacement

Implications of Proposed Medicare Cuts

Severe aortic stenosis (AS) is a progressive life threatening "surgical" illness. Previous studies have shown a substantial improvement in quality of life as well as survival after valve replacement in patients with severe AS (1). Transcatheter aortic valve replacement (TAVR) is recommended for the treatment of severe AS in patients who are at prohibitive or high risk for valve replacement surgery (1). Due to recent advancement of TAVR technology and indications (e.g., including intermediate risk patients), a rise in number of TAVR procedures is expected for the treatment of severe AS. However, the economic burden of TAVR procedures in severe AS, a disease of aging, has not been described. We explored the expenditure of TAVR hospitalizations by different primary payers, and performed cost comparison with surgical aortic valve replacement (SAVR) hospitalizations. Furthermore, due to proposed Medicare cuts in the forthcoming health care bill, we examined the contribution of Medicare as a primary payer in TAVR hospitalizations.

We retrospectively studied the National Inpatient Sample (NIS) from 2012 to 2014. The details of using NIS database have been described previously (2). International Classification of Diseases-9th Revision-Clinical Modification procedural codes 35.05 and 35.06, 35.20, and 35.21 were used to identify TAVR and SAVR hospitalizations, respectively (2). Hospitalizations for aortic valve replacement with age <18 years were excluded. We also excluded hospitalizations, which had TAVR and SAVR during the same admission. The NIS variables were used to identify primary payers (e.g., Medicare, Medicaid, private insurance, and others). Cost of hospitalization was calculated by multiplying total hospital charge with cost-to-charge ratio provided by Healthcare Cost and Utilization Project-NIS (3). The total annual expenditure associated with TAVR hospitalizations was calculated by multiplying number of hospitalizations with cost of hospitalization for the calendar year, and data were stratified by primary payer (3). Average cost