

EDITOR'S PAGE

Is the Pen Mightier Than the Stent?

As I become increasingly depressed about the prospects of meaningful health care reform, I wonder in the early morning sleeplessness what we interventional cardiologists can do. The inertia created by the self-interested components of healthcare delivery may result in squandering an opportunity to fix a severely flawed system. It seems the insurance and pharmaceutical industries have been given a by in the process, while the physicians and hospitals remain clearly in the crosshairs of the cost-savings initiative. I can claim no expertise on the *business* of medical practice, which struggles to remain a profession but is now becoming no less a business than the payers (nonpayers) or the sacred cows (non-negotiable drug prices). Whether we see a bill passed or not, the draconian cuts in reimbursement for imaging and interventions are moving forward. How do we align the business of interventional practice with the profession we love?

First, what do we do well? We are the champions of acute coronary syndromes, especially the treatment of ST-segment elevation myocardial infarction. There is little discussion about our ability to interdict emergency coronary situations and save lives. We will continue to be effective in defending these endeavors. In addition, fantastic tools for treating structural heart disease with less invasive and potentially less expensive therapies are being employed. Treatment of peripheral obstructive disease causing disability is an area where we excel. Where are we vulnerable? Stable ischemic heart disease is under intensive review for the most appropriate therapies. "Stable" sounds benign but we know that all patients dropping dead from acute myocardial infarction had stable ischemic heart disease at some point before the event. How to prevent the disaster from an interventional perspective leads to thoughts of imaging advances and pre-emptive interventional strikes with invasive local therapy. The problem is that we have not yet been able to demonstrate our ability to reliably predict either the site or the time of the disaster. When there is ischemia we can improve symptoms, cardiac function, and in some situations, survival. As the FAME (Fractional Flow Reserve Versus Angiography for Multivessel Evaluation) trial showed, when the lesions are angiographically significant but not hemodynamically obstructive, an intervention is not effective. Nonetheless these patients will in many cases develop cardiac disasters. How do we prevent those? The evidence points more clearly to the "Pen" than the "Promus." Prescribed and complied with medical therapy has strong evidence for prevention of cardiac events.

We, the interventional cardiologists, have spent our careers studying and observing the ravages of atherothrombosis. We know about effective therapies, understanding that many patients benefit from blood pressure control, antiplatelet therapy, and low-density lipoprotein reduction. We are increasingly convinced of the pleathrophic effects of statins. We also know that many metabolic defects may make the patient vulnerable to cardiac events. The raising of high-density lipoprotein in metabolic syndrome patients and control of other lipid abnormalities is gaining credibility. Glitazones in diabetic patients may stabilize atherosclerotic lesions, as may angiotensin-converting enzyme inhibitors and angiotensin-receptor blockers. Most interesting is the growing knowledge about genetic variations among patients with atherothrombosis including vulnerability to acute events and susceptibility to benefit from statin and thienopyridine therapy. In the near future the effectiveness of a personalized attack on preventing progression of atherothrombosis and cardiac events will become more evident.

Who will be the leaders in applying this knowledge for the most effective and most cost-effective approaches? I suggest that it is the interventional cardiologists who should lead. There



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should not be a conflict with primary care physicians or our noninvasive colleagues, but “atherothrombosis is our life” and we should not abandon the chronic care or early detection of this condition.

If the cath lab and imaging businesses suffer, the waiting room may flourish. The patients we stent need our expert medical care. Their families with similar genetic make-up and lifestyle habits need to be identified and their disease interrupted if it is present, and when individuals are identified at low risk, then expert advice to avoid unnecessary medical expense should be given.

The future of interventional cardiology will take many forms. Some operators will apply highly-specialized techniques for treating structural defects. We may see a day when regenerative medicine will necessitate interventional methods for rebuilding failing hearts. But in the near term, we are the experts in atherothrombosis. If we want to align our profession with our business, why not take advantage of the tide of opinion? There should be increased emphasis on prevention and medical therapy applied by those with the ability to intervene, if required, but focused on avoiding the need for further interventions.

Talk radio commentators decry health care reform with any government involvement as communism in disguise.

Physicians are bombarded with propaganda from the insurance industry and others that a public option for insurance is going to reduce their income. As I remember, the 1965 fight against Medicare the arguments were similar, but if Medicare legislation had not passed, we would all be living in smaller houses. Universal coverage and affordable drug pricing are not radical ideas. Hopefully some meaningful legislation will be enacted that will improve the fight against our main nemesis, atherothrombosis. However, whatever system evolves, our profession demands that care for our patients should be our central concern. Available evidence points to our interventional procedures as important solutions for many conditions. The evidence also suggests that whatever system evolves we should apply our “pen” as well as our stents.

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