



## ESC 2014: New Myocardial Revascularisation Guidelines



One of the most important treatment principles in cardiology includes myocardial revascularisation by percutaneous coronary intervention (PCI) or surgical placement of coronary artery bypass grafts (CABG). However, in order to use these principles effectively, it is important to identify patients who require revascularisation as well as accurately select the method that should be used to achieve restored blood flow. This is important to be able to maximise benefits and to avoid procedures that may cause more harm than good.

That is precisely why this area is undergoing tremendous research and development efforts. New data are collected continuously and published as and when diagnostic and therapeutic methods are refined. It has now become evident that lesion-specific ischaemia must be considered when selecting a revascularisation target and surgical procedures can be performed at lower risk. Also, newer stent generations have demonstrated improved outcomes as compared to the ones that were used before.

In order to continue improving the outcomes of myocardial revascularisation, the ESC and the European Association for Cardio-Thoracic Surgery (EACTS) have jointly developed and published new Guidelines on Myocardial Revascularisation. These guidelines have been developed under the leadership of Stephan Windecker and Phillippe Kolh. It is believed that these guidelines will have significant influence on care throughout Europe and beyond.

The new 2014 guidelines have built upon the version published in 2010. They cover the selection of patients requiring revascularisation as well as the methods recommended in patients with stable CAD and acute coronary syndromes. They also provide information about revascularisation strategies in specific patient subgroups as well as procedural aspects of CABG, PCI and adjunctive medical therapy.

With respect to the selection of patients who require revascularisation in stable CAD, emphasis is placed on the documentation of ischaemia. FFR measurement holds a Class I recommendation if non-invasive proof of ischaemia is not available. For prognostic reasons, revascularisation of left main stenoses, proximal LAD stenoses, stenoses in two or triple-vessel disease with impaired LV function is recommended. However, this applies if there is lesion-specific evidence for ischaemia by FFR or non-invasive testing for lesions that show 90 percent diameter stenosis. The guidelines also recommend revascularisation for any other stenosis causing ischaemia of 10 percent or more of the left ventricle. In addition, revascularisation is also recommended for all stenoses which cause ischaemia and symptoms that cannot be relieved by medical therapy.

Substantial changes have been made from the previous guidelines primarily because of the longer-term outcome data generated by the SYNTAX trial and because more evidence is now available for new generation

drug-eluting stents. PCI is now regarded as equivalent to CABG in several lesion subsets which were previously treated by surgery.

The new guidelines comprehensively cover adjunctive pharmacotherapy and medical treatment after revascularisation. They also cover other specific clinical situations in great detail and offer help for decisions with respect to providing optimum care to patients being considered for revascularisation. There is no doubt that the 2014 joint ESC/EACTS guidelines will be welcomed by the medical community and will be heavily used by cardiologists and cardiovascular surgeons across the globe.

Source: European Society of Cardiology

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Published on : Tue, 2 Sep 2014